



2026 ANNUAL MEETING **Delegates Handbook**



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- II. MSV Foundation Report
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- IV. MSV Medical Student Section Report

- V. Virginia Board of Medicine Annual Report
- VI. Physician Assistant Section Report

MEMORANDUM

Date: July 15, 2026

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
2026 Annual Meeting of the Medical Society of Virginia House of Delegates

Resolutions should be submitted online by September 1st, 2026, 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 1st, 2026 will be subject to consideration under the Rules of Procedure.
- If your society has a scheduled meeting that occurs after September 1st, 2026, 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 16th, 2026. Please email Scott Castro at 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

Call to Order

The Speakers

Pledge of Allegiance

Alexia Childress

Invocation

Cynthia Romero, MD

Speaker Acknowledgements

The Speakers

Welcome Guests

In Memoriam

MSV Past Presidents

Recognize New Delegates

Recognize 20+ year MSV members

Recognize 50+ year MSV members

Recognize Second Century Circle members

Presidential Address

Mark Townsend, MD

Virginia Delegation to the American Medical Association Update

Clifford Deal, MD

MSV Foundation Raffle Drawing

The Speakers

MSVPAC Update & Awards

Raziuddin Ali, MD

Clancy Holland Award

MSV Legislative Champion Award

Credentials Committee Report

To Be Announced

Rules Committee Report

To Be Announced

Request for approval of the 2025 MSV House of Delegates sessions minutes

Steven Lewis, 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

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 18, 2026

Call to Order

The Speakers

Speakers Remarks

The Speakers

Commending and Memorial resolutions

The Speakers

MSV Chief Executive Officer & EVP Remarks

Melina Davis

Guest Speakers

To Be Announced

Credentials Committee Report

To Be Announced

Nominating Committee Report

Sterling Ransone, MD

Election of Officers and Directors

The Speakers

Election of President-Elect

The Speakers

Installation of MSV Board of Directors Officers

Judith Rosencrantz

Incoming President's Remarks

Arturo Saavedra, MD

Election of the 2026-2027 Nominating Committee

The Speakers

Reference Committee Reports

Reference Committee 1: Bobbie Sperry, MD

Reference Committee 2: Lee Ouyang, MD

Announcements

The Speakers

Adjournment

The Speakers



2026 Delegate References

1. Quick Guide to Parliamentary Procedure
2. Rules of Procedure 2026
3. MSV Bylaws

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

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

MM = Main Motion

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

²Restricted

³Not debatable when applied to undebatable motion

⁴Member may interrupt proceedings, but not a speaker

⁵Withdraw may be applied to all motions

⁶Renewable at discretion of presiding officer (chair)

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

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

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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, Oct. 2025

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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 Monday 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~~ 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 Amendments Desk. The Speaker shall not formally recognize the amendment until the Amendments Desk 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.

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**AMENDED AND RESTATED BYLAWS OF
THE MEDICAL SOCIETY OF VIRGINIA
EFFECTIVE OCTOBER 26, 2025**

**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) out-of-state, (e) honorary active, and (f) 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 out-of-state 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 out-of-state member of the Society for at least ten years and has become retired, in which event he/she shall be granted lifetime membership effective on January 1 of the year retirement is confirmed by Society staff. Physicians granted such lifetime membership status shall not be charged annual dues.

Section 3. Public Service Active Members. A public service active member shall 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 out-of-state member of the Society for at least ten years and has become retired, in which event he/she shall be granted lifetime membership effective on January 1 of the year retirement is confirmed by Society staff. 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. Any Resident Physician Member shall have the right to vote.

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. Any Student Member shall have the right to vote.

Section 6. Out-of-State Members. An Out-of-State member shall be a person not currently practicing medicine in Virginia and who holds or has held an active license as a doctor of medicine or osteopathic medicine by a Board of Medicine in any state. Out-of-State 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. Out-of-State 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 active 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 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 out-of-state 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.

169
170 **G.** The specialty organization must be active within its field of medicine and hold at
171 least one (1) meeting of its members annually.

172
173 **H.** The specialty organization must submit a resolution or other official statement to
174 show that the request is approved by the governing body of the specialty organization.

175
176 **Section 2.2.** The members of each specialty section shall adopt rules and regulations to
177 provide for the conduct of the meetings of the section and for the selection of the section's officers and its
178 delegate and alternate to the House of Delegates.

179
180 **Section 3.** Component Student Societies, Qualifications and Guidelines. Component student
181 societies shall be comprised of students in medical schools accredited by the Liaison Council on Medical
182 Education (LCME) or the American Osteopathic Association (AOA) and located in the Commonwealth of
183 Virginia. One component student society shall be recognized by the Society at each medical school in
184 the Commonwealth of Virginia accredited by the LCME or the AOA.

185
186 **Section 4.** Component Resident Physician Sections, Qualifications and Guidelines. There shall be
187 one component resident physician section recognized by the Society. Any intern, resident or fellow in
188 good standing in an Accreditation Council for Graduate Medical Education (ACGME) approved training
189 program in the Commonwealth of Virginia shall be eligible for membership in the section.

190
191 **Section 5.** Hospital Medical Staff Section, Qualifications and Guidelines. The hospital medical staff
192 section shall consist of members of the Society who also are active voting members of hospital medical
193 staffs with clinical privileges who have been selected for membership. The hospital medical staff section
194 shall consist of one (1) physician selected by the medical staff of each hospital located in Virginia. This
195 section shall adopt rules and regulations to provide for the conduct of its meetings and for the selection of
196 its officers and its delegate and alternate to the House of Delegates.

197
198 **Section 6.** Academic Medical Schools, Qualifications and Guidelines. Each medical school shall be
199 accredited by the LCME or the American Osteopathic Association.

200
201 **Section 6.1.** The following guidelines must be satisfied in order for a medical teaching
202 institution to be recognized as an academic medical school of the Society:

203
204 **A.** The academic medical school must not discriminate employment on the basis of
205 race, religion, national origin, gender, or handicap.

206
207 **B.** The academic medical school must represent a field of medicine that has
208 recognized scientific validity.

209
210 **C.** The academic medical school must have a group contract with the Society.

211
212 **D.** One hundred percent (100%) of the academic medical school's full-time faculty
213 (physicians) who are eligible for Society membership are members of the Society.

214
215 **Section 7.** Health Systems, Qualifications and Guidelines. Each health system shall be composed
216 of a medical group with one hundred (100) or more employed physicians affiliated under a single entity.

217
218 **Section 7.1.** The following guidelines must be satisfied in order for an employed medical
219 group to be recognized as a health system of the Society:

220
221 **A.** The health system must not discriminate employment on the basis of race,
222 religion, national origin, gender, or handicap.

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

226
227 **C.** One hundred percent (100%) of the health system's employed physicians who
228 are eligible for Society membership are members of the Society.
229

230 **Section 8.** Physician Assistant Section. There shall be a section comprised of Physician Assistants
231 and Physician Assistant students who are members of the Society. Organization and governance within
232 the section shall be as determined by the section. The physician assistant section may introduce
233 resolutions to the House of Delegates.
234

235 **Section 9.** Attendance at Annual Meeting. Each component society, component student society,
236 component resident physician section, specialty section, the hospital medical staff section, health
237 systems, and academic medical schools shall send to each annual meeting of the Society the number of
238 delegates and alternates fixed by Article V, Section 3 herein.
239

240 **Section 10.** Member Rosters. The secretary of each component society, component student society
241 and component resident physician section shall keep a roster of its members. Once a year, not later than
242 July 1, the secretary of each component student society and component resident physician section shall
243 send a list of its members to the Executive Vice President and Chief Executive Officer of the Society. In
244 odd-years, not later than July 1, the secretary of each component society shall send a list of its members
245 to the Executive Vice President and Chief Executive Officer of the Society.
246

247 **Section 11.** Component Meetings. The component societies, component student societies and
248 component resident physician sections shall cooperate with the officers of the Society to carry out the
249 plans and objectives of the Society and to this end shall meet at least once each year. Once a year, each
250 component society shall notify the Society in writing, by mail or electronically, of their active status and
251 current officers, no later than May 1. The Society shall support component society membership for its
252 members and emphasize that an active component society membership results in a strong state society.
253

254 **Section 12.** Failure to Comply with Bylaws. If a component society, component student society,
255 component resident physician section, or physician assistant section fails to comply with the provisions of
256 these Bylaws, the Board of Directors shall request a report of the component regarding the organization
257 in question. After considering such report, the Board of Directors then may make a recommendation
258 concerning the status of the organization as a component society, component student society or
259 component resident physician section as being active or inactive.
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263 **ARTICLE IV**
264 **ANY MEETINGS OF MEMBERS**
265

266 **Section 1.** Annual Meeting. There shall be an annual meeting of the Society, with the date and
267 place to be determined by the Board of Directors.
268

269 **Section 2.** Attendees. Meetings of members of the Society shall be open to all registered members
270 and guests.
271

272 **Section 3.** Voting. Active, student and resident physician members may vote on any matter that the
273 House of Delegates determines is of sufficient importance that it should be submitted to the voting
274 members of the Society.
275

276 **Section 4.** Virtual Meetings. Any meeting of members described in these Bylaws may be held
277 virtually at the discretion of the President and in consultation with the Executive Vice President and Chief
278 Executive Officer.
279

**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. In the event a District does not have an active component society, each Director and Associate Director who represents that District shall be a member in good standing of the Society and live or work in that District, as verified by Society staff.

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.

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ARTICLE X INDEMNIFICATION

Section 1. Definitions.

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

"Expenses" includes reasonable counsel fees.

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

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

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

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

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

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

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

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

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

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

C. By special legal counsel in a written opinion:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE XI COMMITTEES

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

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

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

ARTICLE XII ETHICS

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

928 **ARTICLE XIII**
929 **RULES OF ORDER**

930
931 **Section 1.** Rules of Order. In all matters not covered by its bylaws, special rules of order, and
932 standing rules, this organization shall be governed by the current edition of the *American Institute of*
933 *Parliamentarians Standard Code of Parliamentary Procedure.*
934

935 **ARTICLE XIV**
936 **AMENDMENTS**

937
938 **Section 1.** Authority to Amend Bylaws. Bylaw amendments may be proposed by any member.
939 Proposed amendments shall be submitted in writing through the Executive Vice President and Chief
940 Executive Officer. The Bylaws Committee shall consider and make written recommendations for
941 disposition of all properly proposed amendments in its report to the House of Delegates. Amendments
942 made at the time of the annual meeting shall lay on the table at least twenty-four (24) hours before they
943 may be considered for adoption and shall be handled in accordance with rules established by the House
944 of Delegates in accordance with Article V, Section 2. All previous Bylaws of the Society are repealed
945 when these Bylaws are adopted and put into effect.
946

947 **Section 2.** Vote to Amend Bylaws. These Bylaws shall be amended only by a two-thirds majority
948 vote of the members of the House of Delegates present and shall be effective as of the vote or as
949 provided for in the Resolution of the House of Delegates.
950

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; Roanoke Valley Academy of Medicine; Virginia Tech-Carillion Medical School 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

986

APPENDIX A (Continued)

987 **Specialties:**

988

989 Allergy

990 Anesthesiology

991 Cardiology

992 Dermatology

993 Emergency Medicine

994 Family Practice

995 Gastroenterology

996 Hematology/Oncology

997 Internal Medicine

998 Neurological Surgery

999 Neurology

1000 Obstetrics/Gynecology

1001 Occupational & Environmental Medicine

1002 Ophthalmology

1003 Orthopaedic Surgery

1004 Otolaryngology

1005 Pathology

1006 Pediatrics

1007 Physical Medicine & Rehabilitation

1008 Physician Assistant

1009 Plastic Surgery

1010 Preventive Medicine

1011 Psychiatry

1012 Radiology

1013 Rheumatology

1014 Sleep Medicine

1015 Surgery

1016 Thoracic Surgery

1017 Urology

1018

1019

1020

1021

1022

1023 ND 4930-4844-7832



Minutes and Actions of the 2025 House of Delegates

1. Medical Society of Virginia 2025 House of Delegates Minutes
2. Final Actions of the 2025 Medical Society of Virginia House of Delegates

First Session

Call to Order

The Annual Meeting of the Medical Society of Virginia (MSV) House of Delegates was called to order by the Speaker, Dr. Michele Nedelka at 10:00 am. Delegates, medical students, guests, sponsors, and staff were welcomed, and appreciation was expressed for their dedication to the advancement of medicine and patient care in Virginia.

Pledge of Allegiance and Invocation

The Pledge of Allegiance was led by VCU medical student Sonia Feeser. An invocation was offered by Dr. Randy Gould, former MSV President, emphasizing service, wisdom, compassion, and responsible leadership in medicine.

Introduction of Guests

The following guests were acknowledged by the Speakers:

- Dr. Willie Underwood, American Medical Association President-Elect
- Senator Mamie Locke, representing Virginia's 23rd Senatorial District
- Dr. Bryant Cameron Webb, as proxy for the Spanberger for Governor campaign
- Dr. John Poole, American Medical Association Southeastern Delegation Member & AMPAC Chair
- Terri Folk, American Medical Association Regional Political Director
- Dr. Carl J. Westcott, North Carolina Medical Society President-Elect
- Gene Ransom, MedChi CEO
- Dr. William Harp, Virginia Board of Medicine Executive Director
- Brent Rawlings, Virginia Hospital and Health Care Association Senior Vice President & General Counsel

Legislative Champion Award

The 2025 Golden Stethoscope Award was presented to Senator Mamie Locke in recognition of her leadership and dedication to health policy, patient safety, physician workforce development, and physician-led care.

In Memoriam

The House observed a moment of silence in remembrance of physicians, colleagues, and past MSV leaders who had passed away since the previous meeting.

Member Recognitions

Former Presidents, New delegates, medical student participants, Second Century Circle members, and members celebrating significant years of service were acknowledged. Special recognition was given to Dr. Carol Shapiro and Dr. Owen Brody for their long-standing contributions to the profession.

Commending Resolution

The House also adopted a commendation honoring Dr. William Harp for more than twenty-five years of distinguished service as Executive Director of the Virginia Board of Medicine.

President's Address

MSV President Dr. Joel Bundy shared remarks, highlighting organizational accomplishments, legislative advocacy efforts, and member support initiatives. The report noted successful opposition to legislation that would have repealed Virginia's medical malpractice cap and advocacy efforts that secured funding for adult psychiatric access line programs. Updates were also provided on physician wellness initiatives, including Safe Haven and the Physician Leadership Institute.

American Medical Association Delegation Report

Dr. Clifford Deal presented a report regarding the activities of Virginia's delegation to the American Medical Association. The report highlighted physician and medical student participation in national policy deliberations and leadership opportunities within organized medicine.

Clarence A. Holland, MD Award

Dr. Razi Ali, Midlothian, Chair of the MSV Political Action Committee, presented the Clarence A. Holland, MD Award to Dr. Thomas Eppes. This award is for MSV member physicians with high personal integrity who have demonstrated outstanding leadership in their fields.

Credential Committee Report

Dr. Sharon Sheffield, 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 resolution was submitted and 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.

- 25-002 Resolution for Evidence-Based Care

Approval of the 2024 MSV House of Delegates Minutes

Dr. Larry Mitchell, former Secretary-Treasurer, asked for comments on minutes from the 2024 meetings of the House of Delegates. Hearing none, the minutes were approved without objection.

Consent Calendar: Informational Reports

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

- MSV Board of Directors Actions on the 2024 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

Continued Business of the 2024 House of Delegates

At the conclusion of last year's House of Delegate's session, the House passed Reference Committee 2's report en bloc, minus three extractions that were tabled for discussion by the House until 2025. Dr. Bobbie Sperry presented those three extracted resolutions for additional discussion.

- 24-201 Access to Healthcare for People Experiencing Homelessness
- 24-210 Transgender Hormonal Treatment and Surgeries for Minors
- 24-212 Supporting Innovative Models of Primary Care

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 11:47 am

Second Session

Call to Order

The second session of the 2025 Medical Society of Virginia (MSV) House of Delegates was called to order by the Speaker, Dr. Michele Nedelka at 8:00 am. Opening remarks emphasized the Society's role as a national leader among state medical societies and highlighted the importance of physician leadership, respectful debate, advocacy, innovation, and service to patients throughout the Commonwealth. Administrative announcements and meeting procedures were reviewed.

Memorial and Commending Resolutions

The House adopted memorial resolutions honoring former MSV Presidents Dr. Chris Alexander and Dr. Charles Caravati. The resolutions were approved by unanimous consent and directed to be shared with their families. The House observed a moment of remembrance in recognition of their contributions to organized medicine.

The House also adopted a special commending resolution recognizing Conor Castro of Richmond, Virginia, for his courage, resilience, and recovery from significant health challenges.

Chief Executive Officer and Executive Vice President Report

Melina Davis, CEO and EVP, presented a report summarizing the conclusion of the Society's five-year strategic plan, RAISE, and reviewed organizational accomplishments during that period. Highlights included sustained revenue growth, expanded physician advocacy efforts, increased physician leadership development, successful physician wellness initiatives, and national recognition of MSV programs including SafeHaven, VMAP, and HealthHaven.

Ms. Davis introduced the Society's new strategic plan, TRUST, which focuses on:

- Transforming healthcare delivery through physician-led innovation.
- Reimagining the role and influence of medical societies.
- Supporting professional and personal growth of physicians.
- Addressing systemic healthcare challenges.
- Advancing evidence-based policy through physician expertise.

Guest Speaker

Dr. Willie Underwood, President-Elect of the American Medical Association, addressed the House regarding physician workforce challenges, healthcare access, physician reimbursement, prior authorization reform,

physician well-being, telehealth, and the responsible implementation of artificial intelligence in healthcare. He encouraged continued physician engagement in advocacy and public policy efforts.

Credentials Report

Dr. Sharon Sheffield, on behalf of the Credentials Committee, reported that a quorum was present with representation from the required number of districts. The House was declared duly constituted to conduct business.

Nominating Committee Report

As the Nominating Committee Report was displayed, Dr. Cyn Romero, Chair of the Nominating Committee, opened the floor for additional nominations.

OFFICER (Elected for 3-year term)

Secretary-Treasurer Steven Lewis, MD

OFFICERS (Elected for 1-year term)

Speaker Michele Nedelka, MD

Vice Speaker Atul Marathe, MD

DIRECTORS (Elected for 2-year term)

District 1 Bobbie Sperry, MD

District 3 Carolyn Burns, MD

District 3 Sidney Jones, MD

District 5 Gary Miller, MD

District 7 John Mason, MD

District 7 Karen Rheuban, MD

District 9 Jan Willcox, DO

Academic Peter Netland, MD

DIRECTORS (Elected for 1-year term)

MSV Foundation Lee Ouyang, MD

Resident Terry Henry, MD (VCU-Ophthalmology)

Medical Student Shawn Dziepak (VCOM)

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 1 Andrey Rissler, MD

District 3 Joynita Nicholson, DO

District 7 Scott Just, MD

District 9 Stephen Combs, MD

Academic Scott Strayer, MD

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 5 Jacqueline Fogarty, MD

Resident Matthew Adsit, MD (VCU-Orthopedics)

Medical Student Vignesh Senthilkumar (UVA)

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

Clifford Deal, MD

Sterling Ransone, MD
Alice Coombs, MD
Bhushan Pandya, MD
Cynthia Romero, MD

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.

Election of President-Elect

Without objection, Dr. Art Saavedra was elected as President Elect of the MSV.

Installation of the MSV Board of Directors Officers

The installation ceremony was conducted by Dr. David Ellington. The following officers were installed for the 2025–2026 term:

- President: Dr. Mark Townsend
- President-Elect: Dr. Art Saavedra
- Secretary-Treasurer: Dr. Steven Lewis
- Speaker: Dr. Michelle Nadelka
- Vice Speaker: Dr. Atul Marathe

Outgoing officers were recognized and thanked for their service and leadership.

Incoming President's Remarks

Newly installed President Dr. Mark Townsend addressed the House. He reflected on the importance of humility, evidence-based medicine, continual learning, and respectful discourse. He encouraged delegates to approach policy development thoughtfully and collaboratively while advancing the interests of physicians and patients in Virginia.

Election of the 2025-2026 Nominating Committee

The 2025-2026 Nominating Committee was presented for election and the following were elected by unanimous vote:

District 1	Sterling Ransone, MD (Chair)
District 2	Cynthia Romero, MD
District 3	Tovia Smith, MD
District 5	Pradeep Pradhan, MD
District 6	Cynda Johnson, MD
District 7	Claudette Dalton, MD
District 8	Carol Shapiro, MD
District 9	Abraham Hardee, DO
District 10	Soheila Rostami, MD
Academic	Carolyn Burns, MD
AMA Advisor	Clifford Deal, MD
2023-2024 Former President Advisor	Alice Coombs, MD
2024-2025 Former President Advisor	Joel Bundy, MD

Reference Committee Reports

Reference Committee recommendations were presented for acceptance as consent calendar items.

Reference Committee 1 and 2 extracted resolutions were discussed at length by the House. The final actions of the House of Delegates for all resolutions are attached to these minutes.

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

- Resolution 25-107: Virginia Medicaid Managed Care Organizations
- Resolution 25-108: Medicare for All
- Resolution 25-109: Private Equity and Healthcare Transactions

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

- Resolution 25-201: Physician Exercise of Conscience
- Resolution 25-206: Patient's Right to Save
- Resolution 25-209: Direct Primary Care Referrals
- Resolution 25-211: Physician-Assisted Suicide
- Resolution 25-213: Evidence-Based Public Health Recommendations

Adjournment

The 2025 Annual Meeting of the House of Delegates of the Medical Society of Virginia adjourned at 11:44 am.

SUMMARY OF ACTION

ADOPTED

- 25-101: MSV 2026 Proposed Budget
- 25-103: Amending MSV Bylaws to Provide Further Clarity on Membership Types, Voting Privileges, and Lifetime Membership
- 25-105: Protect Immigrants From Discrimination
- 25-115: Resolution to Amend MSV Policy 40.22.02 - State Funding for Childhood Vaccines
- 25-207 Exploration of Social Prescribing Programs
- 25-208 Protecting Mental Health Treatment Privacy In Legal Proceedings
- 25-211 Physician Assisted Suicide (PAS)
- 25-212 Support for Medicaid Coverage for Hearing Devices and Related Services

ADOPTED AS AMENDED OR SUBSTITUTED

- 24-210 Transgender Hormonal Treatment and Surgeries for Minors
- 25-102 MSV 2025 Policy Compendium 10-Year Review
- 25-104: Protecting Patients' Access to Safe and Effective Vaccines
- 25-107: Resolution to Transition Virginia Medicaid from a Managed Care Organizations to a Managed Fee for Service Program
- 25-109: Regulating Private Equity in the Healthcare Market – Resolved Clause 1
- 25-111: Prioritizing Child Safety in Custody Decisions
- 25-112: Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
- 25-203 Guidance for Healthcare Facilities Regarding Immigrant Detention
- 25-206 Resolution to Support the Patient's Right to Save Act
- 25-209 Reducing DPC Patient Burden
- 25-213 Evidence-Based Care

REFERRED TO THE BOARD OF DIRECTORS FOR ACTION

- 25-204 Guidance for Physician Education Regarding Immigrant Detention
- 25-109: Regulating Private Equity in the Healthcare Market – Resolved Clause 2

NOT ADOPTED

- 25-202 Fairness and Funding in the Virginia Birth-related Neurological Injury Compensation Program

RECOMMENDED FOR AMENDMENT OF MSV POLICY IN LIEU OF

- 24-201 Access to Healthcare for People Experiencing Homelessness - Amend MSV Policy 10.1.18
- 25-114: Achieving Parity in Reimbursement for Emergency Department on Call Coverage for Specialty Physicians/Practices – Amend MSV Policies 30.2.03 Medical License Linkage to Hospital ER Call and 40.1.13 Emergency Department On-Call Physicians.

MSV POLICIES REAFFIRMED IN LIEU OF

- 24-212: Resolution Supporting Innovative Methods of Primary Care - Reaffirm MSV Policy 10.3.08
- 25-106: Resolution Condemning Forced Organ Harvesting in China – Reaffirm MSV Policy 5.4.04 - Organ Harvesting Without Consent
- 25-108: Medical Society of Virginia Endorsement of the 2025 Medicare for All Act – Reaffirm MSV Policy 10.3.17 - Guidelines for Health Care System Reform
- 25-110: A Resolution on Self Defense for Domestic Violence Victims – Reaffirm MSV Policy 40.23.01 - Anti-Domestic Violence Statement
- 25-113: Adopting the Definition of Anti-Palestinian Racism and Recognizing its Impact on Mental and Physical Health – Reaffirm MSV Policy 5.4.01 - Access without Discrimination
- 25-205 Resolution Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services – Reaffirm MSV Policy 25.1.04 - Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services
- 25-210 Resolution in Support of Tardive Dyskinesia Screening in Alignment with APA Clinical Guidelines – Reaffirm MSV Policy 25.3.02 - Legislation, Standards of Care, and the Patient/Physician Relationship

MSV POLICY REAFFIRMED

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

24-201 Access to Healthcare for People Experiencing Homelessness (AMEND MSV POLICY 05.4.01 IN LEU OF)

MSV Policy 05.4.01- Access without Discrimination

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

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

24-210: Transgender Hormonal Treatment for Minors (ADOPTED AS AMENDED)

RESOLVED, that the MSV supports evidence based care for transgender persons 18 years of age and younger.

24-212: Resolution Supporting Innovative Methods of Primary Care (REAFFIRM MSV POLICY 10.3.08 IN LIEU OF)

MSV Policy 10.3.08- Free-Market

The Medical Society of Virginia endorses a plurality of health care delivery and financing systems in a free market setting.

25-101: Medical Society of Virginia 2026 Proposed Budget (ADOPTED)

RESOLVED, that the Medical Society of Virginia approve, as presented, the proposed budget for 2026.

25-102: 2025 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 archive the following policy:

40.20.06 - Sales/Smoking in Health Care Facilities

25-103: Amending MSV Bylaws to Provide Further Clarity on Membership Types, Voting Privileges, and Lifetime Membership (ADOPTED)

RESOLVED, that the Medical Society of Virginia House of Delegates amend current bylaws as specified in the provided draft to provide further clarity on membership types, voting privileges, and lifetime membership.

25-104: Protecting Patients' Access to Safe and Effective Vaccines (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia endorses the ~~use of vaccines to prevent communicable disease in appropriate population groups as recommended by~~ evidence-based recommendations of national specialty societies including the American Academy of Pediatrics, the American College of

Obstetrics and Gynecologists, the Infectious Diseases Society of America, the American College of Physicians, and the American Academy of Family Physicians for the use of vaccines to prevent communicable disease in appropriate population groups; ~~and be it further~~

~~RESOLVED, that the Medical Society of Virginia (MSV) urges the State of Virginia to adopt regulations allowing pharmacies to provide vaccines “off label” without prescription, provided such vaccinations are administered in accordance with evidence-based guidelines or recommendations published by one of the above national specialty societies; and be it further,~~

~~RESOLVED, that the Medical Society of Virginia encourage all other Virginia health professionals and their societies to join the MSV in endorsing the use of vaccines to prevent communicable disease in appropriate population groups as recommended by the above-listed national specialty societies.~~

25-105: Protect Immigrants from Discrimination (ADOPTED)

RESOLVED, that our MSV amend Policy 05.4.01 as follows:

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

25-106: Resolution Condemning Forced Organ Harvesting in China (MSV POLICY 5.4.04 REAFFIRMED IN LIEU OF)

MSV Policy 5.4.04 - Organ Harvesting Without Consent

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.

25-107: Resolution to Transition Virginia Medicaid from a Managed Care Organizations to a Managed Fee for Service Program (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia supports the study of Managed Care Organizations, fee-for-service programs; and all efforts to enhance health outcomes for Medicaid beneficiaries in the Commonwealth.

25-108: Medical Society of Virginia Endorsement of the 2025 Medicare for All Act: Resolution of the General Assembly of Virginia Endorsing Universal Comprehensive Healthcare and Calling on Congress to Pass the 2025 Medicare for All Act (REAFFIRM MSV POLICY 10.3.7 IN LIEU OF)

MSV Policy 10.3.17 - Guidelines for Health Care System Reform

The Medical Society of Virginia adopts the following guidelines for health care system reform:

1. Every individual should be required to have an insurance policy that meets individual and family needs. The health care system should be structured so as to encourage the individual purchase of insurance, which may include public, private and/or employer-based incentives.

2. All Virginians should be granted access to essential health care through a defined minimum benefit package.

3. Universal health care should be provided that encourages and emphasizes the responsibility of the individual.

4. Government programs should provide assistance to those unable to provide coverage for themselves or their families. Public financial support for the indigent should be provided through appropriate patient vouchers, incentives and tax credits for the purchase of health insurance.

5. All reform should include Medicare, Medicaid and federal employee health benefits programs. The Medicaid program should be reformed and/or replaced with an alternative system designed to provide benefits to persons at or below the poverty level.

6. The health insurance market should be reformed to increase availability of affordable health insurance options. These reforms should include:

- community based rating
- creation of state risk pools
- elimination of waiting periods and pre-existing condition clauses
- approved health benefit insurance options
- greater emphasis on providing coverage for catastrophic, long term and preventive care
- portability of coverage

7. The health care system should place increased emphasis upon the patient's responsibility for his/her health and insurance premiums should be structured to encourage healthy lifestyles and preventive care. Individuals should be encouraged and rewarded for healthy behaviors (e.g., reduced consumption of alcohol and tobacco, use of seat belts, healthy eating habits and body weight, consistent exercise).

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

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

9. Quality of care is paramount in the doctor/patient relationship and should be promoted by:

- appropriate initial and continuing physician education programs
- credentialing of physicians subject to any willing provider provisions • encouraging the ethical practice of medicine

- eliminating economic disincentives to provide appropriate care
- appropriate quality assurance mechanisms

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

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

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

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

25-109: Regulating Private Equity in the Healthcare Market (RESOLVED 1 ADOPTED AS AMENDED, RESOLVED 2 REFERRED TO THE MSV BOARD OF DIRECTORS FOR ACTION)

RESOLVED, that the Medical Society of Virginia supports regulating the corporate practice of medicine, including the acquisition of healthcare practices and facilities by private equity firms.

REFER RESOLVED, that the Medical Society of Virginia support the restriction of the sale of healthcare facilities to real estate investment trusts.

25-110: A Resolution on Self Defense for Domestic Violence Victims (REAFFIRM MSV POLICY 40.23.01 IN LIEU OF)

MSV Policy 40.23.01 - Anti-Domestic Violence Statement

The Medical Society of Virginia opposes any type of domestic violence and supports the inclusion of educational material regarding resources, criminal laws, and prevention in government publications related to marriage and families.

25-111: Prioritizing Child Safety in Custody Decisions (ADOPTED AS AMENDED)

RESOLVED, that MSV supports legislative efforts to strengthening child custody laws in a manner that prioritizes child safety in cases of family violence, including but not limited to the use of qualified expertise, evidence-based practices, trauma-informed training, and consideration of prior abuse in child custody cases.

25-112: Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia (MSV) advocate for the Virginia Delegation to the American Medical Association (AMA) to introduce a resolution urging the AMA to develop model state legislation and guidelines for incorporating critical medical treatment planning into emergency/disaster preparedness plans, ~~including but not limited to dialysis treatments, chronic oxygen therapy, chemotherapy, and radiation therapy,~~ and be it further

RESOLVED, that the MSV support interdisciplinary cooperative planning agreements ~~involving city/regional authorities, hospitals, physicians, medical equipment providers, and transportation companies~~ to ensure continuity of critical medical treatments during emergencies.

25-113: Adopting the Definition of Anti-Palestinian Racism and Recognizing its Impact on Mental and Physical Health (REAFFIRM MSV POLICY 5.4.01 IN LIEU OF)

Amend MSV Policy 05.4.01- Access without Discrimination

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

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

25-114: Achieving Parity in Reimbursement for Emergency Department on Call Coverage for Specialty Physicians/Practices – AMEND MSV POLICIES 30.2.03 AND 40.1.13 IN LIEU OF)

30.2.03 - Medical License Linkage to Hospital ER Call

The Medical Society of Virginia opposes any linkage of a physician's medical license or hospital privileges to providing hospital emergency department on call coverage.

40.1.13 - Emergency Department On-Call Physicians

The Medical Society of Virginia supports and encourages health care organizations and governmental agencies to assure adequate emergency department on-call specialist access. The Medical Society encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage.

25-115: Resolution to Amend MSV Policy 40.22.02 - Childhood Immunizations (ADOPT)

RESOLVED, that MSV Policy 40.22.02 Childhood Immunizations be amended to read,

"The Medical Society of Virginia supports the evidence-based ~~immunization~~ recommendations of the American Academy of Pediatrics and the American Academy of Family Physicians ~~and the Centers for Disease Control~~ as the required schedule for immunizations for infants and for school entry, including

higher education, in the Commonwealth of Virginia. The Medical Society of Virginia supports the elimination of all non-medical vaccine exemptions in Virginia."

25-201: Ensuring Appropriate Transparency and Appropriate Disclosures to Limit Patient Harm from Physician and Institutional Conscience Clauses (AMEND MSV POLICY 30.3.07 IN LIEU OF)

MSV Policy 30.3.07 – Physician’s Exercise of Conscience

The Medical Society of Virginia supports the AMA Code of Medical Ethics Opinion 1.1.7 “Physician Exercise of Conscience,” and emphasizes the importance of provider disclosure and patient referral.

25-202: Fairness and Funding in the Virginia Birth-related Neurological Injury Compensation Program (NOT ADOPTED)

RESOLVED, that the Medical Society of Virginia hereby petitions the Virginia House of Delegates to undertake a study of the current need for and the equitable nature of mandatory funding of a Commonwealth program providing for birth-related neurologically injured persons.

25-203: Guidance for Healthcare Facilities Regarding Immigrant Detention (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia ~~oppose legislation which seeks to require~~ opposes requiring healthcare facilities to ask the immigration status of a patient.

25-204: Guidance for Physician Education Regarding Immigrant Detention (REFERRED TO THE MSV BOARD OF DIRECTORS FOR ACTION)

RESOLVED, that the Medical Society of Virginia distribute already extant educational materials to MSV Members, such as those published by Physicians for Human Rights and the National Immigration Law Center, via the MSV website and newsletter related to the rights and responsibilities of healthcare providers in the presence of immigration agents.

25-205: Resolution Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services (REAFFIRM MSV POLICY 25.1.04 IN LIEU OF)

MSV Policy 25.1.04- Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services

The Medical Society of Virginia opposes any government mandated efforts to restrict the provision of medically appropriate care, as decided by the physician and patient, in the management of reproductive health.

Comprehensive reproductive health services including assisted reproductive technology such as in vitro fertilization (IVF), 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.

25-206: Resolution to Support the Patient's Right to Save Act (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia supports ~~for~~ the enactment of legislation in Virginia which includes the following components:

Letting patients ask providers to disclose their cash prices for covered services;

Allowing patients to apply lower cash prices toward their deductible;

Providing savings incentives for patients who choose lower-cost care options after meeting their deductible to empower patients, lower healthcare costs, and improve the functioning of the healthcare market.

25-207: Exploration of Social Prescribing Programs (ADOPTED)

RESOLVED, that our MSV supports health institutions in the Commonwealth of Virginia in establishing social prescribing pilot programs and assessing their benefits, limitations, methods, and effectiveness.

25-208: Protecting Mental Health Treatment Privacy in Legal Proceedings (ADOPTED)

RESOLVED, that the Medical Society of Virginia (MSV) advocate for the Virginia Delegation to the American Medical Association (AMA) to introduce a resolution urging the AMA to develop model state legislation ensuring that mental health treatment records are protected from discoverability in civil and criminal trials, thereby fostering a safe and supportive environment for healthcare professionals to seek necessary mental health care.

25-209: Reducing DPC Patient Burden (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia supports ~~legislation to ensure~~ that patients enrolled in HMO insurance plans who choose to receive primary care through a Direct Primary Care (DPC) practice shall have access to in-network referrals and covered ancillary services based on referrals from their DPC physician, without requiring the DPC physician to participate in the plan's provider network.

25-210: Resolution in Support for Routine Tardive Dyskinesia Screening in Alignment with APA Clinical Guidance (REAFFIRM MSV POLICY 25.3.02 IN LIEU OF)

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

The Medical Society of Virginia opposes efforts to interfere with or jeopardize the sanctity of the patient/physician relationship.

The MSV supports broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties.

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

25-211: Physician Assisted Suicide (ADOPTED AS AMENDED)

RESOLVED, that the MSV establish in its Policy Compendium a position of opposition to PAS consistent with the AMA Code of Ethics to read "In accordance with the above statements, the Medical Society of Virginia adopts a position of opposition to physician assisted suicide..." Policy Compendium Page 69, 25.2.04- Medical Care for the Terminally Ill, and be it

RESOLVED, that the MSV adopt the AMA use of PAS referring to "the practice of facilitating a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act.

25-212: Support for Medicaid Coverage of Hearing Devices and Related Services (ADOPTED)

RESOLVED, that our Medical Society of Virginia support Medicaid coverage of hearing services and devices, including digital hearing aids, for hearing-impaired patients of all ages.

25-213: Evidence Based Care (ADOPTED AS AMENDED)

RESOLVED, the Medical Society of Virginia supports public health recommendations that are based on scientific evidence, standard medical practice, or expert guidelines/recommendations and opposes those that are not and encourages the Virginia Department of Health to do the same.

2026 Nominating Committee Report

1. 2026 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's membership.

MSV BOARD OF DIRECTORS

Term 2026-2027/2028

OFFICERS (Elected for 1-year term)

President-Elect	Michele Nedelka, MD
Speaker	Atul Marathe, MD
Vice Speaker	Joshua Lesko, MD

DIRECTORS (Elected for 2-year term)

District 2	John Sweeney, MD
District 2	Sharon Sheffield, MD
District 6	Daniel Pauly, MD
District 8	Marc Alembik, MD
District 10	Lauren Grawert, MD
District 10	Soheila Rostami, MD
Academic	Peter Netland, MD

DIRECTORS (Elected for 1-year term)

MSV Foundation	Lee Ouyang, MD
Resident	Kira Dubester MD (UVA)
Medical Student	Vignesh Senthilkumar (UVA)

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 2	Jessica Burgess, MD
District 6	Mark Kleiner, MD
District 8	Zerline Chambers-Kersey, MD
District 10	Barbara Boardman, MD
Academic	Scott Strayer, MD (VCU)

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 5 at-large	Jacqueline Fogarty, MD
Resident	Morgan Hopp, MD (Inova)
Medical Student	Russell Hawes, III (UVA)

2026-2027/28 VIRGINIA DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

Elected for a 2-year calendar year term

DELEGATES

Joshua Lesko, MD
Michele Nedelka, MD
Lee Ouyang, MD

ALTERNATE DELEGATES

Thomas Eppes, Jr., MD
Mohit Nanda, MD

2026-2027 NOMINATING COMMITTEE

Elected for a 1-year term

District 1	Sterling Ransone, MD(Chair)
District 2	Cynthia Romero, MD
District 3	Tovia Smith, MD
District 5	Pradeep Pradhan, MD
District 6	Mark Kleiner, MD
District 7	Claudette Dalton, MD
District 8	Carol Shapiro, MD
District 9	Abraham Hardee, DO
District 10	Andrea Giacometti, MD
Academic	Carolyn Burns, MD
AMA Advisor	Clifford Deal, MD
2024-2025 Former President Advisor	Joel Bundy, MD
2025-2026 Former President Advisor	Mark Townsend, MD



Reference Committee One Index

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

Medical Society of Virginia Proposed 2027 Budget

Submitted by: MSV Board of Directors

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

MSV 2026 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

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

Date: 11/7/2004

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

Reaffirmed 11/5/2006

Reaffirmed 10/16/2016

10.8.01- The Credentialing of Physicians by Insurance Companies and Other Third Parties and Competition in the Health Care Market Place

Date: 10/30/1993

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

Reaffirmed 11/5/2006

Reaffirmed 10/16/2016

25.2.06- Treatment of Dying Patients

Date: 10/16/2016

The Medical Society of Virginia encourages medical schools, post-graduate specialty programs, and all Virginia physicians to advance and promote their ‘at end of life’ training.

The Medical Society of Virginia encourages universal use of ‘Advance Care Plans’ such as ‘Living Wills’ in Virginia so that every patient expresses his or her wishes for care in end of life decisions.

30.7.10- Physician Participation in Efforts to Control Healthcare Costs

Date: 10/16/2016

The Medical Society of Virginia supports efforts to increase transparency for charges related to the provision of health care.

40.6.03- Promote Physical Fitness; Schools

Date: 11/8/1997

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

Reaffirmed 11/5/2006

Reaffirmed 10/16/2016

40.17.01- Cannabis for Medicinal Use

Date: 10/16/2016

Expanding Research on Medicinal Cannabis

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

The Medical Society of Virginia supports down-scheduling marijuana’s status as a federal Schedule I controlled substance, with the goal of facilitating the conduct of clinical research and development of

cannabinoid-based medicines and alternate delivery methods and minimizing patient barriers to treatment by removing legal and logistical obstacles.

Medicinal Use of Cannabinoids

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

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

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

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

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

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

40.19.03- Ionizing Radiation; Patient Education

Date: 10/16/2016

The Medical Society of Virginia encourages and facilitates the voluntary distribution of information from the American College of Radiology on radiation safety concerns to patients in waiting areas of facilities in Virginia where radiologic or nuclear medicine procedures are ordered or performed using educational media.

45.5.04- Associate Physician

Date: 10/16/2016

The Medical Society of Virginia opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate U.S. medical education.

55.2.08- Statement of Individual Board Member's Responsibility

Date: 1/22/2000

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

Reaffirmed as amended 10/16/2016

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

Date: 1/22/2000

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

Reaffirmed 10/24/2010

Reaffirmed as amended 10/16/2016

Recommendation Reaffirm as Amended

05.5.04- Burnout and Suicide Prevention

Date: 10/16/2016

The Medical Society of Virginia supports efforts to address the mental health of medical students, residents, ~~and~~ physicians, PA students, and PAs.

The Medical Society of Virginia will work cooperatively with state and national stakeholders to develop and promote strategies for comprehensive education, screening and treatment of mental health issues including burnout and suicide prevention.

10.1.06- Screening for Breast Cancer

Date: 11/2/1996

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

Reaffirmed as amended 10/16/2016

10.10.01- Medical Utilization Review

Date: 10/30/1993

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

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

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

Reaffirmed 11/5/2006

Reaffirmed 10/16/2016

30.7.11- Telemedicine Records

Date: 10/16/2016

The Medical Society of Virginia ~~will develop legislation and/or regulations~~ supports requiring entities providing telemedicine services outside of a patient's primary medical setting to ask the patient to identify a physician or care setting of record and to provide that clinical setting with a full record of the provided telemedicine service.

~~The Medical Society of Virginia will explore the feasibility of including such legislation and/or regulations in the 2017 legislative agenda.~~

The Medical Society of Virginia will educate and advocate to the Medical Society of Virginia members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

Recommended for Archive

05.5.05- Medical Practitioner Drug Addiction Guidelines

Date: 10/16/2016

The Medical Society of Virginia will create a study group/subcommittee to study the problem of drug/opioid abuse among physicians and other healthcare providers and will recommend guidelines for its members and the medical community on how to respond to suspected or known medical practitioner drug addiction and/or impairment.

15.4.03- Peer Review

Date: 10/16/2016

It is the policy of the Medical Society of Virginia that in absence of a court order the proceedings, minutes, records and reports of the committees set forth in Virginia Code Section 8.01-581.17.B are privileged and confidential and shall only be disclosed as necessary for such committees to carry out official duties or as required by state or federal law.

The Medical Society of Virginia will pursue legislation to amend Virginia Code Section 8.01-581.17 consistent with the Medical Society of Virginia policy.

20.4.04- Evaluating the Effectiveness of the Step 2 Clinical Skills Exam

Date: 10/16/2016

The Medical Society of Virginia will establish a workgroup to evaluate the USMLE Step 2 Clinical Skills Exam, including relative value, cost and accessibility. The workgroup shall be composed of students from the Medical Student Section, physician members including International Medical Graduates, medical school faculty, and residency directors.

The Medical Society of Virginia will work with the AMA to address issues of cost and accessibility of the USMLE Step 2 Clinical Skills Exam

40.6.02- AMA Program on Child and Adolescent Health

Date: 11/2/1996

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

Reaffirmed 11/5/2006

Reaffirmed 10/16/2016

Amending MSV Policy 15.3.01 to Reflect Evolving Member Needs in Modern Political Climate

Submitted by: MSV Board of Directors

- WHEREAS, the Medical Society of Virginia established Policy 15.3.01- Medical Malpractice Cap on Damages in 1991 and reaffirmed that policy in 2011 and 2021, and
- WHEREAS, MSV Policy 15.3.01- Medical Malpractice Cap on Damages states that our society “supports maintaining the cap on professional medical liability awards at a level consistent with the Code of the Commonwealth § 8.01-581.15 and seeks legislation that would implement a cost-effective alternative to address cases involving substantial medical expenses. Furthermore, the Medical Society of Virginia opposes efforts to extend the cap or attempts to increase, stack, or repeal the cap, including any attempt to add on an inflation factor,” and
- WHEREAS, the MSV and the Virginia Trial Lawyers Association effectively negotiated a 20-year agreement wherein the medical malpractice cap would rise incrementally from \$2 million to \$3 million over the course of 20 years, by \$50,000 per year, and
- WHEREAS, the MSV recognizes the significant political pressures to address cases involving substantial medical expenses by amending Virginia Code § 8.01-581.15 in a manner that raises Virginia’s medical malpractice cap, and
- WHEREAS, the MSV understands that an unwillingness to negotiate with Virginia House and Senate leadership could ultimately result in a forfeit of our seat at the table in crafting a reformed medical malpractice landscape for decades to come, and
- WHEREAS, the MSV led the House of Medicine as the key healthcare stakeholder representing the interests of the entire healthcare landscape of the Commonwealth during the 2026 legislative session, and
- WHEREAS, Virginia is a national leader in maintaining a stable and predictable medical liability climate and is recognized by the American Medical Association as a top state for medical liability. Preserving this position is critical to strengthening the Commonwealth’s healthcare workforce, supporting the retention and recruitment of healthcare practitioners, and ensuring Virginians have continued access to high-quality care., therefore be it
- RESOLVED, that MSV Policy 15.3.01 – Medical Malpractice Cap on Damages be amended to read,

“The Medical Society of Virginia supports maintaining ~~the a~~ cap on professional medical liability awards ~~at a level consistent with the Code of the Commonwealth § 8.01-581.15~~ and seeks legislation that would implement a cost-effective alternative to address cases involving substantial medical expenses. Furthermore, the Medical Society of Virginia opposes efforts to ~~extend the cap or attempts to increase, stack, or repeal the a cap structure in Virginia, including any attempt to add on an inflation factor.~~ The Medical Society of Virginia supports strengthening protections for individual providers, including but not limited to pursuing personal asset protections.”

Fiscal Impact: None

Existing Policy: 15.3.01 – Medical Malpractice Cap on Damages

References:

Medical Liability Guardrails to Protect Patients, Physicians, and Access to Care**Submitted by: Virginia Chapter, American College of Physicians**

- WHEREAS, patients injured by medical negligence should have fair and appropriate redress, and
- WHEREAS, Virginia's current medical malpractice cap helps promote stability in the medical liability system and supports continued patient access to care, and
- WHEREAS, weakening or eliminating the current cap could increase liability exposure, raise the cost of medical liability insurance, and threaten access to care, particularly in high-risk specialties and underserved areas, and
- WHEREAS, a balanced medical liability system should protect patients' ability to obtain fair compensation while also promoting access to healthcare, encouraging physicians to practice in Virginia, and reducing incentives for excessive or economically inefficient litigation, and
- WHEREAS, additional safeguards are appropriate to promote fairness, predictability, and accountability within Virginia's medical liability system, particularly if the existing medical malpractice cap is reduced or repealed, therefore, be it
- RESOLVED, that the Medical Society of Virginia support a reasonable statute of limitations for medical malpractice claims, such that any action must be filed no later than three years after the date of injury or one year after the date the claimant discovered, or reasonably should have discovered, the injury, whichever period is later, and be it further
- RESOLVED, that the Medical Society of Virginia supports the principle that defendant physicians in medical malpractice actions remain jointly liable for all economic damages awarded to the plaintiff, as well as for any punitive damages assessed against the defendants, and be it further
- RESOLVED, that the Medical Society of Virginia support minimum qualification and disclosure requirements for medical expert witnesses, including appropriate board certification or equivalent expertise, current clinical or academic experience in the relevant specialty, appropriate medical licensure, disclosure of the frequency of expert-witness testimony and the percentage of income derived from such activities, and disclosure of any actual or potential conflicts of interest, and be it further
- RESOLVED, that the Medical Society of Virginia supports reasonable safe-harbor protections for physicians and other clinicians who provide care consistent with applicable

evidence-based clinical guidelines and accepted standards of care, while preserving appropriate avenues for compensation when negligence occurs, and be it further

RESOLVED, that the Medical Society of Virginia support policies protecting physicians from the forced loss of essential personal assets, including primary residences and retirement accounts, in satisfaction of medical liability judgments, while preserving fair and appropriate compensation for patients injured by negligence, and be it further

RESOLVED, that the Medical Society of Virginia supports a reasonable sliding-scale structure for attorney fees in medical malpractice cases that preserves meaningful access to legal representation for injured patients while discouraging excessive or economically inefficient litigation.

Fiscal impact: None

Existing Policy:

References:

1. [Medical Liability Reform: Innovative Solutions for a New Health Care System](#)

Opposition to refiling of medical malpractice actions due to voluntary nonsuit without penalty

Submitted by: Lee Ouyang, MD

WHEREAS, Virginia law allows plaintiffs in medical malpractice actions to request a nonsuit (Code of Virginia § 8.01-380), and

WHEREAS, a “nonsuit” is a legal term used to indicate that a filed case is being voluntarily withdrawn and dismissed, before the trial starts or during the proceedings, with the potential ability to bring it back by refiling it, and

WHEREAS, Virginia law allows a plaintiff to refile a lawsuit without penalty within 6 months of the first requested nonsuit in medical malpractice action (Code of Virginia § 8.01-229), and

WHEREAS, medical malpractice lawsuits cause enormous stress upon physician and practice defendants, and

WHEREAS, increases in the length of medical malpractice actions and trials introduce great disruption and costs to physicians, their practices, and their patients, therefore be it

RESOLVED, that the Medical Society of Virginia opposes the ability of a medical malpractice plaintiff to refile a lawsuit without penalty after a voluntary nonsuit in cases where a physician or physician assistant is a defendant.

Fiscal impact: None

Existing Policy:

15.2.02- Malpractice Review Panels

The Medical Society of Virginia supports enactment of meaningful tort reform by amending the statute relating to medical malpractice review panels to require the full participation by all parties after the panel has been requested.

The Medical Society of Virginia supports the idea that the panel decision alone, and not evidence of testimony and deliberations of the panel, should be admissible at the trial of the negligence action.

The Medical Society of Virginia supports the establishment of a formal, post-panel settlement conference, with adverse financial consequences for the party not following the settlement conference recommendations and later receiving an adverse verdict at trial.

The Medical Society of Virginia supports legislation to restore the notice of claim language to the Code of Virginia relating to proceedings and panels.

Date: 10/30/1993, Reaffirmed 10/28/2007, Reaffirmed 10/22/2017

15.2.05- Support of Countersuits

The Medical Society of Virginia supports pursuit of justifiable countersuits.

Date: 11/5/1994, Reaffirmed 11/7/2004, Reaffirmed 10/26/2014, Reaffirmed 10/20/2024

15.2.06- Tort Reform

The Medical Society of Virginia believes that malpractice issues should be resolved in an efficient, fair and less costly manner. Therefore, the Medical Society supports:

1. Alternative dispute resolution such as processes including mediation and arbitration, that are designed to divert claims from the civil justice system and resolve them more quickly and more cost effectively,
2. Uniform standards for medical liability claims including:
 - a. Mandatory offsets for collateral sources, such as health insurance.
3. Requiring an expert witness certification stating that the standard of care was violated prior to serving a medical malpractice lawsuit.
4. Preserve equal access to the treating physicians and their health records for the plaintiff's and the defendant's attorneys.
5. Procedural and evidentiary legislation that better enables fairness and equity in the defense of a medical liability case, which may include legislative initiatives from the following:
 - a. Amending the "dead man's statutes" to clarify that a treating physician may testify as to the health care and professional services rendered to a deceased patient,
 - b. Amending Va. Code §8.01-399 regarding physician communications to eliminate the requirement that documentation must be contemporaneously entered in the patient's chart during the course of treatment,
 - c. Clarifying venue statutes to create a preference that medical malpractice cases filed in the jurisdiction where the care is rendered,

d. Amending the “dead man’s statute” to create an exception so that a defendant physician may introduce evidence of habit and custom when lacking documentation in defense of a wrongful death action, and

Furthermore, the Medical Society of Virginia opposes adoption of a comparative negligence doctrine, and believes that in a claim for contributory negligence, the negligence of the plaintiff does not have to coincide in time with that of the defendant.

Date: 11/8/1997, Reaffirmed 10/10/2020

15.3.01- Medical Malpractice Cap on Damages

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

Date: 11/9/1991, Reaffirmed 10/30/2011, Reaffirmed 10/23/2021

15.3.02- Malpractice Coverage for Operational Medical Directors

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.

Date: 11/5/1994, Reaffirmed 11/7/2004, Reaffirmed 10/26/2014, Reaffirmed 10/20/2024

15.3.03- Availability of Insurance

The Medical Society of Virginia shall monitor the availability of malpractice coverage in the Commonwealth and keep the Legislature informed.

Date: 11/4/1995, Reaffirmed 11/06/2005, Reaffirmed as amended 10/25/2015, Reaffirmed 10/26/2025

15.3.04- Premium Discounts as Incentive for Panel Service

The Medical Society of Virginia encourages malpractice companies to provide appropriate premium discounts to physicians who participate in medical malpractice review panels.

Date: 11/8/1997, Reaffirmed 10/28/2007, Reaffirmed 10/22/2017

15.3.05- Statute of Limitations

ADULT PATIENTS – The Medical Society of Virginia supports a two-year statute of limitation from the date of injury and in cases of retained foreign bodies, fraud, or failure to diagnose cancer, one year from the date of discovery.

MINOR PATIENTS – The Medical Society of Virginia supports the longer statute of limitations for minors as currently set forth in Virginia law.

Date: 11/8/1997, Reaffirmed 10/28/2007, Reaffirmed as amended 4/28/2018

15.3.06- Medical Insurance Payment Guidelines and the Standard of Care

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.

Date: 08/14/2014, Reaffirmed 10/20/2024

References:

<https://law.lis.virginia.gov/vacode/title8.01/chapter13/section8.01-380/>

<https://law.lis.virginia.gov/vacode/8.01-229/>

https://www.law.cornell.edu/rules/frcp/rule_41

Preventing Vision Loss Through a Uniform Adult Medicaid Vision-Material Benefit in Virginia

Submitted by: Jeffrey Gu, Neha Sripathi, and Sunnie Li (MSV-MSS)

- WHEREAS, uncorrected refractive error is a leading cause of visual impairment but can often be corrected immediately with prescription eyeglasses, making access to corrective lenses a necessary tool to prevent vision-related disability¹, and
- WHEREAS, in a population-based study of African American adults, refractive error accounted for 68.7% of presenting visual impairment, and the authors concluded that universal vision-care and eyeglass coverage could reduce visual impairment in this population by more than two-thirds¹, and
- WHEREAS, a 2024 national analysis found that 14.6 million adult Medicaid enrollees lived in states without comprehensive eyeglass coverage, with 20 state fee-for-service programs not covering eyeglasses and 35 not covering low-vision aids², and
- WHEREAS, the Virginia Department of Medical Assistance Services states that Cardinal Care managed care plans offer varying adult vision benefits, including eye examinations and glasses, meaning that there are plan-dependent gaps in access that leave some Virginia patients without benefits for necessary services³, and
- WHEREAS, Medicaid adult vision coverage was found to increase eye-care visits by 4.4%, reduced unmet need for eyeglasses or contacts due to cost by 5.3%, reduced self-reported difficulty seeing and vision-related functional limitations, and increased appropriate correction of distance vision by up to 10%^{4,5}, and
- WHEREAS, vision impairment is associated with risk for serious health consequences, as older adults with self-reported vision impairment had substantially more recurrent falls and fall-related activity limitation, and Medicare beneficiaries with vision impairment had a 14% higher adjusted risk of hospitalization over three years^{6,7}, and
- WHEREAS, although no analysis has quantified net savings to Virginia Medicaid specifically, vision loss and blindness resulted in a cost of \$134.2 billion nationally in 20178, and
- WHEREAS, among hospitalized Medicare beneficiaries, severe vision loss was associated with 22% higher adjusted odds of readmission and 12% higher hospitalization and 90-day postdischarge costs, producing an estimated \$584 million in excess annual costs, while a low-income community eye program that dispensed low-cost glasses cost approximately \$111 per participant and \$207 per detected case of eye

disease, illustrating the comparatively modest cost of preventive intervention^{9,10}, and

WHEREAS, a National Academies–commissioned United States population model estimated that correcting uncorrected refractive error with an examination, lenses, and frames could generate average net direct and indirect savings exceeding \$87.7 billion annually over ten years, a modeled return of approximately \$40 for every dollar spent¹¹, and

WHEREAS, Medicaid adult vision benefits have also been associated with increased hours worked and movement into occupations requiring greater skill, demonstrating broader returns on preventive coverage through preserved independence and economic productivity¹², and

WHEREAS, existing MSV policy supports Medicaid coverage of hearing services and devices for patients of all ages based partly on the downstream costs of untreated sensory impairment, but no analogous policy establishes uniform adult Medicaid coverage of medically necessary vision materials¹³, therefore be it

RESOLVED, that the Medical Society of Virginia supports establishing a uniform Virginia Medicaid adult vision-material benefit covering medically necessary eyeglasses and simple frames, replacement eyewear when medically necessary, contact lenses when eyeglasses cannot adequately treat the condition, and low-vision aids.

Fiscal impact: None

Existing Policy: 10.6.01 Increased Medicaid and FAMIS Reimbursement; 10.6.04 Funding for Medicaid; 10.6.09 Medicaid Coverage of Hearing Devices and Related Services; 10.6.08 Virginia Medicaid Transition from Managed Care Organization to a Managed Fee for Service Program; 40.6.04 Prevent Blindness Virginia/Conexus.

References:

1. Dhablania N, Torres M, Burkemper B, McKean-Cowdin R, Varma R; African American Eye Disease Study Group. Uncorrected Refractive Error in the African American Eye Disease Study. *JAMA Ophthalmol.* 2024;142(4):292-298. doi:10.1001/jamaophthalmol.2023.6781
2. Lipton BJ, Garcia J, Boudreaux MH, Azatyan P, McInerney MP. Most State Medicaid Programs Cover Routine Eye Exams for Adults, But Coverage of Other Routine Vision Services Varies. *Health Aff (Millwood).* 2024;43(8):1073-1081. doi:10.1377/hlthaff.2023.00873
3. Virginia Department of Medical Assistance Services. Cardinal Care Managed Care Launch: Member Frequently Asked Questions. 2025. Accessed August 24, 2026. DMAS document.
4. Lipton BJ, Decker SL. The Effect of Health Insurance Coverage on Medical Care Utilization and Health Outcomes: Evidence from Medicaid Adult Vision Benefits. *J Health Econ.* 2015;44:320-332. doi:10.1016/j.jhealeco.2015.10.006

5. Lipton BJ, Decker SL. The Effect of Medicaid Adult Vision Coverage on the Likelihood of Appropriate Correction of Distance Vision: Evidence from the National Health and Nutrition Examination Survey. *Soc Sci Med*. 2016;150:258-267. doi:10.1016/j.socscimed.2015.10.055
6. Ehrlich JR, Hassan SE, Stagg BC. Prevalence of Falls and Fall-Related Outcomes in Older Adults with Self-Reported Vision Impairment. *J Am Geriatr Soc*. 2019;67(2):239-245. doi:10.1111/jgs.15628
7. Bal S, Kurichi JE, Kwong PL, et al. Presence of Vision Impairment and Risk of Hospitalization among Elderly Medicare Beneficiaries. *Ophthalmic Epidemiol*. 2017;24(6):364-370. doi:10.1080/09286586.2017.1296961
8. Rein DB, Wittenborn JS, Zhang P, et al. The Economic Burden of Vision Loss and Blindness in the United States. *Ophthalmology*. 2022;129(4):369-378. doi:10.1016/j.ophtha.2021.09.010
9. Morse AR, Seiple W, Talwar N, Lee PP, Stein JD. Association of Vision Loss With Hospital Use and Costs Among Older Adults. *JAMA Ophthalmol*. 2019;137(6):634-640. doi:10.1001/jamaophthalmol.2019.0446
10. Newman-Casey PA, Niziol LM, Elam AR, et al. Michigan Screening and Intervention for Glaucoma and Eye Health Through Telemedicine Program: Impact on Vision, Follow-up, and Costs. *Ophthalmology*. 2025;132(9):1033-1044. doi:10.1016/j.ophtha.2025.04.027
11. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, et al. Understanding the Epidemiology of Vision Loss and Impairment in the United States. NCBI Books September 15, 2016. Accessed August 28, 2026. <https://www.ncbi.nlm.nih.gov/sites/books/NBK402366/>
12. Boudreaux MH, Lipton BJ. Medicaid Benefit Generosity and Labor Market Outcomes: Evidence from Medicaid Adult Vision Benefits. *J Hum Resour*. 2021;56(2):539-569. doi:10.3368/jhr.56.2.1117-9193R2
13. Medical Society of Virginia. Policy 10.6.09: Medicaid Coverage of Hearing Devices and Related Services. Adopted 2025.

Transparency and Accountability for the 340B Drug Pricing Program

Submitted by: Neha Sripathi and Russell Hawes

- WHEREAS, the federal 340B drug pricing program is a program administered under the Health Resources and Services Administration (HRSA) that supports the medical safety net by providing discounted outpatient pharmaceuticals for underserved populations¹, and
- WHEREAS, there are 18 categories of “covered entities” under the 340B program, with the primary ones being federal grantee clinics and disproportionate share hospitals¹, and
- WHEREAS, Virginia has 36 participating 340B hospitals² and 1,923 covered entities according to a search of the HRSA OPAIS database as of June 2026³, and
- WHEREAS, a broad survey of community health centers showed that 92% utilize 340B savings to serve low income, rural, and underserved patients, and 86% use contract pharmacies⁴, and
- WHEREAS, clinics in rural Virginia that heavily rely on 340B savings have already started to close due to the savings not keeping pace with rising healthcare needs⁵, and
- WHEREAS, Bon Secours Mercy Health in Richmond, VA, was shown to be keeping 340B savings rather than reinvesting them to benefit the patients and communities they were meant to serve, creating a crisis of trust among stakeholders and patients⁶, and
- WHEREAS, as of 2020 pharmaceutical companies have started to limit the number of contract pharmacies to which they deliver 340B covered medications⁷, and
- WHEREAS, drug manufacturer Eli Lilly has started to refuse to offer discounts to qualifying entities unless they submit their pharmacy claims data to Eli Lilly, a direct violation of the 340B statute⁸, and
- WHEREAS, West Virginia and Maryland passed laws requiring drug manufacturers to comply with 340B statute and offer discounts to contract pharmacies, and these laws were blocked by the fourth circuit court of appeals in April 2026^{9,10}, and
- WHEREAS, in May 2026, the fourth circuit court of appeals agreed to reconsider both of these cases due to faulty reasoning in the original decisions, as well as an opposing ruling in the fifth circuit court of appeal, creating a legislative opening for Virginia in this evolving policy space^{11,12}, and

WHEREAS, Virginia state senator Srinivasan introduced SB278 in the 2026 session, which required that pharmaceutical companies not limit the number of covered entities and contract pharmacies that medications were sent to and was sent to a working group¹³, and

WHEREAS, the MSV did not lobby or comment on this bill because we currently lack policy on state regulation of the 340B drug pricing program, and

WHEREAS, physicians have a duty to advocate for patients' access to affordable medication while also holding institutions accountable for the money saved by this program, therefore be it

RESOLVED, that the MSV support legislation that enforces the 340B drug pricing program at the state level by requiring pharmaceutical manufacturers and wholesalers to offer discounts to qualifying entities according to HRSA guidelines, and be it further

RESOLVED, that the MSV support legislation to require qualifying entities to disclose 340B savings and demonstrate how those savings benefitted target patient populations.

Fiscal impact: None

Existing Policy: None

References:

1. Knox RP, Wang J, Feldman WB, Kesselheim AS, Sarpatwari A. Outcomes of the 340B Drug Pricing Program: A Scoping Review. *JAMA Health Forum*. 2023;4(11):e233716. Published 2023 Nov 3. doi:10.1001/jamahealthforum.2023.3716
2. A closer look at 340B in your community. PhRMA. Published October 2023. Accessed July 13, 2026. <https://cdn.aglty.io/phrma/fact-sheets/340b/%20Fact%20Sheet%20%20340B%20State%20Profiles%20-%20Virginia%20-%202024.pdf>
3. Health Resources and Services Administration Office of Pharmacy Affairs OPAIS. Accessed July 13, 2026. <https://340bopais.hrsa.gov/SearchCe>
4. 340B: A critical program for health centers. National Association of Community Health Centers. Published June 13, 2022. Accessed July 13, 2026. <https://www.nachc.org/wp-content/uploads/2022/06/NACHC-340B-Health-Center-Report - June-2022-.pdf>
5. Woods, CR. Eight school-based health clinics close in Southwest Virginia as federal funding pressures mount. [cbs19news.com](https://www.cbs19news.com). Published July 10, 2026. Accessed July 13, 2026. https://www.cbs19news.com/news/state/eight-school-based-health-clinics-close-in-south-west-virginia-as-federal-funding-pressure-mount/article_4c848128-855a-55ac-b091-495_01641ccd8.html

6. Blair, T. Report shows Bon Secours made \$276 million by exploiting program for Richmond hospital in low-income community. [wric.com](https://www.wric.com/news/local-news/richmond/bon-secours-276-million-exploitation-richmond-community-hospital/). Published April 24, 2025. Accessed July 13, 2026. <https://www.wric.com/news/local-news/richmond/bon-secours-276-million-exploitation-richmond-community-hospital/>
7. Rogers, HA. Litigation continues over use of contract pharmacies in 340B drug discount program. [Congress.gov](https://www.congress.gov/crs-product/LSB11163). Published May 23, 2024. Accessed July 13, 2026. <https://www.congress.gov/crs-product/LSB11163>
8. Morse, S. Eli Lilly follows through on threat to withhold 340B discounts. [healthcarefinancenews.com](https://www.healthcarefinancenews.com/news/eli-lilly-follows-through-threat-withhold-340b-discounts). Published June 23, 2026. Accessed July 13, 2026. <https://www.healthcarefinancenews.com/news/eli-lilly-follows-through-threat-withhold-340b-discounts>
9. Brown, N, Arreola, B. Fourth circuit blocks West Virginia’s 340B contract pharmacy law. [JacksonKelly.com](https://www.jacksonkelly.com/health-law-monitor/fourth-circuit-blocks-west-virginias-340b-contract-pharmacy-law/). Published April 28, 2026. Accessed July 13, 2026. <https://www.jacksonkelly.com/health-law-monitor/fourth-circuit-blocks-west-virginias-340b-contract-pharmacy-law/>
10. Newton, W. 4th Circuit again sides with drugmakers, vacates ruling upholding Maryland’s 340B contract pharmacy access law. [340breport.com](https://340breport.com/4th-circuit-again-sides-with-drugmakers-vacates-ruling-upholding-marylands-340b-contract-pharmacy-access-law/). Published April 14, 2026. Accessed July 13, 2026. <https://340breport.com/4th-circuit-again-sides-with-drugmakers-vacates-ruling-upholding-marylands-340b-contract-pharmacy-access-law/>
11. Full 4th Circuit to rehear challenges to state contract pharmacy laws. [AHA.org](https://www.aha.org/news/headline/2026-05-29-full-4th-circuit-rehear-challenges-state-contract-pharmacy-laws). Published May 29, 2026. Accessed July 13, 2026. <https://www.aha.org/news/headline/2026-05-29-full-4th-circuit-rehear-challenges-state-contract-pharmacy-laws>
12. Appeals court upholds Louisiana 340B contract pharmacy law. [AHA.org](https://www.aha.org/news/headline/2026-02-09-appeals-court-upholds-louisiana-340b-contract-pharmacy-law). Published February 9, 2026. Accessed July 13, 2026. <https://www.aha.org/news/headline/2026-02-09-appeals-court-upholds-louisiana-340b-contract-pharmacy-law>
13. Wood, CR. As federal drug pricing program reforms lag, Va.senator’s bill seeks state-level solutions. *Virginia Mercury*. Published February 26, 2026. Accessed July 13, 2026. <https://virginiamercury.com/2026/02/26/amid-lag-of-reforms-to-federal-drug-pricing-program-va-senators-bill-seeks-state-level-solutions/>

Performance-Based Sunset of Low-Yield Prior Authorization Requirements

Submitted by: Jeffrey Gu, Cathleen Rabideau, Allison Su, Songhan Pan, and Elka Sterling

- WHEREAS, prior authorization is intended to reduce inappropriate utilization and health care spending, but requirements that rarely alter coverage decisions may impose administrative costs and delay care without providing commensurate clinical or economic value, and
- WHEREAS, a prospective multicenter study of 2,225 prior authorization requests for anti-vascular endothelial growth factor medications found that 96.2% were ultimately approved, while 59.6% of approved requests delayed care by more than 24 hours and each request required a median of 100 minutes of staff time, repeat requests for continued treatment were approved in 99.4% of cases¹, and
- WHEREAS, an analysis of 33,178 anti-VEGF prior authorization requests found ultimate approval rates exceeding 96% across commercial, Medicaid, and Medicare Advantage plans, while economic modeling found that prior authorization increased total societal costs and was not cost-saving in more than 99.9% of modeled scenarios², and
- WHEREAS, although prior authorization studies have not directly demonstrated permanent visual harm, a separate study found that unplanned anti-VEGF treatment delays of at least 21 days were associated with temporary worsening of visual acuity and retinal thickness, with outcomes recovering near baseline after treatment resumed³, and
- WHEREAS, federal and Virginia reforms establish electronic processing requirements, decision timeframes, annual plan-level reporting for medical-service prior authorization, and minimum authorization durations for prescription drugs, but do not require plans to identify and retire individual authorization requirements that consistently produce approval^{4, 5, 6}, and
- WHEREAS, provider-specific “gold-card” programs evaluate whether an individual clinician qualifies for an exemption based on that clinician’s approval history, whereas a performance-based sunset evaluates whether the authorization requirement itself continues to add value and, when triggered, removes the requirement for all clinicians and patients⁷, and
- WHEREAS, existing Medical Society of Virginia policy supports prior authorization transparency, electronic processing, continued validity of approved requests, and elimination of needless administrative waste and opposes mechanisms that delay medically necessary care, but does not establish a quantitative, plan-wide standard

requiring low-yield prior authorization requirements to be evaluated and discontinued⁸, therefore be it

RESOLVED, that the Medical Society of Virginia supports requiring health plans to periodically review and discontinue prior authorization requirements with consistently high approval rates unless the plan demonstrates continued clinical or economic value.

Fiscal impact: None

Existing Policy: 10.4.03 Principles of Managed Care; 10.10.03 Improve Upon the Current Prior Authorization Law in the State of Virginia; 10.10.04 Opposing Health Plans Restricting Medically Necessary Care; 10.10.05 Prior Authorization Retroactive Denials.

References:

1. Dang S, Parke DW, Sodhi GS, et al. [Anti-VEGF pharmaceutical prior authorization in retina practices](#). JAMA Ophthalmol. 2024;142(8):716-721.
2. Leung EH, Khanna S, Lai MM, et al. [Economic impact of antivascular endothelial growth factor prior authorization process from a large electronic database](#). J Vitreoretin Dis. 2026;10(1):38-45.
3. Zehden JA, Ghosh A, Soundararajan S, et al. [The effect of a brief, unplanned treatment delay on neovascular age-related macular degeneration patients](#). Sci Rep. 2023;13:3156.
4. Centers for Medicare & Medicaid Services. [CMS Interoperability and Prior Authorization Final Rule CMS-0057-F](#). January 17, 2024.
5. [Code of Virginia § 38.2-3407.15:8](#). Carrier contracts; required provisions regarding prior authorization for health care services. Effective January 1, 2027.
6. [Code of Virginia § 38.2-3407.15:2](#). Carrier contracts; required provisions regarding prior authorization for drug benefits. Effective January 1, 2027.
7. Texas Department of Insurance. [FAQ on preauthorization exemptions](#). Updated September 2, 2025.
8. Medical Society of Virginia. [2025-2026 Policy Compendium](#). Policies 10.4.03 and 10.10.03-10.10.05.

SAFEGUARDS FOR ARTIFICIAL INTELLIGENCE AND AUTOMATED DECISION- MAKING IN HEALTH INSURANCE

Submitted by: Viknesh Kasthuri, MD

- WHEREAS, health insurance carriers, pharmacy benefit managers, utilization-review entities, Medicaid managed care organizations, and their contractors increasingly use artificial intelligence, algorithms, and other automated decision-making systems to review prior-authorization requests, determine coverage, adjudicate claims, and recommend adverse benefit determinations, and
- WHEREAS, automated systems may improve administrative efficiency but may also rely on incomplete patient information, outdated or proprietary criteria, or generalized predictions that do not adequately account for an individual patient's clinical circumstances, and
- WHEREAS, delays or denials of medically necessary care can result in disease progression, avoidable hospitalization, patient harm, and additional administrative and financial burdens for patients and physician practices, and
- WHEREAS, the American Medical Association supports transparency, evidence-based criteria, individualized human clinical review, meaningful appeals, public reporting, and safeguards against algorithmic discrimination when augmented intelligence is used for prior authorization and claims review^{1,2}, and
- WHEREAS, existing Medical Society of Virginia Policies 10.10.03 through 10.10.05 support prior-authorization transparency, timely access to medically necessary care, and protection from retroactive denials but do not specifically address payer use of artificial intelligence or automated decision-making systems³, therefore be it
- RESOLVED, that the Medical Society of Virginia support legislation and regulation requiring health insurance carriers, pharmacy benefit managers, Medicaid managed care organizations, utilization-review entities, and their contractors to disclose when artificial intelligence, algorithms, or other automated decision-making systems materially influence coverage, prior-authorization, claims-payment, or utilization-management decisions, and be it further
- RESOLVED, that the Medical Society of Virginia support prohibiting an automated decision-making system from independently issuing a final adverse determination involving medical necessity without individualized review of the pertinent patient record by an appropriately qualified human physician who is not financially incentivized to deny care, and be it further

RESOLVED, that the Medical Society of Virginia support requiring automated coverage and payment systems to use accurate and current evidence-based criteria, provide patients and treating physicians with the specific clinical and coverage reasons for adverse determinations, and preserve timely appeal and direct physician-to-physician review rights, and be it further

RESOLVED, that the Medical Society of Virginia support regular independent evaluation of payer automated decision-making systems for accuracy, reliability, security, algorithmic bias, disparate impact, and performance deterioration, together with public plan-level reporting of their uses, approval and denial rates, appeal and reversal rates, and decision turnaround times with appropriate patient-privacy protections, and be it further

RESOLVED, that the Medical Society of Virginia support preserving payer accountability for decisions materially influenced by automated systems, preventing the transfer of resulting liability or new administrative costs to treating physicians or patients, and applying these safeguards to all health plans and utilization-review arrangements within the Commonwealth's regulatory authority while supporting comparable federal protections for other plans.

Fiscal impact: None

Existing Policy: MSV Policies 10.10.03-10.10.05; no existing MSV policy specifically addresses payer use of artificial intelligence or automated decision-making systems.

References:

1. American Medical Association. Policy H-480.931, Assessing the Intersection Between AI and Health Care. AMA PolicyFinder. Accessed September 1, 2026.
2. American Medical Association. Policy D-480.956, Use of Augmented Intelligence for Prior Authorization. AMA PolicyFinder. Accessed September 1, 2026.
3. Medical Society of Virginia. 2025-2026 Policy Compendium, Policies 10.10.03-10.10.05. Updated October 26, 2025.

SUPPORTING RESIDENT AND FELLOW PHYSICIAN UNIONIZATION & COLLECTIVE BARGAINING

Submitted by: Viknesh Kasthuri, MD

- WHEREAS, resident and fellow physicians are simultaneously learners and employees who provide essential patient care while depending on their sponsoring institutions for compensation, benefits, scheduling, supervision, evaluation, and completion of accredited training¹, and
- WHEREAS, the National Labor Relations Board recognizes interns, residents, and fellows at private teaching hospitals as employees who may form collective-bargaining units, and
- WHEREAS, Virginia Code § 40.1-57.2 generally bars state governmental bodies from recognizing a labor organization as bargaining agent for public employees or entering into a collective-bargaining agreement, creating unequal access to collective-bargaining rights among Virginia resident and fellow physicians based on whether their employer is public or private², and
- WHEREAS, existing Medical Society of Virginia policies support efforts to address resident mental health and burnout and appropriate collective negotiation by physicians, therefore be it
- RESOLVED, that the Medical Society of Virginia recognize resident and fellow physicians as both learners and employees and support their right to determine freely whether to form, join, or decline to join a labor organization and, when they choose representation, to bargain collectively without intimidation, interference, discrimination, or retaliation, and be it further
- RESOLVED, that the Medical Society of Virginia support legislation and other lawful measures ensuring that resident and fellow physicians employed by Virginia public institutions have rights and protections to organize and bargain collectively that are substantially equivalent to those available to similarly situated private-sector resident and fellow physicians, and be it further
- RESOLVED, that the Medical Society of Virginia encourage Virginia graduate medical education institutions to respect resident and fellow physicians' organizing choices, refrain from intimidation, interference, discrimination, or retaliation, and, when a representative is lawfully selected, bargain in good faith over terms and conditions of employment while preserving accreditation-based academic standards and uninterrupted access to essential patient care.

Fiscal impact: None

Existing Policy: Policies 05.5.04 (Burnout and Suicide Prevention), 30.1.01 (Right of Physicians to Negotiate Medical Cost and Utilization), and 55.2.02 (MSV Role in Disputes).

References:

1. American Medical Association. Medical Education Issue Brief: Unionization of Residents and Fellows. 2024.
2. Code of Virginia § 40.1-57.2 (current through Aug. 31, 2026).

Preventing Genetic Discrimination by Insurers

Submitted by: Alexia Childress, Nikita Schroll-McLaughlin, Angela Goyal, Andrea Hooberman-Pineiro, Meghana Annambhotla

WHEREAS, the Genetic Information Nondiscrimination Act (GINA) of 2008, which protects individuals against discrimination based on their personal genetic information as it applies to health insurance and employment, excludes life, disability, and long-term care insurance from these safeguards and its regulatory scope¹⁻³, and

WHEREAS, these gaps leave individuals vulnerable to coverage denials and premium increases based on predictive genetic markers, leading to increased patient fear, misunderstanding, and mistrust that deters vital genetic testing and undermines preventative public health interventions^{3,4}, and

WHEREAS, patients have discontinued their life insurance policies after genetic testing led to substantial premium increases, with research finding that these concerns significantly reduced willingness to pursue necessary genetic testing⁵⁻⁷, and

WHEREAS, Virginia Code §§ 40.1-28.7:1, 59.1-599, and 38.2-508.4 provide protections beyond GINA by restricting employers' use of genetic information and direct-to-consumer genetic testing companies' disclosure of genetic information to insurers, however, Virginia law does not expressly prohibit life, disability, or long-term care insurers from using an applicant's genetic information if obtained elsewhere, such as medical records, in underwriting, eligibility, coverage, or premium determinations⁸⁻¹⁰, and

WHEREAS, Florida has moved to eliminate this gap under Fla. Stat. § 627.4301 (2025), which prohibits life and long-term care insurers from using genetic information to determine eligibility, coverage, or premium differentials, while other states, such as California, are also advancing legislation to address these gaps left by GINA¹¹⁻¹⁴, and

WHEREAS, current AMA policy supports advocacy to add long-term care, disability insurance, and life insurance to GINA (D-315.970), while the Medical Society of Virginia has policies that support reducing health disparities but has no policy protecting against the usage of personal genetic information by these insurers^{15,16}, therefore be it

RESOLVED, that the Medical Society of Virginia supports legislative efforts prohibiting life, disability, and long-term care insurers from using an individual's genetic information in underwriting, eligibility, coverage, or premium determinations.

Fiscal impact: None

Existing Policy:

30.7.08- Requests for Patient Information

Date: 5/31/2014

The Medical Society of Virginia opposes insurance companies' unrestricted gathering of patient information.

Reaffirmed as amended 10/22/2017

05.4.01- Access without Discrimination

Date: 11/5/1994

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

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

Reaffirmed 10/30/2003

Reaffirmed 05/31/2014

Amended by Substitution 10/10/2020

Amended by Substitution 10/23/2021

Reaffirmed as Amended 10/26/2025

References:

1. National Human Genome Research Institute. Genetic Discrimination. Genome.gov January 6, 2022. Accessed August 20, 2026. <https://www.genome.gov/about-genomics/policy-issues/Genetic-Discrimination>
2. Genetic Information Nondiscrimination Act of 2008, Pub L No. 110-233, 122 Stat 881 (2008). Accessed August 28, 2026. [govinfo.gov](https://www.govinfo.gov)
3. Lenartz A, Scherer AM, Uhlmann WR, Suter SM, Anderson Hartley C, Prince AER. The persistent lack of knowledge and misunderstanding of the Genetic Information Nondiscrimination Act (GINA) more than a decade after passage. *Genet Med*. 2021;23(12):2324-2334. doi:10.1038/s41436-021-01268-w
4. Lee SG, Dotson WD, Ortmann L. Genetic Discrimination and Misuse of Genetic Information: Areas of Possible Discrimination, Current Legislation, and Potential Limitations. Centers for Disease Control and Prevention. Published October 3, 2022. Accessed August 28, 2026. <https://blogs.CDC.gov/genomics/2022/10/03/genetic-discrimination/>

5. Tiller J, Bakshi A, Dowling G, et al. Community concerns about genetic discrimination in life insurance persist in Australia: A survey of consumers offered genetic testing. *European Journal of Human Genetics* 2023;32(3):1-9. doi: 10.1038/s41431-023-01373-1
6. Muller C, Gallacher L, Keogh L, et al. “Uninsurable because of a genetic test”: a qualitative study of consumer views about the use of genetic test results in Australian life insurance. *European journal of human genetics* 2024;32:827-836. doi: 10.1038/s41431-024-01602-1
7. Boudin M. She’s going to lose her life insurance. Is genetic testing to blame? WCNC Charlotte. February 19, 2026. Accessed August 27, 2026. <https://www.wcnc.com/article/news/health/life-insurance-genetic-testing-2-19-2026/275-71adfceb-fb53-49fc-922a-7b9743fab2ce>
8. § 40.1-28.7:1. Genetic testing or genetic characteristics as a condition of employment. Virginia.gov2026. Accessed August 20, 2026. <https://law.lis.virginia.gov/vacode/title40.1/chapter3/section40.1-28.7:1/>
9. § 59.1-599. Certain disclosures of genetic data prohibited. Virginia.gov2026. Accessed August 20, 2026. <https://law.lis.virginia.gov/vacode/title59.1/chapter56/section59.1-599/>
10. § 38.2-508.4. Genetic information privacy. Virginia.gov2026. Accessed August 20, 2026. <https://law.lis.virginia.gov/vacode/title38.2/chapter5/section38.2-508.4/>
11. National Human Genome Research Institute. Genetic Discrimination. Genome.gov January 6, 2022. Accessed August 20, 2026. <https://www.genome.gov/about-genomics/policy-issues/Genetic-Discrimination>
12. 2025 Florida Statutes :: Title XXXVII - Insurance :: Chapter 627 - Insurance Rates and Contracts :: Part II - The Insurance Contract (Ss. 627.401-627.446) :: 627.4301 - Genetic information for insurance purposes. Justia Law2025. Accessed August 20, 2026. <https://law.justia.com/codes/florida/title-xxxvii/chapter-627/part-ii/section-627-4301/>
13. Navigating Privacy Gaps and New Legal Requirements for Companies Processing Genetic Data | JD Supra. JD Supra2025. Accessed August 20, 2026. <https://www.jdsupra.com/legalnews/navigating-privacy-gaps-and-new-legal-4036290/>
14. AB 1798, the Safeguarding Genetic Information Act, passes committee | Official Website - Assemblymember Lori Wilson Representing the 11th California Assembly District. Asmdc.org. April 15, 2026. Accessed August 20, 2026.

Improving Access to Forensic Medical Evaluations for Asylum Seekers

Submitted by: Neha Sripathi, Sunnie Li, and Jeffrey Gu

- WHEREAS, federal law permits an individual who is physically present in or arriving in the United States to apply for asylum and requires the applicant to establish past persecution or a well-founded fear of persecution based on race, religion, nationality, membership in a particular social group, or political opinion, distinguishing asylum from the overseas refugee-resettlement process¹, and
- WHEREAS, immigration courts in Virginia had 34,515 pending asylum cases in December 2023 and 1,009,625 asylum cases were pending nationwide that same year, demonstrating substantial demand for the timely documentation of evidence that can move cases forward and out of the backlog², and
- WHEREAS, U.S. Immigration and Customs Enforcement lists two immigration detention facilities in Virginia—the Caroline Detention Facility and Farmville Detention Center—and held 65,765 people nationwide as of July 11, 2026, while published research identifies access to specialized forensic asylum evaluations as particularly inadequate for individuals held in immigration detention or other custody^{3,4 5}, and
- WHEREAS, forensic medical evaluation is the process by which a trained clinician documents an asylum seeker’s history of trauma, physical and psychological evidence of abuse, and assesses the degree of consistency between examination findings and specific allegations of persecution, providing immigration judges with evidence relevant to these asylum cases⁶, and
- WHEREAS, forensic medical evaluations substantially increase the likelihood of a successful outcome in an asylum case, with data from Physicians for Human Rights (PHR) showing that cases with a completed evaluation were 90% successful compared to a 30% success rate without⁷, and
- WHEREAS, the demand for forensic medical evaluations continues to outpace the supply of trained evaluators - PHR is the largest source of referrals and estimates that they facilitate about 700 evaluations per year, a small fraction of asylum cases nationwide⁸, and
- WHEREAS, the Asylum Medicine Training Initiative is a free, asynchronous 5-7 hour program for healthcare professionals that is eligible for continuing education credit⁹, and
- WHEREAS, PHR-sponsored student-run asylum clinics were first piloted at Weill Cornell Medical College in 2010 and have since expanded to over 20 medical schools

across the country, with a 2019 analysis showing that they improve the rate of completed evaluations and increase the number of trained clinicians^{10,11}, and

WHEREAS, there are currently no clinics in Virginia that are dedicated specifically to forensic evaluation for asylum seekers, despite the previously highlighted need¹⁰, and

WHEREAS, prolonged asylum-decision periods are associated with increased psychiatric morbidity, poorer emotional and physical health, and elevated mental-health risks among children, while longitudinal and clinical studies document worsening psychological distress and acute psychiatric crises among applicants whose asylum claims have been refused¹²⁻¹⁸, therefore be it

RESOLVED, that the Medical Society of Virginia supports efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for asylum seekers in Virginia using continuing medical education opportunities, communication channels, and existing resources, including, but not limited to, the Asylum Medicine Training Initiative, and be it further

RESOLVED, that the Medical Society of Virginia supports medical student initiatives related to asylum medicine and forensic medical evaluation through methods including but not limited to, supporting educational initiatives and recruitment efforts for student asylum clinics.

Fiscal impact: None

Existing Policy: None

References:

1. 8 U.S.C. § 1158, Asylum; Refugees and Asylum. U.S. Citizenship and Immigration Services. Accessed August 29, 2026. <https://www.uscis.gov/humanitarian/refugees-asylum>
2. Immigration Court Asylum Backlog. Transactional Records Access Clearinghouse. Accessed August 28, 2026. <https://tracreports.org/phptools/immigration/asylumbl/>.
3. Immigration Detention Quick Facts. Transactional Records Access Clearinghouse. Accessed August 29, 2026. <https://tracreports.org/immigration/quickfacts/>.
4. Caroline Detention Facility; Farmville Detention Center. U.S. Immigration and Customs Enforcement. Accessed August 29, 2026. <https://www.ice.gov/detain/detention-facilities/farmville-detention-center>; <https://www.ice.gov/detain/detention-facilities/caroline-detention-facility>
5. Mishori R, Hampton K, Habbach H. et al. “Better than having no evaluation done”: a pilot project to conduct remote asylum evaluations for clients in a migrant encampment in Mexico. BMC Health Serv Res. 2021;21: 508. <https://doi.org/10.1186/s12913-021-06539-5>
6. Ferdowsian H, McKenzie K, Zeidan A. Asylum Medicine: Standard and Best Practices. Health Hum Rights. 2019;21(1):215-225.

7. PHR Asylum Program. Physicians for Human Rights. September 1, 2021. Accessed August 28, 2026. <https://phr.org/issues/asylum-and-persecution/phr-asylum-program/>.
8. Short K. Immigrants who obtained forensic medical evaluations much more likely to be granted asylum or other relief in United States: Study. PHR. November 30, 2021. Accessed August 29, 2026. <https://phr.org/news/immigrants-who-obtained-forensic-medical-evaluations-much-more-likely-to-be-granted-asylum-or-other-relief-in-united-states-study/>.
9. Asylum Medicine Training Initiative. Accessed August 29, 2026. <https://asylummedtraining.org/>.
10. Student Asylum Clinics. PHR. February 11, 2025. Accessed August 29, 2026. <https://phr.org/issues/asylum-and-persecution/student-asylum-clinics/>.
11. Sharp MB, Milewski AR, Lamneck C, McKenzie K. Evaluating the Impact of Student-run Asylum Clinics in the US from 2016-2018. *Health Hum Rights*. 2019;21(2):309-323.
12. Shahzad A, Katona C, Glover N. The psychological impact of spending a prolonged time awaiting asylum. *Eur J Psychotraumatol*. 2025;16(1):2506189. doi:10.1080/20008066.2025.2506189
13. Oren T, Tham S, Cheung C, Milewski A, Kaur G. Post-migration Social Determinants of Health in Asylum Seekers: A Retrospective Qualitative Study. *J Immigr Minor Health*. 2026;28(1):119-129. doi:10.1007/s10903-025-01763-1
14. Hvidtfeldt C, Petersen JH, Norredam M. Prolonged periods of waiting for an asylum decision and the risk of psychiatric diagnoses: a 22-year longitudinal cohort study from Denmark. *Int J Epidemiol*. 2020;49(2):400-409. doi:10.1093/ije/dyz091
15. Phillimore J, Cheung SY. The violence of uncertainty: empirical evidence on how asylum waiting time undermines refugee health. *Soc Sci Med*. 2021;282:114154. doi:10.1016/j.socscimed.2021.114154
16. Nielsen SS, Norredam M, Christiansen KL, Obel C, Hilden J, Krasnik A. Mental health among children seeking asylum in Denmark—the effect of length of stay and number of relocations: a cross-sectional study. *BMC Public Health*. 2008;8:293. doi:10.1186/1471-2458-8-293
17. Jakobsen M, Meyer DeMott MA, Wentzel-Larsen T, Heir T. The impact of the asylum process on mental health: a longitudinal study of unaccompanied refugee minors in Norway. *BMJ Open*. 2017;7(6):e015157. doi:10.1136/bmjopen-2016-015157
18. Schoretsanis G, Bhugra D, Eisenhardt S, et al. Upon rejection: psychiatric emergencies of failed asylum seekers. *Int J Environ Res Public Health*. 2018;15(7):1498. doi:10.3390/ijerph15071498

Prevention of automatic downcoding and transparency in downcoding decisions

Submitted by: Amy Nelson, MD MPH FACOG

- WHEREAS, the global maternity code will be replaced by a new CPT coding system for obstetrical services based on E/M codes starting January 1, and
- WHEREAS, payers disproportionately downcode ob-gyn visits that meet AMA criteria for level 4 or 5 E/M services despite supporting documentation, and
- WHEREAS, payers often provide limited or no explanation for downcoded claims, making it challenging to understand or address the payers rationale, and
- WHEREAS, downcoding increases administrative costs and lowers reimbursement, placing financial pressure on practices, and
- WHEREAS, insurers may not consider downcoding as a denial, forcing healthcare professionals to face a challenging and inconsistent appeal process, therefore be it
- RESOLVED, that MSV support the creation of legislation to address the issues of downcoding for the practice of medicine such that there is transparency in downcoding decisions, the right to appeal and to have a peer to peer review process, reimbursement based on E/M coding guidelines and timely resolution of reviews and appeals.

Fiscal impact: None

Existing Policy: None

References:

Patient Protections For Predispute Arbitration

Submitted by: Medical Student Section

- WHEREAS, predispute binding arbitration agreements and class-action waivers are used in standardized patient-facing health care contracts, including health plan enrollment materials and health care service agreements^{1,2}, and
- WHEREAS, these provisions require patients to waive access to court, a jury trial, and ordinary judicial review for future disputes arising from contracted care^{2,3}, and
- WHEREAS, compared with court litigation, arbitration and class-action waivers can reduce transparency and public accountability and can foreclose collective remedies for widespread harms that may be impractical to pursue individually^{4,5}, and
- WHEREAS, recent empirical work shows that consumers often do not understand predispute arbitration clauses, with 99% of respondents who stated that they had never entered such an agreement doing so erroneously and fewer than 1% correctly understanding the full significance of a sample agreement on rights to sue, obtain a jury trial, use public courts, and appeal legal decisions⁶, and
- WHEREAS, patient-facing arbitration terms may be presented through prewritten enrollment or contract forms drafted by corporate entities rather than individually negotiated and separately presented agreements, heightening the importance of clear disclosure and a meaningful opportunity to decline or rescind when such terms are used^{2,7}, and
- WHEREAS, Virginia law permits agreements to arbitrate medical malpractice claims that have arisen or may thereafter arise if the patient or claimant is allowed to withdraw from the agreement within at least 60 days after termination of health care, demonstrating that arbitration in health care is already a subject of state-level regulation⁸, and
- WHEREAS, state policymakers have recognized coercion concerns when arbitration is tied to access to care, as Colorado prohibits providers from refusing medical care services solely because a patient refused to sign or rescinded such an agreement, and Illinois requires health care arbitration agreements to disclose that a patient cannot be required to sign in order to receive treatment^{9,10}, and
- WHEREAS, Virginia's existing arbitration statute does not comprehensively prohibit health care facilities, health plans, or other corporate health care entities from conditioning medically necessary care, admission, enrollment, continued care, or continued coverage on execution of a predispute arbitration agreement or class-action waiver⁸, and

RESOLVED, that the Medical Society of Virginia support state legislation prohibiting any Virginia health care facility, state-regulated health plan, or other non-physician-owned corporate health care entity from requiring a patient to execute a predispute binding arbitration agreement or predispute class-action waiver as a condition of receiving medically necessary care, admission, enrollment, continued care, or continued coverage, and be it further

RESOLVED, that the Medical Society of Virginia support minimum patient-protective standards for any patient-facing predispute arbitration agreement used in health care, including that the agreement be presented separately from clinical consent forms, clearly explain the meaning of the waiver of court, jury, class-action, and appellate rights in plain language, and provide a meaningful opportunity to decline or rescind consent without jeopardizing access to medically necessary care, admission, enrollment, continued care, or continued coverage.

Fiscal impact: None

Existing Policy: 20.4.02 Teaching of Basics of Dispute Resolution; 10.1.02 Information on Health Care Plans to Patients; 25.3.04 Patient-Physician Communication.

References:

1. Sachs S. The Jury Is Out: Mandating Pre-Treatment Arbitration Clauses in Patient Intake Contracts. *Journal of Dispute Resolution*. 2018.
2. Kaiser Permanente. Account Change Form California. 2025.
3. 9 U.S.C. § 10. Federal Arbitration Act—grounds for vacating an arbitration award.
4. The Market Participant Doctrine and Forced Arbitration. *Harvard Law Review*. 2024.
5. Mullenix LS. Class Action Waivers in Arbitration Agreements. *Emory International Law Review*. 2024.
6. Sommers R, Goldberg M. What Do Consumers Understand About Predispute Arbitration Agreements? *PLoS One*. 2024.
7. Nehf JP. Mandatory Arbitration, Class Waivers, and Consumer Law in the Digital Age. SSRN. 2025.
8. Virginia Code § 8.01-581.12. Arbitration of Medical Malpractice Claims.
9. Colorado Revised Statutes § 13-64-403. Agreement for Medical Services.
- 710 ILCS 15. Illinois Health Care Arbitration Act.

Procedural Safeguards for Payer Payment-Integrity Actions

Submitted by: Medical Student Section

- WHEREAS, commercial health plans and third-party administrators commonly use Special Investigations Units (SIUs) and payment-integrity vendors to conduct post-payment review and recommend corrective actions that can include offsets, recoupments, prepayment review, and provider removal from insurance networks¹, and
- WHEREAS, payment-integrity programs may use contingency-fee or other compensation arrangements that create incentives to maximize recoveries rather than prioritize accurate claim adjudication and uninterrupted access to care for patients of providers under investigation¹, and
- WHEREAS, Virginia law already recognizes the need for fair carrier business practices by requiring written explanations for retroactive denials or recoveries, advance notice before recovery or refund of previously paid claims, and a written claims payment dispute mechanism², and
- WHEREAS, Virginia Medicaid regulations establish a Recovery Audit Contractor program to identify underpayments and overpayments of Medicaid claims, allow payment of recovery audit contractors on a contingent basis from recovered amounts, and require an adequate appeal process for adverse determinations, demonstrating state jurisdiction over payment-integrity vendor design and safeguards³, and
- WHEREAS, SIU-driven payment actions or provider terminations can materially alter provider availability, and such disruption of established patient-clinician relationships is associated with increased urgent care and emergency department use^{4, 5}, and
- WHEREAS, Virginia law requires carriers to notify enrollees when a provider furnishing care is terminated from a provider panel and generally permits continued care for at least 90 days after termination, but these protections repeatedly exclude providers terminated “for cause”⁶, and
- WHEREAS, “for cause” termination based on alleged billing irregularities, SIU findings, or payment-integrity program findings may occur before final adjudication, leaving patients in an active course of treatment without structured notice, transition assistance, or continuity-of-care protections despite no final finding of fraud or patient safety risk, and
- WHEREAS, existing MSV policy supports third-party payer fair business practices, retroactive denial protections, and procedural due process for physicians expelled from health plans, but does not specifically address patient continuity-of-care protections after

SIU or payment-integrity actions or the use of recovery-linked vendor compensation when such arrangements may influence actions that materially affect patient access to care^{7,8}, and

WHEREAS, this issue is appropriate for state-level policy because Virginia regulates state-regulated health plans, provider panel requirements, fair carrier business practices, Medicaid managed care contracts, and Medicaid program-integrity safeguards, therefore be it

RESOLVED, that the Medical Society of Virginia support state legislation, regulation, or Medicaid managed care contracting standards requiring notice to affected enrollees, continuity-of-care protections, and transition assistance for patients in an active course of treatment when a provider is removed from network participation or payment is suspended “for cause” based on Special Investigations Units or other payment-integrity program findings before final adjudication, unless the carrier or Medicaid managed care organization documents an immediate patient safety risk, and be it further

RESOLVED, that our Medical Society of Virginia supports policies prohibiting recovery-linked compensation arrangements for Special Investigations Unit contractors or payment-integrity vendors when such arrangements may influence recommendations that result in provider removal or other actions that materially affect patient access to care.

Fiscal impact: None

Existing Policy: 10.3.16 Third Party Payer Fair Business Practice Principles; 10.8.02 Removal of Physicians from Insurance Plans “Without Cause”; 10.8.05 Plan Expulsion and Licensure Board Discipline; 10.9.10 Third Party Payer Retroactive Denials; 10.9.15 Payment with Remittance Advice.

References:

1. Morse S. Payer Payment Integrity Audits Are a Financial Burden to Providers. Healthcare Finance News. 2020.
2. Virginia Code § 38.2-3407.15. Ethics and Fairness in Carrier Business Practices.
3. 12VAC30-10-445. Recovery Audit Contractors.
4. Sabety AH, Jena AB, Barnett ML. Changes in Health Care Use and Outcomes After Turnover in Primary Care Physicians. JAMA Internal Medicine. 2021.
5. Staiger B. Disruptions to the Patient-Provider Relationship and Patient Utilization and Outcomes: Evidence from Medicaid Managed Care. Journal of Health Economics. 2022.
6. Virginia Code § 38.2-3407.10. Health Care Provider Panels.
7. Medical Society of Virginia Policy 10.3.16. Third Party Payer Fair Business Practice Principles.
8. Medical Society of Virginia Policy 10.9.10. Third Party Payer Retroactive Denials.

Recognizing Progressive Childhood Myopia as a Clinical Disease

Submitted by: Medical Student Section

- WHEREAS, myopia, commonly called nearsightedness, is a refractive condition in which distant objects appear blurred, and progressive childhood myopia often reflects ongoing axial elongation of the eye rather than a static need for glasses¹, and
- WHEREAS, myopia has historically been approached as a correctable refractive error or “blurred vision” problem, but the National Academies of Sciences, Engineering, and Medicine recommended in 2024 that myopia be classified as a disease requiring a medical diagnosis², and
- WHEREAS, the prevalence of myopia appears to be increasing worldwide and in the United States, and the National Eye Institute predicts that 44.5 million people in the United States will be nearsighted by 2050, with greater increases among African and Hispanic Americans¹, and
- WHEREAS, myopia is associated with long-term ocular harm, including increased risk of visual impairment, myopic macular degeneration, retinal detachment, cataract, and open-angle glaucoma, with high myopia carrying the greatest risk and even low-to-moderate myopia carrying meaningful risk³, and
- WHEREAS, a nationwide adolescent study found that myopia was associated with a higher prevalence of anxiety and mood disorders, up to a twofold increased odds of anxiety and mood disorders, and a dose-response relationship with myopia severity⁴, and
- WHEREAS, the same study noted that myopia’s impact on quality of life includes physical discomfort, limitations in daily activities, and psychosocial effects, and that correction alone may not eliminate these burdens, especially for high myopia⁴, and
- WHEREAS, current United States childhood myopia surveillance is inadequate because national data are more than 20 years old, recent population data are regionally limited, measurement methods vary, and without formal policies on myopia surveillance and accountability it is difficult to find rigorous large-scale estimates of childhood myopia prevalence¹, and
- WHEREAS, without classification and accountability as a disease, myopia risks being treated only after vision is already blurred rather than being addressed as a progressive pediatric condition requiring prevention, longitudinal monitoring, and intervention to reduce future ocular morbidity², and

WHEREAS, the National Academies stated that disease classification would enable efforts beyond treating blurred vision and would help ensure that federal and state agencies, professional associations, patients, and caregivers invest in prevention and management of myopia², and

WHEREAS, classification as a disease would support clinical and payer recognition of interventions that modify disease progression rather than merely correct vision, including increased outdoor time, which the National Academies found has unequivocal evidence for slowing excessive eye growth and reducing myopia risk², and

WHEREAS, additional evidence-based myopia-control interventions exist for selected children, including low-dose atropine trials and FDA-approved MiSight contact lenses for slowing myopia progression in children aged 8 to 12 at treatment initiation^{5,6}, and

WHEREAS, this issue is appropriate for state-level policy because the National Academies specifically recommended that state health departments collect harmonized myopia prevalence data, while Virginia controls Medicaid and FAMIS benefit design, state-regulated insurance requirements, and state public health priorities affecting pediatric vision care^{2,7}, therefore be it

RESOLVED, that the Medical Society of Virginia recognize progressive childhood myopia as a clinical disease with long-term ocular, functional, and psychosocial morbidity rather than solely as a routine refractive condition, and be it further

RESOLVED, that the Medical Society of Virginia support state-level surveillance by the Virginia Department of Health or other appropriate state entities to collect and report standardized data on pediatric myopia prevalence, severity, and progression, and be it further

RESOLVED, that the Medical Society of Virginia support Medicaid, CHIP, and state-regulated private insurance coverage for evidence-based myopia-control evaluation and therapies when medically necessary and prescribed by an appropriately licensed clinician.

Fiscal impact: None

Existing Policy: 10.1.18 Insurance Coverage for Medical Conditions; 40.6.04 Prevent Blindness Virginia/Conexus; 40.20.01 Reallocation from General Fund for Preventive Health.

References:

1. National Academies of Sciences, Engineering, and Medicine. Understanding Myopia and Its Prevalence. 2024.

2. National Academies of Sciences, Engineering, and Medicine. New Report Recommends Myopia Be Classified as a Disease. 2024.
3. Haarman AEG, et al. The Complications of Myopia: A Review and Meta-Analysis. *Investigative Ophthalmology & Visual Science*. 2020.
4. Nitzan I, et al. Association of Myopia With Anxiety and Mood Disorders in Adolescents. *Eye*. 2024.
5. Yam JC, et al. Low-Concentration Atropine for Myopia Progression Study. *Ophthalmology*. 2019.
6. U.S. Food and Drug Administration. MiSight 1 Day Contact Lenses Summary of Safety and Effectiveness Data. 2019.
7. Virginia Department of Medical Assistance Services. FAMIS.

Supporting Development of a Virginia Medicaid Nutrition Benefit for Individuals with Diet-Related Chronic Conditions

Submitted by: Medical Student Section

- WHEREAS, diet-related chronic conditions such as obesity, cardiovascular disease, hypertension, and diabetes are increasing in prevalence in Virginia, accounted for \$76.5 billion in hospitalization costs in the Commonwealth in 2023 alone, and remain the leading cause of death among Virginians¹, and
- WHEREAS, food insecurity disproportionately affects Virginia Medicaid members with diet-related chronic conditions, with nearly one-third of Medicaid members with diabetes experiencing food insecurity compared to seven percent of those with private insurance¹, and
- WHEREAS, food is Medicine interventions, including produce prescriptions, medically tailored groceries, and medically tailored meals delivered in clinical settings, are associated with improved food security and improvements in clinical indicators such as hemoglobin A1c, with more limited evidence for increased fruit and vegetable intake and other cardiovascular outcomes², and
- WHEREAS, individual produce prescription and food prescription pilot programs across the country have independently demonstrated meaningful clinical and food-security outcomes, including a 94 percent decrease in food insecurity among participants in a Texas-based food prescription program, sustained engagement among rural and urban participants with cardiometabolic conditions in a Georgia-based program, and improved outcomes among rural, uninsured patients with type 2 diabetes when produce prescriptions were paired with food literacy and culinary medicine education³⁻⁵, and
- WHEREAS, Virginia already has direct, in-state experience with these interventions through programs such as the Southwest Virginia Produce Prescription (SWPRx) Program, operating since 2015 in partnership with Carilion Clinic, Virginia Fresh Match, Feeding Southwest Virginia, Radford University, and the Local Environmental Agriculture Project, which has demonstrated increased fresh produce consumption among 97 percent of participants, as well as the Walnut Hill Food Pharmacy pilot in Petersburg, which demonstrated an average 9.7 percent reduction in hemoglobin A1c among participants¹, and
- WHEREAS, federal Medicaid rules permit states to authorize managed care organizations to offer nutrition interventions as a clinically appropriate and cost-effective “in lieu of service” (ILOS) substitute for more costly covered services, an authority that at least thirteen other states have already used to make Food is Medicine

interventions available to their Medicaid members, while Virginia has not yet done so¹, and

WHEREAS, the national evaluation of USDA-funded produce prescription projects enrolled over 21,000 participants between September 2023 and August 2024 alone, with 93 percent of participants reporting satisfaction with the program and significant improvements in hemoglobin A1c and blood pressure among those with poorly controlled diabetes⁶, and

WHEREAS, the Virginia Joint Commission on Health Care recommended in a December 2025 report that the Department of Medical Assistance Services be directed to develop a plan for a nutrition ILOS managed care benefit, including proposed covered services, eligible populations, evidence of cost-effectiveness, and monitoring provisions, therefore be it

RESOLVED, that the Medical Society of Virginia support the Department of Medical Assistance Services' development and implementation of a Medicaid managed care in-lieu-of-services nutrition benefit for Medicaid members with diet-related chronic conditions, consistent with the recommendation of the Virginia Joint Commission on Health Care, and be it further

RESOLVED, that the Medical Society of Virginia advocate to the Virginia General Assembly for the appropriation of funding necessary to implement the nutrition in-lieu-of-services benefit following its development by the Department of Medical Assistance Services, and be it further

RESOLVED, that the Medical Society of Virginia support state investment in expanding evidence-based Food is Medicine interventions, including produce prescription programs, to additional regions of the Commonwealth.

Fiscal impact: None

Existing Policy:

MSV Policy 40.10.02 (food deserts) and 40.10.03 (nutrition) address related subject matter. This resolution builds on that existing policy by supporting a specific Medicaid financing mechanism, which is not addressed in current MSV policy.

References:

1. Implementation of a Medicaid In Lieu of Service Food and Nutrition Benefit for Individuals with Diet-Related Chronic Conditions. Accessed July 10, 2026.
<https://rga.lis.virginia.gov/Published/2026/RD148>
2. Harper Z, Alvarado AV, Katz SE, et al. Examining Food Security, Fruit and Vegetable Intake, and Cardiovascular Disease Risk Outcomes of Produce Prescription (PPR) Programs: A Systematic Review. *J Nutr Educ Behav.* 2024;56(11):794-821.
doi:10.1016/j.jneb.2024.06.012

3. Aiyer JN, Raber M, Bello RS, et al. A pilot food prescription program promotes produce intake and decreases food insecurity. *Transl Behav Med.* 2019;9(5):922-930. doi:10.1093/tbm/ibz112
4. Owens CE, Cook M, Reasoner T, McLean A, Webb Girard A. Engagement in a pilot produce prescription program in rural and urban counties in the Southeast United States - PubMed. Accessed July 10, 2026. <https://pubmed.ncbi.nlm.nih.gov/38915750/>
5. Stroud BJ, Sastre LR. Evaluation of a Produce Prescription (PRx) Program With Food Literacy and Culinary Medicine Education for Rural, Uninsured Patients With Type-2 Diabetes. *Am J Health Promot AJHP.* Published online May 9, 2025:8901171251340385. doi:10.1177/08901171251340385
6. GusNIP NTAE Impact Findings. Accessed July 10, 2026. <https://www.nutritionincentivehub.org/gusnip-ntae-impact-findings/>

ENSURING HEALTHCARE ACCESS FOR PEOPLE LIVING WITH HIV

Submitted by: Neha Sripathi

- WHEREAS, in order to qualify for Medicaid expansion coverage, starting in January of 2027 Virginia patients will have to meet work requirements of at least 80 hours a month unless they meet exemption criteria¹, and
- WHEREAS, according to the interim final rule released by the Centers for Medicare and Medicaid Services (CMS) on June 1, 2026, a medical frailty exemption has been narrowed to only include patients who can prove that their condition significantly interferes with their ability to complete the work requirement², and
- WHEREAS, Medicaid is the largest source of insurance for people with HIV³ and as of 2022, there were over 27,000 people in Virginia living with HIV⁴, and
- WHEREAS, some patients living with HIV who are being treated with antiretroviral therapy can appear healthy as long as they are being treated appropriately⁵ and therefore may not qualify for a medical frailty exemption, despite having a complex chronic disease that could interfere with their ability to meet work requirements⁶, and
- WHEREAS, patients living with HIV who lose Medicaid coverage in Virginia could fall through the cracks and may lose access to treatment due to existing strain on the Ryan White safety net in Virginia after a recent 20 million dollar state funding cut⁷, and
- WHEREAS, these patients could lose viral suppression and experience a rapid decline in health⁶ as well as start being able to transmit the virus⁸, and
- WHEREAS, as of June 29, 2026, 24 states have sued CMS specifically over the requirement that conditions must impair an individual's ability to complete community requirements in order to qualify for the medical frailty exception³, and
- WHEREAS, there is a model for work requirements implementation in Nebraska where patients under a list of ICD-10 codes for diagnoses including HIV are automatically granted a medical frailty exception that allows them to maintain Medicaid coverage⁹, therefore be it
- RESOLVED, that the Medical Society of Virginia supports adopting a broad definition of the medical frailty exception to Medicaid work requirements that includes people living with HIV, and that this is a permanent exemption for unchanging conditions such as HIV, and be it further

RESOLVED, that the Medical Society of Virginia supports increasing funding to the Virginia Medication Assistance Program (VA MAP) and the Virginia Ryan White program in order to bolster their safety net efforts.

Fiscal impact: None

Existing Policy: None

References

1. DMAS. Federal work requirements. Virginia Medicaid. Accessed July 13, 2026. <https://www.dmas.virginia.gov/news-updates/new-federal-requirements/federal-work-requirements/>.
2. Administration. Medicaid community engagement requirement for certain individuals interim final rule with comment period (CMS-2454-IFC) | CMS. CMS Newsroom. June 1, 2026. Accessed July 13, 2026. <https://www.cms.gov/newsroom/fact-sheets/medicaid-community-engagement-requirement-certain-individuals-interim-final-rule-comment-period-cms>.
3. Dawson L, Tolbert J. Medical Frailty and Medicaid work requirements: Challenges for people with HIV. KFF. July 1, 2026. Accessed July 13, 2026. <https://www.kff.org/medicaid/medical-frailty-and-medicaid-work-requirements-challenges-for-people-with-hiv/>.
4. VDH. People with HIV. VIRGINIA HIV EPIDEMIOLOGY PROFILE 2022. 2022. Accessed July 13, 2026. <https://www.vdh.virginia.gov/content/uploads/sites/10/2023/08/2022-PWH-Epi-Profile.pdf>
5. NIAID. 10 things to know about HIV suppression | niaid: National Institute of Allergy and Infectious Diseases. National Institute of Allergy and Infectious Diseases. March 25, 2025. Accessed July 13, 2026. <https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression>.
6. Burke J. CMS fails to exempt people living with HIV from Medicaid work requirements. HIV + HEP Institute. June 1, 2026. Accessed July 13, 2026. <https://hivhep.org/press-releases/cms-fails-to-exempt-people-living-with-hiv-from-medicaid-work-requirements/>.
7. Legato K. Virginia's HIV safety net is fraying. lawmakers must act. Equality Virginia. February 18, 2026. Accessed July 13, 2026. <https://equalityvirginia.org/virginias-hiv-safety-net-is-fraying-lawmakers-must-act/>.
8. CDC. HIV treatment as Prevention. HIV Public Health Partners CDC. October 24, 2024. Accessed July 13, 2026. <https://www.cdc.gov/hivpartners/php/hiv-treatment/index.html>.
9. Diana A, Tolbert J. The medical frailty exemption from Medicaid work requirements: Key issues to watch for in upcoming CMS guidance. KFF. May 27, 2026. Accessed July 13, 2026. <https://www.kff.org/medicaid/medically-frail-exemptions-for-medicaid-work-requirements-key-issues-to-watch-for-in-upcoming-cms-guidance/>.



Reference Committee Two Index

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

Treating Traumatic Injury Survivorship as A Chronic Disease

Submitted by: Morgan Hopp MD, Inova Fairfax Medical Campus, Department of Surgery

WHEREAS, in 2020 the Centers for Disease Control and Prevention reported that unintentional injury was the fourth leading cause of death in all age groups¹, and

WHEREAS, traumatic injury has increased social burden beyond death with the most significant social burden being disability and future quality of life of traumatic injury survivors², and

WHEREAS, patient with severe or life-threatening injuries are most likely to become a traumatic injury survivor as case fatality rates are only 5% and 20% respectively³, and

WHEREAS, long-term health of traumatic injury survivors indicates that three years after injury, patients continue to have limitations in all quality of life domains, including but not limited to mobility, pain, self-care and ability to perform their activities of daily living⁴, and

WHEREAS, the current standard of care provided comprehensive care during the inpatient stay but, upon discharge, the outpatient system is fragmented with rehabilitation services lacking the appropriate resources to sustain positive long-term health outcomes¹, and

WHEREAS, avoidable and unnecessary emergency department visits and admissions occur most often in the 12 months following discharge, for concerns that could have been addressed in an outpatient setting but usually do not due to the breakdown of care following discharge³, and

WHEREAS, a study with over one hundred traumatic injury patients found that survivors experience high rates of Post-Traumatic Stress Disorder (PTSD) and depression, 32% for each and 23% for both PTSD and depression³, and

WHEREAS, PTSD and depression contribute to poorer outcomes and access to a trauma psychiatrist and behavioral health services should be the standard of care for survivors to attain long term optimal outcomes³⁻⁴, and

WHEREAS, integrated care teams, (e.g. behavioral health social worker, psychiatrist, trauma surgeon, and a nurse practitioner) that coordinate care to be delivered in the same day decrease number of follow-up appointments and improve accessibility to treatment for patients who have limited access to transportation³, and

WHEREAS, multidisciplinary outpatient “trauma quality of life clinics,” comprised of a nurse practitioner or surgeon, psychologist, social worker, and physical therapist, reported improvement in no-show rates as compared to the standard care visit with an advanced practitioner or surgeon, with no show rates for the standard of care visits being 40% compared to 22% for trauma quality of life clinics⁶, and

WHEREAS, among patients with high-risk of developing PTSD or chronic pain, there is greater engagement in comprehensive multidisciplinary trauma follow-up care⁶, and

WHEREAS, patients undergoing follow-up care at a multidisciplinary “trauma quality of life clinic” completed 23 psychology visits in addition to their appointment with the multidisciplinary team versus one psychology visit at a standard of care follow-up clinic⁶, and

WHEREAS, adult trauma patients with low resilience, as defined by a validated Trauma Quality of Life (T-QoL) survey, were more likely to report decreased functional outcomes, chronic pain, and PTSD at six months post-injury which suggests screening for resilience in trauma patients can inform appropriate interventions in long-term follow-up care plans in clinic⁷, and

WHEREAS, stakeholder organizations such as The American Trauma Society, Brain Trauma Foundation, The Trauma Survivor Foundation, Pediatric Trauma Society, American Association for the Surgery of Trauma, Orthopaedic Trauma Association, American College of Surgeons - Committee on Trauma and American Academy of Orthopaedic Surgeons are currently working to improve the long term effects of traumatic injury survivors⁸⁻¹⁵, therefore be it

RESOLVED, that MSV collaborates with appropriate stakeholders to advocate for comprehensive care and improved quality of life strategies and interventions for traumatic injury survivors in Virginia, and be it further

RESOLVED, that MSV recognizes (1) the incidence and prevalence of traumatic injury survivorship and its impact on our healthcare and social resources in Virginia, (2) the chronicity of comprehensive rehabilitation following traumatic injury.

Fiscal impact: TBD

Existing Policy:

10.10.03- Improve Upon the Current Prior Authorization Law in the State of Virginia

40.6.09- Address the Dangers of Head Trauma and Other Potential Injuries in Sports

40.15.05- Trauma Research/Development of Systems

References

1. Leading causes of death and injury - PDFs|Injury Center|CDC. <https://www.cdc.gov/injury/wisqars/LeadingCauses.html> Updated 2020. Accessed Jan 17, 2023.
2. *A national trauma care system: Integrating military and civilian trauma systems to achieve zero preventable deaths after injury*. national academy of science, engineering and medicine.
3. Livingston DH, La Bagnara S, Sieck D, et al. The center for trauma survivorship: Addressing the great unmet need for posttrauma center care. *The journal of trauma and acute care surgery*. 2020;89(5):940-946. <https://www.ncbi.nlm.nih.gov/pubmed/32345893>. doi: 10.1097/TA.0000000000002775.
4. Gabbe BJ, Simpson PM, Cameron PA, et al. Long-term health status and trajectories of seriously injured patients: A population-based longitudinal study. *PLoS Med*. 2017;14(7):e1002322. Accessed Nov 22, 2022. doi: 10.1371/journal.pmed.1002322.
5. Kamdar BB, Suri R, Suchyta MR, et al. Return to work after critical illness: A systematic review and meta-analysis. *Thorax*. 2020;75(1):17-27. <http://dx.doi.org/10.1136/thoraxjnl-2019-213803>. doi: 10.1136/thoraxjnl-2019-213803.
6. Trevino C, Geier T, Timmer-Murillo SC, et al. Feasibility of a trauma quality-of-life follow-up clinic. *The journal of trauma and acute care surgery*. 2020;89(1):226-229. <https://www.ncbi.nlm.nih.gov/pubmed/32176166>. doi: 10.1097/TA.0000000000002672.
7. Nehra D, Herrera-Escobar JP, Al Rafai SS, et al. Resilience and long-term outcomes after trauma: An opportunity for early intervention? *The journal of trauma and acute care surgery*. 2019;87(4):782-789. <https://www.ncbi.nlm.nih.gov/pubmed/31589192>. doi: 10.1097/TA.0000000000002442.
8. American Academy of orthopedic surgeons - AAOS. <https://www.aaos.org/>. Accessed Mar 7, 2023.
9. About Trauma Programs. ACS Web site. <https://www.facs.org/quality-programs/trauma/committee-on-trauma/>. Accessed Mar 7, 2023.
10. Orthopaedic Trauma Association (OTA) Web site. <https://ota.org/node/1>. Accessed Mar 7, 2023.
11. The American Association for the Surgery of Trauma. <https://www.aast.org/Default.aspx>. Accessed Mar 7, 2023.
12. Pediatric trauma society. <https://pediatrictraumasociety.org/>. Accessed Mar 7, 2023.
13. Brain Trauma Foundation. <http://www.braintrauma.org/about>. Accessed Mar 7, 2023.
14. Mission. The Trauma Survivors Foundation Web site. <https://www.thetraumasurvivorsfoundation.com/mission-index-impact>. Accessed Mar 7, 2023.
15. About the American trauma society - American trauma society. <https://www.amtrauma.org/page/About>. Accessed Mar 7, 2023.

Prioritizing Palliative Care Access for Geriatric Trauma Patients

Submitted by: Dr. Morgan Hopp

- WHEREAS, since 2010 there has been a 34.2% increase in the number of Americans over 65 years old¹. The increase in the national geriatric population is multi-faceted with one of the most significant factors being the effect of geriatric-focused medicine improving life expectancy², and
- WHEREAS, compared to younger adults with similar injuries, an elderly trauma patient has an increased risk of morbidity, mortality, and functional decline³⁻⁵. Geriatric patients require specific services based on the physiological effect of aging such as significantly lower cardiac output, increase in pulmonary complications, and delirium, all of which culminate in an increased risk for surgical complications^{1,2,6,7}, and
- WHEREAS, adequate care for the senior population after trauma requires specialized services including but not limited to: geriatric pharmacists, geriatricians, case managers, expedited care in the emergency department, and expedited time to the operating room. In 2016, patients 55 years and older accounted for over 40% of all traumas and over 55% of all trauma-related deaths⁸, and
- WHEREAS, geriatric trauma patients incur a disproportionate amount of the total US trauma expenses due to the complexities of geriatric care⁹, and
- WHEREAS, palliative care in the trauma setting can have a lasting economic value to the healthcare system and the patient contrasting the significant drain on resources of typical trauma care^{10,11}. In the academic trauma center setting, it is estimated that trauma patients with palliative care consults accrued \$30,798 less in total costs and \$14,475 less in hospital costs per day¹⁰, and
- WHEREAS, to address the specific needs of the geriatric patient, there have been significant efforts in identifying the best practices for geriatric surgical patients, and
- WHEREAS, the American College of Surgeons established the Geriatric Verification Program to formally optimize the surgical care of aging adults^{9,11,12}. In recent years, a large body of research by trauma surgeons and trauma nurses has looked at the benefits of palliative care in the outcomes of geriatric trauma patients^{3-5,9,12-14}, and
- WHEREAS, palliative care has three focuses: (1) symptom management, (2) psychosocial support, and (3) aiding with decision-making. By design, palliative medicine as a subspecialty is patient-centered care, and

WHEREAS, early use of palliative care consults has resulted in improved outcomes for geriatric trauma patients^{9,12,14}. When palliative care is involved early in the treatment course, palliative care has a meaningful impact on quality of life, long-term survival, and end-of-life care¹⁵, and

WHEREAS, studies across many fields of medicine have shown that palliative care is delivered late in the patient's course or upon uncontrolled symptoms which diminishes the effectiveness of the consult on quality of life^{6,15-18}, and

WHEREAS, it has been studied that palliative care usage has been inconsistent and imprecise across studies and practice environments⁹, and

WHEREAS, palliative care consults have been shown to improve the quality of care and result in an overall decrease in medical service usage when used promptly^{19,20}. Based on the results of studies in various fields of medicine^{9,12,14,17-19,19-21} the early and effective involvement of palliative care in treating geriatric trauma patients can directly improve patient outcomes, quality of life, and patient-centered approaches to care, and

WHEREAS, offering palliative care early in the course of geriatric trauma care before 24 hours may not provide further benefit as the decisions made at this point in the care process are often critical to the patient's long-term survival and are made within a brief time frame by the patient's surrogate decision maker²¹. However, beyond 24 hours, there does seem to be a benefit of consulting palliative care with evidence of the decreased length of stay in the hospital and unnecessary procedures²¹, and

RESOLVED, that our MSV recognizes (1) the benefit of incorporating palliative care early in geriatric trauma for both the patient and the healthcare system, and (2) incorporation of prompt palliative care greatly improves comprehensive rehabilitation following traumatic injury, and be it further

RESOLVED, that our MSV supports (1) the utilization of palliative care in the trauma setting to provide quality patient-centered care, and (2) research investigating the benefits and barriers of palliative care use in geriatric trauma patients.

Fiscal impact:

Existing Policy:

References:

1. Cho SJ, Stout-Delgado HW. Aging and lung disease. *Annual review of physiology*. 2020;82(1):433-459. <http://dx.doi.org/10.1146/annurev-physiol-021119-034610>. doi: 10.1146/annurev-physiol-021119-034610.

2. Iglseder B, Frühwald T, Jagsch C. Delirium in geriatric patients. *Wiener medizinische Wochenschrift*. 2022. <https://www.ncbi.nlm.nih.gov/pubmed/35006521>. doi: 10.1007/s10354-021-00904-z.
3. Hashmi A, Ibrahim-Zada I, Rhee P, et al. Predictors of mortality in geriatric trauma patients: A systematic review and meta-analysis. *The journal of trauma and acute care surgery*. 2014;76(3):894-901. <https://www.ncbi.nlm.nih.gov/pubmed/24553567>. doi: 10.1097/TA.0b013e3182ab0763.
4. Cooper Z, Maxwell CA, Fakhry SM, et al. A position paper: The convergence of aging and injury and the need for a geriatric trauma coalition (GeriTraC). *The journal of trauma and acute care surgery*. 2017;82(2):419-422. <https://www.ncbi.nlm.nih.gov/pubmed/27893640>. doi: 10.1097/TA.0000000000001317.
5. Kozar RA, Arbabi S, Stein DM, et al. Injury in the aged: Geriatric trauma care at the crossroads. *J Trauma Acute Care Surg*. 2015;78(6):1197-1209. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4976060/>. Accessed Dec 29, 2022. doi: 10.1097/TA.0000000000000656.
6. Rooke GA. Cardiovascular aging and anesthetic implications. *Journal of Cardiothoracic and Vascular Anesthesia*. 2003;17(4):512-523.
7. Sprung J, Gajic O, Warner D. Review article: Age related alterations in respiratory function — anesthetic considerations. *Can J Anesth*. 2006;53(12):1244-1257. <https://www.ncbi.nlm.nih.gov/pubmed/17142659>. doi: 10.1007/BF03021586.
8. Chang, M. C., Stewart, R. M., & Rotondo, M. F. National trauma data bank 2016 annual report. *American College of Surgeons*. 2016;4(5).
9. Aziz HA, Lunde J, Barraco R, et al. Evidence-based review of trauma center care and routine palliative care processes for geriatric trauma patients; A collaboration from the american association for the surgery of trauma patient assessment committee, the american association for the surgery of trauma geriatric trauma committee, and the eastern association for the surgery of trauma guidelines committee. *The journal of trauma and acute care surgery*. 2019;86(4):737-743. <https://www.ncbi.nlm.nih.gov/pubmed/30531333>. doi: 10.1097/TA.0000000000002155.
10. Spencer AL, Nunn AM, Miller PR, et al. The value of compassion: Healthcare savings of palliative care consults in trauma. *Injury*. 2023;54(1):249-255. <https://dx.doi.org/10.1016/j.injury.2022.10.021>. doi: 10.1016/j.injury.2022.10.021.
11. Zaborowski N, Scheu A, Glowacki N, Lindell M, Battle-Miller K. Early palliative care consults reduce patients' length of stay and overall hospital costs. *American journal of hospice & palliative medicine*. 2022;39(11):1268-1273. <https://journals.sagepub.com/doi/full/10.1177/10499091211067811>. doi: 10.1177/10499091211067811.
12. Kupensky D, Hileman BM, Emerick ES, Chance EA. Palliative medicine consultation reduces length of stay, improves symptom management, and clarifies advance directives in the geriatric trauma population. *J Trauma Nurs*. 2015;22(5):261-265. <https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=mdc&AN=26352657&authtype=sso&custid=creight&site=ehost-live&custid=creight>. Accessed Dec 29, 2022. doi: 10.1097/JTN.0000000000000151.
13. Moran ME, Soltis M, Politis T, Gothard MD, George RL. Improving a mature palliative care program at a level I trauma center. *J Trauma Nurs*. 2021;28(2):119-125. <https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=mdc&AN=33667>

- 207&site=ehost-live&custid=creight. Accessed Dec 29, 2022. doi: 10.1097/JTN.0000000000000569.
14. Kupensky DT, Emerick ES, Hileman BM, Chance EA. The association of time to palliative medicine consultation on geriatric trauma outcomes. *J Trauma Nurs*. 2020;27(3):177-184. <https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=mdc&AN=32371737&site=ehost-live&custid=creight>. Accessed Dec 29, 2022. doi: 10.1097/JTN.0000000000000508.
 15. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic Non–Small-cell lung cancer. *The New England journal of medicine*. 2010;363(8):733-742. <http://dx.doi.org/10.1056/NEJMoa1000678>. doi: 10.1056/NEJMoa1000678.
 16. Jordan J. 65 and older population grows rapidly as baby boomers age. www.census.gov Web site. <https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html>. Updated 2020. Accessed January 1, 2022.
 17. FERRIS FD, BRUERA E, CHERNY N, et al. Palliative cancer care a decade later: Accomplishments, the need, next Steps—From the american society of clinical oncology. *Journal of clinical oncology*. 2009;27(18):3052-3058. <http://jco.ascopubs.org/content/27/18/3052.abstract>. doi: 10.1200/JCO.2008.20.1558.
 18. Levy MH, Back A, Benedetti C, et al. NCCN clinical practice guidelines in oncology: Palliative care. *Journal of the National Comprehensive Cancer Network*. 2009;7(4):436-473. <https://www.ncbi.nlm.nih.gov/pubmed/19406043>.
 19. Zimmermann C, Riechelmann R, Krzyzanowska M, Rodin G, Tannock I. Effectiveness of specialized palliative care: A systematic review. *JAMA : the journal of the American Medical Association*. 2008;299(14):1698-1709. <http://dx.doi.org/10.1001/jama.299.14.1698>. doi: 10.1001/jama.299.14.1698.
 20. MORITA T, AKECHI T, UCHITOMI Y, et al. Late referrals to specialized palliative care service in japan. *Journal of clinical oncology*. 2005;23(12):2637-2644. <http://jco.ascopubs.org/content/23/12/2637.abstract>. doi: 10.1200/JCO.2005.12.107.
 21. Duncan AJ, Holkup LM, Sang HI, Sahr SM. Benefits of early utilization of palliative care consultation in trauma patients. *Critical care explorations*. 2023;5(9):e0963. <https://search.proquest.com/docview/2859604015>. doi: 10.1097/CCE.0000000000000963.

Protection for Physicians and Patients Regarding Surgical and Procedural Data

Submitted by: Areesheh Khan, Khalid Elhadi, Morgan Hopp MD, MS

- WHEREAS, many studies have shown evidence that the use of recorded surgical videos is incredibly beneficial for resident learning and therefore have been increasingly utilized for training programs^{1,2}, and
- WHEREAS, the use of surgical recordings has been shown to be effective at assessing surgeon performances, leading to a foreseeable future of operative data used to influence credentialing, certification, and promotions³, and
- WHEREAS, Intuitive dominates the robotic surgical industry and collects data related to its surgical systems, including usage, kinematic, and procedure data for products and services it provides⁴, and
- WHEREAS, the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) found that 67% of platforms use cloud-based storage, raising questions about third-party data access⁵ and found little to no existence or awareness of institutional policies on data ownership and commercialization⁶, and
- WHEREAS, the implementation of electronic health records demonstrated the consequences of insufficient physician involvement in the development of healthcare technologies, resulting in systems shaped by insurance and reimbursement priorities rather than clinical practice⁷, and
- WHEREAS, the widespread collection and use of surgical data may expose surgeons to increased legal scrutiny and create concerns that awareness of being recorded could influence operative decision-making or behavior, potentially shifting attention from clinical judgment and patient-centered care toward “performing for the camera”⁸, and
- WHEREAS, the AMA has already established clear policy, H-406.985, that states responsible, physician-led use of surgical data for education, research, and quality improvement while opposing punitive or out-of-context uses of these data⁹, and
- WHEREAS, there are no current U.S. state or federal law that governs surgical video capture, storage, or use in training¹⁰, and
- WHEREAS, the Medical Society of Virginia should be at the forefront of emerging legal and policy discussions surrounding the use of technology and video recording in the operating room to protect both physicians and our patients, therefore be it

RESOLVED, that the MSV supports the future of technology and surgical recordings in the operating room while ensuring physicians remain at the center of state policy discussions to promote ethical, patient-centered recommendations, and be it further

RESOLVED, that the MSV supports the use of operative data for research, quality improvement, and teaching purposes while protecting physicians from out-of-context use of surgical data in legal proceedings without adequate consideration of surgical complexity and operative decision-making.

Fiscal impact: None

Existing Policy: None

References:

1. Green JL, Suresh V, Bittar P, Ledbetter L, Mithani SK, Allori A. The Utilization of Video Technology in Surgical Education: A Systematic Review. *J Surg Res.* 2019;235:171-180. doi:10.1016/j.jss.2018.09.015
2. Yee A, Padovano WM, Rowe AG, et al. The Effect of Surgical Video on Resident Performance of Carpal Tunnel Release: A Cadaveric Simulation-Based, Prospective, Randomized, Blinded Pilot Study. *Plast Reconstr Surg.* 2020;145(6):1455-1463. doi:10.1097/PRS.00000000000006817
3. Stulberg JJ, Huang R, Kreutzer L, et al. Association Between Surgeon Technical Skills and Patient Outcomes. *JAMA Surg.* 2020;155(10):960-968. doi:10.1001/jamasurg.2020.3007
4. Privacy Policy | Personal Data | Robotic Surgical Company | Intuitive. Accessed July 5, 2026. <https://www.intuitive.com/en-us/about-us/company/legal/privacy-policy>
5. Eckhoff, J. A., et al. (2023). SAGES consensus recommendations on surgical video data use, structure, and exploration (for research in artificial intelligence, clinical quality improvement, and surgical education). *Surgical endoscopy*, 37(11), 8690–8707. <https://doi.org/10.1007/s00464-023-10288-3>
6. Lia, H., Liu, Y., Masino, C., Gatta, P., Altieri, M. S., Langerman, A., & Madani, A. (2026). What are the ethical, legal and social considerations for recording, sharing and utilizing surgical videos? A thematic analysis and framework to guide stakeholders. *Surgical endoscopy*, 40(7), 5691–5701. <https://doi.org/10.1007/s00464-026-12782-w>. <https://pubmed.ncbi.nlm.nih.gov/42301451/>
7. Yang Y, Shi R, Wang Z, Xu J, Xie J, Liu J. Electronic health records-related determinants of healthcare professionals' burnout and mitigation strategies: systematic review and meta-analysis. *Front Public Health.* 2026;14:1751521. doi:10.3389/fpubh.2026.1751521
8. Langerman A, Hammack-Aviran C, Cohen IG, et al. Navigating a Path Toward Routine Recording in the Operating Room. *Ann Surg.* 2023;278(3):e474-e475. doi:10.1097/SLA.0000000000005906
9. H-406.985 Appropriate Use of Data from Surgical Practices | AMA. Accessed August 31, 2026. <https://policysearch.ama-assn.org/policyfinder/detail/Data%20from%20surgical%20practices?uri=%2FAMADoc%2FHOD.xml-H-406.985.xml>

10. Quach WT, Vittetoe KL, Langerman A. Ethical and Legal Considerations for Recording in the Operating Room: A Systematic Review. *J Surg Res.* 2023;288:118-133. doi:10.1016/j.jss.2023.02.017

Establishing Proactive Academic Support for Neurodivergent Medical Students

Submitted by Emma Cook (Eastern Virginia Medical School) & Nicole Willing (Edward Via College of Osteopathic Medicine - Virginia Campus)

- WHEREAS, neurodivergence, including Attention-Deficit/Hyperactivity Disorder (ADHD), autism, dyslexia, and other learning differences, represents an important and increasingly recognized facet of diversity within undergraduate medical education that brings distinct cognitive strengths, spatial reasoning abilities, and varied problem-solving perspectives to the medical field^{1, 2}, and
- WHEREAS, neurodivergent medical learners may encounter barriers related to executive functioning, sensory processing, communication, disclosure, and access to individualized support within academic and clinical learning environments^{3,4,5,6}, and
- WHEREAS, health professions education literature indicates that neurodiversity-informed support is inconsistently available and may depend on the knowledge, preparation, and training of individual educators, learning specialists, and clinical supervisors. This highlights the need for expanded and consistent access to specialized professional development in neurodiversity-informed strategies^{4,5,6}, and
- WHEREAS, neurodivergent health professions learners report more supportive educational experiences when educators and clinical supervisors demonstrate neurodiversity awareness and provide informed, individualized support, and
- WHEREAS, evidence from related health professions settings indicates that structured neurodiversity-focused training can improve professional knowledge, confidence, and self-efficacy, supporting the development of more consistent institutional support practices¹¹, and
- WHEREAS, medical students with disabilities and neurodivergent trainees experience significantly higher rates of severe distress, burnout, depression, leave of absence, and dropout risk, and the literature indicates that individualized mentorship, academic support, and structured transition planning can help qualified learners build on their strengths, navigate barriers, support their well-being, and improve retention^{7,8,9}, and
- WHEREAS, Virginia faces significant physician-workforce shortages, particularly in rural and underserved areas, and reducing avoidable attrition among qualified medical students may help preserve and strengthen the Commonwealth's future physician workforce¹⁴, and

WHEREAS, additional evidence and educator guidance are needed to identify effective and adaptable practices that enable neurodivergent learners to thrive in health professions education^{4,5,6}, and

WHEREAS, national medical education accreditation frameworks mandate that institutions provide effective, equitable, and comparable academic support services to facilitate the professional growth and graduation of all medical trainees¹², and

WHEREAS, the American Medical Association has committed to expanding the diversity of the physician workforce by actively identifying and minimizing institutional barriers that contribute to attrition among historically excluded or marginalized groups, including individuals with unique disability or cognitive profiles¹³, therefore be it

RESOLVED, that the Medical Society of Virginia support collaboration with Virginia medical schools and relevant stakeholders, including neurodivergent medical learners, academic support personnel, accessibility professionals, and medical education experts, to identify and disseminate adaptable, evidence-informed best practices for neurodiversity-informed academic support, and be it further

RESOLVED, that the Medical Society of Virginia encourage medical schools in Virginia to implement adaptable, neurodiversity-informed support practices, including individualized, strengths-based academic coaching, peer mentorship, tailored clinical transition support, and neurodiversity-informed professional development for personnel involved in student support, to help learners meet established academic, clinical, and professional expectations.

Fiscal impact: None

Existing Policy: None

References:

1. Hamilton RH, Williams ZJ, Brodtkin ES. Embracing neurodiversity in medicine: building a more inclusive physician workforce. JAMA. 2025;333(12):1030-1031. doi:10.1001/jama.2025.0094.
2. Richter R. Greater flexibility needed in training neurodiverse medical students. Stanford Medicine News. Published May 21, 2025. Accessed July 2, 2026. <https://med.stanford.edu/news/all-news/2025/05/neurodiversity-education.html>
3. Rogers D. Supporting neurodiverse medical students in clinical settings. Bristol Institute for Learning and Teaching. Published March 23, 2026. Accessed July 7, 2026. <https://bilt.online/supporting-neurodiverse-medical-students-in-clinical-settings/>
4. Gray L, McNeill B, Pecora L, et al. Navigating neurodivergence: a scoping review to guide health professions educators. Med Educ. 2025;59(10):1037-1048. doi:10.1111/medu.15676.
5. Hamilton LG, Petty S. Compassionate pedagogy for neurodiversity in higher education: a conceptual analysis. Front Psychol. 2023;14:1093290. doi:10.3389/fpsyg.2023.1093290.

6. Edwards E. The experiences of autistic healthcare students in a clinical learning environment: a scoping review. *Autism*. Published online 2026. doi:10.1177/13623613261427125.
7. Seaborne HJ, Chehab LZ, Rajapuram N, et al. Disparities in well-being outcomes among medical students: a comparative study between medical students with and without disability. *BMC Med Educ*. 2025;25:199. doi:10.1186/s12909-025-06770-2.
8. Barel M, Javaid A. Supporting neurodiverse junior doctors: challenges, strategies, and policy implications for inclusive medical training. *Cureus*. 2026;18(3):e104746. doi:10.7759/cureus.104746.
9. Dyrbye LN. Medical student well-being: minimize burnout and improve mental health among medical students. *AMA STEPS Forward*. Published December 5, 2019. Renewed February 20, 2024.
10. Janse van Rensburg M, Liang B. Improving autistic students' experiences in higher education: developing a community framework for individual autistic student and autistic community flourishing. *Autism Adulthood*. 2025;7(2):141-154. doi:10.1089/aut.2022.0079.
11. Clarke L, Fung LK. The impact of autism-related training programs on physician knowledge, self-efficacy, and practice behavior: a systematic review. *Autism*. 2022;26(7):1626-1640. doi:10.1177/13623613221102016.
12. Liaison Committee on Medical Education. Functions and structure of a medical school: standards for accreditation of medical education programs leading to the MD degree. Standard 11: Medical Student Academic Support, Career Advising, and Educational Records. Published 2025. Accessed July 14, 2026. <https://lcme.org/standards-and-rules/>
13. American Medical Association. AMA adopts new policy to increase diversity in physician workforce. Published June 17, 2021. Accessed July 23, 2026. <https://www.ama-assn.org/press-center/ama-press-releases/ama-adopts-new-policy-increase-diversity-physician-workforce>
14. Virginia Health Workforce Development Authority. GME supplemental funding application: Cohort 11. Published 2026. Accessed August 5, 2026. <https://www.vhwda.org/programs/graduate-medical-education-gme>

Establishing Public Health Standards for Recreational Cannabis Product Potency in Virginia

Submitted by: Dr. Carl Hoegerl

- WHEREAS, recreational cannabis products now include high-concentration THC products, including concentrates, oils, vape cartridges, waxes, and edibles, that can deliver substantially greater THC exposure than traditional cannabis, and
- WHEREAS, increasing product potency, product variety, and ease of consumption may increase risks of acute intoxication, impaired driving, unintentional pediatric exposures, cannabis use disorder, psychiatric adverse effects, and other preventable harms, particularly among adolescents, young adults, inexperienced consumers, pregnant individuals, and persons with substance use disorders or serious mental illness, and
- WHEREAS, commercially available cannabis products vary widely in THC concentration, formulation, serving size, and route of administration, creating substantial challenges for consumers to understand or safely estimate dose, and
- WHEREAS, sales limits based solely on product weight do not adequately limit the total amount of THC a consumer may purchase or consume, and
- WHEREAS, a public health approach to recreational cannabis regulation should include transparent product testing, accurate labeling, standardized THC dosing information, reasonable potency limits, and ongoing surveillance of cannabis-related harms, and
- WHEREAS, Virginia has an opportunity to establish evidence-informed protections before a fully commercial recreational cannabis market expands further, therefore be it
- RESOLVED, that the Medical Society of Virginia urges the Commonwealth of Virginia to establish and enforce evidence-informed standards governing the manufacture, distribution, marketing, and sale of recreational cannabis products, with particular attention to THC potency and total THC dose, and be it further
- RESOLVED, that the Medical Society of Virginia urges the Commonwealth to establish reasonable limits on THC concentration and total THC content for recreational cannabis products, including cannabis concentrates, vape products, edibles, beverages, and other manufactured products, and be it further
- RESOLVED, that the Medical Society of Virginia urges the Commonwealth to require independent laboratory testing and accurate, standardized labeling of THC

concentration, total THC per package, THC per serving, cannabinoid content, ingredients, contaminants, and recommended serving size, and be it further

RESOLVED, that the Medical Society of Virginia urges the Commonwealth to adopt purchase limits based on total THC content rather than product weight alone, and be it further

RESOLVED, that the Medical Society of Virginia urges the Commonwealth to require prominent health and safety warnings regarding intoxication, delayed effects of edible products, impaired driving, risks of unintentional pediatric ingestion, risks during pregnancy, and potential risks for individuals with psychiatric illness or substance use disorder, and be it further

RESOLVED, that the Medical Society of Virginia urges the Commonwealth to restrict the manufacture and sale of products designed or packaged in a manner likely to appeal to children or facilitate unintentional overconsumption, and be it further

RESOLVED, that the Medical Society of Virginia urges the Commonwealth to establish a statewide surveillance and reporting system to monitor cannabis product potency, poison center calls, emergency department visits, hospitalizations, impaired-driving events, pediatric exposures, cannabis use disorder treatment needs, and other cannabis-related public health outcomes, and be it further

RESOLVED, that the Medical Society of Virginia shall advocate with the Governor, the General Assembly, and appropriate state agencies for the timely development, implementation, and periodic review of these public health safeguards.

Fiscal impact:

Existing Policy:

References:

A Resolution on Self Defense for Domestic Violence Victims

Submitted by: Arthur J Vayer, Jr., M.D., Delegate, District 8, Past President, MSV

WHEREAS, domestic abuse involves a pattern of controlling and abusive behaviors. Individuals use them against family members or intimate partners to intimidate and exert power. Behaviors may include physical assault, verbal attacks and even weapon use, and

WHEREAS, statistics from the Centers for Disease Control and Prevention (CDC) show that a total of 25% of women and almost 10% of men experience domestic violence during their lifetimes (that includes sexual and physical assault, as well as stalking by a family member or an intimate partner). About 35% of women experiencing domestic violence have physical injuries. More than 11% of men who experience domestic violence have physical injuries, and

WHEREAS, according to The National Resource Center on Domestic Violence, more than half (54%) of people identifying as transgender or non-binary experienced some form of domestic violence, including acts of coercive control or physical harm. A 2020 report from the Human Rights Campaign Foundation stated that LGBTQ people have been twice as likely to have experienced an incident of intimate partner violence since the onset of COVID-19, and

WHEREAS, statistics about intimate partner-related homicides reported by the Virginia Department of Health show that

- More than 30% of Virginia's homicides are domestic violence related.
- About 56% of domestic violence homicides involve firearms.
- About 80% of domestic violence homicides happen in people's homes.
- About 40% of domestic violence homicides happen during or after a relationship breakup.
- More than 20% of domestic violence homicides involve a homicide-suicide.
- Women make up 51% of Virginia's population but account for 63% of the people killed by firearms in intimate partner-related homicides, and

WHEREAS, a 2019 VAdata report offers additional insights about domestic violence in Virginia:

- In 2019, more than 22,000 adults and nearly 5,300 children received domestic violence advocacy services.
- A total of 20% of the people who received these services had to relocate or experience homelessness because of domestic violence.

- In 2019, 87% of the domestic violence perpetrators in Virginia were men, and 13% were women, and

WHEREAS, current MSV policy 40.23.01 can be summed up as “we oppose domestic violence, here’s a pamphlet”, and

WHEREAS, humans have the innate properties of self-preservation and self-defense (fight or flight), therefore be it

RESOLVED, that MSV Policy 40.23.01 be amended to read,

“The Medical Society of Virginia opposes any type of domestic violence and supports the inclusion of educational material regarding resources, criminal laws, and prevention in government publications related to marriage and families.

The Medical Society of Virginia supports the individual right of self-defense and self -preservation.”

Fiscal impact: None

40.23.01- Anti-Domestic Violence Statement

Date: 11/4/1995

The Medical Society of Virginia opposes any type of domestic violence and supports the inclusion of educational material regarding resources, criminal laws, and prevention in government publications related to marriage and families.

Reaffirmed 11/06/2005

Reaffirmed as amended 10/25/2015

Reaffirmed 10/26/2025

References

<https://onlinesocialwork.vcu.edu/blog/domestic-violence-virginia/>

VIRGINIA PARTICIPATION IN THE INTERSTATE MEDICAL LICENSURE COMPACT

Submitted by: the Richmond Academy of Medicine

- WHEREAS, in 2015, the Medical Society of Virginia adopted Policy 30.2.04 supporting the development and implementation of an interstate medical compact in Virginia at a time when the Interstate Medical Licensure Compact (IMLC) was newly established, had been enacted by only a limited number of states, and had not yet become operational^{1,2}, and
- WHEREAS, rather than join the IMLC, the Virginia Board of Medicine subsequently established a licensure-by-endorsement pathway to expedite Virginia licensure for certain qualified physicians already licensed in other jurisdictions³, and
- WHEREAS, while licensure by endorsement has streamlined Virginia licensure for eligible out-of-state physicians, it is a Virginia-specific pathway and does not provide Virginia physicians reciprocal or expedited access to licensure in other states or participation in a shared interstate licensure framework^{3,4}, and
- WHEREAS, in the decade since MSV's original policy was adopted, the IMLC has emerged as the established interstate compact for physician licensure, while interstate licensure compacts have become widely adopted mechanisms for facilitating professional mobility across numerous health professions^{5,6}, and
- WHEREAS, the IMLC now includes 44 states, the District of Columbia, and Guam and has facilitated the issuance of more than 200,000 medical licenses, demonstrating substantial growth since MSV's original policy was adopted^{5,7}, and
- WHEREAS, the IMLC provides an expedited pathway for qualified physicians to obtain licenses in participating states while preserving each state's authority to license, regulate, and discipline physicians practicing within that state⁵, and
- WHEREAS, the Virginia Rare Disease Council has recommended that the Governor and General Assembly reconsider Virginia's participation in the IMLC as a means of improving access to physicians, including specialists providing care through telemedicine⁸, and
- WHEREAS, the American Medical Association supports working with state medical associations to encourage states that do not participate in the IMLC to consider joining the Compact⁹, and

WHEREAS, MSV's existing policy supports the concept of an interstate medical compact but predates the IMLC's implementation, widespread adoption, and emergence as the established interstate compact for physician licensure^{1, 2}, therefore be it

RESOLVED, that Medical Society of Virginia Policy 30.2.04, Interstate Licensure Compact in Virginia, be amended by substitution to read,

“The Medical Society of Virginia supports the Commonwealth of Virginia joining and participating in the Interstate Medical Licensure Compact (IMLC) and supports the legislative and regulatory efforts necessary to implement the Compact in Virginia.”

Fiscal impact:

Existing Policy:

References:

1. Medical Society of Virginia. *2025–2026 Policy Compendium*. Policy 30.2.04, “Interstate Licensure Compact in Virginia.” Adopted October 25, 2015; reaffirmed October 26, 2025.
2. Federation of State Medical Boards. *Interstate Medical Licensure Compact Established with Seventh State Enactment; Formation of Compact Commission Triggered*. May 19, 2015.
3. Virginia Board of Medicine. *Board Briefs*, Issue 84.
4. Virginia Administrative Code. 18VAC85-20-141. Licensure by endorsement. Virginia Board of Medicine.
5. Interstate Medical Licensure Compact Commission. *Physician Licensure: A Faster Pathway to Physician Licensure*.
6. U.S. Department of Health and Human Services. *Licensure Compacts*. Telehealth.HHS.gov.
7. American Medical Association. *What's the Interstate Medical Licensure Compact? How can it help physicians?* June 2026.
8. Virginia Rare Disease Council. *2025 Annual Report*. Published 2026.
9. American Medical Association. Policy D-480.964, “Established Patient Relationships and Telemedicine.”

DATA TRANSPARENCY FOR EMERGENCY CARE ACCESS

Submitted by: the Richmond Academy of Medicine

- WHEREAS, timely access to appropriate specialty and subspecialty medical care is essential to achieving optimal outcomes in emergency and time-sensitive clinical situations, and
- WHEREAS, patients, emergency medical services (EMS), and referring clinicians are frequently required to make rapid hospital destination and transfer decisions with limited or incomplete information regarding available specialty services, and
- WHEREAS, hospitals across the Commonwealth vary in the medical specialties and subspecialties they maintain on-site or available on-call, and such availability may change over time, and
- WHEREAS, the lack of accurate, current, and publicly available information regarding specialty coverage can result in delayed definitive care, avoidable interfacility transfers, increased healthcare costs, and potential harm to patients, and
- WHEREAS, EMS agencies and regional trauma systems rely on accurate hospital capability information to support destination protocols, trauma triage, and time-sensitive specialty access, and
- WHEREAS, transparent and standardized reporting of hospital specialty availability serves as a patient navigation and public information measure that enhances emergency care coordination without interfering with clinical judgment or hospital operations, therefore be it
- RESOLVED, that the Medical Society of Virginia supports and advocates for legislation or regulation requiring hospitals in the Commonwealth to maintain a public facing accurate, up-to-date list of medical specialties and subspecialties available on-site or on-call, and be it further
- RESOLVED, that the Medical Society of Virginia supports making such information publicly accessible in a clear, standardized, and regularly updated format to assist patients, EMS systems, and referring providers in making informed decisions during emergencies, and be it further
- RESOLVED, that the Medical Society of Virginia supports aligning these reporting requirements with existing EMS destination protocols and regional trauma system planning to improve coordination of emergency and trauma care, and be it further

RESOLVED, that the Medical Society of Virginia advocates for legislative and regulatory efforts framing these requirements as a patient safety, emergency care access, and public information initiative designed to improve outcomes and system efficiency across the Commonwealth.

Fiscal impact:

Existing Policy:

References:

PRACTITIONER RESPONSIBILITY AND LIABILITY IN THE USE OF ARTIFICIAL INTELLIGENCE IN MEDICINE

Submitted by: the Richmond Academy of Medicine

- WHEREAS, artificial intelligence (AI) technologies are increasingly being developed and integrated into medical practice for purposes including, but not limited to, clinical decision support, diagnostic assistance, documentation, administrative efficiency, and patient engagement, and
- WHEREAS, AI systems function as tools that provide recommendations, analyses, or outputs based on data inputs and algorithms, but do not independently practice medicine or exercise clinical judgment, and
- WHEREAS, the practice of medicine requires the application of professional judgment, training, licensure, and ethical responsibility by a qualified practitioner in accordance with established standards of care, and
- WHEREAS, existing medical-legal principles place responsibility for clinical decisions and patient care on the licensed practitioner, regardless of whether those decisions are informed by reference materials, diagnostic aids, clinical calculators, or other tools, and
- WHEREAS, clarity regarding professional responsibility and liability in the use of AI is necessary to promote appropriate adoption, innovation, patient safety, and accountability within medical practice, therefore be it
- RESOLVED, that the Medical Society of Virginia affirms that artificial intelligence technologies used in medical practice are clinical tools intended to support, but not replace, the professional judgment of licensed practitioners, and be it further
- RESOLVED, that the Medical Society of Virginia holds that the responsibility and liability for clinical decisions made with the assistance of artificial intelligence rest with the licensed practitioner who uses such tools, consistent with existing standards of care and principles of medical malpractice, and be it further
- RESOLVED, that the Medical Society of Virginia supports policies, education, and guidance that emphasize practitioner oversight, informed use, and accountability when artificial intelligence technologies are employed in the delivery of medical care.

Fiscal impact:

Existing Policy:

References:

SUPPORT FOR PHYSICIANS CONFRONTING THE CORPORATE PRACTICE OF MEDICINE

Submitted by: the Richmond Academy of Medicine

- WHEREAS, the Corporate Practice of Medicine refers to arrangements in which non-physician entities exert control or undue influence over clinical decision-making, physician employment, or the delivery of medical care, and
- WHEREAS, the Corporate Practice of Medicine may undermine physician autonomy, interfere with independent medical judgment, and adversely affect the physician–patient relationship, and
- WHEREAS, physicians in the Commonwealth of Virginia are increasingly encountering corporate structures, contractual arrangements, and administrative practices that may constitute or facilitate the Corporate Practice of Medicine, and
- WHEREAS, individual physicians often lack sufficient education, legal resources, or institutional support to identify, understand, and appropriately respond to instances of the Corporate Practice of Medicine, and
- WHEREAS, the Medical Society of Virginia (MSV) has a longstanding responsibility to advocate for physicians, uphold the ethical practice of medicine, and protect patient care from improper non-physician influence, and
- WHEREAS, education and access to legal resources are essential to empowering physicians to recognize, challenge, and resist the Corporate Practice of Medicine when it threatens professional integrity or patient welfare, therefore be it
- RESOLVED, that the Medical Society of Virginia commits to providing educational resources to help physicians understand the Corporate Practice of Medicine, including applicable laws, regulations, and common contractual or operational structures used to exert improper control over medical practice, and be it further
- RESOLVED, that the Medical Society of Virginia will develop and promote resources, guidance, or referral mechanisms to assist physicians in responding to and pushing back against the Corporate Practice of Medicine, and be it further
- RESOLVED, that the Medical Society of Virginia will advocate for policies and initiatives that support and protect physician autonomy and reinforce the primacy of independent medical judgment in the delivery of patient care.

Fiscal impact:

Existing Policy:

References:

ENSURING VIRGINIA-LICENSED PHYSICIAN OVERSIGHT OF AI-ENABLED CLINICAL CARE

Submitted by: the Richmond Academy of Medicine

- WHEREAS, the use of artificial and augmented intelligence (AI) in medicine has expanded rapidly, with more than 80 percent of physicians reporting professional use of AI in 2026 and AI increasingly being incorporated into clinical care and medical decision-making¹, and
- WHEREAS, the Utah Office of Artificial Intelligence Policy has authorized a regulatory pilot involving Doctronic in which AI participates in the renewal of existing prescriptions, including a contemplated phase in which qualifying AI-generated renewals may be transmitted directly to pharmacists², and
- WHEREAS, Virginia law defines the practice of medicine to include the prevention, diagnosis, and treatment of human ailments “by any means or method” and prohibits the practice of medicine in the Commonwealth without a valid license issued by the Virginia Board of Medicine³, and
- WHEREAS, the Medical Society of Virginia supports requiring telemedicine prescribing to conform to the standard of care expected of in-person care, requiring prescriptions to be initiated by appropriately licensed prescribers, and maintaining physician oversight and physician-led patient care teams (MSV Policies 25.3.03,35.4.02, 45.1.03, and 45.1.05)⁴, and
- WHEREAS, the American Medical Association supports compliance of health care AI systems with state medical practice and licensure laws and has adopted policy opposing the use of AI as an independent diagnostic or prescriptive tool or as a care management substitute for a physician (AMA Policies H-480.939 and D-480.947)^{5, 6}, and
- WHEREAS, the current Medical Society of Virginia Policy Compendium does not specifically address licensure or physician oversight when an AI system directly provides or materially determines clinical care for a patient in Virginia⁴, therefore be it
- RESOLVED, that the Medical Society of Virginia supports legislation and regulation requiring that when an artificial intelligence system directly provides or materially determines individualized clinical care for a patient located in Virginia, including diagnosis, treatment, prescribing, or prescription renewal, such care shall be provided under the clinical oversight and final authority of a physician licensed to practice medicine in Virginia, with meaningful authority and ability to review, intervene in, or override the artificial intelligence system's clinical decisions, and be it further

RESOLVED, that this requirement shall not apply to artificial intelligence used solely for administrative, documentation, or physician-facing clinical decision-support functions when an appropriately licensed health care professional independently makes the final clinical decision.

Fiscal impact:

Existing Policy:

References:

1. American Medical Association. *Augmented Intelligence in Medicine: Physician Sentiments on AI*. 2026.
2. Utah Department of Commerce, Office of Artificial Intelligence Policy. *Doctronic AI Regulatory Mitigation Agreement and Prescription Renewals FAQs*. 2026.
3. Code of Virginia §§ 54.1-2900 and 54.1-2902.
4. Medical Society of Virginia. *2025–2026 Policy Compendium*. Policies 25.3.03, *Establishing a Physician-Patient Relationship via Telemedicine*, 35.4.02, *Guidelines for Prescriptions*, 45.1.03, *Assuring Quality in Allied Health Scope of Practice*; and 45.1.05, *Scope of Practice Position Statement*.
5. American Medical Association. Policy H-480.939, *Augmented Intelligence in Health Care*.
6. American Medical Association. Policy D-480.947, *Prohibiting the Independent Practice of Medicine by Artificial Intelligence*. 2026.

RESOLUTION TO TRANSITION VIRGINIA MEDICAID FROM MANAGED CARE ORGANIZATIONS TO A MANAGED FEE-FOR-SERVICE PROGRAM

Submitted by: the Richmond Academy of Medicine

- WHEREAS, Virginia's Medicaid program (Cardinal Care) currently covers approximately 2 million residents—including children, pregnant women, people with disabilities, and working adults—and its stability is essential to the Commonwealth's healthcare infrastructure and to the health of its most vulnerable citizens, and
- WHEREAS, the overwhelming majority of Virginia Medicaid enrollees are administered through private Managed Care Organizations (MCOs), with the Commonwealth paying these MCOs capitation rates that include, on average, 13 percent of every Medicaid dollar diverted from direct patient care to MCO overhead, administrative expenses, and corporate profit—costs that would drop to 4–6 percent under a state-administered model, and
- WHEREAS, Physicians for a National Health Program (PNHP) published *Removing the Middlemen from Medicaid: A Blueprint for Better Care and Lower Costs* (September 2025), a comprehensive analysis demonstrating that states shifting from MCO contracting to direct provider payment could reduce Medicaid MCO expenditures by 10 to 17 percent, generating combined state and federal savings estimated at \$77 billion annually were the model adopted nationwide, and
- WHEREAS, the PNHP Medicaid Blueprint further documents that the MCO overhead burden—averaging 13 cents of every Medicaid dollar—stems from duplicative credentialing, prior authorization bureaucracy, multiple separate provider networks, legal and lobbying expenses, and corporate profit margins, all of which would be largely eliminated in a state-administered, managed fee-for-service system with a single provider network, and
- WHEREAS, Virginia's current MCO-based system imposes serious harm on patients seeking maternity and pediatric care. The U.S. Department of Health and Human Services Office of Inspector General (OIG) has found that many states—including those using MCO models—are failing to leverage Medicaid managed care adequacy requirements to protect maternal health access, with wide variation and inadequacy in MCO network standards for obstetric providers. Narrow MCO networks frequently exclude obstetricians, certified nurse midwives, and pediatric specialists from their panels, forcing patients to travel long distances or forgo care entirely, and
- WHEREAS, the OIG further found that Medicaid MCOs have an overall prior authorization denial rate of 12.5 percent—more than double the 5.7 percent rate of Medicare Advantage—and that 89 percent of Medicaid enrollees do not appeal prior

authorization denials, which means wrongful denials of maternity care, pediatric services, and specialist referrals routinely go unchallenged and uncorrected, and

WHEREAS, a 2024 American Medical Association survey found that 90 percent of physicians report prior authorization leads to increased use of healthcare through delays, additional office visits (68%), emergency department visits (42%), and hospitalizations (29%), imposing human suffering and higher overall costs on the Medicaid program, and

WHEREAS, in a Maryland case described in a 2026 Johns Hopkins University medical student analysis, an MCO repeatedly blocked in-network specialist referrals and test coverage for a young Medicaid patient who ultimately was diagnosed with cancer—demonstrating how narrow networks and prior authorization barriers can delay life-saving diagnoses for vulnerable patients, a pattern that is common rather than exceptional in MCO-administered Medicaid, and

WHEREAS, Virginia's current system requires physicians and other providers to separately to be credentialed and contract with each MCO, negotiate distinct administrative requirements for each plan, manage multiple prior authorization systems, and maintain separate billing relationships— administrative redundancies that consume clinical time, drive providers out of the Medicaid program, and restrict the choices available to patients, and

WHEREAS, under a state-administered managed fee-for-service model, a single statewide provider network would replace the current fragmented MCO-specific networks, meaning any enrolled Medicaid provider would be accessible to any Medicaid beneficiary, dramatically expanding access to obstetricians, pediatricians, and specialists across the Commonwealth — replicating the experience of Connecticut, where physician participation in Medicaid increased by 33 percent within the first year of MCO elimination, and

WHEREAS, Connecticut eliminated its MCO contracts in 2012 and has since saved taxpayers more than \$4 billion. In the first year after transitioning to managed fee-for-service, physician participation rose by 33 percent, emergency department visits and hospitalizations declined, and per-member Medicaid costs dropped by 15 percent over five years. By 2024, despite being a high-cost state, Connecticut's overall Medicaid costs were 14 percent lower than all Northeast states that maintained MCO contracts. Connecticut also experienced a 4.7 percent increase in early cancer detection and 8 percent higher cancer survival rates compared to New Jersey, which retained its MCO model over the same period, and

WHEREAS, the savings mechanism is straightforward: when a state pays providers directly rather than through MCOs, the 13 percent in MCO overhead is replaced by state administrative costs of only 4–6 percent—a net savings of 7–9 cents on every Medicaid dollar. Savings are reinvested through enhanced primary care payments, care coordination programs, and expanded provider networks, producing a

virtuous cycle of increased access, reduced preventable utilization, and lower total costs, and

WHEREAS, multiple states are now pursuing or actively considering Medicaid deprivatization legislation:

- Minnesota: The 2025–2026 Minnesota legislature is considering SF1059/HF255 (the Patient-Centered Care Act), modeled directly on Connecticut's success, which would establish a managed fee-for-service program. Analysis projects Minnesota could save approximately \$1.5 billion annually—enough to offset most of the state's projected Medicaid funding shortfall from federal cuts,
- Washington State: Washington SB 5955, the Medicaid Deprivatization Act, was prefiled on December 29, 2025, and proposes to begin transitioning Medicaid to direct state administration by July 1, 2026, creating a state care coordination division and expanding the statewide provider network;
- Maryland: Maryland HB 1112 (2026) directs the Maryland Health Insurance Coverage Protection Commission to formally study eliminating MCOs and adopting a fee-for-service model, spurred by estimates that transitioning could save Maryland up to \$521 million annually while improving patient access, and

WHEREAS, the 2025 federal Budget Reconciliation Act (H.R. 1) is projected by the Congressional Budget Office to cut federal Medicaid spending by approximately \$915 billion over ten years and increase the uninsured population by 7.5 million by 2034, placing severe pressure on Virginia to find state-level savings, and

WHEREAS, deprivatizing Virginia's Medicaid program offers the Commonwealth a fiscally responsible means of absorbing federal cuts—protecting patient eligibility and benefits—rather than cutting essential services, reducing provider payments, or eliminating eligible Virginians from coverage, and

WHEREAS, a transition to managed fee-for-service in Virginia would maintain and strengthen care coordination through state-supported primary care case management (PCCM) and community-based care teams, consistent with models in Connecticut and North Carolina, ensuring continuity of care management without dependence on profit-driven intermediaries, and

WHEREAS, the Richmond Academy of Medicine and the Medical Society of Virginia stand committed to advancing policies that protect physician-patient relationships, eliminate unnecessary administrative barriers, expand access to care for vulnerable Virginians, and ensure that public Medicaid funds flow directly to patient care rather than corporate overhead, therefore be it

RESOLVED, that the Medical Society of Virginia jointly support and endorse legislation to transition Virginia Medicaid from its current Managed Care Organization model to a state-administered managed fee-for-service program with a single, unified statewide provider network, and be it further

RESOLVED, that the Medical Society of Virginia shall actively advocate to the Virginia Congressional delegation for federal waivers or legislative changes needed to facilitate Virginia's transition, and shall coordinate with physician organizations in Connecticut, Minnesota, Maryland, and Washington to share implementation best practices, and be it further

RESOLVED, that this resolution shall be transmitted to the Governor of Virginia, all members of the Virginia General Assembly, the Director of the Virginia Department of Medical Assistance Services, and the Virginia Congressional delegation.

Fiscal impact:

Existing Policy:

References:

1. The following sources support the factual claims made in this Resolution. Hyperlinks are
2. included for direct access.

I. PNHP Medicaid Blueprint and Related Analyses

1. Physicians for a National Health Program (PNHP). (2025, September 2). *Removing the Middlemen from Medicaid: A Blueprint for Better Care and Lower Costs*. Authored by Ed Weisbart MD, Stephen Kemble MD, Kip Sullivan JD, Mark S. Krasnoff MD, and colleagues. The foundational document for this resolution, provides state-by-state savings projections, the Connecticut case study, and model legislative language.

<https://pnhp.org/removing-themiddlemen-from-medicaid/> | Full

PDF: <https://pnhp.org/system/assets/uploads/2025/08/MedicaidBlueprintFinal.pdf>

2. Center for Medicare Advocacy. (2025, September 4). *New Report on Managed Care and Medicaid*. Summary and analysis of the PNHP Medicaid Blueprint.

<https://medicareadvocacy.org/new-report-on-managed-care-and-medicaid/>

3. Palmer, J., Pettit, C., McCulla, I., & Kinnick, C. (Milliman). (2025, June 30). *Medicaid Managed Care Financial Results for 2024*. Documents the MCO Medical Loss Ratio (MLR) averaging 87% of revenues spent on care—confirming that 13% goes to overhead. <https://www.milliman.com/en/insight/medicaid-managed-care-financial-results-2024>

II. Connecticut Model: Managed Fee-for-Service Success

4. **Managed Healthcare Executive / Burns, J.** (2023, January 20). *MCOs—Connecticut Bucks the Medicaid Managed Care Trend*. Documents Connecticut's 33% physician participation increase in year one, reduction in ER visits and hospitalizations, and per-member cost drop. <https://www.managedhealthcareexecutive.com/view/connecticut-bucks-the-medicaidmanaged-care-trend>

5. **Physicians for a National Health Program.** Connecticut savings documentation: \$4 billion in savings since 2012; 4.7% increase in early cancer detection; 8% higher cancer survival rates vs. New Jersey; 14% lower total Medicaid costs than Northeast MCO states in 2024. Documented in the PNHP Medicaid Blueprint (see #1 above).

III. State Legislation: Medicaid Deprivatization Bills

6. **Minnesota SF1059/HF255 – Patient-Centered Care Act (2025–2026).** Proposes managed fee-for-service Medicaid in Minnesota, modeled on Connecticut. https://www.revisor.mn.gov/bills/text.php?number=SF1059&version=0&session=ls94&session_year=2025&session_number=0

7. **Minnesota Reformer.** (2025, August 11). *Here's How Many Minnesotans May Die Because of Congress' Medicaid Cuts*. Analysis of Minnesota's projected \$1.5 billion annual savings from MCO deprivatization. <https://minnesotareformer.com/2025/08/11/heres-how-manyminnesotans-may-die-because-of-republican-medicaid-cuts/>

8. **Washington State SB 5955 – Medicaid Deprivatization Act (prefiled December 29, 2025).** Proposes MCO elimination beginning July 1, 2026. Full bill text: <https://lawfilesexternal.wa.gov/biennium/2025-26/Pdf/Bills/Senate%20Bills/5955.pdf> | Bill summary: <https://legiscan.com/WA/bill/SB5955/2025>

9. **Maryland HB 1112 (2026).** Directs Maryland's Health Insurance Coverage Protection Commission to study MCO elimination and transition to fee-for-service, with projected savings of up to \$521 million annually. Analysis: <https://www.jhunewsletter.com/article/2026/04/reclaiming-medicaid-from-mcos-in-maryland>

10. **Minnesota Decision to Exclude For-Profit MCOs (2024).** Georgetown Center for Children and Families review documenting Minnesota's 2024 exclusion of for-profit MCOs and direction to develop a fee-for-service option. <https://ccf.georgetown.edu/2025/01/03/medicaid-managed-care-in-2024-the-year-that-was/>

IV. MCO Prior Authorization: Harm to Patients and Providers

11. **U.S. HHS Office of Inspector General.** (2023). *Prior Authorization in Medicaid Managed Care*. Documents the 12.5% Medicaid MCO prior authorization denial rate (more

than double Medicare Advantage), the 89% non-appeal rate among enrollees, and limited state oversight. <https://www.kff.org/medicaid/prior-authorization-process-policies-in-medicaidmanaged-care-findings-from-a-survey-of-state-medicaid-programs/>

12. **MACPAC.** (2024, August). *Prior Authorization in Medicaid*. Comprehensive federal analysis of prior authorization policies, variation, and patient burden in Medicaid fee-for service and managed care. <https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf>

13. **American Medical Association.** (2024). *2024 AMA Prior Authorization Physician Survey*. Reports that 90% of physicians say prior authorization causes delays; 68% report additional office visits; 42% report ED visits; 29% report hospitalizations. Referenced in PNHP Medicaid Blueprint (see #1).

V. MCO Narrow Networks: Maternity and Pediatric Access

14. **Georgetown Center for Children and Families.** (2025, January 3). *Medicaid Managed Care in 2024: The Year That Was*. Documents OIG finding that 'many states are not fully leveraging Medicaid managed care coverage and access requirements to promote access to maternal health care,' and GAO findings that most examined states lacked adequate oversight of MCO denials of pediatric EPSDT services. <https://ccf.georgetown.edu/2025/01/03/medicaid-managed-care-in-2024-the-year-that-was/>

15. **KFF.** (2023). *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes*. Establishes that 72% of Medicaid beneficiaries are enrolled in MCOs nationally; reviews evidence that provider directories overstate physician availability, and that care is highly concentrated among a small number of physicians in MCO networks. <https://www.kff.org/medicaid/medicaid-managed-care-network-adequacy-access-currentstandards-and-proposed-changes/>

16. **Zamora, Jaiswal & Andriessen (Johns Hopkins Medical Students).** (2026, April). *Reclaiming Medicaid from MCOs in Maryland*. Includes case study of a young Medicaid patient whose cancer diagnosis was delayed by MCO prior authorization and narrow network barriers. <https://www.jhunewsletter.com/article/2026/04/reclaiming-medicaid-from-mcos-inmaryland>

VI. Administrative Cost Savings: How the Math Works

17. **Anselm, E. (KevinMD).** (2026, February 4). *Health Insurance Waste: Why Eliminating the Middleman Saves Billions*. Written by a former medical director of multiple national health insurance companies, explains the specific redundancies—credentialing, contracting, peer review, network maintenance—that drive MCO overhead and would be eliminated in a single-payer state model. <https://kevinmd.com/2026/02/health-insurance-waste-whyeliminating-the-middleman-saves-billions.html>

18. **KFF.** (2025). *10 Things to Know About Medicaid Managed Care*. As of July 2025, 42 states contract with risk-based MCOs. Documents the 85% MLR requirement, state oversight structure, and AI use in prior authorization. <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

19. **Indiana Medicare for All.** (2025, October 3). *Save Indiana Medicaid by Removing the Middlemen*. Accessible lay explanation of the PNHP Medicaid Blueprint findings, including New Jersey comparison (\$11 billion 10-year savings potential) and Connecticut cancer outcomes. <https://medicareforallindiana.substack.com/p/save-indiana-medicaid-by-removing>

VII. Virginia Medicaid Context

20. **Virginia Department of Medical Assistance Services (DMAS).** (2025). *Enrollment Reports*. Current enrollment and program data for Virginia Cardinal Care. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/enrollment-reports/>

21. **DMAS / Virginia Cardinal Care.** (2025). *MCO Provider Network Resources*. Documents the separate credentialing and enrollment process required for providers wishing to participate in each MCO's network—illustrating the fragmentation the resolution would eliminate. <https://vamedicaid.dmas.virginia.gov/provider/mco>

22. **DMAS.** (2025, December 5). *Interoperability and Prior Authorization Final Rule Implementation Update*. Describes Virginia's prior authorization reporting requirements under federal rules, effective 2026. <https://vamedicaid.dmas.virginia.gov/bulletin/interoperability-and-prior-authorization-finalrule-implementation-update>

VIII. Federal Medicaid Funding Cuts

23. **Georgetown Center for Children and Families.** (2025, December 18). *Medicaid Managed Care in 2025: The Year That Was*. Reviews H.R. 1 provisions and CBO estimates of 7.5 million newly uninsured by 2034; documents \$915 billion federal Medicaid spending cut over 10 years. <https://ccf.georgetown.edu/2025/12/18/medicaid-managed-care-in-2025-the-year-that-was/>

CONDEMNING UNETHICAL AND FORCED ORGAN HARVESTING ABROAD

Submitted by: Nikhil Chandravel, MD and Joshua Li, MD

- WHEREAS, Medical Society of Virginia Policy 0.54.04 holds that the MSV opposes unethical organ harvesting practices and supports the prosecution of those found to have committed such offenses or to have assisted in the procurement or transportation of human tissue or organs obtained without consent, and
- WHEREAS, credible international investigations have found that the illicit global organ trade — including forced and non-consensual organ harvesting — now accounts for an estimated 5 to 10 percent of kidney transplants performed worldwide each year, according to the World Health Organization's Global Consultation on Human Transplantation (1), and
- WHEREAS, independent investigators estimate that 60,000 to 100,000 organ transplants are performed annually in the People's Republic of China alone — a volume several times larger than China's official, voluntary donor registry can account for, sustaining a transplant industry valued at an estimated \$1 billion per year (2), and
- WHEREAS, non-consensual organ trafficking and transplant tourism have also been documented in countries such as India, Pakistan, the Philippines, Egypt, Iran, Turkey, and Kosovo, disproportionately affecting vulnerable populations such as migrants and refugees in the Middle East and North Africa (3), and
- WHEREAS, since 2021, credible evidence has continued to accumulate that the People's Republic of China (PRC) engages in systematic, state-sanctioned, non-consensual organ harvesting "on a significant scale" from prisoners of conscience, including Falun Gong practitioners, Uyghurs, Tibetans, and House Church Christians, and that detainees are subjected to non-consensual organ compatibility testing (4,5), and
- WHEREAS, no comprehensive state or national registry currently tracks the number of Virginia residents who travel abroad for organ transplantation or the outcomes of those procedures, a data gap that the American Public Health Association has specifically called on the Scientific Registry of Transplant Recipients to close (6), underscoring the need for Virginia physicians and institutions to proactively identify and report such cases as they arise in clinical practice, and
- WHEREAS, established ethical standards, including American Medical Association (AMA) Code of Medical Ethics Opinions 6.1.1 and 6.1.2, emphasize voluntary informed consent, transparency, and prohibition of organ procurement from vulnerable populations, and

WHEREAS, a 2021 report by the AMA Board of Trustees identified ongoing concerns regarding unethical organ procurement practices in the People's Republic of China and recommended increased physician awareness, patient education, and discouragement of transplant tourism to regions lacking transparency (7), and

WHEREAS, Virginia patients are at risk of exposure to unethical transplant systems as the medical tourism industry grows, a system that the AMA Council on Ethical and Judicial Affairs (CEJA) has warned may involve "organs on demand" or victims "killed to order" (8), and

WHEREAS, bipartisan federal legislation — the Stop Forced Organ Harvesting Act (H.R. 1503, 119th Congress), which passed the U.S. House of Representatives 413–2 in May 2025 and is currently pending in the U.S. Senate — would hold perpetrators of forced organ harvesting accountable through sanctions, visa and passport restrictions, and mandatory reporting requirements (9), and

WHEREAS, momentum at the state level reflects growing bipartisan recognition of this issue: Texas (2023), Utah (2024), Idaho (2024), Tennessee (2025), and Arizona (2025) have each enacted laws restricting health insurance coverage for illicit organ transplants performed in, or sourced from, China (10-14), and

WHEREAS, Virginia physicians and institutions must remain vigilant against participating, directly or indirectly, in unethical organ transplantation practices abroad, including referral of patients to China for organ transplants or engagement in academic collaborations that may normalize or obscure forced organ harvesting, therefore be it

RESOLVED, that MSV Policy 0.54.04 be amended to read,

“The Medical Society of Virginia opposes unethical organ harvesting practices and fully supports prosecution and sanction of those found to have committed such offenses or assisted in procurement and transportation of human tissues or organs that were obtained without consent.

Furthermore, the Medical Society of Virginia (MSV) urges the Virginia Delegation to the American Medical Association (AMA) to introduce a resolution supporting federal legislation to prosecute and sanction individuals and institutions engaged in the procurement or transportation of human organs or tissue obtained without consent and to track data regarding organ transplants abroad and their outcomes.

Furthermore, the MSV encourage Virginia physicians to counsel patients on the ethical and medical risks of seeking organ transplants abroad in regions lacking transparency.

Furthermore, the MSV will collaborate with relevant medical organizations to provide continuing medical education regarding unethical organ trafficking abroad.”

Fiscal impact: None

Existing Policy: Relevant MSV AMA Policy

05.4.04- Organ Harvesting Without Consent

Ethical Procurement of Organs for Transplantation H-370.967

6.1.1 Transplantation of Organs from Living Donors

Guidelines for Organ Transplantation from Deceased Donors

References:

1. D.A. Budiani-Saberi, F.L. Delmonico, Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities, American Journal of Transplantation, Volume 8, Issue 5, 2008, Pages 925-929, ISSN 1600-6135, <https://doi.org/10.1111/j.1600-6143.2008.02200.x>.
2. BLOODY HARVEST/THE SLAUGHTERAn Update. BY DAVID KILGOUR | ETHAN GUTMANN | DAVID MATAS endtransplantabuse.org/wp-content/uploads/2016/06/Bloody_Harvest-The_Slaughter-June-23-V2.pdf
3. Erlisa Demneri. (2024, August 21). For sale: The pervasive organ trade in Asia. Harvard International Review. Harvard International Review. <https://hir.harvard.edu/for-sale-the-pervasive-organ-trade-in-asia/>
4. Nice, G., Elliot, M., Khoo, A., Paulose, R., Sadr, S., Vetch, N., & Waldon, A. (2019). Independent Tribunal Into Forced Organ Harvesting from Prisoners of Conscience in China. In *The China Tribunal*. https://chinatribunal.com/wp-content/uploads/2019/07/ChinaTribunal_SummaryJudgment_17June2019.pdf
5. *China: UN human rights experts alarmed by ‘organ harvesting’ allegations*. (2021, June 14). Office of the High Commissioner . <https://www.ohchr.org/en/press-releases/2021/06/china-un-human-rights-experts-alarmed-organ-harvesting-allegations>
6. Building a Public Health Response to Organ Transplant Abuse in China. American Public Health Association. <https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2021/01/13/building-a-public-health-response-to-organ-transplant-abuse-in-china>
7. Mukkamala, B. (2021). Study of Forced Organ Harvesting by China. In *AMA*. <https://www.ama-assn.org/system/files/n21-bot13.pdf>
8. Medical Tourism. (2018). In *AMA*. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/a18_ceja_report_3.pdf
9. AN ACT To Combat Forced Organ Harvesting and Trafficking in Persons for Purposes of the Removal of Organs, and for Other Purposes. (2010). <https://www.govtrack.us/congress/bills/119/hr1503/text>

10. A bill to be entitled an act relating to health benefit plan coverage of a transplant of an organ
<https://capitol.texas.gov/tlodocs/88R/billtext/html/SB01040S.htm>
11. ORGAN TRANSPLANT AMENDMENTS, 2024 GENERAL SESSION, STATE OF UTAH.
<https://le.utah.gov/~2024/bills/sbillint/SB0262.htm>
12. House BILL NO. 670 (2024). <https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2024/legislation/H0670.pdf>
13. AN ACT to Amend Tennessee Code Annotated, Title 56 and Title 68, Relative to the Tennessee Genomic Security and End Organ Harvesting Act (2025).
<https://legiscan.com/TN/bill/HB0395/2025>
14. *HB2109 - 571R - senate fact sheet*. (2025). Azleg.Gov.
<https://www.azleg.gov/legtext/57leg/1R/summary/S.2109HHS.DOCX.htm>

EXAMINATION OF EATING DISORDERS IN VIRGINIA

Submitted by: Allen Ma

WHEREAS, nine percent of the American population will develop an eating disorder¹, and

WHEREAS, the consequences of eating disorder complications are short and long term², and

WHEREAS, there exists a substantial cost to the economy and to the individual³, therefore be

RESOLVED, that the Medical Society of Virginia supports proactive medical screening for and informed, consented treatment of eating disorders in all individuals, appropriated by the funding mechanisms that exist or will exist.

Fiscal impact: None

Existing Policy: None

References:

1. Deloitte Access Economics (2020). Strategic Training Initiative for Prevention of Eating Disorders at Harvard. Retrieved from <https://hsph.harvard.edu/research/eating-disorders-striped/research-reports/economic-costs-eating-disorders/>
2. Focus Journal of Lifelong Learning in Psychiatry (2024). Medical Considerations and Consequences of Eating Disorders. Retrieved from <https://pmc.ncbi.nlm.nih.gov/articles/PMC11231475/>
3. International Journal of Eating Disorders (2021). Social and economic cost of eating disorders in the United States: Evidence to inform policy action. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/33655603/>

FULFILLING THE LINGUISTIC NEEDS OF PATIENTS IN VIRGINIA**Submitted by: Allen Ma**

WHEREAS, english is the primary language of communication in the Virginian healthcare system, and

WHEREAS, seventeen-point-four percent of persons aged five or over in Virginia do not speak English at home¹, therefore be it

RESOLVED, that the Medical Society of Virginia supports, promotes, and advances alternative language services in the healthcare system, subject to compensation through financial systems.

Fiscal impact: None

Existing Policy: None

References:

1. United States Census Bureau (2025). Virginia 2025 Quick Facts. Retrieved from <https://www.census.gov/quickfacts/fact/table/VA>

MSV Involvement in the Electoral Process

Submitted by: Barbara Boardman, MD

WHEREAS, the medical community increasingly recognizes voting as one of several social determinants of health and emphasizes that this is a public health issue. Health influences voting and voting influences health, and

WHEREAS, healthcare providers have been found to be 12% less likely to vote, and

WHEREAS, the American Association of Medical Colleges states that "medical schools and teaching institutions can support inclusive democracy by encouraging civic engagement...nonpartisan voter registrations is a simple, yet effective way for these institutions to advance health equity and is allowable under law", and

WHEREAS, multiple health care organizations have partnered with Vote-ER to encourage voter participation including the American Medical Association (AMA) American Academy of Family Physicians (AFP) American College of Obstetricians and Gynecologists (ACOG), and

WHEREAS, nonpartisan encouragement of voter registration and participation is allowable and consistent with MSV's tax status , therefore be it

RESOLVED, that the Medical Society of Virginia supports physician involvement in state level advocacy and encourages members to participate in the electoral process. Such encouragement shall be non-partisan in a manner consistent with MSV tax status.

Fiscal impact:

Existing Policy:

55.2.05- Physician Involvement in State Legislative Advocacy

Date: 11/4/1995

The Medical Society of Virginia supports physician involvement in state-level legislative advocacy and encourages members to have active ongoing relationships with members of the General Assembly through visits and events during and between sessions and getting to know their representatives' legislative aides.

Reaffirmed 11/06/2005

Reaffirmed as substituted 10/25/2015

References:

1. <https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2023/01/18/access-to-voting> Public health Policy Briefs
2. <https://www.physiciansweekly.com/post/recognizing-voting-as-a-social-determinant-of-health> Physicians Weekly
3. <https://www.aamchealthjustice.org/our-work/policy/voter-fact-sheet> American Association of Medical Colleges
4. <https://pubmed.ncbi.nlm.nih.gov/33483814/> voting behavior of physicians and health care workers R. Solnick, H. Choi, K. Kocher, in J Gen Intern Med, Apr;36(4)1169-71
5. <https://vot-er.org> and <https://vot-er.org/partner-with-us/>

Supporting Advocacy Activities and Physician Involvement in Health Policy Public Debates

Submitted by: Barbara Boardman, MD

WHEREAS, public funding for healthcare in the commonwealth is the result of Programs funded both by the commonwealth and the federal government Public funding and the public policy that determines that funding has a significant impact on health services we provide to our patients in Virginia. In the commonwealth 31.4% on population depends on public insurance, payors for personal health care (PHVC) in the Commonwealth include Medicare \$18.5 billion and Medicaid \$15.3 Billion with private healthcare PHC at \$27.3 Billion, and

WHEREAS, according to 2026 polling from KFF news 64% of adults worry about affording health care costs and 55% say health care costs will have a major effect on their voting decisions, and

WHEREAS, patients engaged through healthcare professionals demonstrate higher voter turnout rates, and

WHEREAS, advocacy actions advanced by the American Medical Association with reference to federal/state programs that have cut funding of health programs (Medicaid) include denouncing cuts to Medicaid, through, but not limited to, press releases, position statements, op-eds in major outlets press conferences and lobbying as well as working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for reversal or mitigation of Medicaid related cuts, therefore be it

RESOLVED, that the Medical Society of Virginia shall support advocacy activities to include physician involvement in health policy public debates for the purpose of educating the voting public regarding health implications of decisions made by the voting public and the legislators they elect. Such education activities must be non-partisan, in accordance with MSV tax status, and consistent with existing MSV policy. These activities may include but are not limited to press releases, position statements, op-eds in major outlets press conferences and lobbying as well as working with, but not limited to, state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations.

Fiscal impact:

Existing Policy:

55.2.05- Physician Involvement in State Legislative Advocacy

Date: 11/4/1995

The Medical Society of Virginia supports physician involvement in state-level legislative advocacy and encourages members to have active ongoing relationships with members of the General Assembly through visits and events during and between sessions and getting to know their representatives' legislative aides.

Reaffirmed 11/06/2005

Reaffirmed as substituted 10/25/2015

References:

1. Health Resources and Services Administration | HRSA (.gov) <https://mchb.tvisdata.hrsa.gov/Narratives/Overview/02953b67-9dc4-4281-b6db-49e9eb621ee3>
2. <https://www.vhha.com/pressroom/report-virginia-families-employers-face-rising-health-insurance-premium-and-deductible-costs-despite-state-health-care-spending-that-is-below-the-national-average/>
3. <https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-and-the-midterms/>
4. Grantmakers In Health <https://www.gih.org/views-from-the-field/the-voters-health-care-reaches/>
5. Georgetown CCF , Medicaid CHIP and affordable healthcare act market place cuts and other provisions in the budget reconciliation act explained Edwin Park and Sabrina Collett Aug 13 2025 <https://ccf.georgetown.edu/2025/07/22/medicaid-chip-and-affordable-care-act-marketplace-cuts-and-other-health-provisions-in-the-budget-reconciliation-law-explained/#heading-2>
6. The big Ugly threat to SafetyNet Hospitals, Eileen O'Grady, Public Citizen <https://www.citizen.org/article/big-ugly-threat/>
7. Medicaid and the Children's Health Insurance Program, a Technical Report, Pediatrics <https://publications.aap.org/pediatrics/article/157/3/e2025075749/206458/Medicaid-and-the-Children-s-Health-Insurance>
8. Children's Hospital Association Fact Sheet <https://www.childrenshospitals.org/content/public-policy/fact-sheet/medicaid-state-directed-payments-and-provider-taxes-are-critical-for-children's-hospitals> <https://stateline.org/2025/07/11/us-hospitals-see-stark-decline-of-obstetric-services-study-shows/>
9. Virginia Impact Report, How the Congressional Reconciliation Bill will Impact Our Communities, Virginia Commonwealth Institute, Megan Davis , Levy Goren, Freddy

Mejia https://thecommonwealthinstitute.org/wp-content/uploads/2025/07/Virginia-Impact-Report_How-Congressional-Reconciliation-Bill-Will-Impact-Our-Communities.pdf

10. HR1 Implementation, VA Senate finance and appropriations committee https://sfac.virginia.gov/pdf/committee_meeting_presentations/2026/Interim%20Meetings%202026/04142026_No2_HR1_Figueroa.pdf
11. Virginia Business: Medicaid Cuts threaten 10 Virginia Hospitals <https://virginiabusiness.com/medicaid-cuts-threaten-10-virginia-hospitals-closure/#:~:text=Bon%20Secours%20Southern%20Virginia%20Regional,Health%20Tappahannock%20Hospital%20in%20Tappahannock>
12. WHRO <https://www.whro.org/health/2026-04-09/medicaid-cuts-could-limit-services-at-10-Virginia-hospitals-a-new-report-finds>
13. Federal changes in Virginia's SafetyNet VAFCC Virginia association of free and charitable clinics 2-20-2026 https://www.vafreeclinics.org/blog_home.asp?display=111



Consent Calendar: Informational Reports

1. MSVPAC Report
2. MSV Foundation Report
3. AMA Virginia Delegation Report
4. MSV Medical Student Section Report
5. Virginia Board of Medicine Annual Report
6. Physician Assistant Section Report

September 16, 2026

Dear MSV Colleagues,

This report summarizes MSVPAC fundraising progress, recent member engagement efforts, and the urgent need for continued participation ahead of the 2027 legislative session.

Last April, the MSV Board of Directors issued a major call to action: strengthen the Political Action Committee and empower our government relations team. Our executive team and CEO led by example with a combined \$20,000 contribution to the PAC and challenged the MSV Board of Directors to contribute personally and help organize practices to participate.

They responded. I'm so pleased to let you know that 100% of the MSV BOD contributed to the PAC - with most contributions over \$1,000. This is a big deal. But it did not end there.

As you will see during our presentation during the first session of the House of Delegates, the MSVIA led by Dr. Cliff Deal rallied behind the PAC and organized a first-of-its-kind \$100,000 contribution from the MSVIA to the MSVPAC.

The MSVIA then organized a call to rally its clients around the impact of changes to Virginia's medical malpractice cap and urged them to support the PAC. That outreach worked: new practices contributed to the MSVPAC for the first time.

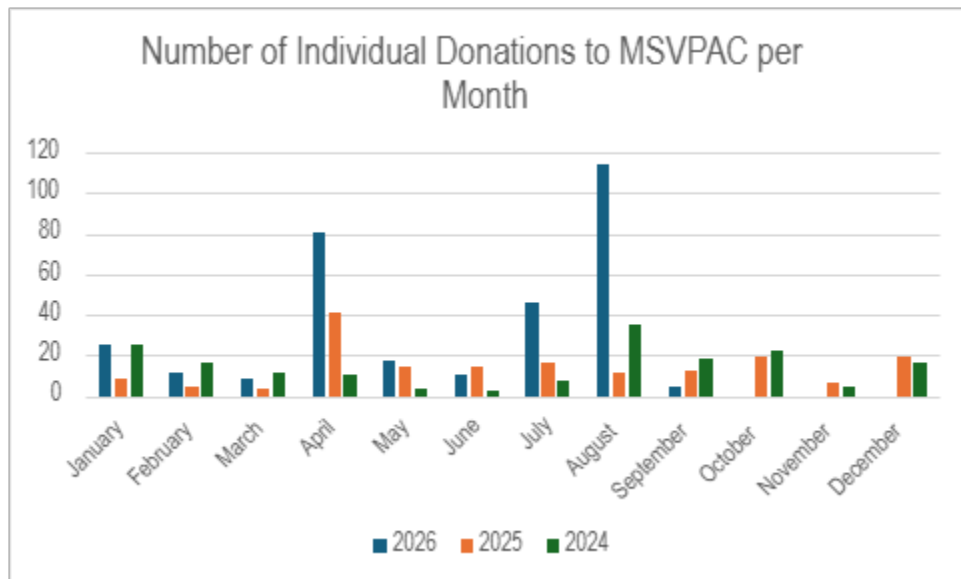
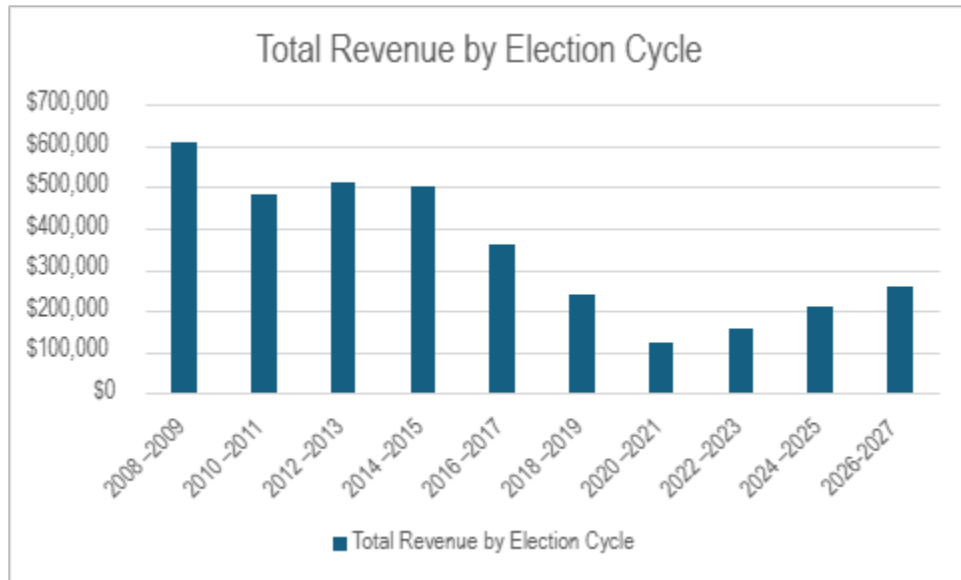
Further lifting the PAC's outreach efforts, MSVIA and the PAC coordinated a letter and follow-up outreach to more than 800 practices in Virginia. The goal was clear: encourage financial contributions to the PAC and active participation in MSV's advocacy efforts. This effort is ongoing, and we look forward to updating you during the annual meeting.

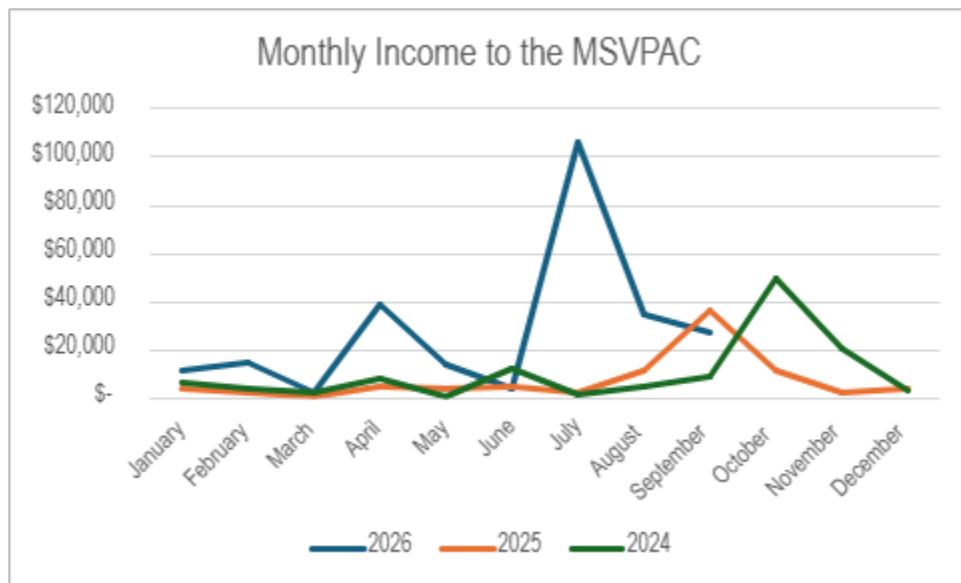
In August the PAC wrapped up its Docs and Hops season with a record amount raised and a record number of attendees.

The GAP team is working tirelessly to inform practices and organize the House of Medicine to speak with a unified voice of medicine – empowered by your political action committee.

The same energy that strengthened the PAC now needs to carry into lobby days. Financial support gives MSV a stronger voice; in-person participation shows legislators that the House of Medicine is organized, visible, and ready to engage.

My primary ask today is simple: set aside time now and register for the 2027 lobby days. Please mark your calendars and join us so MSV can stay ahead of the game and show legislators a strong, unified House of Medicine.





MSVPAC at-a-glance for 2025:

of Donations: 366
 Goal 2025: 270

 Amount Raised 2025: \$87,875
 Goal 2025: \$150,000

MSVPAC at-a-glance for 2026:

of Donations 2026: 320+
 Goal 2026: 300

 Amount Raised 2026: \$253,058+
 Goal 2026: \$155,000

2025 Lobby Day Registrations: Over 400 over three lobby days including PA students

2026 Lobby Day Registrations: 166 over three lobby days (two lobby days were cancelled)

Conclusion

This is our strongest year in over a decade. But it needs to be. We are pursuing every avenue to increase contributions and our number of advocates. We need your continued leadership as we enter into the 2027 GA session.

Andrew Densmore

Political Advocacy Manager, MSV

MSVPAC Board Roster

<u>Member</u>	<u>Term Beg.</u>	<u>Term End</u>	<u>Term Count</u>	<u>District</u>
Bobby Cochram	8/1/26	7/31/28	1	PA
Barbara Boardman*	10/15/26	10/16/28	3	10
Diana Clewett	7/9/26	7/8/28	1	10
Jacqueline Fogarty*	10/29/26	10/28/28	3	5
Rohan Rathi	7/9/26	7/8/27	NA	Student
Austin Thomas	7/9/26	7/8/27	NA	Resident
Razi Ali	7/9/26	7/8/28	2	3 Chair
Priyanka Kumar	7/9/26	7/8/28	1	3
Kenneth Qiu	7/9/25	7/8/27	1	3

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

Contributions of the VA House of Delegates: \$74,000

Jessica Anderson for VA House of Delegates, \$1,000	Cole 4 VA, \$1,000
Friends of Alex Askew, \$1,000	Nicole Cole for Delegate, \$1,000
Ballard for Delegate, \$1,000	Cornett for Delegate, \$1,000
Katrina Callsen for Delegate, \$1,000	Friends of Rae Cousins, \$1,000
Carnegie for Delegate, \$1,000	Karrie Delaney for Delegate, \$2,000
Carr for Delegate, \$1,000	Downey for VA, \$2,500
Friends of Mike Cherry, \$1,000	Debra Gardner for Virginia, \$1,000
Nadarius Clark for Delegate, \$1,000	Hayes for Delegate, \$1,000
Friends of Laura Jane Cohen, \$1,000	Helmer for Virginia, \$1,000

Henson for Virginia, \$1,000

Phil for VA, \$1,000

Friends of Charnielle Herring, \$5,000

Friends of Keith Hodges, \$1,000

Hope for Virginia, \$5,000

Karen Keys-Gamarra for Delegate, \$1,000

Kilgore for Delegate, \$1,000

Krizek for Delegate, \$1,000

Laufer for Delegate, \$1,000

Leftwich for Delegate, \$1,000

Friends of Garrett McGuire, \$1,000

Friends of Marcia Price, \$3,000

Elect Atoosa Reaser, \$1,000

Don Scott for Virginia, \$10,000

Friends of Irene Shin, \$1,000

Friends of Marcus Simon, \$1,000

Simonds for Delegate, \$1,000

Friends of JJ Singh, \$1,000

Rip Sullivan for Delegate, \$2,500

Friends of Virgil Thornton Sr. , \$1,000

Friends of Luke Torian, \$3,000

Kathy for Delegate, \$3,000

Friends of Otto Wachsmann, \$1,000

Wendell Walker for Delegate, \$1,000

Michael Webert for Delegate, \$1,000

Willet for Delegate, \$3,000

Contributions of the State Senate: \$53,000

Friends of Lashrecse Aird, \$2,500

Friends of Lamont, \$2,500

Friends of Jennifer Boysko, \$2,500

Deeds for State Senate, \$5,000

Friends of Bill DeSteph for Senate, \$1,000

Friends of Tara Durant, \$1,000

Favola for State Senate, \$5,000

Friends of Chris Head, \$3,000

Locke for Senate , \$10,000

McDougle for Virginia, \$5,000

McPike for Senate, \$1,000

Christie New Craig for Senate, \$1,000

Friends of Mark Obenshain, \$1,000

Peake for Senate, \$1,000

Friends of Stella Pekarsky, \$1,000

Friends of Russet Perry, \$1,000

Friends of Dr. Todd Pillion, \$2,500

Friends of Saddam Azlan Salim, \$1,000

Kannan for Virginia, \$1,000

Scott Surovell for Senate, \$2,500

VanValkenburg for Virginia, \$2,500

Date: September 12, 2026
To: MSVF Board
From: MSV and MSV Foundation Staff
Subject: Updates to Key MSV/F Programs, Activities, Outcomes

PROGRAMS – MSVF and MSV



HEALTHHAVEN: VIRGINIA'S MENTAL HEALTH ACCESS PROGRAMS

HealthHaven brings together Virginia's mental health access programs—VMAP, VMAP for Moms+, and APAL—to support prescribers across the lifespan with psychiatric consultation, targeted education, and care navigation. In 2026, all three programs were newly branded under the HealthHaven umbrella to create a clearer, more unified experience for prescribers and other audiences. The programs are also being integrated on the back end and operationally so the teams can work together as one coordinated program serving prescribers and their patients across the lifespan.

VMAP

Through 2025, VMAP's pediatric program has achieved:

- **3,014** registered clinicians
- **13,570** calls to the VMAP Line
- **11,376** pediatric patients served
- **2,298** clinicians trained

Impact Highlights

- New data show that **25%** of Virginia PCPs who see pediatric patients have utilized VMAP services.
- **16% increase** in call volume in 2025 compared to 2024.
- Every clinician trained by VMAP improves mental health access for their entire patient panel.

VMAP's impact is validated through data from the VMAP Line, pre- and post-training assessments, provider surveys, and secondary analyses. Key findings include:

- VMAP is used by a **wide range of providers across Virginia**.

- Providers trained by VMAP report **greater confidence** in addressing mental health needs and conduct screenings at significantly higher rates.
- VMAP reaches **vulnerable populations**, including Medicaid recipients and rural communities.

VMAP for Moms+

With state funding in 2023 and 2024, VMAP expanded its pediatric mental health model to include perinatal populations, launching **VMAP for Moms+** in late 2024. This program offers prescribers caring for pregnant and postpartum individuals' expert clinical consultation, targeted education, and care navigation.

Since its launch just over in November 2024, **VMAP for Moms+** has:

- Received **600+ calls** to VMAP For Moms+ Line
- Trained **112 clinicians**
- Served **600+ pregnant or postpartum patients** across Virginia

APAL

APAL continues to expand adult behavioral health access across Virginia. In summer 2026, APAL added PharmD and psychiatry services to the line, further strengthening consultation support for primary care clinicians treating adults with behavioral health and substance use concerns. The team also continues to work toward expansion to an eastern hub.

Education efforts remain a major focus, including a third REACH Adult Behavioral Health in Primary Care course, an ECHO series in partnership with UVA, continued collaboration with the Virginia Academy of Family Physicians, and enduring CME offerings on buprenorphine treatment and motivational interviewing.

APAL continues to work with DBHDS on embedding psychiatric and substance use disorder services in primary care offices through a \$1 million SAMHSA grant promoting the Collaborative Care Model, with practice sites completing Collaborative Care training and beginning the process of enrolling patients.

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



SafeHaven 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.

2026 Goal Updates:

- The team has built a Rural Health Transformation Grant proposal, in collaboration with Atalan, a predictive AI model focused on proactively identifying clinicians at risk of burnout, to bring SafeHaven resources to all rural healthcare providers.
- SafeHaven Trusted services provided by Marvin have been contracted by Privia to provide to their healthcare teams in Virginia, Maryland, and DC.
- The team is building a business proposal for launching its own SafeHaven Coaching Network to provide leadership and wellness coaching for healthcare professionals.

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



THRIVE PROGRAM DESCRIPTION AND UPDATE

Thrive is a financial counseling program provided by the Medical Society of Virginia for medical students and residents. We aim to alleviate the stress and confusion surrounding money so they can confidently plan for their future and focus on what they love—practicing medicine. Thrive lessens the anxiety and uncertainty surrounding major financial decisions these individuals and their families face through large group presentations in addition to free, one-on-one financial counseling sessions led by expert Certified Financial Planners (CFP). Topics include debt management, loan repayment strategies, budgeting, and building savings.

2026 Goal Updates:

- The spring semester provided 148 medical students and residents with financial education workshops and 1:1 financial counseling.
- We have developed several new education programs including Career Pathways, Cash Flow Planning interactive workshop, and Long-Term Strategy interactive workshop.
- Fall presentations are scheduled for residents at HCA LewisGale and August Health, and for PA students at Randolph Macon.
- We have drafted a business plan to bring additional financial wellness resources to all physicians, including financial planning, education, independent practice resources, and a referral network for additional financial wellness services.
- We launched [Money Mindset for Physicians](#) in collaboration with Board Certified Wealth to bring financial wellness and general well-being resources to physicians via our new Learning Management System, Path.

Staff contact: Carolyn McCrea (cmccrea@msv.org)



DR. ALELI ROMERO AND REV. CRIS ROMERO PHYSICIAN LEADERSHIP INSTITUTE

The Dr. Aleli Romero and Rev. Cris Romero 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 2026 PLI weekend is scheduled for November 12-15. Please share your nominations with Jennifer Joss (early career physicians or PAs, including PYG and MS4).

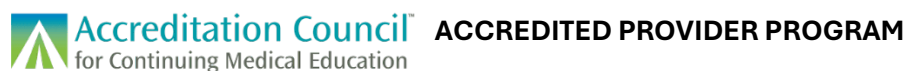
We are offering a NEW 6-month course in designing human-centered innovation and change management, beginning in August, in collaboration with the VCU DaVinci Center. Let us know if you are interested in bringing this exciting new experience to your team.

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

CONTINUING MEDICAL EDUCATION ACTIVITIES

Background

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



As an Accredited Provider, MSV is now able to accredit its own CME activities, including activities for all MSVF programs, streamlining the approval process, saving staff time, and avoiding joint provider fees. MSV is also able to offer accreditation of activities of other eligible organizations through joint providership.

In less than 18 months of accreditation, we provided accredited CME to 610 learners across 26 activities. By the end of 2026, we will bring our total to 231 hours over 34 activities. We have applied for Reaccreditation with Commendation, completing eight criteria: engages interdisciplinary teams, addresses population health, optimizes communication skills, utilizes support strategies, engages in research and scholarship, supports CPD for the CME Team, demonstrates innovation, improves performance.

Our Learning Management System (PathLMS) allows members to register, participate, and track all CME activities in one location. Currently available enduring materials include our CME On-the-Go series! These podcasts are divided into three half-hour episodes and include topics such as Human Trafficking, Defending a Malpractice Lawsuit, Emotional Intelligence, and the Art of Listening.

Through the Accredited Provider Program, we are also able to engage outside organizations in Joint Providership. We have accredited 6 joint provider activities so far and half of them have applied for additional activities this fall. The joint providership program allows MSV to expand the reach of these valuable activities while supplementing our revenue stream.

The Accredited Provider program is managed by Jennifer Joss (jjoss@msv.org).



RECOGNIZED ACCREDITOR PROGRAM

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. The SSCC accredits 30 organizations across six states to grant AMA PRA Category 1 CME credits. The SSCC accredits six organizations from Virginia (Carilion Clinic, Inova Health, Sentara Health, SOVAH Danville, Winchester Medical Center, and ECPI University) and one from West Virginia (WVU-Berkeley Medical Center). Carolyn McCrea sits on the three-member SSCC Governing Board.

The SSCC's Accreditation Review Committee includes members from all three participating states. The ARC meets quarterly to make re-accreditation decisions. Virginia members of the ARC include Michael Moore MD (Sovah Health), Paul Dallas MD (Carilion Clinic), and Patrick Haggerty MD (EVMS). In the two years since the SSCC began operations, the ARC has made 22 reaccreditation decisions, not including Progress Report reviews.

The MSV Recognized Accreditor program is managed by Marc Jackson, MD (mjackson@msv.org).



Yes, I Can! Pathways to Medicine is a community outreach program designed to encourage high school and middle school students to consider a medical career. 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 2026 theme for our annual meeting is: "Party like a Rock Star!" The Gala will be held at the Hotel Roanoke in Roanoke, Virginia on October 17, 2026. Sponsorships raised so far for the event are \$216,350 as of August 31st. Lots of fun activities are planned for the gala this year including a "LIVE" band.

Salute to Service Awards

Our Salute to Service Awards committee met on July 27th to vote on the 23 nominations that were submitted. Winners will all be announced at the 2026 Physicians' Gala on October 17th. The categories are Service to the Profession, Service to the Uninsured and Underserved, Service by a Medical Student or Resident, Service by an Early Career Physician, Distinguished Medical School Faculty Service Award, and Service for Advancing Patient Safety and Quality Improvement.

Shapiro-Konerding Women in Medicine Leadership Award

The committee met on August 5 to vote on the 7 nominations for this leadership award. The winner will be announced at the 2026 Physicians' Gala on October 17th.

Development – January 1 – July 30

As of July 30, 2026: \$351,617

- Gala sponsorship - \$205,720 money collected
- MSVF endowment - \$56,500
- MSVF gifts - \$16,377
- SafeHaven - \$7,491
- 40 Forward collector – 1,480
- Medical Student Sponsorship - \$4,042
- VMAP Support - \$300
- MSVF Endowment – PA scholarship - \$3,490
- MSVF Endowment – Medical Student - \$7,275
- Shapiro-Konerding Leadership Fund - \$31,460
- PLI - \$300
- HealthHaven – APAL - \$200
- MSV Recurring gift - \$2,550
- Wine is my Valentine - \$3,450
- Flying Squirrels - \$1,182
- Raffle tickets - \$750
- Gala tickets - \$9,050

Grand total: \$351,617

Other Development

- 2026 Annual Campaign – Our 2026 theme is “Caring for Everyone. Powered by You.”
- Endowment & Planned Giving Campaigns – We have nine former MSV presidents who are now on our Former Presidents' Wall which is now up in the downstairs hall.
- Here are the names of the new Former Presidents who have recently been added.
 - Dr. Kurt Elward
 - Dr. Alice Coombs
 - Dr. Lawrence Monahan
 - Dr. F. Ashton Carmines
 - Dr. Carol Shapiro has been upgraded to the largest plaque.

- Endowment and planned giving campaigns for 2026 are in the works.
- The Engagement and Advisory Committee is pleased to announce the following events:
 - Next Chapter – group for retired members. RVA Luncheon scheduled for Wednesday, September 2 at MSV offices. Dr. Saavedra will be speaking on “Important Healthcare Legislative Issues.”

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

Colleagues, it is a privilege to report on the work of your Virginia Delegation to the American Medical Association (AMA) House of Delegates (HOD), the policymaking body of American medicine. The House brings together representatives from state and specialty societies, public health organizations, military medicine, and academic medicine to develop consensus on health policy and medical ethics. Throughout the past year, our delegation has advanced policies that protect patients, support science and public health, strengthen academic medicine, and preserve the integrity of the profession. Our national advocacy has focused on prior authorization reform, scope-of-practice defense, physician well-being, and Medicare reform. In February, Drs. Romero, Lesko, Pandya, and Willcox represented Virginia at the National Advocacy Conference, where they met with all 11 members of Virginia's delegation to the U.S. House of Representatives and both U.S. senators. These relationships help ensure Virginia physicians' priorities are heard by national policymakers.

Virginia maintained a strong presence at the AMA Annual Meeting in Chicago this June, with a full complement of delegates and alternate delegates led by Chair Dr. Clifford Deal and Vice Chair Dr. Sterling Ransone. The delegation also expanded Virginia's influence within the AMA through several national leadership roles. Dr. Alice Coombs serves on the Council on Medical Service (CMS); Dr. Bhushan Pandya serves on the Council on Long Range Planning and Development (CLRPD); and Dr. Cynthia Romero was elected in June to the Council on Science and Public Health (CSAPH). Dr. Michelle Nedelka represented Virginia during the Southeastern Delegation's (SED) interview process for several national committees, while Drs. Joshua Lesko and Lee Ouyang continued to represent the Commonwealth in the Young Physicians Section (YPS). Dr. Sterling Ransone's recent appointment to the AMA's American Medical Association Political Action Committee (AMPAC) Board of Directors further elevates Virginia's voice in national physician advocacy, strengthening the Commonwealth's ability to shape the policies and political priorities that affect physicians, physician assistants, and patients nationwide. Together, these appointments ensure that Virginia physicians and physician assistants have a meaningful voice across the AMA's policy and leadership structure.

Virginia advanced two resolutions at the meeting, each addressing a practical threat to the delivery of care. Resolution 209, Protecting Mental Health Treatment Privacy in Legal Proceedings, called on the AMA to develop model state legislation shielding providers' mental health treatment records from discovery in civil and criminal proceedings. The proposal received strong support from multiple organizations and was referred by the House to the AMA Board of Trustees for further review, allowing the issue to receive additional consideration. Resolution 208, *Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness*, sought AMA support for legislation, guidelines, and interdisciplinary planning agreements that account for critical medical treatments and preserve continuity of care during emergencies. The House adopted Resolution 208, giving Virginia an important policy victory and marking the first adoption of a Virginia-sponsored resolution in recent years.

Virginia's engagement in the AMA Medical Student Section (MSS) continues to grow, strengthening the next generation of physician leadership. Yumna Rahman, a fourth-year VCU student, serves as the Region 6 Student Delegate, and Cindy Li, a second-year UVA student, serves as the Region 6 Alternate Delegate. Alexia Childress chairs Region 6, where MSV members lead three of the five regional committees. Vignesh Senthilkumar, a fourth-year MD-PhD student at UVA, serves as the MSS Regional Alternate Delegate after being elected by the full AMA MSS membership. This momentum was evident at the June meeting, where 28 Virginia medical students participated alongside four residents representing the delegation at the AMA Resident and Fellow Section (RFS) Assembly. Two of those residents, Kira Dubester and Austin Thomas, stepped forward to serve as AMA-RFS Sectional Alternate Delegates to the AMA House of Delegates.

As the delegation prepares for the AMA Interim Meeting of the House of Delegates in Orlando, Florida, this November, it is collaborating with other states and specialty societies to review proposed resolutions. Melina Davis continues to represent Virginia with distinction in the House of Delegates and is highly respected by leaders from other states. The delegation's work is also supported by health policy team members Scott Castro and Allyson Flinn, with Chris Fleury serving as staff liaison to both the delegation and the growing student section.

The challenges facing medicine demand a strong, unified physician voice. Your MSV AMA Delegation will continue to translate the concerns of Virginia physicians into meaningful policy and advocacy at the national level. We encourage every physician to strengthen organized medicine through AMA membership and support for AMPAC. As one of the nation's top five medical societies, MSV is well positioned to influence national policy and advance the priorities of physicians and patients across the Commonwealth. We are privileged to represent you, and we are grateful for your continued engagement and support.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "C Deal". The signature is stylized with a large, looped "D" and a long, sweeping horizontal stroke at the end.

Clifford Deal, MD
Chair, Virginia Delegation to the AMA



Date September 15, 2026

To: MSV House of Delegates

From: Areesheh Khan, MSV Medical Student Section Chair
University of Virginia School of Medicine

Re: Medical Student Section Annual Report, 2026 - 2027

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 Eastern Virginia Medical School, part of the Macon and Joan Brock Virginia Health Sciences at Old Dominion University (EVMS at ODU), 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.

I am pleased to announce this year the student section has close to 1000 members and is continuing to grow. We staffed 6 MSV MSS lobby days with 70 students who met with Virginia senators and delegates. We lobbied for key MSV issues, including House Bill 663 Medical Education Loan-for-Service program, which seeks to provide state funded forgivable loans for medical students who commit to practicing in high need specialties in rural and underserved areas. We also discussed House Bill 627 and Senate Bill 128 which would prohibit non-compete agreements for healthcare providers to improve workforce mobility, retain healthcare professionals in Virginia, and increase patients' access to care. Lastly, we supported legislation aimed at protecting healthcare workers from work violence, which would require annual reporting of these incidents to better understand the scope of the problem and guide future efforts to improve health worker safety. 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 an impressive presence at the AMA Annual Meeting in June, with 28 medical students joining the Virginia Delegation. At this meeting, all six policies adopted by AMA from Region 6 were written and led by Virginia medical students. These policies covered a wide breadth of healthcare issues, highlighting the knowledge, leadership, and commitment to advocacy of our student members. Our MSV student members also continued to have influential roles in AMA-MSS leadership this year, with Alexia Childress (UVA) elected as Chair and Rohan Rathi (VCU) as Policy Chair. Through

policy and leadership, Virginia's medical student delegation continues to be highly respected and involved voice in the MSS Assembly.

On September 5th, the medical student leaders attended our Medical Student Leadership Retreat held at MSV's Headquarters. The retreat served as an opportunity for our team to plan, set goals, and establish priorities for the upcoming year. Our student leaders continue to improve the policy adoption process and set clear goals for our Community Service, Engagement, and Legislative committees. At this meeting, our Student Representative to the Advocacy Committee, Vignesh Senthilkumar (UVA), gave a presentation highlighting recent policies adopted with MSV support and reviewed the advocacy and lobbying efforts surrounding these initiatives over this past year. Another member, Alexia Childress (UVA), developed and presented a strong proposal at the 2026 Advocacy Summit, inspiring our student members to work towards submitting an MSS-MSV endorsed proposal this upcoming year. It was exceptional to see how passionate our MSS leaders are about engaging Virginia's medical students to advance MSV's goals and initiatives.

Since the start of the 2026-2027 academic year, MSV has hosted more than a dozen events on our medical school campuses. The events have included lunch lectures, policy workshops, game nights, and MSVPAC's Docs n' Hops events. This upcoming year, we plan to consolidate chapter events from schools on the MSS-MSV student webpage so students across Virginia can stay informed about other chapters' success and draw inspiration from their ideas. From my own experience at UVA, these events have consistently been among some of the most well attended student organization events at our school. Each chapter has a robust event schedule for the remainder of the year with ambitious goals to continue growing MSV's medical student membership.

On behalf of my peers, I can confidently say that the conversations and interactions with MSV's physicians have made our involvement incredibly meaningful. I have been involved in MSV since my first year of medical school, and it has been one of the most important parts of my medical school journey. I am honored to now lead our student section filled with passionate students committed to creating change. I feel incredibly fortunate to be a part of an organization whose leadership has embraced our section, a sentiment that our students will carry with them in their roles as future physician leaders. I have seen firsthand how we have been given many opportunities and a level of support that is not always available in other states. Your continued investment in our students has empowered us to build a strong and influential medical student section and to ensure that Virginia's medical students have a meaningful voice in shaping the future of medicine. We would like to extend a special thank you to Paige Bishop and Chris Fleury, whose guidance, support, and leadership remain essential to our continued success.

It is with sincere gratitude that I thank the leadership and staff of the Medical Society of Virginia for its continued support. If given the opportunity to stay in Virginia, I look forward to continuing my involvement with MSV as a resident next year.

Respectfully,

Areesheh Khan
MS4, UVA SOM

Board of Medicine Report to the Medical Society of Virginia September 15, 2026

1. With new Administrations, change may come. Governor Abigail Spanberger appointed Marvin Figueroa as Secretary of Health and Human Resources, and she appointed a veteran of the Department of Health Professions (DHP) as its new Director. The Board of Medicine happily welcomed back DHP Director David Brown, DC. Dr. Brown served as DHP Director under Governor Terry McAuliffe and Governor Ralph Northam. He not only returns with his experience of directing DHP, but also with his experience as the chiropractic member of the Board of Medicine in the 1990's.
2. The Virginia Board of Medicine is comprised of 18 members appointed by the Governor. There are 11 MD's, 1 DO, 1 DPM and 1 DC. There are also 4 citizen members. The geographic restrictions for 1 MD from each Congressional District and no 2 citizen members from the same Congressional District were removed this year by the General Assembly.
3. Board membership has changed this year. The Board said "farewell" and thanks to Peter Apel, MD, Krishna Madiraju, MD, and Hazem Elariny, MD. They are succeeded by Barbra Jill McCabe, MD, pediatric emergency physician and hospitalist from Loudon County, Lucy Marcil, MD, pediatrician from Alexandria, and Jeffrey Feit, MD, family physician and Chief Medical Information Officer from Winchester.
4. The officers of the Board for 2026-2027 are:
 - President Bo Vaughan, MD, infectious disease specialist in Richmond
 - Vice-President Ken McDowell, DO, internist in Fredericksburg
 - Secretary-Treasurer Michele Nedleka, MD, radiation oncologist in Tidewater
5. Board staff leadership has remained unchanged. The Deputy Executive Directors are as follows:
 - Administration & MD Licensure – Colanthia Opher
 - Allied Health Professions Licensure – Michael Sobowale, LLM
 - Discipline – Jennifer Deschenes, JD

Physicians on staff are:

 - Medical Review Coordinator – Barbara Matusiak, MD
 - Medical Review Consultant – Dianne Reynolds-Cane, MD
 - Executive Director – William L. Harp, MD

6. In June 2025, the Licensing Section of the Board's 21 professions split into two licensing units - a "Doctors" unit and an Allied Health Professions unit. The split was to gain greater efficiency and speed across the licensing process. The division of the Section worked. Licensing times for the Board's 21 professions now average less than 30 days, and some weeks considerably lower.
7. In the last 12 months, over 11,000 initial licenses have been issued across all the Board's professions.
8. In the last 12 months, the Board has had 2,574 complaints lodged against its 99,000 licensees.
9. The total number of disciplinary actions taken since last September has been 109. The number of summary suspensions this past year has been 13. The number of mandatory suspensions was 23. Mandatory suspension is an action taken for loss of one's medical license in another jurisdiction or the conviction of a felony anywhere.
10. In the past year, the Board has continued to move a number of regulatory actions along. Most notably are the regulations to implement HB995 (2024). HB995 creates pathways to licensure for internationally trained physicians with no postgraduate training in the U.S. or Canada. The regulations remain under Executive Branch review. The regulations for the practice of Anesthesiologist Assistants, SB882 (2025), also remain under Executive Branch review. HB1861 (2025) required the Board to establish licensure by endorsement pathways for all professions that did not yet have endorsement. All the regulations for licensure by endorsement have been implemented or will soon be.
11. The 2026 GA passed a number of laws that impacted the Board of Medicine and its licensees.
 - **SB22** – Directs the Boards of Medicine and Nursing to require licensees to obtain continuing education in implicit and explicit bias
 - **SB332** – Directs the Department of Health to develop regulations on how to handle cannabis oils in hospitals and other healthcare facilities for patients that have certificates for their use
 - **SB418** – Authorizes pharmacists, under certain circumstances, to provide an alternative drug in the same therapeutic class of the one that is prescribed
 - **SB641** – Requires buprenorphine prescribers to offer counseling or refer patients to counseling
 - **HB452** – Removes the requirement for licensure by the Board of Medicine for rad techs, limited rad techs, and radiologist assistants who work in hospitals or healthcare systems or urgent care centers connected to either
 - **HB523** – The Military Medics and Corpsmen Program seeks to help military healthcare personnel transition to civilian life and use their knowledge and skills for employment, training, and eventual licensure or certification in their chosen field of healthcare

- **HB573** – Directs the Board of Medicine to develop educational materials for individuals considering breast implants
- **HB574** – Enters the Board of Medicine in the Athletic Trainers Compact
- **HB575** – Enters the Board of Medicine in the Respiratory Care Interstate Compact
- **HB746** – Authorizes physician assistants to practice without a practice agreement after 3 years of practice on an agreement with a physician
- **HB1139** – Removes the requirement that there be 1 MD from each Congressional District, and also removes the requirement that no 2 citizen members be from the same Congressional District

12. The Board of Medicine has been involved in work groups convened to address mandates from the 2026 GA.

- Committee of the Joint Boards of Nursing and Medicine – to modernize the regulatory framework for APRN's
- Experts testifying in court custody cases – to determine if there can be protection for mental health experts from adverse consequences, including Board disciplinary complaints
- Military Medic and Corpsman (MMAC) Program – to facilitate the transition of military healthcare personnel to civilian employment and eventual licensure or certification
- Psychologist Prescribing – to determine the principles under which clinical psychologists will be safe to prescribe psychotropic medications
- Therapeutic Interchange of medications by pharmacists – to develop regulations governing the circumstances under which pharmacists can issue a drug to replace the one that has been prescribed
- Statewide Pharmacist Protocols – to review and revise the 20+ statewide protocols that authorize pharmacists to prescribe drugs for certain diagnoses
- Breast Implant work group – to develop educational materials for patients seeking breast implants – meets 10/31/2026

13. The Board of Medicine was recognized as a 2026 Wellbeing First Champion by the Dr. Lorna Breen Foundation. The Foundation recognizes entities that seek to remove barriers for practitioners in need of help with stress, burnout, or more serious mental health challenges.

14. In the last year, the Board's newsletter, Board Briefs, had articles on:

- Understanding the roles of the Board of Medicine, its Advisory Boards, and professional organizations
- Application for service on the Board and Advisory Boards
- Birth injury fund
- Boundaries
- The Board's support for its licensees' well-being
- Nutrition
- Revisions to the rules governing balance billing for out-of-network providers

- Watch out for scammers!

15. Here are the numbers of licensees for the MD, DO, and PA professions as of September 15, 2025.

- Medicine – 46,646
- Osteopathic Medicine – 6,606
- Physician Assistant – 8,068


Leroy B. Vaughan Jr., MD
President


William L. Harp, MD
Executive Director

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

Date: September 16, 2026

To: MSV House of Delegates

From: Bobby Cockram, President, Virginia Academy of PAs

Re: VAPA Update

The Virginia Academy of PAs (VAPA) has experienced an exceptional year in 2026. Throughout the year, we have remained committed to advancing the PA profession, strengthening engagement among our members and students, and further developing our valued partnership with the Medical Society of Virginia (MSV). We are deeply grateful for MSV's continued collaboration and for the many opportunities to coordinate our efforts in support of Virginia's healthcare professionals and the patients and communities we collectively serve.

During the most recent legislative session, VAPA redesigned its approach to student participation in lobby days in response to the growing number of PA students eager to engage in the legislative process. MSV continues to do an outstanding job organizing its lobby days, including coordinating appointments with legislators. As PA student participation expanded, VAPA recognized an opportunity to develop a complementary experience that would preserve meaningful student engagement while supporting the effectiveness of MSV's broader advocacy efforts.

With this objective in mind, VAPA organized six dedicated PA student lobby days, welcoming more than 190 students and faculty members. These events introduced participants to the legislative process, provided practical advocacy experience, and emphasized the critical responsibility healthcare professionals have to remain engaged in public policy. Through both the VAPA student lobby days and the traditional MSV lobby days, our organizations worked alongside one another in support of important legislative priorities, including the medical malpractice cap, protections addressing violence against healthcare workers, and non-compete provisions.

Our collaboration with MSV extended beyond lobby days. VAPA participated in committee work and joined letters supporting MSV's position regarding the request to grant prescriptive authority to psychologists practicing in Virginia. This work reflects the importance of maintaining open communication and coordinated advocacy when considering policies that may impact patient care and the practice of medicine throughout the Commonwealth.

VAPA also celebrated a significant legislative achievement this year with the passage of legislation establishing parity with our nurse practitioner colleagues by allowing PAs to practice autonomously after three years of practice within a given specialty. Throughout the legislative process, VAPA worked closely with MSV, the Virginia Hospital & Healthcare Association, family practice physicians, and emergency medicine physicians to establish appropriate guardrails within the legislation. The successful outcome demonstrates what can be accomplished through thoughtful

collaboration, constructive dialogue, and a shared commitment to high-quality patient care. It also serves as a powerful example of the strength and value of the partnership between VAPA and MSV.

In addition to our advocacy efforts, VAPA celebrated a highly successful 44th Annual Summer CME Conference in Virginia Beach in July. The conference provided PAs with opportunities to participate in a broad range of continuing medical education sessions, strengthen professional relationships, and connect with colleagues from across the Commonwealth. We extend our sincere appreciation to Dr. Mark Townsend, MSV President, for addressing our members during the conference. His participation was both meaningful and reflective of the strong relationship between our organizations. The conference also marked the inauguration of VAPA's new president, Bobby Cockram.

VAPA has continued to foster statewide connection and professional engagement through two Fireside Chats held during the year. These forums have provided PAs from across Virginia with opportunities to learn about important developments, engage with timely issues, and become more connected to the work of their professional academy.

As we look toward 2027, VAPA is enthusiastic about continuing to strengthen its partnership with MSV. We look forward to participating in the upcoming MSV Annual Meeting and Gala, collaborating during the next legislative session, and advocating alongside MSV on behalf of the practice of medicine throughout the Commonwealth.

On behalf of VAPA and Virginia's PA community, thank you to MSV's leadership, staff, members, and House of Delegates for your continued partnership and support. Together, our organizations are better positioned to advance sound healthcare policy, strengthen the healthcare workforce, and improve care for the people of Virginia.

Sincerely,

Bobby Cockram, DMSc, PA-C, DFAAPA, FACHE

President

Virginia Academy of PAs