MSV℠ MEDICAL SOCIETY OF VIRGINIA

2025 ANNUAL MEETING
Delegates Handbook

MSV℠ MEDICAL SOCIETY OF VIRGINIA

2025 Annual Meeting Delegates Handbook
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MEDICAL SOCIETY OF VIRGINIA

MEMORANDUM

Date: **August 4, 2025**

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
2025 Annual Meeting of the Medical Society of Virginia House of Delegates

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Resolutions should be submitted online by September 9th, 2025, 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 9th, 2025 will be subject to consideration under the Rules of Procedure.
- If your society has a scheduled meeting that occurs after September 9th, 2025, 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 25th, 2025. Please email Scott Castro at scastro@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.

Also, make sure to review two small proposed changes to the Rules of Procedure (here)

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

Questions: Email scastro@msv.org

Call to Order
The Speakers

Pledge of Allegiance
Sonya Feeser, VCU Medical Student

Invocation
Randy Gould, MD

Speaker Acknowledgements
The Speakers

- Welcome Guests
- Legislative Champion Award
- 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
Joel Bundy, MD

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

MSV Foundation Raffle Drawing
The Speakers

MSVPAC Update & Award
Razi Ali, MD

Credentials Committee Report
Sharon Sheffield, MD

Rules Committee Report
Arthur Vayer, MD

Request for approval of the 2024 MSV House of Delegates sessions minutes
Larry Mitchell, MD

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

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

- 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 MSV House of Delegates - 2024 Reference Committee Two Report
The Speakers

- 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

New Business
The Speakers

Announcements and Recess
The Speakers

Recess until 8:00 a.m. Sunday, October 26, 2025

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
Willie Underwood, MD, American Medical Association President Elect

Credentials Committee Report
Sharon Sheffield, MD

Nominating Committee Report
Cynthia Romero, MD

Election of Officers and Directors
The Speakers

Election of President-Elect
The Speakers

Installation of MSV Board of Directors Officers
David Ellington, MD

Incoming President's Remarks
Mark Townsend, MD

Election of the 2025-2026 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

2025 Delegate References

1. New Delegate Orientation PowerPoint
2. Quick Guide to Parliamentary Procedure
3. Proposed Rules of Procedure 2025
4. MSV Bylaws

MSV℠ MEDICAL SOCIETY OF VIRGINIA

New Delegate Orientation

2025 MSV Annual Meeting

MSV House of Delegates

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

Your Delegate Handbook

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

Definitions 101

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

MSV Policy Compendium

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

MSV HOD: Parliamentary Procedure

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

House Process Overview

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

MSV HOD: Resolutions

- Resolutions determine MSV's policy position on a variety of issues
  - Any MSV member, component organization, or society can propose a resolution
- The "Whereas" clause(s) provide background information
- The "Resolved" clause(s) stand alone and will be voted on by the House of Delegates
  - All resolutions will be discussed in Reference Committees on Friday, October 24th

Sample Resolution

PROMOTING AUTOMATIC DUES PAYMENT

Submitted by John Smith, M.D.

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

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

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

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

Motions

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

Motions Continued

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

Subsidiary Motions

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

Amendments

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

Session 1

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

Session 2

- Committee Reports
- Elections
- Reference Committee Reports

HOD Committees

- Credentials
- Tellers
- Rules
- Reference

Reference Committees and Extractions

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

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2019 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Society.

MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES
Report of Reference Committee 1

Dr. Patricia Pletke, Chair

The Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION
19-101 2020 Budget
19-102 2019 MSV Policy Compendium 10 Year Review

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED
19-104 Opposition to Maintenance of Certification
19-107 American "Equal Rights Amendment"
19-108 Advancing Gender Equity in Medicine
19-110 Organ Donation as an Opt-Out or Mandated Choice Program
19-111 Resolution on Medical Care of the Terminally Ill
19-112 Resolution to Stop Robocalls in Virginia

RECOMMENDED FOR REFERRAL TO BOARD OF DIRECTORS
None

RECOMMENDED FOR NOT ADOPTION
19-106 Form a Patient Advocacy Section in the Medical Society of Virginia and Its Component Medical Societies

RECOMMENDED FOR ADOPTION IN LIEU OF
19-103 Resolution Regarding the Maintenance of Certification Process
19-105 Promoting Alternatives to Proprietary ABMS Maintenance of Certification
19-109 GME Funding and Support for Rural Hospitals

HOD Actions

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

Questions?

MSV[SM] MEDICAL SOCIETY OF VIRGINIA

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

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

MSV℠ MEDICAL SOCIETY OF VIRGINIA

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

MM = Main Motion

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

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MSV℠ MEDICAL SOCIETY OF VIRGINIA

Rules of Procedure

of the

Medical Society of Virginia

House of Delegates

2025 Proposed Changes

Adopted Nov. 1995
Revised Nov. 2001, 2005, Oct. 2008, Nov. 2011, Oct. 2013,
Oct. 2014, Oct. 2016, Oct. 2017, Oct. 2018, Oct. 2019, Oct. 2022, Oct. 2023

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I. FORWARD

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

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

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

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

II. INTRODUCTION AND CONDUCT OF BUSINESS

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

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

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

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

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

III. GUIDELINES FOR RESOLUTIONS

A. THE PURPOSE OF A RESOLUTION

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

Possible actions by the House may include:

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

B. WHO MAY PROPOSE A RESOLUTION

A resolution may be proposed by:

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

C. **WHEN A RESOLUTION MAY BE PROPOSED**

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

EXCEPTIONS:

1. A Component Society or Specialty Section or District whose latest regularly scheduled meeting adjourns within the 45 days is allowed 7 days after the close of such meeting to submit any resolution.

2. The Board, as a result of its meeting before the first session of the House of Delegates, may submit any business or resolution for routine consideration by the House.

3. Any Committee of the Society.

LATE RESOLUTIONS are those received after the deadline described above, but before noon of the 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 policy already in force. Any item on the Reaffirmation Consent Calendar can be extracted from it for full debate by the reference committee and the House, by simple request of a single member of the House of Delegates.

6. If two or more policies concerning the same subject are found in the PC, and the two statements either are substantially the same, or are inconsistent or contradictory with one another, the

statement most recently adopted by the House of Delegates will prevail, and the less current policy will be removed from the next edition of the PC.

7. The Ten Year (Sunset) Provision of the New Policy Procedure: Ten years after the adoption of each policy action, the Speakers and MSV Staff will present to the MSV Board a "Ten Year Policy Review Report," encouraging consideration of each item in that report by the mechanisms reported above in paragraphs 4 b through e, or referral of such policies to an appropriate committee for the same purpose. Unless each such policy is acted upon by the subsequent House of Delegates via the 4 b-e mechanisms, it will cease to be policy of the MSV.

8. After each Annual Meeting of the House of Delegates of the MSV, the Speakers and MSV staff will:

    a. Incorporating all statements of new policy and policy changes into the PC;

    b. Assigning a topic category or categories for the index of the PC;

    c. Removing statements of policy that have been rendered moot by changes in law, or that have been superseded by later action of the House of Delegates; and transferring them to the Archives section of the Policy Compendium;

    d. Including any item inadvertently omitted during the process of creating the PC and the new Policymaking Procedure;

    e. As in all matters, the House of Delegates has the final authority over the Speakers and Staff in these largely procedural and secretarial matters.

9. The Speakers and Staff will work diligently with the Board and House of Delegates to fairly execute the new Policymaking Procedure, and to further modify it as necessary in coming years.

V. REFERENCE COMMITTEES

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

A. Organization: The Speaker shall appoint Reference Committees and a Chair for each Committee. The number of Reference Committees appointed shall be at the discretion of the Speaker. Each Reference Committee shall be composed of not less than six delegates, each from a different District, a non-voting Board member and a non-voting Student or Resident Section member. The Speaker shall refer all resolutions to an appropriate Reference Committee. In the assignment of business to Reference Committees, the ruling of the Speaker shall be final, unless the House of Delegates by majority vote directs otherwise.

B. Conduct of the Reference Committee Hearings: Reference Committee hearings are open to all members of the Association, guests, and official observers. Any member of the Society may speak on the resolution or report under consideration. The chair is privileged to call upon anyone attending the hearing if, in his/her opinion, the individual called upon may have information, which would be helpful to the committee. Non-member physicians, or guests may upon recognition by the chair, be permitted to speak. When a Reference Committee member has a special interest in a matter referred to the Committee of which he/she is not a member, he/she may appear before that Committee and participate in the presentation of the subject, but may vote only in the Committee of which he/she is a member.

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

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

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

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

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

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

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

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

1. Identify the resolution or report by number and title;
2. State concisely the committee's recommendation;
3. Comment, as appropriate, on the testimony presented at the hearings; and,
4. Incorporate supporting evidence of the recommendations of the committee.
5. Consent Calendar: The reference committee report will be presented as a Consent Calendar or waiver of debate list. At the time of presentation of the Consent Calendar, a request may be made for removal of any item for debate or individual action without the

need for a vote on permission to separate it from the other items. Items not extracted from the Consent Calendar will be voted on as a block without further debate.

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

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

AMENDED AND RESTATED BYLAWS OF
THE MEDICAL SOCIETY OF VIRGINIA
EFFECTIVE OCTOBER 15, 2023

ARTICLE I
NAME AND PURPOSE

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

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

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

ARTICLE II
MEMBERSHIP, VOTING, FUNDS, DUES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 12. Failure to Comply with Bylaws. If a component society, component student society, component resident physician section, or physician assistant section fails to comply with the provisions of these Bylaws, the Board of Directors shall request a report of the component regarding the organization in question. After considering such report, the Board of Directors then may make a recommendation concerning the status of the organization as a component society, component student society or component resident physician section as being active or inactive.

ARTICLE IV
ANY MEETINGS OF MEMBERS

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

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

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

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

ARTICLE V
HOUSE OF DELEGATES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE VI
ELECTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE VII
OFFICERS

Section 1. President.

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

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

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

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

Section 2. President-Elect.

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

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

Section 3. Executive Vice President and Chief Executive Officer.

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

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

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

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

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

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

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

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

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

Section 5. Secretary-Treasurer.

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

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

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

Section 6. Officer resignations and vacancies

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

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

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

ARTICLE VIII
BOARD OF DIRECTORS

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

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

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

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

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

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

Section 6. Meetings. Meetings of the Board of Directors shall be held upon call of the Executive Vice President and Chief Executive Officer at the request of the President or any five (5) members of the Board of Directors, upon reasonable notice. Actual expenses may be paid members attending meetings of the Board of Directors between annual meetings.

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

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

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

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

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

ARTICLE IX
PROFESSIONAL CONDUCT

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

Each officer, Associate Director, or Director of the Society will utilize the Society's Conflict Resolution Processes, contained within the Society's Board of Directors Handbook, as the primary mechanism to resolve conflict and/or complaints, unless the act or conduct is consistent with Article IX Section 2.

Section 2. Removal Process and Proceedings

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

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

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

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

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

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

ARTICLE X
INDEMNIFICATION

Section 1. Definitions.

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

"Expenses" includes reasonable counsel fees.

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

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

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

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

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

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

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

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

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

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

C. By special legal counsel in a written opinion:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE XI
COMMITTEES

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

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

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

ARTICLE XII
ETHICS

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

ARTICLE XIII
RULES OF ORDER

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

ARTICLE XIV
AMENDMENTS

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

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

APPENDIX A
Approved October 15, 2023

First District:
Mid-Tidewater Medical Society

Second District:
Tri-County Medical Society; Coastal Virginia Medical Society; Eastern Virginia Medical School Student Section

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

Fourth District:
Reserved

Fifth District:
Danville-Pittsylvania Academy of Medicine

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

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

Eighth District:
Prince William County Medical Society

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

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

APPENDIX A (Continued)

Specialties:

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

Minutes and Actions of the 2024 House of Delegates

1. Medical Society of Virginia 2024 House of Delegates Minutes
2. Final Actions of the 2024 Medical Society of Virginia House of Delegates

First Session

Call to Order
Dr. Michele Nedelka, Speaker, convened the first session of House of Delegates at 10:06 am.

Pledge of Allegiance
The Pledge of Allegiance was led by Elizabeth Ransone, a fourth-year medical student at VCU.

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

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

- Dr. Eileen Raynor, President of the North Carolina Medical Society
- Dr. Kristen Sandel, President of the Pennsylvania Medical Society
- Dr. Padmini Ranasinghe (RA-nah-sing), President-Elect of MedChi, the Maryland Medical Society
- Dr. Karen Shelton, Commissioner of the Virginia Department of Health
- Gene Ransom, Chief Executive Officer of MedChi, the Maryland Medical Society
- Delegate Patrick Hope, State Delegate representing Virginia's First District, and finally,
- Brent Rawlings, Senior Vice President and General Counsel at the Virginia Hospital and Healthcare Association

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

Member Recognitions
The Speakers recognized Former Presidents, New Delegates, MSV members who have been members of the Society for 20 years or longer, and Second Century Circle members (MSV Endowment).

Presidential Address
Dr. Alice Coombs, President, shared remarks regarding her year as president. She delivered a heartfelt, reflective, and inspiring address centered on the evolution of medicine, the critical importance of mentorship, the workforce crisis, and the value of graciousness in the medical profession. She expressed deep gratitude to her colleagues, advisors, MSV staff, and family. Her final message: embrace mentorship, model graciousness, and commit to building a sustainable and compassionate healthcare workforce.

Virginia Health Commissioner
Dr. Karen Shelton, Virginia's Health Commissioner, addressed the House and reflected on her journey from being an OB-GYN to a leader in public health. Her transition into public health sparked a passion for addressing health at a broader, systemic level beyond one-on-one patient care. She highlighted her leadership during the COVID-19 pandemic in Southwest Virginia and later experiences as a hospital chief medical officer. She emphasized that while clinical care is essential, it accounts for only about 20% of a person's overall health. The rest stems from social determinants—economic stability, education, environment, behavior, housing, transportation, and food access. Dr. Shelton challenged healthcare providers to consider these broader influences and engage with community resources and policies that impact health. Dr. Shelton also encouraged providers to advocate for "health in all policies," build partnerships with community organizations, and think beyond the clinical encounter to truly meet patient needs. The address closed with a call to action: continue championing community health and work collaboratively to improve health outcomes across Virginia.

Virginia Delegation to the American Medical Association Update
Dr. Thomas Eppes, Chair of the Virginia Delegation to the American Medical Association, provided the House with a report of the delegation's work emphasizing its renewed energy and diversity. The delegation was described as active and prominent, with future leadership plans including supporting delegation members for various committees and Board of Trustees positions in the future. Dr. Eppes stressed the importance of Virginia's continued participation in national medical policy through the AMA.

A heartfelt acknowledgment is given to retiring delegate Claudette Dalton, honoring her years of service and wisdom, and closing with a call for applause in her honor.

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. Peter Kemp's family. This award is for MSV member physicians with high personal integrity who have demonstrated outstanding leadership in their fields.

MSV Legislative Champion Award
Dr. Joel Bundy, President-elect of the Medical Society and chair of the MSV Advocacy Committee, presented the MSV Legislative Champion award to Delegate Parick Hope, State Delegate representing Virginia's First District. This award honors a champion in the legislative arena that demonstrates tireless advocacy for the House of medicine and the patients we care for.

Credential Committee Report
Dr. John Paul Verderese, Chair of the Credentials Committee, reported that a quorum is present with more than twenty-five (25) percent of the number of delegates allowed representing at least eight (8) component districts.

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

- 24-001 Establishment of the Shapiro-Konerding Women in Medical Leadership Fund
- 24-113 Secondhand Marijuana Smoke

Approval of the 2023 MSV House of Delegates Minutes
Dr. Larry Mitchell, Secretary-Treasurer, asked for comments on minutes from the 2023 meetings of the House of Delegates. Hearing none, the minutes were approved without objection.

Consent Calendar: Resolutions
Resolution 24-110 Residency Program Funding Equalization for Family Medicine was extracted from the consent agenda for improvement by the author. Extracted resolution 24-001 establishing the Shapiro-Konerding Women in Medical Leadership Fund was passed by unanimous consent of the House.

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

- MSV Board of Directors Actions on the 2023 Resolutions Referred to the Board
    - Report on the Employed Physicians Section Workgroup
    - Evaluating Drug Donation Programs: A MSV Perspective
- MSVPAC Report
- MSV Foundation Report
- AMA Virginia Delegation Report
- Medical Student Section Report
- Virginia Board of Medicine Annual Report

- Physician Assistant Section Report

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

Conclusion of 1st session
The first session of the House of Delegates recessed at 11:28 am.

Second Session

Call to Order
Dr. Michele Nedelka, Speaker, reconvened the House of Delegates at 8:03 am.

Medical Student Section Poster Symposium Winners Announced
The following three (3) winners for the Medical Student Section Poster Symposium were announced. We had 27 entries this year from all 6 medical schools in Virginia.

1. Yumna Rahman. a 2nd year at VCU
    a. "Voluntary Nicotine Consumption and Reward in a Subset of Diversity Outbred Founder Strains"
2. Ishaan Rischie a 3rd year at UVA
    a. "Medical Futility in Neonatal Care: A Case-Based Critique of Unilateral Termination of Life-Sustaining Treatment"
3. Katherine McLaughlan a 3rd year at EVMS
    a. “Uncovering Gaps in Prenatal Care: A survey-Based Study of Resource Awareness and Access in the Greater Hampton Roads Area"

Commending and Memorial resolutions
The following commending and memorial resolutions were sponsored by the MSV Board of Directors and unanimously adopted by the House

- Honoring the service and dedication of Dr. Larry Mitchell
- Honoring the service and leadership of Dr. Claudette Dalton, who is ending her 24-year tenure as a member of the Virginia AMA Delegation
- Honoring the tireless service of Margaret Harris, Assistant Vice President of IT at the Medical Society of Virginia, in celebration of her 30th year with the organization
- Commending the successful merger of Eastern Virginia Medical School and Old Dominion University
- Honoring the memory of the late Dr. Hazle Konerding
- Honoring the memory of the late Dr. Clarence Holland
- Honoring the memory of the late Dr. George Broman
- Honoring the memory of the late Dr. Peter Kemp

MSV CEO/EVP Remarks
Ms. Melina Davis, Chief Executive Officer and Executive Vice President, (CEO and EVP), opened with personal remarks and gratitude for recognizing those who’ve served MSV (Medical Society of Virginia), acknowledging their lasting impact. She reported that 2024 was an exceptional year for MSV, highlighting organizational and financial achievements, challenges, and the 2025 Budget vision and identity. Ms. Davis presented the traditional bobblehead awards to the following:

- PA Sarah Nicely: for PA-physician unity and leadership.
- Dr. Claudette Dalton: for her pioneering leadership and mentorship.
- Dr. Lee Oyuang: for outstanding PAC fundraising and engagement.

Dr. Alice Cooms was praised for her mentorship and initiating "Pathways to Medicine", a program inspiring young students to pursue healthcare careers—now gaining national interest. Ms. Davis with a playful and heartfelt skit using a “Duplicator” to symbolize replicating leadership and mentorship qualities in others—encouraging everyone to "spread the light" and invest in mentoring the next generation of medical leaders. Ms. Davis closed with the message that MSV’s success is powered by its members' generosity, innovation, and leadership, encouraging everyone to pass their wisdom on to others to ensure a brighter future for medicine.

Credential Committee Report
Dr. Verderese, Chair of the Credentials Committee, reported that a quorum is present with more than twenty-five (25) percent of the number of delegates allowed representing at least eight (8) component districts.

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

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

OFFICERS (Elected for 1-year term)

Secretary-Treasurer	Art Saavedra, MD
Speaker	Michele Nedelka, MD
Vice Speaker	Atul Marathe, MD

DIRECTORS (Elected for 2-year term)

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

DIRECTORS (Elected for 1-year term)

District 3	Sidney Jones, MD
District 7	John Mason, MD
MSV Foundation	José Morey, MD
Academic	Lindsay Robbins, MD
Resident	Matthew Adsit, MD (VCU Orthopedics)
Medical Student	Elizabeth Ransone (VCU)

ASSOCIATE DIRECTORS (Elected for 2-year term)

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

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 3	Joynita Nicholson, DO
District 7	Mohit Nanda, MD
Resident	Terry Henry, MD (VCU-Ophthalmology)
Medical Student	Shawn Dziepak (VCOM)

DELEGATES to the AMA (Elected for 2-year calendar term)
Thomas Eppes, Jr., MD
Michele Nedelka, MD
Lee Ouyang, MD

ALTERNATE DELEGATES to the AMA (Elected for 2-year calendar term)
Sandy Chung, MD
Joshua Lesko, MD
Mohit Nanda, MD

Josephine Nguyen, MD

Election of President-Elect
Without objection, Dr. Mark Townsend was elected as President Elect of the MSV.

Installation of MSV Board Officers
Dr. Cyn Romero, Nominating Committee Chair, conducted the installation of officers.

Incoming President's Remarks
Dr. Joel Bundy, Incoming President, opened with gratitude, recognizing outgoing president Dr. Coombs for her leadership, especially around the *Pathways* initiative, and expressed appreciation for mentors, colleagues, MSV staff, board members, and partners across the healthcare system. Key themes and messages were his gratitude and teamwork, examples of collaborative impact, his vision and priorities for the coming year, and his commitment to advocacy and connections. Dr. Bundy closed with a message to all: *Let us lift one another up when we fall, we truly are stronger together.*

Election of the 2024-2025 Nominating Committee
The 2024-2025 Nominating Committee was presented for election and the following were elected by unanimous vote:

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

Reference Committee Reports
Reference Committee recommendations were presented for acceptance as consent calendar items. Reference Committee 1 extracted resolutions were discussed at length by the House. Reference Committee 2 discussion on the extracted resolutions were tabled for discussion at the 2025 MSV Annual Meeting. The final actions of the House of Delegates for all resolutions are attached to these minutes.

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

- 24-102 Policy Compendium Ten Year Review
- 24-104 Defining Exceptions to Information Blocking
- 24-105 Expanded and Standardized Advanced Practice Registered Nurses' Education
- 24-106 MSV Richt of Conscience Resolution
- 24-107 Physician Opinion of Readiness of Mid-Level Providers for Independent Practice
- 24-111 Supporting Independent Practices
- 24-113 Resolution Secondhand Marijuana Smoke

Dr. Bobbie Sperry presented the consent calendar report of Reference Committee 2. Discussion on the following extracted resolutions were tabled for the discussion at the 2025 MSV Annual Meeting.

- 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

Adjournment

The 2024 Annual Meeting of the House of Delegates of the Medical Society of Virginia adjourned at 11:43 am.

FINAL ACTIONS OF THE 2024 MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

SUMMARY OF ACTION

ADOPTED

- 24-101: MSV Proposed 2025 Budget
- 24-106: MSV Right of Conscience Resolution
- 24-207: Stop the Bleed Training in Medical Schools

ADOPTED AS AMENDED OR SUBSTITUTED

- 24-102: MSV Policy Compendium 10-Year Review
- 24-104: Defining Exceptions for Information Blocking
- 24-105: Expanded and Standardized Advanced Practice Registered Nurses Education
- 24-107: Physician Opinion of Readiness of Non-Physician Providers for Independent Practice
- 24-109: Reducing Stigma Through Modernizing the Accessibility Sign
- 24-111: Resolution Supporting Independent Practices
- 24-112: Resolution on Workplace Safety
- 24-205: Resolution on Expansion of Medicare Open Enrollment
- 24-206: Healthcare for People Who Are Incarcerated
- 24-211: Saving Resources in the Perioperative Arena

REFERRED TO THE BOARD OF DIRECTORS FOR ACTION

- 24-105: Expanded and Standardized Advanced Practice Registered Nurses Education
- 24-204: Equitable Access to Care for Individuals with Disabilities

NOT ADOPTED

- 24-208: Move the Profession of Medicine from its Present Location in an Economic Free Market to the Code of Virginia

RECOMMENDED FOR AMENDMENT OF MSV POLICY IN LIEU OF

- MSV Policy 30.4.06: Remove Restrictive Covenants for Healthcare Providers in Virginia
  - *In lieu of:* 24-103: Ban Non-Compete Employment Covenants
- MSV Policy 40.20.10: Secondhand Smoke
  - *In lieu of:* 24-113: Resolution on Secondhand Marijuana Smoke
- MSV Policy 10.1.18: Insurance Coverage for Medical Conditions
  - *In lieu of:* 24-203: Resolution on Early Prescription Eye Drop Refills in Virginia
- MSV Policy 30.4.04: MSV COPN Policy
  - *In lieu of:* 24-209: Proposal for Removal of Certificate of Need Laws in Virginia
- MSV Policy 25.1.04: Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services
  - *In lieu of:* 24-213: Healthcare Protections for In Vitro Fertilization

MSV POLICIES REAFFIRMED IN LIEU OF

- MSV Policy 40.18.01: Changes in Commitment Law; Funding
  - *In lieu of:* 24-108: Psychiatric Initiatives
- MSV Policy 10.1.18- Insurance Coverage for Medical Conditions

- *In lieu of:* 24-202: Coverage of Human Milk Products by Commercial and Public Insurance

CONTINUED TO 2025 MSV HOUSE OF DELEGATES

- 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

24-101: Medical Society of Virginia 2025 Proposed Budget *(ADOPTED)*

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

24-102: 2024 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 policies:

45.1.02- Diagnosis by Optometrists
The Medical Society of Virginia opposes the use of optometrists and inadequately trained nonmedical personnel for the diagnosis of eye disease and eye injury.

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

40.15.02- Agency Jurisdiction
The Medical Society of Virginia believes that the jurisdiction over Day Care Centers lies with the Department of Social Services which should continue to study existing laws and regulations and make them applicable to all Day Care Centers.

45.1.01- Determination of Fitness to Return to Work
The Medical Society of Virginia opposes the use of persons other than doctors of medicine or osteopathy, or agents under their supervision, to attest to an employee's fitness to return to work.

24-103: Ban Non-Compete Employment Covenants (AMEND CURRENT MSV POLICY IN LIEU OF)

Amend MSV Policy 30.4.06- Remove Restrictive Covenants for Healthcare Providers in Virginia

The Medical Society of Virginia supports policies, regulations, and legislation, that prohibit covenants not-to-compete for healthcare providers. ~~will publish a study that provides a legal summary of the tests the court uses for covenants and summaries of several decisions so to inform members on how the court has ruled. The study will be made available for members by December 31, 2019.~~

24-104: Defining Exceptions for Information Blocking (ADOPTED AS AMENDED)

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

24-105: Expanded and Standardized Advanced Practice Registered Nurses Education (REFERRED TO MSV BOARD OF DIRECTORS FOR ACTION)

RESOLVED, The Medical Society of Virginia supports the standardization of the education and training for advanced practice providers.

24-106: MSV Right of Conscience Resolution (ADOPTED)

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

24-107: Physician Opinion of Readiness of Non-Physician Providers for Independent Practice (ADOPTED AS AMENDED)

RESOLVED, the Medical Society of Virginia supports that a physician's autonomy to rely on their professional opinion as final determining factor in whether a non-physician provider can practice independently. No physician should be forced to sign off on such an affidavit if, in their professional opinion, the non-physician provider does not have the appropriate level of training, and be it further

RESOLVED, MSV shall oppose legislation, regulation, hospital or business policy that forces a physician to sign off when, in their professional opinion, they do not believe the right level of training has been achieved.

24-108: Psychiatric Initiatives (REAFFIRM MSV POLICY IN LIEU OF)

Reaffirm MSV Policy 40.18.01- Changes in Commitment Law; Funding

The Medical Society of Virginia supports the civil commitment of a patient to a private or a public hospital for psychiatric care with a view to the highest quality medical care and adequate funding be provided for the process established by law.

24-109: Reducing Stigma Through Modernizing the Accessibility Sign (ADOPTED AS AMENDED)

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

23-111: Resolution Supporting Independent Practices (ADOPTED AS AMENDED)

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

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

~~RESOLVED, that the MSV delegates encourage the American Medical Association (AMA) to draft and publish a statement in support of independent physicians in private practice, and to continue developing and updating educational materials to support independent physicians in private practice and educate early physicians about options for developing or joining a viable private practice.~~

24-112: Resolution on Workplace Safety (ADOPTED AS AMENDED)

RESOLVED, the Medical Society of Virginia supports allowing an employer to seek a protective order on behalf of an employee with their consent.

24-113: Resolution on Secondhand Marijuana Smoke (AMEND CURRENT MSV POLICY IN LIEU OF)

Amend MSV Policy 40.20.10 Secondhand Smoke

The Medical Society of Virginia supports access to clean smoke-free air for all citizens in the Commonwealth, especially children. The Society supports efforts to eliminate tobacco and marijuana smoking or vaping in public places and places of employment in order to protect Virginians from the hazards of passive smoke inhalation. Further, the Medical Society of Virginia supports efforts to make it illegal to smoke or vape in a vehicle with a minor present.

The Medical Society of Virginia opposes efforts to repeal protections for the public from secondhand smoke.

Archive MSV Policy 40.20.09- Tobacco use in Cars with Minors

The Medical Society of Virginia supports statewide legislative efforts to make it illegal for anyone to smoke tobacco in a car with a minor inside of the car.

24-201: Access to Healthcare for People Experiencing Homelessness (CONTINUED TO 2025 HOUSE OF DELEGATES)

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.

24-202: Coverage of Human Milk Products by Commercial and Public Insurance (REAFFIRM MSV POLICY IN LIEU OF)

Reaffirm MSV Policy 10.1.18- Insurance Coverage for Medical Conditions

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition versus a cosmetic condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition.

24-203: Resolution on Early Prescription Eye Drop Refills in Virginia (AMEND CURRENT MSV POLICY IN LIEU OF)

Amend MSV Policy 10.1.18- Insurance Coverage for Medical Conditions

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition versus a cosmetic condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition, and further,

The Medical Society of Virginia supports insurance coverage for early prescription refills of eyedrops and other essential medications when deemed medically appropriate.

24-204: Equitable Access to Care for Individuals with Disabilities (REFERRED TO MSV BOARD OF DIRECTORS FOR ACTION)

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

24-205: Resolution on Expansion of Medicare Open Enrollment (ADOPTED AS AMENDED)

RESOLVED, the MSV supports legislation and regulations that would ~~identify a transition back to Traditional Medicare and Medicare Supplement and away from Medicare Advantage.~~ allow for year-round open enrollment and guaranteed issue clauses for traditional Medigap plans.

24-206: Healthcare for People Who Are Incarcerated (ADOPTED AS AMENDED)

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

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

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

24-207: STOP THE BLEED Training in Medical Schools (ADOPTED)

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

24-208: Move the Profession of Medicine from its Present Location in an Economic Free Market to the Code of Virginia (NOT ADOPTED)

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

24-209: Proposal for Removal of Certificate of Need Laws in Virginia (AMEND CURRENT MSV POLICY IN LIEU OF)

Amend MSV Policy 30.4.04- MSV COPN Policy

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

24-210: Transgender Hormonal Treatment and Surgeries for Minors (CONTINUED TO 2025 MSV HOUSE OF DELEGATES)

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

24-211: Resolution to Save Resources in the Perioperative Arena (ADOPTED AS AMENDED)

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

24-212: Supporting Innovative Models of Primary Care (CONTINUED TO 2025 MSV HOUSE OF DELEGATES)

Reaffirm 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.

24-213: Healthcare Protections for In Vitro Fertilization (AMEND CURRENT MSV POLICY IN LIEU OF)

Amend 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 ~~include~~ 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.

Continued Business of the 2024 House of Delegates

1. 2024 Reference Committee Two Report
2. Continued Resolutions

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Society.

MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES
Report of Reference Committee 2

Dr. Bobbie Sperry, Chair

Present Members: Dr. John Sweeney, Dr. Razi Ali, Dr. Gary Miller, Dr. Daniel Pauly Dr. Peter Netland, Dr. Andrea Giacometti, Vignesh Senthilkumar, Dr. Larry Michell

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The Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION
24-207: Stop the Bleed Training in Medical Schools

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED
24-205: Resolution on Expansion of Medicare Open Enrollment
24-206: Healthcare for People Who Are Incarcerated
24-211: Saving Resources in the Perioperative Arena

RECOMMENDED FOR NOT ADOPTION
24-208: Move the Profession of Medicine from its Present Location in an Economic Free Market to the Code of Virginia
24-210: Transgender Hormonal Treatment and Surgeries for Minors

RECOMMENDED FOR AMENDMENT TO CURRENT POLICY IN LIEU OF
24-201: Access to Healthcare for People Experiencing Homelessness (Amend MSV Policy 05.4.01)
24-203: Resolution on Early Prescription Eye Drop Refills in Virginia (Amend MSV Policy 10.1.18)
24-209: Removal of Certificate of Need Laws in Virginia (Amend MSV Policy 30.4.04)
24-213: Healthcare Protections for In Vitro Fertilization (Amend MSV Policy 25.1.04)

REAFFIRMIRMATION OF EXISTING POLICY IN LIEU OF
24-202: Coverage of Human Milk Products by Commercial and Public Insurance
24-212: Supporting Innovative Models of Primary Care

REFER TO THE MSV BOARD OF DIRECTORS FOR ACTION
24-204: Equitable Access to Care for Individuals with Disabilities

1) 24-201 ACCESS TO HEALTHCARE FOR PEOPLE EXPERIENCING HOMELESSNESS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 05.4.01 Be Amended In Lieu Of Adoption Of Resolution 24-201.**

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

Your Reference Committee heard supportive testimony regarding the existing health disparities present for those individuals experiencing homelessness and MSV's role in addressing those disparities. Your Reference Committee heard supportive testimony commending the medical student section. Your Reference Committee heard testimony in support of additional resources for state mental health hospitals regarding their role on the issue.

Online comments were not received on this resolution.

Your Reference Committee did not receive opposing testimony.

Your Reference Committee discussed amending existing policy language to reflect the interest of the House of Delegates to incorporate housing insecurity as a social determinant of health and related health outcomes within the purview of the MSV's existing position.

Accordingly, your Reference Committee recommends that MSV Policy 05.4.01 be Amended in Lieu of Adoption of Resolution 24-201.

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.

2) 24-202 COVERAGE OF HUMAN MILK PRODUCTS BY COMMERCIAL AND PUBLIC INSURANCE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 10.1.18 Be Reaffirmed In Lieu Of Resolution 24-202.**

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

Your Reference Committee heard supportive testimony from the Virginia Chapter of the American Academy of Pediatrics regarding the clinical value of donated breast milk, the financial limitations of acquisition, and support for insurance coverage for human breast milk.

Your Reference Committee heard supportive testimony for separating the Resolved into two clauses.

Your Reference Committee discussed the testimony in relation to the associated costs and commercial insurance coverage. Your Reference Committee discussed how current policy (MSV Policy 10.1.18) would already allow the MSV to advocate in favor of insurance coverage for human milk products.

Accordingly, your Reference Committee recommends that MSV Policy 10.1.18 be Reaffirmed in Lieu of Adoption of Resolution 24-202.

10.1.18- Insurance Coverage for Medical Conditions

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition versus a cosmetic condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition.

3) 24-203 RESOLUTION ON EARLY PRESCRIPTION EYE DROP REFILLS IN VIRGINIA

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends **Amending MSV Policy 10.1.18 In Lieu Of Adoption Of Resolution 24-203.**

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

Your Reference Committee heard supportive testimony regarding rising rates of glaucoma and the implications faced by those who require access to eyedrops prior to their prescription refill date. Your Reference Committee heard supportive testimony and remarks regarding the resolution aligning with the standards of care for this specialty and the broader standard physicians follow for prescribing and dispensing.

Your Reference Committee heard no opposing testimony.

Your Reference Committee discussed the protocol for dispensing drops, care delays caused by refill dispensing, and the potential concerns of stakeholders in the pharmaceutical and health insurance industries. Your Committee also discussed how this specialty issue can be more generalized to broader prescribing and dispensing issues. Your Committee discussed medical decision-making requiring nuance rather than standardized protocols and how to incorporate appropriate language.

Your Reference Committee considered the testimony and including additional language past amending existing policy to address the specificity of this example without overly narrowing the language to specific treatments or conditions.

Accordingly, your Reference Committee recommends Amending MSV Policy 10.1.18 In Lieu Of Adoption Of Resolution 24-203.

10.1.18- Insurance Coverage for Medical Conditions

The Medical Society of Virginia affirms the need for government and commercial insurance plans to refer to a nationally recognized medical association or organization, such as the American Academy of Dermatology, in defining what is a medical condition, and be it further,

The Medical Society of Virginia affirms the need for government and commercial coverage for diagnostic evaluation and treatment of all conditions which have been recognized by a national medical association or organization as a medical condition, and further,

The Medical Society of Virginia supports insurance coverage for early prescription refills of eyedrops and other essential medications when deemed medically appropriate.

4) 24-204 EQUITABLE ACCESS TO CARE FOR INDIVIDUALS WITH DISABILITIES

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 24-204 be Referred To The Board For Action As Amended.**

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

Your Reference Committee heard supportive testimony regarding the disparities faced by the disabled population and how those disparities adversely affect their health outcomes. Your Reference Committee heard supportive testimony regarding a language change to require the study be done by an applicable state agency.

An online comment was received for this resolution. The comment expressed support and offered a friendly amendment suggesting removing the Board of Directors as the acting party and instead citing "the MSV and appropriate partners."

Your Reference Committee discussed wanting to provide the Board with more clarifying direction for either report or action. Your Reference Committee considered the commitment and associated cost of staff time and incorporating appropriate stakeholders.

Accordingly, your Reference Committee recommends that Resolution 24-204 be Referred to the Board for Action as Amended.

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

5) 24-205 EXPANSION OF MEDICARE OPEN ENROLLMENT

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 24-205 be Adopted As Amended.**

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

Your Reference Committee heard supportive testimony regarding the negative impact of Medicare Advantage on patients.

Your Reference Committee received no opposing testimony.

Your Reference Committee discussed the shortened enrollment period and the impact on patient coverage, care, and supplemental payment options, and anecdotal evidence on the enrollment experience.

Accordingly, your Reference Committee recommends that Resolution 24-205 be Adopted As Amended:

RESOLVED, the MSV supports legislation and regulations that would ~~identify a transition back to Traditional Medicare and Medicare Supplement and away from Medicare Advantage.~~ allow for year-round open enrollment and guaranteed issue clauses for traditional Medigap plans.

6) 24-206 HEALTHCARE FOR PEOPLE WHO ARE INCARCERATED

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 24-206 be Adopted As Amended.**

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

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

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

Your Reference Committee heard supportive testimony for policies to address the lack of medical care received by incarcerated persons in Virginia. Your Reference Committee discussed whether medical students in Virginia are exposed to supervised clinical training. Your Reference Committee heard testimony in support of the efforts of the MSS on this Resolution.

Your Reference Committee discussed ongoing litigation against state correctional institutions. Your Reference Committee commended the work of the medical student section on identifying and addressing the issue, solution, and policy language. Your reference committee discussed an amendment offered during testimony and further discussed the relevance of maintaining the second Resolved Clause as submitted. Your Reference Committee discussed that cruel and unusual punishment includes, but is not limited to, the denial of healthcare, but narrowing the language would not capture the original intent of the Resolution. Your Reference Committee considered the constitutional implications of failing to provide required healthcare to incarcerated persons. Your Committee also discussed the didactic learning for students experiencing care management of incarcerated individuals.

Accordingly, your Reference Committee recommends that Resolution 24-206 be Adopted as Amended:

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

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

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

7) 24-207 STOP THE BLEED TRAINING IN MEDICAL SCHOOLS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that Resolution 24-207 **be Adopted**

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

Your Reference Committee heard supportive testimony regarding the necessity for medical students to participate in Stop the Bleed training that evidence suggests reduces the number of fatal hemorrhages in the event of trauma. Your Reference Committee heard testimony in support of a language change from mandating the training to supporting adoption at individual institutions with the support of the MSV. Your Reference Committee also discussed potential training equivalencies that currently exist in medical education.

Online comments were received for this resolution. One comment expressed support for adding high school curricula requirements to the resolution. Other comments opposed a mandate on medical schools citing that medical schools recognize the importance of disaster and emergency preparedness currently and without a mandate. Another comment suggested that the training should be “strongly encouraged” in medical schools.

Your Reference Committee discussed the current interest of the leadership of the institutions of medical education to incorporate Stop the Bleed into their curriculum, the nature of the trainings, and the learning outcome. Your Reference Committee discussed the potential need for additional review by the Board before adopting policy endorsing a mandate for training integrated into medical education before considering the testimony encouraging permissive language instead of mandatory direction.

Accordingly, your Reference Committee recommends that Resolution 24-207 be Adopted.

8) 24-208 PROFESSION OF MEDICINE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 24-208 be Not Adopted.**

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

Your Reference Committee heard no testimony in support of the resolution.

Your Reference Committee heard testimony in opposition to this resolution regarding potential issues providers may face if the practice of medicine is codified.

An online comment was received for this resolution. The comment expressed opposition for the resolution on the grounds that moving the practice of medicine to the Virginia Code would result in complete legislative control of the practice.

Your Reference Committee discussed the precedent for the resolution, the well-intentioned spirit, and its history in the MSV House of Delegates.

Accordingly, your Reference Committee recommends that Resolution 24-208 be Not Adopted.

9) 24-209 PROPOSAL FOR REMOVAL OF COPN LAWS IN VIRGINIA

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 30.4.04 Be Amended In Lieu Of Resolution 24-209.**

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

Your Reference Committee heard supportive testimony regarding evidence-based care and the dangers that COPN laws introduce to patients through the restriction of the free market system, as this results in increased costs for patients. Your reference committee heard comments regarding the current work of the State Health Services Plan Task Force and the necessity of its work in Virginia, with the understanding of the political difficulties surrounding COPN laws

Your reference committee heard testimony in opposition requesting reaffirmation of current MSV policy

Your Reference Committee discussed free market economic principles. Your Reference Committee considered testimony that supports COPN reform and charity care requirements. Your Committee discussed the history of the issue before the General Assembly and what MSV's current position would

be to different legislative scenarios without amending the policy. Your Committee discussed the practicality of other states COPN reform and repeal measures. Your Committee discussed the concerns and position of Virginia's hospital systems.

Accordingly, your Reference Committee recommends that Resolution 24-209 be Amend MSV Policy 30.4.04 In Lieu Of Adoption

30.4.04- MSV COPN Policy

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

10) 24-210 TRANSGENDER HORMONAL TREATMENT AND SURGERIES FOR MINORS

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 24-210 be Not Adopted.**

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

Your Reference Committee heard supportive testimony regarding MSV's commitment to safe, evidence-based care within a larger discussion of the evidence and citations brought before the committee. Your reference Committee heard supportive testimony regarding the current therapies and interventions that exist specific to youth experiencing gender dysphoria and protections against discrimination for patients seeking gender-affirming care. Your reference committee heard supportive testimony regarding a request to the staff or the Board of Directors to conduct further research on this topic with respect to the Hippocratic oath. Your Reference Committee also heard opposing testimony aligning concerns to do no harm, and that not offering gender-affirming care may result in that harm to patients.

Your Reference Committee heard concerns on the capacity of minors to give informed consent and the need for legal protections for persons under 18 years of age.

Your Reference Committee heard evidence on the standard of care that incorporates extensive consultations and evaluations with respect to the provider-patient relationship. Testimony was supportive of physicians being equipped to make necessary decisions agreed upon by physicians, their patients, and those families.

Your Reference Committee heard extensive comments regarding potential physiological and psychological risks, unintended consequences, and long-term effects and heard discussion on the claims of patients de-transitioning after undergoing gender affirming therapies.

Your Reference Committee discussed the role of the Medical Society as a professional association and how the policy as written conflicts with existing MSV policies 05.4.01, 25.1.04, 25.3.01, and 25.3.02. Your Reference Committee discussed the data presented before the Committee. Your Reference Committee

discussed the extensive testimony before the Committee and gave great consideration on the impact to the medical specialties incorporated in the discussion due to the nature of the policy.

Your Reference Committee discussed the potential actions that could be taken by the Committee at length. Your Reference Committee considered the potential involvement of the staff and the Board of Directors if Referred.

Your Reference Committee discussed how recommending Not to Adopt is neither a position of support or opposition, but rather a decision based on extensive discussion on the role of the Medical Society and the direct conflict with existing policies.

Accordingly, your Reference Committee recommends that Resolution 24-210 be Not Adopted.

11) 24-211 RESOLUTION TO SAVE RESOURCES IN THE PERIOPERATIVE ARENA

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **Resolution 24-211 be Adopted As Amended.**

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

Your Reference Committee heard supportive testimony regarding medical waste produced in hospitals, OSHs, and physician's offices, will save money and reduce waste

Your Reference Committee considered what non-surgical procedures would be excluded with the language as submitted. Your Committee discussed potential language amendments with consideration to the broader issue around medical waste.

Accordingly, your Reference Committee recommends that Resolution 24-211 be Adopted As Amended.

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

12) 24-212 RESOLUTION SUPPORTING INNOVATIVE MODELS OF PRIMARY CARE

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends **Reaffirmation Of Policy 10.3.08 In Lieu Of Resolution 24-212.**

RESOLVED, that the MSV supports the growth and development of innovative models of primary care delivery and payment with the potential to re-establish the direct relationship between patients and their

physician while providing affordable, accessible, quality care and maintaining physician autonomy, and be it further

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

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

Your Reference Committee heard supportive testimony regarding the innovative primary care practice models and the necessity of supporting innovation to fix the primary care issues faced by physicians.

Your Reference Committee heard no opposing testimony.

Your Reference Committee discussed the support and provisions of existing policy that captures the background presented in this Resolution.

Accordingly, your Reference Committee recommends that MSV Policy 10.3.08 be Reaffirmed In Lieu Of Adoption of Resolution 24-212.

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.

13) 24-213 HEALTHCARE PROTECTIONS FOR IN VITRO FERTILIZATION

RECOMMENDATION:

Madame Speaker, your Reference Committee recommends that **MSV Policy 25.1.04 Be Amended In Lieu Of Resolution 24-213.**

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

Your reference committee heard supportive testimony regarding IVF and its impact for those individuals facing infertility.

Your Reference Committee received no opposing testimony.

Your Reference Committee discussed broadening the language to other reproductive technologies in addition to IVF as written in the resolution.

Accordingly, your Reference Committee recommends Amending MSV Policy 25.1.04 In Lieu Of Adoption.

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 ~~include~~ 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.

Madame Speaker, Your Reference Committee Chair has certified this Report by signature as follows:

I, Dr. Bobbie Sperry, as Chair of Reference Committee #2, offer my signature to confirm that I have verified the attached draft of this report for accuracy of our Committee's discussion and proceedings.
October 18th, 2024.

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24-201

Access to Healthcare for People Experiencing Homelessness

Submitted by the Medical Society of Virginia Medical Student Section

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

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

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

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

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

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

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

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

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

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

Fiscal Impact: none
Existing Policy: none

Citations

1. *State of Homelessness: 2023 Edition*. (n.d.). National Alliance to End Homelessness. Retrieved July 29, 2024, from https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/
2. National Healthcare for the Homeless Council. *Homelessness & Health: What's the Connection?*, Feb. 2019, nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf.
3. Thomas Jefferson Health District. *Why Homelessness Affects Health*, Dec. 2020, www.vdh.virginia.gov/content/uploads/sites/91/2020/12/Homelessness-BW-Insert.pdf.
4. Health Care—National Coalition for the Homeless. (2022, December 28). *National Coalition for the Homeless - Building a Movement to End Homelessness*. https://nationalhomeless.org/health-care/
5. Baggett, T. P., O'Connell, J. J., Singer, D. E., & Rigotti, N. A. (2010). The Unmet Health Care Needs of Homeless Adults: A National Study. *American Journal of Public Health*, *100*(7), 1326–1333. https://doi.org/10.2105/AJPH.2009.180109
6. Fryling, L. R., Mazanec, P., & Rodriguez, R. M. (2015). Homeless Persons' Barriers to Acquiring Health Insurance through the Affordable Care Act. *The Journal of Emergency Medicine*, *49*(5), 755-762.e2. https://doi.org/10.1016/j.jemermed.2015.06.005
7. The Department of Housing and Community Development (DHCD). (n.d.). Virginia's Homeless Programs 2021-2022 Program Year. https://rga.lis.virginia.gov/Published/2022/RD636/PDF
8. *How many homeless people are in the US? What does the data miss?* (n.d.). USAFacts. Retrieved July 30, 2024, from https://usafacts.org/articles/how-many-homeless-people-are-in-the-us-what-does-the-data-miss/
9. *Virginia | Data USA*. (n.d.). Retrieved July 30, 2024, from https://datausa.io/profile/geo/virginia
10. AMA policies related to homelessness: H-160.978, H-160.903, H-345.975
11. Medical Society of Virginia. *2023 Annual Meeting - Delegates Handbook*, 28 July 2023, www.msv.org/wp-content/uploads/2023/09/2023-MSV-Delegate-Handbook.pdf.

24-210

Transgender Hormonal Treatment and Surgeries for Minors

Submitted by Kurt Elward, MD and Thomas Eppes, MD

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

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

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

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

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

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

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

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

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

References:

1 https://cass.independent-review.uk/nice-evidence-reviews/
2 https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf
3 https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical- programme/implementing-advice-from-the-cass-review/
4 https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-interim-service-specification-for-specialist-gender-dysphoria- services-for-children-and-young-people-22.pdf
5 https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/
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24-212

Resolution Supporting Innovative Models of Primary Care

Submitted by The Richmond Academy of Medicine

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

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

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

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

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

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

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

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

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

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

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

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5

2025 Nominating Committee Report

1. 2025 Nominating Committee Report

Nominating Committee Report

The Nominating Committee considered all eligible candidates for the upcoming term of office. The committee recommends the following slate for consideration by the society membership.

MSV BOARD OF DIRECTORS

Term 2025-2026/2027

OFFICERS (Elected for 1-year term)

President-Elect	Art Saavedra, MD
Speaker	Michele Nedelka, MD
Vice Speaker	Atul Marathe, MD

OFFICER (Elected for 3-year term)

Secretary-Treasurer	Steven Lewis, 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	Andreya Risser, MD
District 3	Joynita Nicholson, DO
District 7	Scott Just, MD
District 9	Stephen Combs, MD
Academic	*Nominee To Be Determined*

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 5	Jacqueline Fogarty, MD
Resident	Matthew Adsit, MD (VCU-Orthopedics)
Medical Student	Vignesh Senthilkumar (UVA)

2025-2026 VIRGINIA DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

Elected for a 2-year calendar year term

DELEGATES

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

2025-2026 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	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 One Index

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

25-101

Medical Society of Virginia Proposed 2026 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.

25-102

MSV 2025 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

10.1.04- Post-Delivery Care for Mothers and Newborns
Date: 11/4/1995

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

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

10.1.05- Secondary Insurance Pre-Certification and Reimbursement
Date: 11/4/1995

The Medical Society of Virginia supports legislation requiring secondary insurance to accept the utilization standards, preauthorization guidelines, and reimbursement fee schedule of the primary insurance company when they are acting as a secondary insurer. Their function should be to reimburse for

any coinsurance or deductible payments based on the primary insurance fee schedule and should require no separate preauthorization and have no utilization standards when acting as a secondary insurer.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

10.3.13- Point of Service Option

Date: 11/4/1995

The Medical Society of Virginia supports legislation requiring a point-of-service option for every health insurance policy.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

10.3.14- Medical Savings Accounts

Date: 11/4/1995

The Medical Society of Virginia endorses Medical Savings Accounts as a way to improve patient choice and access to health care.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

10.9.14- Pay for Performance

Date: 11/6/2005

The Medical Society of Virginia supports the AMA's "Principles and Guidelines for Pay-for-Performance Programs."

Reaffirmed as amended 10/25/2015

15.3.03- Availability of Insurance

Date: 11/4/1995

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

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

20.1.03- Opioid Prescribing Education
Date: 10/25/2015

The Medical Society of Virginia (MSV) continues to support efforts to have educational programs on opioid prescribing, the Prescription Monitoring Program (PMP) and on addiction available, easily accessible and affordable for prescribers.

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

Further, the licensing bodies should be mindful of current specialty training requirements that may already address the concern. In response to any such requirements, the MSV should strive to make the prescribed programming easily accessible and affordable for its members.

20.4.02- Teaching of Basics of Dispute Resolution
Date: 11/4/1995

The Medical Society of Virginia believes mediation and arbitration are sound alternatives to settling disputes as they are more efficient, fairer and less costly than litigation. Physicians should become knowledgeable about mediation and arbitration procedures and when feasible request they be used as the initial means of resolving tort claims or other health care conflicts. The Medical Society of Virginia advocates that the teaching of conflict resolution be included the medical school curriculum where appropriate, and supports legislation which would cause mediation and arbitration procedures to be the initial mechanism for handling such disputes.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

25.2.03- Disagreements Regarding Treatment of the Terminally Ill
Date: 11/4/1995

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

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

30.1.03- Responsible Party
Date: 11/4/1995

The Medical Society of Virginia believes the patient, his or her family (in the case of a minor), or legal guardian should be responsible for the cost of physician services.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

30.2.03- Medical License Linkage to Hospital ER Call
Date: 11/6/2005

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

Reaffirmed 10/25/2015

30.2.04- Interstate Licensure Compact in Virginia
Date: 10/25/2015

The Medical Society of Virginia supports the development and implementation of an Interstate Medical Compact in Virginia and supports the required legislative and regulatory efforts necessary to adopt the Interstate Licensure Compact in Virginia.

30.3.06- Prohibition of Nondisclosure Clauses
Date: 11/4/2001

The Medical Society of Virginia supports the prohibition of nondisclosure clauses in physician contracts.

Reaffirmed 10/25/2015

30.4.01- Assistance with New Practice Expenses
Date: 11/9/1991

The Medical Society of Virginia encourages the establishment of community credit sources or an endorsement authority for a physician's new practice expenses.

Reaffirmed 11/4/2001
Reaffirmed 10/25/2015

30.4.03- Physician Determination of Length of Stay
Date: 11/4/1995

The Medical Society of Virginia reaffirms that physician professional opinion should be the determining factor in establishing the need for continued hospitalization.

The Medical Society of Virginia opposes legislation giving anyone other than the attending physician the authority to determine length of stay.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

30.7.09- De-Identified Aggregate Patient Health Data

Date: 05/02/2015

The Medical Society of Virginia supports the use or development of tools which utilize de-identified aggregate patient health data to improve care methodologies and will advocate for appropriate protections that allow such use and analysis.

35.1.01- Urine Collection

Date: 11/4/1995

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

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.1.05- Rural Health Transportation

Date: 11/9/1991

The Medical Society of Virginia supports the Medical Transport System, particularly in underserved areas.

Reaffirmed 11/4/2001
Reaffirmed 10/25/2015

40.1.10- Community Adult Day Care

Date: 11/4/1995

The Medical Society of Virginia promotes the concept of adult day care on the local and statewide level as an integral part of a community's total health services.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.7.01- Screening/Follow-up

Date: 11/4/1995

The Medical Society of Virginia supports the Virginia Department of Health and other legitimate organization's efforts to control communicable disease and to screen for these diseases particularly in high incidence groups.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.10.01- Oppose Sale of Raw Milk in the Commonwealth

Date: 11/6/2005

The Medical Society of Virginia supports the requirement for the pasteurization of all milk and cheese products derived from both cows and goats in the Commonwealth of Virginia and opposes any legislation that would allow the direct sale of raw milk products to individual consumers.

Reaffirmed 10/25/2015

40.11.01- Indoor Tanning Regulation

Date: 11/4/1995

The Medical Society of Virginia supports efforts to educate the public about the health risks of indoor tanning and endorses legislation that would ban minors from utilizing tanning beds.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.15.04- Recertification of EMS Personnel

Date: 11/4/1995

The Medical Society of Virginia maintains it is the primary responsibility of the Operational Medical Director of an EMS agency to assure optimum availability and quality of care to every extent possible. The Medical Society of Virginia believes the Operational Medical Director must retain the ultimate authority in evaluating the cognitive and practice skills of EMS personnel practicing under his/her medical license.

The Medical Society of Virginia encourages development of a statewide standardized approach to evaluation of EMS personnel by their respective Operational Medical Directors.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.15.05- Trauma Research/Development of Systems
Date: 11/4/1995

The Medical Society of Virginia supports a proactive stance in both trauma research and the development of trauma systems across the State.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.15.07- Increase in Staffing of Medical Death Investigators
Date: 11/6/2005

The Medical Society of Virginia supports maintaining full staffing, as defined by the Chief Medical Examiner, of medical death investigators so that the Commonwealth of Virginia can provide a 24/7 death investigation system within the Office of the Chief Medical Examiner.

Reaffirmed 11/5/2006
Reaffirmed 10/25/2015

40.15.09- Striving for Adrenal Crisis Treatment by Virginia EMS Responders (SAVE)
Date: 11/6/2005

The Medical Society of Virginia supports increased education and training among EMS Medical Directors and state government stakeholders on the signs and symptoms of adrenal insufficiency. The MSV supports authorized EMS staff to administer a patient's provided hydrocortisone injection when appropriate medical information is available.

40.16.02- Maternity Care Program
Date: 11/4/1995

The Medical Society of Virginia supports the maternity care programs administered through regional local health departments as appropriate means of protecting women's and children's health.

The Medical Society of Virginia seeks support from state and national legislators to continue financial and staffing support of maternity care programs in regional and local health departments, and supports development of comprehensive maternity care and information programs, based on public and private health provider cooperation where programs are not in existence.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.20.02- High Blood Pressure Screening
Date: 11/4/1995

The Medical Society of Virginia believes in regular screening for high blood pressure.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

40.20.06- Sales/Smoking in Health Care Facilities
Date: 11/4/1995

The Medical Society of Virginia recommends that hospitals and health care facilities in the Commonwealth of Virginia prohibit the sale of tobacco products through gift shops, vending machines or other patient and visitor services, and that smoking in hospitals by employees, medical staff, patients, and visitors be prohibited and/or regulated in a manner consistent with the health care mission of the provider.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.21.03- Elderly Drivers
Date: 11/4/1995

The Medical Society of Virginia believes that drivers over seventy-five years of age should be required to renew their license every two years with an eye examination and road test. This renewal would also require a hearing examination and a physical examination.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

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

45.4.01- MSV Support of Resolving Nursing Shortage
Date: 11/6/2005

The Medical Society of Virginia recognizes and supports where possible the efforts of the various groups working to resolve the nursing shortage.

Reaffirmed 10/25/2015

45.6.01- Nursing Education

Date: 11/4/1995

The Medical Society of Virginia supports the nursing profession and its educational program, including the three-year schools.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

55.1.03- Requests from State Legislators

Date: 11/4/1995

Upon request, the Medical Society of Virginia (MSV) Government Affairs staff will provide any member of the Virginia General Assembly a list of physicians with mailing addresses in his or her legislative district. When the list is sent to the legislator, a clear message will be included stating that the list is intended for constituent communications only, not for political purposes. Because the list is provided as a service to legislators to increase constituent communication between legislators and physicians and not for political purposes, there is no in-kind value assigned to the list. Exceptions to the aforementioned policy will be considered and decided by the MSVPAC Chairman.

Reaffirmed 11/06/2005
Reaffirmed as substituted 10/25/2015

55.2.04- Financial Reports

Date: 11/4/1995

A full accounting/audit for fiscal year shall be available at each Annual Meeting. A report of year-to-date financial results, as well as the audit report accepted by the Board of Directors for the most recent completed fiscal year, can be made available to any Medical Society of Virginia member upon request.

Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

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

55.2.10- Use of the Term Physician
Date: 11/6/2005

The term "physician" shall be referred to as "physician (M.D. or D.O.)" when referencing membership criteria of the Medical Society of Virginia.

Reaffirmed 10/25/2015

Recommendation Reaffirm as Amended

05.5.03- House Staff Depression
Date: 10/25/2015

The Medical Society of Virginia supports the availability of appropriate mental health services for ~~medical students, residents, and physicians~~healthcare providers.

40.10.02- Eradicating Food Deserts and Food Insecurity
Date: 10/25/2015

The Medical Society of Virginia ~~(MSV)~~ supports efforts to reduce or eliminate food deserts and food insecurity in Virginia.

55.3.01- Procedures of the House of Delegates of MSV
Date: 11/4/1995

The Medical Society of Virginia (MSV) adopts the "Rules of Procedure~~s~~ of the House of Delegates" as the official source for the conduct of the MSV Annual Meeting.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

Recommendation to Archive

15.2.06- Malpractice Review Panels-Participation
Date: 11/4/1995

The Medical Society of Virginia supports a legislative initiative requiring that when a malpractice review panel is convened, participation by both plaintiff and defendant be required, and during the proceedings of a malpractice review panel, full disclosure of all known facts be required by plaintiff and defendant.

Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

40.15.01- Medical Examiner System
Date: 11/9/1991

The Medical Society of Virginia recognizes and commends the Medical Examiner system in the Commonwealth and will take active steps to promote physician participation in this worthy public service.

Reaffirmed 11/4/2001
Reaffirmed 10/25/2015

25-103

Amending MSV Bylaws to Provide Further Clarity on Membership Types, Voting Privileges, and Lifetime Membership

Submitted by the MSV Committee on Bylaws

WHEREAS, the MSV bylaws do not currently provide clear distinction between “associate” members and “affiliate” members, and

WHEREAS, the MSV bylaws do not currently make it clear that both resident as well as student members have voting privileges on the MSV Board of Directors, and

WHEREAS, the MSV bylaws require further clarification on how lifetime membership is determined for retired members, and

WHEREAS, the MSV bylaws to not provide clear direction to the MSV Nominating Committee on a nomination process in the event that a component society ceases to exist, therefore be it

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.

AMENDED AND RESTATED BYLAWS OF
THE MEDICAL SOCIETY OF VIRGINIA
EFFECTIVE OCTOBER 15, 2023

ARTICLE I
NAME AND PURPOSE

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

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

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

ARTICLE II
MEMBERSHIP, VOTING, FUNDS, DUES

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

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

Any active member shall have the right to vote, service on the Board of Directors, hold any office in the Society and serve on any committee. Each active or associate 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 associate out-of-state member of the Society for at least ten years and has become fully retired, in which event he/she shall be granted lifetime membership effective on January 1 of the year immediately following the year of application 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 must be a doctor of medicine or osteopathic medicine licensed to practice that profession and practicing or stationed in Virginia and must be (1) a medical officer of the armed forces; (2) a member of the Public Health Service; or (3) employed or engaged by the U.S. Department of Veterans Affairs or Virginia Department of Veterans Services.

Any public service active member shall have the right to vote, service on the Board of Directors, hold any office in the Society and serve on any committee. Each public service active member shall pay dues unless (i) he/she has been granted an exemption because of financial or physical disability, or (ii) he/she has been an active or associate out-of-state member of the Society for at least ten years and has become fully retired, in which event he/she shall be granted lifetime membership effective on January 1 of the year immediately following the year of application 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. Associate Out- of- State Members. An Associate Out- of- State member must shall be a person : (1) a non-resident of Virginia, 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 stateas a physician by the Virginia Board of Medicine.; (2) a medical officer of the armed forces; (3) a member of the Public Health Service; or (4) a doctor of medicine or osteopathy attached to a veterans' hospital. Associate Out- of- State members , other than honorary associate 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. Associate 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 Associate Members. Honorary active membership or honorary associate out of state membership may be granted by a majority vote of the House of Delegates at its annual meeting to no more than two (2) Virginia residents and one non-resident as an acknowledgement of long, faithful and distinguished service. Honorary active members shall not pay dues, but otherwise shall have the same rights as active members.

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

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

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

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

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

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

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

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

Section 12. Approval and Removal of Members. An applicant shall not be accepted as an active physician, affiliate or associate 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 11. Component Meetings. The component societies, component student societies and component resident physician sections shall cooperate with the officers of the Society to carry out the plans and objectives of the Society and to this end shall meet at least once each year. Once a year, each component society shall notify the Society in writing, by mail or electronically, of their active status and current officers, no later than May 1. The Society shall

support component society membership for its members and emphasize that an active component society membership results in a strong state society.

Section 12. Failure to Comply with Bylaws. If a component society, component student society, component resident physician section, or physician assistant section fails to comply with the provisions of these Bylaws, the Board of Directors shall request a report of the component regarding the organization in question. After considering such report, the Board of Directors then may make a recommendation concerning the status of the organization as a component society, component student society or component resident physician section as being active or inactive.

ARTICLE IV
ANY MEETINGS OF MEMBERS

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

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

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

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

ARTICLE V
HOUSE OF DELEGATES

Section 1. Composition. The House of Delegates shall be the policy making body of the Society. The House of Delegates shall consist of delegates elected by the component societies, component student societies, component resident physician sections, specialty sections, the hospital medical staff section, health systems, academic medical schools and the following ex-officio members: The President, President-Elect, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, Secretary-Treasurer, directors and associate directors, all Past Presidents of the Society, any general officer of the American Medical Association who also is a member of the Society, and the delegates and alternate delegates of the Society to the American Medical Association. Delegates elected by component societies, specialty sections, component student societies, component resident physician sections, the hospital medical staff section, health systems, and academic medical schools shall serve a one-year term. Ex-officio members of the House of Delegates, except for the Speaker, as provided in Article VII, Section

4, shall have full voting rights and will not be included in the delegate allotment for each component society. No voting by proxy shall be permitted in the House of Delegates. Each member of the House of Delegates also must be a member of the Society.

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

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

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

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

Section 3.3. Each specialty section listed in Appendix A shall annually elect delegates, who are also members of the Medical Society of Virginia, to membership in the House of Delegates. The apportionment of delegates from each specialty society shall be a minimum of one delegate and one alternate. If at least forty (40) percent of its members are members of the Society the specialty society shall be entitled to two delegates and two alternates; if at least sixty (60) percent of its members are members of the Society the specialty society shall be entitled to three delegates and three alternates. Prior to the annual meeting each specialty section shall submit the name(s) of its delegate(s) and alternate delegate(s) to the Speaker of the House of Delegates or his designee. In the event a delegate for a specialty section is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all privileges.

Section 3.4. If the full number of delegates accredited to a component society, component student society, component resident physician section, specialty section, the hospital medical staff section, health system or academic medical school are not present at a meeting of

the Society, those members present from such component society, component student society, component resident physician section, specialty section, the hospital medical staff section, health system or academic medical school may, from members of that society, section, system or school present, who are voting members of the Society, elect or appoint a sufficient number of delegates to complete its quota.

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

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

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

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

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

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

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

Section 7. Special Meetings. The Board of Directors may, by majority vote, call a special meeting of the House of Delegates when in its opinion such a meeting is necessary. The President shall call such meeting, upon petition of at least one-third (1/3) of the Delegates serving at the last regular meeting of the House of Delegates. Written notice stating the date, place and time of the meeting, and the purpose for which the meeting is called, shall be given not

less than ten (10) nor more than fifty (50) days before the date of the meeting, either personally or by mail, or at the direction of the President or Executive Vice President and Chief Executive Officer, to each member of the House of Delegates serving, or who was authorized to serve, at the last regular meeting of the House of Delegates. If any member is unable to serve, then another member shall be elected or appointed by the Board of Directors to serve. The transaction of business at any special meeting of the House of Delegates shall be limited to the purpose in the notice for the meeting.

ARTICLE VI
ELECTIONS

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

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

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

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

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

until the next annual meeting unless earlier removed in accordance with these Bylaws and applicable law.

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

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

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

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

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

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

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

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

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

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

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

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

at least one (1) year. Associate Directors shall be requested to attend all meetings. Any Associate Director may speak on behalf of the academic medical schools, but shall not vote in Board meetings.

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

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

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

ARTICLE VII
OFFICERS

Section 1. President.

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

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

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

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

Section 2. President-Elect.

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

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

Section 3. Executive Vice President and Chief Executive Officer.

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

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

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

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

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

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

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

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

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

Section 5. Secretary-Treasurer.

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

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

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

Section 6. Officer resignations and vacancies

Section 6.1 Each officer of the Society may resign at any time by giving written notice to the Executive Vice President and Chief Executive Officer, who will inform the President. The resignation will take effect on the date of the receipt of that notice or at a later date as specified

in the notice. Any resignation is without prejudice to the rights, if any, of the organization, as long as the resigning party continues to abide by the bylaws and pays dues.

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

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

ARTICLE VIII
BOARD OF DIRECTORS

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

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

ARTICLE X
INDEMNIFICATION

Section 1. Definitions.

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

"Expenses" includes reasonable counsel fees.

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

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

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

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

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

purpose believed to be in the interests of the participants and beneficiaries of the plan is conduct that satisfies the requirements of this section.

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

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

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

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

C. By special legal counsel in a written opinion:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE XI
COMMITTEES

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

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

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

ARTICLE XII
ETHICS

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

ARTICLE XIII
RULES OF ORDER

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

ARTICLE XIV
AMENDMENTS

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

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

APPENDIX A
Approved October 15, 2023
First District:
Mid-Tidewater Medical Society

Second District:
Tri-County Medical Society; Coastal Virginia Medical Society; Eastern Virginia Medical School Student Section

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

Fourth District:
Reserved

Fifth District:
Danville-Pittsylvania Academy of Medicine

Sixth District:
Lynchburg Academy of Medicine; 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

APPENDIX A (Continued)
Specialties:

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

ARTICLE II
MEMBERSHIP, VOTING, FUNDS, DUES

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

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

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

~~**Section 8.1.** No Right to Vote. Affiliate members shall have no right to vote in the House of Delegates or hold office but shall be entitled to all other privileges of membership including serving on committees or task forces~~.

Section 8.1~~2~~. Physician Assistants. Affiliate members who are physician assistants shall, as a condition of membership, hold an active license as a physician assistant from the Virginia Board of Medicine or, if such physician assistant is retired, hold an inactive license from the Virginia Board of Medicine.

Section 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).

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

Section 2. 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.

APPENDIX A (Continued)

Specialties:

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

25-104

Protecting Patients' Access to Safe and Effective Vaccines

Submitted by: Charles P. Schade, MD, MPH

WHEREAS, the Medical Society of Virginia has generally supported immunization of children and research into the safety and effectiveness of vaccines[1]; and

WHEREAS, vaccination against communicable diseases has saved lives and reduced health care costs in the United States[2]; and

WHEREAS, reducing vaccine coverage among individual susceptible to communicable disease could result in epidemics of illness, deaths, and increase health care costs[3]; and

WHEREAS, the U.S. Department of Health and Human Services (DHHS) has recently altered vaccination recommendations and licensing that narrow eligibility for these preventive treatments among children, pregnant women, and adults[4,5]; and

WHEREAS, the Department has not provided scientific justification for or opportunity for public comment on these changes; and

WHEREAS, these changes conflict with the recommendations and guidelines developed by national professional organizations using evidence-based methods[6]; and

WHEREAS, many physicians do not administer vaccines in their offices, but rely on non-physician providers such as pharmacies to immunize their patients; and

WHEREAS, the DHHS policy changes have caused some vaccine providers in Virginia to stop offering certain vaccines[7]; therefore be it

RESOLVED, that the Medical Society of Virginia endorses the use of vaccines to prevent communicable disease in appropriate population groups as recommended by national specialty societies including the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, the Infectious Diseases Society of America, and the American College of Physicians, and the American Academy of Family Physicians; 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.

Fiscal impact: None

Existing policy: None. Relevant policies 40.22.02, 40.22.04, 40.22.05 are cited in the resolution.

References

[1] Medical Society of Virginia Updated 2024-2025 Policy Compendium. Policies 40.22.02, 40.22.04, 40.22.05. Accessed at https://www.msv.org/advocacy/house-of-delegates/ on 9/2/2025.

[2] Zhou F, Jatlaoui TC, Leidner AJ, et al. Health and Economic Benefits of RoutineChildhood Immunizations in the Era of the Vaccines for Children Program — United States, 1994–2023. MMWR Morb Mortal Wkly Rep 2024;73:682–685. DOI: http://dx.doi.org/10.15585/mmwr.mm7331a2

[3] Kiang MV, Bubar KM, Maldonado Y, Hotez PJ, Lo NC. Modeling Reemergence of Vaccine-Eliminated Infectious Diseases Under Declining Vaccination in the US. JAMA. 2025;333(24):2176–2187. doi:10.1001/jama.2025.6495

[4] Gostin LO, Reiss D, Offit PA. Changed Recommendations for COVID-19 Vaccines for Children and Pregnant Women: A Failure of Process, Policy, and Science. JAMA. 2025;334(8):663–664. doi:10.1001/jama.2025.10658

[5] For example, see Prasad V. Center Director Decisional Memo. SPIKEVAX. Food and Drug Administration 7/9/2025 (BLA: 125752/276). Accessed at https://www.fda.gov/media/187542/download?attachment on 9/3/2025.

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25-105

Protect Immigrants From Discrimination

Submitted by Zain Ahmad, Bhoomi Shah, Cindy Li

WHEREAS, the Medical Society of Virginia's own policy, 05.4.01, also known as the Access without Discrimination supports 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; and

WHEREAS, the Commonwealth is home to nearly 1.2 million immigrants—including about 275,000 undocumented individuals—who comprise roughly 13% of the state's population and workforce; collectively, immigrant-led households contribute over $18 billion in federal, state, and local taxes annually, support entrepreneurship, STEM and service industries, and sustain economic growth statewide[1]; and

WHEREAS, immigrants in the Commonwealth face major insurance and institutional barriers—48% of undocumented children lack health coverage, compared to just 4.9% of all children statewide—which results in delayed treatment and an increased reliance on emergency services; recent federal policy provides Immigration and Customs Enforcement (ICE) access to Medicaid enrollment, further exacerbating this fear amongst immigrant families in seeking health care services[2] [3] [4] [5]; and

WHEREAS, in July 2025, the U.S. Department of Health and Human Services reinterpreted the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which excludes undocumented immigrants from "federal public benefits" like full Medicare and Medicaid coverage, to newly classify programs such as community health centers and Head Start as "federal public benefits," thereby expanding restrictions to bar undocumented immigrants from accessing these safety-net programs and further stripping care from vulnerable populations in Virginia[6] [7]; and

WHEREAS, the "One Big Beautiful Bill" (H.R. 1) reduces Medicaid spending by hundreds of billions, imposes work requirements, reduces federal funding matching rates from 90% to 80%, and penalizes states that provide health coverage to immigrants

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[1] https://thecommonwealthinstitute.org/tci_research/economic-fiscal-impacts-of-mass-deportation-whats-at-risk-in-virginia/

[2] https://thecommonwealthinstitute.org/wp-content/uploads/2023/01/Cover-All-Kids-One-Pager.pdf

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[4] https://apnews.com/article/immigration-medicaid-trump-ice-ab9c2267ce596089410387bfcb40eeb7

[5] https://www.houstonchronicle.com/health/article/ice-medicaid-immigrants-health-care-20782655.php

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regardless of status, which threaten critical safety-net programs and could strip coverage from as many as 630,000 Virginians, disproportionately affecting immigrant and undocumented communities[8] [9]; and

WHEREAS, in 2024, despite bipartisan support, Virginia's 2024 "Cover All Kids" legislation, which would have provided comprehensive state-funded health coverage to all income-eligible children regardless of immigration status, failed to pass the House, leaving an estimated 13,000 children without adequate care and perpetuating health disparities rooted in immigration status[10]; therefore be it

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.

Fiscal Impact: none

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

[8]https://virginiamercury.com/2025/05/23/bill-approved-by-u-s-house-proposes-billions-in-medicaid-cuts-what-happens-to-medicaid-in-virginia-if-it-becomes-law/

[9] https://www.nilc.org/resources/the-anti-immigrant-policies-in-trumps-final-big-beautiful-bill-explained/

[10]https://thecommonwealthinstitute.org/tci_blog/outdated-eligibility-rules-leave-13000-kids-without-health-coverage-options-in-virginia/

25-106

Resolution Condemning Forced Organ Harvesting in China

Submitted by: Joshua Li, M.D., Ph.D.. Vice Chair for Research, Director, Spine Fellowship, Mary M. Stamp Professor of Orthopedic Surgery, Professor of Biomedical Engineering, University of Virginia

WHEREAS, the medical discipline of organ transplantation, when conducted ethically, is one of the great achievements of modern medicine; and

WHEREAS, credible evidence has continued to accumulate that the People's Republic of China (PRC) engages in systematic, state-sanctioned, non-consensual organ harvesting from prisoners of conscience, including Falun Gong practitioners, Uyghurs, Tibetans, and House Christians; and

WHEREAS, the 2019 *China Tribunal*, an independent people's tribunal chaired by Sir Geoffrey Nice KC (chief prosecutor in the trial of Slobodan Milošević), unanimously concluded that forced organ harvesting has been committed for years throughout China "on a significant scale" and continues to this day; and

WHEREAS, the U.S. House of Representatives passed the Stop Forced Organ Harvesting Act (H.R. 1154) on March 27, 2023, by a bipartisan vote of 413–2, condemning the PRC's practice of organ harvesting and authorizing sanctions against perpetrators; and

WHEREAS, on May 6, 2025, the U.S. Congress passed the **Falun Gong Protection Act (H.R. 1540)** to provide for the imposition of sanctions with respect to forced organ harvesting within the People's Republic of China, and for other purposes; and

WHEREAS, the United Nations Special Rapporteurs in 2021 expressed alarm over credible reports that detainees from ethnic, linguistic, and religious minorities in China are being subjected to blood tests, organ scans, and medical examinations consistent with organ compatibility testing; and

WHEREAS, international medical and human rights organizations, including the World Medical Association, The Transplantation Society, Doctors Against Forced Organ Harvesting (DAFOH), and the American Society of Transplantation, have called for an end to China's unethical transplantation practices and for increased medical transparency; 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 the Medical Society of Virginia (MSV) condemns the practice of forced organ harvesting in China and elsewhere as an egregious violation of medical ethics and human rights; and be it further

RESOLVED, that the MSV delegation to the American Medical Association (AMA) submit a resolution urging the AMA to (1) adopt policy explicitly condemning forced organ harvesting in China, (2) support U.S. and international efforts to hold perpetrators accountable, including H.R. 1154 and H.R. 1540, and (3) discourage cooperation with Chinese transplant professionals and institutions until verifiable transparency and ethical standards are established; and be it further

RESOLVED, that MSV encourage Virginia physicians to educate patients on the ethical risks of seeking overseas transplants, particularly in China, and to support human rights–based medical practices globally.

Fiscal impact: None

Existing policy: None.

25-107

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

Submitted by: Bruce A. Silverman , M.D

WHEREAS, Virginia currently contracts with private Managed Care Organizations (MCOs) to administer most Medicaid benefits, paying capitation rates that include 13–15% in overhead costs diverted from direct patient care; and

WHEREAS, research and experience from other states demonstrate that MCOs create perverse incentives to delay or deny care, reduce transparency, and increase administrative burden on providers; and

WHEREAS, Connecticut eliminated MCO contracts in 2012 and successfully transitioned to a state-administered, managed fee-for-service model with care coordination, producing more than $4 billion in taxpayer savings, a 33% increase in physician participation, lower ER visits and hospitalizations, and improved cancer detection and survival rates; and

WHEREAS, Virginia's Medicaid program insures over 2 million residents, including children, Pregnant women, people with disabilities, and seniors, and its stability is essential to the Commonwealth's healthcare infrastructure; and

WHEREAS, transitioning to a managed fee-for-service model would preserve care coordination through state-supported primary care case management and community-based care teams, while avoiding costly MCO overhead. Therefore, be it

RESOLVED, that the Medical Society of Virginia supports legislation to transition Virginia Medicaid from Managed Care Organizations to a state-administered managed fee-for-service program; and be it further,

RESOLVED, that the Medical Society of Virginia urges the Virginia General Assembly to enact legislation ending MCO contracting, implementing direct state payments to providers, and establishing primary care–based care coordination, modeled after successful reforms in Connecticut; and be it further,

RESOLVED, that the Medical Society of Virginia shall advocate for this transition to reduce costs, improve transparency, strengthen physician participation, and enhance health outcomes for Medicaid beneficiaries in the Commonwealth.

Fiscal impact: None

Existing policy: None.

References:
https://pnhp.org/removing-the-middlemen-from-medicaid/
https://www.revisor.mn.gov/bills/text.php?number=SF1059&version=0&session=ls94&session_year=2025&session_number=0

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

Submitted by: Bruce A. Silverman, M.D

WHEREAS, every person in the Commonwealth of Virginia deserves access to high-quality health care; and

WHEREAS, in 2023 approximately 530,000 non-elderly Virginians (ages 0–64)—or 7.6% of that population—lacked health insurance (Virginia Health Care Foundation, 2025); among all Virginians, approximately 6.4% were uninsured in 2023 (Health Journalism, 2025); and

WHEREAS, coverage disparities persist across racial and income lines, with uninsured rates of 21.2% among Hispanic Virginians, 13.4% among American Indian/Alaska Native Virginians, 7.3% among Black Virginians, and 5.1% among White Virginians (Health Journalism, 2025); and

WHEREAS, medical debt remains a significant burden in Virginia, with more than one in four Virginians reporting past-due medical debt, a rate above the national average (Urban Institute, 2016); and

WHEREAS, the Virginia Department of Health, in its 2023 Annual Report to the Governor and General Assembly, documents persistent inequities in health care access and outcomes affecting rural, urban, minority, and economically disadvantaged populations; and

WHEREAS, the COVID-19 pandemic revealed and deepened these inequities, straining Virginia's health systems, increasing mental health needs, and causing many residents to lose employer-sponsored insurance; and

WHEREAS, the Medicare for All Act of 2025 has been introduced in the U.S. Senate by Senator Bernard Sanders (S. 1506) and in the U.S. House of Representatives by Representatives Pramila Jayapal and Debbie Dingell (H.R. 3421), which would guarantee comprehensive, universal coverage for all residents of the United States, including Virginians, eliminating premiums, copayments, deductibles, and out-of-pocket costs while covering services including mental health and long-term care; and

WHEREAS, the Medical Society of Virginia (MSV), representing over 11,000 physicians and allied health professionals, has long supported expanded access to health care and universal coverage principles, and hereby supports this resolution and encourages the General Assembly to adopt it; now, therefore, be it

RESOLVED, by the House of Delegates of the Medical Society of Virginia:
1. That the General Assembly of Virginia endorses the enactment of comprehensive, universal health care coverage for all residents of the United States and specifically supports the Medicare for All Act of 2025 (H.R. 3421 & S. 1506).
2. That the General Assembly respectfully calls upon the United States Congress to adopt

this legislation and ensure that Virginians, along with all Americans, have access to guaranteed, comprehensive, and affordable health care.

3. That the General Assembly acknowledges and thanks the Medical Society of Virginia for its support of this resolution and its ongoing advocacy for universal health care access.

4. That the Clerk of the House of Delegates transmit copies of this resolution to the President of the United States, the Speaker of the U.S. House of Representatives, the Majority Leader of the U.S. Senate, and the members of Virginia's Congressional delegation, so that they may be apprised of the sense of the General Assembly of Virginia in this matter.

Fiscal Impact: None

Current Policy: None

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https://www.msv.org/wp-content/uploads/2023/10/RC-1-Report-2023_FINAL.pdf?utm
https://www.congress.gov/bill/119th-congress/senate-bill/1506
https://www.congress.gov/bill/118th-congress/house-bill/3421

25-109

Regulating Private Equity in the Healthcare Market

Submitted by Russell Hawes

WHEREAS, private equity refers to an investment strategy whereby investors purchase an entity with the intent to resell it for a profit in the near term (three to seven years)[1], and

WHEREAS, private equity ownership of physician practices has increased from 800 to 6,000 practices since 2012[2], a more than six-fold increase, and

WHEREAS, in 2021, 22% of nonprofit hospitals in the United States were owned by private equity[2], and

WHEREAS, Medicare beneficiaries saw a 25.4% increase in hospital acquired conditions, including falls and central line infections, at private equity owned hospitals compared to control hospitals[3], and

WHEREAS, facilities and practices owned by private equity are often forced to reduce costs by laying off staff[4] and relying on non-physician providers[5] to increase profitability upon sale, and

WHEREAS, private equity owners often force facilities to sell the land they stand on to real estate investment trusts (REITs) and pay rent to increase sale profits[6], and

WHEREAS Steward Health Care System was forced to declare bankruptcy due to demands for rent claimed by Medical Properties Trust, the REIT that 30 of its 31 hospitals had been sold to[7], and

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[2] The Dose, May 2, 2025 (Podcast). https://www.commonwealthfund.org/publications/podcast/2025/may/how-private-equity-deals-are-reshaping-your-health-care

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[7] Carlisle C (August 24, 2024) REIT Tells Steward Health to Pay Rent or Leave , Sparking Debate on Hospital Property Use. *CoStar* News. https://www.costar.com/article/1152042077/reit-tells-steward-health-to-pay-rent-or-leave-sparking-debate-on-hospital-property-use

WHEREAS, Hahneman University Hospital in Philadelphia filed for bankruptcy and closed after acquisition by private equity firm American Academic Health System, leading to the loss of 550 active residency positions which left current residents without a place to complete their training[8], and

WHEREAS, in 2024, the state of Massachusetts passed a law addressing the transparency, financial transactions, and investor liability of healthcare acquisitions by private equity[9],

WHEREAS, Virginia Code 12VAC5-220-120 already provides a framework for the oversight of acquisitions in the healthcare space valued at greater than $600,000[10], but does not currently have a framework or guidelines regarding the business practices common to private equity acquisition and sale, therefore be it

RESOLVED, that the Medical Society of Virginia support legislation to regulate the acquisition of physician practices, hospitals, and other healthcare facilities by private equity entities, including increased transaction transparency and investor liability, and

RESOLVED that the Medical Society of Virginia support legislation to restrict the sale of healthcare facilities to real estate investment trusts or other entities that directly threaten the financial solvency and accessibility of those healthcare institutions.

Fiscal Impact: none

Existing Policy: none

[8] https://www.acgme.org/newsroom/2019/7/hahnemann-university-hospital-closure/
[9] https://malegislature.gov/Bills/193/H5159
[10] https://law.lis.virginia.gov/admincode/title12/agency5/chapter220/section120/

25-110

A Resolution on Self Defense for Domestic Violence Victims

Submitted by Arthur J Vayer, Jr., MD

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, many victims of domestic violence are granted Domestic Violence Restraining Orders against their abusers, and

WHEREAS, the incidence of restraining order violation is significant, often resulting in further and escalating domestic violence, and

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

RESOLVED, that the Medical Society of Virginia supports supplying victims of domestic violence, who are granted domestic violence restraining orders, weapons and training for self-defense. The type of weapons or self defense will, of course, be subject to the victim's preferences and comfort level.

Fiscal Impact: Staff salaries for lobbying when legislation is filed.
Existing Policy: Domestic Violence
40.9.02- Support for Firearm Laws Promoting Increased Public Safety
Date: 11/2/2012 The Medical Society of Virginia opposes repeal of existing state or federal laws and regulations that promote safety and responsibility in the purchase, possession or use of firearms and ammunition. The Medical Society of Virginia supports future laws and regulations relating to firearms which would promote trauma control and increased public safety, including:
1. Creating an Extreme Risk Protection Order allowing law enforcement or the courts to temporarily separate firearms from a person who exhibits dangerous behavior that presents an immediate threat to themselves or others.
2. Requiring that any lost or stolen firearm be reported to law enforcement upon discovery.
3. Limiting the number of handguns to be purchased by any person in a 30-day period.
Reaffirmed 10/26/2014, 10/22/2017, Adopted as amended 10/20/2019.

40.9.05- Gun Violence Restraining Orders
Date: 10/22/2017 The Medical Society of Virginia supports gun violence restraining orders as a mechanism to decrease gun related suicides and homicides.

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.

40.23.02- Physicians' Role in Violence Prevention
Date: 11/8/1997 The Medical Society of Virginia recognizes violence as a medical problem that should be of active concern to physicians. The Medical Society of Virginia will promote physician education regarding the epidemiology, recognition, and

prevention of violence and actively explore other ways to educate patients, the public, and payers. Reaffirmed 10/28/2007, 10/26/2014, 10/20/2024.

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

25-111

Prioritizing Child Safety in Custody Decisions

Submitted by The Medical Student Section

WHEREAS, *Parental Alienation* (PA) stems from the discredited theory of *Parental Alienation Syndrome* (PAS) introduced by psychiatrist Dr. Richard Gardner, which wrongly attributes a child's fear or rejection of a parent to deliberate manipulation by the other parent[i,ii,iii]; and

WHEREAS, despite lacking a solid scientific foundation, PA is often misused in custody litigation, including in Virginia, to undermine credible allegations of domestic violence and child abuse, leading to custody decisions that place children at serious psychological risk of developing anxiety, depression, PTSD, and suicidality[iv,v,vi,22]; and

WHEREAS, court-ordered reunification treatments and camps based on PAS forcibly isolate children from their preferred parent, silence disclosures of abuse, and compel affection for the alienated parent–often an alleged abuser–despite lacking empirical evidence and raising significant ethical concerns[5,vii,viii,ix]; and

WHEREAS, major medical and legal institutions–including the United Nations Human Rights Council, the American Psychiatric Association, the American Psychological Association, the World Health Organization, and the DSM-5–reject PAS as a valid diagnosis, and the National Council of Juvenile and Family Court Judges advises courts against admitting PAS testimony[3,x,xi,xii,xiii]; and

WHEREAS, the Child Welfare League of America (CWLA) published 2022 data that 72% of perpetrators of child maltreatment in Virginia are the parents of the child[xiv]; and

WHEREAS, in response to these harms, multiple states–including Arizona, California, Colorado, Pennsylvania, and Utah–have passed laws restricting or banning reunification programs, in alignment with the federal *Keeping Children Safe From Family Violence Act* ("Kayden's Law"), which incentivizes states to enact legislation that protects children from harmful custody proceedings such as reunification programs[xv,xvi,xvii,xviii,xix,xx,xxi], therefore be it

RESOLVED, that MSV support legislative efforts to strengthen 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.

Fiscal Impact: none

Existing Policy:
MSV Policy: 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
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25-112

Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness

Submitted by Joshua Lesko, MD

WHEREAS, the Medical Society of Virginia (MSV) supports the development and implementation of protocols to ensure patient safety during emergencies, as outlined in 40.15.08, and

WHEREAS, the American Medical Association (AMA) encourages hospitals to incorporate disaster plans that address barriers to staff responses during disasters, as stated in H-225.941, and

WHEREAS, critical medical treatments such as dialysis, chronic oxygen therapy, chemotherapy, and radiation therapy are essential for patient survival and require coordinated planning during emergencies, and

WHEREAS, interdisciplinary models of cooperative planning involving city/regional authorities, hospitals, physicians, medical equipment providers, and transportation companies can enhance disaster preparedness and response, therefore be it

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.

Fiscal Impact: $0
Existing Policy: None

25-113

Adopting the Definition of Anti-Palestinian Racism and Recognizing its Impact on Mental and Physical Health

Submitted by Omar Jaber, MD, MPH, FAAP

WHEREAS, the Medical Society of Virginia believes that all persons in Virginia should have access to medical services without discrimination based on race, religion, age, social status, income, sexual orientation or gender identity or expression. The Medical Society of Virginia will support policies and strategic interventions that decrease health disparities in medicine (05.4.01 MSV Policy Compendium), and

WHEREAS, anti-Palestinian racism, anti-Muslim hate (Islamophobia), anti-Arab racism are prevalent issues that impact individuals, communities, and healthcare systems, and

WHEREAS, a reading of the current literature and policy statements does not contain a reference to the issue of anti-Palestinian racism, anti-Arab racism, or anti-Muslim hate (Islamophobia), and

WHEREAS, there is limited to no research on the mental health and physical health impacts of anti-Arab racism, anti-Muslim hate (Islamophobia), and anti-Palestinian racism on children, therefore be it

RESOLVED, that the Society add the issue of opposing anti-Arab racism, anti-Muslim hate (Islamophobia), and anti-Palestinian racism in all its forms in all our medical organizations and educational institutions, and that additional resources be provided to make this a priority in this current environment, and be it further

RESOLVED, that the Society actively promote and support research on the impact of anti-Palestinian racism, anti-Arab racism, anti-Muslim hate (Islamophobia), and on health outcomes and healthcare disparities.

Fiscal Impact: $0
Existing Policy: None

25-114

Achieving Parity in Reimbursement for Emergency Department On-Call Coverage by Specialty Physicians/Practices

Submitted by Lee Ouyang, MD

WHEREAS, Hospital emergency departments maintain on-call specialty physician coverage in order to take the best possible care of patients, and

WHEREAS, Specialty physicians/practices with hospital privileges are expected/encouraged to provide on-call coverage for emergency department patients who are their existing patients, and

WHEREAS, Patients who are "unassigned," or "service," patients who are not patients of a physician or practice that holds privileges at a hospital should be able to obtain specialty consultation/care at the same level as a physician/practice's existing patients, and

WHEREAS, Reimbursement/payment for practices/physicians who provide emergency department on-call specialty coverage for unassigned patients may vary widely between specialties within a hospital, and

WHEREAS, Some specialties receive no reimbursement for this on-call coverage. Therefore be it

RESOLVED, The Medical Society of Virginia supports parity in reimbursement for physicians and/or practices who provide on-call specialist coverage for emergency departments, especially for unassigned/service patients, and be it further

RESOLVED, The Medical Society of Virginia opposes any linkage of a physician's hospital privileges to the physician and/or practice providing hospital emergency department on-call coverage.

Fiscal Impact: none

Existing Policy:

30.2.03- Medical License Linkage to Hospital ER Call

Date: 11/6/2005, Reaffirmed 10/25/2015

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

40.1.13- Emergency Department On-Call Physicians

Date: 10/25/2009, Reaffirmed 10/20/2019

The Medical Society of Virginia supports and encourages health care organizations and governmental agencies to assure adequate emergency department on-call specialist access.

40.1.14- Support for Project Access Programs

Date: 10/25/2009, Reaffirmed 10/20/2019

The Medical Society of Virginia affirms the value of physician-directed Project Access programs and equivalent initiatives around the Commonwealth that provide pro bono health care services to underinsured and uninsured individuals. The Medical Society of Virginia encourages entities to provide financial resources in the form of grants or other support to such initiatives.

40.19.02- Protocols to Reduce Patient Morbidity and Mortality in Hospital Emergency Departments

Date: 10/25/2009, Reaffirmed 10/20/2019

The Medical Society of Virginia supports and encourages hospitals and physicians to develop and implement protocols which ensure patient safety while addressing overcrowding and boarding in the emergency department.

References:

https://policysearch.ama-assn.org/policyfinder/detail/%22on%20call%22?uri=%2FAMADoc%2FHOD.xml-0-248.xml

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25-115

Resolution to Amend MSV Policy 40.22.01 – State Funding for Childhood Vaccines

Submitted by: Dr. Barbara Boardman

WHEREAS, the Medical Society of Virginia supports the Virginia Department of Health in seeking funding to support to purchase vaccines to be administered in physicians offices to all children; and

WHEREAS, there has been a recent divergence of vaccine recommendations of the American Academy of Pediatrics and the Current CDC recommendations. Therefore be it

RESOLVED, that MSV Policy 40.22.01 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."

Fiscal impact: None

Existing policy: MSV Policy 40.22.01 – State Funding for Childhood Vaccines

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https://publications.aap.org/aapnews/news/32835/AAP-releases-evidence-based-immunization-schedule?autologincheck=redirected

Reference Committee Two Index

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

25-201

Ensuring Transparency and Appropriate Disclosures to Limit Patient Harm from Physician and Institutional Conscience Clauses

Submitted by the Richmond Academy of Medicine

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

WHEREAS, declining to provide medical care, regardless of the circumstances, one must be cognizant of the potential harmful implications on the consequential limitations of patient access to health care[1], and

WHEREAS, without disclosure, there is no layer of accountability to protect patients from potential harm from 'conscientious' objections that lead to delays or prevent access to care[1], and

WHEREAS, 'conscientious' objections, without safe regulation, can lead to patient discrimination[2], and

WHEREAS, one in six U.S. hospital beds is in a facility that complies with religious directives that prohibit a range of reproductive health care services, even when a woman's life or health is in jeopardy[3], and

WHEREAS, such conscientious objections have been used to restrict access to routine evidence-based care such as sterilization procedures, contraception, addiction services, access to HIV/AIDS treatments, and other common health services[1-3] [https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine] and, therefore be it

RESOLVED, that the Medical Society of Virginia supports requirements that obligate physicians and institutions disclose to the patient requesting services, refusal or limitations on care based on 'conscience' such that patients can make informed decisions about their health care, and be it further

RESOLVED, that the Medical Society of Virginia supports the duty of physicians to refer a patient to another clinician or institution in a timely manner to provide treatment that the physician has declined to offer.

Fiscal Impact: $0
Existing Policy: None

[1]AMA J Ethics. 2020;22(3):E209-216. doi: 10.1001/amajethics.2020.209.

[2] "Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS." National Women's Law Center, 21 05 2014, https://nwlc.org/resource/health-care-refusals-harm-patients-threat-lgbt-people-and-individuals-living-hivaids/ https://nwlc.org/resource/health-care

[3] "Health Care Denied | American Civil Liberties Union." ACLU, https://www.aclu.org/health-care-denied. Accessed 15 August 2025.

25-202

Fairness in Funding for the Virginia Birth-Related Neurological Injury Compensation Program

Submitted by the Richmond Academy of Medicine

WHEREAS, the Code of Virginia, Chapter 50, SS 38.2-5000 through 38.2-5021 provides for the mandatory monetary assessment of all non-participating providers actively practicing in Virginia, and

WHEREAS, the relevant statutory program was established in 1987 to relieve a crisis in obstetricians obtaining malpractice insurance coverage, and

WHEREAS, insurance and delivery practices have changed substantially since 1987, potentially rendering the "crisis" obsolete, and

WHEREAS, other models of disability insurance are now available for birth-injury victims requiring lifetime assistance, and

WHEREAS, the provisions of the Virginia Code is discriminatory against non-participating physician providers, by excluding nurse practitioners, physician assistants, litigation attorneys and other non-culpable professionals, and

WHEREAS, the Virginia Code is widely considered to be overdue for amendment or replacement entirely, therefore be it

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.

Fiscal Impact: $0
Existing Policy: None
Additional Materials: Virginia's Birth Injury Fund promised lifelong care. Families say it's delivering delays and denials.

25-203

Guidance for Healthcare Facilities Regarding Immigrant Detention

Submitted by the Richmond Academy of Medicine

WHEREAS, an executive order rescinded the prohibition of immigration enforcement actions at or near schools, hospitals, and houses of worship in January 2025, and

WHEREAS, organizations have offered guidance to hospitals regarding how to protect patients from immigration enforcement, and

WHEREAS, some states have enacted legislation which require healthcare facilities to ask the immigration status of patients, and

WHEREAS, 66% of noncitizens reported increased hesitation in seeking care after Florida Gov. Ron DeSantis signed a law in 2023 requiring hospitals that accept Medicaid to ask about a patient's legal status, and

WHEREAS, other healthcare organizations such as the American Academy of Pediatrics have cited the negative ramifications of family separation and detention on child health, including exposure to toxic stress that can disrupt children's brain architecture and affect their short- and long-term health[1], therefore be it

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

Fiscal Impact: $0
Existing Policy: None

[1] Pediatrics (2017) 139 (5): e20170483.

25-204

Guidance for Physician Education Regarding Immigrant Detention

Submitted by the Richmond Academy of Medicine

WHEREAS, an executive order rescinded the prohibition of immigration enforcement actions at or near schools, hospitals, and houses of worship in January 2025, and

WHEREAS, organizations have offered guidance to hospitals regarding how to protect patients from immigration enforcement, and

WHEREAS, some states have enacted legislation which require healthcare facilities to ask the immigration status of patients, and

WHEREAS, 66% of noncitizens reported increased hesitation in seeking care after Florida Gov. Ron DeSantis signed a law in 2023 requiring hospitals that accept Medicaid to ask about a patient's legal status, and

WHEREAS, other healthcare organizations such as the American Academy of Pediatrics have cited the negative ramifications of family separation and detention on child health, including exposure to toxic stress that can disrupt children's brain architecture and affect their short- and long-term health[1], therefore be it

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.

Fiscal Impact: $0
Existing Policy: None

[1] Pediatrics (2017) 139 (5): e20170483.

25-205

Resolution Opposing Legislative Efforts to Restrict the Provision of Reproductive Health Services

Submitted by the Richmond Academy of Medicine

WHEREAS, 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, and

POLICY NUMBER 25.1.04
Amended by Substitution 10/30/2022
Reaffirmed as Amended 10/20/2024

WHEREAS, Misoprostol is a medication used in both miscarriage and abortion care as well as to treat life threatening obstetric hemorrhage, and

WHEREAS, because of its stability at room temperature and its efficacy in treating obstetric hemorrhage, it is routinely kept in hemorrhage kits on labor and delivery so that it is easily accessible and often is the first medication given during a hemorrhage, and

WHEREAS, several states have pursued or are pursuing legislation to change the drug classification of misoprostol to a schedule IV medication which would require it be kept locked in a PYXIS, and

WHEREAS, this new classification prevents misoprostol from being stored in readily available hemorrhage kits and makes possession without a prescription a felony charge, and

WHEREAS, the classification of medication as schedule IV implies that they are dangerous and have risk of misuse, dependance and addiction, putting them in the same category as benzodiazepines and some opioid medications, and

WHEREAS, the safety of misoprostol has been well established for decades for the use of miscarriage, abortion and obstetric hemorrhage, therefore be it

RESOLVED, that 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 and the management of pregnancy loss, obstetric hemorrhage, and other obstetric emergencies, and further be it

RESOLVED, that 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.

Fiscal Impact: $0
Existing Policy: None

25-206

Resolution to Support the Patient's Right to Save Act

Submitted by the Richmond Academy of Medicine

WHEREAS, healthcare prices in the United States are rapidly increasing, outpacing general inflation and creating a significant financial burden for individuals and families (Archambault J et al. 2022), and

WHEREAS, the current healthcare market lacks the fundamental features of a functioning market, including patient choice, price transparency, and aligned incentives (Archambault J et al. 2022), and

WHEREAS, patients are often disconnected from the true cost of their care due to subsidized health insurance, employer-driven plan selection, and insurance designs that obscure price differences (Archambault J et al. 2022), and

WHEREAS, this lack of transparency and misaligned incentives contribute to increased healthcare spending, without a corresponding improvement in quality (Archambault J et al. 2022), and

WHEREAS, the "Patient's Right to Save Act" offers a solution to address these challenges by promoting price transparency and aligning the incentives of patients, providers, and insurers (Archambault J et al. 2022), and

WHEREAS, these principles are consistent with the MSV's "Guidelines for Health Care System Reform" (MSV Compendium 10.3.17), and

WHEREAS, the "Patient's Right to Save Act" has already been passed into law in Arizona, Indiana, Maine, Oregon, Tennessee, and Texas, therefore be it

RESOLVED, that the Medical Society of Virginia advocate for the enactment of legislation in Virginia similar to the Patient's Right to Save Act which includes the following components:

- Letting patients ask providers to disclose their cash prices for 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 (The Patient's Right to Save Act, Model Bill. Cicero Institute,)

to empower patients, lower healthcare costs, and improve the functioning of the healthcare market.

Fiscal Impact: $0
Existing Policy: None
References:

1. Archambault J, Wolfson J, Aliff T. Patient's Right to Save: The Next Generation of Price Transparency. Cicero Institute. October 2022. https://ciceroinstitute.org/wp-content/uploads/2022/10/Right-to-Save-Whitepaper-Oct2022-1.pdf
2. The Patient's Right to Save Act, Model Bill. Cicero Institute, retrieved 5/19/2025. https://ciceroinstitute.org/wp-content/uploads/2023/02/Model-Language-Patients-Right-to Save.pdf

25-207

Exploration of Social Prescribing Programs

Submitted by The Medical Student Section

WHEREAS, the World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,"[1] and a 2023 commentary in the *AMA Journal of Ethics* defines social prescription as "a systematic approach to addressing patients' social needs by referring them to or implementing community-based interventions and facilitating social connection based on individual need,"[2] and

WHEREAS, examples of social prescribing include green space exposure reducing the risk of developing type 2 diabetes[3], dance classes for older adults in nursing homes leading to improved depressive symptoms[4], and art therapy for patients with coronary artery disease lessening depression, anxiety, and anger[5], and

WHEREAS, a WHO scoping review identifies specific policy considerations, including strengthening collaboration between culture, social care, and health sectors, as well as "considering the introduction, or strengthening, of lines of referral from health and social care to arts programmes,"[6] and

WHEREAS, as of 2024, the UK and the Netherlands have implemented social prescribing frameworks into their national health coverage[7], which have been found to have significant benefits for social and psychological well-being[3, 4, 5, 8-29], and there are several social prescribing initiatives underway in Virginia, including at the Benjamin Goldberg Foundation and the College of William and Mary[30-31], and

WHEREAS, CultureRx, a 2020 pilot social prescribing program in Massachusetts, reported initial findings of increased satisfaction and positive experiences from community partners, patients, and physicians with minimal risk[32], and this program helped inform Massachusetts General Brigham's partnership with Art Pharmacy to pilot social prescribing in their community[33], and

WHEREAS, a summary of evidence by the National Academy for Social Prescribing in the UK and an analysis by the Canadian Institute for Social Prescribing on the economic impact of social prescribing found consistent positive social return on investment and some studies with significant reduction of healthcare usage[34, 35], including one that found a 40% reduction in visits to the GP, and

WHEREAS, there are toolkits and field guides that outline how to create effective social prescribing frameworks, including the position of "link workers" to connect patients to social programs after appropriate referral, lessening the burden on physicians[36, 37], and

WHEREAS, there is a need for further evidence on social prescribing methods and appropriate outcome measures, especially because a majority of social prescribing programs and studies have been conducted in the United Kingdom[38, 39], and student movements have globally been instrumental in initiating and promoting social prescribing schemes[40, 41], therefore be it

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.

Fiscal Impact: none

Existing Policy: none

Appendix

1. Constitution of the world health organization. World Health Organization. 1948. https://www.who.int/ about/governance/constitution
2. "What Are 'Social Prescriptions' and How Should They Be Integrated Into Care Plans?" AMA Journal of Ethics 25, no. 11 (November 1, 2023): E795-801. https://doi.org/10.1001/amajethics.2023.795.
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4. "The Effect of Dance on Depressive Symptoms in Nursing Home Residents - ClinicalKey." Accessed July 10, 2025. https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S152586101400231X?returnurl=null&referrer=null.
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25-208

Protecting Mental Health Treatment Privacy in Legal Proceedings

Submitted by Joshua Lesko, MD

WHEREAS, the SafeHaven program provides a confidential resource for healthcare professionals to seek mental health treatment without fear of professional repercussions, and

WHEREAS, the confidentiality of mental health treatment is essential to encourage healthcare professionals to seek necessary care, and

WHEREAS, the discoverability of mental health treatment records in civil and criminal trials may deter individuals from seeking treatment due to concerns about privacy and legal exposure, and

Whereas, the Medical Society of Virginia supports the adoption of programs like SafeHaven to address issues related to career fatigue and wellness in healthcare professionals and students, as outlined in 23-202, therefore be it

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.

Fiscal Impact: $0
Existing Policy: None

25-209

Reducing DPC Patient Burden

Submitted by the Richmond Academy of Medicine

WHEREAS, Direct Primary Care (DPC) is a direct agreement between a patient, the patient's legal representative, or the patient's employer and a health care provider for ongoing primary care services in exchange for the payment of a monthly periodic fee, enabling access to a broad range of primary care services without the need for fee-for-service billing (Code of Virginia 2017), and

WHEREAS, DPC is not health insurance or a health maintenance organization (Code of Virginia 2017), and

WHEREAS, DPC practices have been shown to reduce unnecessary specialist referrals, emergency room visits, and hospitalizations, thereby lowering overall healthcare expenses (Busch et al., 2020), and

WHEREAS, Health Maintenance Organization (HMO) plans, one of the most prevalent and affordable plan types offered on the Virginia insurance marketplace, typically require patients to select an in-network primary care provider in order to access specialist referrals, diagnostic services, and procedures, thereby excluding DPC physicians and limiting patient access to coordinated care, and

WHEREAS, while the Medical Society of Virginia appropriately opposes mechanisms that interfere with the timely delivery of medically necessary care, the current policy does not explicitly recognize and address the unique regulatory and operational barriers faced by patients and physicians in DPC practices, particularly the redundant requirement to establish in-network primary care relationships solely for referrals (MSV Policy Compendium 10.10.04), and

WHEREAS, the American Medical Association (AMA) has expressed support for DPC by opposing payer policies that restrict patients in DPC practices from accessing in-network specialty care, affirming the importance of integrating DPC into the broader healthcare system without penalizing patients for choosing a direct care model (AMA Policy Compendium H-385.912), and

WHEREAS, a separate resolution is necessary to recognize and address the unique regulatory and operational barriers faced by patients and physicians in DPC practices, particularly the redundant requirement to establish in-network primary care relationships solely for referrals, an issue not covered under general policy on medical necessity or real-time benefit access, and

WHEREAS, the State of Maine has established a legislative precedent through a law effective January 1, 2018, which prohibits health insurance carriers from denying coverage for referrals solely because they originate from a DPC provider outside the plan’s

network, thereby affirming that patients should not be penalized for choosing DPC and enabling seamless access to covered services without higher out-of-pocket costs (Maine Code Title 24-A M.R.S. §4303(22)), therefore be it

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.

Fiscal Impact: $0
Existing Policy: None
References:

1. Direct Primary Care Arrangements, Code of Virginia § 54.1-2997 (2017). https://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2997/
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5. American Medical Association. (2019). *Policy H-385.912 – Direct Primary Care*.
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25-210

Resolution in Support for Routine Tardive Dyskinesia Screening in Alignment with APA Clinical Guidance

Submitted by: Dr. Kent McDaniel, MD, PhD, ABPN

WHEREAS, the American Psychiatric Association (APA) recommends routine screening for tardive dyskinesia (TD) in all patients treated with antipsychotic medications, given the risk of persistent, potentially disabling involuntary movements; and

WHEREAS,, the risk of TD is highest among certain vulnerable populations including older adults and individuals with serious mental illness, intellectual and developmental disabilities, central nervous system injury, or substance use disorders, and individuals receiving long-term or high dose antipsychotics; and

WHEREAS, antipsychotic prescribing is increasing across clinical specialties, including primary care and other specialties that may have less experience monitoring and managing movement related side effects for a broadening range of therapeutic uses, raising the need for ongoing monitoring for adverse effects; and

WHEREAS, early identification of TD through validated tools such as the Abnormal Involuntary Movement Scale (AIMS) allows for timely intervention; therefore be it

RESOLVED, that the Medical Society of Virginia supports routine screening for tardive dyskinesia in accordance with APA guidelines and encourages Virginia physicians prescribing antipsychotics to implement standard screening practices as part of comprehensive patient care.

Fiscal impact: None

Existing policy: None.

25-211

Title: Physician Assisted Suicide (PAS)

Submitted by: Dr. Donald Stern and Dr. Thomas Eppes

WHEREAS, the Medical Society of Virginia (MSV) has a position of "engaged neutrality" toward medical aid in dying (PAS), which is the process whereby adult terminally ill patients of sound mind ask for and receive prescription medication that they may self-administer to hasten death, in policy Compendium Page 69, 25.2.04-Medical Care for the Terminally Ill and

WHEREAS, the American Medical Association (AMA) has resolved that physician PAS is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks[1] and

WHEREAS, the AMA defines PAS to refer 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" [2] and

WHEREAS, the AMA notes that "Physician-Assisted Suicide," terms such as 'aid in dying,' 'medical aid in dying (MAiD),' 'assisted death,' or 'death with dignity' "could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance."[2] and

WHEREAS, on June 26, 1997, the United States Supreme Court unanimously rejected any constitutional right of terminally ill patients to physician assisted suicide [3] and

WHEREAS, PAS represents active assistance by a physician in suicide of a patient, and

WHEREAS, physicians are working tirelessly as a profession to decrease suicide rates in the US, and

WHEREAS, the Commonwealth of Virginia currently requires suicide to be recorded on death certificates if it is the cause of death and

WEREAS, requests for PAS and doctors' decisions to assist suicide can be influenced by coercion and by unconscious motivations in doctors, patients and caregivers[9] and

WHEREAS, suffering at the end of life is expertly managed by hospice and palliative care professionals in the US, and

WHEREAS, hospice and palliative care represent passive comfort measures to ensure death with dignity, and

WHEREAS, we preserve the integrity of the medical profession by promoting alternatives such as palliative and hospice care as the solution to end-of-life care, therefore be it

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 ~~as~~ opposed to ~~engaged neutrality toward~~ medical aid in dying…" 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 and MAiD as follows:
Physician Assisted Suicide – refers 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" [2]

Medical Assistance in Dying – "Terms such as 'aid in dying,' 'medical aid in dying (MAiD),' 'assisted death,' or 'death with dignity' "could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance."[2], and be it

RESOLVED, that the MSV advocate for the improvement of hospice and palliative care reimbursement.

Fiscal Impact: none

Existing Policy: THE MEDICAL SOCIETY OF VIRGINIA UPDATED 2024-2025 POLICY COMPENDIUM Page 69, 25.2.04- Medical Care for the Terminally Ill Date: 11/8/1997

References:

1. AMA Code of Medical Ethics, Opinion 5.7

2. AMA Council on Ethical and Judicial Affairs in CEJA Report 03-A-25

3. Wendy K. Mariner, Physician Assisted Suicide and the Supreme Court: Putting the Constitutional Claim to Rest , 87 American Journal of Public Health 2058 (1997). Available at: https://doi.org/https://doi.org/10.2105/AJPH.87.12.2058

4. BMC Fam Pract. 2006 Jun 22;7:39. doi: 10.1186/1471-2296-7-39
Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors Madelyn Hsiao-Rei Hicks 1,✉

25-212

Support for Medicaid Coverage of Hearing Devices and Related Services

Submitted by The Medical Student Section

WHEREAS, of the approximately 28.8 million adults in the United States who could benefit from hearing devices, fewer than 20% use them, demonstrating a significant gap in access and utilization[1,2]; and

WHEREAS, adults with hearing loss experience a 40% higher risk of mortality compared to those with normal hearing, while consistent hearing-aid use among individuals with hearing loss is linked to a 24% reduction in mortality compared to those who do not use them[2]; and

WHEREAS, untreated hearing loss in adults is associated with greater social isolation, higher rates of depression, increased falls, and an increased risk of dementia[3-7]; and

WHEREAS, hearing devices and related audiological services, including diagnostic testing, fitting, and regular replacements, are not covered under the Virginia Medicaid state plan for adults aged 21 and older, and while some Medicaid Managed Care Organizations (MCOs) may offer these services as optional, such coverage is inconsistent across plans and not guaranteed for all adult enrollees[8,9]; and

WHEREAS, out-of-pocket costs for hearing aids, including over-the-counter devices, and related services are unaffordable for most adults with functional hearing loss in the United States[10,11]; and

WHEREAS, although no analysis has quantified the cost of untreated hearing loss to Medicaid, associated conditions contribute substantial expenses, with individuals experiencing social isolation incurring an estimated $2,706 more per person each year, those with dementia costing an additional $6,278 per person each year, and non-fatal fall care costing Medicaid approximately $8.7 billion annually, while hearing aids and related services cost approximately $2,500, illustrating the potential for significant long-term cost savings[10,12-14]; therefore be it

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.

Fiscal Impact: None.

Existing Policy: None.

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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

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September 19, 2025

Dear MSV Colleagues,

I am pleased to provide you with a summary of the development of the MSVPAC for the period between January 1 and September 19, 2025. In short, the MSVPAC raised more than $120,000 in 2024 following another strong year in 2023. The PAC successfully rebounded after the Covid-19 drop off, but the enthusiasm appears to be waning, and paltry financial support is placing our lobbying efforts at a disadvantage.

This report is mixed with some surprising, good news and some serious struggles facing your PAC.

The good news is that the future generation of physician and PA advocates look more engaged than ever with the MSVPAC. More than 200 registered for 5 Docs and Hops (advocacy networking events) which raised $5,820 in ticket sales and sponsorships. This blows away any numbers on record for this event series. The MSVPAC organized three official Lobby Days during the General Assembly session with 312 registrations—and this large number does not account for our successful medical school student lobby days.

Our future advocates are fired up to make Virginia the best place to practice medicine and receive patient care. Our struggle is that practice donations are down as are individual donations. Your PAC is underfunded.

The PAC raised $66,740 to date this year. At this point in 2024 the PAC was at $68,582. Both numbers include committed donations not yet received. In 2023 it was $99,323.

At first glance this appears to be on par. It is not. Virginia Urology is decreasing their support this year from $10K to $5K. Another practice which supported the PAC in the past refused to support us directly, but offered to pass along the request to individual clinicians. Some practices which previously supported us are unresponsive to our requests. We have fewer champions at practices able to support PAC asks. Without those relationships, practices seem willing to politely pass on the request, and our PAC is underfunded as a result.

Responding to this development, the MSVPAC has been soliciting MSV members at practices who are not contributing via emails, direct mail, and phone calls. This tactic can only be so effective without physician leader involvement.

The MSV Board of Directors agreed to assist with outreach to practices. Dr. Razi Ali, Chair of the MSVPAC, has spent hours of his time calling board members to see how he can help you reach out to practices.

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Here is the status of efforts:

Blue Ridge ENT is confirmed for a $5,000 donation. Thank you Dr. Hutchison.
Privia Health is confirmed for a $20,000 donation. Thank you Dr. Eppes.
Virginia Urology is confirmed for a $5,000 donation.

Virginia Cardio – Dr. Townsend is reaching out.
Gastro Health – Dr. Marathe is trying to drum up support from clinicians since corporate refuses to contribute to the PAC.
Gastro Health – Dr. Alembik
Halifax County area docs – Dr. Fogarty is offering them a legislative update.
Centra Health – Dr. Eppes
Virginia Eye Institute - Dr. Henry
Virginia Oculofacial Surgeons – Dr. Henry
Commonwealth Eye Associates – Dr. Henry
VCU Ophthalmology – Dr. Henry
Valley Physician Enterprises – Dr. Hutchens
Valley Intensivists – Dr. Hutchens
Virginia Physicians for Women – Dr. Sheffield
Mid-Atlantic Women's Center – Dr. Ouyang
Nephrology Specialists – Dr. Ali and Dr. Gewanter

The MSVPAC appreciates that you are doing everything you can to bolster our efforts. Thank you. If you are not included in the above list but are able to help, please reach out immediately to GAP staff. Outreach is urgently needed and we are here to support you and run down every opportunity.

Partners in Medicine, a collaboration between the MSVIA, MSF, MSVPAC, and MSV membership team successfully increased practice outreach as well resulting in new legislative updates and relationships benefitting our advocacy efforts.

MSV's marketing team helped as well, crafting fundraising campaigns throughout the summer months. Still, we are not getting the response needed.

We have sent thousands of emails, hundreds of letters, and a lot of phone calls from staff and physicians. If we can get in the door with decision makers at practices, they will likely support the PAC. We are not getting in the door.

The Path Ahead

We need our Board and active MSV members to donate immediately – before the annual meeting. We are asking specialty societies to donate $10,000 to the PAC. We need physician

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leaders to ask specialties. Practices must understand that the MSV is saving them huge amounts of money thanks to our advocacy on medical malpractice, insurance reform and a host of other underlying issues.

We have evidence that if practices are forced to look at the numbers and the savings, then they will support the PAC. We need our members to get us in the door.

Here are the talking points:

Medical malpractice coverage varies by specialty but rates for a $1 million policy for general practice are approximately $12,000 a year. Some specialties such as obstetrics and surgery have rates closer to $58,000 per year for $1 million of coverage.

Taking a median of the two rates, $35,000, and increasing it by 20%, which is in-line with a conservative premium increase based on MSV's actuarial analysis as provided by Milliman, that would mean an additional cost of $7,000 out of pocket per year per physician.

We believe practices should donate 10% of that $7,000 per year per physician—so $700 per every provider in their practice.

MSVPAC at-a-glance for 2024:

Number of donations: 261	2024 Goal: 260
Amount raised since 1/1/24: $121,983	2024 Goal: $120,000

Lobby Day Registrations: 427 over four lobby days.

MSVPAC at-a-glance for 2025:

Number of donations: 310	2025 Goal: 270
Amount raised since 1/1/25: $66,740*	2025 Goal: $150,000

Lobby Day Registrations: 312 over three lobby days.

*this includes $20K from Privia and $5K from Virginia Urology and Blue Ridge ENT committed but not yet deposited.

Large Practice Outreach

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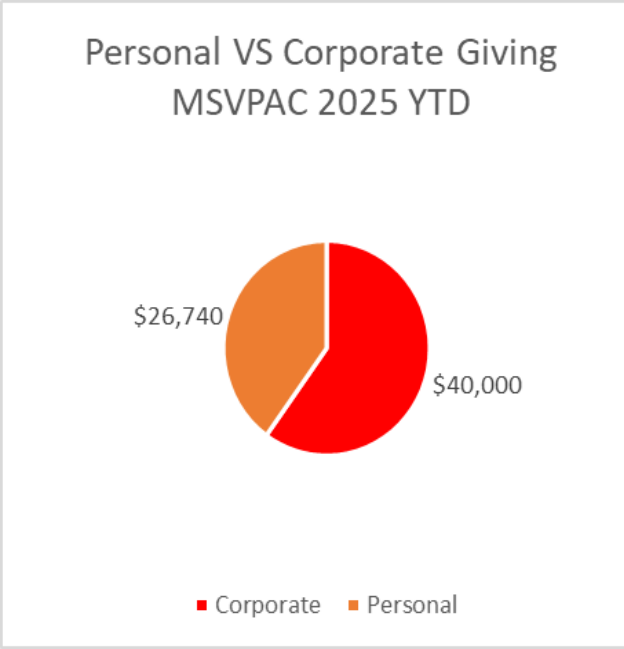
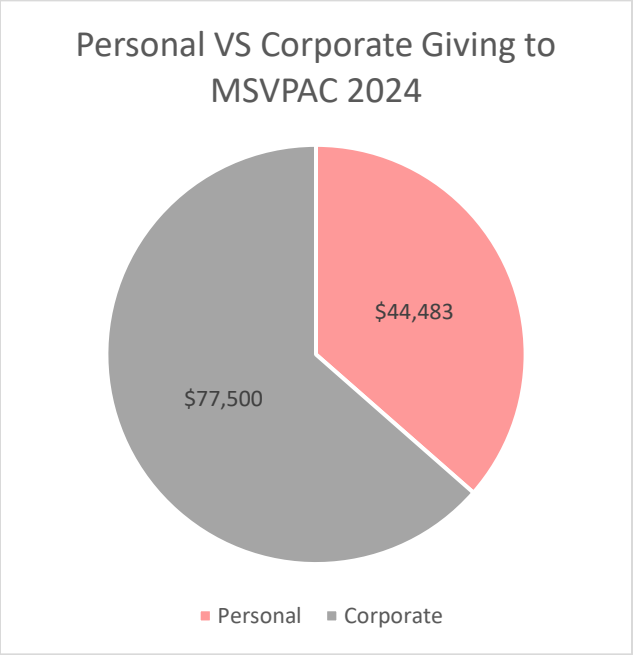
The MSVPAC offers practices, regardless of membership status, legislative updates in person or by zoom. These are not fundraising pitches but intended to help develop relationships with practices so when we ask for money, we are more likely to get a response.

The MSVPAC would like to thank Dr. Harry Gewanter and Dr. Thomas Eppes for outstanding contributions in driving large dollar support.





Docs and Hops

Docs and Hops is a networking series hosted by the MSVPAC for med students to meet established physicians and PAs and receive an introduction to the MSV and advocacy. These events matter and produce new registrations for upcoming advocacy events and requests to join the MSVPAC board directly.

The 2021 Docs and Hops event in Richmond had seven attendees. 42 attendees attended three Docs and Hops events in 2022. In 2023, 101 attendees came to three Docs and Hops events. 2024 Docs and Hops saw more than 107 attendees.

I am pleased to announce that in 2025 we had more than 200 registrations and $5,820 raised in ticket sales and sponsorships over five events.

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Thank you to our sponsors: Kathy Scarbalis (PA-C), Dr. John Sweeney, Dr. Trice Gravatte, Dr. Greg Warth, Dr. Michelle Nedelka, Dr. John Mason, Dr. Kurt Elward, Dr. Joel Bundy, Dr. Randy Gould, and Dr. Peter Netland.

Fundraising Update

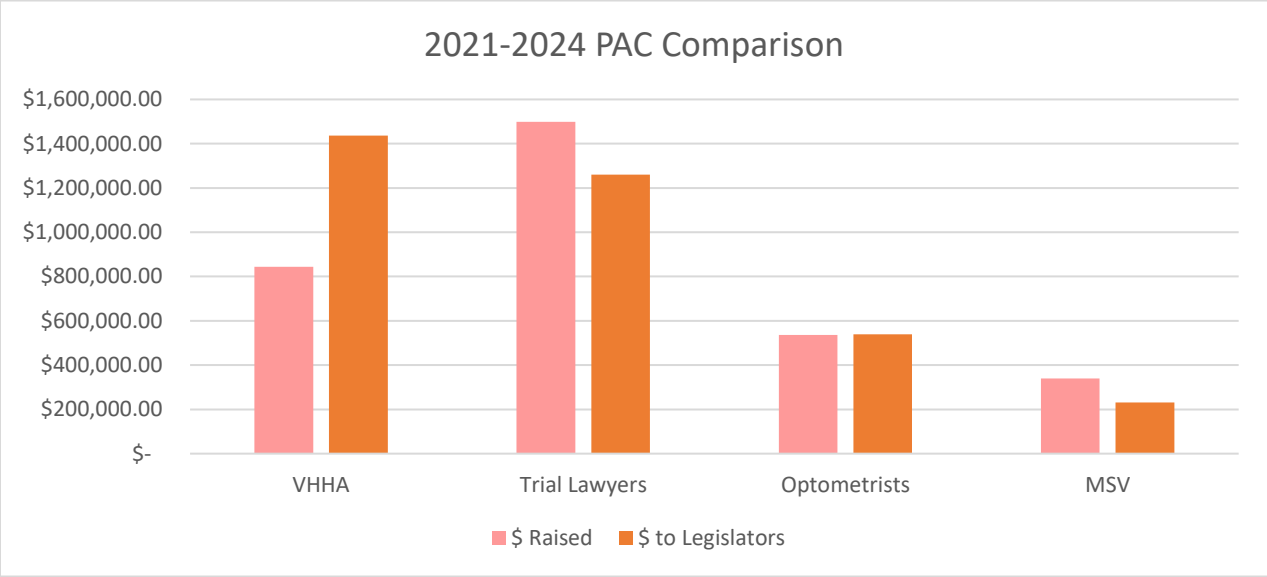
The MSVPAC received contributions from 303 physicians, students, and practices in Virginia for $66,740,* to date in 2025. We include sponsored students and residents who attend Docs and Hops as donors as their tickets are purchased through sponsorships.

For reference (from VPAP):

2016: The MSV PAC contributed $147,000
2016: The Virginia Trial Lawyers Association contributed $232,683
2016: The Virginia Hospital and Healthcare Association contributed $287,056

2020: The MSV PAC contributed $59,070
2020: The Virginia Trial Lawyers Association contributed $266,104
2020: The Virginia Hospital and Healthcare Association contributed $90,117

2024: The MSVPAC contributed $97,128 to candidates
2024: The Virginia Trial Lawyers Association contributed $165,772
2024: The Virginia Hospital and Healthcare Association contributed $212,831



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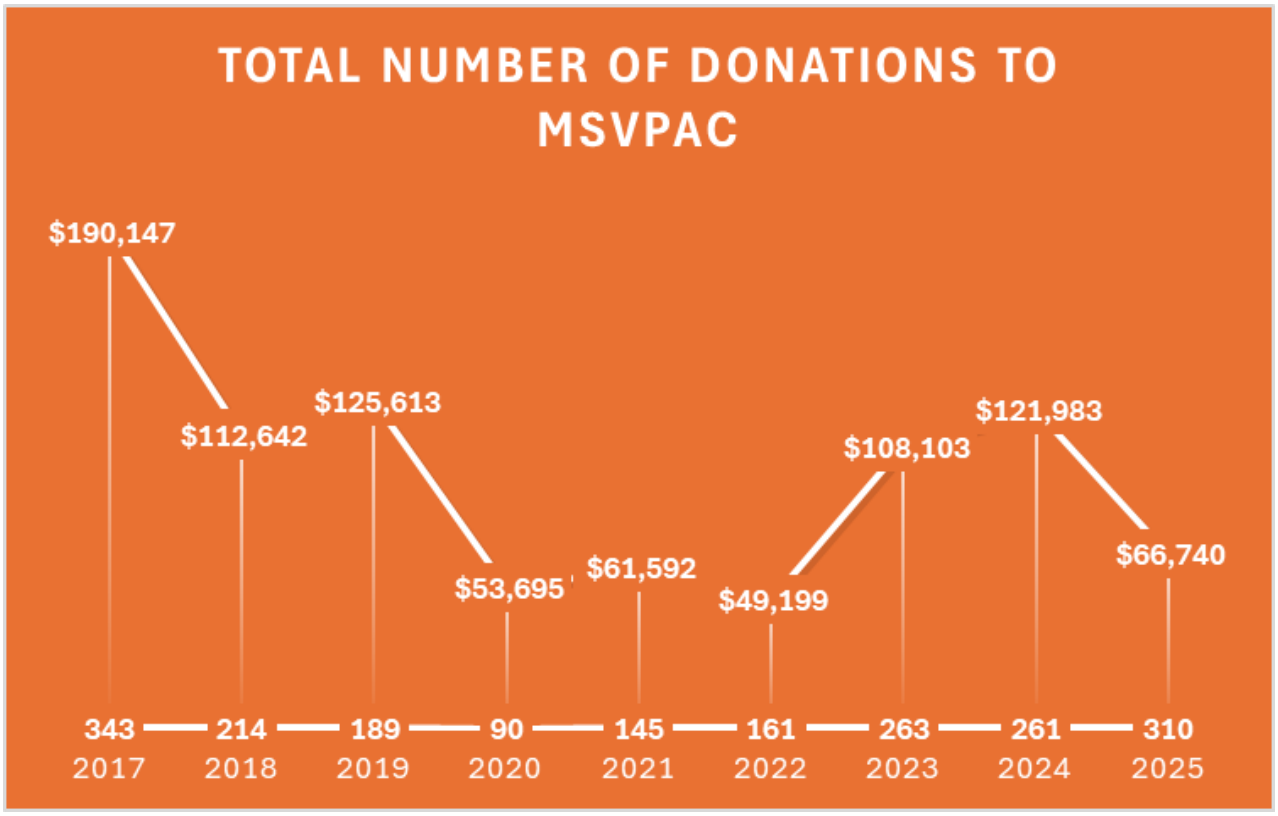

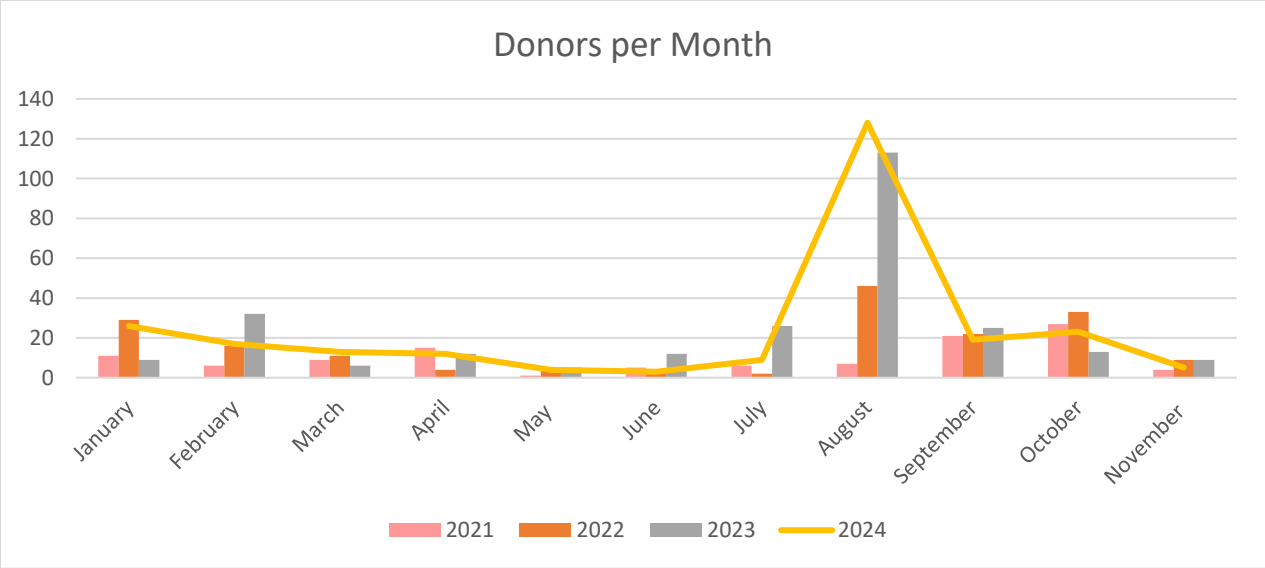

Conclusion

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We rely on personal and professional connections in reaching out to large practices. We have asked most of MSV leadership to assist and will continue to do so. If you can contribute or offer any ideas, please reach out to myself or Drew Densmore on the MSV staff.

Dr. Raziuddin Ali
Chair, MSVPAC

Andrew Densmore
Political Advocacy Manager, MSV

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MSVPAC Board Roster

Member	Term Beg.	Term End	Term Count	District
Bobby Cochran	8/1/24	7/31/26	1	PA
Bruce Silverman*	1/1/22	12/31/23*	2	3
Barbara Boardman	10/15/22	10/16/24	2	10
Diana Clewett	7/9/24	7/8/26	1	10
Jacqueline Fogarty	10/29/22	10/28/24*	2	5
Zain Ahmad	7/9/25	7/8/26	NA	Student
Razi Ali	7/9/24	7/8/26	1	3 Chair
Luke Juckett	4/17/25	4/16/26	1	Resident
Priyanka Kumar	4/17/25	4/16/27	1	6
Kenneth Qui	9/9/25	9/8/27	1	3

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

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Date: **September 17, 2025**

To: **MSV Delegates**

From: **MSV and MSV Foundation Staff**

Subject: **Updates to Key MSV/F Programs, Activities, Outcomes**

PROGRAMS – MSVF and MSV

VMAP
Virginia Mental Health Access Program

PROGRAM DESCRIPTION AND UPDATE

VMAP is excited to celebrate over five years of serving Virginia healthcare providers and their patients through its unique approach to integrated care. **VMAP's model offers true systems change**, supporting prescribing providers who see patients 21 and under and/or perinatal patients by **improving their ability to assess, treat, and manage their patients' mental health**, which in turn **mitigates mental health workforce shortages**. As VMAP marks its fifth anniversary, **16.8% of Virginia PCPs who see pediatric patients have utilized our services**. By the end of 2024, there were **2,313** providers registered for VMAP, which represents a **26% increase** from the year before!

In addition to these direct services, VMAP is estimated to reach hundreds of thousands of Virginia children through their PCPs. Pediatricians have an average patient panel of 1,500 patients. As a result, for every provider trained by VMAP, their entire patient panel benefits from improved access to mental healthcare.

Using data from the VMAP Line, pre- and post-assessment data from trainings, provider surveys, and secondary analysis from other sources, VMAP has triangulated significant findings that demonstrate:

- VMAP is being utilized by a **wide variety of providers** all across Virginia
- Providers who participate in VMAP training **show greater confidence** in serving their patients' mental health needs and perform mental health screenings at significantly higher rates
- VMAP **supports vulnerable patients**, including people with Medicaid and those in rural areas

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. The program supports prescribers caring for pregnant and postpartum individuals through expert clinical consultations, targeted education, and care navigation. Since its

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launch, the VMAP for Moms+ Line has received over 150 calls, and two trainings have been completed, with more scheduled for 2025.

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

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safe haven™ CONFIDENTIAL SUPPORT

PROGRAM DESCRIPTION AND UPDATE

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.

2025 Goal Updates:

- SafeHaven legislation was introduced to expand protections to all licensees that fall within the Department of Health Profession's purview.
- We have contracted Marvin and Uprise Health to expand SafeHaven's vendor-provided well-being services.
- Updated states agreements have been shared with states that have passed SafeHaven legislation or regulatory changes. Georgia has signed the new agreement.
- Georgia has secured $500,000 in state funding to provide SafeHaven resources to rural physicians and contracted Marvin for a pilot of the program.
- Rhode Island asked for a review of SafeHaven-related legislation that they passed.
- Several states, including Hawai'i, Oklahoma, Wisconsin, South Carolina, Montana, and Washington D.C. have expressed interest in SafeHaven legislation or plan to introduce it at their 2025 legislative sessions.

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.

2025 Goal Updates:

- The Virginia Credit Union has provided a $7,500 sponsorship for the next academic year to expand resources.
- New CFP volunteers have been screened to ensure access to resources throughout the 2025-2026 academic year.
- Calendly was purchased to streamline 1:1 counseling requests and is now live on the Thrive site: https://www.msv.org/programs/thrive/
- Thrive's website and marketing materials are being updated for new outreach to the medical schools and residency programs.

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

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ADULT PSYCHIATRIC ACCESS LINE (APAL)

healthhaven™ RECOVERY

PROGRAM DESCRIPTION AND UPDATE

HealthHaven: Recovery (HHR) is a consultation and care navigation program designed for primary care providers who are treating adults struggling with substance use disorders. The program offers access to case consultations, specialized services and resources, and training and education opportunities for participating providers. Through these services, HealthHaven: Recovery aims to 1) support primary care providers in the screening, assessment, diagnosis, and treatment of substance use disorders, and 2) provide quality access to substance use treatment and services for their patients through care navigation. In October 2024, we launched our first hub in the Central region with the Master Center for Addiction Medicine. This spring we have pivoted to exploring other adult behavioral health conditions. Many calls coming into the APAL line fall outside of our initial scope of SUD conditions, so in an effort to be responsive to our user's needs we are in discussions to add other psychiatric resources to the line. Currently, we are exploring adding pharmacology, LMHPs, and care navigation in two new regions of the state.

HHR hosted our first REACH Institute Training on Adult Behavioral Health in Primary Care March 21-23. Over 22 providers joined the course, and we have received excellent feedback on the quality and provider confidence in treating adult mental health conditions. We have confirmed a second REACH Adult Behavioral Health in Primary Care course for December 5-7th. We are working on several other education offerings for HealthHaven, including an ECHO series in partnership with UVA and continued partnership with the Virginia Academy of Family Physicians for webinars, journal series, and more.

We are very pleased to say we are now in the next state fiscal year and are operating on a state general fund budget totaling $2.25 million.

Lastly, we are working with DBHDS on embedding these psychiatric and SUD services in primary care offices through a $1.5 million SAMHSA grant promoting the Collaborative Care Model. We have partnered with CVFP Medical Group and Sentara Halifax to integrate behavioral health screeners and professionals in their offices to measure patient outcomes. Our practice sites have completed Collaborative Care training and will be enrolling patients into the program next month!

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

DR. ALELI AND REV. CRIS ROMERO PHYSICIAN LEADERSHIP INSTITUTE

Dr. Aleli Romero and Rev. Cris Romero Physician Leadership Institute

The newly endowed 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 2025 PLI weekend will be November 13-16 at the Richmond MSV Office and will be facilitated by Dr. Andreya Risser. We would like to maximize capacity again this year, including 2 third/fourth year med students or residents. Please email any physician, PA, or student nominations to Jennifer and Carolyn. We currently have just a few spots remaining!

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Additional plans for 2025 include both virtual and in person opportunities to engage more members and re-engage PLI Alumni. Specifically, we are offering a course in designing transformative change. Let us know if you are interested in bringing an innovative PLI experience to your team.

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

Stroke Smart Medical Practice
(In partnership with VDH, VHHA, and Kwikpoint)

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

- A curated "toolkit" of resources has been developed to assist practices in implementation of the five actions. The MSV and VDH websites (both) house information. Included in the resources is a video describing SSMP and the importance of implementation.
- A recognition program is in place to spotlight practices who have adopted some or all the SSMP criteria.
- Stroke Smart Magnets and Wallet Cards are available to ANY practice or hospital free of charge through VDH website (LINK)

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

PUBLIC HEALTH PROGRAMS: CHRONIC CARE MANAGEMENT (CCM) AND FAMILY HEALTHY WEIGHT

PROGRAM DESCRIPTIONS AND UPDATE
MSVF has partnered with VDH to implement a Chronic Care Management (CCM) model in primary care practices, targeting areas of high chronic disease prevalence. The model incorporates a Community Health Worker (CHW) and pharmacist as part of the care team. Grants to underwrite the cost of a CHW are offered in exchange for program reporting and metrics.

We have partnered with Jencare | Chenmed to implement and test the CCM model and are actively working with two locations -- Richmond City (Hull St) and Colonial Heights (Southpark). Richmond has identified 593 patients to target for inclusion in the program (51 have consented to date) and Colonial Heights has identified 513.

At the end of June, a contract was signed with the United Way of Henry County to employ a CHW to support Martinsville Family Medicine (MFM), testing a hybrid approach to the CCM model. MFM will be working with the CHW in the implementation of the CCM model and supplying data back on effectiveness.

VDH has asked MSVF to serve as a broker between the Healthy Weight Partnership, Inc. and (3) organizations (Sentara Healthcare and (2) Cooperative Extension sites in Loudon County and Charlottesville) in facilitating a Family Healthy Weight Program to improve the well-being of children and their families by promoting healthy behaviors. Contracts with the Cooperative Extension sites are awaiting signature.

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

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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.

ACCREDITED PROVIDER PROGRAM

As an Accredited Provider, MSV is now able to accredit its own CME activities, including activities for all the MSVF programs listed above, 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.

We will be eligible for re-accreditation in March 2027 and are planning to apply for Accreditation with Commendation. At that time, MSV must demonstrate compliance with the Core Accreditation Criteria, Standards for Integrity and Independence and required policies, in addition to the Menu of Commendation Criteria. Choosing from the menu, MSV will need to demonstrate compliance with a total of eight criteria. One criterion on the menu with which we could use help is "Engages Teams" - we need planners and faculty from all areas of the healthcare team to contribute to our educational activities.

Upcoming CME activities include a SafeHaven webinar and a series of podcasts related to a variety of non-clinical topics. To manage all the new activities MSV is offering, we are launching a Learning Management System, PathLMS, allowing members to register, participate, and keep record of all their CME activities in one location.

The education session for the Annual Meeting is *Leading Transformative Change: A Human-Centered Design Approach to Change Management*, facilitated by Garret Westlake, Vice Provost for Innovation and Strategic Design at Virginia Commonwealth University. Objectives include diagnosing the need, engaging stakeholders, and aligning processes, but by the end of the session, Garret will have you thinking about "change" differently. He is incredibly energetic and will certainly provide a unique wakeup call on Saturday morning in Norfolk!

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 began operation on April 1, 2024.
The SSCC accredits 30 organizations across six states to grant AMA PRA Category 1 CME credits. The SSCC accredits five organizations from Virginia (Carilion Clinic, Inova Health, Sentara Health, SOVAH Danville, and Winchester Medical Center) and one from West Virginia (WVU-Berkeley Medical Center). Mary Beth McIntire sits on the three-member SSCC Governing Board.

The SSCC's Accreditation Review Committee (ARC) includes members from all three states. The ARC meets quarterly to make re-accreditation decisions. Three Virginia providers are currently in the process of reaccreditation in Q3 or Q4: Winchester Medical Center, Carilion Clinic, and Inova Healthcare System. Virginia members of the ARC include Michael Moore MD (Sovah Health, who chairs the ARC), Paul Dallas MD (Carilion Clinic), and Patrick Haggerty MD (EVMS).

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The ACCME audits all Recognized Accreditors on an annual basis, assessing their compliance with Markers of Equivalency. The SSCC was recently reviewed and found to be in compliance with all five Markers. Fewer than half of Recognized Accreditors had a perfect score in 2024.

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

MSV MEDICAL SOCIETY OF VIRGINIA | Pathways to Medicine

YES, I CAN!

PROGRAM DESCRIPTIONS AND UPDATE

"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.

- "Health Career Explorers Camp" was held July 17, 1-4pm at Saint Paul's Church – we did an OR Simulation, including anesthesia props and other surgical tools, along with gowns, masks, hats, and gloves for all 20 kids. They loved it!
- To date there have been twenty-one (21) visits completed, with almost 900 students engaged
- Our most successful visits have been to the various Boys & Girls Club locations in the Richmond area – the students are curious and motivated.
- We are working to gain access to specific and practical, hands-on, age-appropriate medical education including Stop the Bleed and CPR.
- 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 2025 theme for our annual meeting is: "Denim and Diamonds: Time to Break out Your Boots and Bowties!" The Gala will be held at the Hilton, the Main in Norfolk, October 25, 2025. Sponsorships raised so far for the event are $218,550 as of September 11, 2025. Lots of fun activities are planned for the gala!

Salute to Service Awards

Our Salute to Service Awards nominations opened April 1 and ended on June 30, 2025. We have seven winners in six categories this year. The committee could not decide between two residents for our Service by a Medical Student or Resident award, so we gave them both the award. All of the winners are amazing, and it is an honor to meet them and talk to them about their great work. These winners will all be announced at the 2025 Gala on October 25th, and we show their videos then.

We have six categories this year:

- Service by a Medical Student or Resident – two winners!
- Service by an Early Career Physician
- Service to the Underserved and uninsured

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- Service for Advancing Patient Safety and Quality Improvement
- Distinguished Medical School Faculty Service Award
- Service to the Profession

Shapiro-Konerding Women in Medicine Leadership Award

Established in 2024, this fund recognizes the extraordinary leadership of MSV's first two female presidents: Dr. Carol Shapiro and Dr. Hazle Konerding, whose dedication to the field of medicine and to their patients is an inspiration. The Shapiro-Konerding Women in Medicine Leadership Fund recognizes and supports future women physicians as they begin their own leadership journeys.

Our nominations for this new leadership award opened April 1 and ended on June 30, 2025. We had four finalists. The winner will be announced at the gala.

Development

As of September 11, 2025: $321,879

- Gala sponsorship - $223,200
- Personal donation - $18,727
- Medical Student Sponsorship - $1,594
- VMAP Support - $110
- 1820 Society - $2,000
- MSVF Endowment – General - $10,675
- MSVF Endowment – PA scholarship - $2,000
- MSVF Endowment – Medical Student - $600
- Shapiro-Konerding Leadership Fund - $53,586
- PLI - $468
- MSV Recurring gift - $200
- Forty Forward Collector - $5,190
- Forty Forward Gold - $540
- Forty Forward Silver - $240
- Forty Forward Bronze - $200
- MSVF gala ticket - $250
- MSV raffle ticket - $350
- Wine is my Valentine - $2,100

Gala updates

- All tickets - $12,455

Grant total: $334,334

Other Development

- 2025 Annual Campaign – Our 2025 theme is Forty Forward to commemorate our MSV Foundation's 40th anniversary this year.
- Endowment & Planned Giving Campaigns – We have nine former MSV presidents who will be on our Former Presidents Wall. We will be adding more at the beginning of 2026 when the entire wall will be unveiled.
    - Dr. Cynthia Romero - Dr. Aleli Romero and Crisanto Romero Physician & PA Leadership Institute
    - Dr. Hazle Konerding
    - Dr. Thomas Eppes, Jr.
    - Dr. Carol Shapiro
    - Dr. George Broman
    - Dr. Kenneth Tuck
    - Dr. Sterling Ransone

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    - Dr. Russell Libby
    - Dr. Lewis Harvie
- Endowment and planned giving campaigns for 2026 are in the works.
- The Engagement and Advisory committee had these events earlier this year:
    - Blue Ridge Tunnel walk and picnic
    - IronClad Whisky Tasting
    - Wine is My Valentine
    - Next Chapter – group for retired members. Luncheons in Northern Virgina, Tidewater and Roanoke were very well attended. Richmond and other locations are being planned for 2026. Two webinars were also well attended and more are being planned for 2026.

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

MSV Foundation Board Directors

At the August 19th MSV Foundation Board of Directors Meeting and the September 13 MSV Board of Directors Meeting, the following individuals were approved to serve a three-year term (October 2025 – October 2028) as directors of the MSV Foundation Board:

- Courtney Corboy, MMS, PA-C
- Lee Ouyang, MD, FACOG

AMA Virginia Delegation Report

Your Virginia Delegation is proud to represent you in the AMA House of Delegates, the policymaking body of American medicine. The House includes representatives from state societies, specialty societies, public health organizations, military medicine, and academic medicine. We work together to reach consensus as we discuss health policy and medical ethics. Our focus is on supporting science and public health while promoting excellence in academic medicine. We advocate for policies that serve our patients' best interests and uphold the integrity of our profession. The AMA concentrates on key national issues such as prior authorization reform, scope of practice defense, physician well-being, and Medicare reforms. We continue our advocacy efforts, representing you on Capitol Hill: this past February, Drs. Eppes, Townsend, Romero, and Coombs attended the National Advocacy Committee and engaged with 12 state elected officials, including the offices of both U.S. Senators. We maintain strong ties with our Virginia Congressional Delegation and remain dedicated to advocating for our issues with national policymakers.

In a significant win for Virginia, the AMA has chosen MSV's own Dr. John Whyte to serve as its CEO. We are proud to have a Virginian leading the AMA and are encouraged by the progress he has already made. The Delegation attended the AMA Annual Meeting in Chicago this June with a full team of Delegates and Alternates representing Virginia. Melina Davis, Dustin Beekman, and Carolyn McCray did an excellent job presenting SafeHaven and highlighting the MSV's efforts to expand the program into multiple states through conversations with many state association leaders. Your AMA Delegation has selected new leadership, with Dr. Clifford Deal now heading the Delegation and Dr. Sterling Ransone as Vice Chairman. We thank Dr. Eppes for his years of service as Chair and his dedication to both organizations, and we look forward to his continued contributions as a delegate. Dr. Alice Coombs continues to serve the Delegation with distinction on the AMA Council on Medical Service. Dr. Pandya was appointed this year to serve on the AMA Council on Long Range Planning and Development, further growing MSV's influence nationally. Dr. Nedelka was selected to serve on Reference Committee J during the upcoming interim meeting. Dr. Lesko and Dr. Ouyang continue to represent Virginia in the Young Physicians Section. Dr. Romero is preparing for her upcoming election to join the AMA Council on Science & Public Health next year, and we look forward to supporting her campaign in June! In the future, we also plan to campaign for Dr. Coombs to join the AMA Board of Trustees. Lastly, we thank Drs. Nguyen and Chung, who are stepping down from the delegation this year. Thank you for your dedication and passion for organized medicine—we wish you both the best and look forward to working with you again soon.

The AMA student section continues to grow and is strongly represented by its leaders. Rusty Hawes, a 6th-year student at UVA, and Yumna Rahman, a 3rd-year student at VCU, serve as Regional 6 Delegate and Alternate, respectively. We are preparing for the upcoming interim AMA House of Delegates meeting in National Harbor, Maryland, this November. We have collaborated with other states and specialty societies, discussing several resolutions proposed for this meeting, and we look forward to convening in a few weeks. We continue to benefit from strong health policy support from Scott Castro and Allyson Flinn of our health policy team. Chris Fleury remains the staff liaison for the Delegation and the ever-expanding student section. Melina Davis has represented us admirably at the AMA House of Delegates and is highly respected by other state officials.

We are currently facing extraordinary challenges in American medicine, but your MSV AMA Delegation views these challenges as opportunities to develop effective policies. We encourage you to consider joining the AMA and supporting AMPAC. The MSV is one of the top 5 medical societies in the country, and it is a privilege to represent you at the national level. We sincerely value your ongoing support for the important work of the Delegation.

Respectfully submitted,

Clifford Deal, MD
Chair, Virginia Delegation to the AMA

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Date September 20, 2024

To: MSV House of Delegates

From: Thérèse Weidenkopf, MSV Medical Student Section Chair
Virginia Commonwealth University School of Medicine

Re: Medical Student Section Annual Report, 2025 - 2026

On behalf of the Medical Student Section (MSS) of the Medical Society of Virginia (MSV), I would like to thank the House of Delegates for their continued support of our section and chapters at Macon & Joan Brock Virginia Health Sciences at Old Dominion University Eastern Virginia Eastern Virginia Medical School (ODU/EVMS), Liberty College of Osteopathic Medicine (LUCOM), University of Virginia School of Medicine (UVA), Virginia Commonwealth University School of Medicine (VCU), Edward Via College of Osteopathic Medicine (VCOM), and Virginia Tech Carilion School of Medicine (VTC).

I am honored and proud to write to the House of Delegates on behalf of our MSS. The opportunity to take part in MSV has proven vital to our development of essential skills – skills that will help us to become strong advocates for our future patients and the profession. It has always been a privilege to work alongside the students and staff of the MSV.

Last year was the first year that the student section achieved engagement levels similar to pre-pandemic. I am pleased to announce this year the student section has over 800 members and is continuing to grow. We staffed 6 MSV MSS lobby days with 70 students and met with 25 senators, and 51 delegates. We lobbied for key MSV issues House Billa 2269 and Senate Bill 1260 Hospital Violence seeking to ensuring incidents of workplace violence among healthcare workers are collected quarterly to better understand how violence affects this community. We also discussed House Bill 1636 SafeHaven Expansion which would extend legal protections and allow licensed professionals to seek support for mental health, burnout, and career fatigue without the fear of repercussions. Lastly, we supported the physician loan repayment program, and exemption from the medical malpractice cap for physicians treating patients of age 10 or younger. 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 40 medical students join the Virginia Delegation at AMA's Annual Meeting in June. One of my peers, Rusty Hawes (UVA), was named AMA Medical Student of the Year, and Ishann Rishchie (UVA) was elected as the CEJA Councilor. 6 of the 8 positions for AMA-MSS leadership were held by MSV members, and include the following: Rusty Hawes (UVA) Chair , Vignesh Senthilkumar (UVA) Policy Chair, Aashri Aggarwal (EVMS) Secretary, Alexia Childress (UVA) Membership Chair, Akila Kunuthuru (VCU) Community Service Chair, Rohan Rathi (VCU) DEIA Chair. Virginia's

medical student delegation continues to be a very respected and involved voice in the MSS Assembly.

On September 6th, the medical student leaders attended our medical student leadership retreat held at MSV's Headquarters. The retreat served as our planning and goal-setting meeting for our team. It included restructuring of MSS elections and clear plans for each section: Community Outreach, Engagement, and Legislation. It was exceptional to see how passionate our MSS leaders are in engaging Virginia's medical students to advance MSV's goals and initiatives.

Since the start of the 2025-2026 academic year, MSV has hosted more than a dozen events on our medical school campuses. The events have ranged from lunch lectures, game nights, study sessions, MSVPAC's Docs n Hops events, and Stop the Bleed Sessions. During these events, we have recruited almost 300 new members, a twofold increase from last year, from the months of July to October. Each chapter has a robust event schedule for the rest of the year with ambitious membership recruitment goals.

On behalf of my peers, the conversations and interactions with MSV's physicians have made our experiences with the MSV both significant and effective. I am honored to be a part of an organization where the leadership has embraced our section, a sentiment that our students will hold tightly in their roles as future physician leaders. In interacting with many of my counterparts across the country, I have seen first-hand how fortunate we are to be members of the MSV. We have been given many opportunities and much support that is not always available in other states.

It is with sincere gratitude that I thank the leadership and staff of the Medical Society of Virginia for its continued support. We would like to extend a special thank you to Jennifer Joss, Paige Bishop, and Chris Fleury, whose guidance, support, and leadership remain essential to our continued success.

The relationships we build in the MSS, both with one another and with the physicians in the MSV, are indispensable. They have proven to be an integral part of not only my medical school experience, but that of many of our members as well. We are planning to incorporate a mentorship program between physicians and students at this year's Annual Meeting. Thank you, once again, for your support - it has allowed us to establish Virginia medical students as a robust and fierce section.

Respectfully,

Thérèse F. Weidenkopf
MS4, VCU SOM

Board of Medicine
Report to the Medical Society of Virginia
September 15, 2025

1. The Virginia Board of Medicine is comprised of 18 members appointed by the Governor. There is 1 M.D. from each of the 11 Congressional Districts, 1 D.O., 1 D.P.M., and 1 D.C. There are also 4 citizen members who must be from different Congressional Districts.

2. Since September 2024, there have been some changes with the members of the Board. Thomas Corry, citizen member of Alexandria, resigned from the Board in 2024 to join the U.S. Department of Health and Human Services as Assistant Deputy Secretary for Communications. That citizen seat remains vacant. Four Board members' 1st terms expired June 30, 2025. They are Oliver Kim, J.D., citizen member of Alexandria, Blanton Marchese, citizen member of Chesterfield, Pradeep Pradhan, M.D. of Danville (5th Congressional District), and Jennifer Rathmann, D.C. of Blacksburg. Blanton Marchese has been reappointed for a second 4-year term. The other Board members will continue to serve until their successors are appointed.

3. The officers of the Board for 2025-2026 are:
    - President Peter Apel, M.D., PhD – pediatric orthopedic hand surgeon in Roanoke
    - Vice-President Bo Vaughan, M.D. - infectious disease specialist in Richmond
    - Secretary-Treasurer Ken McDowell, D.O. - internist in Fredericksburg

4. Board staff leadership has remained unchanged. The Deputy Executive Directors are as follows:
    - Administration & M.D. Licensure – Colanthia Opher
    - Allied Health Professions Licensure – Michael Sobowale, L.L.M.
    - Discipline – Jennifer Deschenes, J.D.
    - Medical Review Coordinator – Barbara Matusiak, M.D.
    - Medical Review Consultant – Dianne Reynolds-Cane, M.D.
    - Executive Director – William L. Harp, M.D.

5. In June 2025, the licensing of the 21 professions regulated by the Board of Medicine was split into two units - a "Doctors" licensing unit and an Allied Health Professions licensing unit. The split was to gain greater efficiency and speed in the licensing process.

6. In the last 12 months, 11,075 initial licenses have been issued across all the Board's professions.

7. In the last 12 months, the Board has received 2,237 complaints against its now 96,000+ licensees.

8. The total number of disciplinary actions taken since September 2024 has been 117. There have been 12 summary suspensions and 23 mandatory suspensions. Mandatory suspension is an action taken for loss of one's medical license in another jurisdiction or the conviction of a felony in any jurisdiction.

9. In the past year, the Board has worked on a number of regulatory actions. Most notable is the development of regulations to implement HB995 (2024 law) which creates pathways to licensure for internationally trained physicians with no postgraduate training in the U.S. or Canada. The Board's Legislative Committee has been drafting the proposed regulations and aims to have a draft ready for the Board's review on October 30, 2025.

10. In January 2025, the Board issued revised regulations - "Governing the Prescribing of Opioids and Buprenorphine." On a related note, in August of 2025, the Board's Executive Committee denied a petition to remove the regulation that prohibits prescribing of buprenorphine to patients under 16 years of age.

11. In February 2025, the regulations - "Governing the Mixing, Diluting or Reconstituting of Drugs for Administration" - were repealed. As noted in the August 2025 Board Briefs, practitioners who prepare drugs for administration in their practice are expected to adhere to the guidance in the U.S. Pharmacopeia.

12. The 2025 General Assembly (GA) passed a number of laws that impacted the Board of Medicine and its licensees.
    - Importantly, the GA established the profession of Anesthesiologist Assistant.
    - Autonomous practice for Licensed Certified Midwives is now possible after 1,000 hours under a practice agreement with a physician, a certified nurse midwife who is authorized to practice autonomously, or a licensed certified midwife who is authorized to practice autonomously.
    - Practitioners must now provide a free copy of a patient's medical record each calendar year if requested by a patient or his/her attorney for the purpose of supporting a claim or appeal under certain provisions of the Social Security Act or any federal or state financial needs-based benefit program.
    - Certified Nurse Midwives, Licensed Certified Midwives, or Pediatric APRN's with pediatric privileges and a neonatal resuscitation certification from the American Academy of Pediatrics, including endotracheal intubation training, can be on the 24-hour on-call duty roster for hospital nursery care if a physician is not available. A physician may consult by telehealth with the nurse.
    - Hospitals are required to track and report workplace violence incidents and submit the data to the Virginia Department of Health.
    - Civil Immunity for participants in Career Fatigue and Wellness Programs expanded to all licensees of the regulatory boards in the Department of Health Professions (DHP) and students in programs that are requisite to licensure by a board in DHP.

13. The 2025 GA required the Boards of Psychology and Medicine to convene a workgroup to determine under what circumstances and with what training clinical psychologists would be able to safely and competently prescribe psychotropic medication. Two meetings were held, and a report will be submitted to the GA by November 1, 2025.

14. In August 2025, the Board of Medicine, the Advisory Board on Midwifery, and other stakeholders met to revise the formulary that licensed midwives are authorized to administer. The Virginia

Formulary is to match the recommendations of the North American Registry of Midwives Job Analysis.

15. In August 2025, the Boards of Nursing and Medicine convened a panel of stakeholders and experts to formulate a report to the GA on best practices of prescribing, monitoring and communicating about psychotropic medications for minors. The report is due December 1, 2025.

16. The Board will provide a report to the GA on the expansion of the scope of practice for Physician Assistants by November 1, 2025.

17. Since last September, the Board Briefs have highlighted the following items:

    - 3rd Temporary Extension of COVID-19 Telemedicine Flexibilities for the Prescription of Controlled Substances from HHS and DEA
    - Drug Overdose Death Reports from the Office of the Chief Medical Examiner
    - Reciprocal Licensing for Physician Assistants with D.C. and Maryland
    - New Board of Medicine Opioid Regulations
    - Overview of the Health Practitioners' Monitoring Program
    - The Board of Medicine wants its licensees to be healthy in all ways
    - The predicament of the Certified Surgical Technologists. In regard to this item - please be aware and spread the word that Surgical Technologists must be certified by the Board to hold themselves out as Surgical Technologists in the Commonwealth.
    - The importance of Human Trafficking continuing education

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

    - Medicine – 47,123
    - Osteopathic Medicine – 6,275
    - Physician Assistant – 7,228

Peter Apel, MD, PhD
President

William L. Harp, MD
Executive Director

Date: September 18, 2025
To: MSV House of Delegates
From: Jenna Rolfs, VAPA President
Re: VAPA Update

The Virginia Academy of PAs (VAPA) has been enjoying a busy and productive year! VAPA's participation in all three of the Medical Society of Virginia's lobby days was very successful. The first lobby day on January 14th showed enough representation from practicing PAs that we were able to have a PA participate in every group that met with legislators. On the second lobby day, January 22nd, we had an incredible showing of students from JMU, South, and Shenandoah universities. In total we had around 150 PA students. We had a little different schedule for the second day to make sure that we supported the students in giving them a beneficial experience. All of the students were able to hear a committee hearing, to see how that works, and then meet with and hear from a number of senators and delegates. They also took a tour of the building and ultimately were able to take some great group pictures including with the lieutenant governor. It turned out to be a really great experience for all of the students!

Our Lobby Days are done in conjunction with the Medical Society of Virginia (MSV) who does a tremendous amount of work planning and coordinating the lobby days and we are very appreciative of their support. This year the items we supported alongside MSV are bills on violence against healthcare workers, a bill requiring payors to disclose fees associated with electronic funds transfers when paying practices for services rendered, a bill we are opposing which would remove the malpractice cap for children under 10 receiving care, and two budget amendments, one for physician loan repayment funding, and another to fund the APAL program (VMAT for adults).

Additionally, VAPA is working on ultimately obtaining independent practice for PAs in Virginia, which will bring us some parity with our NP colleagues. We are working closely with MSV on this, as this continues to be an incredibly important partnership in getting this across the finish line in the end. MSV requested that step one be to request a study be done by the department of health professions on the "optimal time" for practice experience prior to independent practice for PAs. This study is the bill from us this year. Initially, we thought this bill was not going to be presented in committee because the legislative session was a short session and was made even shorter by the delays created with the water issues in Richmond, however, it was heard and was passed by the health professions sub-committee this past week. This study will provide the appropriate groundwork for MSV to support the bill for independent practice next year.

VAPA hosted our 43 Annual Summer CME conference in Virginia Beach in July. This year's conference was a resounding success, and that is a direct result of our membership's presence, engagement, and passion for lifelong learning. The sessions were filled with insightful questions, the exhibit hall buzzed with networking, and the free-flowing evenings were a wonderful opportunity to reconnect with colleagues and forge new connections. VAPA was honored to host a lineup of exceptional speakers who shared cutting-edge clinical knowledge and practical pearls that we can all take back to our practices to improve patient care across the Commonwealth. We want to personally thank Dr. Joel Bundy for presenting at the VAPA Summer Conference this year!

As we carry the momentum from this fantastic conference into the rest of the year, we look forward to our continued collaboration with MSV!

Respectfully,

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