MSV℠ MEDICAL SOCIETY OF VIRGINIA

2024 ANNUAL MEETING
Delegates Handbook

MSV℠ MEDICAL SOCIETY OF VIRGINIA

2024 Annual Meeting Delegates Handbook
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D. AMA Virginia Delegation Report
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F. Virginia Board of Medicine Annual Report
G. Physician Assistant Section Report

MSV℠ MEDICAL SOCIETY OF VIRGINIA

MEMORANDUM

Date: **July 29, 2024**

Memo to: Presidents, Secretaries and Executive Directors of Component and Specialty Societies
Academic Medical Schools
Health Systems

From: Michele A Nedelka, MD, Speaker
Atul Marathe, MD, Vice Speaker

Subject: Call for Resolutions
2024 Annual Meeting of the Medical Society of Virginia House of Delegates

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Resolutions should be submitted online by September 4th, 2024, 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 September 4th, 2024 will be subject to consideration under the Rules of Procedure.
- If your society has a scheduled meeting that occurs after September 4th, 2024, 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 20th, 2024. 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 18, 2024 @ 10:00AM

House of Delegates-First Session

Call to Order
The Speakers

Pledge of Allegiance
Elizabeth Ransone

Invocation
Dr. Kurt Elward

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
Alice Coombs, MD

Guest Speaker
Dr. Kathy Shelton, VDH Commissioner

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
Dr. John Paul Verderese

Rules Committee Report
Dr. Samuel Caughron

Request for approval of the 2023 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 2023 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 20, 2024

Call to Order
The Speakers

Speakers Remarks
The Speakers

Commending and Memorial resolutions
The Speakers

MSV Chief Executive Officer & EVP Remarks
Melina Davis

Credentials Committee Report
Dr. John Paul Verderese

Nominating Committee Report
Cynthia Romero, MD

Election of Officers and Directors
The Speakers

Election of President-Elect
The Speakers

Installation of MSV Board of Directors Officers
Dr. Cynthia Romero

Incoming President's Remarks
Joel Bundy, MD

Election of the 2024-2025 Nominating Committee
The Speakers

Reference Committee Reports
Reference Committee 1: Dr. Richard Szucs
Reference Committee 2: Dr. Bobbie Sperry

Announcements
The Speakers

Adjournment
The Speakers

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2024

Delegate References

1. New Delegate Orientation Presentation
2. Parliamentary Procedure Motion Guide
3. Proposed Rules of Procedure
4. MSV Bylaws

New Delegate Orientation

2024 MSV Annual Meeting

MSV House of Delegates

- Policymaking body of the Society
- Comprised of member ‘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
- Reports

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 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

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’

House Process Overview

- Member resolutions will be brought before the House and their resolved clauses will be modified as needed until they are accepted or rejected by the House.
- The Speakers will lead the house through organized discussion and debate. This process involves various 'motions'.

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 18th

Sample Resolution

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.

Motions

- The resolved clause of a resolution is considered the 'main motion' for consideration
- Main motions can be amended
  - There are other main motions, but the ones most commonly used in the House are: motions to modify or amend a motion that has been adopted and motions to reconsider a motion after a vote has been taken.
- Amendments can be amended one at a time

Motions Continued

- 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).

Subsidiary Motions

- "Higher Order" than a motion
- In descending order:
  - Adjourn, recess, question of privilege, table, vote, limit debate, postpone debate, refer, amend.
- Example: A member seeks to amend the language of the resolution to reflect new language:
  - RESOLVED, the Medical Society of Virginia ~~encourage~~ require its members and others to pay dues online and via credit card at www.msv.org.
    - The House will debate the merits of the amendment and choose to adopt or reject the motion.
    - At this point members can only discuss the amendment and any discussion of the entire resolution will be considered 'out of order'. This does not prohibit further discussion afterward.
  - After much debate, this amendment is accepted and the resolution is further discussed as a main 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

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

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

HOD Actions

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

Questions?

MSV℠ MEDICAL SOCIETY OF VIRGINIA

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

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

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

MM = Main Motion

[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

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, Oct. 2023.

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I. FORWARD

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

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

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

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

II. INTRODUCTION AND CONDUCT OF BUSINESS

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

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

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

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

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

III. GUIDELINES FOR RESOLUTIONS

A. THE **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 15, 2023

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 October 15, 2023

First District:
Mid-Tidewater Medical Society

Second District:
Tri-County Medical Society; Coastal Virginia 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 MedicalSchool Student Section; Liberty University College of Osteopathic Medicine Student Section

Seventh District:
Albemarle 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 2024

Minutes and Actions of the 2023 House of Delegates

1. Medical Society of Virginia 2023 House of Delegates Minutes
2. Final Actions of the 2023 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 10:05 am.

Pledge of Allegiance
The Pledge of Allegiance was led by Lavinia Wainwright, a fourth-year medical student at EVMS.

Invocation
The invocation was provided by MSV former President, Dr. Kurtis Elward of Charlottesville.

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

- Dr. James York, President of MedChi
- Dr. Michael Kuduk, President of the Kentucky Medical Association
- Dr. Susan Bathgate, President of the District of Columbia Medical Society
- John Littel, Virginia Secretary of Health and Human Resources
- Dr. Eric Deaton, Chair of the Virginia Hospital and Healthcare Association
- Sean Connaughton, President and CEO of the Virginia Hospital and Health Care Association
- Gene Ransom, CEO of MedChi

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). Two distinguished members were recognized for being members of the society for more than 50 years.

Presidential Address
Dr. Harry Gewanter, President, shared remarks regarding his year as president.

Secretary of Health and Human Resources Update
Secretary John Littel, Secretary of Health and Human Resources for Virginia addressed the House and disclosed his appreciation for the collaboration between the Medical Society and the State on various issues, particularly in addressing physician burnout, mental distress, and violence against healthcare workers. Transforming our behavioral health system remains a priority for the administration, as the need for timely care. The State is expanding crisis infrastructure, mobile crisis units, and leveraging tele behavioral health to address these needs. Additionally, the administration is focusing on improving maternal health outcomes and addressing workforce shortages through initiatives like universal licensing. Secretary Littel emphasized MSV’s involvement and advice are crucial in these efforts and encouraged continued engagement with legislators to ensure informed decision-making.

Virginia Delegation to the American Medical Association Update
Dr. Thomas Eppes, Chair of the Virginia Delegation to the American Medical Association provided the House with a report of the delegation’s work and success throughout 2023 in advancing the priorities of Virginia physicians on the national stage.

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Clarence A. Holland, MD Award
Dr. Atul Marathe, Woodbridge, 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. John O'Bannon. This award is for MSV member physicians with high personal integrity who have demonstrated outstanding leadership in their fields.

Credential Committee Report
Dr. Soheila Rostami, 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. Art Vayer, Rules Committee Chair, recommended adoption of the proposed Rules of Procedure provided. The Rules of Procedure were adopted by unanimous vote. The following late resolutions submitted were accepted by a two-thirds majority vote for discussion and presentation in a reference committee and will be before the House for vote at the second session of the House of Delegates.

- Employed Physicians Section within the Medical Society of Virginia: Submitted by Dr. Clifford Deal; Co-Authorship by Dr. Sterling Ransone, Dr. Claudette Dalton, Dr. Lee Ouyang, Dr. Michelle Nedelka, Dr. Bhushan Pandya, and Dr. Carolyn Burns.
- Covid Vaccine Fall 2023:Submitted by Dr. Thomas Eppes

Approval of the 2022 MSV House of Delegates Minutes
Dr. Larry Mitchell, Secretary-Treasurer, asked for comments on minutes from the 2022 meetings of the House of Delegates. Hearing none, the minutes were approved without objection.

2023 Resolutions
The resolutions introduced to the House plus two late resolutions were accepted for business and assigned to Reference Committees.

Consent Calendar: Informational Reports
The following informational reports were presented as consent calendar items and filed.

- 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

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 11:10 am.

Second Session

Call to Order
Dr. Alan Wynn, Speaker, reconvened the House of Delegates at 8:04 am.

Commending and Memorial resolutions
The first commending resolution, sponsored by the MSV Board of Directors, honors the service and philanthropy of the Koch family, Dr. Ed Koch and Kathy Koch. The next resolution, sponsored by the MSV Board of Directors, commemorates the service and leadership of our Speaker, Dr. Allan Wynn. And the next

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resolution, also sponsored by the MSV Board of Directors, honors the memory of the late Dr. John Owen. The final resolution, sponsored by the MSV Board of Directors, honors the late Dr. John Butterworth.

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

Credential Committee Report
Dr. Soheila Rostami, 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 a Director for District 8 of the MSV Board of Directors the nominations were closed.

Election of the MSV Board of Directors and AMA Delegation
After the extraction of the vote for President Elect and Speaker of the House, a motion was made to accept the nominations presented and the following were elected by unanimous vote.

OFFICERS (Elected for 1-year term)

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	José Morey, MD
Academic	Arturo Saavedra, MD (VCU)

DIRECTORS (Elected for 1-year term)

District 8	Marc Alembik, MD
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)

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DELEGATES to the AMA (Elected for 2-year calendar term)
Alice Coombs, MD
Claudette Dalton, MD
Cliff Deal, III, MD
Bhushan Pandya, MD
Cynthia Romero, MD
Sterling Ransone, MD

ALTERNATE DELEGATES to the AMA (Elected for 2-year calendar term)
Sandy Chung, MD
Mark Townsend, MD
Jan Willcox, DO

Speaker of the House Election
Without objection, Dr. Michele Nedelka was elected as Speaker of the House.

President Elect Election
Without objection, Dr. Joel Bundy was elected as President Elect of the MSV.

Installation of MSV Board Officers
Dr. Art Saavedra, MSV Board Director for District 7, conducted the installation of officers.

Incoming President's Remarks
Dr. Alice Coombs, Incoming President, addressed the House.

Election of the 2023-2024 Nominating Committee
The 2023-2024 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	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

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. Josh Lesko presented the consent calendar report of Reference Committee 1. Additional discussion occurred on the following extracted resolutions.

- 23-106: Hospital OR Time Set Aside
- 23-107: Skilled Nursing Facility (SNF) Medical Director Listing

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- 23-109: Post-Acute and Long-Term Care (PALTC) Physician Workforce Shortage
- 23-113: Prescription and Administration of mRNA Vaccines

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

- 23-202: SafeHaven for Medical and Physician Assistant Students
- 23-204: GME Parity for Osteopathic Medical Students
- 23-206: COPN Approval of Certified Surgical Suites located in Independent Physicians' Offices
- 23-207: Opposition to Criminalization of Transgender Health Providers and Others
- 23-208: Protection of Minors from Sex Change Treatments, Therapies, and Procedures
- 23-209: Sudden Unexpected Death in Epilepsy: Investigation, Understanding, and Awareness

Adjournment

The 2023 Annual Meeting of the House of Delegates of the Medical Society of Virginia adjourned at 11:50 am.

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FINAL ACTIONS OF THE 2023 MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

SUMMARY OF ACTION

ADOPTED

- 23-101: MSV Proposed 2024 Budget
- 23-105: Insurance Coverage of Fertility Care
- 23-114: Employed Physicians Section within the Medical Society of Virginia
- 23-203: Advancing Health Equity Through Implicit Bias and Health Literacy Education Within Virginia's Academic Medical Centers

ADOPTED AS AMENDED OR SUBSTITUTED

- 23-102: 2023 MSV Policy Compendium 10-Year Review
- 23-112: Increased Oversight of Medicare Advantage Plans
- 23-106: Hospital OR Time Set Aside
- 23-107: Skilled Nursing Facility (SNF) Medical Director Listing
- 23-115: COVID Vaccine Fall 2023
- 23-201: Protecting Physicians from Health Plan Credit Card Fees
- 23-202: SafeHaven for Medical and Physician Assistant Students
- 23-204: GME Parity for Osteopathic Medical Students
- 23-205: Addressing Unique Health Needs of Youth in Foster Care
- 23-207: Opposition to Criminalization of Transgender Health Providers and Others
- 23-209: Sudden Unexpected Death in Epilepsy: Investigation, Understanding, and Awareness

REFERRED TO THE BOARD OF DIRECTORS FOR REPORT

- 23-210: Increasing the Number of Collection Sites for Donated Drugs

NOT ADOPTED

- 23-103: Requirement for Doctors to Practice in Low-Income Communities
- 23-104: Medicine is a Utility Economic Structure
- 23-108: CRNA Scope of Practice
- 23-109: Post-Acute and Long-Term Care (PALTC) Physician Workforce Shortage
- 23-110: Support Single Payer Healthcare
- 23-111: Direct the MSV AMA Delegation to Expand the AMA's Position on Healthcare Reform Options
- 23-113: Prescription and Administration of mRNA Vaccines
- 23-206: COPN Approval of Certified Surgical Suites located in Independent Physicians' Offices
- 23-208: Protection of Minors from Sex Change Treatments, Therapies, and Procedures

RECOMMENDED FOR AMENDMENT OF MSV POLICY IN LIEU OF

- MSV Policy 40.8.03 Protecting Human Health in a Changing Climate
    - *In lieu of:* 23-211: Curbing Green House Gas Emissions

POLICIES REAFFIRMED

- MSV Policy 10.3.02- Single Payer System
- MSV Policy 30.4.04 - MSV COPN Policy
- MSV Policy 40.1.04 - Medically Underserved Areas

- MSV Policy 40.1.08 - Improve Physician Placement
- MSV Policy 45.1.07 - Scope of Practice Position Statement

23-101: Medical Society of Virginia 2024 Proposed Budget *(ADOPTED)*

RESOLVED, that the Medical Society of Virginia approve, as presented, the proposed budget for 2024.

23-102: 2023 MSV Policy Compendium 10 Year Review *(ADOPTED AS AMENDED)*

RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report as well as amend Policy 40.6.01 to read:

40.6.01 Anabolic Steroids

The Medical Society of Virginia believes that the 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 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.*~~

23-103: Requirement for Doctors to Practice in Low Income Communities (NOT ADOPTED)

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.

23-104: The Practice of Medicine is a Utility Economic Structure (NOT ADOPTED)

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.

23-105: Insurance Coverage of Fertility Care (ADOPTED)

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.

23-106: Hospital OR Time Set Aside (ADOPTED AS AMENDED)

~~*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.*~~

RESOLVED that the Medical Society of Virginia endorses the need for equitable access to OR time for physicians who have admission privileges regardless of employment status and encourages local societies advocacy efforts to assure this.

23-107: Skilled Nursing Facility (SNF) Medical Director Listing (ADOPTED AS AMENDED)

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 to appropriate stakeholders a list of all current medical directors whose contact information must be on record with the Virginia Department of Health.

23-108: CRNA Scope of Practice (NOT ADOPTED)

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.

23-109: Post-Acute and Long-Term Care (PALTC) Physician Workforce Shortage (NOT ADOPTED)

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.

23-110: Support Single Payer Healthcare (NOT ADOPTED)

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.

23-111: Resolution to Direct the MSV AMA Delegation to Expand the AMA's Position on Healthcare Reform Options (NOT ADOPTED)

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.

23-112: Oversight of Medicare Advantage Plans (ADOPTED AS AMENDED)

RESOLVED, the MSV ~~will oppose~~ supports ~~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 by relevant authorities 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 potential 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 individuals with disabilities ~~people of disability~~ from misleading marketing tactics.

23-113: Prescription and Administration of mRNA Vaccines (NOT ADOPTED)

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.

23-114: Employed Physicians Section within the Medical Society of Virginia (ADOPTED)

RESOLVED, that the Medical Society of Virginia Board of Directors study the feasibility of establishing an employed physicians section.

23-115: COVID Vaccine Fall 2023 (ADOPTED AS AMENDED)

RESOLVED, the Medical Society of Virginia directs the Virginia delegation to the AMA to submit a resolution to call upon the FDA to ~~demand~~ to assure that as part of their required reporting, the COVID vaccine manufacturers provide post-marketing efficacy and safety studies including ~~to include but not be limited to~~: 1) duration of immunity ~~Length of time it boosts immunity if at all, affecting the timing of when to give the vaccine~~ 2) safety in specific populations ~~especially in males 18-40 as to cardiac effects~~ 3) benefits of new vaccines in previously vaccinated individuals ~~Whether it is needed in those with prior vaccination whether with 2,3,4,5 times vaccination, a history of Covid infection, or both infection and vaccination~~ 4) ~~Whether it makes a significant difference in death, hospitalizations, non-hospital morbidity, and "long Covid." the~~ the impact on health care utilization including death and hospitalization.

23-201: Protecting Physicians from Health Plan Credit Care Fees (ADOPTED AS SUBSTITUTED)

~~*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.*~~

RESOLVED, The MSV affirms AMA Policy H-190.955 Virtual Credit Card Payments, and be it further;

RESOLVED, the MSV supports that physicians and practices must specifically opt-in in writing to being paid by via virtual credit cards.

23-202: SafeHaven for Medical and Physician Assistant Students (ADOPTED AS AMENDED)

RESOLVED, the Medical Society of Virginia supports the adoption of ~~SafeHaven~~ a statewide physician association-run program to address issues related to career fatigue and wellness in healthcare professionals 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.

23-203: Advancing Health Equity Through Implicit Bias and Health Literacy Education Within Virginia's Academic Medical Centers (ADOPTED)

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."

23-204: GME Parity for Osteopathic Medical Students (ADOPTED AS SUBSTITUTED)

RESOLVED, that the Medical Society of Virginia supports AMA Policy H-275. 953.

RESOLVED, the Medical Society of Virginia, in conjunction, with the American Medical Association, conduct national outreach to residency programs regarding the parity of the COMLEX and USMLE exams and not require students to take both to gain admission into residency programs.

23-205: Addressing Unique Health Needs f Youth in Foster Care (ADOPTED AS SUBSTITUTED)

RESOLVED, that the Medical Society of Virginia affirms AMA Policy H-60.910 Addressing Healthcare Needs of Children in Foster Care.

23-206: COPN Approval of Certified Surgical Suites located in Independent Physicians' Offices (NOT ADOPTED)

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.

23-207: Opposition to Criminalization of Transgender Health Providers and Others (ADOPTED AS AMENDED)

RESOLVED, ~~that the MSV adds a new compendium policy stating:~~ The Medical Society of Virginia ~~will~~ opposes ~~discriminatory~~ all 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.~~ that criminalizes obtaining or providing healthcare to patients, consistent with the standard of care, including transgender and gender diverse patients.

23-208: Protection of Minors from Sex Change Treatments, Therapies, and Procedures (NOT ADOPTED)

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.

23-209: Sudden Unexpected Death in Epilepsy: Investigation, Understanding, and Awareness (ADOPTED AS AMENDED)

RESOLVED, that the MSV supports legislative efforts advancing the investigation, understanding, and awareness of Sudden Unexpected Death from Epilepsy (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.

23-210: Increasing the Number of Collection Sites for Donated Drugs (REFERRED TO BOARD FOR REPORT)

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

23-211: Curbing Greenhouse Gas Emissions (AMENDED POLICY 40.8.03 IN LIEU OF)

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.

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.

The Medical Society of Virginia provide information on the MSV website about governmental and nongovernmental resources on climate change available for members to work within the Commonwealth.

The Medical Society of Virginia encourages hospitals and health systems to take steps to reduce emissions related to healthcare.

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2024

Nominating Committee Report

1. 2024 Nominating Committee Report

2024 MSV ANNUAL MEETING & HOUSE OF DELEGATES

Nominating Committee Report

The Nominating Committee considered 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 2024-2025/2026

OFFICERS (Elected for 1-year term)

President-Elect	Mark Townsend, MD
Speaker	Michele Nedelka, MD
Vice Speaker	Atul Marathe, MD

OFFICER (Elected for 3-year term)

Secretary-Treasurer	Art Saavedra, MD

DIRECTORS (Elected for 2-year term)

District 2	Lee Ouyang, MD
District 2	Sharon Sheffield, MD
District 6	Mark Kleiner, MD
District 8	Marc Alembik, MD
District 10	William Hutchens, MD
District 10	William Prominski, MD

DIRECTORS (Elected for 1-year term)

District 7	John Mason, MD
MSV Foundation	José Morey, MD
Resident	Matthew Adsit, MD (VCU Orthopedics)
Medical Student	Elizabeth Ransone (VCU)

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 2	John Sweeney, MD
District 6	Joe Hutchison, MD
District 8	Zerline Chambers-Kersey, MD
District 10	Kevin Donohue, DO

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 7	Mohit Nanda, MD
Resident	Terry Henry, MD (VCU-Ophthalmology)
Medical Student	Shawn Dziepak (VCOM)

2025-2026 VIRGINIA DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

Elected for a 2-year calendar year term

DELEGATES	ALTERNATE DELEGATES
Thomas Eppes, Jr., MD	Joshua Lesko, MD
Michele Nedelka, MD	Mohit Nanda, MD
Lee Ouyang, MD	Josephine Nguyen, MD

2024-2025 NOMINATING COMMITTEE

Elected for a 1-year term

District 1	Sterling Ransone, MD
District 2	Randolph Gould, MD
District 3	Clifford Deal, MD
District 5	Bhushan Pandya, MD
District 6	Cynda Johnson, MD
District 7	Claudette Dalton, MD
District 8	Carol Shapiro, MD
District 9	Abraham Hardee, DO
District 10	Andrea Giacometti, MD (ACMS)
Academic	Cynthia Romero, MD (EVMS) (Chair)
AMA Advisor	Tom Eppes, MD
2022-2023 Former President Advisor	Harry Gewanter, MD
2023-2024 Former President Advisor	Alice Coombs, MD

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2024

Reference Committee One Index

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

24-101

Medical Society of Virginia Proposed 2025 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.

24-102

MSV 2024 Policy Compendium Ten Year Review
Submitted by:
Dr. Michele Nedelka, Speaker and
Dr. Atul Marathe, 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

05.3.01- Physician Members
Date: 11/5/1994
The Medical Society of Virginia believes that physicians should serve on hospital governing boards and
action committees.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

05.4.02- MSV Opinion on Treatment of Family Members
Date: 11/5/1994
The Medical Society of Virginia believes that as a general rule, a physician should not treat themselves or
members of their immediate family.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

05.4.04- Organ Harvesting Without Consent
Date: 08/14/2014
The Medical Society of Virginia opposes unethical organ harvesting practices and fully supports prosecution of those found to have committed such offenses or assisted in procurement and transportation of human tissues or organs that were obtained without consent.

05.5.02- Non-Peaceful Protests
Date: 11/5/1994
The Medical Society of Virginia abhors the use of non-peaceful protests against physicians.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

05.6.01- Use of "Physician"
Date: 11/5/1994
The Medical Society of Virginia supports the concept that the word physician be restricted for use by one
who is a graduate of a school of medicine or osteopathy.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.1.02- Information on Health Care Plans to Patients
Date: 11/5/1994
The Medical Society of Virginia supports increased patient access to information in selecting health care
plans.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.1.03- Transfer of Medical Care
Date: 11/5/1994
The Medical Society of Virginia opposes the detrimental effect on covered patients of insurance policies
that provide in-patient hospital coverage only if rendered in specified hospitals and require as condition of
such coverage that the insured be required to transfer his medical care from his primary physician to a
hospital staff physician.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.03- Catastrophic Care
Date: 11/5/1994
The Medical Society of Virginia endorses the concept of health care plans containing catastrophic
coverage.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

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.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

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.
Reaffirmed 11/07/2004
Reaffirmed 10/26/2014

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.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

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.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

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.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.10- Same Rules for Competitors

Date: 11/5/1994
The Medical Society of Virginia believes that all providers should be subject to the same rules as their
competitors in order to further the development of competition in the health care industry.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.3.11- Tax Fairness

Date: 11/5/1994
The Medical Society of Virginia actively supports the concept that the purchase of health plan coverage
whether by employer, group cooperative, or individual be treated with equal federal and state tax consequences.
The Medical Society of Virginia supports legislation in the Virginia legislature which results in equal
Virginia tax fairness.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

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.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.4.02- Closed Panel HMOs

Date: 11/5/1994
The Medical Society of Virginia opposes the use of tax exempt funds for the establishment of any closed
panel HMO and petitions the General Assembly for legislative relief from such unfair competitive
practices.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.5.03- Principles of Managed Care

Date: 11/5/1994
Introduction
In an ideal world the needs of patients might best be served by free market competition and free choice

by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing. Unfortunately, in the real world unfettered capitalism may not adequately protect the health care needs of Virginia's citizens, both sick and healthy, individual and corporate.

As this state's health care market place becomes increasingly dominated by health plans that utilize various managed care techniques that include decisions regarding coverage and the appropriateness of health care, it is a vital state governmental function to protect patients from unfair managed care practices.

Increasingly, it appears that insurance companies and other managed care organizations are aggressively discontinuing physicians from their networks, making inappropriate decisions to refuse, limit, or terminate health care services, and restricting patient's ability to make choices concerning their health care decisions and providers. It is essential to assure fairness in managed plans and to provide mechanisms for delineating necessary protections for both physicians and patients.

Therefore, The Medical Society of Virginia feels strongly that Virginia should adopt legislation which would require that managed care plans assure fairness to patients and providers. This would include state standards for certification of qualified managed care plans and utilization review programs as well as standards to ensure patient protection, physician and provider fairness, utilization review safeguards and coverage options for all patients, including the ability to enroll in a point of service plan. There should be a certification process with periodic reviews and recertification requirements.

Requirements for meeting the standards of certification should include the criteria articulated throughout the rest of this document.

Definitions

"Managed" care is defined as: systems or techniques generally used by third party payers or their agents to control access and payment for health care services.

Managed care techniques include: (a) Prior, concurrent, and retrospective review of the medical necessity

and appropriateness of services and/or site of services. (b) Financial incentives or disincentives related to
the use of specific providers, services, or service sites. (b2) Limitations on the numbers and types of
providers included in the plan and mechanisms to initially exclude or, later, to deselect providers from
plans, (c) Controlled access to and coordination of services by a gatekeeper (d) Payer efforts to identify
treatment alternatives and modify benefit restrictions for high-cost patients (high cost case management).

A. Utilization Review

The medical protocols and review criteria used in any utilization review or utilization management
program must be developed by physicians. Public and private payers should be required to disclose to
physicians on request the screening and review criteria, weighting elements, and computer algorithms
utilized in the review process, and how they were developed.

A physician of the same branch of medicine (allopathic or osteopathic) and specialty must be involved in
any decision by a utilization management program to deny or reduce coverage for services based on
questions of medical necessity. All health plans conducting utilization management or utilization review
should establish an appeals process whereby physicians, other health care providers, and patients may
challenge policies restricting access to specific services and decisions to deny coverage for services, and
have the right to review of any coverage denial based on medical necessity by a physician consultant
who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of
the reviewing physician on request. Any physician who makes judgments or recommendations regarding
the necessity or appropriateness of services or site of services should be licensed to practice medicine
and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the
reviewed service and should be professionally and individually accountable for his or her decisions. The
names and credentials of individuals conducting necessity or appropriateness reviews must be available

upon request.

Any health plan or utilization management firm conducting a prior authorization program should act within two business days after receipt of any patient or physician request for prior authorization and respond by phone within one business day after receipt of other questions regarding medical necessity of services. Plans may not require prior authorization for emergency care. Prior approval decisions should be valid unless based on fraud or incorrect information.

All health plans should establish a formal mechanism for participating physicians to have meaningful input into the plans' medical policies, including coverage and utilization review criteria. Health plans must safeguard medical record confidentiality and are responsible for making sure that patients sign the forms consenting to disclosure of medical information if prior authorization is required for any procedures or services.

B. Gatekeepers, Limited Provider Panels, and Financial Disincentives

Health care plans should be required to limit appropriately those arrangements in which the providers have a financial incentive to limit or deny services, including referrals for patients to specialists. Any financial arrangements that may tend to limit the services offered to patients, or contractual provisions that may restrict referral or treatment options, should be required by law to be fully disclosed to patients and prospective enrollees by all plans utilizing such arrangements.

Regulations protecting patients from under-referral for financial gain are just as desirable as regulations to limit physician self-referral because of concern about overutilization for financial gain. Physicians and managed care organizations must disclose to their patients any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians may satisfy their disclosure obligations by assuring that the managed care plan adequate makes full disclosure of all such arrangements to patients enrolled in the plan. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage.

Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create undesirable conflicts of interest because of financial incentives to withhold medically

indicated services.

Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives or deny their patients access to appropriate services, including referrals to specialists, based on such inducements. Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care nor should they expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should not be based on performance over short periods of time.

Alternative private health benefit plans, with different schedules of deductibles, coinsurance and premiums, should be available to enrollees so that they are aware of the financial tradeoffs associated with different plans. Both private and public third party payment systems should use deductibles and coinsurance as financial incentives for health care recipients to use health care resources in an appropriate manner. However, cost-sharing should not result in an undue financial burden for the health care recipient, and should not act to prevent access to needed care.

Physicians, other health professionals, and third party payers through their reimbursement policies, should continue to encourage use of the least expensive care settings in which medical and surgical services can be provided safely and effectively with no detriment to quality. Evaluation of "Quality" should place some value on the continuity of the patient-physician relationship.

With the increased specialization of modern health care, it may be advantageous for each patient to have a single physician to help coordinate the medical care of the patient and to act as the repository for all of the medical information on the patient. The physician is best suited by professional preparation to assume this leadership role. It may be appropriate to utilize appropriate financial mechanisms to encourage patients to take optimum advantage of such a primary care provider. It may not be medically

appropriate
or cost effective to require that all medical care be provided by, or with permission from, one’s primary
care provider.

Specialty physicians should have formal and meaningful input into developing each plan's policies on
appropriateness of referrals to specialists.

All restrictive plans should notify physicians annually of their opportunity to apply for plan credentials;
establish credentialing standards with input from physicians and make them available to applicants and
enrollees. Selection criteria must be based on professional competence and quality of care and, in general, no single criterion, including specialty, should provide for the sole basis for selecting, retaining,
or excluding a physician from a health delivery or financing system. Profiling must be adjusted for the
individual physician's case mix.

Physicians cannot be removed from a plan because their patients have rare, unusual or highly complex
conditions which require specialized care and that are expensive to treat. Nor can they be removed under
a contract that allows termination "without cause" or terminated or denied participation without explanation of reasons for the decisions, and an opportunity to appeal.

All plans should demonstrate adequate access to physicians and other providers, including specialists, to
ensure timely, high quality service.

C. High Cost Case Management

The primary goal of high-cost case management or benefits management programs should be to help to
arrange for the services most appropriate to the patient’s needs. Cost containment is a legitimate but
secondary objective. In developing an alternative treatment plan, the benefits manager should work
closely with the patient, attending physician, and other relevant health professionals involved in the
patient’s care.

When inordinate amounts of time or effort are involved in providing case management services required
by a third-party payer which entail coordinating access to other health care services needed by the

patient, or in complying with utilization review requirements, the physician may charge the payer or the
patient for the reasonable cost incurred. "Inordinate" efforts are defined as those more costly, complex
and time-consuming than the completion of standard health insurance claim forms, such as obtaining pre
admission certification, second opinions on elective surgery, certification for extended length of stay, and
other authorizations as a condition of payer coverage."

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.

E. Liability
All health plans utilizing managed care techniques, the medical director, and any involved reviewers
should be subject to legal action for any harm incurred by the patient resulting from application of such
techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from
failure to disclose prior to enrollment any coverage provisions; 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 patient.

F. Consumer Choice
Employers, health plans or networks must allow for patients' choice of physician and system of health
care delivery.

Any sponsor (e.g., employer, regional alliance, insurance pool) who offers a restrictive health benefit plan

must make available a variety of types of plans including HMO's, traditional insurance plans, or a benefit
payment schedule, establishing up front a set amount that will be paid for each covered service. At the time of enrollment in a plan that restricts access, and at least one year thereafter, each patient
shall be offered the opportunity to pay an additional premium for a "point of service" plan that will entitle
him or her to reimbursement for services obtained outside the network or outside any restrictive referral
rules. "Out- of - network" or "point of service" plans include plans that may reimburse for any non-covered service whether it is provided inside or outside the patient's plan.

The additional premium for point of service coverage must reflect the actuarial value of such coverage. A
point of service plan may require a reasonable copayment.

Individuals' and employers' rights to pay for services outside of the health plan or benefit package should
be expressly preserved.

In order for consumers to make fully informed decisions it is imperative that all plans disclose to prospective enrollees clear and accurate information, in a standardized format, on coverage exclusions;
prior authorization or other review requirements that might result in nonpayment for a given procedure or
service; financial arrangements that reward hospitals, physicians and other providers for delivering less
care, or that limit referrals to other providers; the enrollees own liability for coinsurance or for payments
for out-of-plan services; the plan's administrative expenditures as a percentage of total premiums, and
enrollee satisfaction statistics.

Miscellaneous
A state agency must periodically review and revise, if necessary, established standards.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.6.02- 60 Day Recertification of Medicaid Patients
Date: 11/5/1994
The Medical Society of Virginia opposes the 60 day mandatory visitation and recertification of Medicaid
patients in nursing homes and believes that visits should be based on need as determined by the attending physician.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.6.03- Medicaid Cuts
Date: 11/5/1994
The Medical Society of Virginia opposes reductions in the State's Medicaid budget unless it is clear that
such reductions will not adversely affect quality of care for the poor.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

10.8.03- Any Willing Provider
Date: 11/5/1994
The Medical Society of Virginia reaffirms its support of "any willing provider" provisions.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

10.9.05- Fee Guidelines
Date: 11/5/1994
The Medical Society of Virginia recommends use of the following fee guidelines:
1. The fee charged for each service should be based upon the cost of providing that service by the
most efficient high-quality method that is available plus a reasonable compensation for the professional
skill and time that is required.
2. In applying usual, customary and reasonable guidelines, such factors as providing emergency service at night and on weekends, taking care of indigent patients, and sponsoring educational programs must be considered, but these factors should not be used as an excuse for excessive charges.
3. These sample principles should be applied to all other diagnostic procedures, such as blood counts,
electrocardiograms, electroencephalograms, and x-rays. Physicians should not make a profit from
selling another physician's opinion.
4. When physicians draw blood and send it out to a commercial laboratory for testing, they should be
paid a reasonable fee to cover the costs of drawing the blood, but they should not be paid or expect a
fee for interpreting the results of these tests, as this interpretation has already been paid for when the
patient pays for the office visit.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

10.9.13- Assignment of Benefits
Date: 10/30/1999
The Medical Society of Virginia supports legislation in Virginia that physicians or other health care

providers who file insurance claims for their patients and who have appropriately executed Assignment of
Benefits directly receive insurance reimbursement for their medical services from the payer, whether or
not they are participating providers with the insurance plan. The Medical Society of Virginia will continue
to lobby our legislators educationally, and will introduce assignment of benefits legislation when the
situation is appropriate.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

10.9.15- Payment with Remittance Advice

Date: 08/14/2014
The Medical Society of Virginia strongly encourages health plans to include comprehensive remittance
advice in a user-friendly format with any payment or payment retraction, and will address any related
member complaints accordingly.

15.2.04- Physician-Patient Privilege

Date: 11/5/1994
The Medical Society of Virginia supports legislation which would amend the Code of Virginia to allow
defense attorneys the same access to treating physicians, witnesses, and medical records as afforded to
the plaintiffs' attorneys.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.2.05- Support of Countersuits

Date: 11/5/1994
The Medical Society of Virginia supports pursuit of justifiable countersuits.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.3.02- Malpractice Coverage for Operational Medical Directors

Date: 11/5/1994
The Medical Society of Virginia believes that the delegation and supervision of clinical activities
performed by qualified emergency medical technicians certified by the Commonwealth of Virginia should
be included among the ordinary duties of physicians covered in full by medical liability insurance policies,
unless these activities are already legislatively exempted from such liability.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.3.06- Medical Insurance Payment Guidelines and the Standard of Care

Date: 08/14/2014

The Medical Society of Virginia supports legislative efforts to ensure that no payment standard or reimbursement criteria developed or implemented by any public or private payer shall be construed as an appropriate standard of care or legal basis for negligence or duty of care owed by a health care provider to a patient in any civil action for medical malpractice or product liability

15.4.02- Peer Review of Utilization

Date: 11/5/1994

The Medical Society of Virginia endorses local peer review of both inpatient and outpatient medical utilization.

Reaffirmed 11/7/2004

Reaffirmed 10/26/2014

20.1.01- Continuing Medical Education

Date: 11/5/1994

The Medical Society of Virginia: a) recognizes that Continuing Medical Education (CME) is important to patient care and should emphasize the importance of physicians' self-directed learning, and b) supports CME as a requirement for relicensure, contingent upon regulations being established by the Board of Medicine; and c) believes that CME and Virginia medical school curriculum should not be mandated in the Code of Virginia.

Reaffirmed 11/7/2004

Reaffirmed 10/26/2014

20.1.02- Reducing Medical Errors

Date: 11/7/2004

The Medical Society of Virginia encourages physicians to pursue continuing education that includes training in patient safety and risk management.

Reaffirmed 10/26/2014

25.3.01- Opposition to Restraining Appropriate Use of Services

Date: 11/5/1994

The Medical Society of Virginia opposes any legislation which would restrain the appropriate use of needed medical services.

Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.3.03- Hospital Staff Privileges

Date: 11/5/1994
The Medical Society of Virginia opposes any legislation, on both the state and federal levels, which
attempts to mandate a connection between participation and payment programs and staff privileges.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.3.04- Physician's Freedom of Choice

Date: 11/5/1994
The Medical Society of Virginia supports the right of every physician to choose those persons whom he or she will accept as patients and also to exercise his or her choice by the terms of contractual
arrangements with other physicians, medical groups, hospitals, or other institutions.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.4.02- Use of Employees; Transmit Orders

Date: 11/5/1994
The Medical Society of Virginia opposes any amendment to the Code of Virginia that would prohibit a
physician from using his employees to transmit orders for hospitalized patients.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.5.01- Quality Assurance Bodies

Date: 11/5/1994
The Medical Society of Virginia opposes any legislative program which would encourage the dismantling
of hospital staffs or other quality assurance bodies deemed appropriate by the medical profession.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

30.6.02- Liens for Hospital and Medical Services

Date: 11/5/1994
The Medical Society of Virginia supports a statutory change in the Code of Virginia regarding liens for
hospital and medical services such that the amount of the statutory lien is increased to cover the reasonable and necessary charges; that a formal recording system for such liens be created; and that the

payers of personal injury proceeds be liable for satisfaction of hospital/medical liens for up to one year
after the date of payment of proceeds.
Reaffirmed 11/07/2004
Reaffirmed 10/26/2014

30.6.03- Administrative Fees in Medical Offices

Date: 11/7/2004
The Medical Society of Virginia supports the concept that in lieu of other contractual arrangements with
insurance plans, a charge to the patient of an administrative fee for services rendered in the physician's
office by the physician or his/ her administrative staff for administrative time, not associated with the office visit, is both reasonable and ethical.
Reaffirmed 10/26/2014

40.1.09- Programs to Maintain Elderly Patients in Home Environment

Date: 11/5/1994
The Medical Society of Virginia believes that Virginia physicians should assist in the effort to maintain
elderly patients in their home environments. Furthermore, the Medical Society believes that state funding
must be available for the establishment of community programs designed to meet the needs of the
elderly.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.5.01- Screening and Detection Programs

Date: 11/5/1994
The Medical Society of Virginia encourages all physicians to support screening and detection programs
designed to promote the diagnosis of cancer at an early stage.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.5.02- Virginia Cancer Registry

Date: 11/5/1994
The Medical Society of Virginia endorses accreditation through the Commission on Cancer of the
American College of Surgeons and encourages all hospitals to seek approval. In addition, the Medical
Society of Virginia supports hospital participation in the Virginia Cancer Registry.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

40.7.02 - Regulation of Tattoo Parlors
Date: 11/4/2001
The Medical Society of Virginia supports legislation and/or regulation to require that all commercial tattoo parlors and those individuals applying the tattoos be registered with an appropriate state regulatory board and that all methods employed in the application of tattoos be certified as free of potential contamination.
Reaffirmed 10/26/2014

40.12.01- Educational Programs
Date: 11/5/1994
The Medical Society of Virginia endorses educational programs which would encourage all citizens to
retain a primary physician.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.13.01- Funding of Lead Poisoning Program
Date: 11/5/1994
The Medical Society of Virginia requests that the Commonwealth of Virginia continue funding Virginia's
lead poisoning program.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.15.02- Agency Jurisdiction
Date: 11/5/1994
The Medical Society of Virginia believes that the jurisdiction over Day Care Centers lies with the
Department of Social Services which should continue to study existing laws and regulations and make
them applicable to all Day Care Centers.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

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.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.16.01- Access to Obstetrical Care
Date: 11/5/1994
The Medical Society of Virginia encourages the Commonwealth of Virginia:

(1) to study commercial insurance reimbursement policies that may contribute to the maldistribution
of obstetrical care in Virginia,
(2) to study the barriers in Virginia that have resulted in the reduced number of family physicians doing obstetrics in Virginia,
(3) to study the feasibility of implementing in Virginia a program similar to the North Carolina Rural
Obstetrical Incentive Program for obstetricians, family physicians, and nurse midwives that reduces the cost of obstetrical malpractice insurance in areas of need.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

40.18.01- Changes in Commitment Law; Funding

Date: 11/5/1994
The Medical Society of Virginia supports the civil commitment of a patient to a private or a public hospital for psychiatric care with a view to the highest quality medical care and adequate funding be provided for the process established by law.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.18.02- Funding; Public Mental Health Facilities

Date: 11/5/1994
The Medical Society of Virginia supports public and private efforts to enhance the funding of public mental health treatment facilities and opposes any reduction in funding.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.18.03- Psychiatrists: State Hospital and Clinics

Date: 11/5/1994
The Medical Society of Virginia urges the Virginia Department of Behavioral Health and Developmental
Services to ensure that physicians trained in psychiatry be available to its hospitals and clinics.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

40.19.01- Radiation Control; Needless Exposure

Date: 11/5/1994
The Medical Society of Virginia supports methods and practices of radiation control that will reduce
needless exposure of patients and workers to ionizing radiation.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.21.02– Safe Driving Education and Licensing Requirements

Date: 11/5/1994
The Medical Society of Virginia strongly supports stringent licensing requirements and increased

education and safety training for motorcycle and automobile operators.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

40.22.01- State Funding For Childhood Vaccines

Date: 10/30/1993
The Medical Society of Virginia supports the Virginia Department of Health in seeking funding to purchase vaccines to be administered in physicians' offices to all children.
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.23.02- Physicians' Role in Violence Prevention

Date: 11/8/1997
The Medical Society of Virginia recognizes violence as a medical problem that should be of active
concern to physicians. The Medical Society of Virginia will promote physician education regarding the
epidemiology, recognition, and prevention of violence and actively explore other ways to educate
patients, the public, and payers.
Reaffirmed 10/28/2007
Reaffirmed 10/26/2014

45.1.01- Determination of Fitness to Return to Work

Date: 11/5/1994
The Medical Society of Virginia opposes the use of persons other than doctors of medicine or osteopathy,
or agents under their supervision, to attest to an employee's fitness to return to work.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.1.02- Diagnosis by Optometrists

Date: 11/5/1994
The Medical Society of Virginia opposes the use of optometrists and inadequately trained nonmedical
personnel for the diagnosis of eye disease and eye injury.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.1.03- Referrals from Physicians

Date: 11/5/1994
The Medical Society of Virginia believes that a physician should at all times practice a method of healing
founded on a scientific basis. A physician may refer a patient for diagnostic or therapeutic services to
another physician, a licensed limited practitioner, or any other provider of health care services

permitted
by law to furnish such services, whenever the physician believes that this will benefit the patient. As in the case of referrals to physician specialists, referrals to allied health practitioners should be based on their individual competence and ability to perform the services needed by the patient.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

45.3.01- Employment at Secondary School Level
Date: 11/5/1994
The Medical Society of Virginia supports employment of athletic trainers on the secondary school level.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.5.02- NATA's Certification Process
Date: 11/5/1994
The Medical Society of Virginia recognizes the National Athletic Trainers' Association (NATA) as the
official organization for athletic trainers and supports its certification procedures and certification board.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

45.7.01- Office of Emergency Medical Services
Date: 11/5/1994
The Medical Society of Virginia opposes any plans that would lessen or in any other way interfere with
physician direction of emergency medical care provided by non-physicians in the pre-hospital setting.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

50.1.01- Department of Health Professions
Date: 11/5/1994
The Medical Society of Virginia believes that the Department of Health Professions should not be
regulated by or merged with the Department of Health.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

55.1.02- AMA Recruitment of Large Groups; Discounts and other Incentives
Date: 11/5/1994
The Medical Society of Virginia invites the AMA to recruit large groups (greater than 100 members) using discounts or other incentives as deemed appropriate. This invitation is extended on the condition that presentations of such initiatives will take place in person and that the

Medical Society of Virginia and
appropriate component societies will be invited to jointly participate in such presentations.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

55.2.01- Conflict of Interest Policy

Date: 11/5/1994
The Officers, Directors, Associate Directors, Vice Speaker and Executive Vice President of the Medical Society of Virginia (MSV) should avoid any conflict of interest regarding MSV and should fully
and immediately disclose any conflict of interest that they might have in connection with any transaction
with or related to the Medical Society of Virginia.
GUIDELINES:
1. Any person subject to this policy shall exercise the utmost good faith in all transactions touching
upon their duties to MSV. In their dealings with and on behalf of MSV, they shall be held to a strict
rule of honest and fair dealing.
2. The acts of any person subject to this policy on behalf of MSV shall be in the best interest of MSV.
3. Any person subject to this policy shall not accept any gifts, favors, payments or things of value that might influence their decision-making or actions affecting the MSV.
4. Although a duality of interests may exist from time to time, such duality shall not be permitted to
influence adversely the decision-making process of MSV. Any person subject to this policy shall promptly report the possible existence of a conflict of interest for himself/herself or any other person subject to this policy to MSV's President or Executive Vice President.
5. When a conflict of interest exists, the person with the duality of interest shall remove himself/herself from involvement in any decision-making process, and shall not act on behalf of MSV in connection with such issue or decision.
6. A full disclosure of all facts pertaining to any transaction that is subject to any doubt concerning
the possible existence of a conflict of interest shall be made before consummating the transaction.
7. Any person subject to this policy shall adhere to this policy and complete an Annual Disclosure
Questionnaire as a condition of board membership or employment.
8. Any disagreement or dispute with regard to the existence of a conflict of interest shall be resolved
by MSV's Executive Committee upon the request of any MSV Board Member or the Executive Vice President.
PROCEDURES:
1. Each year the Executive Vice President shall send to each person subject to this policy a copy of
this policy and a Disclosure Questionnaire to be completed and returned.

2. An appropriate report shall be submitted to the MSV Board of Directors regarding any interests
disclosed in the questionnaire.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

55.2.02- MSV Role in Disputes

Date: 11/5/1994
The Medical Society of Virginia believes that it should not intervene in disputes between physicians and
hospital medical staff.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

55.2.03- President's Role; Guidelines for Others

Date: 11/5/1994
The Medical Society of Virginia believes that in legislative matters: A. The President is the official spokesman for The Medical Society of Virginia. B. The Society's lobbyists will keep the President informed and represent the official position when the President is not available. C. Medical Society members who speak on behalf of the President or the Society will represent only the official position of the Medical Society.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

Recommendation Reaffirm as Amended

Recommendation to Archive

24-103

Ban Noncompete Employment Covenants

Submitted by Robert C Bernstein, MD and Daniel F Pauly, MD PhD
On behalf of the Virginia Chapter of the American College of Cardiology

WHEREAS, American Medical Association policy supports prohibition of non-compete covenants for all physicians in clinical practice with employment contracts with for-profit and non-profit hospitals, hospital systems, and staffing companies[1], and

WHEREAS, the Commonwealth of Virginia already bans noncompete covenants for citizens earning less than $73,320 (Virginia Code 40.1-28.7:8)[2], and

WHEREAS, the FTC ban on noncompete covenants only applies to for-profit entities[3]. The FTC does not regulate non-profit institutions, and

WHEREAS, employment noncompete covenants have been determined by the FTC to significantly inflate healthcare costs and suppress employee salaries[4], and

WHEREAS, non-compete covenants limit patient access[5] and adversely impact provider well-being[6], and

WHEREAS, employers have other avenues to protect confidential information and specific onboarding investments that are less harmful to workers and patients[7]; therefore be itnon-compete covenants limit patient access[5] and adversely impact provider well-being[6], therefore be it

RESOLVED, the Medical Society of Virginia should establish policy supporting the ban of noncompete covenants in employment contracts for healthcare providers.

MSV policy: 30.4.06 Remove restrictive covenants for healthcare providers in Virginia Date: 9/14/2019 The Medical Society of Virginia will publish a study that provides a legal summary of the tests the court uses for covenants and summaries of several decisions so to inform members on how the court has ruled. The study will be made available for members by December 31, 2019.

1 American Medical Association Policy H-265.988 (2023)
2 Code of Virginia: Labor and Employment, Chapter 3 Protection of employees (2020)
3 Federal Trade Commission Act Section 5(a)
4 Federal Trade Commission Non-Compete Clause Final Rule to prohibit employers from imposing noncompete clauses on workers RIN 3084-AB74 (2024)
5American Medical Association Policy 11.2.3.1 (2017)
6 American College of Cardiology Letter to the Federal Trade Commission (2023)
7 Federal Trade Commission Non-Compete Clause Final Rule to prohibit employers from imposing noncompete clauses on workers RIN 3084-AB74 (2024)

24-104

Defining Exceptions to Information Blocking as it relates to the 21st Century Cures Act

Submitted by Wilson M. File, MD, MMEdL

WHEREAS, the 21st Center Cures Act, Pub. L. No 114-255, including requirements for health care providers to provide complete and immediate electronic health information to patients, and

WHEREAS, the 21st Center Cures Act, Pub. L. No 114-255, allows states to establish exceptions to the requirements for healthcare providers, and

WHEREAS, with immediate release of laboratory results, a patient and family may receive the results at the same time as ordering healthcare provider and, in almost all circumstances, should read a report before the provider has had an opportunity to review the result, and

WHEREAS, the Virginia General Assembly declare that, in certain circumstances, based on the types of laboratory tests and/or imaging evaluations ordered and the potential results of those tests, the ordering healthcare provider needs an opportunity to review the results prior to their release as part of the patient's electronic medical record in order to provide patient and family with appropriate medical expertise and emotional support and to gather the appropriate resources to care for patient, and

WHEREAS, the Virginia General Assembly recognizes the potential harm that maybe caused to the patient and/or family to review diagnostic healthcare information without the interpretation and appropriate planning by the ordering medical provider, and

WHEREAS, such laboratory/radiologic evaluations that have a reasonable likelihood of showing a finding of malignancy or considered surveillance for a malignant condition and/or test that could reveal genetic findings/markers and/or autopsy reports of the deceased be NOT released until 72 hours after the results are finalized unless the health care provider directs the release of the results before the end of that 72 hour period, therefore be it

RESOLVED, that the Medical Society of Virginia supports exceptions to patient's immediate access to electronic health record information when delaying notification would improve patient outcomes by allowing thorough provider review and personal patient notification. Further, such exceptions should not be categorized as "information locking."

Fiscal Impact: none
Existing Policy: none

24-105

Expanded and Standardized Advanced Practice Registered Nurses' Education

Submitted by Bruce A. Silverman, MD

WHEREAS, due to the recent proliferation of programs to educate and credential Advanced Practice Registered Nurses, physicians as leaders in the healthcare industry, should advocate and support the introduction of the expansion and standardization of the academic and clinical training of these individuals. This will promote the health and safety of our patients here in the Commonwealth as well as the nation, therefore be it

RESOLVED, that the Medical Society of Virginia will advocate with the Joint Board of Medicine and Nursing and the Department of Health Professions to expand and standardize the education of Advanced Practice Registered Nurses in Virginia so that they can be functioning at their highest capacity upon graduation from their studies, and be it further

RESOLVED, that the Medical Society of Virginia, will support and advocate for its AMA Delegation to advance policy at the AMA to expand and standardize the education of Advanced Practice Registered Nurses, nationwide, so that they can be functioning at their highest capacity upon graduation from their studies.

24-106

MSV Right of Conscience Resolution: Promoting Sound Medical Ethics & Physicians Exercise of Conscience

Submitted by Dr. Scott Armistead

WHEREAS, the adherence to professional ethical standards is essential to preserving patient trust and public confidence in the medical profession, and

WHEREAS, physician exercise of conscience has become an important issue for Medical Society of Virginia (MSV) members and physicians across the Commonwealth of Virginia committed to practicing ethical medicine, and

WHEREAS, the current MSV Policy Compendium does not include language on physician exercise of conscience, and

WHEREAS, the American Medical Association (AMA) has adopted a robust platform on physician exercise of conscience to promote adherence to the ethical norms and standards of the profession[1], therefore be it

RESOLVED, that the Medical Society of Virginia supports the AMA Code of Medical Ethics Opinion 1.1.7 "Physician Exercise of Conscience."

"Opinion 1.1.7 – Physician Exercise of Conscience"

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

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

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

[1] https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience

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

In following conscience, physicians should:

A) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
B) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
C) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
D) Be mindful of the burden their actions may place on fellow professionals.
E) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
F) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
G) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

Fiscal Impact: $0

Existing Policy: None

24-107

Physician Opinion of Readiness of Non-Physician Providers for Independent Practice

Submitted by VA College of Emergency Physicians

WHEREAS, the Virginia College of Emergency Physicians is concerned about the reduction in years of training from five years to three years required for nurse practitioners to practice independently, and

WHEREAS, we strongly believe that the physician sign-off required in the legislation before a non-physician provider can practice independently should be done with care, supervision by such physician and direct knowledge of the training completed by the provider seeking the signature, and

WHEREAS, we have grave concerns about any non-physician provider practicing independently in an acute care setting, we also strongly support our fellow physicians in all other specialties to also have the autonomy to refuse to sign an affidavit if they don't feel the provider has achieved the appropriate level of training or if they were not the physician to supervise said training, therefore be it

RESOLVED, the Medical Society of Virginia supports that a physician's autonomy to rely on their professional opinion as final determining factor in whether a non-physician provider can practice independently. No physician should be forced to sign off on such an affidavit if, in their professional opinion, the non-physician provider does not have the appropriate level of training. MSV shall oppose legislation, regulation, hospital or business policy that forces a physician to sign off when, in their professional opinion, they do not believe the right level of training has been achieved

Fiscal Impact: $0

Existing Policy: None

24-108

Proposal for Psychiatric Initiatives

Submitted by Jerome Blackman, MD on behalf of the Coastal Virginia Medical Society

WHEREAS, civil commitment laws are far too limited and have not been changed since the 1960s, leading to unnecessary crime, homelessness, mass shootings, and emergency rooms having to deal with violent, psychotic patients, and

WHEREAS, there is a serious lack of psychiatric hospital beds, both for short term and long-term problems, and

WHEREAS, psychiatric hospitals were closed in the 1960s and 1970s due to civil rights issues, but we now have markedly increasing mental health issues, doctors and psychiatrists are not able to manage all of these severely ill patients on an outpatient basis, therefore be it

RESOLVED, that commitment laws should be changed to eliminate "danger" as a criterion. Instead, "seriously mentally ill" should be the determining factor, and be it further

RESOLVED, that "prescreeners" be eliminated, but preserve current laws governing patients' rights, and be it further

RESOLVED, that more psychiatric beds be developed to avoid clogging of emergency rooms and jails. In order to accomplish this, we must increase state mental hospital beds and psychiatrists (MDs) and use any available space in private hospitals.

24-109

Reducing Stigma Through Modernizing the Accessibility Sign

Submitted by Victoria Partin

WHEREAS, approximately 26% of individuals in the United States experience a disability. Often, the term disability is thought to consist of a specific type of population, but there is a diverse demographic of individuals who experience disability in different ways, ranging from cognitive to mobility[1], and

WHEREAS, individuals with a disability experience many barriers that reduce overall quality of life. Barriers can be physical such as a structural obstacle, or nonphysical such as attitudinal[2], and

WHEREAS, attitudinal barriers include stereotyping and stigma. Socially, it may be assumed that individuals with a disability experience a low quality of life, leading to stereotyping. This ideology may cause disabilities to be viewed as something that needs to be fixed or cured, therefore reinforcing social stigmas against individuals with disability, and

WHEREAS, the original and still active accessibility sign, otherwise known at the International Symbol Access (ISA), was designed in 1968, decreasing physical barriers to access for individuals with a disability[3], and

WHEREAS, while the sign was powerful to reduce the physical barriers. The non-physical barriers still need to be addressed. The current design showcases an individual in a static and dependent position, symbolically reinforcing social stigmas as stated previously, and

WHEREAS, New York and Connecticut passed legislation mandating the use of the active wheelchair symbol which showcases an individual learning forward into movement [4]. This newly designed symbol looks to address the nonphysical barriers that individuals with disability experience, symbolically displaying an independent individual emphasizing their personhood rather than disability, and

WHEREAS, the active wheelchair sign is compliant with section 103 of the ADA Accessibility Standards for Equivalent Facilitation. Equivalent Facilitation states that nothing "prevents the use of designs, products, or technologies as alternatives to those prescribed, provided they result in substantially equivalent or greater accessibility and usability." [6] The active wheelchair sign does not significantly differ from the current International Symbol of Access, ensuring that it will be recognized by the average person, therefore be it

RESOLVED, the Medical Society of Virginia (MSV) supports the replacement of any signs with the current International Symbol of Access with the New York Dynamic Wheelchair Symbol Sign when placards are set to expire.

Fiscal Impact: none
Existing Policy: none

1) Centers for Disease Control and Prevention. (2024, April 3). *Disability and health overview*. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html
2) CDC. (2024, May 2). *Disability and Health Disability Barriers | CDC*. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html
3) International Sign Association. https://signs.org/industry-news/koefoed-the-international-symbol-of- access/
4) *New York Dynamic Wheelchair Symbol Signs*. (n.d.). ADA Sign Depot. Retrieved August 7, 2024, from https://www.adasigndepot.com/collections/new-york-wheelchair-symbol-signs
5) *The Accessible Icon Project*. (n.d.). The Accessible Icon Project. Retrieved August 7, 2024, from http://accessibleicon.org
6) *ADA* Accessibility Standards. (n.d.). Retrieved August 7, 2024. https://www.access-board.gov/ada/
catherine.davis@signs.org. (2021, March 25). *Koefoed & the International Symbol of Access*.

24-110

Residency Program Funding Equalization for Family Medicine

Submitted by Dr. Trice Gravatte

WHEREAS, in the Commonwealth there exists a deficit of Primary Care physicians. That deficit is increasing due to population growth, physician retirement and burnout, and limited residency opportunities in Virginia, and

WHEREAS, the ability to train, retain, and grow the next generation of physicians is linked to Commonwealth's funding and support. The key primary care specialty that produces physicians that improve quality for all ages and reduce total health care cost is Family Medicine, and

WHEREAS, currently the Commonwealth funds for the Family Medicine residencies at UVA-Charlottesville, Roanoke Carillion, and Centra Lynchburg at $15,388 per resident per year. At the Virginia Commonwealth University family medicine residencies in Richmond and their 3 other affiliated programs the funding is $39,424 per resident per year, and

WHEREAS, the funding of Family Medicine and primary care is critical for the health of the citizens of Virginia, and

WHEREAS, the lack of funding of UVA, Roanoke, and Lynchburg is and has created a hardship in providing a quality experience for resident physicians, and

WHEREAS, the cost of training resident Family Medicine residents is the same in Richmond, Charlottesville, Fairfax, Roanoke and Lynchburg, and

WHEREAS, residents have a likelihood of practicing within a 100 mile radius of where they train and the deficit is particularly large in rural-semi rural areas, therefore be it

RESOLVED, the MSV supports equalizing residency funding for Family Medicine in the Commonwealth across all programs by raising it to $39,424 per resident per year.

24-111

Resolution Supporting Independent Practices

Submitted by The Richmond Academy of Medicine

WHEREAS, independent medical practices contribute to the diversity of healthcare options, offering patients a range of choices in accessing care and fostering healthy competition, and

WHEREAS, independent medical practices promote physician autonomy, allowing physicians to make clinical decisions based on their medical expertise and patient needs, without undue influence from corporate employers, and

WHEREAS, current trends in healthcare put an ever-increasing burden on physicians in private practice (American Medical Association 2023), and

WHEREAS, the increasing demands on private practice physicians are driving more physicians to sell their practices to larger health systems or private equity firms in favor of becoming employed (American Medical Association 2023), and

WHEREAS, the current healthcare environment discourages early career physicians from entering private practice and steers them to employed practice (American Medical Association 2023), and

WHEREAS, surveys demonstrate that the majority of physicians say that they are employed physicians rather than owners (American Medical Association 2023), and

WHEREAS, the US spends about 4.3 trillion dollars annually on healthcare which amounts to 18.3% of the Gross Domestic Product, nearly twice as much per person on healthcare than all other western nations (Centers for Medicare and Medicaid Services 2021), and

WHEREAS, multiple studies demonstrate that hospital acquisition of physician practices increases overall healthcare costs by up to 20% and does not improve the quality of care (Gale AH 2015, Levins H 2023, Gee E and Gurwitz E 2018), therefore be it

RESOLVED, that the Medical Society of Virginia (MSV) draft and publish a statement in support of independent physicians in private practice, and be it further

RESOLVED, that the MSV research and make available educational materials to support independent physicians in private practice and educate early physicians about options for developing or joining a viable private practice, and be it further

RESOLVED, that the MSV delegates encourage the American Medical Association (AMA)

to draft and publish a statement in support of independent physicians in private practice, and to continue developing and updating educational materials to support independent physicians in private practice and educate early physicians about options for developing or joining a viable private practice.

REFERENCES:

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org/about/research/physician-practice-benchmark-survey
2. 2021 National Health Expenditure Data. Centers for Medicare & Medicaid Services (CMS). 15 Dec. 2022.
https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-andreports/
nationalhealthexpenddata/nationalhealthaccountshistorical
3. Gale AH. Bigger but not better: hospital mergers increase costs and do not improve quality. Mo Med. 2015 Jan-Feb;112(1):4-5. PMID: 25812261; PMCID: PMC6170097.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/
4. Levins H. Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality. Penn Leonard Davis Institute of Health Economics. 19 Jan. 2023.
https://ldi.upenn.edu/our-work/researchupdates/
hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/
5. Gee E and Gurwitz E. Provider Consolidation Drives Up Health Care Costs. Center for American Progress. 5 Dec. 2018.
https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/

24-112

Resolution on Workplace Safety

Submitted by The Richmond Academy of Medicine

WHEREAS, violence and unwanted behavior in the workplace is increasing, and

WHEREAS, medical practices are not immune to this alarming trend, with federal statistics indicating a 63% increase in violence against medical professionals between 2011 and 2018, and

WHEREAS, healthcare workers are four times more likely than average U.S. workers to experience workplace violence, with about 25% of all instances of U.S. workplace violence occurring against healthcare staff (per Bureau of Labor Statistics), and

WHEREAS, individual employees can be targeted by patients, visitors and co-workers, and

WHEREAS, if the unwanted behavior occurs at work and is unrelated to their personal lives, it can become overly burdensome and re-traumatizing to that individual, and

WHEREAS, an employer seeking a protective order depersonalizes the situation, away from the employee experiencing a threat, and

WHEREAS, Virginia law currently only allows the impacted individual to seek a protective order, not an employer, and

WHEREAS, other states allow employers to seek protective orders intended to prevent workplace violence against their employees, therefore be it

RESOLVED, that the Medical Society of Virginia support legislation that would allow an employer to file a request seeking a protective order on behalf of the employee (with their consent), for protective orders that would otherwise be available to individuals under Virginia law. These protective orders would shield an employer's employees from threats by patients, visitors and/or co-workers in appropriate cases, and be it further

RESOLVED, that the legislation also include language providing immunity for employers acting in good faith, both if an employer declines to seek a protective order on an employee's behalf, and if they seek a protective order in good faith.

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2024

Reference Committee Two Index

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

24-201

Access to Healthcare for People Experiencing Homelessness

Submitted by the Medical Society of Virginia Medical Student Section

WHEREAS, rates of homelessness in the U.S. has been on the rise since 2017 with 421,392 people experiencing housing insecurity nationwide in 2022, of which 6,529 are Virginians[1], and

WHEREAS, homelessness has been associated with higher rates of chronic diseases, infectious diseases, mental health disorders, substance use disorders[2], and a shortened lifespan by 25 years compared to those who have not experienced housing insecurity[3], and

WHEREAS, not only can homelessness cause poor health, but poor health and its financial burden are also a contributing factor to homelessness with over 50% of personal bankruptcies in the U.S. resulting from health issues[4], and

WHEREAS, despite an increased need for healthcare compared to the general population, the homeless population has been shown to be underinsured, have unmet medical needs[5], and have a lower understanding of whether they qualify for Medicaid[6], and

WHEREAS, according to the Virginia Department of Housing and Community Development, there was a 12% increase in homelessness in Virginia from 2021 to 2022[7], and

WHEREAS, housing insecurity disproportionately affects individuals of racial and ethnic minorities[8]: in 2021, 59% of those rapidly rehoused in Virginia due to housing insecurity were Black, African American, or African[7], which is over three times the percent this demographic represents in the total Virginia population (18.6%)[9], and

WHEREAS, in Virginia's rapid re-housing program in 2021, 36% were victims of domestic violence, 28% had a mental health disorder, 16% had a chronic health condition, and 15% had a physical disability, demonstrating the need for healthcare access among Virginia's homeless population[7], and

WHEREAS, the American Medical Association has three policies that explicitly advocate for improving healthcare access for the homeless[10], and

WHEREAS, while the MSV Board of Directors has recognized the importance of housing as healthcare in their 2023 HOD report, no policies or actions have been taken to improve access to care or eradicate homelessness in Virginia[11], therefore be it

RESOLVED, that our Medical Society of Virginia supports evidence based and cost-effective efforts to eradicate homelessness and supports initiatives to enhance healthcare access for individuals experiencing housing insecurity.

Fiscal Impact: none
Existing Policy: none

Citations

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24-202

Coverage of Human Milk Products by Commercial and Public Insurance

Submitted by Jonathan Swanson MD, MSc, MBA and Jenny Fox, MD, MPH

WHEREAS, human milk is universally acknowledged by the American Academy of Pediatrics, Academy of Breastfeeding Medicine and the European Society for Pediatric Gastroenterology, Hepatology and Nutrition as the optimal source of nutrition for infants, providing essential nutrients, immunological benefits, and promoting healthy growth and development[1], and

WHEREAS, the use of pasteurized donor human milk (PDHM) is a critical intervention for infants who cannot receive their mother's own milk, particularly for very low birth weight and other high-risk infants, significantly reducing the risk of serious health complications such as necrotizing enterocolitis, sepsis, and mortality[2,3], and

WHEREAS, human milk products can serve as a life-saving medical intervention, especially in neonatal intensive care units where vulnerable infants require specialized nutrition for survival and optimal development, and

WHEREAS, numerous studies have demonstrated the cost-effectiveness of using PDHM and human milk products by reducing the length of hospital stays and lowering healthcare costs associated with treating complications related to formula feeding in high-risk infants[4,5], and

WHEREAS, access to PDHM and human milk products should not be restricted by socioeconomic status, and equitable access is essential to ensuring all infants can benefit from these life-saving and health-promoting interventions, therefore be it

RESOLVED, that the Medical Society of Virginia supports and advocates for the inclusion of pasteurized donor human milk and human milk products in the coverage plans of both commercial and government insurance providers; and will work with healthcare providers, insurance companies, and policymakers to promote the implementation of policies that ensure reimbursement for PDHM and human milk products, ensuring all infants in need have access to these essential nutritional resources.

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[4] Swanson JR, Becker A, Fox J, Horgan M, Moores R, Pardalos J, et al. Implementing an exclusive human milk diet for preterm infants: real-world experience in diverse NICUs. *BMC Pediatr* 2023; 23(1):237.

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24-203

Resolution on Early Prescription Eye Drop Refills in Virginia

Submitted by The Richmond Academy of Medicine

WHEREAS, glaucoma is a common eye condition that affects over 3 million Americans and is the second leading cause of blindness[1], and

WHEREAS, 75% of glaucoma patients will require one or more topical eye drop for an extended period of treatment[1], and

WHEREAS, 53-61% of patients regularly administer more than the prescribed one drop at a time due to difficulty self-administering eye drops, physical disabilities, and other challenges leading to many patients running out of eye drops before their next refill[2,3], and

WHEREAS, restrictions on eye drop refills puts patients at risk of permanent visual impairment and blindness and causes significant financial burdens on patients who are disproportionately elderly, and

WHEREAS, 30 states have passed laws allowing early refills of prescription eye drops with the support of the American Academy of Ophthalmology and the American Glaucoma Society[4,5], therefore be it

RESOLVED, that the Medical Society of Virginia supports legislation requiring insurance reimbursements for early refills of prescription eye drops.

Fiscal Impact: None

Existing Policy: None

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[4] American Academy of Ophthalmology. AAO and AGS Statement on Glaucoma Eye Drop Availability - 2014. Accessed August 4, 2024. https://www.aao.org/education/clinical-statement/aao-ags-statement-on-glaucoma-eye-drop-availabilit

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24-204

Equitable Access to Care for Individuals with Disabilities

Submitted by the Medical Society of Virginia Medical Student Section

WHEREAS, there are roughly 42.5 million people in the United States who live with a disability of hearing, vision, cognitive, walking, self-care or independent living difficulties, which is about 13% of the general population[1], and

WHEREAS, in Virginia there are 994,957 residents living with one or more disability, which equates to about 12% of the Virginia population[2], and

WHEREAS, despite the Americans with Disabilities Act passed in 1990 requiring full and equal access to healthcare services and facilities for individuals with disabilities[3], people with disabilities still face significant barriers to basic health care[4], and

WHEREAS, individuals with disabilities face significant difficulties accessing preventative care services[5]: for example, women with disabilities have been shown to have significantly lower rates of timely mammogram screenings and pap tests compared to women without disabilities[6], and

WHEREAS, patients with disabilities have reported difficulty using common medical equipment such as exam tables, imaging equipment, weight scales, and exam chairs due to accessibility, safety issues, and discomfort[7], and

WHEREAS, the Virginia Board for People with Disabilities reported wide gaps in the availability of healthcare services for individuals with disabilities in rural communities compared to urban ones[8], and

WHEREAS, a recent audit in Richmond, Virginia found several compliance issues with ADA requirements at 12 different facilities run by Virginia's behavioral health agency including hospitals and medical centers[9], and

WHEREAS, while the Medical Society of Virginia has no policies on this topic, the American Medical Association has 7 extensive policies that advocate for equitable and full access to healthcare services and facilities for individuals with disabilities[10], therefore be it

RESOLVED, that the Medical Society of Virginia Board of Directors do research and produce a report on the disparities in access to healthcare faced by individuals with disabilities in the state of Virginia.

Fiscal Impact: none
Existing Policy: none

Citations:

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24-205

Resolution on Expansion of Medicare Open Enrollment

Submitted by The Richmond Academy of Medicine

WHEREAS, Medicare Advantage plans, while increasingly popular with patients, are fraught with problems, and

WHEREAS, these policies have become increasingly difficult to utilize appropriately for not only patients but for physicians, hospitals, and other providers, and

WHEREAS, many providers are beginning to exit these programs due to difficulties with prior authorizations and poor payment rates. As these providers leave these plans, patients will be left with even more narrow network of providers over time, and

WHEREAS, this comes at a time for seniors when they likely need more specialty care rather than less, and

WHEREAS, studies also show that Medicare Advantage costs taxpayers more per beneficiary than Traditional Medicare. The Health and Human Service's Department's inspector general has reported that some Advantage plans have denied coverage for care that should have been provided under Medicare's rules. Again, leaving patients without appropriate care, and

WHEREAS, switching back from Medicare Advantage to Traditional Medicare and a Medicare Supplement can be difficult for most individuals. Unless this transaction takes place in the first year of Medicare eligibility, patients may need to undergo underwriting of their Medicare Supplement policy and therefore pay a markedly increased premium or be denied entirely, and

WHEREAS, this is contrary to the tenets of the ACA, which has sought to protect people with pre-existing illnesses from excessive premiums. Seniors should not be subjected to this when we all agree younger patients are not, and

WHEREAS, several states have provided legislation to liberalize the path back to Traditional Medicare and Medicare Supplements. These include NY, ME, MA, and CT. They have provided for a variety of situations to allow this conversion which include extended open enrollment periods or at least periodic open enrollment periods, as well as guaranteed issue, and

WHEREAS, guaranteed issue allows the patient the benefit of the lower premium provided to individuals of the same age who started with Traditional Medicare without any discrimination regarding pre-existing illness, and

WHEREAS, increased regulatory and administrative burdens including prior authorization as part of Medicare Advantage Plans create moral injury for physicians, their staff, and their patients, therefore be it

RESOLVED, that MSV supports legislation and regulations that would identify a transition back to Traditional Medicare and Medicare Supplement and away from Medicare Advantage.

Supplemental Information

- CT Medicare Guaranteed Issue 38a-495a-8a.pdf
- Connecticut Insurance Department Medigap Fact Sheet.pdf
- Maine.Buy_Switch Outside Open Enrollment _ PFR Insurance.pdf
- Mass.Section 71.10 - Open Enrollment and Guarantee Issue for Medicare Supplement Insurance.pdf
- Medicare Advantage Is Under Fire. What It Means for Your Health—and Wallet. - Barron's.pdf
- Medigaps in New York State.pdf
- Protections For Medicare Beneficiaries Residing in New York State.pdf

24-206

Healthcare for People Who Are Incarcerated

Submitted by the Medical Society of Virginia Medical Student Section

WHEREAS, since 2002 the United States has had the highest incarceration rate in the world[1], of which 23,934 are Virginia state inmates as of February 2023[2], and

WHEREAS, people who are incarcerated have shown an increased risk of earlier mortality[3], decreased access to mental health resources[4], and lower rate of receiving preventative services[5], and

WHEREAS, the number of incarcerated adults aged 50 and older is increasing, but many facilities are ill-equipped to handle their specific needs[6], leading to higher rates of geriatric conditions in incarcerated individuals compared to the general population[7], and

WHEREAS, in Virginia, the third court-ordered monitoring report of the Scott v. Clark case for Fluvanna Correctional Center for Women in 2022 indicates that, despite the 2016 settlement intended to enhance healthcare for the inmates, the facilities still fail to provide adequate medical care; five women received incorrect prescription medications, two women encountered issues accessing disability-related equipment, and one woman did not receive batteries for both of her hearing aids for months[8,9], and

WHEREAS, an ongoing lawsuit involves Charles Givens, an intellectually disabled inmate at Virginia's Marion Correctional Treatment Center who, over five years, was repeatedly hospitalized showing signs of abuse, was admitted five times for hypothermia in his final year, and was allegedly beaten to death by correctional officers[10], and

WHEREAS, the grand jury in the Charles Givens lawsuit described the conditions of southwest Virginia prisons as “inhumane and deplorable”[11], and

WHEREAS, records and reports showed that inmates at Marion, which houses predominantly mentally ill offenders, were hospitalized for hypothermia at least 13 times in three years during cold-weather months which concerned medical providers, exterior windows were allegedly opened as a form of punishment during winter, and multiple witnesses observed ice forming on the toilets[11], and

WHEREAS, while the Medical Society of Virginia has no policies on this topic, the American Medical Association has over 30 policies covering healthcare needs and protections for the incarcerated population[12], therefore be it

RESOLVED, that the Medical Society of Virginia supports efforts to provide high quality, routine, protective and accessible healthcare to people who are and have previously been incarcerated, and be it further

RESOLVED, that the Medical Society of Virginia is against the cruel and unusual punishment of people who are incarcerated and supports livable and safe conditions for all those who are incarcerated, and be it further

RESOLVED, that the Medical Society of Virginia supports providing medical students with access to specialized training focused on healthcare for individuals who are currently or formerly have been incarcerated.

Fiscal Impact: none
Existing Policy: none

Citations

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24-207

Mandatory Stop the Bleed Training in Medical Schools

Submitted by the Medical Society of Virginia Medical Student Section

WHEREAS, per the World Health Organization, hemorrhage secondary to severe trauma is the leading cause of death under age 45, accounting for 35% of injury-related mortality in the United States[1], and

WHEREAS, Virginia has seen an exponential rise in mass casualty events, including a 72% increase in firearm ED visits from 2018 to 2021, 42% increase in gun violence deaths and a 24% increase in motor vehicle traffic accident fatalities, over the past decade[2,3], and

WHEREAS, studies have consistently shown that hemorrhage is the most common cause of preventable death[4], and

WHEREAS, hemorrhage from a major arterial source may rapidly lead to exsanguination and death in as little as 3-5 min[5], and

WHEREAS, in trauma patients predicted to require massive transfusions upon emergency department arrival, time to definitive care was a median of 57 minutes, with a range of 12-232 minutes[6], and

WHEREAS, firearms and motor vehicle traffic accidents are the first- and second-leading causes of death among children and teens in Virginia[7], and

WHEREAS, bystander intervention in rapid hemorrhage control has effectively demonstrated a 4.5 fold decrease in the risk of hypovolemic shock, significantly decreasing pre-hospital mortality[8], and

WHEREAS, Stop the Bleed is a nationally-recognized, evidence-based hemorrhage control program, designed to teach medical and non-medical persons appropriate use of tourniquet placement and wound packing[9,10], and

WHEREAS, hemorrhage-control training is not a standardized course offered in Virginia medical schools[11], and

WHEREAS, the implementation of hemorrhage control training at the University of Arkansas for Medical Sciences College of Medicine has been shown to improve medical students' preparedness to manage life-threatening bleeding and contribute effectively during mass casualty events, demonstrating the feasibility and benefits of such education[4], therefore it be

RESOLVED, that the MSV supports implementation of Stop the Bleed Training in Virginia medical school curricula.

Fiscal Impact: none
Existing Policy: none

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24-208

Resolution to move the Profession of Medicine from its present location in an economic free market to the Code of Virginia

Submitted by Dr. Monroe Baldwin

WHEREAS, it is an established fact that the preponderance of illness is located in low-income communities, and

WHEREAS, the practice of medicine is out in the free market economic structure requiring patients to be able to pay, thereby creating a financial obstruction preventing low-income patients from the care of physicians, and

WHEREAS, water, gas, and electricity are distributed by utilities favorably regulated by government and are located in the Code of Virginia, and

WHEREAS, healthcare could be considered a product as are gas, electricity, and water to be delivered as a utility in the Code of Virginia, therefore be it

RESOLVED, that the profession of medicine be moved to the Code of Virginia where rules, regulations, with penalties and exceptions can be described.

24-209

Proposal for Removal of Certificate of Need Laws in Virginia

Submitted by Gregory J. Warth, MD and Keith Berger, MD
on behalf of the Coastal Virginia Medical Society

WHEREAS, there are over (120) economic peer reviewed studies that have been already performed at the federal and states level across the country in the past three decades that have demonstrated that Certificate of Need (CON) laws result in significantly higher health care costs without improving access or quality of care, and

WHEREAS, these laws are in fact responsible for lack of adequate numbers of hospital beds resulting in the unsafe overcrowding of emergency rooms all over the state, leading to poor quality of care, and

WHEREAS, seventeen states other than Virginia and even the Federal Government have already determined that CON laws are detrimental to patient care and significantly increase costs, and as a result, have repealed their CON laws, therefore be it

RESOLVED, that MSV strongly supports and encourages legislation to completely repeal Virginia's Certificate of Need laws which restrict access to patient care, increase healthcare costs and serve no useful purpose for the betterment of healthcare.

MSV Policy: 30.4.04- MSV COPN Policy Date: 1/20/2016 The Medical Society of Virginia supports the deregulation of COPN. The Medical Society of Virginia will consider supporting individual COPN legislation on a case-by case-basis, with decision for approval derived from previously adopted principles of patient safety and access to quality, affordable health care. The Medical Society of Virginia continues to support the economic viability of Virginia's academic health centers. Newly deregulated services should be required to meet a charity care commitment as well as recognized standards of accreditation or quality. Reaffirmed 5/6/2017 Reaffirmed 10/15/2023

References:

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24-210

Transgender Hormonal Treatment and Surgeries for Minors

Submitted by Kurt Elward, MD and Thomas Eppes, MD

WHEREAS, so called Gender-affirming hormonal treatments and surgeries (GAHS) are being promoted to youth and parents for gender dysphoria (GD), and

WHEREAS, the governments and medical/academic institutions of the UK [1-4] Sweden [5-7] Finland, [8] and Denmark [9] have rejected prioritizing gender transition in favor of emphasizing extended mental health evaluation and support; for example

- The UK closed the world's largest pediatric gender clinic, NHS's Tavistock Gender Identity Development Service,i [10] per findings of the Cass Review Interim Report. 11] and
- Comprehensive literature reviews done in the UK, [12-15] Sweden, [16-17] Finland, [18] and Germany [19] show GAHS is out of step with the evidence base for gender dysphoric youth, and

WHEREAS, transition procedures are not proven effective, not proven safe, [20,21,22] do not improve mental health, [23,24,25, 26] and do not reduce (and may increase) suicides, [27-29], and

WHEREAS, GAHS does not comprise a standard of care for gender dysphoria, for example,

- The 2017 Endocrine Society Guidelines, carries this disclaimer: "The guidelines cannot guarantee any specific outcome, nor do they establish a standard of care." [30]
- So-called gender affirming care "guidelines" derive from the World Professional Association for Transgender Health's SOC 7, rated by a 2021 BMJ review with a quality score of 0 out of 6 [31] ii and yet the latest SOC 8 version goes further to remove age restrictions for medical and surgical interventions. [32, 33]
- The American Academy of Pediatrics' current policy has been questioned as misrepresenting references that actually contradicted their transition policy and in fact advised watchful waiting, as well as omitting the fact of desistance over puberty being the norm for gender dysphoria in minors, among other serious flaws. [34] and

WHEREAS, GAHS imperils already at-risk gender dysphoric youth with experimental and unproven hormonal and surgical gender procedures, which medicalize prematurely and permanently [24, 35-37], and

WHEREAS, minors cannot give fully informed consent, [38] because children have developing and immature brains; their decision processing skills are still being formed; they are prone to risk taking and vulnerable to peer-pressure; and they have difficulty recognizing long-term consequences. [39-41] as per a recent ruling in Bell vs. Tavistock (2020) which specified, "There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years." [42], therefore be it

RESOLVED, that the MSV opposes transgender both hormonal and surgical procedures on persons 18 years of age and younger.

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24-211

Resolution to Save Resources in the Perioperative Arena

Submitted by The Richmond Academy of Medicine

WHEREAS, we are not good stewards of resources in the peri-operative space, wasting medication and creating huge amounts of medical waste, and

WHEREAS, for example, if a patient receives eyedrops during or after a surgical procedure, the medication is thrown away instead of given to the patient, event when that medication is required for continued treatment, and

WHEREAS, Colorado has passed legislation that would allow a health-care provider, a health-facility, and a hospital pharmacy to provide a patient with certain facility-provided medications if the medication is required for continued treatment (SB24-087), therefore be it

RESOLVED, that the MSV supports patient retention of any unused medication administered during a surgical procedure or appointment upon discharge when the medication is required for continued treatment.

Reference:
Colorado Legislation -https://leg.colorado.gov/sites/default/files/2024a_087_signed.pdf

24-212

Resolution Supporting Innovative Models of Primary Care

Submitted by The Richmond Academy of Medicine

WHEREAS, lack of access to affordable, high-quality primary care is a serious problem for many, especially the uninsured (Crowley R et al. 2020), and

WHEREAS, even individuals with health insurance confront many barriers to obtaining timely, adequate primary care services (Crowley R et al. 2020), and

WHEREAS, primary care physicians in typical insurance-based practices are experiencing high rates of burnout and job dissatisfaction due to the ever-increasing administrative burdens placed on them by the third-party payer system (Agarwal SD et al. 2020), and

WHEREAS, interest in primary care specialties among medical students continues to decline (Knight V 2019), and

WHEREAS, innovative models of primary care delivery and payment have emerged in The Commonwealth of Virginia and around the country, notably the Direct Primary Care (DPC) practice model, which is a model that "can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Patients, in turn, benefit from having a DPC practice because the contract fee covers the cost of many primary care services furnished in the DPC practice. This effectively removes any additional financial barriers the patient may encounter in accessing routine care primary care, including preventative, wellness, and chronic care services" (AAFP Policy 2023), and

WHEREAS, direct primary care practices allow for greater physician autonomy while managing smaller panels of patients, spending more time with their patients, and being able to better monitor and achieve quality of care, and

WHEREAS, in 2017 Virginia passed DPC legislation that recognizes that DPC is not insurance (Code of Virginia 2017), and

WHEREAS, new policies are needed to support innovation and growth in primary care, therefore be it

RESOLVED, that the MSV supports the growth and development of innovative models of primary care delivery and payment with the potential to re-establish the direct relationship between patients and their physician while providing affordable, accessible, quality care and maintaining physician autonomy, and be it further

RESOLVED, that the MSV supports legislation to enable the growth and development of physician-led innovative primary care practice models as part of the overall solution to the healthcare system problems in the US, and be it further

RESOLVED, that the MSV supports the efforts of physician-led innovative primary care practice models to create financial independence for primary care practices from the third-party payer system.

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24-213

Healthcare Protections for In Vitro Fertilization

Submitted by David Archer, MD on behalf of the Coastal Virginia Medical Society

WHEREAS, women's health rights are being attacked in many states across the country resulting in loss of civil rights of women and their families to plan their own lives, and

WHEREAS, MSV does not yet have a policy regarding in-vitro fertilization (IVF), and

WHEREAS, the Commonwealth of Virginia currently is protective of IVF and women's reproductive rights, and

WHEREAS, we wish to continue to protect IVF and women's reproductive rights in Virginia, therefore be it

RESOLVED, that MSV opposes legislative or regulatory restrictions on access to IVF.

MSV Policy: Abortion and Reproductive Decision Making
25.1.01- Opposition to Title X Prohibition on Abortion Counseling or Referral Date:
11/9/1991 The Medical Society of Virginia opposes Title X regulations that prohibit counseling or referral for abortion services and prohibit any discussion of abortion between the physician and the patient. The Medical Society of Virginia urges federal legislation or executive action to overturn or rescind such regulations. Reaffirmed 10/30/2011 Reaffirmed 10/23/2021

25.1.02- Opposition to Criminalization of Reproductive Decision Making
Date: 11/2/2012 The Medical Society of Virginia will oppose any legislation or ballot measures that could criminalize or impose civil penalty for obtaining or providing evidence-based reproductive health services. Amended by Substitution 10/30/2022

25.1.03- Support of Expansion of Access to Long Acting Reversible Contraception (LARC)
Date: 10/20/2019 The Medical Society of Virginia supports efforts to promote and sustain Long Acting Reversible Contraceptives (LARC) initiatives in Virginia, including continued funding. The Medical Society of Virginia further supports efforts that allow physicians to more efficiently offer LARC services in their practices.

25.1.04- Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services
Date: 10/20/2019 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 includes the provision of contraception or abortion. 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 and clinics that in turn make it economically or physically difficult for healthcare providers and clinics to provide services. Amended by Substitution 10/30/2022

Reference: American Society for Reproductive Medicine, Written Testimony for the Senate Judiciary Committee Hearing on "The Continued Assault on Reproductive Freedoms in a Post-Dobbs America," American Society for Reproductive Medicine, March 20, 2024.
https://www.cvmedicalsociety.org/support-files/asrm-womens-rights.pdf

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2024

Consent Calendar: Informational Reports

1. MSV Board of Directors Actions on the 2023 Resolutions Referred to the Board
2. MSVPAC Report
3. MSV Foundation Report
4. AMA Virginia Delegation Report
5. MSV Medical Student Section Report
6. Virginia Board of Medicine Annual Report
7. Physician Assistant Section Report

MSV BOARD OF DIRECTORS

Report on the Employed Physicians Section Workgroup

Membership

Randolph Gould, MD; Brenda Stokes, MD; Peter Netland, MD; Mark Townsend, MD; Brooke Trainer, MD; Bobbie Sperry, MD; Cliff Deal, MD

Meetings

07/24/2024, 08/20/2024

Report

During the April MSV Board meeting, the Board approved action on 2023 MSV HOD Resolution *23-114: Employed Physicians Section within the Medical Society of Virginia*. MSV staff worked with President Dr. Alice Coombs to establish a member-led workgroup to review this issue before the 2024 House of Delegates Meeting and to produce a report with recommendations.

The workgroup's first meeting explored MSV resolution 23-114, which proposed that the MSV Board of Directors study the feasibility of establishing an employed physicians section. The main discussion centered on forming a specific section for employed physicians or creating an ad hoc advisory committee or caucus established by the President. The group also reviewed and discussed the findings from a survey of other state medical associations, noting a general lack of specific groups for employed physicians. The group reached consensus and proposed the formation of an ad hoc advisory committee that will focus on the needs of employed physicians, including holding open forums and a meeting during the MSV Annual meeting. Scott Johnson, legal counsel for the MSV, noted that the group would need to remain vigilant to ensure that committee discussions would remain legal by never discussing compensation or benefits.

During the second meeting of the workgroup, the members reviewed the AMA's ongoing efforts to support employed physicians, the resources available to its members, and their reporting on employment trends within the physician community. The workgroup expressed concerns that health systems are moving from contracts to COMPACs (Compensation and Benefits Advisory Committees), which are more restrictive and may not be adequately addressed by the AMA's current framework. Members discussed the prevalence of non-compete contracts for employed physicians and the need for the AMA to advocate for their elimination. Additional discussion was had regarding the challenges of managing nursing staff within health systems, with many physicians reporting difficulties in retaining and incentivizing their team members due to a lack of control over staffing decisions. Members suggested that developing a "Bill of Rights" for employed physicians should be considered to address these concerns. The workgroup agreed that this would be a valuable resource for employed physicians and could be used as a foundation for further discussions on improving working conditions in Virginia and the United States.

Recommendations

The workgroup recommends the following actions:

- The MSV President should establish an Ad Hoc Advisory committee focused on the needs of employed physicians. This group should initially function for a trial period of three years, after which its effectiveness can be assessed. This committee should hold regular meetings, either monthly or bimonthly, to maintain its momentum.
- The MSV should gather feedback from employed physicians to ensure that its efforts align with their needs. This should start by polling the membership to gather information regarding various elements of their employment scenarios.
- The MSV should create a dedicated resource page on the MSV website that offers easy access to AMA policies, contract templates, and other support materials relevant to employed physicians.
- The MSV House of Delegates should consider drafting a "Bill of Rights" for employed physicians that addresses key issues such as non-compete clauses, COMPACs, staffing control, and termination processes. A review of existing AMA policies should be conducted beforehand to determine their applicability in Virginia.
- The MSV should partner with the AMA to establish a model that can be used in other states to support their employed physician population.

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Evaluating Drug Donation Programs: A MSV Perspective

Access to essential medications is a significant challenge for low-income and uninsured patients in the United States.[1] One solution gaining traction nationally is drug donation programs, which facilitate the redistribution of unused, unexpired prescription medications. These programs work to reduce pharmaceutical waste while improving healthcare equity. The 2023 Medical Society of Virginia (MSV) House of Delegates (HOD) saw the introduction of *Resolution 23-210: Increasing the Number of Collection Sites for Donated Drugs*. The final report from the HOD directed the MSV Board of Directors to produce a report for its consideration of the topic. Accordingly, this report seeks to evaluate drug donation programs' implementation, benefits, and challenges, offering recommendations for how the Medical Society of Virginia (MSV) may move forward on evaluating policy on these programs.

Prescription drug donation and reuse programs or drug repositories aim to increase medication access, especially to underserved populations without insurance or limited financial means. These programs collect unused, unexpired prescription medications and redistribute them to qualifying locations for use within socioeconomically disadvantaged populations. Generally, these programs exclude controlled substances and drugs requiring special storage involving refrigeration. Federal and state regulations govern the donation and redistribution of prescription drugs collected in this manner. Programs must adhere to quality assurance measures, ensuring that donated medications are unexpired, properly stored, and in original packaging. Compliance with Food and Drug Administration (FDA) guidelines and state-specific regulations is essential to ensuring the safety and efficacy of donated medications.[2]

Virginia and 43 other states, Washington D.C. and Guam, have enacted legislation establishing prescription drug repository programs. [3] Some variations exist across states regarding the types of drugs accepted for re-distribution, eligibility parameters, protocols for drug transfer, pharmacy dispensing fees, agency oversight, and funding mechanisms. Most states permit cancer drug donation, but five states, Florida, Iowa, Michigan, Montana, and Nebraska have a separate repository program for specific cancer drugs. In Virginia, the Board of Pharmacy (BOP) registers and maintains the list of active pharmacies that apply for a permit to serve as drug donation sites.[4] Once registered, a drug donation site may receive eligible drugs, transfer them to another donation site, or deliver them to be re-dispensed to socioeconomically disadvantaged patients of hospitals or clinics.[5] Currently, there are only 17 locations that serve as collection sites for donated drugs in the Commonwealth, as maintained by BOP records.[6]

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In the United States, hospitals and long-term care facilities are estimated to incinerate or dispose of at least $5 billion of unexpired medicines yearly.[7] Medication in these settings often goes unused because patients' conditions improve, they change doses, change care settings, or pass away. Drug donation programs have a notable economic impact by reducing pharmaceutical waste, which ultimately cuts costs for healthcare systems and patients. They have been found to significantly improve access to medications for underserved populations by addressing medication adherence.[8] The reasons for patient medication nonadherence are complex[9], but one major barrier to adherence is the cost of the medicine prescribed.[10] Medication nonadherence has numerous consequences, including increased rates of comorbid diseases, more hospitalizations, avoidable deaths, and greater healthcare expenditures.[11] The United States sees at least 100,000 preventable deaths a year due to medication nonadherence and over $100 billion in preventable medical costs.[12] Additionally, medication nonadherence was found to be significantly associated with an increased risk of hospitalization, longer hospital stays, and greater hospitalization costs.[13] Drug donation programs effectively save the entire healthcare system money and reduce the overall financial burden of socioeconomically disadvantaged populations in hospitals and emergency rooms.

Cancer affects 40% of all Americans during their lifetime, and the financial burden of cancer care represents a significant contribution to the overall cost of health care in the United States.[14] Although many new anticancer drugs are costly, oral antineoplastics often have the most significant fiscal impact on patients.[15] Unfortunately, it is quite common for patients to have limited access to, or to discontinue treatment with, oral antineoplastics because of cost.[16] The abandonment rate of newly initiated oral oncolytic medications was found to be 10%[17], and the rates were higher for individuals who had greater cost-sharing requirements. Cancer drug repository programs offer a unique solution for patients with limited financial ability to access lifesaving medications while

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reducing medical waste.[18] The establishment of such a program in Virginia could provide additional cost savings to the healthcare system but would require renewable funding sources to be ultimately successful.

In 2022, the Virginia Board of Pharmacy released a report on the prescription drug donation program as requested by Senator Favola's SB 14 (2022)[19]. The workgroup found that while Virginia does not track the success of the current drug donation program, participation is believed to be low. The workgroup offered various recommendations to increase program participation, including consideration of a central donation model, streamlined BOP regulations, and increased public awareness.[20] While the effectiveness of donated drug programs in Virginia is not currently tracked, it is programmatically limited by the number and location of collection sites currently in place and current public awareness of the program. Additional locations could permit individuals to donate qualifying medications more easily and strengthen the logistical network to deliver donations to socioeconomically disadvantaged populations across the Commonwealth.

The MSV can advocate for expanding those donated drug sites, but if it does, it should ideally play a supporting role in those advocacy efforts. The MSV could work with the Virginia Pharmacy Association[21] and the Board of Pharmacy to support correspondence, outreach, legislation, regulatory reforms, or budget language to increase the number of participating pharmacies. Likewise, similar efforts could be made to establish a separate repository program for cancer drugs. Because Virginia does not track the efficacy of these programs, the MSV could consider working with stakeholders to require a statewide reporting structure before advancing efforts to expand the program further. Additionally, the MSV could support educational initiatives by working with its component societies to promote the program's existence in their regions. A webpage could be established to inform MSV members and their patients of the program and foster greater participation of qualifying facilities on how and where to donate medications.[22]

Drug donation programs offer a practical and impactful solution to improve medication access while reducing pharmaceutical waste. By supporting the expansion of these programs, the MSV can contribute to a more equitable healthcare system and enhance public health outcomes for socioeconomically disadvantaged patient populations in Virginia.

[18] Heater NK, Kircher S, Weldon C, Trosman J, Benson A. Oncologic Drug Repository Programs in the United States: A Review and Comparison. *Health Affairs Scholar*. 2024;2(3). doi:https://doi.org/10.1093/haschl/qxae031
[19] Legislative Information System. Virginia.gov. Published 2024. Accessed September 1, 2024. https://lis.virginia.gov/cgi-bin/legp604.exe?221+sum+SB14
[20] Board of Pharmacy, Health. RD791 (Published 2022) - Report of the Virginia Board of Pharmacy on the Prescription Drug Donation Program Pursuant to Chapter 703, Senate Bill 14 – December 1, 2022. Virginia.gov. Published 2022. Accessed September 1, 2024. https://rga.lis.virginia.gov/Published/2022/RD791
[21] Home - Virginia Pharmacy Association. Virginia Pharmacy Association. Published August 7, 2024. Accessed August 28, 2024. https://virginiapharmacists.org/
[22] Drug Recycling Program | Tulsa County Medical Society | United States. TCMS. https://www.tcmsok.org/drug-recycling-program

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September 24, 2024

Dear MSV Colleagues,

I am pleased to provide you with a summary of the developments of the MSVPAC for the first nine months of 2024.

Due to the MSV Board of Directors' contributions in 2023, the MSVPAC brought in the most individual donations since 2017. In short, this means that our individual donations are on par with 2017, but our practice donations are still down by half.

During the September MSV board meeting, the MSV PAC Board respectfully asked the Board of Directors to again engage in a fundraising push targeted toward medical practices. Many board members are taking action. As we enter the final months before the General Assembly session, we must urge everyone to reach out and get practices to contribute as soon as possible.

After the MSVPAC September board meeting, Dr. Razi Ali of Richmond accepted the chairmanship of the MSPAC from Dr. Bruce Silverman. We thank Dr. Silverman for his service to the PAC and recognize that as a member and interim chair, his leadership is crucial to our success. The PAC is currently recruiting new board members. Please notify Andrew Densmore or MSV staff if you are interested or have a suggestion. The MSVPAC had a fantastic turnaround in all categories over the past three years. Yet we have much further to go to catch up to pre-Covid levels.

MSVPAC at-a-glance for 2023:		MSVPAC at-a-glance for 2024:	
# of Donations 2023:	267	# of Donations:	202
# of Donations 2022:	160	Goal 2024:	260
Amount Raised 2023:	$118,103.31	Amount Raised 2024:	$68,582[1]
Goal 2023:	$120,000	Goal 2024:	$130,000

2024 Lobby Day Registrations: 427 over four lobby days

Large Practice Outreach

[1] *includes $20,000 from Privia not yet received.

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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.

Docs and Hops and upcoming events

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. So far in 2024 we have hosted three of four Docs and Hops with a total of 94 attendees.

Other events:

MSVPAC October Board Meeting – Sunday October 19th, 7:30AM in-person at the Annual Meeting

2025 Session Review and Lobby Day Announcements via Zoom – November 21, 2024

Annual Meeting

The MSVPAC will again host a sailing fundraiser with Sail Nauticus on the Saturday of the MSV Annual Meeting from 1:30-4:00PM. Tickets are $200 per person or $300 for two tickets.

Fundraising Update

The MSVPAC received contributions from 2,022 physicians, PAs, students, and practices in Virginia for $68,582 in 2024. 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 $45,00 to incumbents with more committed but not yet sent.

For reference:

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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. Razi Ali

Chair, MSVPAC

Andrew Densmore

Political Advocacy Manager, MSV

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MSVPAC Board Roster

Member	Term Beg.	Term End	Term Count	District
Bobby Cochran	8/1/24	7/31/26	1	PA
Bruce Silverman*	1/1/22	12/31/23*	2	3
Barbara Boardman	10/15/22	10/16/24	2	10
Diana Clewett	7/9/24	7/8/26	1	10
Jacqueline Fogarty	10/29/22	10/28/24	2	5
Russell Hawes	7/9/24	7/8/25	NA	Student
Matthew Adsit	7/9/24	7/8/25	NA	Resident
Razi Ali	7/9/24	7/8/26	1	3 Chair

*denotes they continue in their position until a replacement is approved in accordance with MSVPAC bylaws.

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Candidate Contributions to Date 2024

Delegate Jason Ballard	$1000	Senator Creigh Deeds	$1500
Delegate Todd Gilbert	$2500	Senator Barbara Favola	$1000
Delegate Cliff Hayes	$1000	Senator Ghazala Hashmi	$3500
Delegate Charniele Herring	$1500	Senator Chris Head	$2000
Delegate Keith Hodges	$1000	Senator Mamie Locke	$2500
Delegate Patrick Hope	$2500	Senator Louise Lucas	$3000
Delegate Jay Leftwich	$1000	Senator Stella Pekarsky	$1000
Delegate Bobby Orrock	$2000	Senator Todd Pillion	$2500
Delegate Cia Price	$2500	Senator S. VanValkenburg	$1000
Speaker Don Scott	$5000		
Delegate Mark Sickles	$3000		
Delegate Luke Torian	$3000		
Delegate Otto Wachsmann	$1000		

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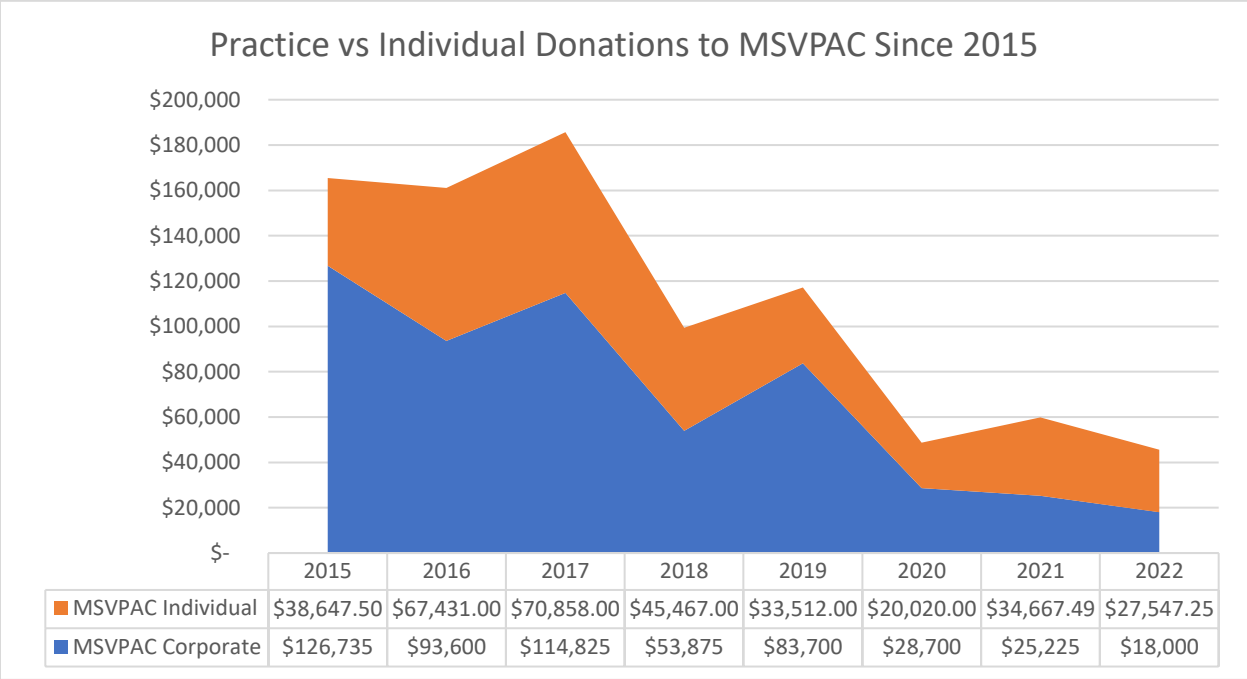
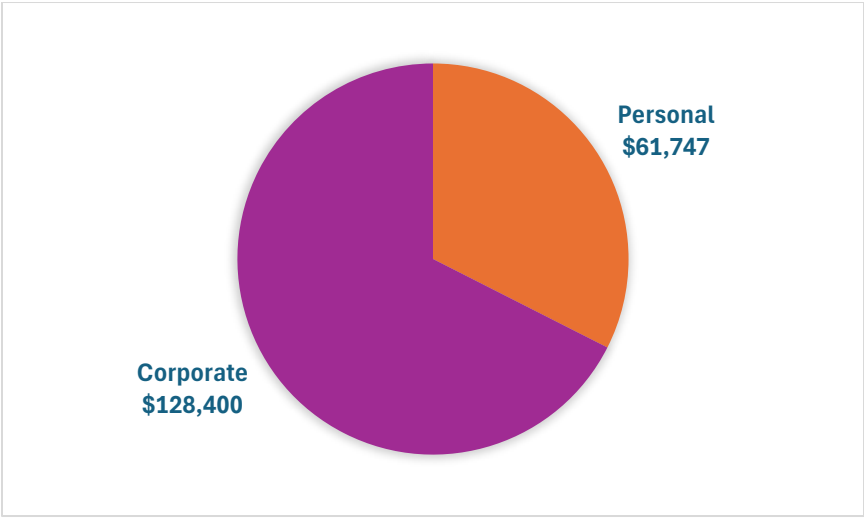


	2015	2016	2017	2018	2019	2020	2021	2022
MSVPAC Individual	$38,647.50	$67,431.00	$70,858.00	$45,467.00	$33,512.00	$20,020.00	$34,667.49	$27,547.25
MSVPAC Corporate	$126,735	$93,600	$114,825	$53,875	$83,700	$28,700	$25,225	$18,000

MSVPAC 2017 Donation Breakdown



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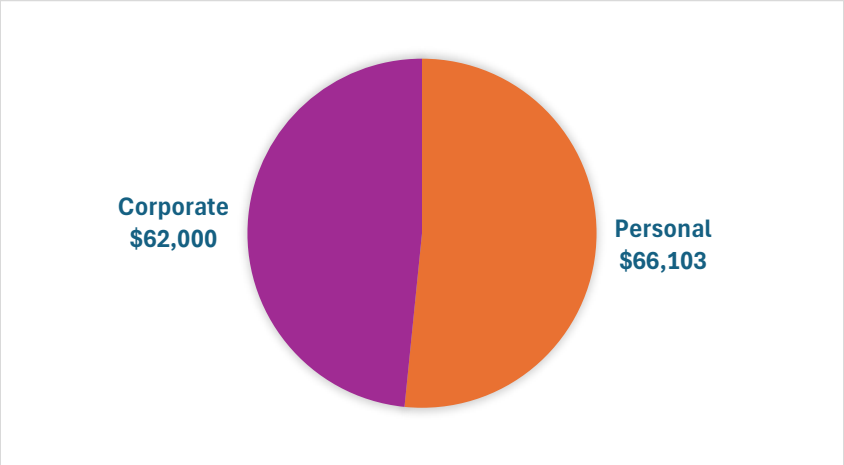
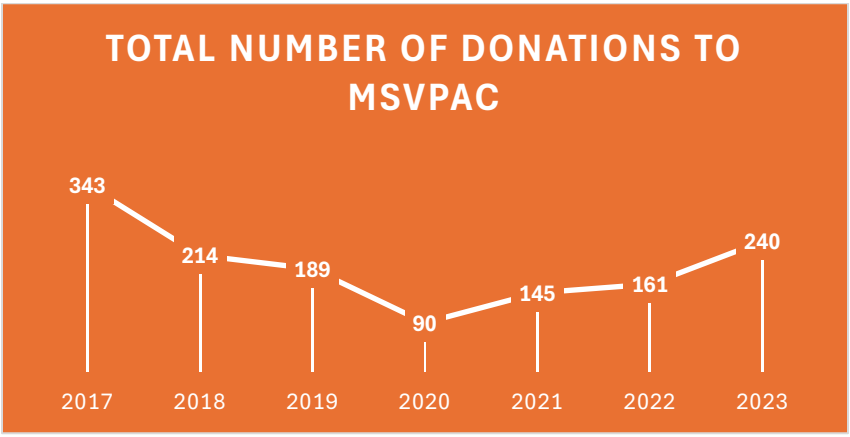
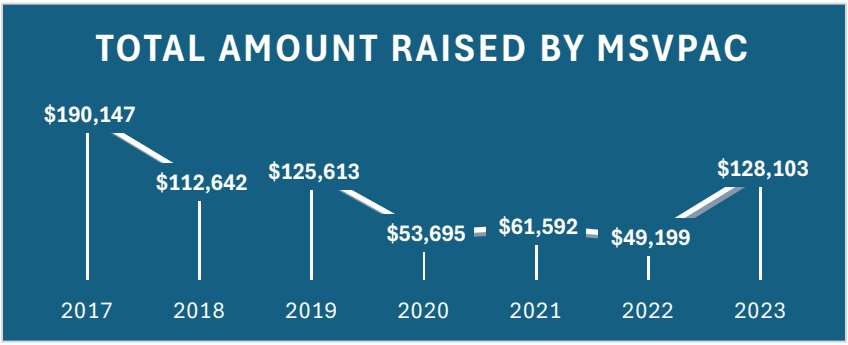
MSVPAC 2023 Donation Breakdown (excluding Privia)







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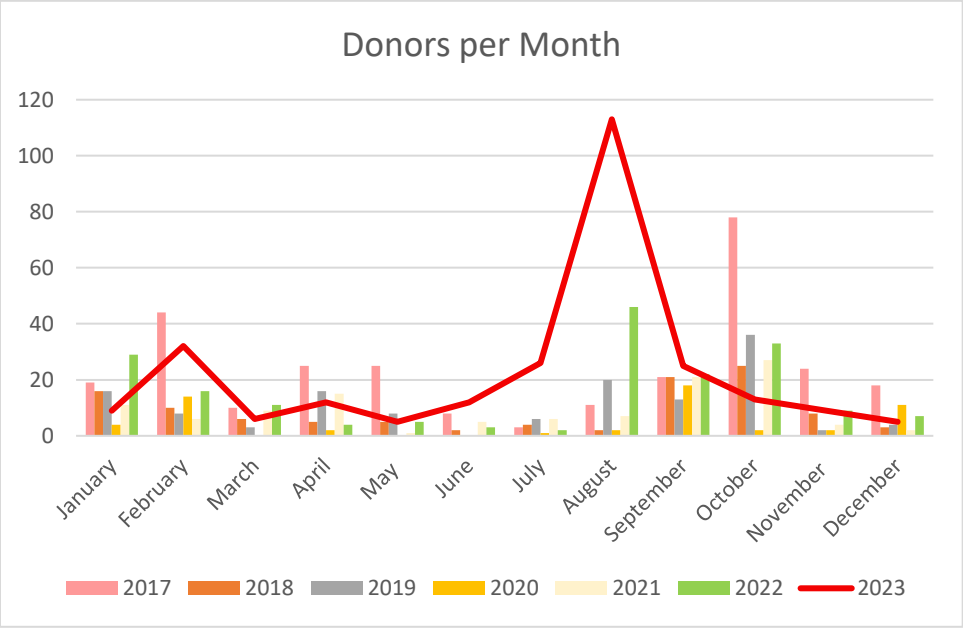

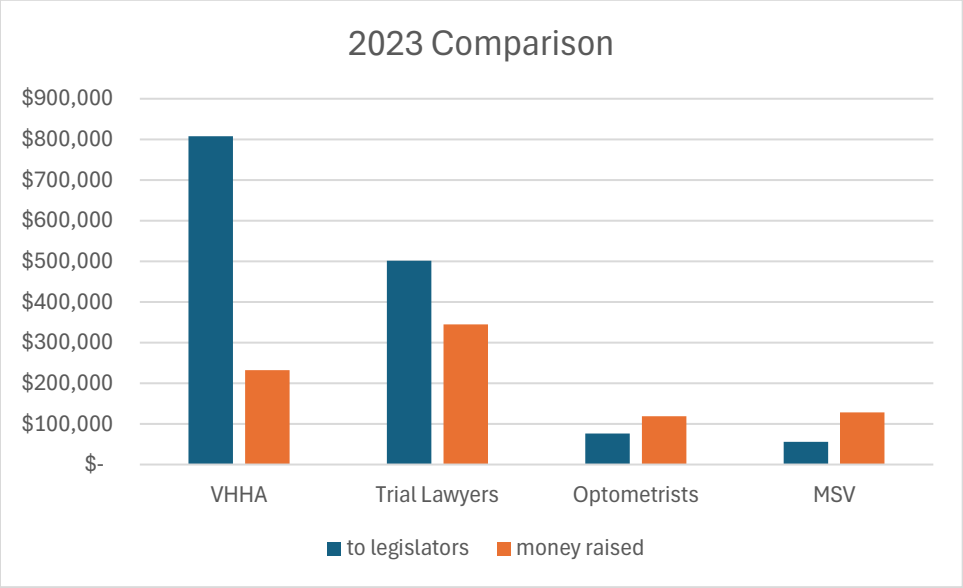

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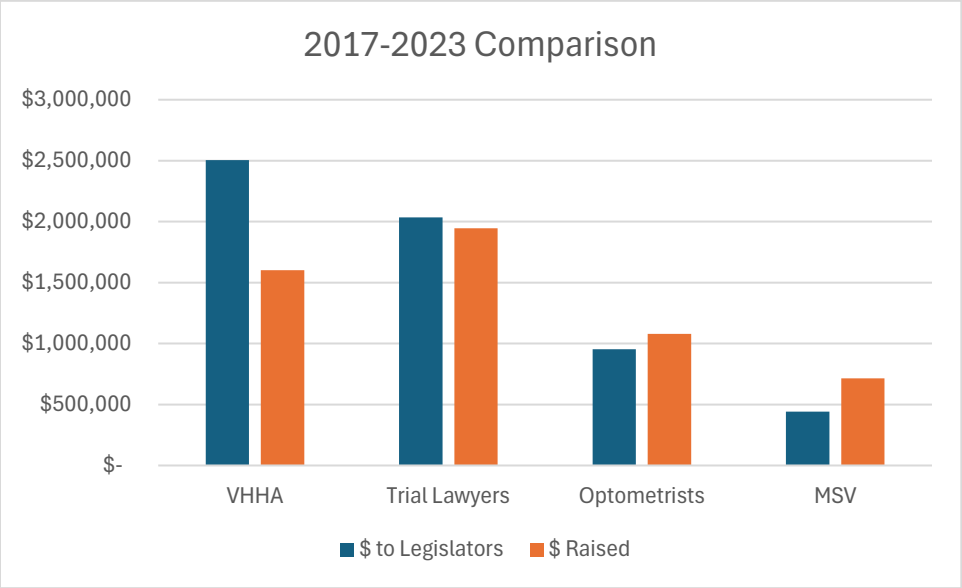

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Date: **September 18, 2024**

To: **MSV Delegates**

From: **MSV Foundation Staff**

Subject: **Updates to Key Foundation and MSV Programs, Activities, Outcomes**

GOVERNANCE

The Medical Society of Virginia Foundation Board met on August 19th 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 14th.

Officers to serve on the MSV Foundation Board for the term of October, 2024 – October, 2025

- Jose Morey, MD – President
- Steven Lewis, MD, MPH – Vice-President
- Mark Townsend, MD, FAAP, FACC, FACP – Secretary

Directors to serve on the MSV Foundation Board for the term of October, 2024 – October, 2027:

- Abraham Hardee, DO, PhD
- Kathleen Scarbalis, PA-C
- Mary Schmidt, MD, FIDSA, MPH
- Carol Shapiro, MD, MBA

PROGRAMS – MSVF and MSV

Virginia Mental Health Access Program (VMAP)

Program Description and Update

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 receives $850,000 a year in HRSA funding through VDH for the next three years.

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Since being named contract administrator in 2020, 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 6,673 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 1,335 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 support for PCPs treating patients ages 5 and under. In 2023, VMAP added early childhood-specialized physicians (developmental pediatricians and/or early childhood child psychiatrists), mental health professionals, and care navigators to the VMAP Line. VMAP also launched multiple new early childhood training programs for PCPs. VMAP's Early Childhood Line – "Press 6 for under 6" went live in April 2023. Call volume for providers calling regarding patients ages 5 and under has been increasing since launch.

In the 2023 General Assembly, the MSV 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 patients.

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 half of the requested amount ($3.9 million) in new funding for FY23-24. The remaining $3.9 million was allocated to VMAP in FY25-26, bringing VMAP's total state funding to $14.8 million per year. As a result, VMAP is in the process of launching its new "VMAP for Moms+" initiative where it will offer training, consultation, and referral support to maternal health specialists, midwives, and PCPs seeing perinatal patients with mental health concerns. The VMAP for Moms+ Line and education programming are set to launch later in 2024.

Staff Contact: Ally Singer Wright (asingerwright@msv.org)

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safe haven™ CONFIDENTIAL SUPPORT

Program Description and Update

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. To date, we have over 8,000 clinicians enrolled in the program.

2024 Goal Updates:

- Legislation was expanded to include dentists and dental hygienists, expanded protections to include outpatient healthcare, and amend the mandatory reporting statute to no longer require reporting if an individual voluntarily admits themselves for treatment and they are deemed no longer to be a danger to themselves or others within 30 days of the initial report.
- Georgia and Illinois have passed legislation and/or updated regulations to offer SafeHaven protections to their healthcare providers. Both have signed agreements with MSV to promote SafeHaven approved resources in their state. The SafeHaven Business Development team will travel to Georgia for the MAG

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Annual Meeting and to host initial conversations with Georgia clinician leaders about offering the SafeHaven resource throughout the state.

- Arizona has also passed legislation and MSV awaits their signed copy of the SafeHaven agreement.
- SafeHaven now has its first two full-time employees: Tiffany Barlow, Project Manager, and Brent Klich, Business Development Manager. Tiffany has built several organizational processes to improve efficiency, and Brent will be responsible for identifying and engaging sales prospects for SafeHaven approved resources in Virginia and other states as we expand.
- SafeHaven is working with the CFP ProBono program to offer complimentary financial wellness presentations and 1:1 planning sessions to Medical Students and Residents in Virginia, under the moniker WealthHaven. Presentations have been delivered to UVA and VCU residents and medical students, with additional presentations requested by VCOM and Carilion.
- The SafeHaven team is continuing to have robust discussions with health systems, practices, specialty organizations, and foundations regarding enrolling clinicals in SafeHaven. We have presented to Virginia's Office of Emergency Medical Services about including their providers in the 2025 legislative update, and, at the request of the Virginia Department of Health Professions, have contacted the Virginia Optometric Association and the Virginia Veterinary Medical Association, as well as their national regulatory boards, to gauge their interest in legislative protections for their providers.

To learn more about SafeHaven, please visit www.SafeHavenhealth.org or contact Carolyn McCrea (cmccrea@msv.org).

HealthHaven: Recovery (also known as Adult Psychiatric Access Line (APAL)):

Program Description and Update:

HealthHaven: Recovery is a consultation and care navigation program designed for primary care providers who are treating adults struggling with substance use disorders. The program offers access to case consultations, specialized services and resources, and training and education opportunities for participating providers. Through these services, HealthHaven: Recovery aims to 1) support primary care providers in the screening, assessment, diagnosis, and treatment of substance use disorders, 2) provide quality access to substance use treatment and services for their patients through care navigation. HealthHaven: Recovery is currently in its pilot year, with plans to open regional hubs in the Central and Western regions of Virginia in the coming months.

Catherine Ford joined the MSV as the Program Director on April 29th. Since, we have signed on our Family Medicine Medical Director Sterling Ransone and our Psychiatric Medical Director Varun Choudhary. We have also completed the HealthHaven: Recovery Education contract with the Virginia Academy of Family Physicians and begun the CME qualifying HealthHaven: Recovery education at the VAFP annual meeting. Additionally, we are under contract for our Central region and first hub, the Master Center for Addiction Medicine. We are completing user testing on our HealthHaven: Recovery Salesforce database which has rendered positive feedback. With these milestones met, we anticipate being operational in the Central hub in October. We anticipate a press event with the Governor's administration in mid-October.

We are strongly focused on diversified funding and sustainability efforts. We will hear about a SAMSHA grant opportunity this fall and have advocated to secure a budget item in the Governor's proposed state budget, to be debated next year.

Staff contacts: Catherine Ford (cford@msv.org) and Mary Beth McIntire (mmcintire@msv.org)

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Physician Leadership Institute

Program Description and Update:
The Physician Leadership Institute (PLI) is a program aimed at early-stage physician leaders focusing on building interpersonal skills, business/system literacy, and innovation/leading change.

The 2024 PLI weekend will be held November 14-17 at the Richmond MSV Office. Nominations from Board Members are strongly encouraged and will give the participant a $500 tuition discount.

We have begun developing a travel version of PLI, to bring a distilled version of our weekend intensive to practices and systems for leadership development teams. If you or your colleagues are interested in bringing PLI to your team, please contact Carolyn and Jennifer.

Staff contacts: Carolyn McCrea (cmccrea@msv.org), Jennifer Joss (jjoss@msv.org)

STROKE SMART MEDICAL PRACTICE
(In partnership with VDH, VHHA, and Kwikpoint)

Program Description and Update:
Stroke Smart Virginia is an initiative aimed at reducing pre-hospital delay for strokes. MSVF, in collaboration with VDH and Kwikpoint, developed Stroke Smart Medical Practice (SSMP), a subset aimed at medical practices. Studies show that 1/3 of people experiencing a stroke will call their family doctor to get an appointment because they do not recognize the medical emergency. SSMP consists of five actions a medical facility can implement, focused on two main objectives: 1) ensure patients exhibiting stroke signs aren't given an appointment but are directed to call 911 and 2) educate the public to recognize stroke signs and the urgency of calling 911.

- Along with VHHA, VDH, and Kwikpoint, we have curated a "toolkit" of resources to assist practices in implementation of the five actions. The VDH website https://www.vdh.virginia.gov/stroke/stroke-smart-virginia/ along with the MSV website (link) houses all the information.
- We continue to partner with health systems and medical practices to assist them with implementation. Health systems who have undertaken the initiative include VCU, Bon Secours, Augusta, Mary Washington, Inova, Riverside and various independent practices. UVA and Centra are undertaking SSMP and taking steps to get Stroke Smart City proclamations in their respective cities.
- We developed a recognition program to spotlight practices who have adopted some or all the SSMP criteria. It was formally approved by the Virginia Stroke System Task Force in April. Practice can share what they have done, what worked well and suggest improvements. Levels include Stroke Smart Champion, Silver, Gold, and Platinum. Two practices have achieved Gold status (Bon Secours Neurology Clinic at MRMC and St. Mary's) and two have received Platinum Status (VCU Health ACC 2 Clinic and Mary Washington Primary Care, Bowling Green).
- Stroke Smart Magnets and Wallet Cards are available to ANY practice or hospital free of charge through VDH website (LINK)

Staff contacts: Amy Swierczewski (aswierczewski@msv.org), Jennifer Joss (jjoss@msv.org)

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CHRONIC CARE MANAGEMENT (CCM)

Program Description and Update

MSVF has partnered with VDH to implement a Chronic Care Management (CCM) model in primary care practices, targeting areas of high chronic disease prevalence (in 2023-24 - Petersburg, Portsmouth, Roanoke and in '24-25 expansion to Danville, Martinsville, Richmond City, Norfolk). The model incorporates a Community Health Worker (CHW) and pharmacist as part of the care team. Grants to underwrite the cost of a CHW are offered in exchange for program metrics.

We have partnered with Jencare | Chenmed to implement and test the model in up to (4) of their locations, beginning with their Richmond City location. Jencare is in the process of hiring a Community Health Worker, analyzing and developing new workflows, and defining patient enrollment criteria. Upon implementation, the model will be replicated at the Colonial Heights (Southpark) location for further testing and refinement.

Staff contacts: Amy Swierczewski (aswierczewski@msv.org), Mary Beth McIntire (mmcintire@msv.org)

CME ACCREDITATION ACTIVITIES

Background:

There are two roles in the CME world. Recognized Accreditors are authorized by the ACCME to accredit other organizations to provide CME. Accredited Providers are authorized – either by the ACCME or by a state medical society – to provide CME credit to their learners.

MSV has been an ACCME Recognized Accreditor since the 1980s, and now functions as a Recognized Accreditor as part of the Southern States CME Collaborative (SSCC), along with the North Carolina Medical Society and the Mississippi State Medical Association.

MSV has never been an Accredited Provider, relying instead on other providers to accredit our CME activities through joint providership. MSV is applying to be accredited by the ACCME.

Southern States CME Collaborative **Recognized Accreditor Program Update**

The SSCC accredits 34 organizations across six states to grant AMA PRA Category 1 CME credits. Program managers from the three state medical societies each oversee the in-state and adjacent-state providers that they managed prior to forming the collaboration. MSV is responsible for five organizations from Virginia (Carillion Clinic, Inova Healthcare, Sentara Healthcare, SOVAH Danville, and Winchester Medical Center) and one from West Virginia (WVU-Berkeley Medical Center). Mary Beth McIntire sits on the three-member SSCC Governing Board.

The ACCME reviews each Recognized Accreditor yearly. This year's audits began before the SSCC was formed on April 1. Each of the three state medical societies received compliance on all five ACCME Markers of Equivalency. In 2025, the SSCC will be reviewed as a single accreditor, rather than as three medical societies.

The SSCC's Accreditation Review Committee (ARC) has met twice since the last MSVF Board meeting and has made two accreditation decisions; three more decisions are in process for decision-making in 2024.

MSV's West Virginia CME provider, West Virginia University-Berkeley Medical Center has had their survey interview, and their reaccreditation decision will be on the agenda of the SSCC's September 18 ARC meeting.

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Three other MSV-based accredited providers will have reaccreditation decisions in 2025 and are beginning their preparations now: Carilion Clinic, Inova Healthcare System, and Winchester Medical Center

Accredited Provider Program Update

MSV had a successful pre-application to the ACCME and will be submitting our full application by the October 1 deadline. The application includes a full description of our educational program, policies, and processes, along with documentation materials from two recent CME activities. A survey interview will be conducted by the ACCME in November. A decision on our application will come in March 2025.

Once we receive provisional accreditation from the ACCME, MSV will be able to accredit its own activities, streamlining the approval process, saving staff time, and avoiding joint provider fees. Additionally, MSV will be able to act as a joint provider for other organizations seeking CME accreditation, depending on our availability.

The MSV Recognized Accreditor program is managed by Marc Jackson (mjackson@msv.org) with assistance from Amy Swierczewski (aswierczewski@msv.org). The Accredited Provider program is managed by Jennifer Joss (jjoss@msv.org).

Pathways to Medicine

Program Description and Update

"Yes, I Can! Pathways to Careers in Medicine" is designed to encourage high school and middle school students from underrepresented minority groups to consider a medical career. Through scheduled school visits and intentional follow up for advice and/or mentoring, physician members can impact the number of clinicians in underserved areas, reducing healthcare disparities and improving patient outcomes for minority groups.

- To date there have been TEN visits completed
- Over 600 students in 12 hours of visit time
- Marketing materials are available in English and Spanish, including giveaways for the students
- We are exploring new locations and anticipate some repeat visits this fall
- If you would like to visit a school, serve as a mentor, or have other ideas for program engagement, please contact MSVF.

Staff contact: Jennifer Joss (jjoss@msv.org)

DEVELOPMENT ACTIVITIES

Physicians' Gala

The 2024 theme for our annual meeting is: "Vegas, Baby." The Gala will be held at the Hilton, the Main in Norfolk, October 19, 2024. Sponsorships raised so far for the event are $225,450 as of August 28, 2024. Lots of fun activities are planned for the gala!

Salute to Service Awards

Our Salute to Service Award winners have been chosen. We are busy setting up interviews for the videos which will be shown at the Gala. Such awesome winners were chosen in five categories.

MSV SM MEDICAL SOCIETY OF VIRGINIA FOUNDATION

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|377-1056

www.msvfoundation.org

Development

2024 totals - $348,780 development dollars collected as of August 28, 2024

- Gala sponsorship - $225,450
- MSVF Endowment - $63,506
- Personal donation - $23,425
- MSVF Endowment, Wellness Fund - $5,631
- MSVF Foundation endowment, Advocacy/Policy - $5,600
- MSVF endowment, PA student sponsorship - $3,750
- SafeHaven - $3,195
- 1820 Society - $2,925
- Medical Student Sponsorship - $1,918
- MSVF raffle ticket - $500
- VMAP Support - $200
- MSVF recurring gift - $600
- 1820 Society – Recurring, 300
- Medical Student sponsorship – endowment
- MSVF Endowment, Community Fund, Legacy of Caring
- Wine is my Valentine, 2024 - $1,725
- White Coats and Whisky, 2024 - $360
- Gala registration - $11,480

Development News

- 2024 Annual campaign – Theme is “Coming together to create solutions for physicians, PAs, and patients.”
- Endowment & planned giving campaigns – We have several former presidents who already have a spot on the permanent Former Presidents’ Wall, and we have new members of our 2nd Century Circle.
- We also have an 1820 Society member campaign going on all year with special gifts for new members.
- The Engagement and Advisory committee had three successful events and another one is planned:
  - Wine is my Valentine – Friday, February 9th – Virtual Bluestone Vineyard, about 40 –45 attendees
  - White Coats and Whisky – Friday, March 8th – Virtual Catoctin Creek Distillery, about 30 attendees
  - MSVF English Tea – Sunday, February 25th at Dr. Soheila Rostami’s home in northern Virginia. We had 15 attendees with many folks not being a member of the MSV. We are following up with them.
  - Next event: September 29th, Hike in Blue Ridge Tunnel with picnic after at Kathy Scarbalis’ house in Nellysford.
- Next Chapter Group – newly named group which is made up of retired and semi-retired members of the MSV. We have formed a committee with committee chairs: Dr. Pat Pletke and Dr. Mary Schmidt. The committee will meet in the fall. Initiatives include helping on Pathways, mentoring, volunteering for crises around the world, how to keep active, and other activities.

Development Staff Contact: Denise Kranich (dkranich@msv.org)

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Date September 20, 2024

To: MSV House of Delegates

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

Re: Medical Student Section Annual Report, 2024 - 2025

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 our section and chapters at Macon & Joan Brock Virginia Health Sciences at Old Dominion University Eastern Virginia Eastern Virginia Medical School (EVMS), Liberty College of Osteopathic Medicine (LUCOM), University of Virginia School of Medicine (UVA), Virginia Commonwealth University School of Medicine (VCU), Edward Via College of Osteopathic Medicine (VCOM), and Virginia Tech Carilion School of Medicine (VTC).

I am honored and proud to write to the House of Delegates on behalf of our MSS. The opportunity to take part in MSV has proven vital to our development of essential skills – skills that will help us to become strong advocates for our future patients and the 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 100 medical students representing all 6 of Virginia's medical schools supporting the MSV at the General Assembly. We staffed eight MSS lobby days and three MSV lobby days. We lobbied for key MSV issues such as the Virginia physician loan repayment program, increased Medicaid reimbursement rates, prior authorization, scope of practice, and attempts to remove the medical malpractice cap. Joining the MSV in advocating for the profession and our patients was a truly impactful and inspiring experience for all those who attended.

Virginia had 28 medical students join the Virginia Delegation at AMA's Annual Meeting in June. Our students had great success, two of my peers won prestigious leadership elections on AMA's Medical Student Region 6 Board representing AMA medical student members in Virginia, DC, Maryland, Pennsylvania, and New Jersey. Shaylyn Fahey (VTC) was elected as Secretary and Delegation Chair for Region 6, while Rusty Hawes (UVA) was elected as Policy Chair. Catie Blaukovitch (LUCOM) was selected to serve as the Student Representative on the AMA Foundation Board of Directors. Virginia MSS members and chapters were also recognized with various awards in June. Rusty Hawes and Sneha Krish (VCU) received the Standing Committee Star Award, Shaylyn Fahey received the Visionary Advocacy Award, and EVMS

received the Exemplary Chapter Award. Virginia's medical student delegation continues to be a very respected and involved voice in the MSS Assembly.

In August, 30 medical student leaders attended our medical student leadership retreat held at MSV's Headquarters. The retreat served as our planning and goal-setting meeting for our team. 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 2024-2025 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 with ambitious membership recruitment goals.

On behalf of my peers, the conversations and interactions with MSV's physicians have made our experiences with the 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 hold tightly in their roles as future physician leaders. In interacting with many of my counterparts across the country, 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 Jennifer Joss, Paige Bishop, and Chris Fleury, 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 fierce section.

Respectfully,

Ishan R. Perera

MSV ANNUAL MEETING 2024

AMA Virginia Delegation Report

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.

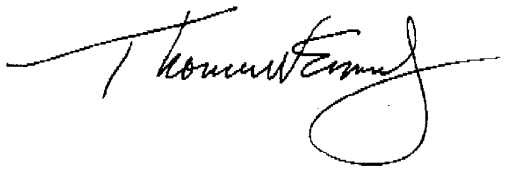
The AMA maintains its focus on prior authorization reform, scope of practice defense, physician well-being, and efforts to reform Medicare. We have continued advocacy efforts as we represent you on Capitol Hill through in-person and virtual lobbying. This February Drs. Eppes, Townsend, and Coombs attended the National Advocacy Committee and lobbied 8 state elected officials including the offices of both US Senators. We maintain strong relationships with our Virginia Congressional Delegation and continue to advocate for our issues with national policymakers.

The Delegation attended the AMA Annual Meeting in Chicago this June with a full slate of Delegates and Alternates representing Virginia. It was a blessing to a blessing that our Delegation gathered with their colleagues from other states to continue advancing our policymaking agenda. Melina Davis did a tremendous job presenting SafeHaven and showcasing the MSV's efforts to expand the program before the OSMAP section meeting. Your AMA Delegation has strong leadership, with Dr. Thomas Eppes serving as Chairman and Dr. Clifford Deal serving as Vice Chairman. Dr. Alice Coombs continues to serve the Delegation with distinction serving on the AMA Council on Medical Service. Dr. Pandya continues his work with the International Medical Graduates Section, offering his experiences as an IMG. Dr. Lesko and Dr. Ouyang continue to represent Virginia in the Young Physicians Section, and they celebrated the expansion of their families this past year with newborn children! Dr. Nedelka took the lead for Virginia during the AMA candidate interview process and is now the primary member of the Delegation tasked with reviewing medical education resolutions. Dr. Chung has brought a wonderful perspective to the Delegation and has leveraged her contacts at the AAP to bolster our resolution review process. Dr. Romero continues to be the primary on public health and will serve as a reference committee chair during the upcoming meeting. Dr. Ransone was appointed to serve on the SED's legislative committee providing us with vital information on regional support for resolutions. This was the first AMA meeting for Drs. Nanda, Nguyen, and Wilcox all did a fantastic job in committee and were able to learn the process from our most seasoned delegates. In the coming years, we look forward to campaigning for Dr. Coombs to join the AMA Board of Trustees and for Dr. Romero to join the AMA Council on Science & Public Health. Lastly, we'd like to thank Dr. Claudette Dalton who is leaving the Delegation this year after many years of service to the Medical Society and the American Medical Association. We wish her the best and are eternally grateful for the mark she has left during her time.

The AMA student section continues to grow. Shaylyn Fahey, 4th year at VTC SOM, and Rusty Hawes, 5th year at UVA, serve as Regional 6 Delegate and Alternate respectfully. We are preparing for the interim AMA House of Delegates meeting in Orlando, Florida 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 a few weeks. We continue to benefit from solid health policy support provided by Scott Castro from our health policy team. Chris Fleury continues to be the staff liaison for the Delegation, and in his new role with the membership team will extend his involvement to promote 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

Board of Medicine
Report to the Medical Society of Virginia
September 19, 2024

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, 1 DO, 1 DPM and 1 DC. Additionally, there are 4 citizen members.

2. This past year, the Board bid a fond farewell to Alvin Edwards, MDiv, PhD of Charlottesville, Jane Hickey, JD of Richmond, Jake Miller, DO, family physician of Virginia Beach, Manjit Dhillon, MD, orthopedist of Chester, Karen Ransone, MD, pediatrician of Cobbs Creek, Joel Silverman, MD, psychiatrist of Henrico, David Archer, MD, OB-GYN of Norfolk, and Ryan Williams, MD, neurologist of Suffolk.

3. The Board welcomed Patrick McManus, MD, internist in Fredericksburg, Elliott Lucas, MD of Hampton, Thomas Corry of Alexandria, Deborah DeMoss Fonseca of McLean, Kamlesh Dave, MD, cardiologist of Chester, Kenneth McDowell, DO, internist in Fredericksburg, Michele Nedelka, MD, radiation oncologist in Virginia Beach, and Bo Vaughan, MD, infectious disease specialist in Henrico.

4. The officers of the Board this year are President Randy Clements, DPM, podiatrist in Roanoke, Vice-President Peter Apel, MD, orthopedist in Roanoke, and Secretary-Treasurer Tom Corry of Alexandria.

5. In late 2023, the Board notified all its licensees by email and newsletter that beginning January 1, 2024, 1 hour of continuing education in Human Trafficking would be required for renewal.

6. In March 2023, the Board began reciprocal licensing of physicians with the state of Maryland and the District of Columbia. To date, almost 1,000 Maryland and DC physicians have applied for licensure in Virginia with a lesser number of Virginia physicians applying for licensure in Maryland and DC.

7. In August 2024, the Board implemented reciprocal licensing of physician assistants with Maryland and the District of Columbia.

8. The 2024 General Assembly also gave the Board another pathway for physician assistant licensing by passing the Interstate Licensure Compact for Physician Assistants. The Compact Commission is being formed to develop the rules for the Compact. Justin Hepner, PA of Midlothian, is Virginia's representative on the Commission.

9. The 2024 General Assembly passed law that requires prescribers to provide specific information to patients for whom opioids are being prescribed. The information provided must be documented in the patient's record.

10. Other actions by the 2024 General Assembly include:

    a. An attorney may serve as Executive Director for the Board of Medicine.
    b. Creation of a pathway to Virginia licensure for physicians who were educated, licensed and have practiced in another country.
    c. Expansion of the scope of practice for athletic trainers to include "inpatient" settings.
    d. A hospital with an emergency department must have at least 1 physician on duty and physically present at all times.
    e. Physician assistants employed by a hospital, certain facilities of the Department of Behavioral Health and Developmental Services, and federally qualified health centers can practice without a separate practice agreement if the credentialing and privileging requirements of the facility include a practice arrangement.

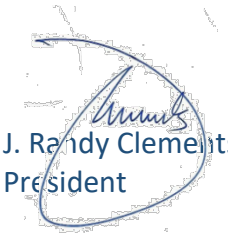
11. Every 4 years, the Board of Medicine does a periodic review of its regulations for all 20 professions. The amended regulations must be reviewed by the Executive Branch prior to becoming final. The amended regulations include the recommendation to repeal the section on Mixing, Diluting or Reconstituting of drugs for administration.

12. The Disciplinary Statistics for the Board from September 2023 to September of 2024 are as follows:

    a. 42 Informal Conferences
    b. 14 Formal Hearings

c. 66 Cases settled by Pre-Hearing Consent Orders
d. 12 Summary Suspensions
e. 23 Mandatory Suspensions

Mandatory suspensions occur when an individual is convicted of a felony or her/his license in another state is suspended.



J. Randy 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

License Count Report for Medicine

Occupation	State	License Status	License Count
Assistant Behavior Analyst			
Assistant Behavior Analyst	Virginia	Current Active	233
Assistant Behavior Analyst	Out of state	Current Active	33
Total for Assistant Behavior Analyst			266
Athletic Trainer			
Athletic Trainer	Virginia	Current Active	1,496
Athletic Trainer	Virginia	Current Inactive	4
Athletic Trainer	Out of state	Current Active	325
Athletic Trainer	Out of state	Current Inactive	2
Total for Athletic Trainer			1,827
Behavior Analyst			
Behavior Analyst	Virginia	Current Active	1,862
Behavior Analyst	Virginia	Current Inactive	2
Behavior Analyst	Out of state	Current Active	1,293
Behavior Analyst	Out of state	Current Inactive	8
Total for Behavior Analyst			3,165
Chiropractor			
Chiropractor	Virginia	Current Active	1,423
Chiropractor	Virginia	Current Inactive	24
Chiropractor	Out of state	Current Active	269
Chiropractor	Out of state	Current Inactive	63
Total for Chiropractor			1,779
Genetic Counselor			
Genetic Counselor	Virginia	Current Active	146
Genetic Counselor	Out of state	Current Active	477
Genetic Counselor	Out of state	Current Inactive	4
Total for Genetic Counselor			627
Genetic Counselor-Temporary			
Genetic Counselor-Temporary	Virginia	Current Active	6
Genetic Counselor-Temporary	Out of state	Current Active	6
Total for Genetic Counselor-Temporary			12
Interns & Residents			
Interns & Residents	Virginia	Current Active	2,756
Interns & Residents	Out of state	Current Active	880
Total for Interns & Residents			3,636
Licensed Acupuncturist			
Licensed Acupuncturist	Virginia	Current Active	509
Licensed Acupuncturist	Virginia	Current Inactive	3
Licensed Acupuncturist	Out of state	Current Active	127
Licensed Acupuncturist	Out of state	Current Inactive	4
Total for Licensed Acupuncturist			643

Occupation	State	License Status	License Count
Licensed Midwife			
Licensed Midwife	Virginia	Current Active	86
Licensed Midwife	Out of state	Current Active	40
Licensed Midwife	Out of state	Current Inactive	2
Total for Licensed Midwife			128
Licensed Surgical Assistant			
Licensed Surgical Assistant	Virginia	Current Active	624
Licensed Surgical Assistant	Out of state	Current Active	205
Total for Licensed Surgical Assistant			829
Limited Radiologic Technologist			
Limited Radiologic Technologist	Virginia	Current Active	452
Limited Radiologic Technologist	Virginia	Current Inactive	16
Limited Radiologic Technologist	Out of state	Current Active	26
Limited Radiologic Technologist	Out of state	Current Inactive	1
Total for Limited Radiologic Technologist			495
Medicine			
Medicine	Virginia	Current Active	23,224
Medicine	Virginia	Current Inactive	424
Medicine	Virginia	Probation - Current	1
Medicine	Out of state	Current Active	20,106
Medicine	Out of state	Current Inactive	971
Medicine	Out of state	Probation - Current	2
Total for Medicine			44,728
Occupational Therapist			
Occupational Therapist	Virginia	Current Active	4,117
Occupational Therapist	Virginia	Current Inactive	68
Occupational Therapist	Virginia	Probation - Current	1
Occupational Therapist	Out of state	Current Active	1,094
Occupational Therapist	Out of state	Current Inactive	61
Total for Occupational Therapist			5,341
Occupational Therapy Assistant			
Occupational Therapy Assistant	Virginia	Current Active	1,538
Occupational Therapy Assistant	Virginia	Current Inactive	36
Occupational Therapy Assistant	Out of state	Current Active	198
Occupational Therapy Assistant	Out of state	Current Inactive	9
Total for Occupational Therapy Assistant			1,781
Osteopathic Medicine			
Osteopathic Medicine	Virginia	Current Active	2,714
Osteopathic Medicine	Virginia	Current Inactive	12
Osteopathic Medicine	Out of state	Current Active	2,880
Osteopathic Medicine	Out of state	Current Inactive	79
Total for Osteopathic Medicine			5,685
Physician Assistant			
Physician Assistant	Virginia	Current Active	4,623
Physician Assistant	Virginia	Current Inactive	11
Physician Assistant	Out of state	Current Active	2,060
Physician Assistant	Out of state	Current Inactive	46

Occupation	State	License Status	License Count
Total for Physician Assistant			6,740
Podiatry			
Podiatry	Virginia	Current Active	412
Podiatry	Virginia	Current Inactive	10
Podiatry	Out of state	Current Active	131
Podiatry	Out of state	Current Inactive	20
Total for Podiatry			573
Polysomnographic Technologist			
Polysomnographic Technologist	Virginia	Current Active	334
Polysomnographic Technologist	Virginia	Current Inactive	4
Polysomnographic Technologist	Out of state	Current Active	143
Total for Polysomnographic Technologist			481
Radiologic Technologist			
Radiologic Technologist	Virginia	Current Active	3,739
Radiologic Technologist	Virginia	Current Inactive	25
Radiologic Technologist	Out of state	Current Active	1,962
Radiologic Technologist	Out of state	Current Inactive	13
Total for Radiologic Technologist			5,739
Radiologist Assistant			
Radiologist Assistant	Virginia	Current Active	14
Radiologist Assistant	Out of state	Current Active	3
Total for Radiologist Assistant			17
Respiratory Therapist			
Respiratory Therapist	Virginia	Current Active	3,082
Respiratory Therapist	Virginia	Current Active - Military	1
Respiratory Therapist	Virginia	Current Inactive	96
Respiratory Therapist	Virginia	Probation - Current	2
Respiratory Therapist	Out of state	Current Active	1,872
Respiratory Therapist	Out of state	Current Inactive	31
Total for Respiratory Therapist			5,084
Restricted Volunteer			
Restricted Volunteer	Virginia	Current Active	50
Restricted Volunteer	Out of state	Current Active	11
Total for Restricted Volunteer			61
Surgical Technologist			
Surgical Technologist	Virginia	Current Active	1,596
Surgical Technologist	Out of state	Current Active	1,037
Total for Surgical Technologist			2,633
University Limited License			
University Limited License	Virginia	Current Active	8
University Limited License	Out of state	Current Active	3
Total for University Limited License			11
Total for Medicine			**92,281**

Date September 10, 2024

To: MSV House of Delegates

From: Jenna Rolfs, VAPA President

Re: VAPA Update

The Virginia Academy of PAs has been enjoying a busy and productive year. We had a successful 2024 legislative year. First, our bill that would remove the need for a practice agreement for PAs who are credentialed and privileged by large hospital institutions was passed and signed by the Governor. We give many thanks to Senator Chris Head for sponsoring this bill for VAPA. This permits PAs to practice as part of a patient care team without a practice agreement in specific institutional settings governed by credentialing and/or privileging

Additionally, the bill for inclusion of Virginia in a PA licensure compact was passed. As the seventh state that passed a bill for inclusion in the licensure compact, the Compact was initiated. AAPA is working on moving forward with implementation.

We appreciate the support of MSV in moving our legislative and regulatory initiatives forward, and we look forward to continued collaboration in 2025.

VAPA continues to monitor the progress of two regulatory changes that we hope will improve patient access to care and treatment. The first regulatory change would be to remove the requirement for a physician's name on prescriptions written by PAs. Many pharmacies misinterpret the regulation as currently written, which delays patients' access to needed medications. The second proposed regulatory change is to remove the requirement for a physician to see a patient whose condition has not improved after 2 visits with a PA. We feel the requirement for physicians to see patients with ongoing conditions should be decided at the practice level. It takes up to 2 years or more to get regulatory change approved, but we will try to keep you updated as these move through the process. There will be a time during which the regulatory changes are presented to the public for a second time with an opportunity for public comment.

VAPA hosted our 42nd 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 2024 VAPA Awards. This year, we introduced a revamped conference format designed to offer greater flexibility and cater to a wide range of interests. Attendees had the opportunity to earn their opioid CME credits, participate in various workshops, and explore a leadership CME track.

After careful consideration of attendance trends and feedback from recent years, the VAPA Board has decided not to hold an in-person Fall conference this year. Rest assured, we continue to assess the needs of our members across the state and are committed to providing valuable opportunities for professional growth. We will, however, proceed with the annual Student Challenge Bowl, a much-anticipated event where PA students from Virginia's programs compete

for the coveted title.

VAPA will kick-off PA Week by hosting our annual Fireside Chat via Zoom on October 3rd. 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,

Jenna Rolfs, DMSc, MBA, PA-C, DFAAPA
VAPA President