AM '22 FMA Annual Meeting 2022

House of Delegates Handbook

Florida Medical Association, Inc.
August 5-7, 2022
at the Hyatt Regency Grand Cypress

First House – Saturday, August 6, 2022
8:00 am – 9:30 am

Second House – Sunday, August 7, 2022
8:00 am – 12:00 pm

FMA
Florida Medical Association

Notice: This information is published for members of the FMA House of Delegates. The reports contained herein are preliminary and are subject to necessary changes. They will be official only after they, or some modification of or substitute for them, have been acted on by the 2022 House of Delegates.

FMA DELEGATE HANDBOOK

CONTENTS

General Information

- Speakers' Letter to all Delegates
- House of Delegates Order of Business Delegate
- Rosters as of June 29, 2022
- Procedures of the House of Delegates
- Privilege of the Floor
- 2022 Reference Committees
- Reaffirmation Calendar
- In Memoriam, Florida Physicians
- In Memoriam, Past Presidents
- 2021 House of Delegates –Status of Resolutions

Elections and Candidate Information

- Announced Candidates for FMA Elective Offices
- Candidates – FMA Officers
- Candidates – FMA Board of Governors
- Candidates – AMA Delegates
- Election Process and Campaign Rules

Reference Committee No. I - Health, Education and Public Policy

- Agenda
- Board Report A
- Resolutions

Reference Committee No. II - Finance and Administration

- Agenda
- Board Report B
- Resolutions

Reference Committee No. III – Legislation

- Agenda
- Board Report C
- Resolutions

Reference Committee No. IV - Medical Economics

- Agenda
- Board Report D
- Resolutions

General Information

Speakers' Letter

Speaker: Ashley Norse, MD | Vice Speaker: Mark Rubenstein, MD

1430 Piedmont Dr E, Tallahassee, FL 32308 | (850) 224-6496

TO: Members of the 2022 House of Delegates

We look forward to seeing you August 5-7 at the Hyatt Regency Grand Cypress in Orlando for the 2022 FMA Annual Meeting. The contents of this Delegate Handbook contain general information including 2022 delegate rosters, announced candidates for 2021 elective office, candidate bios, reference committee agendas and resolutions. A Handbook Addendum, if needed, will be available on Friday, July 1, 2022.

Meetings of the House of Delegates (House)

The House is scheduled to meet in two sessions in Grand Cypress Ballroom A-I

Saturday, August 6, 8:00 a.m. - 9:30 a.m.

Sunday, August 7, 8:00 a.m. - 12:00 noon

New Delegate Orientation

If you are a new or first year returning delegate we encourage you to attend New Delegate Orientation from 3:30-4:30 on Friday, August 5 in Regency Hall 3,4 *(location subject to change).*

Rules and Order of Business

The Rules and Order of Business for the House are set forth in this Handbook.

Reference Committees

Online Reference Committee testimony will take place July 5-15. Delegates are invited to submit written testimony during those weeks. The following week, Reference Committees will meet virtually, review the submitted testimony, and craft recommendations based on the testimony. This will act as the starting place for Reference Committees to begin in-person debate on Saturday, August 6.

Reference Committees are scheduled to meet on Saturday, August 6, from 10:00 a.m. - 11:30 a.m. The policy of the House of Delegates restricts attendance at Reference Committee meetings to FMA members, other Doctors of Medicine or Osteopathy who are guests of the association, staff to assist the reference committees, and individuals invited by FMA officers to the Reference Committee itself.

As a reminder, the primary purpose of a Reference Committee is to provide members an opportunity to appear and be heard and thus have a voice in the business of the FMA. Members who are interested in any report or resolution should attend the Reference Committee meeting to which the resolution is assigned. Reference Committees have the added advantage of time for robust discussion leading to thoughtful deliberation in crafting recommendations, thereby mitigating the need for long discussions during the House. Members, interested in particular resolutions, may request the Chair of a Reference Committee defer those items so they can participate in the discussion. All resolutions should have a sponsor present to address the Reference Committee to which it is assigned. At the conclusion of each Reference Committee, a report will be compiled and available on our website, August 6, prior to the second session of the House.

Speakers' Letter

Speaker: Ashley Norse, MD | Vice Speaker: Mark Rubenstein, MD

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Resolutions

Resolutions that were received by the FMA prior to June 10 have been assigned to one of four reference committees and are included as part of this Handbook. Resolutions received after 5:00 p.m. on June 10 and prior to 11:00 a.m., August 5 are considered 'late' and will be sent to the Credentials and Rules Committee for review. Sponsors of late resolutions are required to attend the Credentials and Rules Committee meeting on Friday, August 5 at 2:00 pm in Regency Hall 1,2 to discuss the reason for the late submission. If accepted, the late resolution(s) will be assigned and distributed to the appropriate Reference Committee.

Credentials and Standing Rules Committee

The Speaker has appointed the following members to serve on the Credentials and Rules Committee. This Committee is responsible for determining whether to accept late filed resolutions, providing the roll call report to the House of Delegates and monitoring the distribution of election ballots and electronic voting devices to voting delegates. The Committee is also responsible for counting ballots and providing election results to the Speaker. The Committee is scheduled to meet on Friday, August 5 at 2:00 pm in Regency Hall 1,2.

Credentials and Rules	
John Armstrong, M.D., Chair	Fl. Ch. American College of Surgeons
Ankush Bansal, M.D.	Fl. Ch. American College of Physicians
Malleswari Ravi, M.D.	Duval
Joel Silverfield, M.D.	Hillsborough

Delegate Registration and Check In- Registration I

Friday, August 5, 2022	12:00 p.m. – 5:00 p.m.
Saturday, August 6, 2022	6:30 a.m. – 4:00 p.m.
Sunday, August 7, 2022	6:30 a.m. – 10:00 a.m.

Elections

Elections in contested races will be held by electronically beginning at 2:00 p.m. on Saturday August 6, and end at 8:00 a.m. Sunday August 7. If run-off races are necessary, they will be conducted after the start of the House.

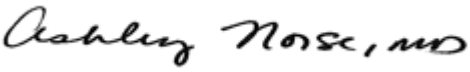
We are available at any time to assist the members of the Florida Medical Association in this process. Please do not hesitate to contact us at communications@flmedical.org.

FMA Liability for Damages

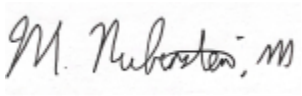
The policy* concerning FMA liability for the attendance by members of the Florida Medical Association at any meetings of its House of Delegates, Board of Governors, Executive Committee, Councils and Committees, or any other meetings or conferences of any nature: The responsibility of such member for travel to and from such meeting is the member's sole responsibility, and any such member shall not be considered to be involved in or be performing any business of or for FMA exceptand only during the time he is physically present in an official meeting room in an official meeting of the Committee,

Council, Executive Committee, Board of Governors, or House of Delegates in which he is participating as such a member.

*Board of Governors, October 1970.



Ashley Norse, M.D.
Speaker



Mark Rubenstein, M.D.
Vice Speaker

2022 FMA HOUSE OF DELEGATES ORDER OF BUSINESS

FIRST MEETING - Saturday, August 6, 2021
Grand Cypress Ballroom A-I
8:00 – 9:30 a.m.

Call to Order

Invocation

Pledge of Allegiance

National Anthem

Recognition of Distinguished Guests

Memorial Service

Remarks from the Speaker of the House – Ashley Norse, M.D.

Adopt the Rules, Order of Business

Introduction of Members of Credentials and Rules Committee

Report from the Credentials and Rules Committee Introductions

Late Resolutions and Emergency Resolutions

Reference Committee Updates

FMA President's Annual Address – Douglas Murphy, M.D.

Report from the FMA Treasurer – Charles Chase, D.O.

Report from the Council on Legislation – James St. George, M.D.

Report from FMA PAC – Jason Goldman, M.D.

Nominations for Uncontested Election - FMA President-elect

Uncontested Elections – FMA Officers

Uncontested Elections – FMA Board of Governors

Installation of the 146th President – Joshua Lenchus, D.O.

Announcements

The House will recess until Sunday morning, August 7, 2022 at 8:00 a.m.

FMA CELEBRATION
Saturday, August 6, 2021 6:30 p.m. – 9:00 p.m.
Celebration event for Joshua Lenchus, D.O., the 146th FMA President.

2022 FMA HOUSE OF DELEGATES ORDER OF BUSINESS

Second Meeting – Sunday, August 7, 2022
Grand Cypress Ballroom A-I
8:00 a.m. – 12:00 p.m.

Call to Order

Report of Credentials and Rules Committee

Announcements

Reference Committee I Report - Health, Education and Public Policy*

David Paulus Symposium Winners

Reference Committee II Report - Finance and Administration*

Election Results – Runoff race if needed

Reference Committee III Report – Legislation*

Reference Committee IV Report – Medical Economics*

Candidates for Elective Office 2023

Closing Remarks

Adjournment **

*Order of Reference Committees are subject to change

** At the conclusion of the House of Delegates, the newly seated Board of Governors should plan to assemble for a photograph, followed by lunch and a post-convention Board of Governors meeting.

AM '22 FMA Annual Meeting 2022

House of Delegates

Board of Governors Delegates

County Medical Society Delegates

Specialty Medical Society Delegates

Rosters effective June 29, 2022

BOG/Past Presidents/County Medical Society	Delegate Name	Delegate Type
22 of (23) Delegate Positions Filled - Board Of Governors	Rebekah Ann Bernard, MD	Board of Governors Delegate
	George Hubert Canizares, MD	Board of Governors Delegate
	Charles Joseph Chase, DO	Board of Governors Delegate
	Lisa Anne Cosgrove, MD	Board of Governors Delegate
	Mark Alan Dobbertien, DO	Board of Governors Delegate
	Jason Michael Goldman, MD, FACP	Board of Governors Delegate
	Ryan Chaloner Winton Hall, MD	Board of Governors Delegate
	Edward Dubois King, MD	Board of Governors Delegate
	Catherine Nina Kowal, MD	Board of Governors Delegate
	Alexander David Lake, DO	Board of Governors Delegate
	Joshua David Lenchus, DO, FACP	Board of Governors Delegate
	Rudolph Guy Moise, DO	Board of Governors Delegate
	Douglas R. Murphy, Jr., MD	Board of Governors Delegate
	Ashley Booth Norse, MD	Board of Governors Delegate
	Nitesh Nandlal Paryani, MD	Board of Governors Delegate
	Pareshkumar Bhaichandbhai Patel, MD	Board of Governors Delegate
	Michael Louis Patete, MD	Board of Governors Delegate
	Sanjay Jaykumar Pattani, MD	Board of Governors Delegate
	Ramsey Kay Pevsner, DO	Board of Governors Delegate
	Jayant David Rao, MD	Board of Governors Delegate
	Mark Allen Rubenstein, MD	Board of Governors Delegate
	Diana Ruth Twiggs, MD	Board of Governors Delegate
5 Delegate Positions Filled - Past President	David James Becker, MD	Past President Delegate
	Ronald Frederic Giffler, MD, JD, FCAP	Past President Delegate
	Corey Lee Howard, MD, FACP	Past President Delegate
	John Nonda Katopodis, MD	Past President Delegate
	Carl Wildrick Lentz, III, MD	Past President Delegate
12 of (32) Delegate Positions Filled - Alachua CMS	Christopher John Balamucki, MD	County Delegate
	Christopher Lawrence Bray, MD	County Delegate
	Brittany Sorensen Bruggeman, MD	County Delegate
	Jean Ellen Cibula, MD	County Delegate
	Christopher Ramin Cogle, MD	County Delegate
	Carl A. Dragstedt, IV, DO	County Delegate
	Coy D. Heldermon, MD	County Delegate
	Eduardo I. Marichal, MD	County Delegate

	Steven Allen Reid, MD	County Delegate
	Charles Edwin Riggs, Jr., MD	County Delegate
	Elias Henry Sarkis, MD	County Delegate
	Joseph Edward Thornton, MD	County Delegate
5 of (5) Delegate Positions Filled - Brevard CMS	Devin Kumar Datta, MD	County Delegate
	Adam Ryan Fier, DO	County Delegate
	Lance Francis Grenevicki, MD	County Delegate
	Robert James Kennedy, MD	County Delegate
	Lauren Nicole Loftis, MD	County Delegate
15 of (17) Delegate Positions Filled - Broward CMS	Abram Berens, MD	County Delegate
	Amanda Lisa Berg, MD	County Delegate
	Kutty Kunsan Chandran, MD	County Delegate
	Robert Bruce Donoway, MD	County Delegate
	Aaron Elkin, MD	County Delegate
	Shahnaz Fatteh, MD	County Delegate
	Adela Manuela Fernandez, MD	County Delegate
	Vania Enid Fernandez, MD	County Delegate
	Ann Marie Font, MD	County Delegate
	Jason Lincoln Kelly, MD	County Delegate
	Audrey Jean La Noce, DO	County Delegate
	Lloyd Ian Maliner, MD	County Delegate
	Arthur Edward Palamara, MD	County Delegate
	Yvonne Smallwood-Sherrer, MD	County Delegate
	Antonio Ham Wong, MD	County Delegate
11 of (11) Delegate Positions Filled - Capital CMS	John Temple Bailey, DO	County Delegate
	Andrew Hicks Borom, MD	County Delegate
	David Jerry Dixon, Jr., DO	County Delegate
	Michael William Forsthoefel, MD	County Delegate
	Rohan Abraham Joseph, MD	County Delegate
	Fang Sarah Ko, MD	County Delegate
	Amulya Konda, MD	County Delegate
	Alma Brown Littles, MD	County Delegate
	Maribel Urrutia Lockwood, MD	County Delegate
	Seymour Robert Rosen, MD	County Delegate
	Hugh Edward VanLandingham, MD	County Delegate

2 of (2) Delegate Positions Filled - Charlotte CMS	Lee Steven Gross, MD	County Delegate
	David Michael Klein, MD	County Delegate
1 of (2) Delegate Positions Filled - Clay CMS	John Joseph Zapp, MD	County Delegate
7 of (7) Delegate Positions Filled - Collier CMS	George Brinnig Brinnig Jastrzebski, MD	County Delegate
	Alexandra Rose Grace, DO	County Delegate
	Glenn Edward Groat, MD	County Delegate
	Zubin Pachori, MD	County Delegate
	Alejandro Daniel Perez-Trepichio, MD	County Delegate
	Rebecca Gwendolyn Smith, MD	County Delegate
	Gary D. Swain, MD	County Delegate
	Rafael Christopher Haciski, MD	Alternate County Delegate
	Erik Douglas Hiester, DO	Alternate County Delegate
13 of (22) Delegate Positions Filled - Dade CMS	Patricia Adriana Ares-Romero, MD	County Delegate
	Carmel Jean Barrau, MD	County Delegate
	Jeffrey Sherwood Block, MD	County Delegate
	Steven Falcone, MD	County Delegate
	Eugene Shyh-Shing Fu, MD	County Delegate
	Julie Lynn Kantor, MD	County Delegate
	Jorge Luis Marcos, MD	County Delegate
	Erin Marie Marra, MD	County Delegate
	Antonio Mesa, DO	County Delegate
	Barbara Ann Montford, MD	County Delegate
	Jonathan Nieves, MD	County Delegate
	Jose David Suarez, MD	County Delegate
	Stephen Edward Vernon, MD	County Delegate
26 of (26) Delegate Positions Filled - Duval CMS	Suny Mariel Caminero, MD	County Delegate
	Ingrid Anne Carlson, MD	County Delegate
	Jayanth Dasika, MD	County Delegate
	Elizabeth Louise DeVos, MD	County Delegate
	Ferdinand Joseph Formoso, DO	County Delegate
	Tra'chella Johnson Foy, MD	County Delegate
	Ruple Jayantilal Galani, MD	County Delegate
	Julie Clift Greenwalt, MD	County Delegate

	Lantie Elisabeth Jorandby, MD	County Delegate
	Sunil Nalin Joshi, MD	County Delegate
	Steven B. Kailes, MD	County Delegate
	Ali Kasraeian, MD	County Delegate
	James Knox Kerr, III, MD	County Delegate
	Yazan Khatib, MD	County Delegate
	Glenn William Knox, MD, JD	County Delegate
	Haley Parks Letter, MD	County Delegate
	Catherine Constance Madaffari, MD	County Delegate
	John Michael Montgomery, MD, MPH, FAAFP, CPE	County Delegate
	Ruchir Puri, MD	County Delegate
	Malleswari Sivanaga Ravi, MD	County Delegate
	Todd Larrieu Sack, MD, FACP	County Delegate
	Sophia Shahintaj Sheikh, MD	County Delegate
	Tracy A. Sinha-Khona, MD	County Delegate
	James Kevin St. George, MD	County Delegate
	Daniel Alexander Thimann, MD	County Delegate
	Janet Marie West, MD	County Delegate
7 of (7) Delegate Positions Filled - Emerald Coast CMA	Avery Baron Brinkley, Jr., MD	County Delegate
	Sherryl Mitchell Hernandez	County Delegate
	Huy Bao Nguyen, MD	County Delegate
	Toni Lynn Pennington, MD	County Delegate
	Jeffrey R. Pyne, DO	County Delegate
	Zachary Wayne Wilson, MD	County Delegate
	Samuel Brian Wolf, DO	County Delegate
	Jacob Andrew Martin, MD	Alternate County Delegate
6 of (7) Delegate Positions Filled - Escambia CMS	Alejandro Redaelli Arevalo, MD	County Delegate
	Brian Scott Kirby, MD	County Delegate
	Ellen Gladys McKnight, MD	County Delegate
	Kacey Anne Montgomery, MD	County Delegate
	Maureen O'Hara Padden, MD	County Delegate
	Karen Guthrie Snow, MD	County Delegate
	Anthony Gilbert Pietroniro, MD	Alternate County Delegate
20 of (26) Delegate Positions Filled - Hillsborough CMS	Madelyn Espinosa Butler, MD	County Delegate
	Eva Marie Crooke, MD	County Delegate

	Wanda Elizabeth Cruz, DO	County Delegate
	William Andrew Davison, MD	County Delegate
	Stanley Robert Dennison, Jr., MD	County Delegate
	Rosemarie Elizabeth Garcia Getting, MD	County Delegate
	Diane Therese Gowski, MD	County Delegate
	John Robert Hamill, Jr., MD	County Delegate
	Carlos Lamoutte, MD	County Delegate
	Subhasis Misra, MD	County Delegate
	Raj Narayan Mohapatra, MD	County Delegate
	Michael Christopher Morgan, MD	County Delegate
	Michael James Murphy, MD	County Delegate
	C. Christopher Pittman, MD	County Delegate
	Radhakrishna Kanthawara Rao, MD	County Delegate
	Nicole Demers Riddle, MD	County Delegate
	Bruce Dennis Shephard, MD	County Delegate
	Joel Charles Silverfield, MD	County Delegate
	Nam Duy Tran, MD	County Delegate
	Michael Andrew Zimmer, MD, MACP	County Delegate
9 of (11) Delegate Positions Filled - Lee CMS	Fadi Abu Shahin, MD	County Delegate
	Jon Patrick Burdzy, DO	County Delegate
	Scott Raymond Caesar, MD	County Delegate
	Justin Thomas Casey, MD	County Delegate
	Andres Laufer, MD	County Delegate
	Mary Magno Mouracade, MD	County Delegate
	Florentino Enrique Palmon, MD	County Delegate
	Jessica Lee Rogers, DO	County Delegate
	Tracy Vo, DO	County Delegate
6 of (7) Delegate Positions Filled - Manatee CMS	Sean Alexander Castellucci, DO	County Delegate
	Ian Michael Kahane, MD	County Delegate
	Karen Furey Liebert, MD	County Delegate
	Jennifer R. McCullen, MD	County Delegate
	Aaron Matthew Sudbury, MD	County Delegate
	Anna Maria Widmyer, MD	County Delegate
6 of (6) Delegate Positions Filled - Marion CMS	Odest Frank Cannon, Jr., MD	County Delegate
	Claudia Jane Emmons, MD	County Delegate

	Stephen Edward Fischer, MD	County Delegate
	Rakesh Prashad, MD	County Delegate
	Sushil Rao Puskur, MD	County Delegate
	David Charles Willis, MD	County Delegate
1 of (1) Delegate Positions Filled - Nassau CMS	Stephanie Pearson Meyer, MD	County Delegate
1 of (1) Delegate Positions Filled - Okaloosa CMS	Steven Jay Clark, MD	County Delegate
15 of (20) Delegate Positions Filled - Palm Beach CMS	Stephen Babic, MD	County Delegate
	Shawn Bonifacio Baca, MD	County Delegate
	Jeffrey Howard Dresner, MD, FACP	County Delegate
	Roger Lee Duncan, III, MD	County Delegate
	Allison H. Ferris, MD	County Delegate
	Marc Jay Hirsh, MD	County Delegate
	James Thomas Howell, MD	County Delegate
	Heather M. Johnson, MD	County Delegate
	Leonard Kaufman, MD	County Delegate
	Claudia Elia Mason, MD	County Delegate
	Emanuel Newmark, MD	County Delegate
	Vicki Diana Norton, MD	County Delegate
	Alan Barth Pillersdorf, MD, FACS	County Delegate
	Martha Mercedes Rodriguez, MD	County Delegate
	Jack Zeltzer, MD	County Delegate
23 of (40) Delegate Positions Filled - Phys Soc of Central FL	Mayra Abreu Fuentes, MD	County Delegate
	Puja Aggarwal, MD, MBA	County Delegate
	Musaddeque Ahmad, MD	County Delegate
	Basher M. Atiquzzaman, MD	County Delegate
	Andrew John Cooke, MD	County Delegate
	Megan Bevis Core, MD	County Delegate
	Melanie Kaye Cross, MD	County Delegate
	Monique Dieuvil, MD	County Delegate
	Muhaimeen Shagir Hossain, DO	County Delegate
	Samuel Jean, MD	County Delegate
	Tera Jones, MD	County Delegate
	Wendy Ann Lavezzi, MD	County Delegate
	Stephen Ernest J Mandia, MD	County Delegate

	Ismene Nina Maravegias, MD	County Delegate
	Elizabeth Dorothy Nelson, MD	County Delegate
	Steven Eugene Pillow, MD	County Delegate
	Kerry Martin Schwartz, MD	County Delegate
	Srinivas Seela, MD	County Delegate
	Clifford Allen Selsky, MD	County Delegate
	Nikita Bhakta Shah, DO	County Delegate
	Kevin Mark Sherin, MD, MPH	County Delegate
	Athena Theodosatos, DO	County Delegate
	Cecil Bruce Wilson, MD	County Delegate
5 of (5) Delegate Positions Filled - Polk CMS	James Judson Booker, IV, MD	County Delegate
	Debra L. Seoane, MD	County Delegate
	Sergio Benito Seoane, MD	County Delegate
	Arvind Bunty Soni, MD	County Delegate
	Dale Evelyn Wickstrom-Hill, DO	County Delegate
2 of (2) Delegate Positions Filled - Santa Rosa CMS	Dawn Marie Hannah, DO	County Delegate
	Caroline Morris Wolverton, DO	County Delegate
9 of (9) Delegate Positions Filled - Sarasota CMS	Jody G. Abrams, MD	County Delegate
	William Brodie Adams, MD	County Delegate
	Nicole Garofola Bentze, DO	County Delegate
	Sean Matthew Daley, MD	County Delegate
	Jonathan David Dreier, MD	County Delegate
	Wadi Gomero-Cure, MD	County Delegate
	Katarzyna Ewa Piotrowska, MD	County Delegate
	Rajivi Pothiraj Rucker, MD	County Delegate
	H. Cory Scott Weitzner, MD	County Delegate
4 of (4) Delegate Positions Filled - St. Johns CMS	Jeremy Alan Caudill, DO	County Delegate
	Michael Christopher Hanes, MD	County Delegate
	Joanna Lee McGetrick, MD	County Delegate
	Jocelyn Amber Soto, DO	County Delegate
	Teresa Marie Brennan, DO	Alternate County Delegate
	Russell William Denea, MD	Alternate County Delegate
4 of (9) Delegate Positions Filled - Volusia CMS	Michael Andrew Diamond, MD	County Delegate

Elizabeth Anne Eads, DO	County Delegate
Jan Richard Rhodes, MD	County Delegate
Nichole Ella Robinson, DO	County Delegate

Specialty Society Delegate Roster	Delegate Name	Delegate Type
15 of (16) Delegate Positions Filled - FL Acad. of Family Physicians	Noureen Akbar, MD	Specialty Society Delegate
	Michelle J. Brandhorst, MD	Specialty Society Delegate
	Liudmila Buell, MD	Specialty Society Delegate
	Michael Allen Cromer, MD	Specialty Society Delegate
	Alfred Chege Gitu, MD	Specialty Society Delegate
	Shermeeka Michelle Hogans-Mathews, MD	Specialty Society Delegate
	E. Coy Irvin, Jr., MD	Specialty Society Delegate
	Ajoy Kumar, MD	Specialty Society Delegate
	Carol Anne Mancero, MD	Specialty Society Delegate
	Dennis Ronald Mayeaux, MD	Specialty Society Delegate
	Lolita Tina Ontiveros, MD	Specialty Society Delegate
	Elizabeth Brooke Shepard Orr, MD	Specialty Society Delegate
	George Andrew W Smith, MD	Specialty Society Delegate
	Trishanna Crystal Sookdeo, MD	Specialty Society Delegate
	Carrie Garretson Vey, MD	Specialty Society Delegate
1 of (1) Delegate Positions Filled - FL Acad. of Pain Medicine	Abraham Rivera, MD	Specialty Society Delegate
1 of (2) Delegate Positions Filled - FL Allergy Asthma & Immunology Soc., Inc.	Hugh Harmon Windom, MD	Specialty Society Delegate
4 of (11) Delegate Positions Filled - FL Ch. Am. Acad. of Pediatrics and Fl. Pediatric Soc.	Mavara Mirza Agrawal, MD	Specialty Society Delegate
	Patricia Jacques Emmanuel, MD	Specialty Society Delegate
	Sarah Marie Marsicek, MD	Specialty Society Delegate
	Mobeen Hasan Rathore, MD, MBBS	Specialty Society Delegate
5 of (13) Delegate Positions Filled - FL Ch. Am. College of Cardiology	Patricia Adriana Guerrero, MD	Specialty Society Delegate
	Neelima Katukuri, MD	Specialty Society Delegate
	Sarah Rosanel, MD	Specialty Society Delegate
	A. Allen Seals, MD	Specialty Society Delegate
	David Edwin Winchester, MD	Specialty Society Delegate
21 of (21) Delegate Positions Filled - FL Ch. Am. College of Physicians	Angeli Maun Akey, MD	Specialty Society Delegate
	Jose Miguel Baez, MD, FACP	Specialty Society Delegate
	Ankush Kumar Bansal, MD	Specialty Society Delegate
	Daniel Sergio Bendetowicz, MD	Specialty Society Delegate
	George Douglas Everett, MD	Specialty Society Delegate

	Antonio Maria Gordon, MD	Specialty Society Delegate
	Farzanna Sherene Haffizulla, MD	Specialty Society Delegate
	Manning H. Hanline, Jr., MD, FACP	Specialty Society Delegate
	Stuart Benson Himmelstein, MD, FACP	Specialty Society Delegate
	Himangi Kaushal, MD	Specialty Society Delegate
	Fernando C. Larach, MD, MBA	Specialty Society Delegate
	Benjamin Mena, MD	Specialty Society Delegate
	Cynthia Eve Miller, MD	Specialty Society Delegate
	Naresh Hemantkumar Pathak, MD, FACP	Specialty Society Delegate
	Cristina I. Pravia, MD	Specialty Society Delegate
	Michelle Lynn Rossi, MD, FACP	Specialty Society Delegate
	Natalia V. Solenkova, MD	Specialty Society Delegate
	Elisa Marie Sottile, MD	Specialty Society Delegate
	Sabrina Nichole Taldone, MD	Specialty Society Delegate
	Joyce Marian Thomas, MD	Specialty Society Delegate
	Claudio Daniel Tuda, MD	Specialty Society Delegate
	Abdo Raymond Asmar, MD	Alternate Specialty Society Delegate
7 of (7) Delegate Positions Filled - FL Ch. Am. College of Surgeons	John Hulse Armstrong, MD	Specialty Society Delegate
	Christopher Garnet Ducoin, MD	Specialty Society Delegate
	Susan Jane Hoover, MD	Specialty Society Delegate
	Mark George McKenney, MD	Specialty Society Delegate
	Jose Mario Pimiento Echeverry, MD	Specialty Society Delegate
	Jay Alan Redan, MD	Specialty Society Delegate
	Jason Paul Wilson, MD	Specialty Society Delegate
	Ziad Tarik Awad, MD	Alternate Specialty Society Delegate
	Toan Thien Nguyen, MD	Alternate Specialty Society Delegate
2 of (1) Delegate Positions Filled - The Florida Society for Post-Acute and Long-Term Care Medicine (Previously FDMA)	Maria Rosaida Gonzalez, MD	Specialty Society Delegate
	Robert G. Kaplan, MD	Specialty Society Delegate
14 of (14) Delegate Positions Filled - American College of Obstetricians & Gynecologists (ACOG) District XII (Florida)	Christina Stough Adams, MD	Specialty Society Delegate
	Guy Ieshua Benrubi, MD	Specialty Society Delegate
	Eliza Gallo Bruscato, MD	Specialty Society Delegate
	Joanna Nicola Dalton Ayoung, MD	Specialty Society Delegate
	Nicole Joy Fanarjian, MD	Specialty Society Delegate

	Victor M. Feldbaum, MD	Specialty Society Delegate
	Andrea King Friall, MD	Specialty Society Delegate
	Karen Eloise Harris, MD	Specialty Society Delegate
	Monica M. Lee-Griffith, MD	Specialty Society Delegate
	Lindsay Maggio, MD	Specialty Society Delegate
	Sujatha Prabhakaran, MD	Specialty Society Delegate
	Maritza Amaly Rivera Montalvo, MD	Specialty Society Delegate
	Shannon Scott Schellhammer, MD	Specialty Society Delegate
	Anna Edouardovna Varlamov, MD	Specialty Society Delegate
8 of (9) Delegate Positions Filled - FL Orthopaedic Soc.	Adam Scott Bright, MD	Specialty Society Delegate
	Mark S. Bromson, MD	Specialty Society Delegate
	Julio Gonzalez, MD	Specialty Society Delegate
	Aaron John Guyer, MD	Specialty Society Delegate
	Lawrence Steven Halperin, MD	Specialty Society Delegate
	Hector Alberto Mejia, MD	Specialty Society Delegate
	John Charles Nordt, III, MD	Specialty Society Delegate
	Michael Andrew Wasylik, MD	Specialty Society Delegate
7 of (8) Delegate Positions Filled - FL Psychiatric Soc.	Debra Marie Barnett, MD	Specialty Society Delegate
	Colleen Elizabeth Bell, MD	Specialty Society Delegate
	Francis Kevin Butler, MD	Specialty Society Delegate
	Jacqueline Ann Hobbs, MD	Specialty Society Delegate
	Rigoberto Rodriguez, MD	Specialty Society Delegate
	Caryn Beth Schorr, MD	Specialty Society Delegate
	Gilbert Albert Smith, DO	Specialty Society Delegate
7 of (10) Delegate Positions Filled - FL Radiological Soc., Inc.	Gregg Anthony Baran, MD	Specialty Society Delegate
	Douglas Neal Hornsby, MD	Specialty Society Delegate
	Patricia Joan Mergo, MD	Specialty Society Delegate
	Sukhwinder Johnny Singh Sandhu, MD	Specialty Society Delegate
	Ravichandra Kumar Sandrapaty, MD	Specialty Society Delegate
	Jeffrey Alan Stone, MD	Specialty Society Delegate
	Timothy John Sweeney, MD	Specialty Society Delegate
8 of (9) Delegate Positions Filled - FL Soc. of Anesthesiologists	Paul David Anderson, MD	Specialty Society Delegate
	Christian Diez, MD	Specialty Society Delegate

	Steven Irvin Gayer, MD	Specialty Society Delegate
	Elena Juliana Holak, MD, PharmD, MPH	Specialty Society Delegate
	Frank Rosemeier, MD	Specialty Society Delegate
	Brence Alan Sell, MD	Specialty Society Delegate
	Jonathan Howard Slonin, MD	Specialty Society Delegate
	Todd Jeffery Smaka, MD	Specialty Society Delegate
7 of (15) Delegate Positions Filled - FL Soc. of Clinical Oncology, Inc.	Dhananjay Deodatta Bendre, MD	Specialty Society Delegate
	Timothy Patrick Boyett, MD	Specialty Society Delegate
	Steven Eric Finkelstein, MD	Specialty Society Delegate
	William V. Harrer, III, MD	Specialty Society Delegate
	Thomas Ray Johnson, MD	Specialty Society Delegate
	Shahla Masood, MD	Specialty Society Delegate
	Luis Estuardo Raez, MD	Specialty Society Delegate
3 of (3) Delegate Positions Filled - FL Soc. of Dermatologic Surgeons	Jeffrey Blake Stricker, DO	Specialty Society Delegate
	Jeremy Alexander Sunseri, MD	Specialty Society Delegate
	Jon Ryan Ward, MD	Specialty Society Delegate
5 of (5) Delegate Positions Filled - FL Acad. of Dermatology	Amy Jane Derick, MD	Specialty Society Delegate
	Brad Peter Glick, DO	Specialty Society Delegate
	Sima Jain, MD	Specialty Society Delegate
	Clifford Warren Lober, MD, JD	Specialty Society Delegate
	Cynthia Jill Yag-Howard, MD	Specialty Society Delegate
3 of (3) Delegate Positions Filled - FL Soc. of Nephrology	Jaime Ann Baynes, DO	Specialty Society Delegate
	Rohit Laxman Pankhaniya, MD	Specialty Society Delegate
	Ashok Dattu Sastry, MD	Specialty Society Delegate
	Mauro Braun, MD	Alternate Specialty Society Delegate
3 of (3) Delegate Positions Filled - FL Soc. of Neurology	Amparo Gutierrez, MD	Specialty Society Delegate
	Daniel Harry Jacobs, MD	Specialty Society Delegate
	Daniel Kantor, MD	Specialty Society Delegate
6 of (6) Delegate Positions Filled - FL Soc. of Ophthalmology	Courtney Elise Bovee, MD	Specialty Society Delegate
	Luxme Hariharan, MD, MPH	Specialty Society Delegate
	Darby Douglas Miller, MD	Specialty Society Delegate

	Javier Antonio Perez, MD	Specialty Society Delegate
	Ankit Anil Shah, MD	Specialty Society Delegate
	Sarah Rae Wellik, MD	Specialty Society Delegate
3 of (4) Delegate Positions Filled - FL Soc. of Pathologists	Marilyn Yuanxin Ma Bui, MD	Specialty Society Delegate
	Patricia Moody McNab, MD	Specialty Society Delegate
	Qihui Zhai, MD	Specialty Society Delegate
2 of (2) Delegate Positions Filled - FL Soc. of Plastic Surgeons	David Eric Halpern, MD	Specialty Society Delegate
	Max Lionel Polo, MD	Specialty Society Delegate
1 of (2) Delegate Positions Filled - FL Soc. of Rheumatology	Robert William Levin, MD	Specialty Society Delegate
2 of (2) Delegate Positions Filled - FL Vascular Soc.	Deepak Gopalan Nair, MD	Specialty Society Delegate
	Charles Stuart Thompson, MD	Specialty Society Delegate

Special Section Delegate	Delegate Name	Description
7 of (9) Delegate Positions Filled - Medical Student Section	Andrew M. Joseph, OMS3	Lake Erie Coll of Osteo Med
	Biura Markarian	Nova Southeastern University - Osteopathic Medicine
	Christopher Miquel-Chambers	University of South Florida College of Medicine
	Harsh Moolani	University of Miami School of Medicine
	Joseph M. L. Nygaard, BS	University of Central Florida College of Medicine
	Joseph Brandon Parker	Florida State University
	Zachary D. Zippi, MS	Florida International University College of Medicine
3 of (4) Delegate Positions Filled - Resident & Fellow Section	Leah Kemble, DO	UCF/HCA GME Consortium-Gainesville
	Brandon Peter Lucke-Wold, MD	Univ. of Florida
	Tisha Delise Van Pelt, MD	

AM '22 FMA Annual Meeting 2022

Procedures of the House of Delegates

PROCEDURES
OF THE
FMA HOUSE OF DELEGATES

Last Updated 4/08/2022

INTRODUCTION

This booklet, "Procedures of the House of Delegates," was originally adopted by the FMA House of Delegates in May 1993 as the official method of procedure in handling and conducting the business brought before the House. The following, serving as Speaker and Vice Speaker, have been responsible for its current preparation.

Ashley Norse, M.D.
Speaker

Mark Rubenstein, M.D.
Vice Speaker

Your Speakers have attempted to clarify confusion of parliamentary procedure typically encountered by the House. It is anticipated that revisions of this section will be required as the House modifies its conduct of business, and other parliamentary procedures may merit consideration in the future.

This outline of procedures of the House is offered as a guide in the hope that it will contribute to the efficient operation of the FMA House of Delegates. A similar publication was adopted by the AMA House of Delegates in 1969. Your Speakers have used the AMA publication in its most recent edition (1999) as a guide in developing this booklet. Appreciation is hereby expressed to the leadership of the AMA.

Contents

Preface 4
Business of the House of Delegates 5
Agenda of the House of Delegates 5
Reports 5
Resolutions 5
Submitting Resolutions 6
Emergency Resolutions 6
Structure of Resolutions 6
Presentation of Resolutions 7
Credentials and Standing Rules 7
Reference Committees 8
Reference Committee Reports 8
Consent Calendar 9
Form of Action upon Reports and Resolutions 11
Parliamentary Procedure in the House Of Delegates 11
Bylaws 13
Charter 13
Elections of FMA Officers and Board of Governors 14
Election of Delegates to the American Medical Association 14
Standard Code of Parliamentary Procedures 15

Preface

The House of Delegates transacts its business according to a blend of rules imposed by its Charter and Bylaws, established by tradition, decreed by its presiding officer, and guided by the most current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*. No rigid codification of its rules exists. The purpose of parliamentary law is to aid an assembly in the orderly, expeditious, and equitable accomplishment of its desires. Any compulsive adherence to an inflexible set of directives may thwart rather than abet such an objective.

The majority opinion of the House in determining what it wants to do and how it wants to do it should always be the ultimate determinant. It is the obligation of the Speaker to sense the will of the House, to preside accordingly, and to make rulings always subject to challenge from and reversal by the assemblage. The following outline of procedures is offered as a guide, subject to reasonable modification, in the hope that adherence to its principles will facilitate the work of the House by reducing confusion and misunderstanding.

Business of the House of Delegates

The business of the House of Delegates (House) is established by a blend of tradition and requirements of the Charter and Bylaws, and includes:

1. Setting policy for the FMA by acting on recommendations from the Board of Governors (Board) and resolutions presented by component county medical societies, recognized specialty medical societies, special sections, and delegates;

2. Hearing addresses and reports from the Treasurer, Speaker, and outgoing and incoming Presidents;

3. Presenting awards recognizing distinguished work by members of the FMA and others as decided by the FMA; and

4. Electing FMA officers, Board members and AMA delegates/alternates.

Additional presentations may be arranged by the Speaker or by request of a member of the House with unanimous consent of the House for discussion.

Agenda of the House of Delegates

The Speaker is responsible for preparing the agenda and assuring consideration and completion of its business within the allotted time. The Speaker may discourage unscheduled presentations, not because of any lack of merit to the presentations, but because of the need to conserve time for regular business.

Reports

Reports are routinely received as business of the House when they come from the Board and, at times, councils, and committees. Except under special circumstances, such reports are referred to appropriate Reference Committees so that hearings may be held on the substance thereof.

Recommendations contained in reports for action by the House are placed at the beginning of the report. The Speaker may request acceptance of a report by unanimous consent or by a vote without referral, but a motion to refer is always in order.

Fiscal Note: *All reports introduced in the House whose implementation necessitates an expenditure of funds must include a fiscal note supplied by the Board, council, or committee submitting the report. No report requiring finances may be considered by the House without the attachment of a fiscal note. The FMA Division of Finance can assist sponsors with the development of fiscal information, but requests of this nature should be forwarded well in advance of the deadline of submitting reports.*

Resolutions

Business is introduced into the House through the presentation of resolutions by voting delegates on behalf of their county or specialty medical society, special section or individually. In order to be considered as regular business each resolution must be submitted to the FMA Headquarters Office no later than sixty (60) days prior to commencement of the session at which it is to be considered.

Fiscal Note: All resolutions introduced in the House whose implementation necessitates an expenditure of funds must include a fiscal note. No resolution requiring finances may be considered by the House without the attachment of such fiscal note. The Division of Finance can assist sponsors with the development of fiscal information, but requests of this nature should be forwarded well in advance of the deadline of submitting resolutions. The Board adopted policy that fiscal notes are an estimate of the cost to implement a given resolution and all resolutions adopted by the House will be referred to the FMA Committee on Finance and Appropriations for fiscal considerations.

Submitting Resolutions

Resolutions received by close of business (5 p.m. EST) on **May 27, 2022**, will be published in the Delegate Handbook. Resolutions received after **May 27th** but prior to 5 p.m. EST on **June 10th** will be published in the Handbook Addendum. Resolutions received after **June 10th** but **prior to 11:00 a.m. on August 5th** will be considered late and referred to the Credentials and Standing Rules Committee for review.

Resolutions should not be late-filed unless they are from a section conducting business the same weekend as the Annual Meeting or address an urgent or time-sensitive issue that arises after the **June 10th** deadline. If a resolution is late the sponsor is required to attend the Credentials and Standing Rules Committee to testify why it is late and its importance for consideration by the House. The Credentials and Standing Rules Committee meets on **Friday August 5, 2022.** If accepted, the Speaker will assign it to the appropriate Reference Committee for consideration.

Emergency Resolutions

Resolutions received later than 11:00 a.m. on **Friday, August 5, 2022** will be considered an emergency resolution and must be printed and distributed to the members of the House; a 2/3 vote is required for consideration as business of the House. The Speakers will determine a time to hold debate on such resolutions and a majority vote is required for its passage.

Structure of Resolutions

The essential element of a resolution is its portion expressed as one or more "Resolved" sections setting forth its specific intent. It may carry with it an introductory statement or preamble explaining the rationale of the resolution. This may also be accomplished by a series of "whereas" statements.

It is not necessary for a resolution to have a preamble or whereas when the full significance of the resolved portion seems apparent. If such introductory statements are supplied, they should identify the problem briefly, and advise the House as to the timeliness or urgency of the problem, the effect of the issue upon the FMA and indicate if the action called for is to set new FMA policy or is contrary to current FMA policy.

It is a general principle of the common law that an assembly, in adopting a resolution, formally adopts only the "Resolved" section. It follows that the important matter before the House is to state in a free-standing "Resolved" precisely that upon which it wishes to act. It is not necessary to amend the title or language of the introductory portions of a resolution unless it is the desire of the House to do so. On occasion the introduction to a resolution will contain detailed sets of guidelines, rules, regulations, or principles which the resolution proposes to approve. In such circumstances, it may be entirely appropriate to amend this related material to bring it into conformity with the will of the House.

In general, the question which will ultimately be before the House is the adoption or other disposition of a specific "Resolved" or a series of "Resolves." It is time-consuming, unnecessary (except as indicated above) and, therefore, usually out-of-order to propose formal amendments to the working of accessory statements or the language of the Reference Committee report in making its recommendations.

Experience has shown that some resolutions suffer from imprecision, inaccuracy, and grammatical or structural defects. Early submission of resolutions allows time for the Speaker to review and advise the sponsors on improvement in form.

When preparing resolutions, close attention should be given to the following:

1. The title of the resolution should appropriately reflect the action for which it calls.

2. Information contained in the resolution should be checked for accuracy. Inflammatory statements or other language that reflects poorly upon the FMA will not be permitted.

3. The Resolves should stand alone and not refer back to the prefatory statement (such as "RESOLVED that the FMA support such programs or policies") since the House adopts only the Resolves and the whereases do not appear in the Proceedings.

4. Fiscal notes should be added, when appropriate, and should set forth the estimated cost, if any, of the policy, program or action proposed by a resolution.

Presentation of Resolutions

At the appropriate time, the Speaker will call for the introduction of resolutions. Resolutions which have complied with the deadline dates are regarded as officially received and distributed in the Delegate Handbook or Handbook Addendum. Opportunity is given during Reference Committee hearings for the sponsor to make changes if they wish. Similar opportunity exists for the withdrawal of any resolution without vote when desired by the sponsor.

The Speaker assigns resolutions to Reference Committees in advance of the first session of the House. If, after review of a resolution, the Speaker determines it to be identical or substantially similar to an existing policy, it is placed on the Reaffirmation Consent Calendar. The Reaffirmation Consent Calendar is presented during the first session of the House and members have the opportunity to publicly extract an item for placement in a Reference Committee.

The Credentials and Standing Rules Committee reviews all late resolutions and makes recommendations to the Speaker whether to accept or reject them for consideration. If considered, the Speaker assigns it to a Reference Committee. Sponsors, or a representative, must be present at the Credentials and Standing Rules Committee for the late resolution to be considered.

Credentials and Standing Rules

The Speaker shall appoint at least three members of the House to review and approve a Delegate's ability to participate in deliberations of House business and render a vote. The Speaker shall designate one of the members as Chair, who shall report at each session the number of delegates officially registered and whether a quorum is present.

Reference Committees

Reference Committees are groups of at least five delegates, who are not current officers or members of the Board of Governors, selected by the Speaker to conduct open hearings on matters of business of the House of Delegates. All members of the Reference Committee are voting members. Having heard discussion on the subject before it, the Committee draws up a report with recommendations to the House for disposition of its items of business.

Online testimony will be open to delegates on **Tuesday, July 5th at 9:00 a.m. EST** and close on **Friday, July 16th at 9:00 p.m. EST.** Delegates may submit testimony on any properly filed resolution. Delegates who choose to submit testimony must indicate their support or opposition of each respective resolution. The Reference Committees will meet in executive session during the week of **July 18-22, 2022** to create a Reference Committee report. The reports will be published online prior to the start of the FMA Annual Meeting. Delegates will have the opportunity to debate the committee's recommendation during in-person Reference Committee hearings on **August 6, 2022.**

Reference Committee hearings are open to delegates, all members of the FMA staff, MDs or DOs who are guests of the FMA, and others invited by a FMA officer or the Reference Committee itself. Any FMA member is privileged to speak on a resolution or report under consideration. Non-member physicians, guests, or interested outsiders may, upon recognition by the Chair, be permitted to speak. 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. 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, and the like. 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 (e.g., "straw polls" are prohibited).

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 arguments with the 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 from the floor of the House. It is recognized, however, that the concurrence of Reference Committee hearings creates difficulties in this respect, as does service by delegates on other Reference Committees, and there is never compulsion for mute acceptance of Reference Committee recommendations at the time of the presentation of its report. If a delegate wants to testify at more than one hearing, Chairs of the various Reference Committees should make every effort to accommodate them by adjusting the Reference Committee agenda.

Following the open hearings, the members of all four Reference Committees will separately meet in executive session for deliberation and construction of their report. They may call into such executive session anyone whom they may wish to hear or question.

Minority reports from Reference Committees are in order.

Reference Committee Reports

Reference Committee reports comprise the bulk of the official business of the House. Reports should be constructed swiftly and succinctly after completion of the hearings so that they may be processed and made available to the delegates as far in advance of formal presentation as possible.

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 of disposition of the business before them, such as adoption, rejection, amendment, referral, and the like.

Basically, at the time of the Reference Committee report, each report or resolution which has been accepted by the House as its business is the matter which is before the House for disposition together with the Reference Committee recommendations in this respect. 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.

Your Speakers recommend that each item referred to the Reference Committee be reported to the House as follows:

1. Identify the resolution by number and title, and reports by council or committee name or letter of Board report.

2. State concisely the Reference Committee's recommendation.

3. Comment, as appropriate, on the testimony presented at the hearings.

We suggest that Reference Committee reports not contain a direct motion. The Chair will open for discussion the matter which is the immediate subject of the Reference Committee report. The effect is to permit full consideration of the business at hand, unrestricted to any specific motion for its disposal. Any appropriate motion for amendment or disposition may be made from the floor. In the absence of such a motion, the Chair will state the question in accordance with the recommendation of the Reference Committee. Examples of five common variants employing this procedure are as follows:

1. The Reference Committee is reporting on informational material provided to the House which encompasses no specific proposals for action. The Reference Committee expresses appreciation of the report and recommends that the matter be filed for information. The Chair declares the original matter to be before the House for discussion. In the absence of any other motion from the floor, the Chair places the question on the adoption or approval of the Reference Committee recommendation to file for information. When it appears that there is no debate, the Chair may declare "it is filed" without the necessity of a formal vote. Such a statement records the action and concludes such an item of business.

2. The Reference Committee is reporting on a resolution which, in its opinion, should be rejected or not adopted, and it so recommends. The Chair places the resolution before the House for discussion. In the absence of other motions from the floor, the Chair, at the appropriate time, places the question on adoption of the resolution, worded in the affirmative, making it clear that the Reference Committee has recommended a vote in the negative.

3. The Reference Committee is reporting on a resolution or report which it feels should be referred for further consideration to the Board, or through the Board to an appropriate council or committee (for study and report back or for action), and it so recommends. The Chair places the original matter before the House for discussion. It may be that the House prefers to adopt this matter, amend it, postpone it, or table it, any one of which it is free to do, or the House may wish to follow the Reference Committee's recommendation.

   If there is no motion from the floor, the Chair will put the motion on the recommendation of the Reference Committee "to refer." If this fails to pass, the motion is then on the adoption of the original resolution or report.

4. The Reference Committee is reporting on a resolution or report which it wishes to amend by addition, deletion, alteration, or substitution. In order to permit the normal procedures for parliamentary handling, the matter which is placed before the House for discussion is the amended version as presented by the Reference Committee together with the recommendation for its adoption. It is then in order for the House to apply to this Reference Committee version amendments of the first and second degree in the usual fashion. Such procedure is clear and orderly and does not preclude the possibility that someone may wish to restore the matter to its original unamended form. This may be accomplished quite simply since it may be moved to amend the Reference Committee version by restoring the original language.

5. The Reference Committee is reporting on two or more kindred resolutions or reports, and it wishes to recommend a consolidation into a single resolution, or it wishes to recommend adoption of one of these items in its own right and as a substitute for the rest. For orderly handling, the matter before the House for consideration is the recommendation of the Reference Committee of the substitute or consolidated version. A motion to adopt this substitute is a main motion and is so treated. If the Reference Committee's version is not adopted, the entire group of proposals has been rejected, but it is in order for any delegate to then propose consideration and adoption of any one of the original matters.

Consent Calendar

All items in a Reference Committee's report to the House are placed on a consent calendar. This means that any item that is not extracted for discussion by the House will remain on the consent calendar with a waiver of debate and approval of the recommendation for that item. All items appearing in the Reference Committee's report are grouped according to the recommendation of the Reference Committee as follows:

For adoption;
For adoption as amended or substituted;
For referral to the Board of Governors (with directive to act or report back to House);
For not adoption;
For filing or reaffirmation of policy.

When the Reference Committee report is presented, the Speaker will remind delegates that all items are on the consent calendar and that delegates have the right to extract any item they wish to discuss without the need for a second, debate, or vote on permission to extract it. When all items have been extracted, the remaining items not extracted will be considered as a package for adoption of the Reference Committee's recommendations. Each extracted item will then be considered individually by the House.

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 issues in a controversial matter, may properly be filed for information. This does not have the effect of placing the FMA on record as approving or accepting responsibility for any of the material in the report.

2. When a report offers recommendations for action, these recommendations may be **ADOPTED, APPROVED**, or **ACCEPTED**, each of which has the effect of making the FMA responsible for the matter. In the interest of clarity, the use of the terms "accepted for information" or "approved in principle" should be avoided.

3. 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 its entirety or in specific part, or to adopt as amended (**Amend and Adopt**).

Parliamentary Procedure in the House of Delegates

In a large assembly, it is necessary to insist that each individual speaking to an issue be recognized by the Speaker, be at a microphone, and be properly identified by stating the delegate's name, whether or not he/she is speaking as an individual or on behalf of their group, and whether they rise in support or opposition to the question at hand.

In the absence of specific provisions to the contrary in the Bylaws of the FMA or in this manual of "Procedures of the House of Delegates," the House shall be governed by the most current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure.*

A few comments on specific procedures may be helpful.

A. **The motion to REFER**: If it is desired that a matter be referred to the Board or through the Board to the appropriate council or committee, it should be specifically indicated if a report back to the House is desired at a definite time. Without such a directive, the matter of reporting back and its timing is up to the body receiving the referral. If the motion to **REFER** is adopted, all pending or adopted amendments as well as the subject are referred. All referrals to specific councils or committees are made through the Board.

   The motion to REFER FOR DECISION: When the House 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, the Board subsequently will inform the House by written communication to the delegates prior to the next meeting and may use other appropriate means such as FMA publications.

B. **The motion to RECONSIDER**: If a motion to **RECONSIDER** is sustained, debate resumes on the

motion which is being reconsidered. Any member may offer the motion to be reconsidered.

C. **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.

D. **The motion to VOTE IMMEDIATELY**: A motion to vote immediately is the same as the older form, **PREVIOUS QUESTION**, and has the effect of closing debate on a pending motion. It requires a 2/3 affirmative vote to sustain such a motion. It is, in effect, a statement by the assembly that it has heard enough and wishes to vote on the matter at hand at once. It applies only to the immediately pending question unless the delegate making the motion to vote immediately qualifies the motion by specifically stating that it applies to all pending questions. A motion to **VOTE IMMEDIATELY** on all pending matters will only be accepted if the Speaker rules that both sides have been heard on **ALL** pending matters. In the event such latter motion prevails, the House must act without further debate on the item of business and all pending amendments in proper order of precedence.

The Speaker will not recognize the motion to vote immediately or terminate the debate as being "in order" if it is added at the conclusion of a significant discussion of the immediately pending question. At the option of the Speaker, a motion to **VOTE IMMEDIATELY** will not be accepted until the House has heard at least one speaker representing each side of the issue.

E. **WITHDRAWAL of a Resolution**: Occasionally the sponsor of a resolution becomes persuaded that his/her resolution is somehow inappropriate or inaccurate. At any time prior to acceptance of the resolution as the business of the House, with referral to a Reference Committee, the sponsor may withdraw his resolution, and it does not become the business of the House. After referral to a Reference Committee, it is the business of the House.

At the time of the Reference Committee hearings, the sponsor may become persuaded that he/she would like to withdraw the resolution and may suggest to the Reference Committee that withdrawal would be preferable to other action. If the Reference Committee agrees, and the sponsor concurs, it may recommend to the House in its report on the matter that **LEAVE TO WITHDRAW** be accorded by the House. The Speaker, having confirmed approval by the sponsor, places the question on granting **LEAVE TO WITHDRAW**. A majority vote in the affirmative accomplishes withdrawal. If there is more than one resolution, withdrawal can be accomplished by a consent calendar requiring a single vote.

F. **The motion to POSTPONE or DEFER CONSIDERATION of a question**: Such deferment may take two forms - (1) Postpone to a certain time and (2) Table.

1. **To a certain time** is of higher rank than referral, and a lesser rank than limiting debate, and can be amended as to the definite time for consideration, with debate limited to brief discussion of the time or reason for postponement, requiring a majority vote to enact.

2. **Table** is the same motion as “postpone temporarily”, is the highest-ranking subsidiary motion to be applied to a main motion, requires a 2/3 vote and can have no other motions applied to it. It can be applied to a motion even after it has been determined that debate on the motion has been terminated which would, in effect, temporarily postpone that vote on the main motion and allow the motion to be brought from the

table for resumption of debate. When such debate is resumed, if the vote to terminate debate has been previously decided, it would simply require that the vote, at that time, be taken without further debate.

Bylaws

The Bylaws may be amended by submission to the Board of proposed amendments by the House, component county medical societies, councils, committees or the Board itself, followed by study by the Board of Governors; and the report of the Board of Governors shall be submitted to the House and the appropriate Reference Committee.

After the report of the Reference Committee, it shall require a majority vote of the delegates seated to pass such an amendment. The amendment as submitted to the House shall not be modified or substantially altered by the Reference Committee or by the House. Minor changes in grammar or phraseology may be made, provided they do not alter the intent or purpose of the amendment. Bylaws amendments adopted by the House will become effective upon adjournment of the House at which the amendment is adopted.

Charter

The Charter may be amended by resolution adopted in the same manner as an amendment to the Bylaws.

Elections of FMA Officers and Board of Governors

FMA officers and non-appointed members of the Board are elected by the House. The House does not have a nominating committee. Members announce their candidacy and run for office. The lengths of terms and limits on numbers of terms served are specified in the Bylaws for each elected office. Nominations for office are made from the floor of the House during one of its sessions. Except for the President-Elect, nominating speeches are waived in uncontested elections. Voting in contested elections is by secret ballot, using electronic voting devices or paper ballots, whichever the Speaker deems appropriate, on the morning of the final session of the House. A majority vote is required for election, and run-offs are held during the final session.

Election of Delegates to the American Medical Association

The FMA has sixteen (16) delegate & sixteen (16) alternate delegate seats in the AMA House of Delegates. In 2022, eight (8) delegate seats and eight (8) alternate delegate seats are up for election for a two-year term. The first eight (8) candidates receiving the most votes will be elected as AMA delegates and the next eight (8) receiving votes in descending order will become alternate delegates.

Each candidate running for a seat on the AMA Delegation is allowed a one-minute speech to be submitted for viewing on the FMA website. Portions beyond one minute will be truncated. Videos can be uploaded in .mp4, .mov, or .m4v formats, or in the case of phone users any format your phone records. All video will be trimmed to 1 minute, sized to 1920 x 1080 pixels and posted for review. You may upload your video here https://flmd.us/up. All materials, including the video are due by June 10, 2022.

American Institute of Parliamentarians Standard Code of Parliamentary Procedure				
BASIC RULES				
Order of precedence[1]	***Can interrupt?***	***Requires a Second?***	***Debatable?***	**Amendable?**
Privileged Motions				
1. Adjourn	No	Yes	Yes[2]	Yes[2]
2. Recess	No	Yes	Yes[2]	Yes[2]
3. Question of privilege	Yes	No	No	No
Subsidiary Motions				
4. Table	No	Yes	No	No
5. Close debate	No	Yes	No	No
6. Limit or Extend debate	No	Yes	Yes[2]	Yes[2]
7. Postpone to a certain time	No	Yes	Yes[2]	Yes[2]
8. Refer to committee	No	Yes	Yes[2]	Yes[2]
9. Amend	No	Yes	Yes[3]	Yes
Main Motions				
10. a. The main motion	No	Yes	Yes	Yes
b. Specific main motions				
Adopt in-lieu-of	No	Yes	Yes	Yes
Amend a previous action	No	Yes	Yes	Yes
Ratify	No	Yes	Yes[3]	Yes
Recall from committee	No	Yes	Yes[2]	No
Reconsider	Yes[4]	Yes	Yes[2]	No
Rescind	Yes	Yes	Yes	No
INCIDENTAL MOTIONS				
No order of precedence	***Can interrupt?***	***Requires a Second?***	***Debatable?***	***Amendable?***
Motions				
Appeal	Yes	Yes	Yes	No
Suspend the rules	No	Yes	No	No
Consider informally	No	Yes	No	No
Requests				
Point of order	Yes	No	No	No
Inquiries	Yes	No	No	No
Withdraw a motion	Yes	No	No	No
Division of question	No	No	No	No
Division of assembly	Yes	No	No	No

1 Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

2 Restricted.

3 Is not debatable when applied to an undebatable motion.

4 A member may interrupt the proceedings but not a speaker.

2022 FMA House of Delegates - Privilege of the Floor

The privilege of the floor shall be restricted to:

FMA members who are seated delegates

Members of the Board of Governors

FMA Past Presidents

AMA Delegates and Alternate Delegates

FMA Council and Section Chairs

Presidents of the County Medical Societies

Members of the Specialty Society Section

AMA General Officers

Reference Committee Meetings
Saturday, August 6, 2022
10:00 am – 11:30 am

Reference Committee I
Health, Education, and Public Policy

Reference Committee I

Christina Adams, M.D., Chair	ACOG
Ruple Galani, M.D.	Duval
Rosemary Garcia Getting, M.D.	Hillsborough
Rohan Joseph, M.D.	Capital
Rajn Mohapatra, M.D.	Hillsborough
John Montgomery, M.D.	Duval
Martha Rodriguez, M.D.	Palm Beach

Reference Committee II
Finance and Administration

Reference Committee II

Michael Forsthoefel, M.D.	Capital
Larry Halperin, M.D.	Florida Orthopedic Society
Elizabeth Orr, M.D.	Fl. Academy of Family Physicians
Brence Sell, M.D.	Florida Society of Anesthesia
Bruce Shephard, M.D.	Hillsborough
Janet West, M.D.	Duval

Reference Committee III
Legislation & Miscellaneous

Reference Committee III

Jason Wilson, M.D., Chair	Fl. Ch. American College of Surgeons
Megan Core, M.D.	Physicians Society of Central Florida
Michael Cromer, M.D.	Fl. Academy of Family Physicians
Michelle Falcone, M.D.	Florida Society of Ophthalmology
David Halperin, M.D.	Florida Society of Plastic Surgeons
Michael Murphy, M.D.	Hillsborough
Daniel Thimann, M.D.	Duval

Legislation Committee IV
Medical Economics

Reference Committee IV

Aaron Sudbury, M.D., Chair	Manatee
Courtney Bovee, M.D.	Florida Society of Ophthalmology
David Dixon, M.D.	Capital
Vania Fernandez, M.D.	Broward
Ali Kasraeian, M.D.	Duval
Maribel Lockwood, M.D.	Capital
Kerry Schwartz, M.D.	Physicians Society of Central Florida

Reaffirmation Calendar

The Speaker, in consultation with FMA staff, have reviewed all resolutions submitted for consideration by the 2022 House of Delegates and have determined the following resolution to be a reaffirmation of existing FMA policy or action already taken. The Speaker therefore recommends reaffirming the following resolution:

RESOLUTION TO REAFFIRM:

22-406	Restrictive Covenants & Physician Non-Compete Clauses	Polk County Medical Association

Resolution 22-406
Restrictive Covenants & Physician Non-Compete Clauses
Polk County Medical Association

Whereas, American Bar Association has "prohibited restrictive covenants between attorneys" and the ABA Model Rules of Professional Conduct state that a lawyer shall not participate in making "a partnership, shareholders, operating, employment, or other similar type of agreement that restricts the right of a lawyer to practice after termination of the relationship." Rule 4-5.6(a) of the Rules of Professional Conduct of The Florida Bar states that "[a] lawyer shall not participate in offering or making…[an] agreement that restricts the right of a lawyer to practice after termination of the relationship." The Florida Bar Professional Ethics Committee Opinion elaborates: "The 'special trust and confidence' inherent in an attorney-client relationship dictates 'that clients be given greater freedom to change legal representatives than might be tolerated in other employment relationships.' When lawyers leave firms, they can go where they please and bring their clients with them; and

Whereas, Physicians should enjoy the identical freedom, mobility, and right to continuously care for their patients just as lawyers do for their clients; and

Whereas, If it is unethical for attorneys to have non-compete restrictions in Florida, how is it not unethical for physicians to have non-compete; and

Whereas, The case, Humana Medical Plan, Inc. v. Jacobson, M.D., 614 So. 2d 520 (Fla. 3d DCA 1992), rev. denied, 623 So. 2d 494 (Fla. 1993), The court stressed that "patients are not property or chattel of an HMO" and elaborated on the "doctor/patient relationship [as]…vital to the provision of health care" and as evolving "over time, by a doctor learning a patient's history and exercising professional judgment in not only evaluating a patient's complaints, but in developing a specific strategy for treating a patient's ailments;" and

Whereas, The AMA has stated that restrictive covenants are "not in the public interest;" and

Whereas, Protection of the doctor-patient relationship is a matter of public health and safety. For this reason, in Florida there should be invalidation of physician non-compete agreements; and

Whereas, Covenants not to compete are designed to restrict otherwise lawful competition.
Whereas, despite debates by legal practitioners, academics, state legislatures and economist regarding restrictive employment covenants there are very few studies examining these agreements to provide evidence and guidance; and

Whereas, Employers seek to restrict the postemployment activities of their physicians' regardless of their rank and status. When a physician is still employed by a particular entity, the physician has fiduciary duties that protect against unfair competition with the employer. These fiduciary duties consist of the duty of care and the duty of loyalty; and

Whereas, The duty of loyalty helps ensure that physician employees will serve the firm's interests and refrain from harmful competition with it during their employment. However, once employment is terminated—for whatever reason—these duties end, and the departing physician employee is should be free to engage in any lawful competition; and

Whereas, The employer's goal for restrictive postemployment covenants is to control the activities of a former employee after the usual employee-employer relationship ends, effectively retaining exclusive use of the information and competitive advantage by contract. In the case of a CEO, there is a far greater risk of harm associated with losing that key employee to a competitor. This is because CEOs typically help create or have knowledge of and have unencumbered access to all of a company's trade secrets, supplier and strategic plans, strengths, and weaknesses. However, physicians have no such valve. The vast majority of physicians that are employed are hired to provide direct medical services to patients; and

Whereas, The CEO is a highly valuable employee and possesses sought-after skills that set him or her apart in a very competitive marketplace for managerial talent. Only the CEO will have unconstrained access to nearly every aspect of the business and its strategic direction. This unique position at the top of the firm's governance structure allows the CEO access to all of the firm's proprietary information, trade secrets, and supplier relationships, product cost structures, research and development information, and strategic plans. As a result, the CEO is the employee who can most harm the company if he or she leaves the firm to work for a competitor. Physician employee's do not have access to this type of information, they do not have unconstrained access to every aspect of the business, nor do physician employees' make decisions that involve the governance, strategic direction of the corporation/hospital; and

Whereas, Covenants not to compete relates to the well-known academic argument that the economic growth of Silicon Valley was made possible in part because of California does not enforced non-competes. California's longstanding, strong public policy of protecting employee freedom of mobility, and its statutory ban on contractual restrictions on employee mobility and the rise of the tech economy in the state have led to a burst of recent scholarship that attempts to test the effect of non-compete enforcement on various business outcomes—in other words, a so-called "California effect;" and

Whereas, Florida court have aggressively enforced non-competes (Office of Economic Policy U.S. Department of the Treasury Non-compete Contracts: Economic Effects and Policy Implications March 2016). Although non-compete contracts can have important social benefits, principally related to the protection of trade secrets, a growing body of evidence suggests that they are frequently used in ways that are hostile to the interests of workers and the broader economy. More importantly, Physician employee's, the vast majority of which are exclusively involved in providing medical care, possess no trade secrets, since medical knowledge and medical/surgical skills are not patentable; and

Whereas, There is evidence that non-compete clauses tend to suppress wages and discourage labor market mobility; and

Whereas, Several states have essentially banned non-compete provisions in physician contracts include California, Massachusetts, Delaware and Colorado. A New Mexico statute first enacted in 2015 prohibits provisions in agreements which restrict the right of healthcare practitioners; and

Whereas, The average cost to take a non-compete to court in Florida is at least $100,000
Whereas, non-compete provisions have a tremendous impact on physicians, resulting in restriction on their future mobility, financial health, and ability to continue practicing medicine. Most non-compete agreements are so prohibitive that it blocks physicians from making a move that might be better for themselves and their patients. Even if the restraint does not immobilize the doctor, it can force physicians not only to relocate, but abandon their ethical responsibility to the patients; and

Whereas, AMA guidelines and stressed the "sensitive and personal nature of the doctor-patient relationship." In Farber, the Arizona Supreme Court explained that "the doctor-patient relationship is special and entitled to unique protection" and that "[i]t cannot be easily or accurately compared to relationships in the commercial context;" and

Whereas, In light of non-compete negative impact on the doctor-patient relationship; that fact that the legal profession considers non-compete unethical and that the majority of non-compete provisions in Florida with physicians are between large Hospital and Corporate entities we should significantly limit or ban non-compete clauses for Florida physician's; and

Whereas, Another reason the law frowns on non-compete agreements for attorneys is because they provide public service, which is to be encouraged. Physicians, who also serve the public and have ethical duties to make their care available, directly trigger that statutory concern with "public health, safety, and welfare;" and

Whereas, Restrictive covenants for doctors are not just ill-advised, but actually injurious to the public; and

Whereas, Such restraints cause a shortage of necessary specialists in a particular community, and also obstruct the continuity of the doctor-patient relationship which fosters quality health care; and

Whereas, Today's non-compete agreements can likewise block doctors from parting with an ill-suited employer and making a move that could inure to the benefit of patients and society at large; and

Whereas, Medicine has always adhered to the unremarkable proposition that a patient's ability to form over time a trusting relationship with a chosen doctor brings lots of health benefits. In contrast, when a restrictive covenant results in the involuntary loss of a physician, it can impose serious physical and psychological damage on the patient; and

Whereas, Physicians blocked from seeing or even contacting former patients under their contracts are, thus, hobbled in their effort to fulfill their obligations to human beings; therefore be it

RESOLVED, That the Florida Medical Association adopts a policy to oppose restrictive covenants and non-complete clauses as it applies to physicians.

Fiscal Note:

Description	Amount	Budget Narrative
0 staff hours	$0	Can be accomplished with current staff
Total	$0	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

In Memoriam FMA Physician Members

Edward John Wilkinson, MD	ALACHUA
Maurice J. Galard, MD	BAYS
Joseph Cangney Von Thron, MD	BREVARD
Jose N. Basagoitia, MD	BROWARD
Edward K. Edwards, Jr., MD	
Kirk Joseph Mauro, MD	CAPITAL
Julia Revell St. Petery, MD	
Andrew Joseph Dauer, DO	CENTRAL FLORIDA
Donald Edward Pearson, MD	
James Kenneth Clary, DO	COLLIER
Michael John Ropele, DO	
Amador N. Hormilla, MD	DADE
A. Frederick Schild, MD	
Robert Glenn Davis, MD	DUVAL
Richard Stephen Lucie, MD	
William R. Bender, MD	ESCAMBIA
Julian Manuel Aviles, Jr., MD	FLDIRECT
Clinton James Potter, MD	
Allen Gerald Zippin, MD	
Alan Roy Marks, MD	HILLSBOROUGH
Muni Sheldon Polsky, MD	
Anthony Lawrence Randich, DO	
Raymond Dean Dominick, MD	LAKE-SUMTER
James Joseph Orlowski, MD	
Raymond Donald Santucci, MD	LEE
Antonio Peraza Rosado, MD	MARTIN
Joseph Charles Babey, III, MD	OUT OF STATE

In Memoriam FMA Physician Members

Martin B. Farkas, DO	
Cary G. Hodnett, MD	
Richard Alexsander Ilka, MD	
Thomas John James, MD	
Elizabeth Charlotte Jones, MD	
Stanley Howard Stoler, MD	
Neil Alden Venard, MD	
Daniel Christian Vittone, MD	
Alvin Sheldon Zelickson, MD	
David Mcmullin Fowler, MD	PALM BEACH
Salvatore Matthew Laraia, MD	
William Squire Merrell, MD	
Andrew Nicholas Risner, MD	PINELLAS
Philip M. Lascelle, MD	SARASOTA
Harvey William Schefsky, MD	VOLUSIA

Florida Medical Association, Inc.

Past Presidents - In Memoriam

1874	Abel S. Baldwin, M.D., Jacksonville (2 terms)
1876	Thomas M. Palmer, M.D., Monticello
1877	Francis P. Wellford, M.D., Jacksonville
1878	R. D. Murray, M.D., Key West
1879	Richard P. Daniel, M.D., Jacksonville
1880	Charles J. Kenworthy, M.D., Jacksonville
1881	George W. Betton, M.D., Tallahassee
1882	R.B.S. Hargis, M.D., Pensacola
1883	Emil T. Sabal, M.D., Jacksonville
1884	John P. Wall, M.D., Tampa
1885	N. D. Phillips, M.D., Gainesville
1886	Joseph Y. Porter, M.D., Key West
1887	J. W. Hicks, M.D., Orlando
1888	R. A. Lancaster, M.D., Gainesville (2 terms)
1890	Thomas P. Gary, M.D., Ocala
1891	J. Harris Pierpont, M.D., Pensacola
1892	Sheldon Stringer, M.D., Brooskville
1893	Frank H. Caldwell, M.D., Sanford
1894	J. D. Rush, M.D., Apalachicola
1895	C. B. Sweeting, M.D., Key West
1896	H. K. DuBois, M.D., Port Orange
1897	R. B. Burroughs, M.D., Jacksonville
1898	R. P. Izlar, M.D., Ocala
1899	J. Harrison Hodges, M.D., Gainesville
1900	W. H. Hughlett, M.D., Cocoa
1901	A. J. Wakefield, M.D., Jacksonville
1902	J. Harris Pierpont, M.D., Pensacola
1903	DeWitt Webb, M.D., St. Augustine
1904	E. N. Liell, M.D., Jacksonville
1905	J. M. Jackson, M.D., Miami
1906	John MacDiarmid, M.D., Deland
1907	W. P. Lawrence, M.D., Tampa
1908	J. F. McKinistry, M.D., Gainesville
1909	Henry E. Palmer, M.D., Tallahassee
1910	J. D. Love, M.D., Jacksonville
1911	A. H. Freeman, M.D., Ocala
1912	John S. Helms, M.D., Tampa
1913	P. C. Perry, M.D., Jacksonville
1914	F. C. Moor, M.D., Tallahassee
1915	R. H. McGinnis, M.D., Jacksonville
1916	E. W. Warren, M.D., Palatka
1917	Ralph N. Greene, M.D., Coral Gables
1918	F. J. Walter, M.D., Daytona
1919	William E. Ross, M.D., Jacksonville
1920	W. P. Adamson, M.D., Tampa
1921	S.R.M. Kennedy, M.D., Pensacola
1922	L. M. Anderson, M.D., Lake City
1923	H. Marshall Taylor, M.D., Jacksonville
1924	John C. Vinson, M.D., Fort Myers
1925	John S. McEwan, M.D., Orlando
1926	H. Mason Smith, M.D., Tampa
1927	John A. Simmons, M.D., Arcadia
1928	Frederick J. Waas, M.D., Jacksonville
1929	Henry C. Dozier, M.D., Ocala
1930	Julius C. Davis, M.D., Quincy
1931	Gaston H. Edwards, M.D., Orlando
1932	Gerry R. Holden, M.D., Jacksonville
1933	William M. Rowlett, M.D., Tampa
1934	Homer L. Pearson Jr., M.D., Miami
1935	Herbert L. Bryans, M.D., Pensacola

1936 Orion O. Feaster, M.D., St. Petersburg
1937 Edward Jelks, M.D., Jacksonville
1938 W. Henry Spiers, M.D., Orlando
1939 Leigh F. Robinson, M.D., Fort Lauderdale
1940 J. Sal Turberville, M.D., Century
1941 Walter C. Jones, M.D., Miami
1942 Gilbert S. Osincup, M.D., Orlando
1943 Eugene G. Peek Sr., M.D., Ocala
1944 John R. Boling, M.D., Tampa (2 terms)
1946 Shaler Richardson, M.D., Jacksonville
1947 William C. Thomas Sr., M.D., Gainesville
1948 Joseph S. Stewart, M.D., Miami
1949 Walter C. Payne Sr., M.D., Pensacola
1950 Herbert E. White, M.D., St. Augustine
1951 David R. Murphy Jr., M.D., Tampa
1952 Robert B. McIver, M.D., Jacksonville
1953 Frederick K. Herpel, M.D., Wt Palm Beach
1954 Duncan T. McEwan, M.D., Orlando
1955 John D. Milton, M.D., Coral Gables
1956 Francis H. Langley, M.D., St. Petersburg
1957 William C. Roberts, M.D., Panama City
1958 Jere W. Annis, M.D., Lakeland
1959 Ralph W. Jack, M.D., Miami
1960 Leo M. Wachtel, M.D., Jacksonville
1961 S. Carnes Harvard, M.D., Brooksville
1962 Robert E. Zellner, M.D., Orlando
1963 Warren W. Quillian, M.D., Coral Gables
1964 Samuel M. Day, M.D., Jacksonville
1965 H. Phillip Hampton, M.D., Tampa
1966 George S. Palmer, M.D., Tallahassee
1967 W. Dean Steward, M.D.
1968 Jack Q. Cleveland, M.D., Coral Gables
1969 Henry J. Babers, M.D., Gainesville
1970 James T. Cook Jr., M.D., Marianna
1971 Floyd K. Hurt, M.D., Jacksonville
1972 William J. Dean, M.D., St. Petersburg
1973 Joseph Von Thron, M.D., Cocoa Beach
1974 Thad Moseley, M.D., Jacksonville
1975 Vernon B. Astler, M.D., Fletcher, NC
1976 Jack A. MaCris, M.D., St. Petersburg
1977 Louis C. Murray, M.D., Orlando, FL
1978 O. William Davenport, M.D., Miami
1979 Richard S. Hodes, M.D., Tampa
1981 Sanford A. Mullen, M.D., Jacksonville
1982 Robert E. Windom, M.D., Sarasota
1984 Frank C. Coleman, M.D., Tampa
1985 Luis M. Perez, M.D., Sanford
1992 A. Frederick Schild, M.D., Miami
1993 Arthur L. Eberly, M.D., Lighthouse Point
1994 Dick Van Eldik, M.D., Gainesville
1995 Alvin E. Smith, M.D., Ormond Beach
1998 Harold G. Norman Jr., M.D., Coral Gables (Honorary Pres.)
2007 Karl M. Altenburger, M.D., Ocala
2008 Edward R. Annis, M.D., Miami (Honorary Pres.)
2009 James B. Dolan, M.D., Ponte Vedre Beach

REPORT OF ACTIONS FROM THE 2021 HOUSE OF DELEGATES AND UPDATES

Action on Recommendations from the Board of Governors – pgs. 2-13

Action of 2021 Resolutions – pgs. 13-33

Resolutions Referred to the Board of Governors:

21-108 Educating Patients and Physicians on the Dangers of Automatic Prescription Refills
South Florida Caucus

21-109 Kratom Safety Risk
Florida Society of Addiction Medicine

21-206 Employed Physicians
Broward County Medical Association

21-303 Country Origin
Hillsborough County Medical Association

21-304 Pharmacies
Capital Medical Society

19-308 Medical Cannabis
Florida Society of Addiction Medicine

21-310 Restrictive Covenants
Polk County Medical Association

21-311 Opioid Use Disorder Treatment
Florida Society of Addiction Medicine

21-312 Physician Contract Non-Compete Clause
Escambia

21-313 Corporate Practice of Medicine
South Florida Caucus

D-2 Board of Governors Recommendation D-2, Initial Assessment and Treatment Recommendations by Specialists

Action on Recommendations from the Board of Governors

Board Recommendation A-1
2012 FMA Policy Review – Reaffirmation and Sunset

House Action: **Adopted policies to reaffirm and sunset as presented in original report.**

Board Recommendation A-2
Resolution 19-104 FMA Endorsement of ABMS Vision for the Future Commission Final Report (2019 House of Delegates)

House Action: **Not adopted**

RESOLVED, The FMA send a letter to the ABMS by August 31, 2019, urging it, and its subsidiary boards, to move quickly to:

- Implement the specifics and the spirit of the ABMS Vision for the Future Final Report regarding Assessment Recommendation which states "Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge."
- Abandon Continued Certification processes characterized by high-stakes summative outcomes (pass/fail examinations), specified timeframes for high-stakes assessment, or require burdensome testing formats (such as testing centers or remote proctoring) that are inconsistent with the desired goals for continuing certification,
- Develop innovative formative Continued Certification processes grounded in adult learning principles (e.g. frequent, spaced learning with timely feedback; repeated for reinforcement; gap analysis to aid focus) and support diplomates in their commitment to continuing professional development aimed at keeping current and improving patient care, and be it further

RESOLVED, That the FMA submit a resolution at the 2019 AMA Interim Meeting requesting the AMA to send a similar letter to the ABMS by November 30, 2019.

RESOLVED, The resolution will make recommendations protecting physicians who professionally use information and their knowledge to optimize care for patients; and be it further

RESOLVED, The resolution should include a provision that will, when necessary, employ the services of our Litigation Center to protect affected physicians; and be it further

RESOLVED, That the resolution should include the right of physician communication be evaluated by our American Medical Association's Council of Ethical and Judicial Affairs, and be clearly incorporated into our Code of Medical Ethics.

Board Recommendation A-3
Resolution 19-108, Online Database for Physicians and Patients Interested in Stem Cell Therapy
(2019 House of Delegates)

House Action: **Not adopted**

RESOLVED, That the Florida Medical Association create standard criteria that will evaluate the training and expertise of physicians that provide high quality, reputable, and trustworthy stem cell therapies; and be it further
RESOLVED, That the Florida Medical Association create an online database that will direct physicians and patients to those physicians that meet the criteria established by the Florida Medical Association.

Board Recommendation B-1
Resolution 19-203, Educating Members Regarding Legal and Legislative Efforts to End MOC Mandates
(2019 House of Delegates)

House Action: Not adopted

RESOLVED, That the FMA develop an educational campaign in the form of a separate, stand alone, comprehensive email, detailing the legal and legislative efforts being made in our state and across the nation, specifically highlighting the legal action currently being taken against ABIM, including the lawsuit being brought by Practicing Physicians of America and The American Association of Physicians and Surgeons; and be it further

RESOLVED, That the FMA is committed to educate their members on these legal and legislative matters in order to allow individual members to support these efforts nationwide.

Board Recommendation B-2
Resolution 19-206, Composition of the Body of Medical Staff's Executive Committee and/or Board of Trustees
(2019 House of Delegates)

House Action: Adopt AMA Policy H-225.950 in lieu of Resolution 19-206

Original language:
RESOLVED, That the FMA support legislative or administrative changes to define that the medical staff bylaws in hospitals will require that a majority of the Medical Executive Committee voting members will not be contracted physicians or employed physicians, but rather medical staff members with independent practices without conflict of interest; be it further
RESOLVED, That the FMA will advocate to the AMA to adopt the right to fair market and transparent economic competition in our communities between hospitals with or without employed physicians and other allied healthcare professionals and independent physicians and groups in the delivery of healthcare services and compensation based on appropriate community need.

The substitute language reads as follows:

Principles for Physician Employment (language adopted from AMA Policy H-225.950)
Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify

the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians

should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
i. The agreement is for the provision of services on an exclusive basis; and
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Compendium updated – 245.016

Board Recommendation C-1
Resolution 19-315, Limit Expansion of Cosmetic, Dermatologic Surgery and/or Facial Aesthetics

(2019 House of Delegates)

House Action: Not Adopt

RESOLVED, The Florida Medical Association shall support legislation to restrict the practice of cosmetic and/or dermatologic surgery and/or facial aesthetics to MDs or Dos unless done by dentists or APRNs under the direct supervision of an MD or DO.

Board Recommendation D-1
Resolution 19-307, Medicare Reimbursement Standard for Out-of-Network Medicaid Treatment
(2019 House of Delegates)

House Action: Not Adopt

RESOLVED, That the Florida Medical Association send a letter to the Governor's Office and the Agency for Health Care Administration with a request to reconsider their position on not mandating out-of-network physicians receive the same Medicare Level reimbursement rates when treating Pediatric Medicaid Beneficiaries as in-network physicians; and be it further

RESOLVED, That the Florida Medical Association pursues legislation that will mandate that all physicians treating Pediatric Medicaid Beneficiaries shall receive Medicare level reimbursement for their services if the Governor's Office and Agency for Health Care Administration do not reverse their policy.

Board Recommendation D-2
Resolution 19-102, Initial Assessment and Treatment Recommendations by Specialists
(2019 House of Delegates)

House Action: Refer to the Board of Governors for decision; substitute language adopted in lieu of Recommendation D-2, Resolution 19-102, Initial Assessment and Treatment Recommendations by Specialists

RESOLVED, that the FMA communicate to the various specialty societies, either directly or through their representatives, the concern regarding the increasing and, at times, risky use of nurse practitioners and physician assistants for initial evaluation of patients referred to specialist physicians; and be it further

RESOLVED, that the FMA encourage the various specialty societies to develop and adopt appropriate clinical guidelines to ensure patients referred to specialist physicians have their initial assessment, diagnostic evaluation, and formulation of a treatment plan performed by the specialty physician

rather than a non-physician practitioner.

October 2021 – The 2021 House of Delegates referred Board Recommendation D-2, Resolution 19-102, Initial Assessment and Treatment Recommendations by Specialists to the Board of Governors for decision. The 2019 House of Delegates referred the original resolution, 19-102 to the Board of Governors for study and report back. The resolution was studied by both the Council on Medical Economics and Practice Innovation and the Council on Medical Education, Science, and Public Health. As a result of those studies, the Board of Governors proposed substitute language be adopted by the 2021 House of Delegates. The 2021 House of Delegates was divided on the proposed substitute language and referred Recommendation D-2 to the Board of Governors for decision. The Board agreed that a task force was needed to study this resolution and appointed a task force in October 2021.

June 2022 – The Task Force met, and after much discussion felt that a blanket statement or set of guidelines would not suffice. The Task Force reviewed the language the Board of Governors agreed on in 2021 which read:

> *RESOLVED, that the FMA request that the various primary care and specialty societies and publish appropriate guidelines on the use of Advanced Registered Nurse Practitioners and Physician Assistants for referrals and evaluations.*

The Task Force felt that the statement didn't clearly state that the Board would be working in consultation with various specialties. An amended to that statement was proposed and ultimately agreed upon. This is now P 283.023 in the Policy Compendium.

> *RESOLVED, that the FMA request that the various primary care and specialty societies work collaboratively to develop and publish appropriate guidelines on the use of Advanced Registered Nurse Practitioners and Physician Assistants for referrals and evaluations.*

Board Recommendation D-3
Resolution 19-402, The ASAM Criteria Addiction Treatment Guidelines and ASAM Continuum as Standard for Third Party Payor Reimbursement
(2019 House of Delegates)

House Action: Adopted substitute language in lieu of Resolution 19-402

Original Language:

RESOLVED, That the Florida Medical Association petitions the Florida Office of Insurance Regulation, to accept a position statement that supports the established, nationally accepted and recognized treatment guidelines of the various national medical specialty organizations as the standard for third party payor payment criteria, treatment criteria, placement criteria and

all additional matters relating to the medical care of patients and strongly discourages the use of other self-created, non-evidence based, non-validated and non-nationally established treatment guidelines.

Substitute Language:

RESOLVED, That the Florida Medical Association continue to work with the various state and national medical societies, including the Florida Society of Addiction Medicine, to identify and evaluate gaps in coverage that limit access to medically necessary care for Floridians; and be it further

RESOLVED, That the Florida Medical Association shall work with the various state and national medical societies, including the Florida Society of Addiction Medicine, to resolve gaps in coverage that limit access to medically necessary care for Floridians, such as by supporting appropriate legislative and regulatory remedies.

Board Recommendation D-4
Resolution 19-404, Inclusion of Medical Students as Recipients of Benefits of Workers Compensation (2019 House of Delegates)

House Action: **Adopt substitute language in lieu of Resolution 19-404**

Original Language:

RESOLVED, That our Florida Medical Association support legislation that would guarantee medical students at a state medical school the benefits provided by section 440.09, Florida Statutes, if the medical student suffers an accidental compensable injury or death arising out of actions performed in the course and scope of their medical school education.

Substitute Language:

RESOLVED, That our Florida Medical Association will encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students exposed to a needlestick injury in the course of their medical student duties.

Compendium updated – 490.008

Resolution 21-102
Physicians for the Advancement of Gun Ethics Research and Safety (P.A.G.E.R.S.)
Northeast Delegation

House Action: Adopted as amended

RESOLVED, That the FMA will join with other societies to ~~the ACS and ACEP and~~ support research and education in firearm safety including the development of technology that increases firearm safety; and be it further
RESOLVED, That the FMA will promote both public and private funding into firearm safety and injury prevention research.

Compendium updated: P 190.008

Resolution 21-103
Support for Focus of Physician Training Responsibilities
Northeast Florida Delegation

House Action: Substitute language adopted in lieu of Resolution 21-103

~~*RESOLVED, The Florida Medical Association support efforts to require residency programs, medical schools, physician practices, and other institutions involved in physician training to focus primarily on the education and training of future physicians; and further be it*~~

~~*RESOLVED, The Florida Medical Association will form a Task Force to research and make recommendations regarding the appropriate role and compensation for physicians in the training of non-physician providers.*~~

RESOLVED, that the Florida Medical Association form a Task Force to assess the impact of non-physician training on physician training and clinical faculty in physician practices, hospitals, and medical centers.

October 2021 – The Board discussed this resolution at length. Questions arose as to how non-physician training has impacted students and residents. The Board felt that it needed to determine why this was happening in the first place. A task force was appointed to study this issue in depth.

Resolution 21-104
Retire Florida Rule 64B8-9.012 Standards for the Prescription of Obesity Drugs
Physicians Society of Central Florida

House Action: Adopted

RESOLVED, That the FMA work with interested Specialty Societies to encourage the Board of Medicine to amend Florida Rule 64B8-9.012 Standards for the Prescription of Obesity Drugs to reflect the current standard of care for patients affected by obesity in the State of Florida.

P 130.026 in the Policy Compendium. The FMA House of Delegates passed Resolution 21-104, asking the FMA to encourage the Board of Medicine to amend Rule 64B8-9.012 in order to reflect the current standard of care for patients affected by obesity in Florida. Rule 64B8-9.012, FAC, sets the standards of practice for medically assisted weight loss and has not been updated since 1998 when the rule was first promulgated in response to the "fen-phen" epidemic. The rule refers to outdated obesity thresholds, is largely redundant with established law, requires in-person examinations (now inconsistent with Florida's telehealth law), and overall no longer accurately reflects the standard of practice in the area of prescription weight management.

On October 7, 2021, the Boards of Medicine and Osteopathic Medicine held a joint workshop to develop updated standards for the prescription of obesity drugs. While it was generally agreed upon that the rule could be repealed in its entirety, the Boards are required by statute to establish practice guidelines to safely prescribe phentermine, fenfluramine (no longer on the market), and other drugs used to treat obesity. As such, the workgroup voted to strike the rule in its entirety and develop less onerous standards to be considered at the upcoming December 2021 meeting.

Resolution 21-105
Opposition of Proof of Vaccination to COVID-19
Jon Ward, M.D.

House Action: Adopted substitute language in lieu of Resolution 21-105

~~*RESOLVED, that the FMA support any legislation that would protect an individual's decision to receive or not receive the COVID-19 vaccine; and be it further*~~

~~*RESOLVED, That the FMA's delegation to the AMA submit a resolution at the 2021 AMA Interim Meeting requesting the AMA to support federal legislation to prohibit any state or local government, business or educational institution from implementing a requirement that a person provide any documentation certifying COVID-19 vaccination or post-infection recovery to gain access to, entry upon or service from the state or local government, business or educational institution.*~~

Healthcare Professional Readiness for COVID-19

RESOLVED, that the FMA publish a statement upon the conclusion of the 2021 Annual Meeting recommending that all health care practitioners and medical support staff receive the COVID-19 vaccine

and utilize harm reduction techniques, such as the wearing of masks, for the safety, protection, and well-being of our communities.

August 2021 – The FMA and Douglas Murphy, M.D., President and Chair of the FMA Board of Governors put out a statement that read:

"The Florida Medical Association further renewed its commitment in combatting COVID-19 - and its variant - as we work tirelessly to educate Florida patients on the lifesaving benefit of getting vaccinated. Physicians continue to see daily upticks in coronavirus cases in younger, unvaccinated patients, which is why it is even more important for all healthcare practitioners and medical support staff to receive the vaccine. FMA members have been at the frontlines of this pandemic, and we must not allow COVID cases to reach 2020 levels," said FMA President Doug Murphy, MD.

Resolution 21-106
Opposition of Future Curtailment of Individual Liberties During Pandemics
Jon Ward, M.D.

House Action: Not adopted

RESOLVED, That the FMA condemn the use of lockdowns and business closures as non-pharmaceutical interventions for any future pandemics regardless of the CDC or NIH recommendations, unless they are based on randomized controlled trials or a similarly high level of evidence; be it further

RESOLVED, The FMA amend its bylaws to provide that the Board of Governors may not issue a public health recommendation that is not supported by randomized controlled trials or a similar high level of evidence and that such a recommendation may only be approved by a majority vote of the House of Delegates.

Resolution 21-107
Graduate Physician
Palm Beach County

House Action: Adopted as amended

RESOLVED, That the Florida Medical Association seek legislation that establishes a time-limited position, "graduate physician", which would allow unmatched U.S. medical school graduates (MDs and DOs), who have passed the USMLE Steps 1-3, to practice within the same scope as a physician assistant under the Florida Board of Medicine and under the supervision of an Attending Physician who has completed an ACGME-accredited residency program within a given specialty; further be it

RESOLVED, The Florida Medical Association recognize that the position of "Graduate Physician" is not to

be considered an alternative path to full unsupervised licensure in lieu of completing an ACGME-accredited residency program.

Compendium updated – 440.003

Resolution 21-108
Educating Patients and Physicians on the Dangers of Automatic Prescription Refills
South Florida Caucus

House Action: Referred to the Board of Governors for study and report back to the 2022 House of Delegates; the Board of Governors recommends to not adopt.

RESOLVED, that our FMA will recognize:

1. That automatic prescription refills increase the risk of medical errors
2. Automatic prescription refills can sometimes be associated with fraudulent transactions resulting in overbilling of government programs such as Medicaid
3. That a prescription refill is not the same as authorizing automatic refills
4. Many patients are enrolled in these programs without their consent; be it further

RESOLVED, The FMA delegation to the AMA submit a resolution to the AMA at the appropriate time to adopt a policy recognizing the dangers of automatic prescription refills.

January 2022- The Council on Medical Education, Science, and Public Health studied this resolution. In preparation for the meeting, FMA staff spoke informally to the Program Manager of the PDMP (a pharmacist), a member of the Florida Board of Pharmacy, and the Board's legal counsel to determine whether there was available information regarding any adverse impacts of automatic prescription refills in Florida. These individuals were unable to provide any substantive information that these programs present any problems in Florida. After much discussion, the Council acknowledged that the issue of automatic prescription refills is one that has both pros and cons for patients. On one hand, patients can benefit from the ease and convenience of choosing this option for regular prescriptions and it could lead to better medication compliance. On the other hand, for patients who frequently change medications or are trying a new medication, an automatic refill might lead to unwanted/unneeded refills. The Board of Governors reviewed the Council's report and agreed that due to the limited information, there was insufficient data to support the adoption of this resolution. The Board of Governors voted to recommend that the 2022 House of Delegates not adopt Resolution 21-108. The Board of Governors did vote to extend an invitation to the Board of Pharmacy to give further comment at the June Board of Governors meeting.

Resolution 21-109
Kratom Safety and Risk
Florida Society of Addiction Medicine

House Action: Referred to the Board of Governors for study and report back to the 2022 House of Delegates; the Board of Governors recommends adopting substitute language

RESOLVED, That our Florida Medical Association (FMA) amend policy P 125,000, "Drugs-Abuse" to add a new section P 125.005 to read as follows:

P 125.005 Kratom Risk and Safety

RESOLVED, That the Florida Medical Association adopt the following policy on "KratomRisk and Safety as follows:

1. Our FMA opposes the sale or distribution of kratom by retailers in Florida.
2. Our FMA will work with stakeholders to require that Florida retailers display warnings to the public, in a conspicuous location near the point of sale inside their retail establishments, regarding the potentially fatal dangers of kratom and the fact that there have no controlled clinical trials conducted to determine its safety for human use.

January 2022- The Board of Governors referred Resolution 21-109 to the Council on Medical Education, Science, and Public Health. After hearing testimony from representatives from the Florida Society of Addiction Medicine and American Society of Addiction Medicine, the Council agreed that Kratom potentially poses a risk to Floridians. The Council also had the opportunity to review existing AMA policy on Kratom and felt that any FMA policy should mirror policy language already adopted by the AMA. The Board of Governors recommends that the 2022 House of Delegates adopt the following substitute language:

That the FMA support legislative and/or regulatory efforts prohibiting the sale or distribution of Kratom in Florida, while still allowing opportunity for proper scientific research.

Resolution 21-110
Maintenance of Certification Review
Ellen McKnight, M.D.

House Action: Not adopted

RESOLVED, That the FMA petition the American Board of Internal Medicine/American Board of Specialty Medicine for an immediate cessation of the mandatory Maintenance of Certification (MOC) program required every two years and for substantiation of their claim that physician participation in MOC is a necessity. These studies could be conducted now comparing those doctors who participate in MOC to those doctors who do not in order to determine if MOC mandates improve patient outcomes or is superior to CME.

Resolution 21-111
Prescription Off-Label Medication

Ellen McKnight, M.D.

House Action: Adopt as amended

RESOLVED, That the FMA adopt the following policy on physician off-label prescribing of medications:

1. *Off-label prescribing of medications is ~~common and~~ necessary to the practice of medicine.*
2. *The FMA is opposed to ~~any infringement by a non-medical entity of a~~ the interference by non-medical entities in the physician-patient relationship by restricting a physician's ability to prescribe medications off-label.*
3. *The FMA affirms American Medical Association Policy H-120.988, Patient Access to Treatments Prescribed by Their Physicians. ~~Economically motivated interference by non-medical entities in physician off-label prescribing is a flagrant, potentially harmful interference in the physician-patient relationship.~~*
4. *~~4. The FMA delegation to the American Medical Association shall submit a resolution at the appropriate time requesting that the AMA adopt policy opposing the infringement by a non-medical entity of a physician's ability to prescribe medications off-label.~~*

Compendium updated – 130.025

Resolution 21-112
Addressing Racism as a Public Health Issue
Medical Student Section, Alachua Medical Society, Dade County Medical Association, Hillsborough County Medical Association

House Action: Adopted as amended

RESOLVED, That our Florida Medical Association recognizes the public health threat of racial health inequities ~~racism as a public health issue~~; and be it further

RESOLVED, That our Florida Medical Association ~~denounce~~ condemn racism in all forms;, ~~and support efforts to mitigate its harmful effects on clinical outcomes in minority and mortality in minority populations;~~ and be it further

RESOLVED, That our Florida Medical Association ~~will pursue avenues to~~ collaborate with the American Medical Association and other stakeholders to eliminate the harmful impact of prejudices on clinical outcomes in racial and ethnic minorities and at-risk populations. ~~as a means to actively combat racism and promote racial justice.~~

Compendium updated – 420.046

Resolution 21-114
Naturally Acquired Immunity
Jon Ward, M.D., Ellen McKnight, M.D.

House Action: Not adopted

RESOLVED, That the FMA recognize that natural immunity which results from SARS-CoV-2 infection and recovery is an equivalent level of immunization as commercially available vaccines to SARS-CoV-2; be it further

RESOLVED, That the FMA send a letter to the Florida Dept. of Health and to the Centers for Disease Control that the Physicians of Florida demand recognition of documented natural immunity as proof of full immunization; be it further

RESOLVED, That the FMA take this resolution to the AMA at the interim meeting for immediate policy change which currently does not include natural immunity as a form of proof of immunization.

Resolution 21-201

PAC Membership

Polk County Medical Association

House Action: Adopted as amended

RESOLVED, That the members of the Florida Medical Association House of Delegates and the members of the Florida Medical Association Board of Governors are ~~required~~ encouraged to become members of the Florida Medical Association PAC and the ~~required~~ encouraged membership in the FMA PAC shall be the minimum monetary amount necessary to become a FMA PAC member.

Resolution 21-202

Medical Cannabis Committee

Dade County Medical Association, Broward County Medical Association

House Action: Adopted substitute language in lieu of Resolution 21-202

Original Language:

RESOLVED, That the FMA establish an ad hoc committee to advise the Board of Governors on evidence-based medical cannabis policies that emphasize physician education and public health awareness.

Substitute Language:

RESOLVED, That the FMA Board of Governors request that the Council on Medical Education, Science, and Public Health evaluate the status of evidence-based medical cannabis policies and their impact on

physician education and public health awareness.

Resolution 21-203
Expanded Resource Base for Neurological Injury Compensation Association (NICA)
Northeast Florida Delegation

House Action: Adopted as amended

RESOLVED, That the FMA ~~seek~~ support legislation to amend Florida Statute 766.314 to require all ~~licensed medical professionals~~ healthcare practitioners not requiring physician supervision in Florida to pay the annual NICA Assessment; and be it further,

RESOLVED, That the FMA ~~seek~~ support legislation to require the State of Florida to review the licensed medical professional assessment established in Florida Statute 766.314 taking into consideration the additional revenue generated by expanding the fee to all ~~licensed medical professionals~~ healthcare practitioners not requiring physician supervision to ensure the ~~fee is reasonable yet actuarily sound to ensure the~~ sustainability of the program while decreasing the amount of the individual fees yet remaining actuarily sound.

Compendium updated: 335.006

Resolution 21-204
NICA Exemption
Physicians Society of Central Florida

House Action: Not adopted

RESOLVED, That the FMA seek legislation to exempt non-participating physicians from the annual $250 payment into NICA.

Resolution 21-205
NICA Reform
South Florida Caucus

House Action: Adopted as amended

RESOLVED, That the FMA ~~review the support of the present~~ continue to consult on an ongoing basis withthe NICA program to ensure that there is transparency in the program, that injured infants are being treated appropriately and that there is equitable support from hospitals and physicians.

Compendium updated: 335.007

Resolution 21-206
Employed Physician
Broward County Medical Association

House Action: Referred to the Board of Governors for decision; substitute resolution adopted

RESOLVED, That the Florida Medical Association establish and create a Section for Employed Physicians to ascertain problems associated with employment; recommend solutions; and employ the strength of the Florida Medical Association as a resource when resolving conflicts and challenges between employed physicians and their employers; be it further

RESOLVED, That the Florida Delegation to the American Medical Association submit the following resolution for consideration at their November, 2021 Interim meeting; be it further

RESOLVED, That the American Medical Association establish and create a Section for Employed Physicians to ascertain problems associated with employment; recommend solutions; and employ the strength of the American Medical Association as a resource when resolving conflicts and challenges between employed physicians and their employers.

October 2021 - The Board discussed this resolution at length and was divided over the issue. It is estimated that at least 50% of FMA membership is comprised of employed physicians. A substitute resolution was adopted. This language is now P 395.011 in the Policy Compendium. It reads as follows:

RESOLVED, The FMA publicize the services that are currently available for employed physicians that include but are not limited to contract evaluation, workplace issues, and a forum where concerns can be voiced.

Resolution 21-301
Use of Marijuana in Pregnancy
American College of Obstetricians and Gynecologists (ACOG, District XII)

House Action: Adopted

RESOLVED, The Florida Medical Association support legislation to remove current statutes that allow theuse of medical marijuana in pregnancy at any dose.

Compendium updated: P 307.006

Resolution 21-302
Bleeding Control Kits in Schools and Public Spaces

House Action: Adopted

RESOLVED, That the Florida Medical Association seek state appropriation to fund purchase, placement, and maintenance of bleeding control kits in schools and high-trafficked public spaces in Florida.

Compendium updated P 445.027

Resolution 21-303
Country of Origin Designation
Hillsborough County Medical Association

House Action: Referred to the Board of Governors for decision; not adopted

RESOLVED, That the Florida Medical Association seek legislation to require the labeling "Country of Origin" on all the generic medications dispensed by local and online pharmacies.

June 2022: The Board of Governors referred this resolution to the Council on Legislation to study. Testimony on behalf of the resolution noted that greater transparency as to the country of origin of prescription drugs would greatly benefit patient safety. While noting that patient safety in this sphere is a laudable goal, a legal analysis of the factors that would have to be considered in any effort to pass legislation requiring country of origin labeling was conducted. Existing federal regulations on prescription drug labeling were discussed, along with corresponding state laws. Federal preemption was discussed and noted as a potential roadblock to state legislation. Practical considerations presented by the difference between FDA regulations and those enforced by the US Customs Headquarters were discussed, and finally, it was noted that there was pending federal legislation that would impose country of origin disclosure statements on online advertising. Based on the numerous problems, both legal and practical posed by the resolution's request, the Board decided that pursuing state legislation on this issue was not a wise use of FMA resources.

Resolution 21-304
Pharmacies
Capital Medical Society

House Action: Referred to the Board of Governors for study and report back to the 2022 House of Delegates; the Board recommends that the 2022 House of Delegates adopts substitute language in lieu of original Resolution 21-304, Pharmacies.

~~RESOLVED, That the FMA supports legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher~~

~~than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient.~~

June 2022: This resolution was referred to the Council on Medical Economics and Practice Innovation. The resolution was written to pursue the laudable and important goal of helping patients receive affordable and appropriate medications. However, there are several roadblocks to successfully implementing this proposal that are worth considering.

Implementing the resolution would likely increase the administrative burden of physicians and pharmacists without placing any additional requirements on the pharmacy benefit managers that ultimately have a greater say in the cost of drugs. In order for this resolution to fulfill its intended function, pharmacists would have to reliably inform physicians of the lowest cost medication available as described in this resolution and physicians would have to render decisions concerning whether to prescribe those medications. This would therefore result in a new, legally mandated administrative task that would affect both pharmacists and physicians. The additional time required by pharmacists and physicians to act on these notifications could make this requirement very difficult to effectively operationalize in already-strained pharmacies and medical practices.

Additionally, the least expensive medication within a given class may not be a clinically appropriate option in the opinion of the prescribing physician. When such discrepancies exist, this could lead to confusion amongst patients who expect this new legal requirement to lower their costs and thereby have a potentially negative impact on the physician-patient relationship.

If this resolution were transformed into legislation, the onus to inform the patient of this information may be shifted towards physicians rather than pharmacists. In fact, such legislation has been attempted. This year, HB 947, which the FMA opposed, and which failed to pass the Florida Legislature, was introduced and would have legally required physicians to provide, upon the patient's request, "real-time, patient-specific information regarding prescription drug benefits, coverage, and costs in order to facilitate a discussion of benefit, coverage, and cost options…" Although this legislation would have also required insurers to provide this information to physicians in order to facilitate these discussions, physicians would have certainly incurred an increased administrative burden as a result of its enactment. Thus, advocating for legislation that would transform this resolution into law may inadvertently create an even greater, legally mandated administrative burden on prescribing physicians.

Finally, a resolution with identical language was previously submitted to the AMA House of Delegates in 2020. This resolution was referred for a report back that was published by the AMA Council on Medical Service at the 2021 AMA November meeting. The AMA analyzed this resolution and began by recognizing the untenable situation that physicians and patients find themselves in when dealing with incomplete information concerning the affordability of medications. The report notes that, at the point at which a prescription is issued, cost information is not universally available to the prescribing physician. The report notes that "In the absence of a technology tool, the only way to know which medications are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or call the insurance

plan or PBM."

The report goes on to state that "the ultimate decision regarding which medication is most appropriate for a patient is made directly between physicians and patients, requiring pharmacists to research patients' formularies and discuss their research with the physician unnecessarily adds burden to both physicians and pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may increase confusion among patients and scope of practice concerns as patients seek prescription guidance from their pharmacists. Rather than imposing burdensome new legal requirements on pharmacists, the goal of improved prescription drug price transparency at the point of prescribing could be accomplished via improved HIT." The report further explains that a physician's ability to access Real-Time Prescription Benefit (RTPB) technology depends on the business relationship between the physician's RTPB tool software provider and the patient's drug plan. The report notes that "some physicians may have access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit information across all prescription drug plans, and tools do not yet integrate with all EHRs prescribing systems. To achieve that level of universal access and transparency, a non-proprietary RTPB standard is required."

The report concludes by recommending that, in lieu of adopting the resolution, the AMA advocate to continue to support efforts to publish a RTPB standard that meets the needs of all physicians, to require payors to keep an up-to-date RTPB standard tool that integrates will all EHR vendors, and to take other actions that support the availability and understanding of RTPB technology.

Substitute language was proposed:

> RESOLVED, That the FMA supports legislation that would enhance communication, drug pricing transparency and software interoperability between payors, PBMs, and clinician EHRs.

Resolution 21-306
Forming an Office for the Coordination of Interdisciplinary Affairs
Northeast Florida Delegation

House Action: Adopted substitute language in lieu of Resolution 21-306

Original language:

RESOLVED, That the FMA establish a task force to study whether building an office or a department of interdisciplinary coordinated affairs will assist the FMA with its legislative agenda and present a report to the Board of Governors prior to the 2022 Annual Meeting.

Substitute language:

Resolved, That the FMA continues to work with other health care professions on issues of common

interests, when appropriate.

Compendium updated – 280.013

Resolution 21-307
Transparency of Care
Megan Core, M.D., Physicians Society of Central Florida

House Action: Adopted as amended

RESOLVED, That the Florida Medical Association seek ~~support~~ legislation requiring independent ~~health care facilities and medical practices that are utilizing~~ non-physician practitioners without physician supervision to provide notice to patients through the posting of signage in waiting rooms and public areas in their work setting that the ~~facility~~ practitioner does not have a physician's ~~providing~~ oversight of the patient's care; and be it further,

RESOLVED, That the Florida Medical Association seek ~~support~~ legislation that requires non-physician providers that are working ~~without physician supervision~~ independently to secure written informed consent from patients that they understand that they are being assessed and treated by non-physician providers practicing without physician oversight.

Compendium updated – 360.007

Resolution 21-308
Medical Cannabis
Florida Society of Addiction Medicine

House Action: Referred to the Board of Governors for decision; adopted as amended by deletion

RESOLVED, That the FMA support policies that advance ~~the following in the State of Florida:~~

- ~~Cannabis should not be recommended to pregnant persons. All patients should be screened for cannabis and other substance use disorders and referred to treatment as appropriate before receiving a recommendation to use cannabis for medical purposes;~~
- ~~Cannabis should not be recommended for the treatment of opioid use disorder;~~
- ~~Cannabis recommended by Florida clinicians should be reported to Florida's Prescription Drug Monitoring Program. Healthcare professionals who recommend cannabis should check the PDMP prior to making any such recommendation;~~
- ~~Potency of non-FDA approved cannabis should be determined and clearly displayed on the label. Healthcare professionals should consider the ratio of CBD to THC with respect to the indication and minimize potential adverse effects;~~

- ~~Combustion or vaporization of cannabis as a drug delivery method should be discouraged; and~~
- Robust state funding for state university scientific and clinical research on cannabis and its compounds. ~~Research needs for cannabis to be used for medical purposes include basic outcomes studies for well-defined conditions using well-defined medical cannabis products.~~

June 2022: The Board of Governors referred this resolution to the Council on Medical Education, Science, and Public Health. Recently a review and evaluation were conducted on the status of evidence-based medical cannabis policies as directed by Resolution 21-311. The Board did not feel it was in the position to adopt clinical recommendations surrounding the use of medical marijuana without further research. At this time, the Board believes that the focus should be on encouraging more robust research in this area as the existing information is still lacking quality evidence-based data to the degree that physicians would normally rely on in other areas within the practice of medicine. Compendium updated: P 307.007

Resolution 21-309
Independent APRN Patient Safety
South Florida Caucus

House Action: Not adopted

RESOLVED, That Independent APRNs come under the regulation of the Florida Board of Medicine through the FMA seeking legislation and/or policy changes; and be it further

RESOLVED, That the FMA seek legislation to increase malpractice limits from 100,000/300,000 for Independent APRNs to a minimum of 500,000/1,000,000; and be it further

RESOLVED, that the Florida Medical Association seek legislation requiring clear posted notice to patients in settings where there is not a physician on site or providing oversight to the patient's care; and be it further,

RESOLVED, that the Florida Medical Association seek legislation that requires the education of patients and written informed consent by patients prior to said patients being treated by Independent APRNs.

Resolution 21-310
Restrictive Covenants
Polk County Medical Association

House Action: Referred to the Board of Governors for decision; not adopted

RESOLVED, That the Florida Medical Association adopts a policy to oppose restrictive covenants and non-complete clauses as it applies to physicians.

October 2021 - The Board of Governors studied Resolution 21-310 and 21-310 together. It was noted that similar resolutions (19-202 and 19-317) came to the Board of Governors for decision last year, were studied in depth, and a substitute resolution was adopted. Given the similarities of the resolutions from last year, the Board of Governors voted to not adopt Resolutions 21-310 and 21-312. Below is the Board's findings from May 2021.

May 2021: In May 2020, the Board of Governors discussed this resolution at length and analyzed the arguments for and against the use of restrictive covenants by physicians in Florida. Given that there are valid arguments on both sides of the issue, the Board of Governors conducted a thorough study of physician non-compete clauses in Florida and evaluate whether any changes to the current Florida statute are needed. At the June 18, 2020 conference call, the Board instructed FMA staff to conduct an in-depth study and evaluation of Florida's non-compete statute. At the May 2021 Board of Governors Meeting, the FMA General Counsel presented the findings of an in-depth study on Florida's restrictive covenant statute. After considerable discussion, the Board concluded that the best approach would be to educate physicians through a variety of methods including webinars, white papers, CME programs, and other means on the legal and practical aspects of restrictive covenants. Accordingly, the Board of Governors voted to adopt the following policy in lieu of Resolutions 19-202 and 19-317:

> *The FMA will proactively educate physicians, through webinars, white papers, CME programs, and other means, on the legal and practical aspects of restrictive covenants and their application to physicians, physician practices and physician employers.*

Resolution 21-311
Access to Evidence Based opioid Disorder Treatment in Florida Correctional Facilities
Florida Society of Addiction Medicine

House Action: Referred to the Board of Governors for decision; substitute language adopted in lieu of Resolution 21-311

RESOLVED, That our Florida Medical Association (FMA) amend policy P 125.00, "DRUGS- ABUSE," to add a new section P 125.004 to read as follows:

P 125.004 Medications for Opioid Use Disorder in Florida Correctional Facilities

1. Our FMA endorses the medical treatment model of employing medications for

opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated.

2. Our FMA advocates for legislation, standards, policies and funding that require correctional facilities in Florida to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when available and desired by the person with OUD, in correctional facilities within Florida and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our FMA advocates for legislation, standards, policies, and funding that require correctional facilities within Florida to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the FDA for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, including medications for addiction treatment.
4. Our FMA advocates for all correctional facilities in Florida to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.
5. Our FMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs in Florida to provide access to a continuum of health care services for juveniles and adults in the correctional system.
6. That our FMA encourages the Agency for Health Care Administration to work with the Florida Department of Corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

June 2022: The Board of Governors referred this resolution to the Council on Medical Education, Science, and Public Health. Both the Council and the Board recognized that the network responsible for providing medical care to incarcerated individuals is both complex and everchanging. It was acknowledged that the AMA spent considerable time researching this issue before developing Policy H-430.987 Medications for Opioid Use Disorder in Correctional Facilities. The Board ultimately decided that it was best to collaborate with the AMA in its efforts to streamline the medical treatment of incarcerated individuals, particularly those afflicted by opioid use disorder. By supporting the AMA policy, and the foundation of research that the policy was founded upon, the FMA's policy will remain up to date with the standard of care in

correctional settings. Proposed substitute language was considered and adopted by the Board of Governors, it is now P 125.004 in the Policy Compendium:

The FMA support AMA Policy H-430.987 Medications for Opioid Use Disorder in Correctional Facilities, and work collaboratively with the AMA to accomplish the goals set forth by H-430.987 in Florida.

H-430.987 Medications for Opioid Use Disorder in Correctional Facilities H-430.987
1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.
2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.
3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.
4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Resolution 21-312
Physician Contract Non-Compete Clause
Escambia County Medical Society

House Action: Referred to the Board of Governors for decision; not adopted

RESOLVED, That within one year the FMA Board of Governors choose between a legislative vs constitutional amendment strategy to limit enforcement of non-compete clauses in physician contracts to those cases where termination of the contract is sought by the physicians within two years of the initial employer physician contract.

October 2021 - See Resolution 21-310

Resolution 21-313
Corporate Practice of Medicine
South Florida Caucus

House Action: Referred to the Board of Governors for decision; adopted as amended by deletion

RESOLVED, That FMA will prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in Florida. The results of this review will be compiled into a resource and announced to members as an available electronic download~~; and be it further~~

~~RESOLVED, That the FMA will provide assistance to physician-owned groups who are threatened with contract loss to a corporate entity or to hospital-owned physicians whose site will be taken over by a corporate entity by providing, upon review of the legality of the corporation obtaining the contract for physician services; and be it further~~

~~RESOLVED, That FMA will seek legislation for the further restriction of the corporate practice of medicine similar to dentistry and optometry statutes, limiting ownership of physician practices or groups to physicians only.~~

June 2022: The Board of Governors studied this resolution extensively. The Board of Governors concluded that the preparation of a comprehensive review of the legal and regulatory matter related to the corporate practice of medicine and fee splitting in Florida would be within the capability of the FMA staff and would be a useful resource for physicians. The Board, however, noted legal problems with providing legal representation to individual members and concluded that provided written review of the legality of proposed practice acquisitions is not a service the FMA can provide.

The Board also determined that legislation restricting the corporate practice of medicine is not an objective that can be obtained given the current status of the law and the opposition of a significant portion of FMA members. Accordingly, the Board adopted the first resolved, while deleting the second and third.

Resolution 21-314
Credentialing of Anesthesiologist Assistants
Florida Society of Anesthesiologists

House Action: Adopted as amended

RESOLVED, That the Florida Medical Association ~~seek~~ support a change in statute that Certified Anesthesiology Assistants (C-AA) may not be denied clinical privileges at hospitals or ambulatory surgicalcenters, except for cause, so long as the supervising physician is a staff member in good standing.

Compendium updated: P 50.005

Resolution 21-315
Timely Actions on Credentialing Applications

Florida Society of Anesthesiologists

House Action: Not adopted

RESOLVED, That Florida Medical Association seek a change in statute that would require hospitals and ambulatory surgical centers to credential Certified Anesthesiology Assistants within ninety (90) days of their initial completed application.

Resolution 21-316
PA Name Change
Megan Core, M.D.

House Action: Adopted substitute language in lieu of Resolution 21-316

Original language:

RESOLVED, That the FMA join the AMA and work with other medical societies to actively oppose efforts and legislation that seeks to change the title of "physician assistant" to "physician associate" in state and federal policies.

Substitute language:

RESOLVED, That the Florida Medical Association adopt policy to oppose efforts and legislation that seeks to change the title of the "physician assistant" to "physician associate" or any term that would elevate their status in a manner in which would confuse a patient as to the role and education of a Physician versus a "physician assistant."

RESOLVED, That the FMA continue working with the AMA and other medical societies to actively oppose efforts and legislation that seeks to change the title of "physician assistant" to "physician associate" in state and federal policies.

Compendium updated – 360.008

Resolution 21-317
Repeal Parental Consent
Broward County Medical Association

House Action: Adopted substitute language in lieu of Resolution 21-317

Original language:

RESOLVED, The Florida Medical Association will actively and aggressively seek repeal of the "Parent's Bill of Rights" legislation.

Substitute language:

RESOLVED, That the Florida Medical Association seek legislation to fix the problems in HB 241 mandating parental consent for the treatment of minors.

Compendium updated – 280.014

Resolution 21-403
Facilitating Timely and Accurate Price Transparency
Physicians Society of Central Florida

House Action: Adopted as amended

RESOLVED, That the FMA ~~seek~~ support legislation that would mandate commercial insurers set up a dashboard for providers and patients that would provide accurate and up to date estimates of a patient's out of pocket costs for inpatient services, outpatient physician services, and facility fees and an enforcement mechanism to promote insurance carrier compliance.

Compendium updated: 260.054

Resolution 21-404
Billing and Collections Transparency
South Florida Caucus

House Action: Adopted as amended

RESOLVED, That FMA supports the ~~physician's~~ right of physicians to see what is billed and collected for his or her services, regardless of whether ~~or not~~ the billing and collection is assigned to ~~another~~ a third-party entity ~~within the limits of state and federal law~~. ~~The physician shall not be asked to waive access to this information~~;

~~RESOLVED, That no member of FMA will, directly or indirectly, deny another physician the ability to receive detailed itemized billing and remittance information for medical services they provide; be it further~~

RESOLVED, That FMA seek legislation ~~will petition the appropriate state legislative and regulatory bodies to establish the~~ requirement that revenue cycle management entities, ~~regardless of their ownership structure,will~~ to require employers to directly provide ~~every~~ each physician it bills or collects for with a detailed, itemized statement of billing and remittances for the medical services they provide biannually and upon request ~~on at least a quarterly basis~~; be it further

RESOLVED, That the FMA opposes requiring physicians to waive access to this information

Compendium updated – 260.053

Resolution 21-405
Insurance Coverage for HPV Vaccination
American College of Obstetricians and Gynecologists

House Action: Adopted

RESOLVED, That the Florida Medical Association (FMA) advocate as its official position that insurance coverage for the HPV vaccine be expanded to cover vaccination in patients between the ages of 27 and 45 in patients whose physicians determine, after a shared decision-making process, that the HPV vaccine would be beneficial to the patient's care.

Compendium updated – 485.012

Elections

Open Seats and Announced Candidates
FMA Elected Offices 2022

FMA members wishing to announce their intent to run for elected office should contact the FMA by phone at 1-800-762-0233 and ask for Brittany Jackson or by email at bjackson@flmedical.org
Elections will begin on August 6th and run through August 7th at 7:59 am (Eastern time).

FMA Officers

Elected Seats Expiring in 2021

Office	Term	Incumbents *(term expires August 5, 2022)*	2022 Announced Candidates
President-Elect	1 yr.	Joshua Lenchus, D.O.	Jason Goldman, M.D.
Vice President	1 yr.	Jason Goldman, M.D. (1st term)	Lisa Cosgrove, M.D. (1st term)
Secretary	1 yr.	Lisa Cosgrove, M.D. (3rd term)	Alma Littles, M.D. (1st term)
Treasurer	1 yr.	Charles Chase, D.O. (1st term)	Charles Chase, D.O. (2nd term)
Speaker	1 yr.	Ashley Norse, M.D. (2nd term)	Ashley Norse, M.D. (3rd term)
Vice Speaker	1 yr.	Mark Rubenstein, M.D. (2nd term)	Mark Rubenstein, M.D. (3rd term)

FMA Board of Governors

Elected Seats Expiring in 2022

Office	Term	Incumbents *(term expires August 5, 2022)*	Announced Candidates
District A	3 yr.	Paresh Patel, M.D. *(appointed due to vacancy)*	Paresh Patel, M.D. (1st term)
District B	3 yr.	Mark Dobbertien, D.O. *(appointed due to vacancy)*	Mark Dobbertien, D.O. (1st term)
District C	3 yr.	Jay Rao, MD (1st term)	Ajoy Kumar, M.D. (1st term)
District D	3 yr.	Sanjay Pattani, M.D. (1st term)	Sanjay Pattani, M.D. (2nd term)
District F	3 yr.	Ramsey Pevsner, D.O. (1st term)	Roger Duncan, M.D. (1st term)
District G	3 yr.	Rudolph Moise, D.O. (1st term)	Rudolph Moise, D.O. (2nd term)
Primary Care	2 yr.	Diana Twiggs, M.D.	Naresh Pathak, M.D.
Medical Specialties	2 yr.	Catherine Kowal, M.D.	
Surgical Specialties	2 yr.	George Canizares, M.D.	Daniel Daube, M.D.
RFS	2 yr.	Alexander Lake, D.O.	Alexander Lake, D.O.

Last update 6/1/2022

AMA Delegation

Elected Seats Expiring in 2022

In 2022, eight (8) delegate seats and eight (8) alternate delegate seats are up for election for a two-year term. Voting will be for eight (8) delegates. The first eight (8) candidates receiving the most votes will be elected as AMA delegates and the next eight (8) receiving votes in descending order will become alternate delegates. Following are the incumbent AMA Delegates and Alternates whose terms expire in 2022 and announced candidates for a new two-year term (2022-2024).

Incumbent AMA Delegates *Terms expiring August 6, 2022*

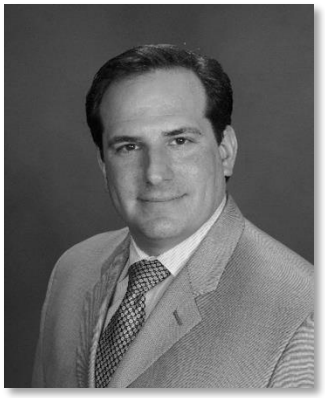
Christie Alexander, M.D.
Madelyn Butler, M.D.
Tra'chella Johnson Foy, M.D.
Ronald Giffler, M.D., J.D.
John Montgomery, M.D.
Douglas Murphy, M.D.
Ralph Nobo, M.D.
Michael Patete, M.D.

Incumbent AMA Alternate Delegates Terms expiring August 6, 2022

Eva Crooke, M.D.
Rafael Haciski, M.D.
Larry Halperin, M.D.
Rebecca Johnson, M.D.
Arthur Palamara, M.D.
Sergio Seoane, M.D.

2022 AMA Announced Candidates *2-yr term expiring 2024*

Eva Crooke, M.D.
Tra'chella Johnson Foy, M.D.
Ronald Giffler, M.D., J.D.
Rafael Haciski, M.D.
Larry Halperin, M.D.
Rebecca Johnson, M.D.
John Montgomery, M.D.
Douglas Murphy, M.D.
Ralph Nobo, M.D.
Arthur Palamara, M.D.
Michael Patete, M.D.
Sergio Seoane, M.D.



FMA Elections 2022

Jason M. Goldman, MD, FACP

Candidate: FMA President-Elect

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE

Board Certified Internal Medicine, Solo Practice, Affiliate Assistant Professor of Clinical Biomedical Science in the Charles E. Schmidt College of Medicine 2013 to present, Clinical Assistant Professor of Medicine at Nova Southeastern College of Medicine 2017 to present

LOCATION: 3001 Coral Hills Drive, #340, Coral Springs, FL 33065

SERVICE TO THE FMA

FMA Vice President 2021-2022
Treasurer, FMA 2016-2021
FMA PAC President 2021-present
FMA PAC President-Elect 2017-2021
Treasurer-Designee, FMA PAC executive committee 2015-2017
FMA Board of Governors, Primary Care Representative 2014-2017
Chair MD 1000 Club, FMA PAC executive committee 2013-2015
Florida Medical Association Reference Committee Chair Legislation 2013
Florida Medical Association Reference Committee Chair Medical Economics 2012
Florida Medical Association Reference Committee Medical Economics 2011
Florida Medical Association Reference Committee Finance and Administration 2010
Florida Medical Association Reference Committee Health, Education and Public Policy 2009

FMA PAC Executive Board 2013 to present; Board Member Florida Medical Association PAC 2008 to present (raised over $160,000); MD 1000 club; MD 10,000 club

FMA Scope of Practice Task Force member 2012
Delegate to the FMA for the Florida Chapter, American College of Physicians 2005 to 2015

SERVICE TO OTHER MEDICAL ORGANIZATIONS

ACP Liaison to CDC ACIP 2018-present
National ACP Board of Regents 2020 to present
ACP Richard Neubauer National Advocate for Internal Medicine 2018
National ACP Vice-Chair ACP Medical Practice Quality Committee 2019-2020
National ACP Executive Committee Board of Governors 2019-2020
National ACP Board of Governors 2016-2020
National ACP Medical Practice Quality Committee 2016-2020,2021-present
National ACP PAC Board 2015-2017
Florida Chapter ACP, Governor 2016-2020
Florida Chapter ACP, Governor Elect 2015
Treasurer, Florida Chapter of ACP 2011 to 2016
Vice-Chair of Industry ACP 2011 to 2016
Florida Chapter ACP Internist of the Year 2013
Florida Chapter ACP Legislative Key Contact 2010
Florida Chapter ACP Chair of Legislation 2021 to present
National ACP Top 10 National Legislative Key Contact 2008

President of the Florida Internal Medicine PAC 2009 to 2011
Chairman of Membership Committee FL Chapter American College of Physicians 2008 to 2016
Medical Economics Committee Florida Medical Association 2007
Appointee to the Healthier Florida Advisory Board to the Florida Legislature for Medicaid Services 2007 to 2009
Legislative Committee Florida Chapter, American College of Physicians 2005 to present
Vice-Chairman Legislative Committee Florida Chapter, ACP 2008 to 2016
MERC Committee, Florida Chapter, American College of Physicians 2005 to present
Tallahassee Legislator Visitation Program, Florida Chapter, ACP 2005 to present
Washington, D.C. Congressional Visitation Program Florida Chapter ACP May 2005 to present
Broward County Medical Association Board of Directors 2016 to present

COMMUNITY LEADERSHIP SERVICE

Member of Medical Executive Committee Northwest Medical Center 2009 to 2010; Chairman Peer Review Committee Northwest Medical Center 2009 to 2010; Chairman of Quality Committee Northwest Medical Center 2007 to 2014; Member Quality and Credentials Committee Northwest Medical Center 2008 to 2014; Member Patient Care Key Group Committee Coral Springs Medical Center 2007 to 2008; Member of Quality Committee Northwest Medical Center 2006 to 2014; Infectious Disease Committee Coral Springs Medical Center 2002 to 2004; Emergency Department Quality Committee Coral Springs Medical Center 2002-2003; Medical Management Committee West Boca Medical Center 2005 to 2011

ADDITIONAL PERSONAL INFORMATION: Divorced, 2 children (Evan 17 and Ryan 14) and dog Ruby

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted

COUNTY MEDICAL SOCIETY ENDORSEMENT: FL Chapter American College of Physicians, Florida Pulmonary Society, Florida Society of Interventional Pain, Physicians, Florida Society of Plastic Surgery, Florida Academy of Family Practice, South Florida Caucus, Broward County Medical Association, Palm Beach County Medical Association, Dade County Medical Association, Physician Society of Central Florida, Collier County Medical Society, Hillsborough County Medical Association, Duval County Medical Association, Northeast Florida Delegation, Alachua County Medical Society, Sarasota County Medical Society

PERSONAL STATEMENT

My name is Jason Goldman, and I am running for the Florida Medical Association office of President-Elect. I have a strong track record of leadership in the FMA and ACP, including serving as the current FMA Vice President, past FMA Treasurer, FMA PAC President, the past Treasurer designee of the FMA PAC, past Treasurer of the ACP, Past Governor of the FLACP, National ACP Board of Regent, as well as having an extensive record of advocacy and strong ability to unify and represent different groups of our membership. In addition, I am in solo private practice and fully understand, as well as have experience with, the many issues we face on a daily basis. A President-Elect and officer of the organization needs to focus on advocacy, education, and membership in order to lead our organization.

As a passionate advocate for physicians, I work with all groups, members and politicians in order to help physicians practice medicine in Florida. Primary among our priorities is scope of practice. Our noble profession has been under attack by those groups who would seek to undermine the foundation of what it is to be a doctor. We are not providers; we are physicians and deserve the respect that we have earned through our years of schooling and sacrifice. I will always stand against any non-physician group from expanding their scope of practice to infringe upon the practice of medicine. This is a sacrosanct issue and one that I will passionately defend.

Our House of Delegates has crafted excellent policies over the years that need to be implemented with skill and diplomacy. Your President-Elect must represent you without alienating our political allies or becoming dogmatic. If I am elected, I will help to guide that course. I promise to continue to fight for you for improved reimbursement, decreased administrative burdens, and better patient access. Above all else, your elected officers need to have honesty, integrity and acceptance of all members. While the majority prevails, the minority must always be heard. I promise that I will always protect the rights of all our members to be heard and will oppose all forms of discrimination and prejudice.

Our organization engages in more than just political activity, as we have tremendous CME programs and educational resources. I am proud of all the educational offerings and resources that our FMA has for our membership, and I want to see this not only continued but expanded to serve the needs of all our members at every level. In my various roles in the American College of Physicians, I have extensive experience with our resident and student meetings and helped to develop curriculum for our scientific meeting. As faculty at Florida Atlantic University, I enjoy teaching medical students and want to expand our mentoring programs within the FMA to recognize and encourage the next generation of physician leaders.

As an organization it is critical that we make the right decision that will lead us down the path to a bright future. You deserve leadership that can take your needs and ideas and implement them effectively and appropriately. We cannot hope to succeed by acting as obstructionists, tilting at windmills, or alienating all those who would help us. We must stand up for our beliefs but also exist in the real world where it is necessary to have discourse with people who do not agree with us and are actively seeking to destroy our profession. Through advocacy, education, and membership we can work together and unify our organization to truly help physicians practice medicine. I have the experience, ability, and professionalism to be your Vice President and I humbly ask for your vote so I may continue to serve the house of medicine.

FMA Elections 2022

Lisa Ann Cosgrove, M.D.

Candidate: FMA Vice President

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE:

Board Certified Pediatrics, Private Practice

LOCATION:

Duval County

SERVICE TO THE FMA:

FMA Board of Governors Secretary 2019- present
AMA Florida Delegate 2021-present
AMA Florida Alternate Delegate 2019-2021
FMA Board of Governors Specialty Society Representative 8/2017-2018
FMA Board of Governors District D representative 8/2010 to 8/2016
FMA Board of Governors Primary Care Representative 8/2008 to 8/2010
FMA Foundation Committee member 2005 to present
FMA "Eagle" 2004 Constitutional Amendment
FMA Board of Governors IMG Representative August 2003-2004
FMA Rules and Credentials Chair 2002, 2003,2004
FMA Rules and Credentials Member 1999-2004
FMA IMG Section Secretary 2001,2002,2003
FMA Delegate for Florida Pediatric Society 2005 to 2008
FMA Delegate for Brevard County 1995 to 2004

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

AAP Board of Governors 2018-2021
FCAAP President 2010-2012
FCAAP 1st Vice President 11/2009 to 5/2010
FCAAP 2nd Vice President 6/2008 to 11/2009
Brevard County Medical Society President 2008
Brevard County Medical Society Board of Governors 1995-1998 and 2004 to 2007
Brevard County Medical Society Secretary 1998
AMA Member 1985 to 2003
FMA PAC Member 1996 to present

COMMUNITY LEADERSHIP SERVICE:

BCBS Physicians advisory Board 1/2009 to 2010
AAP Quality Improvement Network Steering committee member 1/2009 to present
Florida Medicaid Pharmacy and Therapeutics Board Member and Chair 1/06 to 6/09
Florida Immunization Coalition Champion 2005 to 2007

Florida PROS (Pediatric Research in Office Setting) Coordinator 1996-2000
Florida Chapter AAP ADHD Workshop Steering Committee Member 1996
Florida Chapter of AAP HIV/Adolescent Health Team Leader 1996
Florida Chapter of AAP Regional Representative 2005-2007
Chair of CHAC (Children's Health Advisory Committee) State of Florida 2004 to 2006
Florida Chapter of AAP School Health Committee 2003 to 2005
Partnership for Promoting Physical Activity and Healthful Nutrition Committee Member 2002 - 2004
Chairperson Perinatal Committee Cape Canaveral Hospital 1996 to 2000
Credentials Committee Cape Canaveral Hospital 2004 to 2005
Bylaws Committee Cape Canaveral 1998, 2000, 2004
Neonatal and Infant Mortality Review Board January 1996 to 1998
Perinatal Healthcare Coalition January 1995 to 1996
Future Planning Committee Cape Canaveral Hospital 1995 to present

ADDITIONAL PERSONAL INFORMATION:

I am a single mom of three fine men and four grandchildren. I enjoy cruising and spending time with my friends. Most of all I enjoy my family time and will be looking forward to my grandchildren coming to visit soon. I enjoy practicing full time as a pediatrician and I now am moving toward retirement and also have a telehealth practice.

CONFLICT OF INTEREST:

Conflict of Interest Declaration submitted to the FMA

COUNTY MEDICAL SOCIETY ENDORSEMENT:

Coming

PERSONAL STATEMENT:

I am a physician of pediatrics just as you are physicians of many specialties and areas of focus. I believe as I am sure you all believe that we are knit together by our common ground to serve and care for our patients and help them keep healthy and live long fruitful lives. Sometimes it can be difficult to teach prevention of maladies, but in the end every bit of prevention certainly works towards a cure. As physicians, I know there are ups and downs yet we will prevail and keep plodding along. And as for me, I won't stop until every physician in Florida knows the FMA is in their corner.

FMA Elections 2022

Alma B. Littles, MD

Candidate: Secretary

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Family Medicine: 1989 - Present
Board Certified, American Board of Family Medicine; Participating in Continuing Certification
Senior Associate Dean for Medical Education and Academic Affairs, FSU College of Medicine

LOCATION:

1115 West Call Street
Tallahassee, FL 32306

SERVICE TO THE FMA:

Member, CEO Search Committee – October 2021-March 2022
Chair, Council on Medical Education, Science and Public Health – August 1, 2015 - present
Vice-Chair, Council on Medical Education and Science – 2012-2015
Member, Council on Ethical and Judicial Affairs – 2019 – Present
Member, Wellness Committee – 2018 – present
Chair, Wellness Committee – 2018-2019
Executive Search Committee – September 2007 – January 2008
Member, Task Force on Uninsured, Underinsured and Health Disparities – 2006 - 2008
Chair, Workgroup on Health Disparities – 2007 - 2008
Member, Task Force on Disaster Preparedness – 2006 – 2012
Member, Board of Governors – 2006 – 2007
Former Member, Membership and Public Relations Committees

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

American Academy of Family Physicians
- Member, Robert Graham Center Advisory Board – 2003 - present
- Chair, Scientific Program Committee – 2000 - 2001

American Medical Association
- Delegate, Academic Physicians Section – 2020 – present
- Member, Council on Medical Education GME Subcommittee – 2018 – present
- Chair, Academic Physicians Section – 2015-2016

Association of American Medical Colleges Medical Education Senior Leaders Group – 2019 – current
Capital Medical Society: President, 1996; Delegate to FMA
Florida Academy of Family Physicians
- Board Chair – 2000 - 2001
- President – 1999-2000

Delegate, American Academy of Family Physicians – 2000 – 2020
Chair, Bylaws Committee – 2015, 2020
Member, Professional Development Committee (CPD) – 1997 - present
Representative, AAFP Family Medicine Congressional Conference - 2006

Florida Academy of Family Physicians Foundation
Board of Trustees, 1990 – 1996, 2007 – 2010, 2016 – current
Vice-President, 1994 -1996, 2016 – current
Secretary - Treasurer, 1993 - 1994

World Organization of Family Physicians (WONCA) – 2001, Scientific Program Committee
Durban, South Africa

COMMUNITY LEADERSHIP SERVICE:

Florida Department of Health Physicians Workforce Advisory Council – 2015 – 2019
Vice-Chair – 2017 – 2019

State University System of Florida Board of Governors
Special Consultant to Health Initiatives Committee – 2013 - 2016

State of Florida Correctional Medical Authority – 2009 - 2012

Florida Corrections Commission - Chair – 2000 – 2002

Tallahassee Memorial Hospital Board of Directors – August 2008 – 2017, Chair – 2016-17
Professional Affairs and Quality Committee – 2009 – 2016
Finance Committee Chair – 2013 - 2014
Audit/Compliance Committee – 2009 – 2013

Big Bend Hospice Board of Directors – Chair, October 2002 – September 2004

Maclay School Board – 2001 – 2007; Secretary – 2003 – 2007

Capital City Bank Group Board of Directors - 2004 - present

University of Florida Medical Alumni Association Board of Directors 1993-97

PERSONAL INFORMATION: Married to Mr. Gentle Littles, III; Son: Gentle Germaine Littles

COUNTY MEDICAL SOCIETY ENDORSEMENT: Capital Medical Society, Florida Academy of Family Physicians

PERSONAL STATEMENT:

As an active member of the FMA since I was a medical student, I welcome the opportunity to help lead the organization forward during these challenging times. I bring the experience of private practice, residency program director, and medical school administration and teaching, along with long-standing active participation in organized medicine at the local, state and national levels. I have always recognized the importance of being a part of, and giving back to, the community. My goal is to continue to promote the mission of the FMA as we help physicians practice medicine to the benefit of our patients!

I continue to believe that we must always have a seat at the table to advocate for our patients and our profession, an unwavering strength of the FMA. Throughout the past four decades, I have been in the room, sometimes at the table, as FMA leadership tackled the day-to-day challenges impacting the practice of medicine, whether at FMA Board meetings, FMA's AMA Delegation meetings or alongside FMA leaders testifying at the Florida legislature. Increasing numbers of uninsured and underinsured patients, encroachment upon the scope of medical practice by others, decreasing reimbursement and increasing hassle factors and liability claims all threaten to interfere with the sacredness of the patient-physician relationship and disrupt OUR profession. While the healthcare landscape is changing, what hasn't changed is our calling and commitment to health, healing, caring and compassion. With the support of my wonderful husband and my employer, I am now ready to join my colleagues in leadership as we continue to represent all of you and help Florida's physicians practice medicine. I humbly ask for your support as Secretary of the FMA.

FMA Elections 2022

Charles J. Chase, D.O.

Candidate: FMA Treasurer

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Anesthesiology 1993 to present
Diplomate: American Board of Anesthesiology
Health Care Risk Manager
Envision Healthcare (formerly Anesthesiologists of Greater Orlando) 1999 to present

LOCATION:

2065 Venetian Way, Winter Park, FL 327789 (Orange County)
Email address: zzzchase@yahoo.com

SERVICE TO THE FMA:

FMA Delegate from the FSA	2007-2010; 2013-2015; 2019-2021
FMA Delegate from the Seminole County Medical Society	2011-2012
FMA Delegate from the Orange County Medical Society	2016-2018
FMA Council on Medical Economics, District D	2010-2013
FMA Annual Meeting Reference Committee Member - Finance	2013
FMA PAC Board Member	2013-present
FMA PAC Board, President-Elect	2021-present
FMA Ad Hoc Committee on POLST	2015
FMA Council on Legislation	2016-present
FMA Council on Legislation, Vice Chair	2017-2018
FMA Council on Legislation, Chair	2018-present
FMA Chair, MD 1000+ Club	2016-2018
FMA Annual Meeting Reference Committee Member–Legislation	2017

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

American Society of Anesthesiologists	
ASA Delegate from the FSA	2007-2021
Chairman, ASA Local Activities Committee	2008
ASA Anesthesia Care Team Committee	2008-2009; 2011-2017
ASA Patient Safety and Education Committee	2008-2014
ASA Carrier Advisory Committee	2009-2018
ASA Committee on Obstetrical Anesthesia	2011-2017
ASA Ethics Committee	2017-2018
ASA Lifeline Advisory Council	2009-2010
ASA Reference Committee Member, Finance	2009
American Osteopathic Association	
AOA Delegate from FOMA	2016-present
Florida Osteopathic Medical Association	
FSA District Director	2003-2009
FSA Economics Committee	2004-2018
FSA Chairman, Economics Committee	2006-2020
CMS Carrier Advisory Committee Alternate Delegate	2007-2008
CMS Carrier Advisory Committee Delegate	2009-2018
FSA Board of Trustees	2008-present
FSA Legislative Affairs Committee	2016-2021
FSA Secretary/Treasurer	2008-2009
FSA 2nd Vice President	2009-2010
FSA Vice President	2010-2011
FSA President Elect	2011-2012
FSA President	2012-2013
FSA Immediate Past President	2013-2014

FOMA District Society 3 President	2014-2016	FSA Distinguished Service Award	2020
FOMA District Society 3 Alternate Trustee	2013-2014	**Orange County Medical Society/**	
FOMA District Society 3 Trustee	2015-2018	**Physicians Society of Central Florida**	
FOMA Membership Committee	2013-2018	OCMS Trustee	2014-2018
FOMA Board of Trustees	2017- present	OCMS Nominations Committee	2016
Florida Society of Anesthesiologists		OCMS Secretary	2017
FSA Governmental Affairs Committee	2002	OCMS Treasurer	2018
FSA Anesthesia Care Team Committee	1996-2001	PSCF Vice President	2019
FSA Nominations Committee	2010, 2012, 2014-2018	PSCF President Elect	2020
		PSCF President	2021
FSA Chairman, Nominations Committee Co-Chairman	2014, 2015		
FSA Judicial Committee Member	2015-2019		

COMMUNITY LEADERSHIP SERVICE:

Orange County Prescription Drug Abuse Workgroup	2011
Orange County Prescription Drug Task Force	2011-2012
Co-Chairman, Pharmacy and Healthcare Subcommittee	
Chair, State Senator Jason Brodeur Health Care Coalition	

PERSONAL INFORMATION:

Married to Elena Holak, M.D., PharmD, MPH,
Children: Alexandra, Connor.
Hobbies: Competitive Tennis, Running, Health Policy and Legislative Affairs at the Federal, State and local level.

COUNTY MEDICAL SOCIETY ENDORSEMENT: The Physicians Society of Central Florida enthusiastically endorses the candidacy of Charles J. Chase, D.O. as Treasurer of the Florida Medical Association.

PERSONAL STATEMENT:

Your vote for FMA Treasurer is very important, thus, I humbly ask for your support of my candidacy. My past positions as Treasurer of both the Orange County Medical Society and the Florida Society of Anesthesiologists has provided experience on both the County and State levels. As President of Billing and Administrative Services, LLC, I headed a company with over $20M in annual revenue until it was successfully acquired by a larger entity. My extensive experience as a partner in private practice, as an employed physician with Envision Healthcare and working for the University of Florida provides insight into financials from distinctly varied perspectives.

Currently, I am the President-Elect of the FMA PAC, sit on the President's Advisory Council and serve as Chair of the FMA Council on Legislation. I have had the privilege of representing my County and Specialty Society in the House of Delegates since 2007 and have served on numerous committees within the FMA.

Balance sheets, income statements, cash flow, profit and loss statements and the development of a budget are all financial tools with which I am very well acquainted. I have been diligent in executing my duties in my prior service as treasurer.

While serving on the FMA Board of Governors, I have had the distinct pleasure of working with the current Treasurer, Dr. Jason Goldman and the Chief Financial Officer, Kristy Jones. Their insightful stewardship has guided the FMA through difficult times and I hope to have the opportunity to continue on with their superb work.

I would greatly appreciate your support for FMA Treasurer and will continue to work diligently on your behalf.

FMA Elections 2022

Ashley Booth Norse, MD

Candidate: FMA Speaker

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE

Emergency Medicine
Board Certified by the American Board of Emergency Medicine (2005, 2015)
Academic Practice: Associate Professor of EM, University of Florida COM- Jacksonville

LOCATION: 655 West 8th St, Jacksonville, FL 32210

SERVICE TO THE FMA

Florida Medical Association Speaker	2020-present
Florida Medical Association Vice-Speaker	2017-2019
Florida Medical Association Board of Governors; Member	2008-present
Board of Governors Executive Committee Member	2008-2009; 2016-present
FMA Facility Based Physicians Advisory Committee; Member	2018-present
Florida Medical Association Presidential Advisory Committee; Member	2017-present
Florida Medical Association Finance Committee; Member	2009-2011; 2015-present
Florida Medical Association Political Action Committee; Member	2006-present
Treasurer-Designate 2021-present	
MD 1000 Club Club Chair 2019-2021	
Florida Medical Association Council on Legislation; Member	2006-2021; Vice Chair 2016-17
Florida Medical Association Bylaws Committee; Member	2016-2021
FMA- Reference Committee on Health, Education and Public Policy; Member	2013-2014
Florida Medical Association Audit Committee; Member and Chair (2014-15)	2008-2011; 2012-2015
Florida Medical Association Federal Legislative Affairs Committee; Member	2012-2014
Florida Medical Association Council on Ethical and Judicial Affairs; Member	2011-2015
Florida Medical Association Delegate to the AMA	2012-2014
Florida Medical Association Alternate Delegate to the AMA	2006-2012
Florida Medical Association- Reference Committee on Legislation, Member	2009-2010
Florida Medical Association Membership Committee; Member	2005-2009
FMA- Reference Committee on Finance and Administration; Chair	2008-2009
FMA- Reference Committee on Health, Education and Public Policy; Member	2007-2008
Florida Medical Association Young Physician Section, Chair	2006-2012

SERVICE TO OTHER MEDICAL ORGANIZATIONS

Duval County Medical Society:

DCMS Foundation Board of Directors, President (2013-14)	2006-2018
DCMS Mentoring Task Force, Member	2015-2018
DCMS Board of Directors, President 2012-13	2006-2014
DCMS Bylaws Committee; Member	2013-2014
DCMS Nominating Committee; Chair	2013-2014
DCMS Task Force on Committees; Member	2013-2014
DCMS Membership Committee; Chair 2010-11	2005-2011

DCMS Governmental and Legislative Affairs Committee; Vice-Chair	2013-2018
DCMS Governmental and Legislative Affairs Committee; Member	2005-2013
DCMS, Delegate to the FMA	2004-2010
DCMS; Young Physician Representative	2005-2006

Florida College of Emergency Physicians:

FCEP Board of Directors:

Immediate Past President	2015-2016
President	2014-2015
President-Elect	2013-14
Vice-President	2012-13
Secretary-Treasurer	2011-12
Member	2008-2016
FCEP Medical Economics Committee, Member, Chair 2008-2013	2013-present
FCEP Governmental Affairs Committee, Member	2008-present
FCEP Academic Affairs Committee, Member	2008-present
FCEP, Councilor to ACEP	2006-present

American College of Emergency Physicians:

ACEP Delegate to the AMA	2019-present
ACEP Federal Governmental Affairs Committee; Member, Chair 2015-18	2005-present
ACEP State Legislative Affairs Committee; Member	2014-present
ACEP Section Grant Task Force; Member	2007-2018
ACEP Academic Affairs Committee; Member	2006-2013
ACEP's Council Steering Committee; Member	2010-2012

COMMUNITY LEADERSHIP/SERVICE: Attending Staff Foundation BOD (Vice-President)

ADDITIONAL PERSONAL INFORMATION: Married to Ron Norse and have 3 children: Hudson (11), Emma (9) and Adeline (7)

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted.

COUNTY OR SPECIALTY MEDICAL SOCIETY ENDORSEMENT: Duval County Medical Society and Florida College of Emergency Physicians

PERSONAL STATEMENT

Medicine faces many challenges. The uncertainty over what the future of healthcare in this country holds is creating a rift between physicians and the patients we take care of everyday. We need to fix that. During this critical time of change in the American healthcare system we need strong leaders who are capable of addressing the uncertainty and effectively addressing the challenges. I have built my career around healthcare policy and I believe that I can be a strong Speaker for the FMA and help the physicians of Florida shape our state's healthcare policies over the next several years.

I am an ardent physician and patient advocate and will work tirelessly as your Speaker. I have been active politically throughout my career and currently chair my national specialty society's governmental affairs committee. However the role of Speaker is about running the House of Delegates in a way that allows everyone voice to be heard and consensus to be reached as well as representing that consensus voice at the FMA BOG.

I am committed to the physicians of Florida, the FMA and organized medicine as a whole. It has been an honor to serve and represent the physicians of Florida over the past nine years as an FMA Board of Director's member and I would be honored to work collaboratively with the Speaker to serve as the voice for the House of Delegates. Together we have the opportunity to make changes that will improve healthcare delivery and safety both now and into the future.

FMA Elections 2022

Mark Rubenstein, M.D.

Candidate: FMA Vice Speaker

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Diplomate, American Board of Physical Medicine and Rehabilitation
Subspecialty Certificate (Board Certified) in Pain Medicine, American Board of PM&R
Diplomate, American Board of Electrodiagnostic Medicine
Diplomate, American Academy of Pain Management
Private Practice

LOCATION:

Jupiter, Florida (Palm Beach County)

SERVICE TO THE FMA:

Member-at-large, FMA Board of Governors	2018- present
Chair, Council on Ethics and Judicial Affairs	2014- 2020
Chair, Council on Medical Service	2013-2014
Vice-Chair, Council on Medical Services and Health Care Delivery Innovation	2012
Reference Committee, Health, Education and Public Policy	2012
Reference Committee, Medical Economics	2007, 2010
Reference Committee, Finance and Administration	2008, 2015
Delegate to the FMA	2002- present
MD 1000 Club	

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

AMA Delegate/Alternate Delegate from FMA	2007-2018
AMA: Reference Committee, Constitution and By-Laws	2013
Florida Attorney General's Opioid Abuse Working Group	2019
American Board of Medical Specialties: Safety in Opioid Prescribing Committee	2018
Voluntary Assistant Professor of Medicine and Voluntary Asst Professor of Physical Medicine & Rehabilitation @ Leonard M. Miller School of Medicine at the University of Miami	
Clinical Assistant Professor of Biomedical Science in the Charles E. Schmidt College of Science at Florida Atlantic University	
Clinical Associate Professor of Family Medicine @ Nova Southeastern University	
President, Palm Beach County Medical Society	2006
President-Elect, Palm Beach County Medical Society	2005
First Vice-President, Palm Beach County Medical Society	2004
Second Vice-President, Palm Beach County Medical Society	2003
Treasurer, Palm Beach County Medical Society	2002
Board of Directors, MEDPAC of Palm Beach County Medical Society	
Board of Trustees, Palm Beach County Medical Society	
Chairman, By-laws Committee, Palm Beach County Medical Society	2011
Chairman, Medico-legal Committee, Palm Beach County Medical Society	2006-2009
Chairman, Board of Censors and Mediation, Palm Beach County Medical Society	2003

Chairman, Membership Committee, Palm Beach County Medical Society	2004
Chairman, Finance Committee, Palm Beach County Medical Society	2002
President, Florida Society of Physical Medicine & Rehabilitation	2020-present
Member-At-Large, Florida Society of Physical Medicine & Rehabilitation Board of Directors	2004-2018
American Board of Physical Medicine & Rehabilitation, Part I Board Exam Item Writer	1995-present
American Board of Physical Medicine & Rehabilitation, Part II Oral Examiner	2002-present
American Board of Anesthesiology, Pain Medicine Examination Committee	2017-present
American Board of Anesthesiology, Pain Medicine Board Question Writer	2006-present
Expert Medical Advisor, Florida Workers' Compensation System	1997-present
Section Chief, Division of Rehabilitation Medicine, St. Mary's Hospital	1998-2006
Section Chief, Division of Rehabilitation Medicine, Good Samaritan Medical Center	1998-present
Member, Patient Safety Committee, St. Mary's Medical Center	2004-present
Member, Quality Assurance Committee, St. Mary's Medical Center	1998-2006
Member, Quality Assurance Committee, Good Samaritan Medical Center	1998-2018
Member, Quality Assurance Committee, Palm Beach Gardens Medical Center	2006-2020
Member, Ethics Committee, Palm Beach Gardens Medical Center	2006-present
Manuscript reviewer for the Archives of Physical Medicine & Rehabilitation	1998-present
Medical Reserve Corps for Disaster Preparedness, Palm Beach County Medical Society	

COMMUNITY LEADERSHIP SERVICE:

Board of Trustees, Palm Healthcare Foundation, West Palm Beach, FL	2008-2018
Advisory Board, Keiser University	2010-present
Board of Directors, Seagull Industries for the Disabled, Inc.	1998-2000
Board of Directors, Rebekah's House, (Home for Abused Women)	1999-2000
Special Service Award from the Legal Aid Society of Palm Beach County	2002
Board of Directors, Business and Professions Division of the Jewish Federation of Palm Beach County	

PERSONAL INFORMATION: Married with two children

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted to the FMA.

COUNTY MEDICAL SOCIETY ENDORSEMENT: Palm Beach County

PERSONAL STATEMENT:

Since seventh grade, I have always assumed a leadership role in various affiliated organizations. This includes presidency of various youth groups, student councils, and after-school activity programs. In college I served as a liaison from various organizations to the school officials. In medical school I was a class officer, and served as Chief Resident in my specialty training. Since moving to Florida in 1995 to continue my full-time clinical practice, I have enjoyed affiliations on a local, state, regional, and national level. Roles have included Board of Directors positions at all of these levels.

I enjoy teaching, and serve the students of the South Florida medical schools as a faculty member. My philosophies revolve around the concept of "servant leadership." I view the roles in various organizations as a privilege. These activities are not for self-serving purposes. Promulgation of ethical and quality medical standards requires dedicated professionals who are willing to provide their valuable time for the promotion of our chosen profession.

Advancing in leadership at the FMA level is a privilege that I do not take lightly. Organized medicine is critical to the practice of medicine in our country. My role as a vice-speaker/speaker of the FMA would be promote engagement, quality representation, integrity, and responsibility to insure that the voices and policies of the House of Delegates are heard, created, and followed to meet our mission role: Helping Physicians Practice Medicine.

I hope to continue my involvement to help build relationships integral to the viability of the future of our profession. If we don't collectively promote our passionate views regarding the practice of medicine, then the future of our chosen, special profession is in jeopardy.

FMA Elections 2022

Pareshkumar Patel, MD

Candidate: FMA Board of Governors

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Hematology-Oncology
Board Certified in Hematology and Medical Oncology
Work at Community based clinic- Florida Cancer Specialist

LOCATION: Florida Cancer Specialist

2351 Phillips Road, Tallahassee, FL 32308

SERVICE TO THE FMA:

FMA PAC board member since 2017
Help raise significant money for FMA PAC

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

FLASCO- Legislative Committee chair, Since 2016
FLASCO- Board member since 2014
Capital Medical Society Board member since 2015
President, Capital Medical society, 2022

COMMUNITY LEADERSHIP SERVICE:

Served as Board of Director for Big Bend Hospice in past
Served as Principle Investigator for multiple clinical trial

PERSONAL INFORMATION: Married to Yamini Patel, I have three children Dhenu, Sonu and Shiv. I love to play tennis and spend time with my family.

COUNTY MEDICAL SOCIETY ENDORSEMENT: Capital Medical Society

PERSONAL STATEMENT:

I attended B.J. Medical College and graduated with First Class Honors. I did completed residency in the Internal medicine and a chief year at the Jersey Shore Medical Center in Neptune, New Jersey. I did receive an award for excellence in Clinical research.

I was academic hospitalist and assistant professor at the Virginia Commonwealth University for several years. I did pursue and completed training in the Hospice and Palliative care followed by the Hematology and Oncology Fellowship. I did move to Tallahassee in July-2011 and Joined Florida Cancer Specialist in January 2012. I have been serving in Quality Committee Vice Chair on the Florida Cancer Specialist Executive board.

FMA Elections 2022

Mark A. Dobbertien, DO, FACS, MBA

Candidate: District B Representative to the FMA Board of Governors

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE:

Minimally Invasive Surgeon (MIS), General/Bariatric Surgeon, Diplomate, American Board of Surgery, Fellow, American College of Surgeons
Emergency Medicine

LOCATION:

Flagler Hospital
Lake City Medical Center
Putnam Community Medical Center

SERVICE TO THE FMA:

District B Representative, FMA Board of Governors
Board of Governors Surgical Specialties Representative 2018-2020
Chair, Council on Ethical and Judicial Affairs (CEJA)
Reference Committee Member, Delegate, CMS President (St. Johns County, Duval County Medical Medical Society)

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Executive Committee, Board of Governors, American College of Surgeons
Governor, American College of Surgeons
President-Elect, Treasurer, Secretary, Florida Chapter American College of Surgeons
Advocacy Committee Chair, Membership Committee Chair, Florida Chapter American College of Surgeons
President, Duval County Medical Society
President, St. Johns County Medical Society

COMMUNITY LEADERSHIP/SERVICE:

Board of Trustees, St. Johns Country Day School
Eucharistic Minister, St. Catherine's Catholic Church

ADDITIONAL PERSONAL INFORMATION:

Married, Lisa A Dynan-Dobbertien DO, Four children, 2 dogs, Sport's nut, Notre Dame Fan

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted.

COUNTY OR SPECIALTY MEDICAL SOCIETY ENDORSEMENT: Florida Chapter of the American College of Surgeons, Duval County Medical Society, St. Johns County Medical Society, Nassau County Medical Society, Clay County Medical Society

PERSONAL STATEMENT: Ever since serving as a delegate to the Medical Student Section of the American Medical Association, I have a remained convinced that organized medicine has been the best vehicle to improve care for patients in Florida and the United States. Organized medicine relies on committed individuals to donate their time, treasure and talents to ensuring that the mission of quality, timely, fully accessible patient care is realized every day. Your FMA Board of Governors serves the House of Delegates as an important communication, policy and membership link between grassroots physicians in Florida and the House of Delegates and are a key source of information on activities, programs and policies of the FMA. I humbly ask for your vote to continue to serve as your District B Representative on the FMA Board of Governors and promise to work hard advocating for you and our patients, implementing policy and always providing bidirectional communication.

FMA Elections 2022

Ajoy Kumar, MD, MBA, FAAFP

Candidate: FMA District C Representative, Board of Governors

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Family Medicine
Board Certified, American Board of Family Medicine
Administrative- Physician Advisor, Past- Chief Medical Officer

LOCATION:

Tampa/Saint Petersburg, Florida

SERVICE TO THE FMA:

Committee Member, Council on Medical Services and Health Care
Chair, Medical Economics Reference Committee, 2011 FMA Annual Meeting
Committee Member, Finance Reference Committee, 2009 FMA Annual Meeting

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Past President and Board Chair, Florida Academy of Family Physicians
Past President, Southern Medical Association
Past Treasurer, Pinellas County Medical Association
Past Chair & Co-Chair, Pinellas Delegation to Annual Florida Medical Association
Past AMA-Delegate, American Academy of Family Physicians
Past FAFP-Delegate, American Academy of Family Physicians' Congress of Delegates
Past AAFP-Delegate, American Medical Association Young Physician's Section
Past Hospital Delegate, American Medical Association's Organized Medical Staff Section

COMMUNITY LEADERSHIP SERVICE:

Physician Education and Leadership Board Treasurer- Bayfront Health-Saint Petersburg, FL
Past Medical Director, St. Petersburg Free Clinic -Health Center
Past Chief Medical Officer, FL4 State Medical Response Team
Past Chief Medical Officer, FL3 Disaster Medical Assistance Team
Physician, Pinellas County Medical Reserve Corps
Past Chair, Exercise Sub-Committee, St. Petersburg Metropolitan Medical Response System

PERSONAL INFORMATION:

Married to a Licensed Clinical Social Worker (LCSW) with a Master's degree
Have a 6-year-old son
Main goals at this stage in my life: Supportive husband, positive role model for my son, mentor/teach for next generation of physician leaders, and diligent professional at work.

COUNTY MEDICAL SOCIETY ENDORSEMENT: N/A

PERSONAL STATEMENT:

It has been 17 years since I have moved to Florida from the Washington D.C. metro region. My goal was to complete my training in Family Medicine, work to bring high level of education and training to the most disenfranchised populations around the world. In turn, I wanted to leave a positive impact in the communities by training the next generation of physicians. On this journey, I quickly realized that our own communities in the United States needed similar.

I realized that it was not enough and sustainable just to practice medicine in areas of high need and to do everything by myself. Such a heavy lift would lead to physician burn-out. As such, at the behest of my colleagues and mentors I became more involved in the "system-ness" of care by being involved in my hospital's physician-led medical staff committees, followed by County Medical Association, and then State, Regional, and National Medical Associations.

I found solace, kinship, and mentorship in many like-minded physicians from diverse backgrounds who were just as engaged in making fundamental changes within the healthcare industry. All of them wanted to re-establish a physician-led turn-around of the entire healthcare ecosystem, but each through their lens. It was very eye-opening and empowering to see how impactful medical associations are at all levels (local, state, regional, and national). Being involved in medical associations within their committees and leadership structures as well as with their political advocacy are the vehicles to developing the environment that will lead to that change.

Now having the experience and the network I have gained a greater understanding on how best to pave a pathway for that change. More importantly, I have learned that I do not have to do all of this by myself, rather my focus is now on supporting those who are making those changes at the patient-care level, committee-level, at the local Medical Association level, etc. In addition, it was critical to share my experiences with the next generation of physician leaders. It is vital that our leaders support, advocate, and amplify the voices who we seek to lead and represent.

With these experiences, I would like to have your support and represent not only physicians in my district but members within FMA. There is no greater way to fundamentally change the healthcare industry than through helping physicians practice medicine; fervently supporting the patient-physician relationship at all levels. Thank you in advance for your time.

FMA Elections 2022

Sanjay Pattani, MD, MHSA

Candidate: Board of Governors, District D

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE

Emergency Medicine
Board Certified by the American Board of Emergency Medicine (2008, 2018)
Fellow, American College of Emergency Physicians
Practice: Attending, Adventhealth Orlando, FEP of Teamhealth
Administration: Associate Chief Medical Officer AdventHealth Central Florida Division, South Region

LOCATION: Orlando

SERVICE TO FMA

FMA Delegate

SERVICE TO OTHER MEDICAL ORGANIZATIONS

Orange County Medical Society

OCMS PAC Board Member

Florida Chapter of Emergency Physicians

FCEP President (current)
FCEP Vice-President
FCEP Secretary
FCEP Board Member
FCEP PAC Co-Chair
FCEP Inaugural Class, Leadership Academy
FCEP Governmental Affairs Co-Chair
FCEP EM Days Advocacy Conference Co-Chair
FCEP Medical Economics Committee

American College of Emergency Physicians

ACEP State Legislative Affairs Committee

AdventHealth Waterman

Board Member
AdeventHelath Neuroscience Foundation Board Member

COMMUNITY LEADERSHIP SERVICE

Rotary Club Windermere

ADDITIONAL PERSONAL INFORMATION

Born: October 12, 1973
Wife: Kavita Pattani, MD, MS—Head and Neck Surgeon
4 sons: Shaan (15), Krish (11), Neel (9), Jay (7)
Dogs: 2 boxers, Ella and Sasha
Parents (live in): Nalini Pattani

COUNTY MEDICAL SOCIETY ENDORSEMENT

Physicians Society of Central Florida
Florida Chapter of Emergency Physicians

PERSONAL STATEMENT

The healthcare delivery system is evolving as a direct result of pressures exerted from both financial and legislative arenas. Narrowing networks threaten independent practices. Scope of practice expansion by ARNP, PAs, and even pharmacists threaten the quality and safety of the medicine our patients receive. CMS constantly changes coding, metrics, and other performance measures to contain their costs at the expense of physician revenue. Balance billing and PIP reform encroach on fair payment and free market principles of daily medical practice. Today more than ever, we need leaders with a strong sense of advocacy for the medical profession who can challenge these outside forces and effectively navigate the political agendas.

As Associate Chief Medical Officer at one of the largest Medicare healthcare providers in the country, I have oversight and accountability across multiple surgical service lines. This position gives me perspectives from multiple vantage points: private, employed, solo practice, and group practices. I also appreciate the pivotal role hospitalist medicine plays within our acute care setting. Through population health risk products, the critical importance for primary care network integrity with post-acute care follow up will shape the future delivery of medicine as bundled payments and cost sharing financial models penetrate our markets. As a front line practicing Emergency Medicine physician, I am able to appreciate many of the challenges our medical profession faces.

As a devoted FMA member for many years I will continue to build unity and trust within the organization by forging strong personal and professional relationships with all physicians of Florida. My goal is to constantly strive towards both patient and physician experience and wellness.

If elected, it would be an honor and a privilege to serve on the FMA BOG

FMA Elections 2022

Roger Lee Duncan, III, M.D.

Candidate: District F Seat,

Board of Governors

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE: Diplomate, American Board of Anesthesiology, Fellow, American Society of Anesthesiology**;** Hospital Based Physician
LOCATION: West Palm Beach, Florida
SERVICE TO THE FMA: FMA House of Delegate Representative 2019, 2021, 2022; FMA Medical Economics Reference Committee Member

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

National Medical Association, Committee on Medical Education
March 2020-Present
Florida Society of Anesthesiology & Palm Beach County Medical Society –
2022 Legislative Days Representative, Tallahassee, FL January 2022
2020 Legislative Days Representative, Tallahassee, FL January 2020
2019 Legislative Days Representative, Tallahassee, FL March 2019
2019 Legislative Days Representative, Washington, DC May 2019
2022 ***Doctor of the Day, Florida Senate.*** **Tallahassee, Florida, March 2, 2022.**
NSU Florida Patel College of Allopathic Medicine, Executive Leadership Council.
September 2021-Present
T. Leroy Jefferson Medical Society. Past President 2002-2004, 2014-2016.
Mentorship and Youth Development Chair 2008 to Present
Community Health Fair Chairman June 1999- June 2009. Over 5,000 participants served.
Healthcare and Science Career Symposium. Founder and Chairman. March 2012-present. Over 10,000 participants.
Good Samaritan Medical Center Student Externship. Founder and Chairman. 2010 to 2021.
Dream Big Career Day Founder and Chairman 2010 – 2021.
Palm Beach County Medical Society. Board of Directors, 2007 – Present.
Palm Beach County Medical Society. 102nd President. 2021. Member-at-Large, Hospital -Based Physician Chair, Cultural Competency Initiative Advisory Council, Finance Committee, Judicial & Ethics
Palms West Hospital
Peer Review Committee, Blood Utilization Review Committee, **Envision Physician Services**
Project TEMPO Coordinator, Narcotic Compliance Department Coordinator, Regional
Anesthesia Enhancement and Safety Improvement Committee, Chair

COMMUNITY LEADERSHIP SERVICE:

Economic Council of Palm Beach County, Member. January 2022- Present
American Heart Association, Palm Beach County Board of Directors **May** 2021 - Present
Chairman, Leadership Development
NSU Florida, President's Area Advisory Committee Board. March 2016– December 2021.

PERSONAL INFORMATION: Married. Father of four.
COUNTY MEDICAL SOCIETY ENDORSEMENT: Palm Beach County Medical Society
PERSONAL STATEMENT:
I am Dr. Roger L. Duncan, III, and I have been dedicated to leadership in medicine, youth development and community service for the last thirty-five years. I am a Fellow of the American Society of Anesthesiologists and the Vice-Chief of Anesthesia at Palms West Hospital in West Palm Beach. As the son of trail blazing parents from San Diego, California, I was taught early to strive for excellence and leave an impactful legacy on the world. With that foundation, I has sought to get every youth with whom he has encountered, excited about the sciences, and filled with the hope that if they can dream it, they can accomplish it.

Relentless in my commitment, even at Yale Medical School, I gave back to the community. I have performed NIH funded research at Yale, worked with a Nobel Prize winner at the Salk Institute, dedicated time to organizing holiday events for homeless children and lectured to children at near by schools about the importance of science and math. I realizes and stresses the importance of having a seat at the table if one desires to effect change, and to that end, I have held many leadership roles in a variety of local and national organizations whose missions are to advance the medical profession, serve medically neglected and socio-economically disadvantaged groups, and expose all youth to fields in the sciences.

Over the years, I have been fortunate to be the recipient of numerous awards for my community work and leadership including, the prestigious Hero in Medicine and the Health Care Educator awards from the Palm Beach County Medical Society, the Meritorious Achievement Award for the National Medical Association, the Legacy Award from the T. Leroy Jefferson Medical Society, the Outstanding Community Samaritan Award from FAU Schmidt College of Medicine and the Trailblazer Award from the BEST Academy. Also, as result of my programmatic efforts, the T. Leroy Jefferson Medical Society has been awarded small chapter of the year by the National Medical Association 3 years during a 5 year period. In December of 2021, I was the commencement speaker and received and **Honorary Doctorate of Medicine from the Medical College of Wisconsin**. In March 2022, I served as the ***Doctor of the Day, for the Florida Senate.*** I have additionally helped to raise hundreds of thousands of dollars in grant funding to improve health and wellness access.

I have served on several area medical and philanthropic Boards including, as Presidents of both the Palm Beach County, and T. Leroy Jefferson Medical Society, the National Medical Association, Committee on Medical Education, the Executive Leadership Council for NSU Florida, Dr. Kiran C. Patel College of Allopathic Medicine, the American Heart Association, Palm Beach County, and the Economic Council of Palm Beach County.

How do you change the world and leave it better than you found it? One program and one student at a time. This is the mantra that has resulted in hundreds of hours of programing, the inception and implementation of numerous community and youth programs and the impact to thousands of students and family lives over the last 30 years. I have been a mentor, influencer, educator, dreamer, believer and so much more to so many:

- ***Mentor and Influencer*** - I has played a vital role in inspiring a passion for science and technology in over 5,000 inner city elementary, middle, and high school children by teaching them how gratifying being a doctor can be and the essential uses of math and science.

- ***Impactful Legacy*** - I have helped to raise $5,000 annually; awarding over 35 scholarships to high school students aspiring to pursue a career in pre-health and the sciences.

- ***Educator*** **-** formulation and operation of year-long Hospital Externship for 8th graders.

- ***Dreamer*** - I started ***"A day at the County Club"*** where students are asked to mingle with medical professionals and their families and encouraged to dream big. The students are exposed to golf, tennis, luncheons and the luxurious life style and shown what they can achieve through hard work, dedication and perseverance.

- ***Believer*** - One of the my most impactful programs is the Annual Healthcare and Science Career Symposium. Now in its 10th year, this program has taught over 7,000 students to believe that with or without a stethoscope, they can have a meaningful impact with a career in healthcare or the sciences. Student attend lectures presented by over 150 exhibitors in over 37 different careers and also hear from Keynote speakers that have ranged from former National Medical Association Presidents, Dr. Cato Laurencin, a Harvard-MIT trained, medical school dean who invented the field of regenerative medicine, to the Former US Surgeon General and Head of the Center for Disease Control Dr. David Satcher. Over ~85% of participants in the program have stated that the program was highly influential and informative in their decision to pursue career in healthcare or science.

I am a California native who received his undergraduate degree from California Polytechnic State University and my medical degree and public health training from Yale University School of Medicine. For several years, I served as an Assistant Professor of Anesthesiology at the University of Texas Medical Branch. There, I not only provided direct patient care, but also served as the Director of Obstetrical Anesthesiology, among other numerous leadership positions. In recognition of my works and accomplishments, I was awarded an Honorary Doctorate of Medicine from the Medical College of Wisconsin.

I believe that my background, experience and training have equip me to be a solid contributor to the Florida Medical Association's Board of Governors as District F representative.

FMA Elections 2022

Rudolph G. Moise DO, MBA, JD

Candidate: Board of Governors District G

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE

Primary Care (1982 to Present)
Board Certified In General Practice
Graduate, Physician Leadership Academy

LOCATION:

671 NW 119TH ST, NORTH MIAMI. FLORIDA 33168
Email address: rmoise@phpgfl.com

SERVICE TO THE FMA

Appointed by the President to the Board of Governors	January 2019
Delegate to the FMA House of Delegates, FMA Annual Meeting	2016-present
Reference Committee Member on Medical Economics	2017
Member FMA PAC 1000+ Club	

SERVICE TO OTHER MEDICAL ORGANIZATIONS

Member American Medical Association	1995-present
Member American Osteopathic Association	1982-present
Member Florida Osteopathic Medical Association	2002-present
Member Haitian Medical Association	1983-present
President-Elect, Dade County Medical Association	2019
Medical Director Miami Dade Ambulance	2008-present
United States Air force Colonel and a retired Flight Surgeon	
President, Comprehensive Health Center, LLC	1986-present
President, Primary Health Physician Group	2000-present

COMMUNITY LEADERSHIP/SERVICE

Doctor of the day, Florida Senate	2017-2018

Doctor of the day, Florida House of Representative	2015-2016
Past Chairman, Jackson Memorial Foundation	
Chair, Community Outreach Committee	
Dade County Medical Association	2018-2019

PERSONAL INFORMATION:

Married to Mirjam Moise ARNP

Two children: Maya Moise and Rudolph Moise Jr.

COUNTRY MEDICAL SOCIETY ENDORSEMENT: The Dade County Medical Association enthusiastically endorses the candidacy of Rudolph Moise DO, as member of the Board of Governors, District G.

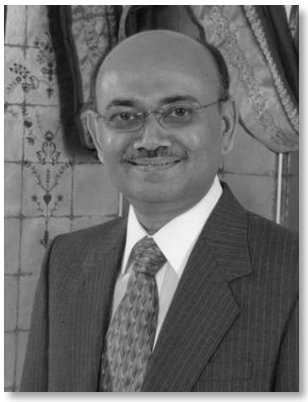
PERSONAL STATEMENT

My involvement with the FMA began in 2016 as a Delegate to the FMA House of Delegates at the FMA annual meeting. I have been returning every year since.

I have the opportunity to network and meet several Florida physicians in different specialties. I also witnessed how the FMA operates and the significant contributions the organization makes to protect the practice of medicine through the efforts of the FMA PAC and the FMA's Lobbing team.

As a Primary Care Physician, I am on the front line of medicine witnessing barriers to access care due to inadequate financial resources. I also witnessed how physicians are being denied payment for services render, and are being overwhelmed with increasing regulations.

As a recent appointee to the Board of Governors, I would like to continue to serve the physicians in my district as well as in the State of Florida.



FMA Elections 2022

Naresh Pathak, MD, FACP, FAAHPM

Candidate: Primary Care Representative for the Board

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Internal Medicine, Private Practice - 1989 → Now
Fellow of American Collage of Physicians & American Academy of Hospice & Palliative Medicine

LOCATION:

7471 W. Oakland Park Blvd, Suite 110, Lauderhill, FL 33319
e-mail: jaima310@gmail.com
web page: www.carehealthcenter2.com

SERVICE TO THE FMA:

Delage of FMA (for American Collage of Physicians) for may years (current)
Served on Reference Committee IV of FMA (past)
Vice Chair, Specialty Society Section of FMA (Current)
1000+ Club Member (for many years)

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Member, Governor's Advisory Council, American Collage of Physicians (many years)
Chair, Medical Economics Regulatory Committee (FL ACP, many years)
Bylaws Committee, FL ACP (past)
Executive Committee, FL ACP (past)
Education Committee, FL ACP (past)
Candidate for Governor, FL ACP (past x 3)
AMA, Member (many years)
American Academy of Hospice & Palliative Medicine, member (many years)

COMMUNITY LEADERSHIP SERVICE:

Medical Mission Service abroad (for 25+ years)
Self Improvement Classes for Doctors and patients
Wellness seminars for doctors and patients
Teaching Chemistry, Calculus, Physiology, Clinical Correlation & Bedside Medicine
Community Based Teacher of the year, FL ACP
Internist of the Year, FL ACP
Outstanding Service Award, FL ACP
Key Contact Award, FL ACP

Volunteerism Award, FL ACP
Wellness Champion Award, FL ACP

PERSONAL INFORMATION:

Married, 3 Children
2 Children are Physicians (1 served on FL ACP Governor's Advisory Council)
All 3 children served on Medical Missions abroad for many years
4 Grand Children
Hobbies / Interests → Flying Small Planes, Poetry writing, Pencil Sketching, Tennis

PERSONAL STATEMENT:

"To find oneself, one needs to lose oneself in the service of others" — Mahatma Gandhi.

I have been so blessed and have received so much from the profession of Medicine, that giving back in the form of service is the only way I find fulfilment. I have served patients during medical missions all over the world for past 25 years and served my colleagues by be serving as the voice of their conscious to the law makers.

Primary care providers are at the heart of doctor-patient relationship. Educating 1 patient at a time and showing them how we, the doctors, are their biggest advocate and that their voice in the state has power to bring about the change for the betterment of their health care and their doctor's ability provide it.

I bring the Primary Care voices from the trenches of private practice to enrich the voice of Board of Governors. It will be my honor to serve FMA for the good of all the doctors and the patients of Florida.

FMA Elections 2022

Daniel C Daube, M.D. FACS

Candidate: Surgical Specialties Representative, Board of Governors

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Otolaryngology, Head and Neck Surgery - 1994
Facial Plastics and Reconstructive Surgery – 1995
Single Specialty group; ENT and Allergy of Florida

LOCATION: 200 Doctors Drive, Panama City Florida 32405**;** Email skipdaube@gmail.com

SERVICE TO THE FMA:

PAC, 2020- present
Member, Florida Medical Political Action Committee (FLAMPAC), 1996-present
Young Physician Representative on Florida Medical Association (FMA) Council on Public Relations, Communications, & Membership, 1999-2001
Young Physician Governing Council, District A, 1997-2000
Chairman, Young Professionals (YPS) for the FMA, 1999-2002
Council on Managed Care, 2003-2004
Delegate to American Medical Association (AMA), 1998-2002
Delegate to Florida Medical Association (FMA), 1999-2005, 2012,1016-present
Distinguished Physician Award, 2004
Florida Delegation to the American Medical Association (AMA) Young MD Section, 1997-2000
Florida Medical Association (FMA) Young Physician, Vice Chairman, 1998-2000

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Gulf Coast Medical Centre
Bioethics Committee, 1999-2007; Chairperson, 2002, 2006
Board of Trustees, 2005,2021
Bylaws Committee: 2003-2008; Chairman 2007, 2008, 2014 2021
Cancer Committee, 1997-2007
Cancer Liaison Physician; American College of Surgeons, 2004-2007
Credentials Committee, 2006-2011
Quality Coordinating Council; 1999, 2001, 2005; Chair 2006
Medical Executive Committee: 2004, 2005, 2006
Secretary/Treasurer, 2001
Surgery Quality Assurance Committee, 2002-2005
Chief of staff, Gulf Coast Regional Medical Center, 2005, 2021-present
Clinical Faculty 2020-2023 Alabama College of Osteopathic Medicine
Board of Gulf Coast Regional Medical Centre, 2020-present
Board of NFO 2018- present
Board of ENTAAF 2018-present
American Academy of Facial Plastic & Reconstructive Surgery (AAFPRS); 1993-Present
Committee for Current Procedural Terminology (CPT) Coding, 1996-2000
Membership and Residency Relations, 1997-1999
American Academy of Otolaryngology-Head and Neck Surgery (AAOHNS), 1990-Present
American Association of Accreditation of Ambulatory Surgery Facilities (AAAASF), Member 2001-2021
Inspector Committee, 2002-2010; April 2013-2019

American Medical Association (AMA); September 1985-2021
American Society for Laser Medicine and Surgery (ASLMS), Fellow, 1996-Present
Fellow, American College of Surgeons (FACS), 1999-Present
Bays Medical Society (now ECMA); 1995 to 2007, 2012-present
Chair, Scientific Session, 2003, 2004
Board, 2017 to present
Educational Committee, 2002 to 2006
Member at Large, 1998
Nominating Board, 1996
Past President, 2002, 2003
President Elect, 2001
Treasurer, 1997, 1999, 2000
Medical Advisory Committee, Healthplan Southeast, 2000-2001
Medical Staff Healthsouth Emerald Coast Rehabilitation Hospital, 1997-2001, 2010-2013
New Mexico Medical Society; 1985-1994
Preceptor, Medical School of West Virginia, 2005
Preceptor, Vanderbilt University Medical Center, 2001
The Triologic Society, November 1995-2007
Florida Society of Facial Plastic and Reconstructive Surgery, 2002-Present
Florida Society of Otolaryngology and Head and Neck Surgery, 2002-Present
Advisory Board for Advanced Home Health Care, 1996-1999
Advisory Board Chairman, 1999-2001
Agency for Healthcare Administration, Special Expert Witness Program, 1996-1997
Alpha Omega Alpha, Honor, Medical Society; since junior year of medical school
Association of American Physicians and Surgeons, 2001-2003
Bay Cares, Member 1996-2003, (Providing care to indigent patients in Bay County.)
Bay Cares Board - Secretary/Treasurer: 1997, 1999-2001
Bay Medical Center, 1995-2005, 2010-February 2013
Credentials Board, June 1996-June 1997
Forum for Medical Affairs, 1999-2001
Board of Covenant Hospice, 2002-2003
Board of Gentiva Health Services, 2003
Board of Suncoast Imaging, 2005-2007
Clinical Faculty, Tulane University Medical Center, September 1, 1995-2000
Federal Ambulatory Society of America Member, 2005-Present
Workshop for Ambulatory Surgical Center, October 2005, Chicago
Florida Independent Physicians Association (FIPA) and the Independent Physicians Association (IPA), Quality Assurance Committee, 2000
Florida Physicians Association, 1999-2004

COMMUNITY LEADERSHIP SERVICE:

Military Affairs Committee, 2020-present
Civilian Commander with WEG Tyndall AFB 2021 - present, Medical Squadron 2020 -2021, 2nd squadron 2017-2019

PERSONAL INFORMATION: Father of Ella Rose, my teenage daughter

COUNTY MEDICAL SOCIETY ENDORSEMENT: Endorsement of the Emerald Coast Medical Society

PERSONAL STATEMENT:

At an early age, I became an Eagle scout and learned how fulfilling it was to serve, it was something I had learned as a child in Church but did not fully grasp until scouting. I later graduated Summa Cum Laude from **UNM** on a swimming scholarship, in Albuquerque, and then from that university's **School of Medicine** in the Top 10% of my class. I became **Board Certified** in *Otolaryngology-Head and Neck Surgery* in 1994, and was Fellowship Trained and Board Certified in *Facial Plastic and Reconstructive Surgery* from **Louisiana State University**. Prior to opening **Gulf Coast Facial Plastics & ENT Center** in Panama City, I was part of the Clinical Faculty of **Tulane University Medical Center**. As a practicing physician I have conceptualized and created a high functioning surgical center and medical practice.

I feel it is these experiences that equip me to serve on the board of the FMA and represent surgical specialties. I have been an active member of the FMA for almost 30 years and a resident of Florida for the same. I am driven by service and achieving goals. My motive and desire is to serve in a meaningful way. I would be honored to serve and humbly ask for your support.

FMA Elections 2022

Alexander D. Lake, DO

Candidate: FMA Board of Governors, RFS Representative

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Internal Medicine, ABIM-certified
Gastroenterology, 2nd year fellow

LOCATION:

Tampa, FL

SERVICE TO THE FMA:

Resident/Fellow Representative, President's Advisory Board, 2021 – present
Resident/Fellow Representative, Board of Governors, 2020 – present
Chair, Resident/Fellow Council, 2019 – present

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Fellow Representative, Hillsborough County Medical Association Executive Council, 2021 – present
Member, Hillsborough County Medical Association Government Affairs, 2021 – present
Member, American Gastroenterological Association (AGA), 2020 - present
Member, American College of Gastroenterology (ACG), 2020 - present
Member, American College of Physicians (ACP), 2020 – present

COMMUNITY LEADERSHIP SERVICE:

Trinity Soup Kitchen
Youth Mentoring
Young Adults Ministry Group

PERSONAL INFORMATION:

Married
Tampa Bay Bucs Season Ticket Holder x4 years

COUNTY MEDICAL SOCIETY ENDORSEMENT: Hillsborough County Medical Association

PERSONAL STATEMENT:

Before beginning as the Chair of the RFS council in 2019, I had no political or organized medicine background. I was just highly bothered by seeing the Florida legislature indirectly say my education did not matter; there was an easier way to independent practice. Consequently, I sat down one night and wrote an

essay that somehow ended up in the hands of the AMA senior legislative attorney. I approved her request to 'amplify my viewpoints' through media and marketing. I thought it was great, but I did not truly understand why they were so fond of my essay. After serving three years as the Chair of the RFS Council and two years on the BOG - learning from the remarkable leaders of this influential association - I know precisely why the AMA chose to use my voice. It is simple and a tale as old as time.

It starts with the fact that there are quite a few present-day controversial topics that we, as physicians and as humans, simply do not agree on. Emotions tend to run high, and it is easy to speak your mind. However, I genuinely believe we let our emotions run wild too often, negatively affecting our relationships, losing trust with others, and thus failing to make a difference in our area of influence. Therefore, I believe a leader, especially a physician leader in organized medicine, should never forget these two traits:

- Number one is maintaining our fundamentals. We are PHYSICIANS and are the most prestigious, respectable profession forever in history. We have been tested all our life, so why expect it to be different now? Who does not want to be like a 'doctor'? A white coat is a white coat. Doctors make mistakes, and so do other 'providers.' However, the fundamentals are different. Moreover, the scary thing is that our legislators, most of our patients, and probably one of your family members do not know that.
- Number two is timing. What is trying to be accomplished - is it the right situation, time, and place? Knowing when it is the right time can be the difference between genuinely making a difference or ruining everything you have worked for. Sometimes it is better to take a step back and look at the big picture. Illustrating the climate in the area of desired influence is more important than creating the resolution that you feel will change the world.

I have come a long way since that essay in 2019, and I intend to continue my development as a young voice advocating for physician. With that being said, I would be honored for your humble support as the Resident and Fellow Representative on the Florida Medical Association Board of Governors.

FMA Elections 2022

Eva M. Crooke, M.D.

Candidate: Delegate to the AMA

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE

Board Certified Obstetrics & Gynecology
Fellow, American College of Obstetricians & Gynecologists
Private Practice

LOCATION: Tampa, Florida (Hillsborough County)

SERVICE TO FMA

Alternate delegate to the American Medical Association (2020-present)
Delegate from Hillsborough County Medical Association (2017-present)
FMA member (2012-present)
FMA PAC member (2020-present)
Completion of Karl M. Altenburger, M.D. Physician Leadership Academy

SERVICE TO OTHER MEDICAL ORGANIZATIONS

Hillsborough County Medical Association President (2022-present)
Hillsborough County Medical Association President-Elect (2021-2022)
Hillsborough County Medical Association Vice President (2020-2021)
Hillsborough County Medical Association Chair of Government Affairs Committee (2020-present)
Hillsborough County Medical Association Treasurer (2019-2020)
HILLPAC Board Member (2019-present)
Hillsborough County Medical Association Secretary (2017-2019)
Hillsborough County Medical Association Executive Committee member (2014-2017)

COMMUNITY LEADERSHIP SERVICE

USF MCOM Alumni Society Board of Directors (2018-present)
Volunteer physician, Catholic Charities San Jose Mission, Dover, FL (2018-present)

ADDITIONAL PERSONAL INFORMATION

Born: January 12, 1982
Husband: Jace

COUNTY MEDICAL SOCIETY ENDORSEMENT

The Hillsborough County Medical Society is privileged to endorse the election of Eva M. Crooke, M.D. as Delegate to the AMA. She has dedicated time and passion to the county medical society on the board and numerous committees. She serves on the executive council, HILLPAC board, has helped form the physician wellness program, and currently acts as chair of the government affairs committee. She serves with professionalism, enthusiasm, and integrity.

PERSONAL STATEMENT

Advocacy for our profession and our patients is as important now as it has ever been and I want to be a voice for the physicians and patients of Florida. As a devoted county medical society member serving as a delegate at the state level for several years, I would like to continue expanding my commitment to the national level.

I believe we need a cohesive yet diverse group of members to take the opinions and recommendations from the FMA to the AMA. I believe I can add a strong and professional voice of support for our state and work together with a group of delegates to present a united front that represents our resilient organization. I believe in the power of organized medicine, and I want to support our profession. As a delegate to the AMA, I can learn from other experienced delegates while offering a new perspective as a young physician.

I commit to always representing the FMA with respect and upholding all responsibilities of a delegate to the AMA.

FMA Elections 2020

Trachella Johnson-Foy, M.D.

Candidate: AMA Delegate

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE:
Family Medicine, Private Practice Affiliated with Baptist Health

LOCATION: Jacksonville , FL

SERVICE TO THE FMA:
Delegate since 2007
FMA leadership Academy
Council on Science and Medical Education since 2013
Poster Judge on Multiple Occasions
CME Presenter for Mandatory HIV talk on 3 occasions
AMA Delegate x 2 (?) terms
Task Force Appointment

SERVICE TO OTHER MEDICAL ORGANIZATIONS:
DCMS President 2017
DCMS Delegate since 2007
DCMSF- Treasurer 2022
DCMS Public Health committee
NEFMS Vice President 2013-2018
Board of Directors for Baptist Primary care

COMMUNITY LEADERSHIP/SERVICE:
We Care Jacksonville, Medical Director
JSMP- Board since 2021
Doctor for the Day State Senate 2019, 2020 and 2021
Motivational Speaker
Florida Blue Physician Advisory Panel since 2014
Community Action Group-
Annie Ruth Foundation Volunteer/Mentor
Fluvax Jax Co-Chair
Local News Health Contributer

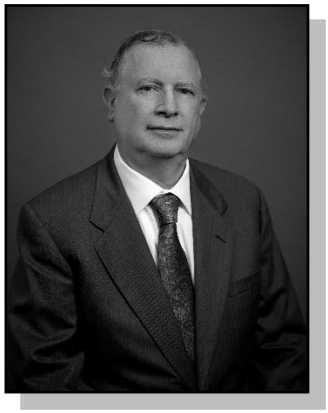
ADDITIONAL PERSONAL INFORMATION:
Owner of Barbershop and Hair Salon- Platinum Cutts
Married with one Son

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted.

COUNTY OR SPECIALTY MEDICAL SOCIETY ENDORSEMENT: Duval County Medical Society

PERSONAL STATEMENT:

I am eager to serve as a delegate to the American Medical Association. I have worked diligently throughout my career to ensure the interest of patients were represented. However, in this process it became clear that there was a need to make sure that there was an earnest fight for the dedicated physicians who take care of these patients. I want to be a part of the positive change and continued progress of the field of medicine.



FMA Elections 2022

Ronald F. Giffler, M.D.

Candidate: AMA Delegate

SPECIALTY, CERTIFICACTIONS, TYPE OF PRACTICE:

Board Certified – Anatomic and Clinical Pathology
Fellowship – Surgical Pathology U. of Texas M.D. Anderson Hospital
M.B.A. - NOVA University
J.D. – University of Miami School of Law
Florida Health Care Risk Manager, 1996 – 2007

LOCATION: 3141 W. McNab Road, Pompano Beach, FL 33069
954-977-6653, rgiffler@firstpathllc.com

SERVICE TO THE FMA

FMA Board of Governors and President's Advisory Committee 2021-2022
FMA Immediate Past President 2020-2021
FMA President 2019- 2020
FMA President-Elect 2018-2019
FMA Vice President 2016-2018
FMA treasurer 2012-2016
FMA Board of Governors Executive Committee 2011-2021
FMA Services President 2008 -2015, Vice President 2015-
Florida Medical Foundation Treasurer 2011-2015, Board Member 2015-
Florida Medical Foundation Board, 2002 – 2003, 2004 –2009, 2011-
FMA PAC Board 2006 –
FMA PAC Fundraiser of the Year Award - 2010
PRN (Professionals Resource Network) Treasurer 2012 - 2016
FMA Delegation to AMA, 2006 –
FMA Finance Committee Chair 2011 -
Litigation Center Committee 2009 -
FMA President's Recognition Award, 2005
By-laws Committee, 2003 – 2007, 2012 -
FMF Abel Baldwin Society Founding Member, 2001
FLAMPAC 1000 Club, 1999 –
Delegate to FMA House, 1994 –
FMA Member 1982 –

SERVICE TO OTHER MEDICAL ORGANIZATIONS

Broward County Medical Association
Chair, Board of Trustees 2009 – 2010
Board of Trustees 2002 - 2010

President, 2005 – 2006
Prior Service as President-Elect, VP, and Treasurer
Chair, Board of Censors, 1998 – 2005
Chair, CME Committee, 1996 – 1998

American Medical Association, 1973 –
Florida Delegate 2014 - , Alternate Delegate 2006 –2014
Member Reference Committee G (Medical Practice)- 2012, 2020
Resolution Committee 2021

Palm Beach and Dade County Medical Societies – member

Florida Physicians Association – President 2004-2005
Board of Directors, 1996 – 2005

College of American Pathologists (CAP), 1976 –
Inspector in (CAP) Laboratory Accreditation Program, 1993 –

American Society of Clinical Pathology, 1976 –

Lee County Medical Society, 1978 – 1980

Association of Military Surgeons of the U. S., 2002 –

Caducean Society of Greater Fort Lauderdale, 2000 –

Fort Lauderdale Surgical Society, 2003 –

North Ridge Medical Center Medical Staff Executive Committee, 2001 – 2008

COMMUNITY LEADERSHIP SERVICE

Community Blood Center of S. Fla. Medical Advisory Board, 1991 –

Broward County Medical Reserve Corps, 2004 –

Women in Distress of Broward County, Board of Directors, 1996 – 2002
Secretary, Board of Directors, 2001 – 2002

Broward County Med. Assoc. / S. Fla. Hospital Association Joint Liability
Reform Task Force, 2003 –

ADDITIONAL PERSONAL INFORMATION

Daughter: Sara Giffler, Veterinarian

Military Service: Colonel, Medical Corps, U.S. Army Reserve, 2002-2015
Graduate Command and General Staff College

CONFLICT OF INTEREST: None, Conflict of Interest Declaration submitted to the FMA.

COUNTY MEDICAL SOCIETY ENDORSEMENT: Miami-Dade, Palm Beach

PERSONAL STATEMENT:

I believe physicians play a unique role as advocates for the medical profession, individual patients, and public health. Our front line heroes in the COVID-19 pandemic need our support. The FMA is the only organization capable of representing all Florida physicians, regardless of specialty. By fighting for our professional and financial independence, the FMA makes it all possible.

I would like to continue my service on the AMA delegation. If elected, I will fight for the interests of the physicians and patients of our great state, and work diligently to keep our organization financially secure. For me, the most important issues are preserving the independence of the practice of medicine, and successfully adapting to the many and evolving changes in health care delivery. This, I believe, is the best hope for the solution to our current problems of access and quality of care.

Thank you for your time and consideration. Ron Giffler

FMA Elections 2022

Rafael C. Haciski M.D. F.A.C.O.G

Candidate: AMA Delegate

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE

Diplomate, American Board of Obstetrics and Gynecology,
Fellow, American Congress of Obstetrics and Gynecology,
Private Solo Practice of Gynecology in Naples, Florida

EDUCATION and TRAINING

1970 – Gilman School, Baltimore, Maryland
1973 – S.B. from Massachusetts Institute of Technology, Cambridge, Mass.
1977 – M.D. from Emory University School of Medicine, Atlanta, Georgia
1981 – completed residency in Obstetrics and Gynecology, the Johns Hopkins Hospital, Baltimore, MD
1983 – completed Fellowship in Reproductive Endocrinology and Infertility, University of Chicago, IL

SERVICE TO ORGANIZED MEDICINE

Maryland Commission on Hereditary Disorders, Comm on Reproductive Technologies, 1988
Baltimore City Medical Society 1983-2003:

- Educational Program Committee, 1984, 1985
- Delegate to the Maryland Medical Society 1987-2003
- Managed Care Committee 1999, 2000
- Legislative Committee, 1994 - 2001
- Board of Directors, 1995, 1996, 1997, 1998, 2001, 2002, 2003
- Treasurer, 1997, 1998
- Vice-President, 2003

the Medical and Chirurgical Faculty of Maryland (State Medical Society) 1983-2003:

- Medico-Legal Committee, 1986 – 1990
- Young Physicians Committee 1989, 1990, 1991
- Young Physicians Delegate to the AMA, 1991
- Public Relations Committee, 1989, 1990, 1991, 1992, 1993, 1994, 1995
- Managed Care Committee co-chair 2001, 2002, 2003
- Computers in Medicine Committee, Chairman, 1989, 1990, 1991, 1992, 1996, 1998
  committee member 1989 – 1998

Manatee County Medical Society, member 2004-2007:

- Board of Directors 2005, 2006
- Delegate to the Florida Medical Association 2005, 2006

Collier County Medical Society, member since 2007

- Delegate to the Florida Medical Association 2009 - 2016, 2018
- Chairman, Membership Committee 2011, 2012, 2013, 2014, 2015; committee member 2016 – 2018
- Health Information Exchange Committee 2012
- Board of Directors 2012, 2013, 2014, 2015 (at large –>secretary –> treasurer–> VP)
- President 2016

Florida Medical Association

- House of Delegates 2004-2007 representing Manatee County
- House of Delegates 2009-2016, 2018 representing Collier County
- House of Delegates 2017 representing American Congress of Obstetrics and Gynecology, Dist-12
- Committee on Health Information Technology 2011
- Member, Reference Committee on Medical Economics 2012
- Chair, Reference Committee on Medical Economics 2014
- Member, Credentials Committee 2015

CONFLICT OF INTEREST: None

COUNTY MEDICAL SOCIETY ENDORSEMENTS: Collier County Medical Society

PERSONAL STATEMENT

House of Medicine is under assault, with the detrimental challenges and changes coming at us at increasing pace, interfering with our ability to practice good medicine. We have two choices: continue to moan, groan, complain, and do the same thing we have been doing, or step up and take charge, participate, effecting positive influence on those inevitable changes. That is what I wish to do on your behalf at the AMA. In as much as the voice of AMA has weakened over the years, it still remains the de-facto voice of the physicians in the nation. We need to redirect that voice, strengthen it, and make it more effective, and make sure it represents what we want and need at the grass root level. I will fight for logic and reason, not expediency. I will fight for our professional and financial independence, and indeed our survival. But change is inevitable, and we must mold it to our and our patients' needs. I ask for your support to represent us, our patients, and the Florida Medical Association at the AMA.

FMA Elections 2022

Lawrence S. Halperin, M.D.

Candidate: AMA Delegation

PRACTICE and CERTIFICATIONS

Board Certified Orthopedic Surgery
Fellow, American Academy of Orthopedic Surgeons
Private Practice at Orlando Orthopedic Center since 1990

SERVICE TO MEDICAL ORGANIZATIONS

Florida Orthopedic Society, President
AMA Delegation- two terms
FMA PAC Board of Directors
FMA Legislative Reference Committee
FMA 1000 Club
Orange County Medical Society Board of Directors
(Secretary, Treasurer, Vice President)
Orange County Medical Society PAC Board of Directors
American Academy of Orthopedic Surgeons (AAOS) Board of Directors
Chairman, AAOS Board of Councilors
AAOS PAC Board of Directors
AAOS Council on Advocacy
AAOS Council on Education
AAOS Council on Research and Quality
Chief of Orthopedics, Lucerne Hospital

PERSONAL INFORMATION

Born June 2, 1958
Married to Susan Halperin July 5, 1981
Three grown Children

PERSONAL STATEMENT

Representing the interests of physicians has been the most important part of my journey through organized medicine. I have fought for physicians locally, statewide, and in Washington, D.C.

It is rewarding when our efforts pay off and make a difference. I am not afraid of a fight, nor do I shy away from taking on Goliath. I am especially proud of having played a role in the struggle to change the way recertification is done by the American Board of Orthopedic Surgery.

I ask for your vote. I want to represent you as we fight for payment reform, cost of living adjustments, and MIPS/MACRA repeal. We need relief from unreasonable prior authorization practices. We must battle the creeping Scope of Practice expansion by inadequately trained practitioners.

I promise to zealously advocate for the betterment of your practice and preservation of your livelihood.

FMA Elections 2022

Rebecca L. Johnson, MD

Candidate: AMA Delegate

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE: Pathology; Certified in Anatomic and Clinical Pathology, Hematology, Immunopathology; Chief Executive Officer, American Board of Pathology.

LOCATION: Tampa, Hillsborough County

SERVICE TO THE FMA: HOD-delegate from Hillsborough County 2013-present; AMA HOD Alternate Delegate 2013-present.

SERVICE TO OTHER MEDICAL ORGANIZATIONS: **American Medical Association**: Delegate (College of American Pathologists) AMA HOD 1997-2012; AMA Pathology Section Council Chair 2000-01 and 2008-12, Vice Chair 1998-00; Reference Committee E Chair 2000; Specialty and Service Society Section Ad Hoc Committee on Long Range Planning 1999-2001; Relative Value Update Committee (RUC) Practice Expense Advisory Committee 1998-03; American Medical Accreditation Program (AMAP) Federation Advisory Committee 1998-99, Standards Committee 2000. **Hillsborough County (FL) Medical Association:** Executive Council 2013-present. **Massachusetts Medical Society**: Board of Directors Trustee 2005-12, Alternate Trustee 2001-04; Committee on Legislation 1992-10; Committee on By-Laws 1999-10, Chair 2001-09; District Leadership Council 1998-03; Task Force on Member Services 1999-01; House of Delegates 1996-12, served on numerous reference committees and chaired several; Committee on Member Services 1999-2012; Committee on Recognition Awards, Vice-Chair 2008-12; Judicial Committee 2008-12; Committee on Strategic Planning 2011-12; served on numerous Task Forces; **Berkshire District Medical Society** President 2000-2001, Executive Committee 1996-2012. **Massachusetts Society of Pathologists:** President 1999-01, Treasurer 1993-94; Secretary 1995-96, President-Elect 1997-98, Past-President 2001-03, Executive Committee 1990-2012. **Rhode Island Society of Pathologists**: Secretary-Treasurer and President-Elect 1989-90. **Connecticut Society of Pathologists:** President 1987-88, Secretary-Treasurer 1986-87, Chair, Education Committee 1983-87. **Accreditation Council for Graduate Medical Education (ACGME**): Council of Review Committee Chairs 2007-09; Residency Review Committee, Pathology 2003-09, Chair-elect 2005-07, Chair 2007-09, ex-officio 2012-present; Pathology Milestones Working Group 2011-12. **Association of Pathology Chairs:** APC Council 1998-00; Senior Advisory Committee; Program Directors Section Chair 1998-00, Vice-Chair, 1997-98, Past-Chair 2000-02, Nominating Committee 1995 and 2003, Coordinating Council 1997-2012, Curriculum Committee Chair 1998. **Association of American Medical Colleges**: Woman Liaison Officer 1994-2012. **College of American Pathologists**: Board of Governors 2010-12; House of Delegates Vice-Speaker 2010-12, Sergeant-at-Arms 2006-08, House Steering Committee 2006-08; 2010-12, Delegate from MA 1994-2012, Delegate from FL 2013-present, Reference Committee Member and Chair multiple times; Council on Education 2013-present; Archives of Pathology & Laboratory Medicine Executive Advisory Board 2015-present; Council on Government & Professional Affairs 2001-12; Strategic Planning Committee 2006-09; Council on Public Affairs 1992-2001; Practice Management Committee, Chair 2003; Professional & Economic Affairs Committee 1999-03, Vice-Chair 2001; RBRVS Practice Expense Work Group 1999-03; RBRVS Five Year Refinement Work Group 1999-03; Nominating Committee 1994, 1999; Strategy Management Committee 2012; Council on Membership and Professional Development 2010-11; Practice

Guidelines Committee 1995-97; Publications Committee 1991-2000; Diagnostic Immunology Resource Committee 1992-99, Chair 1994-97; Laboratory Accreditation Program Team Leader and Inspector 1981-2012; Commission on Clinical Pathology 1994-97; Commission on Public Services 1992; Award Committee 2000-02; Newspath Editorial Board 1993-01; Education Committee 2001, 2004; Image Analysis Working Group, Chair 1994; Ad Hoc Committee on Pap Smear Coverage & Payment Policy 1997; Ad Hoc Committee on Leadership 2002; Interdisciplinary Work Group on Gyn Cytology Liability 1997-98. **American Society of Clinical Pathologists:** Board of Directors 2000-02; Commission on Graduate Medical Education 1999-02**;** Bylaws Committee 2000-02; Board of Registry Board of Governors 1998-00; Hematology Exam Committee 1990-96; Research & Development Committee 1998-2000. **American Board of Pathology:** Trustee 2002-12; President 2009; President- Elect 2008; Immediate Past President 2010; Treasurer 2005-07; Executive Committee 2005-10; Chair, Neuropathology Test Development & Advisory Committee 2002-12; Maintenance of Certification Committee 2004-12; Examination Committee 2004-12; Finance Committee Chair 2005-07; Clinical Pathology Test Committee 2000-01; **American Board of Medical Specialties:** Board of Directors 2009-2018; Secretary-Treasurer 2020-, Executive Committee 2014-17, 2020-; Assembly Representative 2002-10; Database Advisory Committee 2002-05; Committee on Certification, Subcertification, Recertification, and Maintenance of Certification (COCERT) 2005-10; CEO Search Committee 2011-12; Strategic Planning Committee 2013-15; MOC Part III Task Force 2014; International Engagement Planning Committee 2014: Improvement in Medical Practice Task Force 2015-present; Focused Expertise/Added Proficiency Task Force 2016. Chair, Organizational Standards Task Force 2016-2018; Advancing Practice Task Force 2019-present. **U.S. Department of Health and Human Services Health Care Financing Administration:** RBRVS Refinement Panel - Pathology representative 1996. **U.S. and Canadian Academy of Pathology**: Ambassador 2001-12.

COMMUNITY LEADERSHIP SERVICE: College of American Pathologists Foundation Board of Directors 1998-07; President 2005-06; Vice-President 1999-05; Advisory Board 1997. CAP Media Spokesperson; Public Service Announcement "Quality of Pap Smears" 1988; Video New Release "Oncogenes" 1988; Video News Release "Network Report on Cancer Screening Misleads American Women" 1994; Documentary "America's Women: In Pursuit of Health" Medical Consultant 1994. Berkshire Area Health Education Consortium (AHEC) Board of Directors 1994-2010; Finance Committee 1996-01, 2006-10. Medical Advisory Board Y-ME of the Berkshires.

ADDITIONAL PERSONAL INFORMATION: Married to Michael Kelly, FMA Alliance President 2015-16.

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted to the FMA.

MEDICAL SOCIETY ENDORSEMENTS: Hillsborough County Medical Association, Florida Society of Pathologists.

PERSONAL STATEMENT: I have been a member of the FMA and the Hillsborough County Medical Association since relocating to Florida in 2012. I have been a member of the HCMA Executive Council and a delegate to the FMA HOD since 2013. I have a long history of volunteer engagement in organized medicine, including the AMA. As an AMA delegate from my specialty society for 16 years, Chair of the Pathology Section Council, delegate in the Specialty and Service Section, and member of the New England Delegation, I have many friends and acquaintances, who your current AMA delegates can tell you are very important in the "house of medicine". I have served as an Alternate Delegate in the FMA delegation to the AMA since 2013 and hope that I have contributed my expertise. I humbly ask for your vote and the opportunity to continue to serve the FMA as a delegate.

FMA Elections 2022

John M. Montgomery, M.D.

Candidate: AMA Delegate

SPECIALITY, CERTIFICATIONS, TYPE OF PRACTICE:

BA	Bachelor of Arts, Biology, Brown University
MPH	Master of Public Health, Infectious Disease Epidemiology, Yale University School of Medicine
MD	Medical Doctor, Brown University School of Medicine
FAAFP	Fellow American Academy of Family Physicians
CHIE	Certified Health Insurance Executive, Association of Health Insurance Plans
CPE	Certified Physician Executive, Certifying Commission in Medical Management
FACPE	Fellow American College of Physician Executives Board Certified Family Physician

LOCATION: 2636 Country Side Drive Orange Park, FL 32003

SERVICE TO THE FMA:

FMA Member, 2001-Present
FMA Delegate, Duval County Medical Society, 2002-Present
Chair, Northeast Florida Delegation to FMA 2014-2018
Member, FMA Committee on Accreditation & CME, 2005-Present
Medical District B Rep., FMA Committee on Membership, 2011-2013
Associate Editor, FMA Publications, 2011-2013
Member, FMA Credentials and Rules Committee, 2005
Member, FMA Council on Medical Economics, 2006-2009
Chair, FMA HOD Reference Committee IV, Medical Economics, 2007
Member, FMA Sub-Committee on Disparities, 2007-2009
Member, FMA Sub-Committee on Membership Outreach, 2007-2009
Member, FMAPAC, 2006-Present, and MD 1000 Club, 2006-Present

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Duval County Medical Society (DCMS):

DCMS Member, 1996-Present
Chair, Northeast Florida Delegation to FMA 2014-2018
DCMS Board of Directors, 2004-2008; DCMS Ex-Officio Board Member, 2009-Present
DCMS President-Elect, 2006; DCMS President, 2007; DCMS Immediate Past President, 2008
Member, Northeast Florida Legislative Committee, 2005-2013
Member, DCMS Health Information Technology Committee, 2008-2012
Co-Chair, DCMS Bioterrorism, Disaster Preparedness & Homeland Security Committee, 2004-2009; Member, 2010-2011
Member, DCMS Emergency Preparedness and Public Health Committee, 2012
Member, DCMS Public Health Committee, 2013
Chair, DCMS Membership Committee, 2009, 2013-Present
Chair, DCMS Nominating Committee, 2009; Member, 2014
DCMS Council of Past Presidents, 2009-Present

Florida Academy of Family Physicians (FAFP): Member, 1996-Present; Member, FAFP Disaster Preparedness Committee, 2008-2012; Member, FAFP Quality Practice Management Committee, 2008-2009; Member, FAFP Scope of Practice Committee, 2008-2009; Member, FAFP Government Relations Committee, 2008-2009

American Medical Association (AMA): Member, 1986-Present; AMA Delegate 2014-2016, 2011-2013; AMA Alternate Delegate, 2008-2010, 2014; 2019-A, Chair, Reference Committee A; 2018-I, Chair; Committee on Rules and Credentials; 2017-A Member, Committee on Rules and Credentials Southeast Delegation Interview Committee for Council on Science and Public Health AMA Annual Meeting 2016; Member Reference Committee D 2016; Teller, AMA Interim 2011, Member Reference Committee E, 2010; Commissioner, AMA-NMA Commission to End Health Care Disparities, 2005-2009; **AMPAC Capitol Club Gold Member,** 2006-2010, 2012-Present

Florida Public Health Association: Member, 2006-2012; Board of Directors, 2006-2009

National Medical Association: Member, 2006-Present; NMA Delegate, Florida, 2008-2009, 2011

American College of Physician Executives: Member, 1996-2018

Clay County Medical Society: Member, 2003-Present

American Assoc. of Public Health Physicians: Member, 2008-2010; Board of Directors, 2009-2010

Northeast Florida Medical Society: Member, 1996-Present

COMMUNITY LEADERSHIP SERVICE:

American Cancer Society, Florida Division: North Florida Area Board Member, 2016-Present, State Lead Ambassador, Florida 2015-2106; Member National Stakeholder Committee, 2014-2016; ACS Board Chairman, 2014-Present; Medical Vice Chairman of Board, 2011-2013; Board of Directors, 2006-Present; Member, Executive Committee, 2007-Present; Chair, Public Policy Committee, 2010-Present; Chair, Cancer Control Committee, 2008-2010; Member, Cancer Control Committee, 2006-2010; Member, MSABC Workgroup, 2010

Florida Prostate Cancer Advisory Council: Member 2012-2018

American Cancer Society, National Office: Delegate, National Assembly, 2009-2012

Board of Directors, Community Asthma Partnership: 2003-2009

President, FBI Citizens' Academy: 2007-2009

Medical Director, Jaguars Foundation Straight Talk Youth Advisory Board: 2005-2009

Board of Directors, Agape Community Health Center: 2003-2005

Florida Patient Safety Corporation: Member, Florida Patient Safety Corporation, 2005-2010; Secretary, 2008-2010; Chair, Scientific Advisory and Research Committee, 2006-2007; Chair, Finance Committee, 2007-2009

ADDITIONAL PERSONAL INFORMATION:

30-year resident of Northeast Florida; Born in Providence, Rhode Island; two adult children, John Michael (34) and Joy Michelle (26)

Military Service: LCDR, USN, Family Physician, 1993-2001

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted and reviewed by CEJA.

COUNTY MEDICAL SOCIETY ENDORSEMENT: The Duval County Medical Society and Clay County Medical Society enthusiastically endorse the candidacy of Dr. John M. Montgomery for AMA Delegate.

PERSONAL STATEMENT: Now more than ever, the pandemic impacting our health care system, and the unrest throughout our state and nation has further driven my commitment and passion for our profession, and I once again ask for your continued support and endorsement as a candidate to our AMA Delegation. The years I have served as a Delegate representing you has allowed me the opportunity to support and drive issues important to Florida physician at our AMA and throughout our health care system. During these years, I have leveraged my experience and leadership, working on behalf of the FMA. The hard work as a Delegate and the commitment to our Delegation has not gone unnoticed at the AMA and I have been selected by the AMA Speaker to twice serve in the Role of Committee Chair since last asking for your vote as a Delegate. I stand resolute in my commitment to you and our FMA and to representing the interest of all Florida's physicians at the local, state and national level.

30 years of commitment to our profession, and I feel now more than ever that the experience and expertise I have developed over these years, can and will help address the emerging challenges to the practice of medicine and the profession we hold so dear. I will continue to do all I can on behalf of physician in our State and across this country, and I respectfully ask for your vote to allow me to continue to represent Florida Physicians as a Delegate to the AMA.

FMA Elections 2022

Douglas R. Murphy, Jr., M.D., FACOG

Candidate: AMA Delegate

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE:

Obstetrics/Gynecology 1984 to present
Board Certified, American Board Obstetrics & Gynecology
Private Group Practice Gynecology

LOCATION:

1500 SE 17 Street, Suite # 200, Ocala, FL 34471 (Marion County)
Email address: drmurphy3576@yahoo.com

SERVICE TO THE FMA:

FMA President	2021-2022
FMA President-Elect	2020-2021
FMA Vice President	2019-2020
FMA Secretary	2018 to 2019
Chairman, FMA Council on Legislation	2014 to 2018
FMA Political Action Committee President	2019-present
FMA Political Action Committee Board of Directors	2003-2013; 2013-present
1000+ Club	2003 to present
FMA Board of Governors, District G	2013
Member of AMA Delegation	2016-present
FMA Council on Legislation, Member	2013
Delegate of the FMA (Marion County)	1986 to 2014; 2016 to present
Chairman, Gator Group Caucus	2013 to 2014; 2009 to 2010
Chairman, Marion County FMA Delegation	1991; 1999 to 2002
Member FMA Malpractice Committee	1988

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

President, Marion County Medical Society	1994
President-Elect, Marion County Medical Society	1993
Secretary-Treasurer, Marion County Medical Society	1992
Chairman, Marion County Medical Society, Public Relations Committee	1986 to 1988; 2002 to 2005
Marion County Medical Society, Professional Review Committee, Member	1990; 1995
Marion County Medical Society, Delegate Representative	

to Executive Committee	1991; 1999 to 2002
Marion County Medical Society, Member at Large	2009 to 2014
Marion County Medical Society, Legislative Committee Chairman	1993
Medical Director, Operating Room, Munroe Regional Medical Center	2012 to present
Member, Quality Committee, Munroe Regional Medical Center	2009 to 2011
Obstetrics/Gynecology, Chief of Staff, Munroe Regional Medical Center	1993 to 1995
Florida Society of Obstetrics and Gynecology Member	1984 to present
American Medical Association, Member	

COMMUNITY LEADERSHIP SERVICE:

We Care Program Participant	1988 to present
We Care Program Medical Director	1995
Anatomy and Physiology Teacher, Trinity Catholic High School	2008-present
Special Olympics Volunteer Physician	
Big Sun Regional Science Fair Judge, Health and Medical Section	

PERSONAL INFORMATION:

Married to Susan A. Murphy, BSN
Three daughters: Deanna Dorsy, Kelly Tusha, Mary Katherine Murphy
Grandsons: Declan Dorsy, Ronan Dorsy, Liam Tusha

COUNTY MEDICAL SOCIETY ENDORSEMENT: The Marion County Medical Society enthusiastically endorses the candidacy of Douglas R. Murphy, Jr., M.D. as AMA Delegate for the Florida Medical Association.

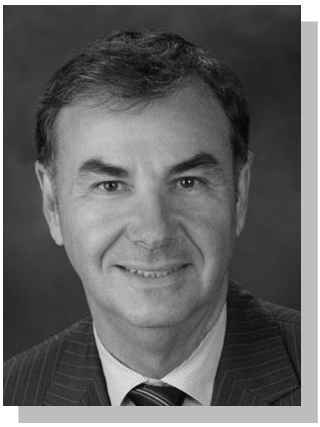
PERSONAL STATEMENT:

Throughout my three decades of service to the Florida Medical Association, it has been gratifying to play an active role in carrying out our mission: Helping physicians practice medicine. Time and time again, I have witnessed the power of organized medicine to make physicians' voices heard and to achieve meaningful, lasting change. Whether at the county, state or national level, unity and strong leadership are key to protecting the integrity of medicine and our patients' well-being.

I would like to thank you for the privilege of serving as an FMA delegate to the American Medical Association for the past six years. I am currently Vice Chairman of the delegation and we continue to work on setting policy to improve the practice of medicine and the ability to take care of our patients. Now, I humbly ask for your support again for that position.

My involvement with the FMA began in 1986 as a delegate representing Marion County, and I have served on many committees over the years. Joining the FMA PAC Board 23 years ago awakened me to the importance of building relationships with legislative candidates and actively participating in the political process. We are never going to win all our battles in the legislature but we must try to protect the practice of medicine.

No single person has all the answers, that is why having the House of Delegates and the FMA Board of Governors is important. Great ideas can come from anyone with a desire to serve the physicians and patients of Florida. I will remain open to those ideas and help to make them FMA and AMA policy. After 34 years of service to the FMA, I humbly ask your support to remain a delegate to the American Medical Association.



FMA Elections 2022

Rafael (Ralph) J. Nobo, Jr., MD

CANDIDATE: AMA Delegate

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE:

Obstetrics and Gynecology
Private Practice (Solo)

LOCATION: 222 W. Main Street, Bartow, FL 33830, Polk County, Florida

SERVICE TO THE FMA and FMA AMA Delegation:

Member of the FMA for 38 years
FMA President and Chair, Board of Governors 2015-16
AMA Representative -The Joint Commission Professional and Technical Advisory Committee (PTAC) for the Hospital Accreditation Program – 2016 & 2017
FMA Executive Committee 2008-2017
FMA Vice President 2011-14
FMA Secretary, 2009 to 2011
Former President FMA PAC 2013-15
Vice President to FMA PAC 2011 to 2013
Physician Foundation Board Member
Finance and Appropriations Committee 2009- present
FMA PAC Executive Committee 2004-2017
Chair, Task Force on Medical Staff Autonomy, 2009
Resident and Medical Student Advisor for FMA and the AMA 2008-2018
Chair, Committee on Bylaws
Chairman of AMA Legislation Reference Committee – November 2017
Former Chair, AMA Rules & Regulations
Vice Chair, Council on Medical Economics, 2008-2009
Member of the FMA Board of Governors, Medical District E, 2006-2009
Delegate to the FMA House of Delegates
Delegate to the AMA
Secretary of FMAPAC 2009-2011
Council on Legislation
Past Treasurer of FMA PAC. 2007-2009
Past Treasurer Designate of FMA PAC. 2005-2007
Member of FMA PAC Board (FLAMPAC)
Member of the 1000 Club
Reference Committee on Legislation at the FMA Annual Meeting two years.
FMA Eagle Award in 2004.
FLAMEDCO (FPA and FMA Services)

Served on the following committees:, Committee on Membership, Committee on Geographic Practice Cost Indices (GPCI), Committee for Uninsured, Underinsured, and Disparities in Health Care, Florida Medical Association Foundation, Inc., and Committee on EVP/Board Relationship. Member of Medical School Committee, and Membership and Disciplinary Committee.

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Service to the Polk County Medical Association: Chairman of the Board of Trustees and served as President, President-Elect, Vice-President, and Chairman of the Board of Censors. Member of the Executive Committee. Past President and member of the "We Care" program of the Polk County Medical Association.

Member, Society of Laparoscopic Surgeons, Past President of Bartow Regional Medical Center Medical Staff, Vice Chief of Staff at Bartow Regional Medical Center; Past Chairman of Medical Executive Committee. Previously served as Director of Out-patient Services, Chairperson of the Clinical Committee, Chair of Ob-Gyn Section, Member Credentialing and By-Laws Committee, and Medical Records Liaison of Bartow Regional Medical Center. Previously served as Chief of Medical Staff Morrow Memorial Hospital, and President of Medical Executive Committee. Founder and Past President of Central Florida Physicians Alliance.

COMMUNITY INVOLVEMENT:

Bartow Chamber of Commerce Board of Directors, 1985-1988, 2001-2007. Bartow Leadership Florida, Charter Member 1984-1986. American Cancer Society, Past Medical Advisor Bartow Chapter. Florida Sheriff Youth Villa, Bartow Volunteer Gynecologist. Past Healthy Start Voting Member. Past President, We Care of Polk County, Past President and Chair of Board of Trustees, Polk Museum of Art. Past Treasurer, Board Member and President of Polk Theatre. Member, Polk Vision Steering Committee. Vice Chair, Polk County Board of County Commission Citizens Health Care Oversight Committee, Vice Chair, Polk County Board of County Commission Citizens Health Care Oversight Committee.

ADDITIONAL PERSONAL INFORMATION:

Devoted father to two sons, Rafael, and Christopher, and one daughter, Laura. Doting grandfather to seven grandchildren.

CONFLICT OF INTEREST:

Conflict of Interest Declaration submitted to the FMA.

COUNTY MEDICAL SOCIETY ENDORSEMENT:

Polk County Medical Association

PERSONAL STATEMENT:

It has been my privilege to serve the FMA for over 38 years, as the former FMA President and Chair of the Board of Governors and member of the AMA Delegation.

During my tenure with the AMA, I have been appointed to various leadership positions including Chair of the Legislative Reference Committee, Rules and Credentials Committee, and others. Due to my leadership within the AMA and the FMA Delegation to the AMA, I have had key roles in getting the FMA's resolutions and priorities heard, and ultimately passed at the House of Delegates.

It remains my utmost priority to see that physicians of Florida are advocated for at the national level. Currently I am the Co-Chair of the Physician Foundation and AMA Telehealth Committee, which has proved to be a vital resource during the COVID-19 pandemic. We have made great headway in our telemedicine advocacy but there is much to be done. My dedication to the FMA, my commitment to the principals of the FMA, and my devotion to our profession will guide me as I continue leading the physicians of Florida at the AMA.

FMA Elections 2022

Arthur Palamara, M.D., FACS

Candidate: AMA Delegate

SPECIALTY, CERTIFICATIONS, TYPE OF PRACTICE:

Vascular and Endovascular Surgery, American Board of Surgery Certified 1979, 1988
Memorial Healthcare Systems, Hollywood, Florida
Voluntary Associate Professor of Surgery, University of Miami, Miller School of Medicine

LOCATION:

1150 N. 35th Avenue, Suite 460
Hollywood, FL 33021
Phone: 954-989-5533
Fax: 954-2658373
Email: aepal@bellsouth.net

SERVICE TO THE FMA:

Vice President, 2001-2002
Committee on Blue Cross and Blue Shield, 1997-1998
Council on Ethical and Judicial Affairs, 1999-2001
District F Representative, FMA Board of Governors, 1998-2001
Task Force on the Uninsured, 1999-2000, 2006
Commissioner, Florida Commission on Excellence in Health Care, FMA representative, 2000-2001
Medical Liability Task Force, 2001-2003
Board of Governors, 2002-2003
FLAMPAC, Board Member, 2002-2012
Advisory Committee, Patient Safety Task Force, 2004-2008
Co-Chair, Membership Recruitment, 2007-2008
Candidate for President Elect, 2010
Recipient, Certificate of Appreciation, 2007
Advisor, Medicaid Committee, 2010-2011
Committee on Federal Legislation, 2012
Delegate, American Medical Association, 2004-2018
Alternate Delegate, American Medical Association. 2018-

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

President, Broward County Medical Association (BCMA), 1997-1998
Chairman, Board of Trustees, BCMA, 2000-2002
Editor, the RECORD, Broward County Medical Association, 1998-2000
Chairman and Founder, BCMA, Managed Care Committee, 1996-1999
President, Physician/Employees Health Plan, BCMA, 1997-2001
Chairman, Board of Censors, BCMA, 1990-1994
Chair, Legislative Committee, 2003-2017
Board of Governors, Florida Vascular Society, 1997-1999

President, South Florida Society for Vascular Surgery, 1996-1998
Councilor, South Florida Chapter, American College of Surgeons, 1991-1996
Florida Patient Safety Committee, Provider Advisory Committee, 2004-2006
President, Florida Vascular Society, 2009-2010
Memorial Healthcare Network, Quality and Information Technology Committee, 2012-
Surgical Services Executive Committee, Memorial Regional Hospital, 2012-present
Chair, Broward Partnership for the Homeless Task Force, 2013-14
President, BCMA Political Action Committee, 2003 – 2006, 2012 – present
Chair, Legislative Committee, Florida Vascular Society, 2019 - present

COMMUNITY LEADERSHIP SERVICE:

United Way, Chairman, Health Care Professionals, 1993-1999
Chairman, Program Services Committee, Broward Project for the Homeless (BPHI), 1997-2005
Board of Directors, BPHI, 1997-2006
Member, Committee of 100, Hollywood, Florida 1988-present
Board Member, American Committee for the Shaare Zedek Medical Center, Israel, 1999-2001
Candidate for the Florida House of Representatives: endorsed by the Sun Sentinel and Miami Herald, 1998, 2006
First Annual Lifetime Achievement Award, Florida Medical Business, 2006
Certificate in Excellence, Memorial Regional Hospital, 2009
Patient Care Award, Memorial Regional Hospital, 2011
Visiting Professor, Gaala Military Hospital, Heliopolis, Egypt, April, 2013

ADDITIONAL PERSONAL INFORMATION:

Graduate, University of Rome, School of Medicine, Italy, 1971
Intern, Medicine, Suburban Hospital, Bethesda, Md., 1972
Intern, Surgery, Harlem Hospital Center, New York, New York, 1973-1974
Surgical Residency and Chief Resident, St. Luke's Hospital, New York, New York 1978
Cardiovascular Fellowship, Methodist Hospital, Houston, Texas 1979
In practice in Hollywood, Florida for 39 years.
33 years in private practice and 8 as hospital employee.
Full time vascular and endovascular surgeon with ER call.
Married to Patricia Palamara for 46 years; three children – Christopher, Alison, Alexander; 8 grandchildren

CONFLICT OF INTEREST:

Conflict of Interest Declaration submitted to the FMA.

MEDICAL SOCIETY ENDORSEMENTS: Broward County Medical Association; Dade County Medical Association; Palm Beach County Medical Society; Southeast Florida Delegation

PERSONAL STATEMENT - Issues on which I have spoken on the floor of the House of Delegates

1. Certificate of Maintenance. While improved, it is necessary to keep the pressure on the ABMS. Internal Medicine board has been recalcitrant to change.
2. Empowering and strengthening the position of employed physicians. With the Covid-19 pandemic and the increasing cost of health care, there is tremendous pressure placed on employed doctors to lower their reimbursements by corporate and hospital entities. This has a direct impact on patient care.
3. Mechanisms to address the high cost of pharmaceutical prices
4. Screening CT scans for lung cancer
5. *Reasonable* legislation to promote gun safety
6. Recommendations for expediting entry of competently trained IMGs into workforce
7. Opposition to balanced billing/surprise billing. Allowing insurance companies to determine reimbursement is patently unfair to practicing physicians.

I am a strong advocate for physician autonomy and patient care and deeply resent other entities that attempt to restrict the practice of medicine!!! I would appreciate your continued support to represent you as your delegate to the AMA.

FMA Elections 2022

Michael L. Patete, M.D.

Candidate: AMA Delegate

SPECIALTY, CERTIFICATION, TYPE OF PRACTICE

Board Certified Otolaryngology
American Academy of Otolaryngology-Head & Neck Surgery
Fellow, American College of Surgeons
Private Practice

LOCATION: Venice, Florida (Sarasota County)

SERVICE TO FMA

FMA President-Elect
FMA Vice President
FMA PAC President
FMA Secretary
FMA Delegate
AMA Delegate
FMA Committee on Membership
FMA 1000+ Club
FMA Board of Governors - District E Representative

SERVICE TO OTHER MEDICAL ORGANIZATIONS

Sarasota County Medical Society President 2008
Sarasota County Medical Society Board of Governors
Sarasota County Medical Political Action Committee President
Sarasota County Medical Society Board of Censors
Chief of Surgery Venice Regional Medical Center

COMMUNITY LEADERSHIP SERVICE

Bon Secours Foundation Board
Venice Youth Boating Association

ADDITIONAL PERSONAL INFORMATION

Born: April 22, 1962
Wife: Celeste

Daughter: Carissa

COUNTY MEDICAL SOCIETY ENDORSEMENT

The Sarasota County Medical Society is privileged to endorse the election of Michael L. Patete, M.D. as a delegate to the FMA's AMA Delegation. He has dedicated immeasurable time to the Medical Society and serves on both SCMS Board of Governors & Censors and SAMPAC Board with honor, integrity and dedication.

PERSONAL STATEMENT

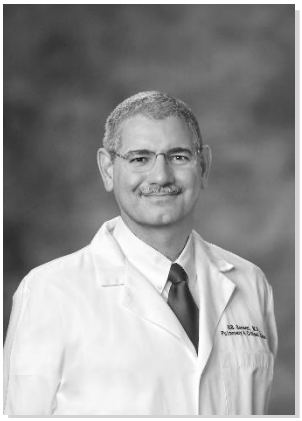
Consistency and resilience are both important components of a strong organization.

As I announce my candidacy for the FMA's AMA Delegation, I am honored of the opportunity to continue my journey of advocacy for organized medicine. My commitment and loyalty to our profession will never waiver although it appears we're on the battlefield every day as we promote our efforts of stabilizing healthcare.

As a devoted FMA and FMA PAC member for many years and serving on numerous FMA committees and councils, I understand the importance of unity and trust within an organization. As a delegate to the AMA delegation, I will continue to build strong personal and professional relationships with all physicians of Florida. I will encourage my peers to support the FMA with preferred levels of memberships as we continue to work for the betterment of all physicians.

As a member of the FMA's AMA Delegation I will ensure the integrity of the board governance of the policies and procedures of the organization. I will also assume the responsibility for implementation of decisions made by the Board of Governors.

I will *always* represent the FMA with dignity and respect.



FMA Elections 2022

Sergio B. Seoane, M.D.

Candidate: AMA Delegate

SPECIALTY, CERTIFICATIONS, TYPES OF PRACTICE:

Solo Practice in Family Medicine, Lakeland FL, 1999-Present
Family Medicine, Internal Medicine, Pulmonary & Critical Care Medicine
Aviation & Aerospace Medicine (FAA Senior Aviation Medical Examiner)

LOCATION:

118 Allamanda Drive
Lakeland, Florida 33803
Polk County, Florida

SERVICE TO THE FMA:

Florida Medical Association, Member
Florida Medical Association, Reference Committee III, Legislation (2008)
Florida Medical Association, Council on Ethical and Judicial Affairs (2007)
Florida Medical Association, Delegate from 2004 thru 2012
Florida Medical Association, Alternate Delegate to AMA, 2009-2021
Florida Medical Association, Board of Governors District E, 2015-2020
Florida Medical Association PAC Board Member (2015-2020)

SERVICE TO OTHER MEDICAL ORGANIZATIONS:

Polk County Medical Association, Member
Polk County Medical Association, President, 2016-2018
Polk County Medical Association, Chairman, Board of Trustees, 2007-2018
Polk County Medical Association, Board of Trustees, 2006-2022
Polk County Medical Association, President 2006
Polk County Medical Association, President Elect 2006
Polk County Medical Association, Treasurer 2004
Polk County Medical Association, Secretary, 2003
Polk County Medical Association, Executive Committee Member 2002-2022
Co-Founder Polk County Medical Association PAC (2008)
Central Florida Physicians Alliance, (IPA) Board of Directors, 2006-2020
Central Florida Physician Alliance, (IPA), Treasurer, 2017-2022
Central Florida Physicians Alliance, (IPA) Medical Director 2008
Central Florida Physicians Alliance, (IPA) President-Elect, 2008
Central Florida Physician Alliance, (IPA) President, 2009-2010
Central Florida Physician Alliance, (IPA) Secretary, 2011-2012
Florida Academy of Family Physicians

Civil Aviation Medical Association, Life Member and Member Board of Directors, 2011-2022
Ochsner Alumni Association

COMMUNITY LEADERSHIP SERVICE:

Civil Air Patrol, USAF Auxiliary, Col, CAP, USAF Auxiliary
Medical Director, We Care of Polk County (Non Profit Organization giving Medical Care to Poor), 2006-2008
We Care of Polk County Board of Directors, 2005-2008
Knights of Columbus, St. Joseph Council, Lakeland, FL
Lakeland Volunteers in Medicine, Board of Trustees, 2006-2008
Citizens Health Care Oversight Committee, Member (Ensure the integrity of the expenditure of the indigent health care sales tax in Polk County, Florida), member 2009-2012
Medical Director, Sun N Fun Airshow, Lakeland Florida

ADDITIONAL PERSONAL INFORMATION: Born and raised in Miami Florida. Married to Debra L. Seoane, M.D.; Children: Bryce (16 years old) and Taylor (13 years old). I am an avid pilot and am passionate about aviation.

CONFLICT OF INTEREST: Conflict of Interest Declaration submitted to the FMA.

MEDICAL SOCIETY ENDORSEMENTS: Polk County Medical Association**;** Florida Academy of Family Physicians

PERSONAL STATEMENT: I want to thank all of you for your service and dedication to the Florida Medical Association, your County Medical Society and to organized Medicine.

The AMA, is the only organization on a national level that represents physicians and has a national platform and the clout to make our voice heard on the national stage. We need to make sure that the AMA maintains its focus on the needs of physicians and the practice of Medicine.

I am asking that you continue to give me the opportunity to represent you, the members of the Florida Medical Association in the AMA House of Delegates.

It has been an honor to represent you at the AMA.

I am asking for your vote for AMA Delegate.

Thank you all for your support and dedication to the Florida Medical Association!

Reference Committee I

Reference Committee No. I
Health, Education and Public Policy

Saturday, August 6, 2022
10:00 a.m. – 11:30 a.m.

Members:

Christina Adams, M.D., Chair	ACOG
Ruple Galani, M.D.	Duval
Rosemary Garcia Getting, M.D.	Hillsborough
Rohan Joseph, M.D.	Capital
Rajn Mohapatra, M.D.	Hillsborough
John Montgomery, M.D.	Duval
Martha Rodriguez, M.D.	Palm Beach

Agenda:
Board of Governors Report A

1. Board Recommendation A-1: 2014 FMA Policy Review
2. Board Recommendation A-2: Resolution 21-108
3. Board Recommendation A-3: Resolution 21-109

Resolutions:

22-101	Trust in Public Health Interventions
22-102	Support for the State Surgeon General
22-103	Rejection of the Premise that the American Medical System is Racist
22-104	Intimate Partner Violence Education
22-105	Minimal Credentialing in PALTC Medicine
22-106	Medical Directors in PALTC Medicine
22-108	Promoting Supporting Clinical Research
22-109	Elder Protections
22-110	Online Patient Reviews
22-111	Ethics Resolution
22-112	Gender Affirming Care
22-113	End the Monopoly on Certifying Physicians by the American Board of Medical Specialties
22-114	Opioid Settlement Resolution
22-115	Amend Prescription Off-Label

Report A
of the Board of Governors

Douglas Murphy M.D., FMA President and Chair

The Board of Governors submits the following report to the House of Delegates. This report contains **three recommendations** and a summary of major actions taken by the Board. The issues in this report relate to public health, medical education, and methods whereby physicians may be assisted in maintaining their professional competence, educational and scientific programs for CME. Other items include specialty society issues, policy review for reaffirmation or sunset and items relating to Professionals Resource Network (PRN). Informational items reported to the Board on the same topics are also included in this report.

Recommendation A-1

2014 FMA Policy Review

That 2014 policies on pages 6 thru 19 of this report be reaffirmed (pages 6-17) or sunset (pages 18-19) according to the FMA's seven year policy review mechanism.

Description	Amount	Budget Narrative
		No Fiscal Impact

Background: In keeping with the FMA's seven year policy review mechanism, policies from 2014 were distributed to the appropriate FMA councils for review with a report back to reaffirm or sunset.

Discussion: After receiving input from FMA's councils and committees, the Board believes that policies listed on pages 6-17 are still relevant and should be reaffirmed for an additional seven years and further, that the policies listed on page 18-19 are out of date, newer or similar policies exists, or the objective has been accomplished, therefore the policies should sunset. Sunset policies are maintained in a separate archive system.

Upon approval by the House of Delegates, the FMA Policy Compendium will be updated accordingly.

Recommendation A-2

Resolution 21-108

Educating Patients and Physicians on the Dangers of Automatic Prescription Refills

South Florida Caucus

That Resolution 21-108 from the 2021 House of Delegates be not adopted.

RESOLVED, that our FMA will recognize:

1. That automatic prescription refills increase the risk of medical errors
2. Automatic prescription refills can sometimes be associated with fraudulent transactions resulting in overbilling of government programs such as Medicaid
3. That a prescription refill is not the same as authorizing automatic refills

4. Many patients are enrolled in these programs without their consent; be it further RESOLVED, The FMA delegation to the AMA submit a resolution to the AMA at the appropriate time to adopt a policy recognizing the dangers of automatic prescription refills.

Description	Amount	Budget Narrative
	$	
	$	No Fiscal Impact.

Background: On August 1, 2021 the FMA House of Delegates referred Resolution 21-108 to the Board of Governors for study and report back to the 2022 House of Delegates.

Discussion: This resolution was discussed at the January 2022 Board of Governors meeting. The resolution was referred to the Council on Medical Education, Science, and Public Health. In preparation for the meeting, FMA staff spoke informally to the Program Manager of the PDMP (a pharmacist), a member of the Florida Board of Pharmacy, and the Board's legal counsel to determine whether there was available information regarding any adverse impacts of automatic prescription refills in Florida. These individuals were unable to provide any substantive information that these programs present any problems in Florida. After much discussion, the Council acknowledged that the issue of automatic prescription refills is one that has both pros and cons for patients. On one hand, patients can benefit from the ease and convenience of choosing this option for regular prescriptions and it could lead to better medication compliance. On the other hand, for patients who frequently change medications or are trying a new medication, an automatic refill might lead to unwanted/unneeded refills. The Board of Governors reviewed the Council's report and agreed that due to the limited information, there was insufficient data to support the adoption of this resolution. The Board of Governors voted to recommend that the 2022 House of Delegates not adopt Resolution 21-108.

Recommendation A-3

Resolution 21-109
Kratom Safety and Risk
Florida Society of Addiction Medicine

That substitute language be adopted in lieu of Resolution 21-109.

Original Resolution Language:
RESOLVED, That our Florida Medical Association (FMA) amend policy P 125,000, "Drugs-Abuse" to add a new section P 125.005 to read as follows:

P 125.005 Kratom Risk and Safety

RESOLVED, That the Florida Medical Association adopt the following policy on "KratomRisk and Safety as follows:

1. Our FMA opposes the sale or distribution of kratom by retailers in Florida.
2. Our FMA will work with stakeholders to require that Florida retailers display warnings to the public, in a conspicuous location near the point of sale inside their retail establishments, regarding the potentially fatal dangers of kratom

andthe fact that there have no controlled clinical trials conducted to determine its safety for human use.

Substitute Language:

That the FMA support legislative and/or regulatory efforts prohibiting the sale or distribution of Kratom in Florida, while still allowing opportunity for proper scientific research.

Background: On August 1, 2021, the House of Delegates recommended that Resolution 21-109 be referred to the Board of Governors for study and report back to the 2022 House of Delegates.

Discussion: In January 2022, the Board of Governors referred Resolution 21-109 to the Council on Medical Education, Science, and Public Health. After hearing testimony from representatives from the Florida Society of Addiction Medicine and American Society of Addiction Medicine, the Council agreed that Kratom potentially poses a risk to Floridians. The Council also had the opportunity to review existing AMA policy on Kratom and felt that any FMA policy should mirror policy language already adopted by the AMA. The Board of Governors recommends that the 2022 House of Delegates adopt the proposed substitute language in lieu of the original language in Resolution 21-109.

Council on Medical Education, Science and Public Health

Major Board Actions:

- Reviewed and approved recommendations to reaffirm public policies from 2014.
  - (See Recommendation A-1)
- Reviewed and approved recommendations to sunset public policies from 2014.
  - (See Recommendation A-1)
- Adopted Resolution 22-308 Medical Cannabis as amended by deletion
- Adopted substitute language in lieu of Resolution 21-311, Access to Evidence Based opioid Disorder Treatment in Florida Correctional Facilities

Resolution 21-308
Medical Cannabis
Florida Society of Addiction Medicine

House Action: Referred to the Board of Governors for decision; adopted as amended

RESOLVED, That the FMA support policies that advance ~~the following in the State of Florida:~~

- ~~Cannabis should not be recommended to pregnant persons. All patients should be screened for cannabis and other substance use disorders and referred to treatment as appropriate before receiving a recommendation to use cannabis for medical purposes;~~
- ~~Cannabis should not be recommended for the treatment of opioid use disorder;~~
- ~~Cannabis recommended by Florida clinicians should be reported to Florida's Prescription Drug Monitoring Program. Healthcare professionals who recommend cannabis should check the PDMP prior to making any such recommendation~~
- ~~Potency of non-FDA approved cannabis should be determined and clearly displayed on the label. Healthcare professionals should consider the ratio of CBD to THC with respect to the indication and minimize potential adverse effects;~~
- ~~Combustion or vaporization of cannabis as a drug delivery method should be discouraged; and~~
- Robust state funding for state university scientific and clinical research on cannabis and its compounds. ~~Research needs for cannabis to be used for medical purposes include basic outcomes studies for well-defined conditions using well-defined medical cannabis products.~~

Discussion: The Board of Governors referred this resolution to the Council on Medical Education, Science, and Public Health. Recently a review and evaluation were conducted on the status of evidence-based medical cannabis policies as directed by Resolution 21-311. The Board did not feel it was in the position to adopt clinical recommendations surrounding the use of medical marijuana without further research. At this time, the Board believes that the focus should be on encouraging more robust research in this area as the existing information is still lacking quality evidence-based data to the degree that physicians would normally rely on in other areas within the practice of medicine.

Resolution 21-311

Access to Evidence Based opioid Disorder Treatment in Florida Correctional Facilities
Florida Society of Addiction Medicine

House Action: Referred to the Board of Governors for decision; adopted substitute language in lieu of Resolution 21-311

RESOLVED, That the FMA support AMA Policy H-430.987 Medications for Opioid Use Disorder in Correctional Facilities, and work collaboratively with the AMA to accomplish the goals set forth by H-430.987 in Florida. (Attachment I)

Discussion: The Board of Governors referred this resolution to the Council on Medical Education, Science, and Public Health. Both the Council and the Board recognized that the network responsible for providing medical care to incarcerated individuals is both complex and everchanging. It was acknowledged that the AMA spent considerable time researching this issue before developing Policy H-430.987 Medications for Opioid Use Disorder in Correctional Facilities. The Board ultimately decided that it was best to collaborate with the AMA in its efforts to streamline the medical treatment of incarcerated individuals, particularly those afflicted by opioid use disorder. By supporting the AMA policy, and the foundation of research that the policy was founded upon, the FMA's policy will remain up to date with the standard of care in correctional settings.

Informational Items:

- In October 2021 Alma Littles, M.D., Chair, Council on Medical Education, Science & Public Health reported that the council has been focused on CME programming for the 2022 FMA Annual Meeting.
- Based on the directive of Resolution 21-202 Medical Cannabis Committee in which the council was instructed to evaluate the status of evidence-based medical cannabis policies and their impact on physician education and public health awareness, took the following steps:
    - Reviewed existing FMA and AMA policy related to medical cannabis.
    - Heard a presentation from the Consortium for Medical Marijuana Clinical Outcomes Research (MMCOR) titled *Efficacy & Effectiveness of Cannabis and Cannabinoids in Qualified Conditions – A Status Update*. CMMCOR was legislatively established to conduct, disseminate and support rigorous scientific research on the clinical outcomes of medical marijuana use. The presentation primarily featured an overview of the evidence that is available regarding the efficacy/effectiveness of medical cannabis for the qualifying conditions specified by Florida law. Their evidence categories for efficacy ranged from conclusive evidence to substantial to moderate to limited to no evidence.
    - Based on existing FMA and AMA policy and the limited evidence that is currently available regarding the efficacy of medical marijuana for specific conditions, it is difficult to recommend specific strategies to educate physicians and the public. Therefore, the Council felt that the key priority for the FMA at this time is to continue its support of research in this area. The Council also suggests that current FMA policy be reviewed to determine if amendments, additions or deletions are required to ensure this objective.

Council of Florida Medical School Deans

Informational Items:

- The Council of Florida Medical School Deans has created a select, collegial group to address matters relating to diversity, equity, and inclusion (DEI).
- There are two separate organizations of medical school deans in Florida: The Council of Florida Medical School Deans (CFMSD) and the Florida Medical Schools Quality Network (FMSQN). The CFMSD, chaired by Dean John Fogarty from FSU COM, serves as a collegial body that addresses topics of mutual interest to the deans. The FMSQN, organized as a corporation for which Dean Charles Lockwood serves as president, is a more formal entity that, among other things, focuses primarily on quality, access, and clinical outcomes.
- The Council of Deans had an opportunity to briefly address FMA Resolution 21-107 - Graduate Physician Resolution. While the Council of Deans generally recognizes that it might be helpful to enable unmatched students to be able to practice in some way, potentially helping the individual secure a residency during the next matching period; there were several concerns with the proposal for unmatched medical students to serve as Physician Assistants (PAs). The following questions were raised during discussion:
    - Since these students will not have graduated from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), will there be confusion over their titles (e.g., Physician assistant, assistant physician, associate physician, etc.)?
    - Would they be eligible to take and/or need to pass the Physician Assistant National Certifying Examination (PANCE) without graduating from an accredited PA school?
    - What manner of supervision would they require?
    - Would they be eligible to submit medical bills?
    - What would be their scope of practice and how would it differ from medical interns/residents or practicing PA's?
- Dean John Fogarty, M.D., announced his retirement from Florida State University College of Medicine.
- Florida Atlantic University named Dr. Julie Pilitsis as the new dean of the Charles E. Schmidt College of Medicine.
- The Diversity, Equity, and Inclusion (DEI) Working Group was pleased to see the filing of HB 657 relating to the Medical Education Reimbursement and Loan Repayment Program.
- The GME Working Group continues to focus on the physical and emotional wellness of residents and faculty during the COVID pandemic. The overall number of resident slots in the state have increased from 2016-2021 but more slots are needed to meet future workforce estimates.
- The UME Steering Committee has been dedicated to working on ways to improve education for Florida's medical students, including sharing clinical assessment ideas since the USMLE Step 2 Clinical Skills exam has been permanently discontinued.
- After a two-year hiatus, the Council in cooperation with the FMA and Florida Osteopathic Medical Association was able to provide a free webinar, "Expedite Your Licensure" to incoming residents and program directors. Dean Lockwood thanked Assistant General Counsel Mary Thomas and Senior Vice President of Education and Membership, Melissa Carter for their role in making the webinar a success.
- The Council is working with the Department of Health to potentially create programs that would benefit high school students who have an interest in pursuing health care careers.
- The Council of Florida Medical School Deans thanked FME CEO, Chris Clark, FMA General Counsel, Jeff Scott, and the entire FMA lobbying team on the $6 million appropriated to fund the Medical Education Reimbursement and Loan Repayment Program.

- The Agency for Health Care Administration has created a position of Chief Medical Officer and appointed Dr. Chris Cogle to that position. Dr. Cogle will become a regular participant in meetings with the CFMSD and will join the council during the mid-year meeting which is held in conjunction with the FMA Annual Meeting.
- The Council thanked the FMA for a successful virtual Deans' Day and is looking forward to returning to Tallahassee in 2023.
- The Council of Florida Medical School Deans announced their endorsement for Dr. Alma Littles who is running for Secretary on the FMA Board of Governors.

PRN

Informational Items:

- PRN has met all of its contractual obligations.

POLICIES TO REAFFIRM

P 10.000 ACCIDENT PREVENTION

P 10.004 MOTORCYCLE HELMET REQUIREMENT

The Florida Medical Association supports legislation requiring all occupants of motorcycles wear appropriate protective helmets while riding on public roads. *(Res 06-8, HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 10.009 REQUIRING ADDITIONAL INSURANCE FOR MOTORCYCLE RIDERS

The Florida Medical Association supports legislation requiring non-helmeted motorcyclists to procure at least $40,000 of PIP protection. (*Res 14-313*, *HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 30.000 ADVERTISING

P 30.002 PROVIDER DEGREE IDENTIFICATION FOR CONSUMER PROTECTION

The Florida Medical Association shall sponsor legislation that following the name of any health care provider licensed by the state of Florida, there shall be immediately following his/her name, in all professional correspondence and announcements and advertising with the public in any form of public notice relating to his/her professional practice or activities, his/her degree for which he/she is licensed to practice. *(Res 90-52, HOD 1990) (Reaffirmed HOD 2000) (Reaffirmed HOD 2009) (Reaffirmed HOD 2012)*

Council on Legislation Recommendation: Reaffirm

P 30.003 ~~BOGUS~~ UNRECOGNIZED BOARDS

The Florida Medical Association shall continue working with the Florida Board of Medicine to enforce ~~code~~ Chapter 64B8-11.001, F.A.C.; and further continue to monitor and, when appropriate, offer recommendations pertinent to certification by ~~non-AMA and non-~~AOA non-ABMS boards. *(Res 96-24, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014 with editorial change)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; editorial changes needed

P 90.000 CHILDREN & HEALTH

P 90.017 PENALTIES FOR CARETAKERS WITHHOLDING INFORMATION FROM PHYSICIANS/HEALTH CARE PROFESSIONALS CARING FOR A CHILD

The Florida Medical Association supports legislation that would make it a crime for caretakers to purposely withhold and/or provide false or misleading information to treating physicians/health care professionals regarding the true nature of a child's injury or condition. *(Res 12-313, HOD 2012)*

Council on Legislation Recommendation: Reaffirm

P 90.020 PROHIBITING MINORS FROM INDOOR TANNING

The Florida Medical Association (FMA) supports current and future legislative efforts to ban the use of indoor tanning amongst minors (under the age of 18). (*Res 14-108*, *HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 104.000 CREDENTIALING

P 104.005 ECONOMIC PROFILING OF PHYSICIAN CARE IN FLORIDA

The Florida Medical Association opposes arbitrary use and abuse of economic profiling and credentialing of physicians by government and private entities for use in health insurance and other health programs;

and further seeks legislation and administrative code that specifically prohibits the arbitrary use and abuse of economic profiling and credentialing of physicians by government payers, health insurance carriers and any other private entity in the state of Florida; and further explore the feasibility of legal action designed to prevent the arbitrary use and abuse of economic profiling and credentialing of physicians in Florida. *(Res 06-10, HOD 2006*) *(Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 105.000 CRIME

P 105.002 CRIMINAL PENALTIES FOR NEGLIGENCE

The Florida Medical Association supports taking appropriate action in the development of its judicial, legislative and other legal initiatives to formulate, promote and encourage measures to deter, dissuade or otherwise discourage legal actions involving unwarranted criminal charges or penalties against medical doctors and health care practice groups. *(Res 95-40, HOD 1995) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 115.000 DISABLED

P 115.001 HEARING IMPAIRED

The Florida Medical Association opposes any legislation that increases the cost of hearing interpreters. *(BOG Rpt C-1, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 130.000 DRUGS – PRESCRIBING AND DISPENSING

P 130.009 FILLING PRESCRIPTIONS

The Florida Medical Association opposes any legislation or rule change that allows a pharmacist to fill a prescription in any way other than what the treating physician has instructed. *(BOG November 2004) (Reaffirmed HOD 2012)*

Council on Legislation Recommendation: Reaffirm

P 135.000 DRUGS – REGULATION

P 135.003 USE OF SAMPLE MEDICATIONS

The Florida Medical Association actively and aggressively opposes enactment of legislation to limit or prohibit the use of sample medications by Florida physicians. *(Res 86-09, I-1986; Reaffirmed A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 135.009 REQUESTING DEA NUMBER

The Florida Medical Association seeks through legislative means to cause pharmacists and pharmacies to cease in requesting a DEA number from a physician in regard to medications prescribed which ~~**are reimbursed by insurance and**~~ are not controlled substances *(Res 96-58, A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 140.000 EDUCATION (MEDICAL)

P 140.001 ACCREDITED SYSTEMS

The Florida Medical Association supports the concept that undergraduate medical education be conducted in the state of Florida only by appropriately accredited educational systems, even if

legislative changes are required. *(BOG March 1983) (Reaffirmed 1993) (Reaffirmed HOD 2003) (Reaffirmed HOD 2014)*
Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 140.002 MEDICAL EDUCATION PLAN OF ACTION
The Florida Medical Association supports medical education at all levels from undergraduate and residency training programs through continuing medical education for practicing physicians. *(BOG Rpt C, A-1985) (Reaffirmed A-1995) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*
Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 140.008 CREATION OF A FUND TO SUPPORT GRADUATE MEDICAL EDUCATION AND RESEARCH
The Florida Medical Association endorses the concept of the formation of a fund to support graduate medical education and research which should involve assessing the adequacy of Florida's current and future physician workforce needs and developing legislative alternatives to address a possible physician workforce shortage. (*BOG Rpt A, A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*
Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 140.012 PHYSICIAN OPPORTUNITIES FOR PROFESSIONAL RETRAINING
The Florida Medical Association encourages the collaboration of Florida's medical schools to assure access to regional programs to provide enhanced educational opportunities in Florida for physicians identified by the Florida Board of Medicine in need of retraining in defined aspects of medical practice. *(Res 05-1, HOD 2005) (Reaffirmed HOD 2014)*
Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 145.000 EDUCATION – (CONTINUING MEDICAL EDUCATION – CME)
P 145.001 SUBJECT-SPECIFIC CME
The Florida Medical Association seeks legislative elimination of mandatory continuing medical education requirements that are subject specific as part of license renewal. *(Res 94-24, HOD 1994) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*
Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 145.002 EDUCATIONAL REQUIREMENTS ON SOCIAL ISSUES
The Florida Medical Association takes a firm stand and lobbies against any future legislation that dictates additional education of practicing physicians on specific issues or topics. *(Res 94-38, HOD 1994) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*
Council on Legislation Recommendation: Reaffirm

P 145.007 ELIMINATE LEGISLATIVELY MANDATED CME
The Florida Medical Association shall coordinate efforts with the Board of Medicine to eliminate all legislatively mandated CME for physician licensure renewal and work to institute a policy whereby the

Board of Medicine determines topics for physician renewal. *(Res 02-11, HOD 2002) (Reaffirmed with technical amendment HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 155.000 EMERGENCY MEDICAL SERVICES

P 155.002 IMPROVING EMERGENCY CALL COVERAGE

The Florida Medical Association supports legislation for an emergency call coverage solution that can be applied on a fair and uniform basis across all hospitals in the state. (*Res 05-38; BG Rpt C-6, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 220.000 HEALTH INFORMATION TECHNOLOGY

P 220.016 ELECTRONIC HEALTH RECORD TRANSFER FEES

The Florida Medical Association seeks legislation prohibiting Electronic Health Record (EHR) companies from charging fees to physicians for the transferring of health records between EHR companies. (*Res 14-314, HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 240.000 HOSPITALS

P 240.003 JOINT VENTURE

The Florida Medical Association's policy pertaining to joint ventures between physicians and hospitals is that the ultimate primary role of the physician is to provide the best quality care possible to the patient at the most economical cost at all times. *(BG October 1985) (Reaffirmed A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 245.000 HOSPITALS: MEDICAL STAFFS

P 245.011 MEDICAL STAFF MEMBER BILL OF RIGHTS

The Florida Medical Association supports and adopts the amended Medical Staff Member Bill of Rights to include rights number 9 and 10 as follows: (9) the right of freedom from personal loss or liability for adverse outcomes relating to medical practice based on compassion and good judgment within community standards and (10) the right to fair market and transparent economic competition in our communities between hospitals with or without employee physicians and other allied healthcare professionals and independent physicians and groups in the delivery of healthcare services and compensation based on appropriate community need. (*Amended Resolution 13-204, BoG May, 2014*)

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 245.012 MEDICAL STAFF MEMBER BILL OF RIGHTS

The Florida Medical Association encourages the formation of Medical Staff Advocacy Committees throughout Florida; and further supports the Medical Staff Advocacy Committees' role with medical staff issues and communications between physicians and hospitals and any other appropriate agency; and further will report, or support such report, by a local medical society to the appropriate agency any concern or violation of the Physicians Bill of Rights not resolved by communications between the medical society and hospitals; and further urges county medical societies to disseminate this bill of rights to their members and the hospitals they serve, and further presents the Physician and Medical Staff Membership Bill of Rights to the American Medical Association as a national model to be distributed to all physicians, hospitals and other entities. (*Amended Resolution 13-204, BoG May, 2014*) (*Reaffirmed HOD 2015 Resolution 15-102)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 260.000 INSURANCE

P 260.002 COVERAGE FOR CHILDREN

The Florida Medical Association supports legislation mandating insurance coverage of health maintenance examinations and activities for children. *(BOG February 1986)(Reaffirmed A-96) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 260.011 WRITTEN CONFIRMATION OF DENIALS

The Florida Medical Association shall develop and seek legislation that requires all insurance carriers to automatically confirm all denials in writing to the physicians and patients within ten days of the denial. *(Res 96-23, A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 260.040 BEERS LIST

The Florida Medical Association (FMA) supports the use of Beers or similar medication criteria for patients solely as part of an educational process to inform physicians on appropriate medication use in clinical practice; and further the FMA will oppose the use of Beers or similar criteria to deny coverage for medications deemed appropriate for patients by their physicians; and further the FMA supports legislation and administrative rules that prevent insurance companies from denying medications or coverage of medications on "Beers List" prescribed by Florida licensed physicians for their patients and from penalizing physicians, such as through HEDIS Measures or Five Star Performance Ratings, for prescribing these medications based on their best clinical judgment. (*Res 14-402, HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 280.000 LEGISLATION

P 280.007 STATEWIDE LIEN LAW

The Florida Medical Association supports the Florida Orthopedic Society in seeking a statewide lien law. *(BOG July 2004) (Reaffirmed HOD 2012)*

Council on Legislation Recommendation: Reaffirm

P 283.000 LIABILITY / PROFESSIONAL LIABILITY

P 283.001 PROFESSIONAL LIABILITY MANDATORY INSURANCE

The Florida Medical Association disapproves the requirement of professional liability insurance as a condition of licensure and seeks such action as a legislative objective. *(BOG October 1985)(Reaffirmed HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 283.009 MEDICAL DEVICES AND PHYSICIAN RESPONSIBILITY

The Florida Medical Association supports the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research, and clinical investigation, and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration. *(Res 96-27, HOD 1996) (Reaffirmed HOD 2006) ((Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 283.019 FABRE CHANGES

The Florida Medical Association opposes any legislation changing current law relating to the Fabre doctrine. *(BOG Rpt C-1, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 283.020 USE OF FMA FORM FOR WAIVER OF PATIENT'S RIGHTS TO SUE

In order to use the FMA form for the waiver of a patient's right to sue a physician for non-economic damages greater than $250,000, a physician must be a member of the FMA and his or her county medical society; and further all members of a group practice must be members of the FMA and their county medical society in order for any member of the group practice or the group to use the FMA waiver form with the exception that if all members of a group practice are not members of the FMA, a group practice may use the FMA waiver form only if the group practice pays the FMA a licensing fee per non-FMA member in an amount to be determined by the FMA. *(BOG October 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 285.000 LICENSURE

P 285.004 LICENSURE EXAMINATION

The Florida Medical Association supports the coordination with the Department of Health in developing legislative support for a proposal to ensure that all individuals applying for and taking the medical licensure examination in Florida have met the same educational standards and training requirements necessary to practice medicine in the state. *(BOG October 1985) (Reaffirmed A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 285.006 EDUCATIONAL REQUIREMENTS

The Florida Medical Association supports the efforts of the Florida Board of Medicine in upholding the standards of licensure; and further encourages the Florida Legislature to provide that requirements for licensure include adequate premedical education as determined by the Board of Medicine, a medical school curriculum deemed adequate in duration, and in course content as determined by the Florida Board of Medicine, and include at least one year of appropriate postgraduate training as determined by the Florida Board of Medicine. *(Res 86-26, A-1986) (Reaffirmed A-1996) (Reaffirmed HOD 2006) (Reaffirmed as amended HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 285.013 FLORIDA LICENSURE FOR DIRECTORS OF PUBLIC HEALTH

The Florida Medical Association seeks legislation requiring that not only the state health officer but also directors of county public health departments be physicians or certified, licensed providers licensed under Chapter 458, F.S., or Chapter 459, F.S. *(Res 96-22, A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 285.015 MEDICAL DIRECTORS IN POST-ACUTE CARE FACILITIES

The Florida Medical Association believes that ~~that~~ medical directors of post-acute care facilities, including but not limited to adult living facilities, nursing homes, rehabilitation facilities, skilled nursing units, and subacute care units, should be physicians licensed under Florida Statutes 458 and 459; and

further opposes any attempts to abolish mandates that only physicians licensed under F.S. 458 and F.S. 459 be medical directors at post-acute care facilities. *(Res 96-13, A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; editorial change needed

P 285.020 FOREIGN PHYSICIAN LICENSURE

The Florida Medical Association opposes legislation that allows a physician to practice in Florida without meeting the same requirements as all other applicants. *(BOG Rpt. C-1, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 285.021 LICENSURE OF INTERNATIONAL MEDICAL GRADUATES

The Florida Medical Association supports equal licensure requirements for all International Medical Graduates and United States Medical Graduates; and further supports educating legislators about the importance and relevance of an ACGME-approved training program designed to achieve the highest patient quality and safety standards. *(Res 06-32, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 285.022 RESTRICTED LICENSURE FOR CERTAIN FOREIGN-LICENSED PHYSICIANS

The Florida Medical Association opposes any waivers of postgraduate training requirements for medical licensure. *(Res 06-33, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation Recommendation: Reaffirm

P 295.000 MANAGED CARE

P 295.002 MANAGED CARE

The Florida Medical Association supports the position that managed care organizations (HMOs, PPOs, IPAs, etc.) should not compromise nor affect the quality of access to appropriate health care. *(BOG February 1986) (Reaffirmed HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 295.014 INAPPROPRIATE USE OF DEA NUMBER BY HMOS

The Florida Medical Association will work with the Agency for Health Care Administration and the Pharmaceutical Branch of the Department of Health to abolish the practice by third parties of requesting a physician's DEA for other than scheduled drugs. *(Res 96-36, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed as amended HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 295.015 HMO ASSIGNMENT OF FINANCIAL RISK TO PHYSICIANS

The Florida Medical Association encourages state legislation to prohibit an insurer, managed care organization or managed care entity from allowing an individual health care provider to indemnify or assume financial liability for patient care. *(Res 96-10, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 295.023 EXPANSION AND ENFORCEMENT OF FLORIDA PROMPT PAY LAW

The Florida Medical Association seeks legislation to expand and enforce the Florida Prompt Pay law; and further that the Florida Prompt Pay law be amended to require in addition to the current interest on an

overdue payment of a claim, a late fee per each overdue payment of a claim with timeframes that begin from receipt of a claim as defined by Florida Statutes. *(Res 06-29, HOD 2006) (Reaffirmed HOD 2014)*
Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 295.031 ADOPTION OF ASAM CRITERIA FOR DETERMINING ESSENTIAL BENEFITS OF SUBSTANCE ABUSE DISORDER
The Florida Medical Association supports requiring managed care organizations to provide comprehensive coverage for the ASAM recommended standards for the assessment and treatment of substance use disorder in Florida. *(BoG February 2014)*
Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 300.000 MEDICAID
P 300.004 MEDICAID AUDIT
The Florida Medical Association adopts as a legislative priority that the Florida Medicaid program have any/all audits conducted by a physician from the same specialty and similar locality as the physician being audited. *(Res 96-65, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*
Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 300.013 MODIFY FLORIDA MEDICAID PREAUTHORIZATION PRESCRIBING PROGRAM
The Florida Medical Association shall continue to participate in legal activity related to Florida Medicaid's prior authorization program; and further work with the Agency for Health Care Administration to make the prior authorization process more physician-friendly. *(Sub Res 05-71, BOG Rpt D-2, HOD 2006) (Reaffirmed as amended HOD 2014)*
Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 300.026 Ensuring Medicaid Payment Increase to Medicare Rates ~~in 2016~~
The Florida Medical Association (FMA) seeks legislation that mandates a fine on Medicaid HMO's ~~(beginning in 2016)~~ that do not pay at least at Medicare rates after 2 years of continuous operation, that the fine equal at least 10% of the payment (Medicare rate or above) due to the physician, that the fine be levied and accrue on a monthly basis beginning 30 days after the initial infraction if appropriate payment (Medicare rate or above) is not received by the physician, and that the physician be paid the sum of the payment owed (Medicare rate or above) and all fines levied against the Medicaid HMO. *(Res 14-403, HOD 2014)*
Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 315.000 MEDICAL SCHOOLS
P 315.003 MEDICAL SCHOOLS AND GME TRAINING POSITIONS IN FLORIDA
The Florida Medical Association supports private-public partnerships to finance new postgraduate training positions; and also supports the establishment of new medical schools only if a new medical school provides evidence that the medical school graduates could find postgraduate training positions in the state of Florida. *(Res 05-3, HOD 2005) (Reaffirmed HOD 2014)*
Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 370.000 PEER REVIEW /PEER REVIEW ORGANIZATIONS

P 370.014 PEER REVIEW INVESTIGATIONS

The Florida Medical Association supports federal legislation that would make peer review investigations confidential in civil or administrative proceedings. *(BOG November 2004) (Reaffirmed HOD 2012)*

Council on Legislation: Reaffirm

P 380.000 PHYSICIAN PAYMENT & REIMBURSEMENT

P 380.012 PHYSICIAN COMPENSATION FOR EMERGENCY DEPARTMENT CALL ROTATION

The Florida Medical Association supports the concept of financial compensation for physicians required to participate in "on-call" rotation for the purpose of maintaining hospital staff privileges. *(Res 06-30, HOD 2006) (Reaffirmed as Amended HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 395.000 PHYSICIANS

P 395.003 USE OF TERM "PHYSICIAN"

The Florida Medical Association supports legislation prohibiting the use of the term "physician" as a descriptor other than in the context of a medical doctor or doctor of osteopathy, with the exception of "physician's assistant." *(Res 97-58, HOD 1997) (Reaffirmed BOG 2007) (Reaffirmed HOD 2012)*

Council on Legislation: Reaffirm

P 400.000 PRACTICE OF MEDICINE

P 400.005 PHYSICIAN PRACTICE ECONOMIC VIABILITY AS TOP PRIORITY FOR THE FMA

The Florida Medical Association establishes that "Physician Practice Viability Affecting Access to Care" is a top priority for all organizational activities including legislation, Association initiatives, member services, relationships with private and public payers, and public relations; and that the FMA's most substantial efforts and resources be directed at addressing the economic and regulatory burdens affecting physician practices that damage access to care for our patients until otherwise directed by the FMA House of Delegates. *(Substitute Res 06-9, HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 400.006 OUTPATIENT FACILITY OWNERSHIP OPPORTUNITIES

The Florida Medical Association supports the efforts of physicians and specialty societies that explore new ownership options for physicians for the diagnosis and treatment of patients in outpatient settings. *(Res 06-14, HOD 2006) (Reaffirmed HOD 2014)*

Council of Medical Economics and Practice Innovation Recommendation: Reaffirm

P 420.000 PUBLIC HEALTH

P 420.007 COUNTY PUBLIC HEALTH FUNDING FOR PRIMARY CARE SERVICES

The Florida Medical Association continues to actively support as a top legislative priority of the Association the adequate funding of primary care services through County Health Departments (CHDs). *(Res 96-11, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 420.038 NATURAL GAS FRACKING: MONITORING TO PROTECT HUMAN HEALTH

The Florida Medical Association (FMA) favors legislation that: 1) requires the full disclosure of chemicals placed into the natural environment for oil & gas extraction, including disclosure of the specific chemicals and wastewater injected, quantities, & locations 2) requires the State of Florida to record and monitor this data, to monitor for human exposures, and to share this information with physicians & Floridians 3) supports research into the health impacts of oil and gas exploration and extraction in Florida; and further the FMA favors measures to educate physicians and the public concerning the potential health and environmental effects resulting from oil and gas extraction. *(HOD July 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 435.000 RESEARCH

P 435.004 RESEARCH LIBRARIES

The Florida Medical Association endorses the concept of maintaining health science and medical research libraries to ensure adequate learning resources for the present and future. *(BOG July 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 440.000 RESIDENCIES AND INTERNSHIPS

P 440.001 RESIDENCY PROGRAMS AND HEALTH SYSTEM REFORM

The Florida Medical Association (FMA) shall work with the Florida Legislature, the Florida Congressional Delegation, the American Medical Association (AMA), and the Accreditation Council on Graduate Medical Education (ACGME) to ensure that the allocation of residency slots continues to be made by the private sector on the basis of quality rather than political, geographical, or local demographic considerations; and further the FMA will work with the AMA and the ACGME to improve the emphasis on primary care residency programs and address the public policy concerns related to the need for improved access to primary care; and further the FMA shall work with the Florida Legislature to ensure that any legislative proposal to implement a state-level consortium should address the issue of residency programs. *(Res 94-72, A-1994) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 445.000 SCHOOL HEALTH

P 445.018 SCHOOL START TIMES

The Florida Medical Association supports legislation and endorses public schools (elementary to high school) start classes at 8:00 am or later. *(Amended Res 12-110, HOD 2012)*

Council on Legislation: Reaffirm

P 445.019 CPR TRAINING

The Florida Medical Association (FMA) supports legislation requesting high school students be properly trained in CPR. (*Res 14-103, HOD 2014)*

Council on Legislation: Reaffirm

P 450.000 SCOPE OF PRACTICE

P 450.001 OPTOMETRISTS' USE OF DRUGS

The Florida Medical Association provides strong support and assistance to the Florida Society of Ophthalmology in opposing legislation which allows use of drugs by optometrists. *(BOG January 1983) (Reaffirmed HOD 1993) (Reaffirmed HOD 2003) (Reaffirmed HOD 2011) (Reaffirmed HOD 2012) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 450.004 HOSPITAL STAFF PRIVILEGES FOR OPTOMETRISTS

The Florida Medical Association opposes legislation that would mandate hospital staff privileges for optometrists. *(BOG February 1986) (Reaffirmed A-1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 450.005 DENTAL ANESTHESIA

The Florida Medical Association opposes legislation granting privileges authorizing dentists to administer non-dental anesthesia. *(BOG February 1986) (Reaffirmed HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 450.025 "DOCTOR-NURSES" REPLACING PHYSICIANS

The Florida Medical Association pursues legislation making it unlawful for a nurse to represent him or herself as a physician (MD/DO), to include such activity under the scope of "unlicensed practice of medicine" and to stipulate felony-level penalties for such representation; and further is directed to establish an ad hoc committee to investigate the apparent scope of practice and conflicts of interest involved in the doctor of nursing practice. *(Res 10-305, HOD 2010) (Reaffirmed HOD 2012)*

Council on Legislation: Reaffirm

P 450.028 DOCTOR OF NURSING PRACTICE (DNP)

Due to the extreme likelihood that patients treated by a Doctor of Nursing Practice (DNP) will be misled into thinking that their "doctor" is a physician, the FMA is directed to introduce legislation mandating that all persons other than M.D.s, D.O.s, dentists and chiropractors holding themselves out as "doctors" wear a conspicuous name tag or signage which have letters no smaller than 4mm per letter and which fully spells out the exact name of their formal degree (Doctor of Nursing Practice, etc.) and that they further be required to orally state that they are not physicians with each and every encounter. *(Amended Res 13-322, HOD 2013) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 460.000 SURGERY

P 460.001 LASER SURGERY

The Florida Medical Association supports working with the Florida Department of Health and the Florida Board of Medicine and any other appropriate state agency and the Florida State Legislature to define "laser surgery" as a surgical operation and that only practitioners appropriately trained in the use of lasers and licensed pursuant to Chapters 458, 459, 461 and 466 be allowed to utilize lasers in the treatment of human conditions, disorders, anomalies, dysfunction and disease. *(Res 96-56, C-11, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 475.000 TORT REFORM

P 475.001 ELIMINATION OF THE DOCTRINE OF JOINT AND SEVERAL LIABILITY

The Florida Medical Association supports elimination of the doctrine of joint and several liability and supports placing a cap on general damages (non-economic) as a professional liability legislative objective. *(BOG October 1985) (Reaffirmed HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 475.002 CONTINGENCY FEES FOR FRIVOLOUS LAWSUITS

The Florida Medical Association seeks the enactment of legislation requiring an attorney who files a liability suit on a contingency fee basis to pay a portion of the defendant's court cost if the suit is lost. *(Res 86-34, HOD 1986) (Reaffirmed HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 475.009 COMPENSATION OF MINORS IN MEDICAL MALPRACTICE AWARDS

The Florida Medical Association establishes as a legislative priority the enactment of legislation requiring that in medical malpractice awards involving a minor, at least 75 percent of the award go to the injured minor. *(Res 96-62, HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Council on Legislation: Reaffirm

P 485.000 VACCINES

P 485.008 HPV VACCINATION PUBLIC AWARENESS CAMPAIGN

That the Florida Medical Association (FMA) advocates as its official public health position that all eligible adolescents be vaccinated against HPV ~~as early as 9 but prior to age 26~~ in accordance with the guidance recommended by the CDC. *(Adopted as amended, Res 14-109, HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

P 485.009 CLARIFICATION OF RELIGIOUS EXEMPTION TO VACCINATION REQUIREMENTS

The Florida Medical Association will work with the Florida Department of Health to protect the health of all residents by requiring parents requesting a religious exemption for their children to not be vaccinated, to state why their religion is opposed to vaccination, and have their religious leader or by way of religious text validate the claim against vaccination. (*Res 14-114, HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Reaffirm; still relevant

POLICIES FOR SUNSET

P 90.000 CHILDREN & HEALTH

P 90.018 NEONATAL PULSE OXIMETRY HEART DISEASE

The Florida Medical Association supports legislation requiring that all Florida newborns be screened for critical congenital heart disease using pulse oximetry, and further that such legislation require newborn pulse oximetry be added to the list of mandated newborn screening tests, and further that such legislation direct Children's Medical Services, within the Florida Department of Health, to develop and implement such a screening program for CCHD and track the results in all newborns. *(Amended Res 12-318, HOD 2012)*

Recommendation by the Council on Legislation: Sunset – Accomplished. The Department of Health screens all newborns for critical congenital heart disease as a core disorder. Abnormal results are managed by the Newborn Screening Follow-up Program which is a part of Children's Medical Services. Per Rule 64C-7.002(4)(c), F.A.C., a pulse oximeter device must be used to test the oxygen level in the right hand and either foot. Newborns must be at least 24 hours of age or prior to hospital discharge to obtain the oxygen level.

120.000 DISASTER PREPAREDNESS

P 120.002 CONTINUANCE OF HEALTH RELATED RESEARCH

The Florida Medical Association shall work with the Florida medical schools to identify the requirements and resources which are necessary to assure the continuance of Florida's health related research enterprises in the event of a natural or other disaster. *(BOG October 2005) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Sunset; accomplished

P 120.003 PERMANENT STORAGE OF MEDICAL EDUCATION RECORDS

The Florida Medical Association shall work with the Florida medical schools to assure the permanent storage of resident physician and medical student education records to be in mirror image off-campus secure sites (in event of natural or other disaster). *(BOG October 2005) (Reaffirmed HOD 2014)* enterprises in the event of a natural or other disaster. *(BOG October 2005) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Sunset; accomplished

P 140.000 EDUCATION (MEDICAL)

P 140.007 TEACHING MEDICAL STUDENTS BASIC ASPECTS OF MEDICAL ECONOMICS

The Florida Medical Association actively promotes the teaching of basic aspects of medical economic issues in medical schools and post-graduate training programs. *(Res 95-18, A-1995) (Reaffirmed HOD 2005) (Reaffirmed with technical amendments HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Sunset; accomplished

EDUCATION- (CONTINUING MEDICAL EDUCATION – CME)

P 145.008 REVIEW REQUIREMENTS FOR CME ACCREDITATION

The Florida Medical Association supports the endeavor to simplify the CME process for organizations to provide CME, therefore making it easier to apply for CME credits; and further endeavors to simplify the process and expand opportunities for organizations to provide CME at a reasonable cost and use less paperwork. *(Res 03-01, HOD 2003) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Education, Science & Public Health: Sunset; obsolete

P 249.000 IMMUNITY (SOVEREIGN)

P 249.001 MALPRACTICE COVERAGE FOR PHYSICIANS PROVIDING INDIGENT CARE

The Florida Medical Association supports extension of the State of Florida limited sovereign immunity to include physicians on contract with county health departments. *(Res 86-44, HOD 1986) (Reaffirmed HOD 1996) (Reaffirmed HOD 2006) (Reaffirmed HOD 2014)*

Recommendation by the Council on Medical Economics and Practice Innovation: Objective accomplished.

P 420.000 PUBLIC HEALTH

P 420.034 LEGALIZING SYRINGE EXCHANGE PROGRAMS IN THE STATE OF FLORIDA

The Florida Medical Association seeks legislation amending Chapter 893 of the Florida Statutes to **legalize Syringe Exchange Programs in the state of Florida. (*Res 12-311, HOD 2012)***

Recommendation by the Council on Legislation: Sunset - Accomplished.

P 450.000 SCOPE OF PRACTICE

P 450.026 PA'S ORDERING MEDICATIONS

The Florida Medical Association supports legislation requested by the Florida Academy of Physician Assistants which would clarify their authority to order medications for the supervisory physician's patient in a hospital setting. *(BOG October 2012*)

Recommendation by the Council on Legislation: Sunset.

AMA Policies on Opioid Use Disorder Treatment Post Incarceration

H-430.987 Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.

2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Resolution 22-101
Restoring Trust in Public Health Interventions
Emerald Coast Medical Association

Whereas, At the 2021 FMA Annual Meeting the House of Delegates passed Resolution 21-105 Healthcare Professional Readiness for COVID-19,

Whereas, Through this resolution the FMA adopted a policy to recommend all healthcare providers receive the Covid-19 vaccine,

Whereas, Young otherwise healthy men and women, many of whom have natural immunity, in the healthcare field are at greater risk from vaccine complications than they are from the actual virus, especially men under the age of 30,

Whereas, There are multiple published studies demonstrating that recovery from COVID-19 infection is superior to vaccine-induced immunity. This includes a Jan 28, 2022, study in the CDC's MMWR finding that from July 2021 forward, natural immunity was significantly superior (3-5x) to vaccine immunity,

Whereas, There is no high quality data demonstrating that the wearing of masks other than properly fitted N-95 masks are protective against COVID-19,

Whereas, Currently available COVID-19 vaccines do not prevent the transmission of the COVID-19 variants which are predominate in the United States,

Whereas, By allowing decades of scientific precedence to be replaced by a one size fits all policy, the FMA, AMA, AAP, and individual doctors have caused damage to the credibility of the medical profession, therefore be it

RESOLVED The FMA rescind Resolution 21-105 encouraging all healthcare practitioners and medical support staff receive the COVID-19 vaccine; and be it further

RESOLVED, The FMA affirm the position of the state surgeon general recognizing natural immunity as equivalent to vaccine immunity; and be it further

RESOLVED, The FMA affirm the position of the state surgeon general in recommending against the use of COVID-19 vaccines in healthy children; and be it further

RESOLVED, The FMA publicly thank our FMA PAC endorsed gubernatorial candidate Ron DeSantis and the state surgeon general for having the courage to follow the science by declaring the wearing of cloth masks by both health care workers and the general public as ineffective; and be it further

RESOLVED, The FMA through its delegation to the AMA urge an end to all COVID-19 vaccine mandates and end the requirements for healthcare workers and patients to wear masks routinely in hospitals and healthcare facilities nationwide, except in the case of infectious diseases in which situations fitted N95 masks are appropriate.

Fiscal Note:

Description	Amount	Budget Narrative
13 staff hours	$820	Can be accomplished with current staff
Total	$820	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-102

Support for the State Surgeon General on the Treatment of Gender Dysmorphia

Emerald Coast Medical Association

Whereas, The Florida Surgeon General has issued guidance for the state of Florida against the use of gender affirming care for children and adolescents with gender dysphoria, and

Whereas, A disturbing trend of adolescent females seeking gender transitioning may be being influenced by the cultural promotion of being transgendered on social media and by some television personalities, and

Whereas, The data is clear on the most effective treatment for gender dysphoria being puberty, with a resolution rate of greater than 80%, and

Whereas, The resolution rate of gender dysphoria in adolescents treated with puberty blockers is less than 5%, and

Whereas, The discipline of pediatric endocrinology is being adversely impacted by the adoption of hormone blockers and cross sex hormone use and the number of applicants to these programs have steadily declined as the proliferation of academic gender dysphoria clinics proliferate, and

Whereas, There is no data on long term success and improvement of psychiatric symptoms in patients who have completed transition, and

Whereas, There are multiple reports of patients who express extreme regret and anger after being placed into the transitioning track that is being promoted in the United States, and

Whereas, Many European nations (Sweden, Finland, UK, and France) have stopped their medical and surgical transitioning programs due to concerns about the effects on those patients who underwent irreversible treatments and later expressed extreme regret, therefore be it

RESOLVED, The FMA adopt the Florida Surgeon General's stance on the Treatment for Gender Dysphoria for Children and Adolescents in which social, medical, and surgical transitioning is not recommended; and be it further

RESOLVED, The FMA send a letter to Governor DeSantis, the FMA PAC endorsed gubernatorial candidate, thanking him for this important policy to protect children from predatory clinicians and social media trends in our state.

Fiscal Note:

Description	Amount	Budget Narrative
6 staff hours	$390	Can be accomplished with current staff
Total	$390	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-103

Rejection of the Premise that the American Medical System is Racist

Emerald Coast Medical Society

Whereas, The proliferation of diversity, equity, and inclusion (DEI) statements are being adopted by the Federation of State Medical Boards and the American Board of Medical Specialties, which include making one's board certification contingent on personal commitment to DEI, and

Whereas, In its April 15, 2022, statement on DEI in medical regulation, the FSMB claims: "Systemic racism and structural inequities are embedded in the American health care system and have given rise to a public health crisis," and

Whereas, While there are individual instances of abhorrent practices that were racially targeted, there is no objective evidence that the American healthcare system is biased against racial minorities, therefore be it

RESOLVED, The FMA issue a statement that systemic racism and structural inequities do not exist in the American Health Care System; and be it further

RESOLVED, The FMA oppose any diversity, equity, and inclusion language that could impact physicians through either legislation or rulemaking at the Dept. of Health; and be it further

RESOLVED, That the FMA through its delegation to the AMA advocate this position when issues involving healthcare disparities and diversity, equity, and inclusion initiatives are raised.

Fiscal Note:

Description	Amount	Budget Narrative
staff hours	Unknown	Unable to determine staff hours required for 2nd resolve
Total	Unknown	Unknown impact on the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-104

Implementing Intimate Partner Violence Education in Medical School Curricula

FMA Medical Student Section

Whereas, the WHO identifies intimate partner violence (IPV) as a major public health problem and it is estimated that one third of the population has experienced IPV[1,2]; and

Whereas, the COVID-19 pandemic exacerbated the incidence of intimate partner violence rates in the United States and abroad[3]; and

Whereas, IPV has serious health consequences including adverse effects on cardiovascular health and increased incidence of sexually transmitted infections, miscarriage, pre-term delivery, child mortality and morbidity, depression, post-traumatic stress disorder, substance use disorder, and pain syndromes[3,5-8] ; and

Whereas, IPV is the leading cause of nonfatal injury to women worldwide and a major source of preventable morbidity and mortality[9]; and

Whereas, one in three women presenting to the emergency department after trauma were injured by their partner[6]; and

Whereas, survivors of IPV are often hesitant to disclose IPV for many reasons, including fear of inappropriate responses and lack of understanding from health care providers[2,10-12] ;

Whereas, survivors of IPV have identified health care as the institution with the greatest potential to help them, but many survivors report that they were not screened effectively[12,13]; and

Whereas, physicians are important stewards of public health information, and a lack of public knowledge about harmful health consequences of IPV has been cited as a reason survivors of IPV may not seek support[13,14]; and

Whereas, evidence supports direct questioning to identify IPV, but only 14% of patients presenting to health care practitioners for IPV-related injuries are asked such questions[15-18]; and

Whereas, uncertainty of how to respond to a disclosure has been cited by physicians as a barrier to asking about IPV and 50% of physicians are unaware of available resources[2,16,19]; and

Whereas, when surveyed, physicians significantly underestimate the prevalence of IPV, and as many as 50% of physicians have never been trained in IPV[16,20]; and

Whereas, there are validated tools and programs available for educating health care providers on IPV[2,17,21]; and

Whereas, nearly half of all women who reported being asked about domestic or family violence said that they were asked in a primary care setting[22]; and

Whereas, the prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis[23]; and

Whereas, the integration of IPV education programs have been demonstrated to improve perceptions, knowledge, and skills in the management of suspected cases of domestic violence[24]; and

Whereas, there exists state-to-state variability in mandatory reporting requirements for domestic violence cases as seen in Oklahoma, New Hampshire, and Pennsylvania, who have exceptions for reporting injuries due to domestic violence[25]; therefore be it

RESOLVED, That our FMA actively promotes the teaching of intimate partner violence detection for medical students.

Fiscal Note:

Description	Amount	Budget Narrative
10 staff hours	$325	Can be accomplished with current staff
Total	$325	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

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https://www.ncbi.nlm.nih.gov/books/NBK493194/

Didn't look at these but if we need them….

Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research

Responding to intimate partner violence: Healthcare providers' current practices and views on integrating a safety decision aid into primary care settings

User-Involvement in the Development of a Culturally Sensitive Intervention in the Safe Pregnancy Study to Prevent Intimate Partner Violence

WHO COVID-19 and violence against women

Understanding management and support for domestic violence and abuse within emergency departments: A systematic literature review from 2000-2015

Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis

Prevalence of Interpersonal Violence Among Latinas: A Systematic Review

Domestic Violence During the COVID-19 Pandemic: A Systematic Review

Screening women for intimate partner violence in healthcare settings

Measures for screening for intimate partner violence: a systematic review

Risk and protective factors for violence against women

Intimate partner violence during pregnancy and risk of fetal and neonatal death: a meta-analysis with socioeconomic context indicators

Intimate partner violence in the Americas: a systematic review and reanalysis of national prevalence estimates

Intimate Partner Violence and its Resolution among Mexican Americans

Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies

Intimate partner violence and perinatal health: a systematic review

Prevalence of Intimate Partner Violence in Pregnancy: An Umbrella Review

The effects of an intimate partner violence educational intervention on nurses: A quasi-experimental study

Training healthcare providers to respond to intimate partner violence against women

Domestic violence and substance abuse during COVID19: A systematic review

Relevant AMA policy just for our information -

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982

Resolution 22-105

Minimal Credentialing in Post-Acute and Long-Term Care (PALTC) Medicine

The Florida Society for Post-Acute and Long-Term Care Medicine

Whereas, Unlicensed and fraudulent health care providers exist in the PALTC arena; and

Whereas, PALTC patients/residents and their families have the appropriate expectation that providers caring for them have been properly vetted; and

Whereas, A minimal set of credentialing for medical practitioners in PALTC should be efficient and effective; therefore, be it

RESOLVED, That the Florida Medical Association promotes a professional standard that all health care providers practicing in the Post-Acute and Long-Term Care (PALTC) setting will present, at a minimum, proof of identification, i.e., a current government issued photo identification (e.g., driver's license), a current state issued professional license, and, as appropriate, a current DEA certificate.

Fiscal Note:

Description	Amount	Budget Narrative
300 staff hours	$45,000	Can be accomplished with current staff
Total	$45,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-106

Requirement for Minimum Education Standards for Medical Directors

The Florida Society of Post-Acute and Long-Term Care Medicine

Whereas, It is well established that Medical Directors in Post-Acute and Long-Term Care (PALTC) must possess an adequate specific fund of knowledge and unique skill set to optimally perform the functions and tasks mandated by this position; and

Whereas, There exists evidence-based literature suggesting that the presence of a Medical Director with additional training may improve care quality and is generally more engaged; and

Whereas, In the past several years there has been an influx of specialists into the PALTC arena serving in the role of Medical Director, often without any formal supplemental training; and

Whereas, It is the desire of the Florida Medical Association to promote the highest quality of care to patients/residents in the PALTC setting; therefore be it

RESOLVED, That the Florida Medical Association support and encourage all initiatives (Federal, State and Local) to promote minimum education standards for physicians serving in the role of Medical Director in Post-Acute and Long-Term Care, to include the completion of a specified number of initial and maintenance education credits within a defined time period.

Fiscal Note:

Description	Amount	Budget Narrative
305 staff hours	$45,350	Can be accomplished with current staff
Total	$45,350	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-108

Promoting, Supporting Clinical Research

Collier County Medical Society; Raymond Phillips, M.D.

Whereas, Across all socioeconomic and ethnic groups there is profound mistrust of clinical research and reduced confidence in evidence-based health care recommendations as demonstrated during the Covid-19 pandemic leading to unnecessary morbidity and mortality; and

Whereas, There is poor understanding of clinical research in the US and how this research is critical for developing medical therapy, which contributes to mistrust of evidence-based recommendations; and

Whereas, Education can help correct this deficiency of understanding of clinical research and rebuild the public's and medical community's trust; and

Whereas, There appears to be no FMA policy with respect to the promotion of clinical research to the public or medical community; therefore, be it

RESOLVED That the FMA develop and promulgate an educational campaign directed to the public and medical community to clarify how clinical research is performed in the U.S., and be it further

RESOLVED, That the FMA promote clinical research by facilitating the identification of clinical research activity in component society areas to create a community-based resource for interested public and medical community members, and be it further

RESOLVED, That the FMA provide physicians conducting clinical research in their communities with the tools necessary to promote the importance of clinical research and reinforce the trust-building needed for vibrant participation of the public and the medical community.

RESOLVED, That the FMA formulate an Action Plan for Promoting Clinical Research (APPCR) that can be carried through to component societies, including but not limited to:

a. Identifying physicians involved in clinical research
b. Facilitating the formation of research networks
c. Creating a website for listing clinical trials, case studies and involved physicians
d. Coordination of the participation of graduate medical education programs
e. Coordination of the participation and resources of community hospitals, clinics, medical foundations, and pharmaceutical stakeholders.

Fiscal Note:

Description	Amount	Budget Narrative
300 or more staff hours	$ 20,000 plus	Cannot be accomplished with current staff
Public Education Campaign	$200,000 plus	Public Education campaigns can cost millions
Physician Toolkit	$ 25,000 plus	Creation and distribution can vary in cost
Total	$245,000 plus	$245,000 plus added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-109
Elder Abuse in Florida
Kevin Sherin, M.D. and The Physicians Society of Central Florida

Whereas, Elder abuse commonly includes financial, verbal and emotional abuse; and

Whereas, Patient reports of verbal emotional forms of abuse and financial abuse do not currently automatically trigger adult protective investigations; and

Whereas, Florida physicians and other healthcare providers who care for the vulnerable elderly are reporters of suspected abuse; therefore be it

RESOLVED, That the FMA work with the state to assure that Florida physicians and providers who report patients with financial, verbal or emotional forms of elder abuse be linked to the FL Department of Elder Affairs protective services investigation; and be it further

RESOLVED, That the FMA investigate strategies with the state to standardize the documentation of financial, verbal or emotional forms of elder abuse in EHR systems, when indicated, which trigger appropriate referrals; and be it further

RESOLVED, That the FMA review existing legislation on elder protection and develop advocacy strategies for further strengthening laws to further protect Florida's elderly.

Fiscal Note:

Description	Amount	Budget Narrative
25 staff hours	$2,150	Can be accomplished with current staff
Total	$2,150	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-110
Physician Online Ratings
Mark Trolice, M.D.

Whereas, online patient reviews are accessible to any current and future patient; and

Whereas physicians are unable to thoroughly reply to online patient reviews due to HIPAA violations; and

Whereas 91% of people regularly or occasionally read online reviews[1]

Whereas 84% of consumers trust online reviews as much as personal recommendations[1]

Whereas 84% of patients use online reviews to evaluate physicians[2]; and

Whereas 77% of patients use online reviews as their first step in finding a new doctor[2]; and

Whereas unsubstantiated online reviews can have a damaging effect on a doctor's reputation and business[3]; and

Whereas online reviews are not vetted to confirm the validity of the source[4]; and

Whereas consumers who use online reviews are only receiving a unilateral subjective opinion; and

Whereas HIPAA precludes the disclosure of a patient's identify, diagnosis, and course with a physician; and

Whereas online reviews by a patient with an appropriate physician reply will allow consumers more accurate information to establish their opinion, be it

RESOLVED that the Florida Medical Association create a training course for physicians that would provide guidance on how to effectively respond to negative online reviews without violating HIPAA guidelines and give physicians tools to address such matters.

Fiscal Note:

Description	Amount	Budget Narrative
100 staff hours	$ 8,000	Can be accomplished with current staff
Professional Services	$10,000	Course curriculum
Vendor Webinars	No cost	Sponsored webinars from preferred vendors
Total	$18,000	$10,000 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

REFERENCES

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2. https://www.digitalcommerce360.com/2016/11/15/77-patients-use-online-reviews-first-step-finding-doctor/#:~:text=In%20fact%20the%20survey%20of,in%20finding%20a%20new%20doctor
3. https://www.practicebuilders.com/blog/how-online-reviews-influence-doctor-reputation/
4. https://www.forbes.com/sites/christopherelliott/2018/11/21/why-you-should-not-trust-online-reviews/?sh=142362472218

Resolution 22-111
Ethics Resolution
American College of Obstetricians and Gynecologists, District XII, Broward County Medical Society, Florida Society of Ophthalmology

Whereas, Physicians are held to a high standard of behavior, action, and interaction with the public due to their unique expertise and position in society that often can mean the difference between life and death; and

Whereas, Physicians are consistently ranked in the top most respected professions by Americans for many years running; and

Whereas, The ubiquity of social media and independent content production has resulted, for better or worse, a larger audience by individuals, including physicians; and

Whereas, Per tradition of Western medicine dating back to ancient times and per international ethical guidelines, physicians have a duty to not only harm their own patients but the general public at large through misleading or blatantly false claims or encouraging behavior that risks public health; and

Whereas, The derivation of the word "doctor" is "teacher" in Latin and "learned person" in Middle English and a teacher would be expected not to mislead or harm those he/she/they teach; and

Whereas, The guiding principles of medical ethics includes beneficence, non-maleficence, autonomy, and justice; and

Whereas, The meaning of non-maleficence (and in accordance to documents by the Florida Board of Medicine) means "obligation to do no harm to patient or society;" and

Whereas, Current FMA policy 175.003, entitled "Code of Ethics" states, in part, that all FMA members and agree and comply with the American Medical Association's (AMA) and FMA's Principles of Medical Ethics; and

Whereas, The AMA is a founding and current member of the World Medical Association (WMA) that, in 2022, represents 115 national medical associations, including the AMA; and

Whereas, The WMA was created in 1947 with the mission "to serve humanity by endeavoring to achieve the highest standards in Medical Education, Medical Science, Medical Art and Ethics, and Health Care for all people in the world" through its work on ethical guidance by way of Declarations, Resolutions, and Statements; and

Whereas, The WMA currently has a Physician Pledge, termed the Declaration of Geneva, last revised in 2017, and first published worldwide in the Journal of the American Medical Association; and

Whereas, The WMA also has policies on social media, public health, misinformation and disinformation, and many other ethical issues of interest to medicine; therefore be it

RESOLVED, That current FMA policy 175.003 be revised to include World Medical Association's (WMA's) policies with regard to medical ethics that have all been approved by the AMA Delegation according to the AMA Code of Medical Ethics, by the following revised statement by addition:

"The Florida Medical Association (FMA) is committed to the principles of medical ethics and requires that all members agree and comply with the American Medical Association's (AMA's), FMA's, and World Medical Association's (WMA's) Principles of Medical Ethics.

Fiscal Note:

Description	Amount	Budget Narrative
1 staff hours	$40	Can be accomplished with current staff
Total	$40	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-112

Support For Gender Affirming Care for Florida Transgender and Gender non-conforming Youth and Adolescents

Leah Kemble, M.D.

Whereas, Providing timely access to gender affirming care for gender incongruent youth is life saving; and

Whereas, Gender affirming care includes a spectrum of reversible to non-reversible treatment options; and

Whereas, Among those options easiest to implement are social transition which involves using the child/adolescent's preferred name and gender pronouns, allowing/encouraging preferred gender expression including wearing clothing, accessories, hair styling according to preferred gender expression[2]. Social transition requires no supervision or monitoring from the healthcare team; and

Whereas, Medical, reversible options for gender affirming care include treatment with 'puberty blockers,' or GNRH analogues. This treatment suppresses the HPG axis, preventing further development of secondary sex characteristics. It prevents adolescents from experiencing further body dysmorphia, and provides them time to decide if less reversible methods of treating gender dysphoria, such as treatment with cross sex hormones, are right for them. Treatment with GNRH analogues is completely reversible, meaning if the medications are stopped, puberty will resume and natal sex hormone production and puberty will occur[2]; and

Whereas, Gender affirmation care can also include treatment with cross sex hormones. Some of the effects of these hormones may not be reversible if treatment is stopped. Gender affirmation surgery is not generally a treatment option for those less than 18 years of age[2]; and

Whereas, Numerous studies have shown an increased rate of mental health disorders among gender non-conforming youth and adolescents. One such study demonstrated that older gender incongruent youth ($\geq$ 15 years of age) and those with late pubertal stage (Tanner stage 4 or 5) presenting for gender affirming medical care had worse mental health than their younger and lower pubertal stage peers[5], and

Whereas, Youth undergoing gender affirming medical care had 60% lower odds of depression and 73% lower odds of suicidality using the PHQ-9 and GAD-7 scales;[3,] and

Whereas, Some have claimed that rates of regret among those who have sought and received gender affirming care are as high as 80%. Recent studies have shown that the opposite in fact is true; and

Whereas, One study demonstrates regret rates are 0.6% for trans women and 0.3% for trans men in the Netherlands[6]; and

Whereas, Another study shows <1% 'clear regret' defined as "patients openly express their regret and have role reversal either by undergoing de-transition surgery or returning to their former gender role" among the 7928 transgender and non-binary individuals in the study[1]; and

Whereas, As a comparison, there exists a 6-30% regret rate among individuals who received a total knee arthroplasty[4]. Procedures and treatments with >99% patient satisfaction rates are generally heralded as successful; therefore be it

RESOLVED, That the Florida Medical Association supports provision of gender affirming medical care for gender non-conforming and trans youth and adolescents in Florida, including methods of gender affirming care such as social transition as well as treatment with 'puberty blockers' and cross sex hormones.

Fiscal Note:

Description	Amount	Budget Narrative
1 staff hour	$40	Can be accomplished with current staff
Total	$40	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

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3 Diana M. Tordoff, M. P. H. (2022, February 25). *Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care*. JAMA Network Open. Retrieved April 25, 2022, from https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2789423

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Resolution 22-113

End The Monopoly On Certifying Physicians by The American Board Of Medical Specialties (ABMS)

Ellen W. McKnight, M. D.

Whereas, The FMA house of delegates passed numerous resolutions affirming the FMA's unwavering commitment to fight Maintenance of Certification mandates in the state of Florida; and

Whereas, In May of 2016, the board of governor's passed the following substitute resolution in lieu of 15-101 and 15-105 which said: "That the FMA seek legislation to improve the efficiency of the health care markets and eliminate unnecessary administrative and regulatory requirements, health care providers shall not be required, by any public or private entity to comply with maintenance of certification requirements after achieving initial board certification, other than the continuing medical education (CME) requirements set by the health care provider's licensing board"; and

Whereas, The adoption of these resolutions has done very little to thwart the almost universal requirement of compliance with MOC mandates and has not prevented the continued harassment and financial shake-down of physicians; and

Whereas, The American Board of Medial Specialties is expanding their authority over physicians through the development of codes of conduct and is threatening to sanction physicians with revocation of their board certification if a physician violates these codes; and

Whereas, The National Board Of Physicians and Surgeons has developed a credible and meaningful process for maintaining certification and should be formally recognized by the Florida Department of Health as a legitimate alternative for physicians to maintain their board certification status and for the purposes of advertising as board certified in the state of Florida; and

Whereas, National Board of Physicians and Surgeons (NBPAS) provides a pathway to maintain board certification for physicians initially certified through an ABMS/AOA board; and

Whereas, NBPAS requires 50 hours of ACCME Category 1 CME and ABMS requires costly, proprietary general specialty exams and MOC that have no data to support that they improve patient care or clinical outcomes; and

Whereas, The Joint Commission (TJC) is adding NBPAS as a "Designated equivalent source" to verify board certification alongside ABMS and AOA (effective July 2022); and

Whereas, NBPAS meets all other national accreditation requirements for hospitals (TJC, DNV) and health plans (NCQA, URAC); and

Whereas, The addition of the National Board of Physicians and Surgeons, as a recognized equivalent board to ABMS, would benefit the physicians already practicing in Florida but also recruit even more to the state; therefore be it

RESOLVED, The FMA formally petition the governor and the surgeon general to add the National Board of Physicians and Surgeons (NBPAS) to the currently approved certifying entities in the state of Florida recognizing that we must finally end the monopoly on certifying physicians by ABMS/AOA; be it further

RESOLVED, The FMA will send a representative(s) to the next meeting of the Florida board of medicine to voice support for recognizing NBPAS as an approved certifying entity in the State of Florida; therefore be it further

RESOLVED, The FMA will formally request a change to 458.3312, by replacing the word "formal" with "initial" as follows: Specialties.

—A physician licensed under this chapter may not hold himself or herself out as board certified unless the physician received ***initial*** recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the board…

Fiscal Note:

Description	Amount	Budget Narrative
320 staff hours	$46,300	Can be accomplished with current staff
Total	$46,300	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Resolution 22-114

Opioid Epidemic and Settlement with Pharmaceutical Companies

Florida Society of Addiction Medicine (FSAM)

Whereas, The opioid epidemic has resulted in almost 8,000 deaths in Florida in 2020[i]; and

Whereas, Prescription drug manufacturers, distributers, and retailers have reached settlement agreements with the State of Florida totaling near $3 billion to abate the impacts of the opioid overdose epidemic[ii]; and

Whereas, The State of Florida has entered into an "Opioid Allocation and Statewide Response Agreement" (hereafter referred to as "the Agreement") with counties and localities that governs the allocation and use of any settlement proceeds[iii] and incorporates The Principles for the Use of Funds from the Opioid Litigation[iv]; and

Whereas, The core strategies of the Agreement include: provider education and outreach on appropriate prescribing and treatment for opioid use disorder, and community-based outreach and support; and

Whereas, Physicians, especially Addiction Specialist Physicians, have an integral role in the treatment of patients with an opioid use disorder; therefore be it [v]

RESOLVED, That our Florida Medical Association (FMA) amend policy P 125.00, "DRUGS-ABUSE," to add a new section P 125.006 to read as follows:

<u>P 125.006: Opioid Epidemic and Settlement with Pharmaceutical Companies</u>

1. <u>Our Florida Medical Association will work with the Florida Society of Addiction Medicine and other medical societies to identify opportunities to support the core strategies of the Agreement, including but not limited to: provider education and outreach on appropriate prescribing and treatment for opioid use disorder, and community-based outreach and support.</u>

2. <u>Our Florida Medical Association will work with the Florida Society of Addiction Medicine and other medical societies to provide education and outreach to physicians and other clinicians about the contents of the Agreement and opportunities to work with state and local officials to support the core principles of the Agreement.</u>

Fiscal Note:

Description	Amount	Budget Narrative
staff hours	Unknown	Unable to determine staff hours for item 2
education and outreach	Unknown	Unable to determine program costs for item 2
Total	Unknown	Unknown impact on the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

[i] Ahmad, F. B., Rossen, L. M., & Sutton, P. (2022). Provisional drug overdose death counts. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[ii] Opioid Settlement Tracker. (2022). Opioid Litigation Global Settlement Tracker. Opioid Settlement Tracker. https://www.opioidsettlementtracker.com/globalsettlementtracker/#statuses

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[iv] Johns Hopkins Bloomberg School of Public Health. (2022). The Principles to Guide Jurisdictions in the Use of Funds from the Opioid Litigation. Johns Hopkins Bloomberg School of Public Health. https://opioidprinciples.jhsph.edu/the-principles/

[v] ASAM - American Society of Addiction Medicine. (2022). Recognition and Role of Addiction Specialist Physicians in Health Care in the United States. asam.org. https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/01/28/public-policy-statement-on-the-recognition-and-role-of-addiction-specialist-physicians-in-health-care-in-the-united-states

Resolution 22-115
Amend Prescription Off-Label Medication
Liudmila Buell, M.D.

Whereas, At the 2021 FMA Annual Meeting, the House of Delegates passed Resolution 21-111, Prescription Off-Label Medication which was added to the Compendium as P130.025; and

Whereas, The physician's responsibilities include providing full informed consent to allow each patient to decide and agree to their course of treatment; and

Whereas, Third parties are not privy to the discussions which occurred during the patient/physician interaction; and

Whereas, Doctors should not be blocked from providing life-saving medical treatment; and
Whereas, It is inappropriate for third parties, who have limited knowledge of the patient's medical history or current conditions, to make medical decisions which override treatment decisions made by the patient with concurrence of their physician; and

Whereas, Medical institutions such as a hospital, which could be considered a medical entity, do not disclose to patients conflicts of interest which may be influencing treatment protocols and procedures in such facility; and

Whereas, Pharmacies, which could be considered medical entities, are third parties which have limited knowledge of patient medical history and should not be allowed to practice medicine without a medical license by deeming prescriptions of FDA approved medications to be invalid; and

Whereas, The physician, having the patient's medical history and current conditions at hand, is in the best position to provide appropriate medical treatment for the optimized patient outcome; therefore, be it

RESOLVED, to amend P130.025 as follows:

P 130.025 PRESCRIPTION OFF-LABEL MEDICATION

The FMA shall adopt the following policy on physician off-label prescribing of medications:

1. Off-label prescribing of medications is necessary to the practice of medicine.
2. The FMA is opposed to the interference by ~~non- medical~~ any entities in the physician-patient relationship by restricting a physician's ability to prescribe medications off-label.
3. The FMA affirms American Medical Association Policy H-120.988, Patient Access to Treatments Prescribed by Their Physicians.

Fiscal Note:

Description	Amount	Budget Narrative
1 staff hour	$40	Can be accomplished with current staff
Total	$40	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: I – Health, Education, & Public Policy

Reference Committee II

Reference Committee No. II
Finance and Administration

Saturday, August 6, 2022
10:00 a.m. – 11:30 a.m.

Members:

Michael Forsthoefel, M.D.	Capital
Larry Halperin, M.D.	Florida Orthopedic Society
Elizabeth Orr, M.D.	Fl. Academy of Family Physicians
Brence Sell, M.D.	Florida Society of Anesthesia
Bruce Shephard, M.D.	Hillsborough
Janet West, M.D.	Duval

Agenda:
Board of Governors Report B

1. Board Recommendation B-1: Bylaws Amendment

Resolutions:

22-201	PAC Participation
22-202	Addressing Disenfranchisement of FMA Members
22-203	Submitting Resolutions
22-204	FMA Delegate Pledge
22-205	Do No Harm to Colleagues

Treasurer's Report

Report B
of the Board of Governors

Douglas Murphy, M.D., FMA President and Chair

The Board of Governors submits the following report to the House of Delegates. This report contains **one recommendation** and a summary of major actions taken on issues related to finance, administration, bylaws, and other sections. Also included in this report are activities as reported by the Committee on Bylaws, Committee on Finance & Appropriations, Florida AMA Delegation, and Medical Student Section, etc.

RECOMMENDATION B-1

Bylaws Amendment
Chapter III, House of Delegates
Section 6. Delegates to the House of Delegates of the American Medical Association

That the Board of Governors recommend to the House of Delegates that the FMA Bylaws be amended to provide that the FMA House of Delegates elect half of the representatives to the House of Delegates of the American Medical Association at each Annual Meeting. And that each year, shortly after the FMA House of Delegates adjourns, that representatives decide by secret ballot who shall serve as a delegate and who shall serve as an alternate delegate from the FMA at the AMA House of Delegates.

Section 6. DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

The House of Delegates shall elect from the active members of the Association representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body and these bylaws in such manner that one-half of the ~~delegates~~ representatives to which the Association is entitled are elected each year. In the event the Association is entitled to an odd- number of ~~delegates~~ representatives, the majority of the ~~delegates~~ representatives (half plus one) shall be elected the first year and the remainder shall be elected the next year. Each ~~delegate~~ representative shall be elected for a two-year term. The ~~delegates~~ representatives shall be elected by secret ballot ~~in such a manner that the candidates with the highest number of votes cast shall be elected to fill the number of delegate seats available for election that year~~. ~~Notwithstanding the two-year term for which delegates are elected, beginning with the Association's Annual Meeting in 1999, delegates elected as r~~ Representatives to the House of Delegates of the American Medical Association shall assume office immediately upon adjournment of the House of Delegates at which they were elected.

Shortly after the adjournment of the FMA House of Delegates, the representatives to the House of Delegates of the American Medical Association shall decide, by secret ballot, who shall serve as a delegate and who shall serve as an alternate delegate until the next meeting of the FMA House of Delegates.

~~There shall also be elected an equal number of alternate delegates. The candidates with the next highest order of votes cast shall be elected as alternate delegates, provided that one alternate delegate seat shall be filled by a member of the Young Physicians Section.~~

~~Early in the electoral year, the delegates and alternate delegates~~ The representatives ~~to the American Medical Association~~ shall also meet and elect by secret ballot the officers of the delegation, who may be

either delegates or alternate delegates to the American Medical Association.

Description	Amount	Budget Narrative
staff hours	$	Can be accomplished with current staff
		No Fiscal Impact.

Committee on Finance and Appropriations & Audit Committee

Major Board Actions:

- The remaining mortgage was paid on the FMA's Legislative Office
- The 2022 budget was approved
- Accepted the audited consolidated financial statements and other financial information report of the Florida Medical Association, Inc. and other subsidiaries for years ending December 31, 2021 and 2020
- Accepted the audited financial statements of the Florida Medical Association Political Action Committee for years ending in December 31, 2021 and 2020

AMA Delegation

Informational Items:

- The 2021 AMA Interim Meeting was held virtually. The major focus of the delegation was the 9.75% proposed CMS pay cuts, which the Florida delegation asked the AMA to take immediate action on.
- The delegation also advocated for a resolution that would end budget neutrality.
- Letter sent to the AMA disapproving of the new House of Delegates procedures.
- Due to Covid-19 the State Advocacy Conference was changed from in-person to a virtual format. FMA leaders made a trip to Washington to lobby the Florida Congressional delegation on their own in lieu or attending virtual meetings.
- The FMA delegation to the AMA will require medical students and residents to obtain an endorsement form from the delegation in order to officially participate in the AMA Annual and Interim meetings.
- 232 resolutions were submitted at the AMA Annual Meeting this year.
- Dr. Howard thanked Shari Hickey and the entire FMA staff for their role in a successful AMA Annual Meeting in Chicago.
- In conjunction with the FMA's federal lobbying team, advocacy trips to Washington D.C. are being planned.

Other

Major Board Actions:

- A task force to study the resolution and House of Delegates process was appointed: Ashley Norse, M.D., Chair, Fraser Cobbe, Ronald Giffler, M.D., Jason Goldman, M.D., Corey Howard, M.D., Joshua Lenchus, D.O., Jay Milson, Michael Patete, M.D., Mark Rubenstein, M.D., Douglas Murphy, M.D.

- The task force met with California and North Carolina Medical Societies to discuss their resolutions and House of Delegates processes
- The task force reviewed the matrix from the AMA to determine resolution priorities

- Appointed a CEO Search Committee: Andy Robinson, Chair, Douglas Murphy, M.D., Joshua Lenchus, D.O., Michael Patete, M.D., Ashley Norse, M.D., Ronald Giffler, M.D., and Vincent DeGennaro, M.D.
  - Approved using operating reserves to pay for the services of CRG Leadership Institute
  - Approved using operating reserves to pay for a search firm (Korn Ferry), to assist in hiring a new CEO
  - Chris Clark was hired as FMA CEO
- In response to Resolution 21-103, a task force was appointed to study the impact of nonphysician training and clinical faculty practices, hospitals, and medical centers: Todd Wills, M.D., Chuck Riggs, M.D., Elizabeth DeVos, M.D., Cyneetha Strong, M.D., Barry Gelman, M.D.
- In response to Board Recommendation D-2, a task force was appointed to further study initial assessment and treatment recommendations by specialists: Amra Resic, M.D., Cynthia Miller, M.D., Tra'chella Johnson Foy, M.D., Aaron Sudbury, M.D., Michael Howell, M.D., and Jeffery Berman, M.D.
- Approved hotel contracts
- Approved spending $100,000 on a joint public relations campaign with the Florida Academy of Family Physicians
- Approved to postpone assessing fees to students and residents until Spring 2022
- Approved the creation of the FMA Medical Student Section Honor Society
- Approved the updated FMA Human Resources Manual
- Adopted substitute language in lieu of Resolution 21-206
- Approved to not adopt Resolution 21-310 and Resolution 21-312

Resolution 21-206
Employed Physician
Broward County Medical Association

House Action: Referred to the Board of Governors for decision; substitute language adopted

RESOLVED, The FMA publicize the services that are currently available for employed physicians that include but are not limited to contract evaluation, workplace issues, and a forum where concerns can be voiced.

Discussion: The Board discussed this resolution at length and was divided over the issue. It is estimated that at least 50% of FMA membership is comprised of employed physicians. A substitute resolution was adopted.

Resolution 21-310
Restrictive Covenants
Polk County Medical Association

House Action: Referred to the Board of Governors for decision; not adopted

RESOLVED, That the Florida Medical Association adopts a policy to oppose restrictive covenants andnon-complete clauses as it applies to physicians.

Discussion: In October 2021, the Board of Governors studied Resolution 21-310 and 21-310 together. It was noted that similar resolutions (19-202 and 19-317) came to the Board of Governors for decision last year, were studied in depth, and a substitute resolution was adopted. Given the similarities of the resolutions from last year, the Board of Governors voted to not adopt Resolutions 21-310 and 21-312. Below are the Board's findings from May 2021.

May 2021: In May 2020, the Board of Governors discussed this resolution at length and analyzed the arguments for and against the use of restrictive covenants by physicians in Florida. Given that there are valid arguments on both sides of the issue, the Board of Governors conducted a thorough study of physician non-compete clauses in Florida and considered whether any changes to the current Florida statute are needed. At the June 18, 2020 conference call, the Board instructed FMA staff to conduct an in-depth study and evaluation of Florida's non-compete statute. At the May 2021 Board of Governors Meeting, the FMA General Counsel presented the findings of an in-depth study on Florida's restrictive covenant statute. After considerable discussion, the Board concluded that the best approach would be to educate physicians through a variety of methods including webinars, white papers, CME programs, and other means on the legal and practical aspects of restrictive covenants.

Resolution 21-312
Physician Contract Non-Compete Clause
Escambia County Medical Society

House Action: Referred to the Board of Governors for decision; not adopted

RESOLVED, That within one year the FMA Board of Governors choose between a legislative vs constitutional amendment strategy to limit enforcement of non-compete clauses in physician contractsto those cases where termination of the contract is sought by the physicians within two years of the initial employer physician contract.

Discussion: See 21-310

Informational Items:

- The Florida Academy of Family Physicians and the FMA have partnered with the Dalton Agency to develop an overarching campaign theme that serves as the unifying element that promotes physicians as the head of the health care team.
    - The "Physician Decision" campaign is aimed at educating patients on the differences between a physician other health care providers.
    - As of May, the website had a 94% video completion rate with Orlando, Jacksonville, and Tampa driving the most traffic to the website.
    - The next steps include an influencer marketing campaign, planned social media content, leveraging healthcare awareness dates, draft articles, and generate one unique piece of

content per month to be amplified on the website, social media, in media pitching, and newsletters.

Resolution 22-201
PAC Participation
Andrew Borom, M.D.

Whereas, The Mission of the Florida Medical Association is "Helping Physicians Practice Medicine;" and

Whereas, The primary method of providing legislative relief and support to physicians is via lobbying of the Florida Legislature and Executive; and

Whereas, The development of a Legislature and Executive receptive to the needs and wants of physicians is vital, and without which the FMA would have remarkably low success; and

Whereas, The FMA PAC is the primary method utilized by physicians to engage with and support candidates who support physicians, which requires substantial monetary input, coming from a disproportionately low percentage of the FMA membership; and

Whereas, Any resolution requesting that the FMA "seek" or "support" legislation requires substantial expenditure of finite political capital; and

Whereas, The participation rate of physicians, both within and outside of the FMA for the FMA PAC is pathetically low, thus decreasing our ability to effect positive outcomes in the legislature that would help physicians practice medicine; therefore be it

RESOLVED, That any County or specialty Medical society wishing to put forward a resolution to the floor of the FMA House of Delegates be required to have a minimum participation percentage in the FMA PAC of 20% of its overall membership, and 100% of its Delegation; and be it further

RESOLVED, That any individual wishing to put forth a resolution to the FMA HOD is required to be an FMA PAC member at the $10,000 club level in the current election cycle.

Fiscal Note:

Description	Amount	Budget Narrative
15 staff hours	$900	Can be accomplished with current staff
Total	$900	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: II – Finance & Administration

Resolution 22-202
Addressing Disenfranchisement of FMA Members
Jon Ward, M.D.

Whereas, The current composition of the FMA House of Delegates does not allow for dues paying FMA members to have a voice in the organization unless they are members of their County Medical Society or their State Specialty Society; and

Whereas, In the last several meetings a majority of the chartered county and specialty societies have had their delegate allocations go unfilled; and

Whereas, The bylaws of the FMA should encourage and enfranchise physician members throughout the state regardless of their association with other organizations; and

Whereas, There are only 26 county medical societies despite the fact there are 67 counties in the state of Florida. These counties represent a population of over 3.5 million Floridians; and

Whereas, Large, rapidly growing counties like Pinellas, Pasco, and Hernando, are unrepresented in our current House of Delegates; and

Whereas, Chartered county medical societies are treated differently than recognized specialty societies in that each county is given credit for every FMA member in their county while the specialty societies are only given credit for their active dues paying members who are also FMA members; and

Whereas, Many FMA members who live in counties with local medical societies have philosophical, economic, and political differences with the leadership of their counties and choose not to participate locally; and

Whereas, The trend toward regional societies is a good one and we should support those efforts; however we should treat each county in the state exactly the same regardless of how it's local society is structured; therefore be it

RESOLVED, The FMA change the bylaws to create a new section referred to as the Unaffiliated Section to represent its members who are not a county medical society member; and be it further

RESOLVED, That all 67 counties in Florida be allocated one voting delegate position and additional delegate position based on the current one per forty member ratio; and be it further

RESOLVED, That these Unaffiliated Section delegate positions be awarded through the FMA membership office on a first come, first serve basis; and be it further

RESOLVED, That societies that encompass more than one county retain its single delegate per county and each county within its area continue to be represented in the one per forty ratio in these calculations; and be it further

RESOLVED, That societies that encompass more than one county must fill its delegate allocation based on the county of practice or residence of its members, and be it further

RESOLVED, That after the roster submission deadline 60 days prior to the annual meeting that any unfilled position any county, specialty, or other section may be filled by the FMA membership office on a first come, first serve basis.

Fiscal Note:

Description	Amount	Budget Narrative
60 staff hours	$5,800	Can be accomplished with current staff
Total	$5,800	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: II – Finance & Administration

Resolution 22-203
Improving The Process For Submitting Resolutions To The Florida Medical Association Annual Meeting
Ellen W. McKnight, M. D.

Whereas, The Florida Medical Association is to be commended for attempting to modernize the process of bringing resolutions to our annual meeting with the continued goal of greater involvement of delegates; and

Whereas, The delegates must feel is that the new rules are fair and responsive to the current needs of our society; and

Whereas, COVID-19 necessitated certain procedural changes and those changes should be formalized if appropriate or canceled if inappropriate; and

Whereas, In order to avoid close contact during COVID, a new rule allowed delegates to submit commentary regarding resolutions to the reference committees in advance of the annual meeting, and, in 2021, the reference committees issued their recommendations regarding resolutions on the Friday evening before the Saturday in-person reference committee meeting had even taken place, signaling their “pre-determined” position on the resolutions; and

Whereas, The early release of the recommendations by the reference committee has the potential to stifle participation and may contribute to delegates feeling like the” fix” is in; and

Whereas, In 2021, a resolution affirming the superior protection provided by natural immunity in protecting healthcare workers who had previously been infected with COVID was discussed in reference committee. Those who disagreed with the resolution offered substitute language which called for the FMA to immediately recommend universal vaccination even in those healthcare workers with previous COVID infection. The author of the original resolution strenuously objected to the substitution language during the reference committee. The committee chose to adopt the substitution language, going completely against the original intent of the physician author. Because parliamentary procedure calls for the substitute resolution to be voted on first on the floor of the house of delegates, the original resolution language was never discussed or voted on by the delegates, only the substitution language. This resulted in a gross distortion of the process whereby the true intent of the physician author was never heard or debated by the house of delegates and, the opposing physicians, who did not submit a resolution through the normal process, were able to make FMA policy; therefore be it

RESOLVED, The FMA shall allow delegates to submit commentary to the reference committees before the annual meeting but the reference committees shall be prohibited from issuing recommendations for or against the resolutions until the in-person reference committee has convened; be it further

RESOLVED, The FMA shall prohibit the reference committees from adopting substitution language to a resolution unless agreed to by the author of the resolution. The reference committee can still make any other appropriate recommendations including the recommendation not to adopt. This shall not prohibit any delegate from offering substitution language during floor debate in the house of delegates.

Fiscal Note:

Description	Amount	Budget Narrative
0 staff hours	$0	Can be accomplished with current staff
Total	$0	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: II – Finance & Administration

Resolution 22-204
FMA Delegate Pledge
Diane Gowski, M.D.

Whereas, The FMA plays a major role in shaping healthcare policy in our state; and

Whereas, It is incumbent upon the FMA, in developing statewide healthcare policies, to follow the principle of subsidiarity; and

Whereas, FMA membership is not contingent upon AMA membership status; therefore be it

RESOLVED, FMA delegates will annually pledge allegiance to " best serve " the healthcare needs of our Florida citizens, regardless of any conflicting AMA or WHA policies. This is to occur at the beginning of the annual meeting of FMA delegates.

Fiscal Note:

Description	Amount	Budget Narrative
1 staff hours	$40	Can be accomplished with current staff
Total	$40	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: II – Finance & Administration

Resolution 22-205

FMA Delegate Pledge: Do No Harm to Colleagues

Diane Gowski, M.D.

Whereas, It is incumbent upon the FMA to foster professional collegiality within its organization and especially among FMA delegates; and

Whereas, It is essential for FMA delegates to maintain a ' united front ' in order to combat any spirit of division among physician colleagues; therefore be it

RESOLVED, That FMA delegates will annually pledge to " DO NO HARM " toward colleagues and to maintain professional collegiality and respectful behavior toward each other. This is to occur at the beginning of the annual FMA delegates meeting.

Fiscal Note:

Description	Amount	Budget Narrative
1 staff hour	$40	Can be accomplished with current staff
Total	$40	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: II – Finance & Administration

AM '22

FMA Annual Meeting 2022

Reference Committee III

Reference Committee No. III
Legislation

Saturday, August 6, 2022
10:00 a.m. – 11:30 p.m.

Members:

Jason Wilson, M.D., Chair	Fl. Ch. American College of Surgeons
Megan Core, M.D.	Physicians Society of Central Florida
Michael Cromer, M.D.	Fl. Academy of Family Physicians
Michelle Falcone, M.D.	Florida Society of Ophthalmology
David Halperin, M.D.	Florida Society of Plastic Surgeons
Michael Murphy, M.D.	Hillsborough
Daniel Thimann, M.D.	Duval

Agenda:
Board of Governors Report C

Resolutions:

22-302	Expanding the Use of Narcan
22-303	Transparency of Costs for Prescribers
22-304	Public Availability of Pregnancy Related Care
22-305	Cultural Competency in Medical Schools
22-306	Artificial Intelligence
22-307	Ivermectin
22-308	Employed Physician Non-Compete Contracts
22-309	Corporate Practice of Medicine
22-310	Prevention of Surprise Hospital Out Patient Billing
22-311	Dedicated On-Site Physician Requirements for Emergency Departments
22-312	Home and Birth Center Safety
22-313	Electronic Prescribing
22-314	Opposition to Permitless Gun Carry
22-315	Abortion
22-316	Anti-Abortion

Report C
of the FMA Board of Governors

Douglas Murphy, M.D., President and Chair

The Board of Governors submits the following report to the House of Delegates. This report contains a summary of major actions taken on recommendations from the Council on Legislation and the Florida Medical Association Political Action Committee (FMA PAC).

Council on Legislation

Major Board Actions:

- Approved the FMA's 2022 Legislative Agenda
- Reviewed and approved recommendations to reaffirm public policies from 2014
  - (See Recommendation A-1)
- Reviewed and approved recommendations to sunset policies from 2014
  - (See Recommendation A-2)
- Resolution 21-303 Country of Origin Designation was not adopted
- Resolution 21-313 Corporate Practice of Medicine was adopted as amended by deletion

Resolution 21-303
Country of Origin Designation

Hillsborough County Medical Association

House Action: Referred to the Board of Governors for decision; not adopted

> RESOLVED, That the Florida Medical Association seek legislation to require the labeling "Country of Origin" on all the generic medications dispensed by local and online pharmacies.

Discussion: The Board of Governors referred this resolution to the Council on Legislation to study. Testimony on behalf of the resolution noted that greater transparency as to the country of origin of prescription drugs would greatly benefit patient safety. While noting that patient safety in this sphere is a laudable goal, a legal analysis of the factors that would have to be considered in any effort to pass legislation requiring country of origin labeling was conducted. Existing federal regulations on prescription drug labeling were discussed, along with corresponding state laws. Federal preemption was discussed and noted as a potential roadblock to state legislation. Practical considerations presented by the difference between FDA regulations and those enforced by the US Customs Headquarters were discussed, and finally, it was noted that there was pending federal legislation that would impose country of origin disclosure statements on online advertising. Based on the numerous problems, both legal and practical posed by the resolution's request, the Board decided that pursuing state legislation on this issue was not a wise use of FMA resources.

Resolution 21-313
Corporate Practice of Medicine

South Florida Caucus

House Action: Referred to the Board of Governors for decision; adopted as amended by deletion

RESOLVED, That FMA will prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in Florida. The results of this review will be compiled into a resource and announced to members as an available electronic download; and be it further

~~RESOLVED, That the FMA will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital owned physicians whose site will be taken over by a corporate entity by providing, upon review of the legality of the corporation obtaining the contract for physician services; and be it further~~

~~RESOLVED, That FMA will seek legislation for the further restriction of the corporate practice of medicine similar to dentistry and optometry statutes, limiting ownership of physician practices or groups to physicians only.~~

Discussion: A study on the corporate practice on medicine was conducted (Attachment I). The Board of Governors concluded that the preparation of a comprehensive review of the legal and regulatory matter related to the corporate practice of medicine and fee splitting in Florida would be within the capability of the FMA staff and would be a useful resource for physicians. The Board, however, noted legal problems with providing legal representation to individual members and concluded that provided written review of the legality of proposed practice acquisitions is not a service the FMA can provide.

The Board also determined that legislation restricting the corporate practice of medicine is not an objective that can be obtained given the current status of the law and the opposition of a significant portion of FMA members. Accordingly, the Board adopted the first resolved, while deleting the second and third.

Informational Items:

- Approved the Legislative Compendium updates
- The 2022 legislative session concluded Monday March 14, accounting for a three-day extension to finalize the state budget. The FMA team of lobbyists tracked 310 bills and numerous amendments that either directly or indirectly concerned the practice of medicine in Florida.
    - COVID-19 Liability Protection Extension: Through SB 7014, the FMA was able to secure a one-year extension of liability protection for COVID-19 related healthcare claims
    - Expansion of Telehealth: Effective July 1, 2022 authorized prescribers will be able to prescribe Schedule III, IV, and V controlled substances via telehealth. The FMA will continue to work toward payment parity for telehealth services.
    - Emergency Medical Care for Minors: The FMA was successful in passing HB 817, expanding the emergency care protections in 743.064 of the Florida Statutes. Effective July 1, 2022 physicians will be able to provide emergency medical treatment to minors anywhere such treatment is needed- not just in hospitals and college health services.
    - Medical Education Loan Forgiveness: The FMA was able to secure an appropriation of $6 million for medical education student loan reimbursement for physicians practicing primary care in rural or underserved areas as determined by the Department of Health.
    - Step Therapy Protocol: The FMA successfully advocated for the passage of HB 459, which will give physicians more power in fighting insurance mandated step therapy protocols.

- Uterine Fibroid Research Education: The legislation creates a centralized database within the Department of Health to collect information on uterine fibroids including prevalence, demographics of women with uterine fibroids, and treatments and procedures utilized by healthcare practitioners.
- Scope of Practice: This year the FMA stopped several scope-of-practice expansion bulls from receiving even a single committee hearing. The FMA's advocacy also prevented the filing of other scope initiatives that would have allowed unqualified optometrists to perform laser surgery and promote deceptive name changes such as physician assistance to "physician associate" and nurse anesthetist to "nurse anesthesiologist."
- Wrongful Death: The DMA defeated legislation that would increased rates for medical malpractice insurance and healthcare costs in general.

FMA PAC

Major Board Actions:

- Approved appointments to the FMA PAC Board of Directors

Informational Items:

- In October 2021, Ronald Giffler, M.D., reported that over $1 million had been raised to date but warned the next election cycle will be very expensive.
- In January 2022. Ronald Giffler, M.D., reported that the PAC raised a total of $1,266,884 in 2021 which the most raised since tracking each election cycle began in 2009.
    - The PAC is on track to raise over $2.5 million this cycle.

Resolution 21-313
Corporate Practice of Medicine in Florida

Resolution 21-313 from the 2021 FMA Annual Meeting, referred to the Board of Governors for decision, requests the FMA to accomplish the following:

- Prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in Florida. The results of this review will be compiled into a resource and announced to members as an available electronic download.
- Provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for physician services.
- Seek legislation for the further restriction of the corporate practice of medicine similar to dentistry and optometry statutes, limiting ownership of physician practices or groups to physicians only.

The Corporate Practice of Medicine Doctrine

Put simply, the "corporate practice of medicine" ("CPOM") doctrine generally prohibits non-licensed persons, including individuals and business entities, from employing physicians to practice medicine on their behalf. The CPOM doctrine is a legal concept that has developed over time that prohibits business entities from profiting from the practice of medicine or directly employing a physician to provide professional medical services. The doctrine has been shaped by state medical practice acts, attorney general opinions, state board of medicine pronouncements and court opinions. Prominent among these is the universal requirement that only licensed individuals may practice medicine. The doctrine has also been shaped by a number of public policy concerns, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation's obligation to its shareholders may not align with a physician's obligation to his/her patients, and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgment. The main concern is that is business entities owned by non-physicians are permitted to control the rendering of care, they will subordinate clinical care to commercial considerations and profits.

Overview of State Laws

The AMA did an analysis of state laws regarding the corporate practice of medicine in 2015 and found that while most states prohibit the corporate practice of medicine, every state provides an exception for professional corporations and/or certain other types of entities to employ physicians. The scope of the exception varies among the states:

> For example, every state allows for the creation of professional corporations, which are corporations organized for the specific purpose of rendering a professional service. State

statutes often specify how the professional corporations should be structured, who can participate as shareholders or owners and who must serve on the board of directors. Most states restrict the shareholders, owners, or board of directors of a professional corporation to persons licensed to render the same professional service as the professional corporation. For example, in Arkansas "[a]ll of the officers, directors, and shareholders of a corporation subject to this subchapter shall at all times be persons licensed pursuant to the Arkansas Medical Practice Act." Other states allow non-physician owners or shareholders, but often limit such ownership to a minority percent. For example, Colorado's statute provides that all shareholders of a medical corporation must be licensed to practice medicine in the state of Colorado except that one or more persons licensed by the board as a physician assistant may be a shareholder as long as the physician shareholders maintain majority ownership of the corporation. In addition, some states allow for the creation of multi-service corporations which are corporations organized by physicians and other health care providers. For example, in Rhode Island physicians, dentists, registered nurses, podiatrists, optometrists, physician assistants, chiropractic physicians, physical therapists, psychologists, and midwives or nurse-midwives can form a professional corporation in which they engage in a combination of their professions.

Many states also provide for an exception to the corporate practice of medicine to allow for the employment of physicians by certain entities. This exception varies by state, with some states explicitly permitting hospitals to employ physicians, some states allowing nonprofit hospitals to employ physicians and other states recognizing an unwritten exception to the corporate practice of medicine for hospitals employing physicians.

Many states that allow hospitals to employ physicians specifically prohibit the hospital from interfering with the independent medical judgment of the physician, thereby protecting the autonomy of the physician's clinical decision making. For example, statutes in Texas allow critical access hospitals, sole community hospitals, and hospitals in counties with fewer than 50,000 people to employ physicians subject to certain protections, including a requirement that physicians must "retain independent medical judgment in providing care to patients at the hospital and other health care facilities owned or operated by the hospital and may not be disciplined for reasonably advocating for patient care." Similarly, in California certain clinics and hospitals may employ physicians as long as the clinic or hospital does "not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon[.]" Indiana's statute provides that an employment or other contractual relationship between a physician and hospital or health system does not constitute the unlawful practice of medicine if the entity does not direct or control independent medical acts, decisions, or judgments of the licensed physician." In Illinois a physician may be employed by a hospital or hospital affiliate, however, the employed physician and employing entity shall "sign a statement acknowledging that the employer shall not unreasonably exercise control, direct, or interfere with the employed physician's exercise and execution of his or her professional judgment in a manner that adversely affects the employed physician's ability to provide quality care to patients." Professional judgment is further defined as "the exercise of a physician's independent clinical judgment in providing medically appropriate diagnosis, care, and treatment to a particular patient at a particular time."

If the FMA were to seek legislation to adopt a ban on the corporate practice of medicine, it would be necessary to define exactly what type of employment is affected and what type of legal entity is a prohibited employer. The "corporate practice of medicine" means many different things depending on the state law at issue. As evident from the AMA's treatise and other state law comparisons (See Appendix 1) the ways to structure such a ban are numerous.

Corporate Practice of Medicine in Florida

There are no state laws in Florida that directly address the corporate practice of medicine. While noting this fact, several reviews of state laws on the corporate practice of medicine (see Appendix 1) conclude that Florida appears to prohibit the CPOM based on an Attorney General's advisory opinion from 1955. This opinion was summarized in a University of Miami Law School law review article thusly:

> CORPORATIONS. *Practice of medicine.* A corporation, whether or not operated for profit, may not practice medicine or surgery in this state directly, because of its inability, as a legal entity, to obtain a license. Nor can it practice indirectly by hiring licensed member of the profession to do the actual professional work involved. It is immaterial whether the compensation to the licensed person so hired be on a straight salary basis or in the form of a contractual percentage arrangement. Were such a practice allowed, it would leave the public unprotected from the capers of " ... quacks, charlatans, and others whose greed would be masked under the practice of one of the healing arts."

This AG opinion has been ignored by everyone except entities trying to figure out the status of the law in Florida. In Florida today, physicians are employed by multiple types of legal entities, from traditional professional associations to for-profit corporations. The owners of these entities are even more varied, and range from hospitals to venture capitalists to health insurance companies. Part IX of Chapter 400 of the Florida Statutes, the "Health Care Clinic Act" (discussed below) indirectly acknowledges the legality of several types of these entities.

More directly, the Florida Board of Medicine, through the advisory opinion process, has clearly stated that Florida law does not prohibit a Florida licensed physician from practicing medicine in the employment of a corporation. *In Re: The Petition for Declaratory Statement of: John W. Lister, M.D., 9* FALR 6299 (1987); *In Re: The Declaratory Statement of: Conrad Goulet, M.D.,* Florida Board of Medicine Case No. 89-BOM-01 (1989); *In Re: The Petition for Declaratory Statement of: Emergency Medical Associates of New Jersey, P.A.,* Final Order No. DOH-03-1018 (2003).

Based on the definitive position of the Florida Board of Medicine, there appears to be universal agreement among health care attorneys in Florida that physicians are free to engage in employment relationships with any type of legally sanctioned entity - hospitals, health insurers, insurance companies, group practices not wholly owned by physicians, etc.

Health Care Clinic Licensure

In response to the problems posed by the ownership of physician practices by non-physicians (predominately among practices providing services to individuals injured in automobile accidents), the

legislature passed the "Health Care Clinic Act" in 2003. This legislation requires any entity that provides health care services to individuals and charges for reimbursement for such services to obtain a license from the Agency for Health Care Administration to operate the clinic in Florida.

There are numerous exceptions to this licensure requirement, with many included in the original legislation, and several having been added over the years. For physicians, the most notable exception is found in section 440.9905(4)(f) and (g):

> (f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.
>
> (g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner if one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) which provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

In their never-ending quest to root out automobile insurance fraud, the legislature added language that provides that despite all of the numerated exceptions, an entity that provides and charges for health care services is deemed a clinic and must be licensed in order to receive reimbursement under Florida's Motor Vehicle No Fault Law, unless exempted under s. 627.736(5)(h). This statute again exempts wholly owned physician practices and other entities as set forth below:

> (h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:
> 1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;
> 2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;
> 3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;
> 4. A hospital or ambulatory surgical center licensed under chapter 395;
> 5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395;
> 6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;
> 7. An entity that is certified under 42 C.F.R. part 485, subpart H; or
> 8. An entity that is owned by a publicly traded corporation, either directly or indirectly through its subsidiaries, that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners if one or more of the persons responsible for

the operations of the entity are health care practitioners who are licensed in this state and who are responsible for supervising the business activities of the entity and the entity's compliance with state law for purposes of this section.

While the Health Care Clinic Act in no way prohibits the corporate practice of medicine, it does recognize the problems that exist when medical practices are not wholly owned by physicians. The licensure requirements imposed by the Act are an effort to "prevent significant cost and harm to consumers" (referred to as "patients" by those providing medical care).

Florida's Prohibition on the Corporate Practice of Dentistry and Optometry

Florida has specific statutes that prohibit the corporate practice of dentistry and optometry.

For dentists, the statute provides as follows:

466.0285 - Proprietorship by nondentists.

(1) No person other than a dentist licensed pursuant to this chapter, nor any entity other than a professional corporation or limited liability company composed of dentists, may:
(a) Employ a dentist or dental hygienist in the operation of a dental office.
(b) Control the use of any dental equipment or material while such equipment or material is being used for the provision of dental services, whether those services are provided by a dentist, a dental hygienist, or a dental assistant.
(c) Direct, control, or interfere with a dentist's clinical judgment. To direct, control, or interfere with a dentist's clinical judgment may not be interpreted to mean dental services contractually excluded, the application of alternative benefits that may be appropriate given the dentist's prescribed course of treatment, or the application of contractual provisions and scope of coverage determinations in comparison with a dentist's prescribed treatment on behalf of a covered person by an insurer, health maintenance organization, or a prepaid limited health service organization.

Any lease agreement, rental agreement, or other arrangement between a nondentist and a dentist whereby the nondentist provides the dentist with dental equipment or dental materials shall contain a provision whereby the dentist expressly maintains complete care, custody, and control of the equipment or practice.

(2) The purpose of this section is to prevent a nondentist from influencing or otherwise interfering with the exercise of a dentist's independent professional judgment. In addition to the acts specified in subsection (1), no person who is not a dentist licensed pursuant to this chapter nor any entity that is not a professional corporation or limited liability company composed of dentists shall enter into a relationship with a licensee pursuant to which such unlicensed person or such entity exercises control over the following:
(a) The selection of a course of treatment for a patient, the procedures or materials to be used as part of such course of treatment, and the manner in which such course of treatment is carried out by the licensee;
(b) The patient records of a dentist;
(c) Policies and decisions relating to pricing, credit, refunds, warranties, and advertising; and
(d) Decisions relating to office personnel and hours of practice.

(3) Any person who violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
(4) Any contract or arrangement entered into or undertaken in violation of this section shall be void as contrary to public policy. This section applies to contracts entered into or renewed on or after October 1, 1997.

For optometrists, the prohibition on corporate practice is found in section 463.014, and provides as follows:

(1)(a) No corporation, lay body, organization, or individual other than a licensed practitioner shall engage in the practice of optometry through the means of engaging the services, upon a salary, commission, or other means or inducement, of any person licensed to practice optometry in this state. Nothing in this section shall be deemed to prohibit the association of a licensed practitioner with a multidisciplinary group of licensed health care professionals, the primary objective of which is the diagnosis and treatment of the human body.
(b) No licensed practitioner shall engage in the practice of optometry with any corporation, organization, group, or lay individual. This provision shall not prohibit licensed practitioners from employing, or from forming partnerships or professional associations with, licensed practitioners licensed in this state or with other licensed health care professionals, the primary objective of whom is the diagnosis and treatment of the human body.
(c) No rule of the board shall forbid the practice of optometry in or on the premises of a commercial or mercantile establishment.
(d) No licensed practitioner may practice under practice identification names, trade names, or service names, unless any dissemination of information by the practitioner to consumers contains the name under which the practitioner is licensed or that of the professional association in which the practitioner participates. Any advertisement or other dissemination of information to consumers may contain factual information as to the geographic location of licensed practitioners or of the availability of optometric services.
(e) No licensed practitioner shall adopt and publish or cause to be published any practice identification name, trade name, or service name which is, contains, or is intended to serve as an affirmation of the quality or competitive value of the optometric services provided at the identified practice.
(2) A corporation or labor organization may employ licensed practitioners to provide optometric services to bona fide employees of such corporation and members of their immediate families or to bona fide members of such labor organization and members of their immediate families, provided the provision of such services is incidental to the legitimate business of such corporation or labor organization. Nothing in this section shall be deemed to authorize the employment of licensed practitioners by corporations or organizations formed primarily for such purposes.

These examples could serve as model language for legislation to prohibit the corporate practice of medicine in Florida. Note that the dental provision applies to contracts entered into or renewed on or after a set date. Legislation seeking to apply the prohibition to contracts already in effect would face problems with state and federal constitutional protections.

Florida's Prohibition on Physician Fee-Splitting - Florida's Patient Brokering Act

The first resolved of Resolution 21-313 seeks a comprehensive review of the legal and regulatory matters related to the "corporate practice of medicine" and "fee splitting" in Florida. While there are no

state statutes that regulate the corporate practice of medicine, there are specific statutory provisions that regulate physician fee-splitting (and federal laws as well). The issue is complicated, and since the Resolution does not ask for legislative changes to the laws on fee-splitting, a short summary of Florida's fee-splitting laws is provided below.

Section 817.505 of the Florida Statutes (The Florida Patient Brokering Act)("PBA") makes it a crime for any person, including a health care provider, to:

> (a) Offer or pay a commission, benefit, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of a patient or patronage to or from a health care provider or health care facility;
> (b) Solicit or receive a commission, benefit, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring a patient or patronage to or from a health care provider or health care facility;
> (c) Solicit or receive a commission, benefit, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for the acceptance or acknowledgment of treatment from a health care provider or health care facility; or
> (d) Aid, abet, advise, or otherwise participate in the conduct prohibited under paragraph (a), paragraph (b), or paragraph (c).

A similar statute, section 456.054, is applicable to all health care providers:

> ## 456.054 - Kickbacks prohibited.
>
> (1) As used in this section, the term "kickback" means a remuneration or payment, by or on behalf of a provider of health care services or items, to any person as an incentive or inducement to refer patients for past or future services or items, when the payment is not tax deductible as an ordinary and necessary expense.
> (2) It is unlawful for any health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients.
> (3)(a) It is unlawful for any person or any entity to pay or receive, directly or indirectly, a commission, bonus, kickback, or rebate from, or to engage in any form of a split-fee arrangement with, a dialysis facility, health care practitioner, surgeon, person, or entity for referring patients to a clinical laboratory as defined in s. 483.803.
> (b) It is unlawful for any clinical laboratory to:
> 1. Provide personnel to perform any functions or duties in a health care practitioner's office or dialysis facility for any purpose, including for the collection or handling of specimens, directly or indirectly through an employee, contractor, independent staffing company, lease agreement, or otherwise, unless the laboratory and the practitioner's office, or dialysis facility, are wholly owned and operated by the same entity.
> 2. Lease space within any part of a health care practitioner's office or dialysis facility for any purpose, including for the purpose of establishing a collection station where materials or specimens are collected or drawn from patients.
> (4) Violations of this section shall be considered patient brokering and shall be punishable as provided in s. 817.505.

In addition, there is a provision in the medical practice act (section 458.331(1)(i), Florida Statutes) that makes is grounds for disciplinary action for:

(i) Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

Some of the conduct prohibited by these statutes is obvious. An ophthalmologist cannot pay an optometrist a fee for each surgery performed on a patient that was referred to the ophthalmologist by the optometrist. This law, however, covers more than just cash payments for specific referrals. It applies to almost any form of remuneration and covers more than referral payments for specific patients by health care providers in separate practices. Giving or receiving items such as sports tickets, restaurant gift certificates, or concert tickets for referrals will be considered an illegal kickback. Even taking someone to an event or meal can be considered an illegal kickback if it is intended to induce referrals.

While the prohibition on referrals from outside a practice group is relatively clear, it is important to note that the law also applies to referrals from within the group practice. A physician practice group may not pay an employee to induce him or her to refer patients to the group for ancillary or other services. Employees of the group practice (as well as independent contractors) can be compensated for services that the employee or contractor actually performs or provides but cannot be paid or rewarded for services they order, such as an x-ray or a referral.

The Patient Brokering Act does have a number of exceptions. Most notably, the law does not apply to payments that are not prohibited by the federal anti-kickback statute (42 U.S.C. s. 1320a-7b(b)). The PBA also does apply to the following payment practices:

(b) Any payment, compensation, or financial arrangement within a group practice as defined in s. 456.053, provided such payment, compensation, or arrangement is not to or from persons who are not members of the group practice.

(c) Payments to a health care provider or health care facility for professional consultation services.

(d) Commissions, fees, or other remuneration lawfully paid to insurance agents as provided under the insurance code.

(e) Payments by a health insurer who reimburses, provides, offers to provide, or administers health, mental health, or substance abuse goods or services under a health benefit plan.
(f) Payments to or by a health care provider or health care facility, or a health care provider network entity, that has contracted with a health insurer, a health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse goods or services under a health benefit plan when such payments are for goods or services under the plan. However, nothing in this section affects whether a health care provider network entity is an insurer required to be licensed under the Florida Insurance Code.

(g) Insurance advertising gifts lawfully permitted under s. 626.9541(1)(m).

(h) Commissions or fees paid to a nurse registry licensed under s. 400.506 for referring persons providing health care services to clients of the nurse registry.

(i) Payments by a health care provider or health care facility to a health, mental health, or substance abuse information service that provides information upon request and without

charge to consumers about providers of health care goods or services to enable consumers to select appropriate providers or facilities, provided that such information service:
1. Does not attempt through its standard questions for solicitation of consumer criteria or through any other means to steer or lead a consumer to select or consider selection of a particular health care provider or health care facility;
2. Does not provide or represent itself as providing diagnostic or counseling services or assessments of illness or injury and does not make any promises of cure or guarantees of treatment;
3. Does not provide or arrange for transportation of a consumer to or from the location of a health care provider or health care facility; and
4. Charges and collects fees from a health care provider or health care facility participating in its services that are set in advance, are consistent with the fair market value for those information services, and are not based on the potential value of a patient or patients to a health care provider or health care facility or of the goods or services provided by the health care provider or health care facility.

(j) Any activity permitted under s. 429.195(2).

The exact parameters of the PBA and the interplay with the federal anti-kickback law are complex. To understand the law as it applies to an individual transaction, it is necessary to examine not only the text of the state and federal laws, but also the implementing regulations, OIG opinions, and the court decisions interpreting the state and federal laws.

EXHIBIT 1

WHAT PHYSICIANS NEED TO KNOW ABOUT THE CORPORATE PRACTICE OF MEDICINE
COHEN HEALTHCARE LAW GROUP

The old days of getting a medical degree and hanging up a shingle by your office are long gone. Most doctors who have a private practice begin their medical career or advance their medical career by considering the best business formation. Formation possibilities include a solo practice, a partnership with other doctors, or working relationships with other hospitals and existing practices.

Experienced healthcare lawyers will review the various options. They'll also review what laws apply. Many states, such as California, prohibit the corporate practice of medicine. Some states allow for exceptions. Physicians also need to consider whether their business and medical relationship might violate Stark Law or the Anti-Kickback Statues.

Decisions about business formation and medical practice issues become more complicated as physicians expand their medical service practices and expand who the physician works with. Developing a medical spa or acupuncture practice to complement a pain management practice, for example, may sound like a great idea, but if the employees at the medical spa aren't licensed physicians, complications can arise.

It's more than just physicians who must understand the corporate practice of medicine issues. Any health venture that wants to set up a clinic or a venture that provides health services needs to understand how corporate practice of medicine applies to them as well.

The corporate practice of medicine concept across the United States

The corporate practice medicine laws were designed for many reasons, according to the American Medical Association (AMA). These reasons include the following concerns:

- If corporations can hire physicians or practice medicine, then the practice of medicine will become commercialized.

- The obligation of a physician should be solely to his/her patient and not to company profits. Physicians should be able to make patient decisions based on independent medical judgment – what's best for the patient.
- Corporations owe a fiduciary duty to their shareholders which may not comport with the doctor's duties to his/her patients

<u>An overview of state corporate practice of medicine laws</u>

The AMA states that the corporate practice of medicine laws are generally based on a variety of issues:

- The individual state statutes
- Case decisions
- Opinions of the attorneys general of the various states
- The positions of the state medical licensing boards

While most states prohibit the corporate practice of medicine, states do provide for professional medical corporations. Many states also have exceptions for employment of doctors by specific entities. These exceptions do vary from state to state.

States the do permit professional medical corporations do regulate:

- How the corporation can be structured
- Who can be a shareholder
- Who can be on the board of directors

Most state laws require that the owners, board of directors, and shareholders must be licensed to render the *"same professional service as the professional corporation."* There are some states that permit non-physicians owners and shareholders – provided that the combined ownership interest is in the minority.

- *"For example, Colorado's statute provides that all shareholders of a medical corporation must be licensed to practice medicine in the state of Colorado except that one or more persons licensed by the board as a physician assistant may be a shareholder as long as the physician shareholders maintain majority ownership of the corporation."*
- In another example of broader ownership interest, in *"Rhode Island; physicians, dentists, registered nurses, podiatrists, optometrists, physician assistants, chiropractic physicians, physical therapists, psychologists, and midwives or nurse-midwives can form a professional corporation in which they engage in a combination of their professions."*

There are many states that have an exception for the employment of doctors by certain entities such as hospitals. Some states grant broad permission for hospitals to hire

doctors. Some require that the hospital be a nonprofit. Others, like California, mostly prohibit hospitals from hiring doctors.

When states do give hospitals the right to hire doctors, there is normally a requirement that the hospital cannot interfere with the "autonomy of the physician's clinical decision making."

- *"For example, statutes in Texas allow critical access hospitals, sole community hospitals, and hospitals in counties with fewer than 50,000 people to employ physicians subject to certain protections, including a requirement that physicians must "retain independent medical judgment in providing care to patients at the hospital and other health care facilities owned or operated by the hospital and may not be disciplined for reasonably advocating for patient care."*
- According to the AMA, California, which has one of the nation's strongest prohibitions against the corporate practice of medicine provides that some hospitals and clinics can hire doctors provided the hospital or clinic *"doesn't interfere with, control, or otherwise direct the professional judgment of a physician and surgeon."* In California, according to the DHHS Office of Inspector General, *"the prohibition does not apply to clinics operated by university medical schools or to public hospitals."*
- Similarly, Indiana's laws also permit hospitals and doctors from entering into employment contracts provided the hospitals don't control or direct the doctor's independent medical judgment.
- In Illinois, hospitals can employ doctors if the doctor signs a statement to the same effect – that the doctor's judgment must be an independent medical judgment as to diagnosis, care, and treatment.
- Some states set forth the independent judgment in the state statutes and codes. In other states, such as Alabama, the state medical licensing commission and the state board of medical examiners authorized hospital hiring of physicians where the agreement specifically requires that the doctor makes all judgments concerning what medical services the patient should receive.

Both doctors and hospitals need to understand that there are dangers in any employment relationship, which should be reviewed by an experienced healthcare lawyer. Professional agreements may also violate Stark Law and the Anti-Kickback statute unless it's clear than an exception or a safe harbor applies.

California's law on the corporate practice of medicine

California's law on prohibiting the corporate practice of medicine is one of the strictest in the nation. The law on the corporate practice of medicine in California is fairly complex. Even the Medical Board of California has this advisory on its website.

*"Note: This area of law can be complicated, therefore **physicians are encouraged to discuss their medical practices and business enterprises with appropriately knowledgeable legal experts**. The Medical Board of California continues to receive complaints and inquiries about the law, and some repeating issues are presented here."*

The two governing statutes on the corporate practice of medicine are:

- **The Medical Practice Act, Business and Professions Code section 2052**. This statute, provides:

"Any person who practices or attempts to practice, or who holds himself or herself out as practicing…[medicine] without having at the time of so doing a valid, unrevoked, or unsuspended certificate…is guilty of a public offense."

- **Business and Professions Code section 2400**, within the Medical Practice Act, provides in pertinent part:

"Corporations and other artificial entities shall have no professional rights, privileges, or powers."

As with the other states, the core idea behind the prohibition is that if unlicensed doctors make any medical judgments that would constitute both the unauthorized practice of medicine and the corporate practice of medicine. **It's the link that's the concern. Corporations shouldn't be the people deciding medical issues because that would constitute the unauthorized practice of medicine**.

Decisions that are medical and not business or management decisions

Examples of medical judgments that must be made by physicians include:

- Analyzing which diagnostic tests such as blood tests or MRIs are required for specific medical complaints and disorders
- Determining when a doctor needs to consult with a medical specialist or refer a patient to a medical specialist – or to another physician
- Deciding what treatment options are advisable and what overall medical care is required for the patient

While the number of patients a doctor must see in a set time (day, week, and month) might seem like a business decision, the Medical Board of California states that the quantity of patients treated by a physician is also a medical decision.

There are many decisions which physicians and medical practices make that may seem like they're more business choices than medical choices. When the choices are clearly business choices, then an independent entity such as a management service organization (MSO) may be qualified to make them. The Medical Board of California requires that only a physician licensed in California make the following decisions:

- *"Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a California-licensed physician.*
- *Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.*
- *Setting the parameters under which the physician will enter into contractual relationships with third-party payers.*
- *Decisions regarding coding and billing procedures for patient care services.*
- *Approving of the selection of medical equipment and medical supplies for the medical practice."*

It *"may"* be permissible for a doctor to consult with an MSO or non-licensed physician about the above items but ultimately the licensed physician must make the final decision.

Additional decisions that may appear business-related that are indeed medical and must be made by a physician include:

- A business relationship in which someone who is not a licensed California doctor owns or runs a company that provides an evaluation, a diagnosis, care, or treatment to the patient.
- Physicians cannot operate a medical practice *"as a limited liability company, a limited liability partnership, or a general corporation."*
- While management service organizations (MSOs) can generally provide administrative staff and services for a medical practice, MSOs cannot arrange for medical services, advertise for medical services, or provide medical services.
- Physicians cannot act as a *"medical director"* unless the physicians own the medical practice. *"For example, a business offering spa treatments that include medical procedures such as Botox injections, laser hair removal, and medical microdermabrasion, that contracts with or hires a physician as its "medical director."*

According to the Medical Board of California, *"It is important to note that pursuant to Business and Professions Code section 2417.5, a business organization that offers to provide or provides outpatient elective cosmetic medical procedures or treatments that is not in compliance with the ban on the corporate practice of medicine is guilty of knowingly*

making or causing to be made a false or fraudulent claim for payment of a health care benefit pursuant to paragraph (6) of subdivision (a) of Section 550 of the Penal Code."
All states want to ensure that physicians are doing what is best for the patient. One of the ways states help to regulate a physician's practice is to ensure that the doctor's business relationships are managed so that the doctor or the medical practice only has one boss – the patient. The corporate practice of medicine laws generally require that doctors create professional medical corporations and that any working relationship with a hospital be based on helping the patient, not the financial well-being of the hospital. States like California take an aggressive approach that most health care ventures may cross the line into the corporate practice of medicine.

Contact Cohen Healthcare Law Group, PC for legal counsel on healthcare transactions, regulatory compliance, and FDA and FTC law. Our experienced healthcare & FDA attorneys advise healthcare companies and healthcare providers ranging from medical centers, to integrative and functional medicine practices, cosmetics and supplement companies, and medical device manufacturers.

EXHIBIT 2

States' Treatment of the Corporate Practice of Medicine Doctrine

Summary:

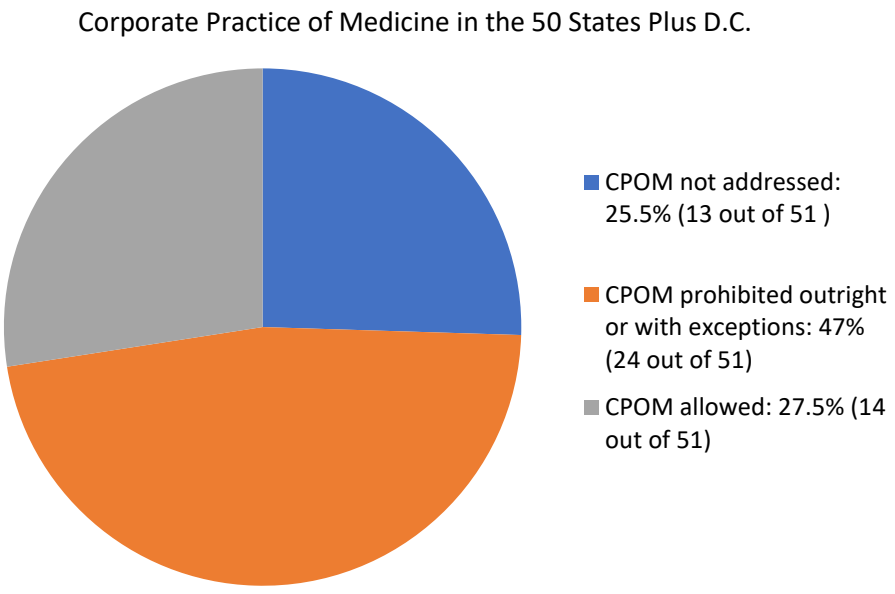
The corporate practice of medicine doctrine (CPOM) prohibits corporations – other than professional service corporations – from employing health care professionals. The information contained herein focuses on CPOM as it relates to physicians.

Most states allow some form of corporate practice of medicine, whether by permitting all CPOM or allowing exceptions to general prohibitions. Fourteen out of the 50 states plus Washington, D.C. allow CPOM, most with the stipulation that a corporation may not interfere with a physician's independent medical judgment and control of care.

Another 24 states prohibit CPOM, but many of those states allow exceptions. The most common exception is for hospitals, and some states also allow nonprofits and health maintenance organizations (HMOs) to employ physicians. Additionally, some states with prohibitions on CPOM fail to enforce them, indicating more common corporate practice than the state laws reflect.

Finally, 13 states have not addressed the issue of CPOM in their statutes, cases, or administrative decisions.

The overall trend shows states are moving toward a greater acceptance of CPOM. Most of the states that either allow CPOM or prohibit it with exceptions have instituted those allowances or exceptions within the last 10 or 20 years.



Alabama: CPOM is allowed if a corporation preserves the physician's independent judgment.
Alaska: Not addressed.
Arizona: CPOM prohibited in case law for optometry and dentistry. Not specifically prohibited for other health care professions.
Arkansas: CPOM prohibited. Exceptions for hospitals and HMOs.
California: CPOM prohibited. Exceptions for 1) clinics operated by public or private nonprofit university medical schools, 2) clinics run by nonprofit corporations exclusively for research or

charitable purposes, 3) narcotics treatment programs, and 4) hospitals owned by health care districts.

Colorado: CPOM prohibited. Exception for hospitals that preserve physicians' independent judgment.

Connecticut: CPOM prohibited in case law for dentistry. Not specifically prohibited for other health care professions.

Delaware: Not addressed.

District of Columbia: Not addressed.

Florida: CPOM is not addressed for physicians, while statutes ban CPOM for dentists as well as for chiropractors with numerous exceptions. CPOM is prohibited by a 1955 attorney general opinion.

Georgia: CPOM prohibited.

Hawaii: Not addressed.

Idaho: CPOM prohibited.

Illinois: CPOM prohibited. Exception for licensed hospitals and hospital affiliates.

Indiana: An employment contract between a physician and a hospital, physician, psychiatric hospital, HMO, health facility, dentist, registered or licensed practical nurse, midwife, optometrist, podiatrist, chiropractor, physical therapist, or psychologist is allowed as long as the physician maintains independent medical judgment.

Iowa: CPOM is allowed if a corporation preserves physicians' independent judgment.

Kansas: CPOM prohibited. Exception for hospitals.

Kentucky: Case law from the 1930s and 1940s indicates CPOM is prohibited, but Kentucky Board of Medical Licensure opinions from the 1990s allow CPOM.

Louisiana: CPOM is allowed if a corporation preserves physicians' independent judgment.

Maine: Not addressed.

Maryland: CPOM prohibited. Exceptions for hospitals and HMOs.

Massachusetts: CPOM prohibited.

Michigan: CPOM prohibited. Exception for nonprofits, including hospitals.

Minnesota: CPOM prohibited. Exception for nonprofits.

Mississippi: CPOM is allowed if a corporation preserves physicians' independent judgment.

Missouri: CPOM is allowed.

Montana: Not addressed.

Nebraska: CPOM allowed.

Nevada: CPOM prohibited. Exception for nonprofits.

New Hampshire: Not addressed.

New Jersey: CPOM prohibited. Exceptions for: 1) licensed HMOs, hospitals, short-term care facilities, ambulatory care facilities, or other health care facilities, 2) corporations not in the business of providing health care services but maintaining a first-aid clinic, 3) nonprofits sponsored by a union, or social, religious, or fraternal organization providing health care services to members only, 4) accredited educational institutions maintaining a clinic for students and faculty, 5) licensed insurance carriers.

New Mexico: CPOM is allowed if a corporation preserves physicians' independent judgment.

New York: CPOM prohibited. Exceptions for nonprofit medical or dental expense indemnity corporation or a hospital service corporation.

North Carolina: CPOM prohibited. Exceptions for nonprofits and public hospitals.

North Dakota: CPOM prohibited.

Ohio: An attorney general opinion from 1952 prohibits CPOM. However, a 1997 amendment to state law allows CPOM as long as it does not hinder physicians' independent judgment.
Oklahoma: CPOM prohibited. Exception for hospitals.
Oregon: CPOM prohibited. Exception for hospitals.
Pennsylvania: CPOM allowed for a health care facility, defined as any facility providing clinically related health services.
Rhode Island: Not addressed.
South Carolina: CPOM prohibited.
South Dakota: CPOM is allowed if a corporation preserves physicians' independent judgment *and* does not profit from the practice of medicine.
Tennessee: CPOM is allowed if a corporation preserves physicians' independent judgment.
Texas: CPOM prohibited.
Utah: CPOM is allowed if a corporation preserves physicians' independent judgment.
Vermont: Not addressed.
Virginia: CPOM allowed.
Washington: CPOM prohibited.
West Virginia: CPOM prohibited.
Wisconsin: CPOM prohibited.
Wyoming: Not addressed.

Source: Michal, Pekarske, and McManus, National Hospice and Palliative Care Organization, Corporate Practice of Medicine Doctrine 50 State Survey Summary (2006), http://www.nhpco.org/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf.

Resolution 22-302

Expanding the Use and Availability of Naloxone in Florida Communities

FMA Medical Student Section

Whereas, Drug overdose in the United States has been the leading cause of injury related death since 2009 and continues to increase[1]; and

Whereas, Opioid-specific drug overdose has been the leading cause of injury-related death since 2016[1]; and

Whereas, In 2019, there were 1,190 related prescription opioid overdose fatalities and 2,873 related synthetic opioid overdose fatalities in Florida, with the rate of synthetic opioid overdoses increasing by 14.4% since 2018[2]; and

Whereas, The COVID-19 pandemic has further exacerbated the opioid epidemic throughout the nation, and especially, in Florida. According to the Florida Medical Commissioners Drug Report in 2020, 6,089 opioid-caused deaths were reported, which is a 42 percent increase (1,795 more) than 2019[3]; and

Whereas, Naloxone (Narcan) is an opioid antagonist that promptly reverses the effects of opioid overdose with no significant side effects[4]; and

Whereas, Increased access to naloxone has been recommended by both the Centers for Disease control and the United States surgeon general to patients taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose[5,6]; and

Whereas, Take-home naloxone has been suggested as a community-based intervention by the Centers for Disease Control and Prevention and the US Food and Drug Administration to patients who receive prescribed opioids, have suspected opioid use disorder, engage in non-prescribed drug use, and/or have the risk of witnessing and opioid overdose[7,8]; and

Whereas, Mandating the prescription of narcan to those at increased risk of overdose in all US states (including Florida) is a key public health strategy to prevent fatal opioid overdoses[9]; and

Whereas, Broader uptake of naloxone in the community has been estimated to prevent 21,000 deaths over a 10 year period, and shown to be more efficacious than further restrictions on opioid prescriptions and expanding medications for addiction treatment[9]; and

Whereas, Narcan is an affordable medicine. The Florida Department of Health reports that the average cost of a two-dose narcan kit is $75[10]; and

Whereas, In Florida in 2017, Centers for Disease Control and Prevention reported that the cost of fatal opioid overdose is $37,473.7 million and the per capita cost of fatal opioid overdose is $1,786[11]; therefore be it

RESOLVED, That our Florida Medical Association supports legislation that increases use and availability of naloxone in Florida communities; and be it further

RESOLVED, That our Florida Medical Association supports legislation to promote the development and implementation of naloxone as a community-based intervention to prevent lethal opioid overdose.

Fiscal Note:

Description	Amount	Budget Narrative
200 staff hours	$30,000	Can be accomplished with current staff
Total	$30,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

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11. Morbidity and Mortality Weekly Report (*MMWR*)-State-Level Economic Costs of Opioid Use Disorder and Fatal Opioid Overdose — United States, 2017. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7015a1.htm. Updated April 2021.

RELEVANT FMA POLICY

P 125.001 SUBSTANCE ABUSE TREATMENT CENTERS The Florida Medical Association adopts policy for increasing awareness of substance abuse treatment centers in Florida as follows: (1) Education (a) stress prevention at an early age; (b) encourage early referrals for treatment; (c) educate the public and health care professionals as to screening, treatment and other resources available. (2) Funding (a) encourage funding from private insurers and government funding; (b) reduce cost of care while effectively treating the person with substance abuse; (c) encourage parity for treatment of substance abuse from both private and government insurers; (d) seek cost-effective methods of care and reduce recidivism while encouraging research and utilization evidence-based medicine. (BOG November 2004) (Reaffirmed as amended HOD 2012)

P 130.010 TREATMENT OF OPIOID DEPENDENCE (ARCHIVED) (Res 05-36, HOD 2005) (Sunset HOD 2014)

P 130.020 ENSURING THAT PHYSICIANS HAVE ACCESS TO THE SAFEST MEDICATIONS WHEN TREATING CHRONIC PAIN IN A COMPLEX REGULATORY ENVIRONMENT The Florida Medical Association supports requiring insurance companies in the State of Florida to have multiple long-acting opioids with abuse deterrent technology on both their tier one and tier two level pharmacy benefits. (Amended Res 16-411, HOD 2016)

P 130.023 POINT OF CARE MEDICATION DISPENSING The FMA should continue to educate members on point of care dispensing of medications consistent with F.S. 465.0276, Dispensing Practitioner. (Substitute Res 19-311, HOD 2019)

Resolution 22-303

Improving Price Transparency of Medical Goods and Services

Medical Student Section

Whereas, In an effort to slow the growth in health care spending and promote patient sovereignty, hospitals are required to provide clear, accessible pricing information online about medical services and products[1]; and

Whereas, The price transparency rule under the Centers for Medicare and Medicaid Services was enacted January 1, 2021 in accordance with President Biden's Competition Executive Order[1]; and

Whereas, Many hospitals are not in compliance with the price transparency rule[1]; and

Whereas, Health care navigation and accessing price-list data has significant barriers and requires high health literacy for patients to be well-informed consumers[2]; and

Whereas, Price transparency tools have led to a decrease in prices of shoppable services[3]; and

Whereas, The burden falls greater on physicians, as stewards of patient financial resources, with increased barriers accessing price data[4]; and

Whereas, Clinicians often overestimate benefits and underestimate harms of healthcare interventions[5]; and

Whereas, Price transparency has been shown to facilitate conversation of out-of-pocket coverage for patients, while not changing physician order patterns[6]; and

Whereas, Increasing price transparency is associated with increased volume, revenue, and patient satisfaction[7]; and

Whereas, Displaying insurance allowable fees for laboratory tests to ordering clinicians reduces the burden of more expensive test orders[8]; and

Whereas, Patient price shopping is often deferred to clinician judgment [9]; and

Whereas, Efforts by insurance companies aim to curb healthcare spending while maintaining price obscurity, such as tiering or high-deductible health plans, which are used to direct patients towards lower quality care or discourage patients from seeking appropriate care[10]; and

Whereas, Models for physician-directed price transparency already exist, such as mandated inclusion of drug costs in the electronic medical record[11]; and

Whereas, Current practice guidelines incorporate physician awareness of price variability and high treatment costs[12]; and be it further,

RESOLVED, That the FMA supports legislation that requires hospitals and insurers to provide transparent pricing information for common goods and medical services offered.

RESOLVED, That the FMA supports legislation to promote the development and implementation of universal price transparency tools.

Fiscal Note:

Description	Amount	Budget Narrative
200 staff hours	$30,000	Can be accomplished with current staff
Total	$30,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

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Notes:

- House/senate bills introduced and most recent session?
- Private practice; no insurance, cash only
- The price we pay
- BOG meeting perspective

Related FMA Policy

Originally written by Dr. Andrew Cooke as a suggested amendment to resolution 21-304; Pharmacies to Inform Physicians When Lower Cost Medication Options 21 are on Formulary, Capital Medical Society which was referred to the Board of Governors for review (updated in 10/2021):

> *"RESOLVED, That the FMA supports legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient."*

Amended to say (but we don't think this was ever actually officially recommended):

> *RESOLVED, That the FMA seek legislation or regulatory action that would require each insurance company to make available to physicians and patients an accessible and user-friendly dashboard that would list the out-of-pocket costs of medications and costs of the formulary alternatives for each pharmacy, and an enforcement mechanism to promote insurance company compliance. This pertains to all commercial insurers, Medicaid, Medicare, and Tricare.*

P 300.027 ACTION TO ENSURE ACCESS TO HEALTHCARE AND CHOICE OF PHYSICIAN The Florida Medical Association (FMA) engage in discussions with all other state medical associations and the American Medical Association (AMA) to devise a method to challenge the federal government on its ability to engage in anti-competitive behaviors, price fixing and predatory pricing and initiate a national campaign with willing allies to pass the Medicare Patient Empowerment Act within the FMA budget; and further asks the AMA: 1) to commit to a well- funded legislative and grassroots campaign to ensure passage of legislation that prohibits everyone including the Federal Government from detrimental anti-competitive price fixing and predatory pricing in the U.S. Congress; and 2) immediately begin its well-funded legislative and grassroots campaign to pass the Medicare Patient Empowerment Act so that all patients can have access to the highest quality of healthcare and further report back to the FMA House of Delegates annually in regards to this matter. (Res 14-404, HOD 2014) (Reaffirmed Res 16-402, HOD 2016)

P 300.030 PHARMACY BENEFIT MANAGERS

The Florida Medical Association supports legislative and regulatory measures that would increase transparency for PBMs by requiring them to disclose at least once a year when there is a price increase in the wholesale acquisition cost, and the aggregate amount of rebates and discounts they receive from manufacturers; and the Florida Medical Association will support legislation that would require coinsurance, deductibles, and other cost-sharing requirements to be calculated based off of a drug's actual net price, and not the inflated list price; and the Florida Medical Association support legislation that would require a PBM to provide notice to patients and physicians if it makes changes to its (1) formulary, (2) step therapy protocol, or (3) prior authorization requirements in such a way that it results in a drug not to be covered. (Motion 2-17- 30, BOG May 2017)

P 260.044 TRANSPARENCY
The Florida Medical Association will support legislation that requires health insurance companies to provide their subscribers with itemized statements on prescription coverage that accurately reflect actual payments made, rather than misleading statements about the amount of money the patient "saved." (Amended Res 17- 308, HOD 2017)

Comments:

- Timeline attached
- Hospitals to resolve clauses? Private practice included
- PBMs is major issue- pharmacy benefit management (sits between insurance and pharmacy and dictates what is appropriate for people)

Resolution 22-304
Public Availability of Pregnancy-Related Care
Medical Student Section

Whereas, existing FMA policy such as P 100.001 and P 255.005 support availability of contraception for all persons, including the use of emergency contraception; and

Whereas, Contraceptive use provides noncontraceptive benefits that play a key role in the general medical care of women[1]; and

Whereas, Abortion is a safe and effective medical procedure[2,3]; and

Whereas, The federal legal precedent that the 14th Amendment of the United States Constitution protects a pregnant woman's liberty to choose to have an abortion without excessive government restriction was established by the US Supreme Court decision on *Roe v. Wade* (1973)[4]; and

Whereas, Subsequent decisions by the U.S. Supreme Court in *Planned Parenthood v. Casey* (1992) and *Whole Woman's Health v. Hellerstedt* (2016) have upheld the right to abortion and limited the government's ability to place restrictions on access that present an "undue burden" to patients[5,6]; and

Whereas, Barriers to abortion care contribute to socioeconomic disparities, as women of lower SES are more likely to experience unwanted pregnancies[7,8]; and

Whereas, Being denied an abortion is associated with increasing financial distress, doubling of unpaid debts, and an increase in bankruptcies and evictions[9]; and

Whereas, The American College of Obstetrics and Gynecology (ACOG), the American College of Physicians (ACP), and the American Academy of Family Physicians (AAFP) forcefully oppose legislative efforts that interfere with the patient-physician relationship in the matter of abortion[10,11]; and

Whereas, The Texas Medical Association (TMA) published a statement in September 2021 opposing Senate Bill 8 of Texas' 87th legislative session and Senate Bill 4 of the special session, stating that they "criminalize the practice of medicine" and "interfere with the patient-physician relationship"[12]; and

Whereas, Only 13 states have strengthened abortion access protection in state law[13]; and

RESOLVED, That our FMA reaffirm policy P 5.002 which states: "The Florida Medical Association supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities…;" and be it further,

RESOLVED, That our FMA oppose any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both; and be it further [**copied from AMA H373.995**]

RESOLVED, That our FMA amend policy P 255.005 "Availability of Contraceptives for Recipients of Public Assistance" to read as follows:

PUBLIC AVAILABILITY OF PREGNANCY-RELATED CARE ~~CONTRACEPTIVES FOR RECIPIENTS OF PUBLIC ASSISTANCE~~ The Florida Medical Association supports legislation that ensures all persons ~~should~~ have access to appropriate forms of pregnancy-related care, including contraception and abortion, regardless of financial means, and that persons receiving public assistance should have all appropriate forms of pregnancy-related care ~~contraceptives~~ available to them, and that public funds be available for this; and further supports that persons requesting financial assistance (including Aid for Dependent Children) should be counseled concerning the timing of a desired pregnancy and the use of pregnancy-related care ~~contraceptives~~, and pregnancy-related care ~~contraceptives~~ should be made available to them with the clear understanding and reassurance that granting of requested aid will not be influenced by their acceptance or rejection of pregnancy-related care ~~contraceptives~~.

Fiscal Note:

Description	Amount	Budget Narrative
staff hours	Unknown	Unable to determine staff hours required from the 2nd resolve
Total	Unknown	Unknown impact on the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

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Relevant FMA Policy (from Compendium):

P 5.001 ABORTION CIVIL DAMAGES The Florida Medical Association supports legislation containing the concept that provides that no person shall be liable in civil damages for any act or omission that results in a person being born alive instead of aborted. (Supp Rpt.BOG Rpt C, HOD 1985) (Reaffirmed HOD 1995) (Reaffirmed HOD 2005)(Reaffirmed HOD 2013)

- I think this essentially means that if an abortion is unsuccessful, the provider is not liable for an civil damages. Not relevant to the current proposal.

P 5.002 ABORTION POLICY STATEMENT The Florida Medical Association supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities. Abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state. No physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case as long as the withdrawal is consistent with good medical practice (BOG Rpt A, HOD 1993) (Reaffirmed HOD 2003) (Reaffirmed as amended, BOG May 2012)

- A tepid statement acknowledging the place for abortion as a medical matter not unlike many others. If providers are not comfortable with the practice they are able to recuse themselves from the case.
- Has not been reaffirmed since 2012 and to date (9 Sept 2021) FMA has not reaffirmed this statement nor expressed opposition to Texas-style abortion ristrictions in Florida.
- This statement does not support codifying the right to safe and effective reproductive health care, including abortions.

P 5.003 REPEAL OF THE FLORIDA STATE LEGISLATION ON NON-MEDICAL TESTING The Florida Medical Association supports the repeal of the Florida state legislation requiring non-medical testing of those seeking to legally terminate a pregnancy. (Res 11-302, HOD 2011) (Reaffirmed HOD 2019)

- Unsure which legislation is being referred to or if this was actively sought out.

P 255.005 AVAILABILITY OF CONTRACEPTIVES FOR RECIPIENTS OF PUBLIC ASSISTANCE The Florida Medical Association supports legislation that all persons should have access to appropriate forms of contraception regardless of financial means, and that persons receiving public assistance should have all appropriate forms of contraceptives available to them, and that public funds be available for this; and further supports that persons requesting financial assistance (including Aid for Dependent Children) should be counseled concerning the timing of a desired pregnancy and the use of contraceptives, and contraceptives should be made available to them with the clear understanding and reassurance that granting of requested aid will not be influenced by their acceptance or rejection of contraceptives. (Res 93-67, A-1993) (Reaffirmed HOD 2005) (Reaffirmed HOD 2013)

- Policy has not been reaffirmed since 2013.
- Could potentially amend this to be inclusive of pregnancy termination services?

P 100.001 ACCESS TO EMERGENCY CONTRACEPTION The Florida Medical Association (FMA) adopts policy of the American Medical Association (AMA) concerning access to emergency contraception and pharmacies and pharmacists' duty to fill prescriptions as developed at the 2005 AMA Annual Meeting. The FMA will work with appropriate organizations to support state legislation that will allow physicians

to dispense medication to their own patients when there is not a pharmacist within a thirty mile radius who is able and willing to dispense that medication. (Res 05-35; HOD 2005) (Reaffirmed HOD 2013).

- Policy has not been reaffirmed since 2013.

Resources:

AMA-MSS Proposal | State and Federal Action to Protect Abortion Access (Molly Benoit)

- We can talk to Molly, a Miami Miller student, to potentially use most of this language in an FMA resolution.

AMA-MSS Resolution Writing Guide

Codifying Roe v Wade and Abortion Access (2021) | Boston Review
S.1975 Women's Health Protection Act of 2021 | US Senate
S.1021 Equal access to abortion coverage in health insurance (EACH) Act of 2021 | US Senate
Righting the Course: Abortion Access in the United States | Guttmacher Policy Review
AMA, Other Medical Organizations File Amicus Brief Against Texas SB8 | Newsweek

Notes:

- Proposal should focus on actively opposing legislation that limits access to reproductive health care, including abortions, and actively supporting legislation that protects right to safe and effective reproductive health care, including abortions.
- Mention how SB8-like bill would infringe upon patient-provider relationship and content of communication with patients requesting reproductive health counseling.
- Mention relevant AMA policy in support of the position that people have the right to terminate pregnancies (see Molly's proposal above).
- Mention socio-economic burden that essentially complete abortion ban would have on people having unintended pregnancies, particularly low-income women.
- If possible, find facts and figures relevant to Florida re: who would be impacted, public opinion, etc.
- If possible, highlight the need for expedited review of this resolution since the next FL legislative session begins in Jan 2022 and the next updates for FMA policy will be months later.
    - Senate President Wilton Simpson (R) and FMA-endorsed House Speaker Chris Sprowls (R) both expressed interest in introducing similar restrictive legislation during the next session in which anti-choice politicians have a majority.

Resolution 22-305
Cultural Competency Curriculum in the State of Florida
FMA Medical Student Section

Whereas, Cultural competence is conventionally defined as a set of consistent behaviors, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations[1]; and

Whereas, Regarding reports from the 2016 National Ambulatory Medical Care Survey, less than half of respondents received organized cultural competency training in either medical school, residency, or post-residency. Overall, only two-thirds of respondents reported receiving cultural competence training at some point[2]; and

Whereas, Patients were more satisfied with physicians who were noted to exude motivation to learn about other cultures, perceived their physicians as more facilitative, and reported seeking and sharing more information during the medical visit[3]; and

Whereas, Wide variation in the conceptualization, implementation, and evaluation of cultural competence training programs leads to differences in training quality[1]; and

Whereas, Adding cultural competency education improved the knowledge, attitudes and skills of health professionals and medical students as well as improved patient satisfaction[1,4-6] ; and

Whereas, The state of Florida is moving toward a majority-minority population[7]; and

Whereas, Healthcare professional cultural values strongly influence informed patient care, the patient-provider relationship, communication, and quality of treatment[8]; and

Whereas, Empirical evidence has supported that holding negative implicit racial biases can influence clinical decision making and behavior when encountering patients from different racial or cultural backgrounds; and,[9-11]

Whereas, Cultural competency is essential to promote and assess in order to create mutually beneficial, non-paternalistic patient-doctor relationships[12]; and be it further,

RESOLVED, That the FMA support legislation requiring the implementation of cultural competency training in medical education, postgraduate and continuing medical education through the creation of CME modules for medical students, residents, and attending physicians.

Fiscal Note:

Description	Amount	Budget Narrative
100 staff hours	$15,000	Can be accomplished with current staff
Total	$15,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

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Resolution 22-306
Artificial Intelligence
Medical Student Section

Whereas, Artificial intelligence (AI) systems have been increasingly implemented in the healthcare space[1]; and

Whereas, AI systems are performing increasingly complex tasks which directly affect patient outcomes[1]; and

Whereas, AI is not held to codified ethical standards, is prone to biases, [2] and can create or exacerbate bias in providers[3]; and

Whereas, AI represents the future of healthcare, particularly in resource-poor regions where program biases can be the most harmful to patient outcomes[3-5]; and

Whereas, AI developed with machine learning does not always clearly demonstrate how the system draws its conclusions[6]; and

Whereas, AI systems that deal with personal information of patients have been mandated by several state governments and the FDA to demonstrate explainability in their decision making[7-11]; and

Whereas, AI systems that augment rather than replace human clinical decision have been shown to be more effective, [6,12-14] are better trusted, and more widely utilized by physicians[15-17]; and

Whereas, AMA Policy Augmented Intelligence in Health Care H-480.939 supports augmenting humans with AI clinical decision support tools rather than utilizing independent AI actors; and

Whereas, FMA POLICY P 220.001 MEDICAL INFORMATION TECHNOLOGY states that "to minimize the potential for adverse patient care consequences, hospitals must obtain input from the medical and nursing staff before implementing medical information technology decisions;" and

Whereas, FMA POLICY P 220.001 MEDICAL INFORMATION TECHNOLOGY further outlines patients' rights as in the AI-augmented healthcare space to include that "All systems must ensure that the physician caring for the patient retain primary control and responsibility over patient care information, subject to the rights of patients to access and release their healthcare information; all systems must secure the privacy of patient care information, including the right to privacy relating to government and insurance entities, subject to the right of the patient to release their FMA Public Policy Compendium 38 healthcare information;" and

Whereas, AI technology has the potential to encroach upon physician autonomy in the realm of patient care and reduce reimbursement for services currently provided[18,19]; and

Whereas, Large scale implementation programs for AI tools have found physicians requesting education on the tools' design in order to implement and improve them[15,20]; and

Whereas, The current state of medical education on AI is inadequate for preparing practitioners for the future of the profession[21,22]; and

Whereas, AMA Augmented Intelligence in Medical Education H-295.857 supports enhanced training across the continuum of medical education regarding AI and recommends the creation of specialty-specific entities to educate and evaluate the implementation of AI in their respective fields; and

Whereas, Improper implementation of AI tools due to misunderstanding of systems' capabilities and internal processes has led to medicolegal issues[4,5]; therefore be it

RESOLVED, That our FMA support legislation that prevents AI programs and AI-derived algorithms from becoming the sole determinants of clinical decision making; and it further

RESOLVED, That our FMA support legislation preventing healthcare entities from being reimbursed for medical decision making performed by AI programs and AI-derived algorithms alone; and be it further

RESOLVED, That our FMA support legislation requiring a physician to endorse/sign-off/approve of any reimbursable action taken by an AI program or AI-derived algorithm; and be it further

RESOLVED, That our FMA create CME courses for FMA members on how to incorporate the next generation of AI programs and AI-derived algorithms into their practice and teach best practices for patient personal data protection.

Fiscal Note:

Description	Amount	Budget Narrative
350 staff hours	$49,000	Can be accomplished with current staff
CME Development	$ 5,000	CME content and course set up
Total	$54,000	$5,000 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

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RELEVANT FMA POLICY

P 220.001 MEDICAL INFORMATION TECHNOLOGY

The Florida Medical Association (FMA) recognizes the potential substantial advantages of medical information technology systems to improve patient care, and supports the ongoing effort to appropriately implement those systems. It is the policy of the FMA that all systems implemented, and any government or hospital regulations that affect those systems, must 1) promote optimal patient care delivery; 2) protect patient rights; 3) benefit as many patients as possible; and 4) anticipate future advances in technology. To do this, those systems and regulations must meet the following guidelines: Optimal Patient Care Delivery: All medical information technology systems must be established and maintained with the delivery of optimal patient care as the primary objective; the physician-patient relationship is central to providing optimal patient care and all systems must preserve physicians’ responsibility for patient care decisions based on their education and experience; medical information

systems are considered supporting technology to assist the physician's care of the patient; physicians are responsible for providing optimal patient care, which may be improved, but is not dependent upon a medical information system; to protect the ability to provide optimal patient care, any system considered for implementation must be shown through adequate demonstration projects to — 1) work 2) be cost effective 3) not impose undue financial strains on practitioners 4) not unnecessarily increase physician workload and 5) benefit patient care; to protect the ability to provide optimal patient care, physicians and/or their office staffs must be allowed sufficient time to successfully adopt any new technology system; hospital-based systems must enhance the ability of physicians and nurses to provide patient care, and not be implemented just for cost considerations or hospital convenience; hospital-based systems must enhance the role of physicians and nurses in providing direct patient care, and not just shift clerical and administrative duties to physicians and/or the nursing staff; to minimize the potential for adverse patient care consequences, hospitals must obtain input from the medical and nursing staff before implementing medical information technology decisions. Patients Rights: All systems must ensure that the physician caring for the patient retain primary control and responsibility over patient care information, subject to the rights of patients to access and release their healthcare information; all systems must secure the privacy of patient care information, including the right to privacy relating to government and insurance entities, subject to the right of the patient to release their FMA Public Policy Compendium 38 healthcare information. Patient Access To New Technology: To encourage the dissemination of medical information technology, systems must be developed and offered that are affordable for small office practices; to ensure that the financial burden of new technology does not slow its implementation, there must be no unfunded government mandates; to ensure all patients ultimately have access to new technology innovations, systems must be developed using accepted standards to allow for the sharing of patient care information between all providers and clinical entities, and must be developed irrespective of specific systems or vendors. Anticipate Future Advances in Technology: Systems must be developed to be flexible and adaptable, in anticipation of future advances in technology, and/or the potential of a future electronic information infrastructure; systems must easily interface with all other systems; further, the cost of system interfaces must not hinder the dissemination of technology designed to improve patient care delivery. (BOG November 2003)(Reaffirmed HOD 2011) (Reaffirmed Res 15-406, BOG January 2016)

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.939

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.

4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

8. Our AMA, national medical specialty societies, and state medical associations—
a. Identify areas of medical practice where AI systems would advance the quadruple aim;
b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
d. Develop practice guidelines for clinical applications of AI systems.

9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and

requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages:
(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications.

Resolution 22-307
Ivermectin
Diane T. Gowski, MD

Whereas, Ivermectin, an FDA approved medication for antiparasitic infection, has been used globally and found to be safe and effective; and

Whereas, the 2015 Nobel Prize (in Physiology or Medicine category) was awarded to two scientists for their discovery of Ivermectin; and

Whereas, Ivermectin is on the WHO's 2021 essential medicines list; and

Whereas, Drug repurposing is a process to identify new therapeutic uses for existing, FDA approved medications; and

Whereas, FMA supports the use of repurposed medications per existing policy; and

Whereas, Ivermectin is a repurposed medication being prescribed for it's use against Covid-19 infection; and

Whereas, Physicians nationwide who prescribe Ivermectin have faced bans regarding its use, along with chart reviews from insurance companies and potential sanctions in their professional practice; and

Whereas, The state of Tennessee made Ivermectin available without prescription in April, 2022; therefore be it

RESOLVED, That the FMA supports legislation to allow Ivermectin, a safe and effective medication, to be dispensed without prescription medication. in our state to allow Florida citizens access here to this.

Fiscal Note:

Description	Amount	Budget Narrative
100 staff hours	$15,000	Can be accomplished with current staff
Total	$15,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Resolution 22-308

Employed Physician Non-Compete Contracts

Palm Beach County Medical Society and Broward County Medical Association

Whereas, The majority of physicians in the US are now employed, generally by large corporations; and

Whereas, Physicians who are employed are more likely to sign non-compete contracts that cover areas that are much larger than the traditional non competes of private practices. Corporate or hospital employment may require non-compete clauses with voluntary loss of hospital privileges. They may even require geographic non-compete areas around multiple facilities, including ones that a physician does not attend; and

Whereas, It is unlikely for a large corporations or hospital systems to be financially damaged proportionately by a physician who wishes to work in the same geographic than a private practice with more limited resources; and

Whereas, Large corporate groups and hospital systems have near monopolistic control over certain geographic areas and constitute unfair advantage against both the physician and the community served especially with an impending doctor shortage; therefore be it

RESOLVED, That the FMA seeks legislation that non-compete clauses should not be allowed in employed physician contracts when the employing entity is not physician owned and operated and has over 30 employed physicians and the employer has no standard mechanism for future proportional equity partnership within the organization.

Fiscal Note:

Description	Amount	Budget Narrative
300 staff hours	$45,000	Can be accomplished with current staff
Total	$45,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee III- Legislation & Miscellaneous

Resolution 22-309

Corporate Practice of Medicine Prohibition

Palm Beach County Medical Society, Broward County Medical Association, Florida Chapter Division of the American Academy of Emergency Medicine

Whereas, A significant number of Florida's physicians are employed by a corporate staffing company with private equity backing or ownership; and

Whereas, Florida already has statutes prohibiting the corporate practice of dentistry and optometry, as well as, statutes prohibiting the fee splitting of physician professional fees; and

Whereas, The Corporate Practice of Medicine (CPOM) doctrine is a legal prohibition that exists in many states to keep the business interest out of the physician-patient relationship. It specifically prohibits the ownership and operation of medical groups or practices by laypersons; and

Whereas, The CPOM prohibition has as its main purpose the protection of patients and the avoidance of the commercialization of the practice of medicine; and

Whereas, Private equity ownership and corporate practice of medicine constitutes a financial conflict of interest that harms the physician-patient relationship and the quality of healthcare; and

Whereas, The CPOM can be detrimental to the physician and the public; therefore, be it

RESOLVED, That FMA will seek legislation for the further restriction of the corporate practice of medicine by amending Florida Statute 458.327, limiting ownership of physician practices or groups to physicians only. Specifically, an amendment prohibiting any person (or entity) other than a physician (or group of physicians or non-profit organization) licensed pursuant to Florida law from:

1. Employing a physician.
2. Directing, controlling, or interfering with a physician's clinical judgment.
3. Having any relationship with a physician which would allow the unlicensed to exercise control over:
    a. The selection of a course of treatment for a patient; the procedures or materials to be used as part of such course of treatment; and the way such course of treatment is carried out by the licensee.
    b. The patient records of a physician.
    c. Policies and decisions relating to billing, credit, refunds, and advertising; and
    d. Decisions relating to the physician or non-physician staffing, office personnel and hours of practice; And be it further

RESOLVED, That the Florida Medical Association bring a resolution to the American Medical Association at the next possible meeting to seek similar legislation or regulation, prohibiting the corporate practice of medicine at a federal level.

Fiscal Note:

Description	Amount	Budget Narrative
305 staff hours Potential Loss of Membership	$45,350	Can be accomplished with current staff Loss of membership paid by corporations on behalf of physicians

	Up to $1,500,000	
Total	$45,350 to $1,500,000	Loss of significant operating resources that would weaken the effectiveness of the FMA

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

References:

Florida's Prohibition on the Corporate Practice of Dentistry

Florida law prohibits the corporate practice of dentistry.[14] This law states that its purpose is to: " . . . [P]revent a non-dentist from influencing or otherwise interfering with the exercise of a dentist's independent professional judgment."

This Florida statute[15] prohibits any person (or entity) other than a dentist licensed pursuant to Florida law from:

4. Employing a dentist or dental hygienist;

5. Controlling the use of dental equipment or material in the provision of dental services; or

6. Directing, controlling, or interfering with a dentist's clinical judgment[16];

7. Having any relationship with a dentist which would allow the unlicensed to exercises control over:

    a. The selection of a course of treatment for a patient, the procedures or materials to be used as part of such course of treatment, and the manner in which such course of treatment is carried out by the licensee;

    b. The patient records of a dentist;

    c. Policies and decisions relating to pricing, credit, refunds, warranties, and advertising; and

    d. Decisions relating to office personnel and hours of practice.[17]

The statute specifies that "Directing, controlling or interfering with a dentist's clinical judgment" is defined as not including dental services contractually excluded, the application of alternative benefits that may be appropriate given the dentist's prescribed course of treatment, or the application of contractual provisions and scope of coverage determinations in comparison with a dentist's prescribed treatment on behalf of a covered person by an insurer, health maintenance organization, or a prepaid limited health service organization.[18]

The statutes does indicate that dentists may contract, lease or rent dental equipment or materials without violating the law. But, any lease agreement, rental agreement, or other arrangement between a non-dentist and a dentist whereby the non-dentist provides the dentist with dental equipment or dental materials shall contain a provision whereby the dentist expressly maintains complete care, custody, and control of the equipment or practice."[19]

This Florida law provides several different remedies. First, violation by anyone is a crime, which may be prosecuted by the State's Attorney as a felony of the third degree.[20]Additionally, the statute itself states that any contract or arrangement that violates this act is void as a matter of public policy.[21]

Florida's Dental Practice Act, in Section 456.028(1)(h), specifically allows disciplinary action to be taken against a licensed dentist for: "Being employed by any corporation, organization, group, or person other than a dentist or a professional corporation or limited liability company composed of dentists to practice dentistry."[22]

The Florida Board of Dentistry has implemented administrative rules, which add additional restrictions and clarifications to enforce this statute.[23] The Florida Board of Dentistry is very active in policing and prosecuting violations of it.

§466.0285, Fla. Stat. (2002), entitled "Proprietorship by Nondentists."

§466.0285, Fla. Stat. (2002).

§466.0285(1), Fla. Stat. (2002).

§466.0285(2), Fla. Stat. (2002).

§466.0285(1) (c), Fla. Stat. (2002).

§466.0285(1)(c), Fla. Stat. (2002).

§466.0285(3), Fla. Stat. (2002).

§466.0285(4), Fla. Stat. (2002).

§466.028(l) (h), Fla. Stat. (2002).

Florida Board of Dentistry rules F.A.C. 64B5-17.013.

§463.014, Fla. Stat. (2002).

§463.014(l)(b), Fla. Stat. (2002).

See Cole Vision Corporation and Vision Works, Inc. v. Department of Business and Professional Regulation, Board of Optometry, 688 So,2d 404, 408 (Fla. 1st DCA 1997) (holding that §§463.014(1)(a) and (b) and §484.006(2) Fla. Stat., when read together, mean that, while optometrists cannot form partnerships or professional associations with or be employed by opticians, opticians can be employed by an optometrist).

F.A.C. 64B13-3.008(5) (prohibiting any control which includes type, extent, availability or quality of optometric services, types of material available, access to or control of records, prescriptions, scheduling

and availability of services, time limitations on patient exams, volume of patients, fee schedules and information disseminated to the public).

F.A.C.64B13-3.008(15)(f).

Fee Splitting/Kickbacks

Court Upholds Phymatrix Ruling
BYLINE: Palm Beach Post Staff and Wire Reports
DATE: July 2, 1999
PUBLICATION: The Palm Beach Post
EDITION: FINAL
SECTION: BUSINESS
PAGE: 7D
MEMO: In brief
A state appellate court has upheld a ruling that doctors can't pay a percentage of their profits to physician management companies that run their offices and handle their business affairs.
The ruling by the 1st District Court of Appeal in Tallahassee upheld a November 1997 order by the Florida Board of Medicine. The June 25 ruling went against PhyMatrix Corp., a company formerly based in West Palm Beach
that bought and managed doctors' practices. At issue was a 30 percent annual fee PhyMatrix charged doctors based on a practice's net income.
The Board of Medicine had said fees based on a percentage violate state law that prohibits paying or receiving payment in exchange for patient referrals. The board said a flat fee would have been acceptable under the
law.
The case, involving a 15-doctor practice in the Tampa area, was brought by Magan Bakarania, a cardiologist who was considering joining the practice.
PhyMatrix is now getting out of the physician practice management business. This year the company moved to Providence, R.I., and changed its name to Innovative Clinical Solutions.

Contract Issues

Percentage of Fees Taken Makes Florida PPM Contract Illegal
According to a report in the *Tampa Bay Business Journal*, a Florida Court of Appeals has affirmed an 18-month old Florida Board of Medicine decision involving a group of Tampa doctors who contracted with a West Palm Beach-based physician practice management company, PhyMatrix Corporation.
The Board found that the PhyMatrix contract with Access Medical Care, the primary care practice employing the physicians in question, was illegal. The contract called for Access, in exchange for various services, to pay PhyMatrix a percentage of the revenues doctors get from PPM-generated referrals. The Board said that such percentage payments amount to fee-splitting to pay for referrals, which is illegal under Florida law. The appeals court agreed. As a result, hundreds of Florida doctor-PPM contracts will likely have to be revamped.
The story quotes Alan Gassman, the attorney who represented Access in the case, as saying that doctors may have another concern as well-making sure they are not violating criminal statutes under Florida's Patient Brokering Act. Gassman said since the appeals court was the highest court to date to review a decision involving practice management contracts, doctors seeking to escape such pacts are now well-

armed to do so in local courtrooms. Further, he said, the Florida decision could have influence in other states, most of which have similar laws against fee splitting.
Note: This ruling has important implications for EM in Florida and may serve as a guidepost in other states. Importantly, the actions of the Florida Board of Medicine point out a largely untapped resource to fight abusive contracts in EM. Under the fee-splitting prohibitions in Florida and other states, one should not be forced to split their fee in order to receive referrals. With the typical EM contract where the pit doctor gives up 30-50% of their fees in order to work in an ED and thereby receive referrals, these statutes are implicated. Emergency physicians in such arrangements should strongly consider reporting the physicians who front for the big groups or the "dictators" who are the sole owners of one or two lucrative contracts to their state Board of Medicine for investigation of fee-splitting. The various Boards of Medicine are primarily composed of physicians responsible for upholding the moral and ethical aspects of the profession and represent an important resource for EPs.
The most direct effect of this ruling is for emergency physicians in Florida whose contracts spell out a percentage-based formula for compensation. Since this ruling invalidates the contract, the rank and file emergency physicians in such a situation are now presented with an opportunity to break away from a contract group or a dictator and take control of their professional future. For more information on fee splitting the reader should access www.aaem.org.

FLORIDA
Statutes
§456.327 (prohibiting the unlicensed practice of medicine)
§641.01 et seq. (Health Care Service Plans)
§641.17 et seq.(HMO Act) (providing for arrangements between physicians and HMOs.)
Cases
Dr. Allison, Dentist, Inc. v. Allison (1935) 360 Ill. 638, 196 N.E. 799, 800 (stating that doctors who were hired by corporations would "owe their first allegiance to their corporate employer and cannot give the patient anything better than a secondary or divided loyalty."); State Bd. of Optometry v. Gilmore (1941) 147 Fla. 776 3 So. 2d 708 (physician employed as salaried optometrist by jewelry store violated statute prohibiting employment of optometrist by corporation); Rush v. City of St. Petersburg (Fla. Dist. Ct. App. 1967) 205 So. 2d 11 (where physician argued that a contract to provide radiological service to the city hospital was void on the ground that performance of the contract would result in the illegal corporate practice of medicine by the hospital, the court held that the hospital was not engaged in the illegal practice of medicine because the doctor-patient relationship was maintained); Cohen v. Department of Professional Regulation Bd. of Optometry, (Fla. Dist. Ct. App. 1981) 407 So. 2d 621 (affirming a finding of practicing optometry under a corporate name).
Recent Decisions Clarify Legality of Percentage-based Physician Management Contracts

By *Mark Bancroft Langdon* and *Larri Short* of Arent Fox

Note: The alert is also available in Adobe PDF format here.
On June 25, 1999, in PhyMatrix Management Co., Inc. v. Bakarania, Fla. Dist. Ct. App., No. 97-4534, 6/25/99, the Florida First District Court of Appeal, in a per curium decision, affirmed a 1997 Board of Medicine ruling that a physician practice paying a percentage of net income to a physician practice management company ("PPMC") in return for "practice-expansion activities" is engaging in illegal fee-splitting in Florida. The PPMC's "practice-expansion activities" involved developing contracts with

insurers, hospitals, and other medical providers designed to generate patient referrals to the practice. The court's decision cannot be appealed.

The Bakarania case came before the Board of Medicine in 1997 when Dr. Bakarania asked the Board for advice about the legality of a contract between PhyMatrix Management Co. and Access Medical Care, Inc., a group medical practice which he was considering joining. Noting that the management company received 30 percent of the physicians' net income in return for services which included practice enhancement activities, attorneys for Dr. Bakarania argued that the payment methodology violated the prohibition against fee splitting in the Florida Medical Practice Act. The Board of Medicine agreed. As written, the ruling could be interpreted to bar all percentage-fee contracts. While not binding outside of Florida, because the Florida statutory provision is similar to those in other states, the decision had a chilling effect upon the growth of PPMCs across the country.

Another recent decision from Florida, however, is not so restrictive. Two weeks before the Florida appellate court's affirmance of the Bakarania decision, the Florida Board of Medicine issued a declaratory statement, ruling that percentage fees paid to a management firm *are* permissible under the fee-split bar if the percentage fees are not tied to activities that are designed to bring more patients into the practice. The case involved a proposed contract between an anesthesiology practice and a management company, where the management company would be paid 50 percent of net collections up to $10,000 a month to be responsible for office space, staff, equipment, personnel, and billing and collection services but not for the types of "practice enhancement" activities with which the Board took issue in the Bakarania case. Although the specific rationale underlying the Board's decision will not be known until its final order is published sometime next month, the decision is significant for the PPMC industry since it appears to confirm that percentage-based arrangements involving only basic management services will not run afoul of the Florida fee-splitting law.

Reading the two decisions together, it appears the legality of percentage-based contracts between PPMCs and Florida physicians depends upon the types of services the PPMC is contractually required to provide. To the extent the management company provides traditional administrative services, such as billing and collections, the fee-split law should not be implicated. However, PPMCs wishing to furnish marketing services designed to generate referrals appear to be restricted to contracts which provide a flat fee for practice expansion activities.

It is ironic that these developments arise from Florida, one of a handful of states which does not prohibit the corporate practice of medicine. Thus, PPMCs operating in Florida can achieve the financial results they seek by restructuring their relationships with physicians from independent contractors to employees. Should other states follow the lead of the Florida Board of Medicine, that option may not be available and PPMCs will be forced to consider alternative financial arrangements with its physicians.

Resolution 22-310
Prevention of Hospital Out-Patient Status Surprise Billing
Steven Babic M.D.

Whereas, Insurance companies and Medicare have taken advantage of doctors, patients and hospitals with a complex and confusing scheme to determine the inpatient versus outpatient status of patients being admitted to the hospital; and

Whereas, The amount of work done by the physicians and hospitals is no longer different regardless of the patient's status; and

Whereas, This arbitrary and capricious system has been devised to shift costs to the patient and underpay the physicians and hospitals; therefore be it

RESOLVED, That the FMA and AMA seek legislation to ensure that the patient, upon hospital admission, be notified if their insurer has remanded them to outpatient status and must be presented with an estimate of their responsibility for out-of-pocket expenses post discharge. Failure of the insurers or Medicare to so notify the patient upon admission will result in the patient being assigned to in patient status.

Fiscal Note:

Description	Amount	Budget Narrative
305 staff hours	$45,350	Can be accomplished with current staff
Total	$45,350	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

Resolution 22-311

Dedicated On-Site Physician Requirement for Emergency Departments

Palm Beach County Medical Society, Florida Chapter Division of the American Academy of Emergency Medicine

Whereas, Emergency medical care facilities should be prepared to offer evaluation and medical diagnosis of undifferentiated acute symptoms, recognition and stabilization of emergency conditions, appropriate emergency treatment when available and/or transfer to a higher level of care for emergency conditions when appropriate, and

Whereas, Facility designations using the term "emergency" within their title may be assumed by laypersons or medical professionals to imply the ability to offer the above emergency duties and services, and

Whereas, In the state of Florida, physicians are the only health professionals authorized to practice medicine in the Emergency Department without limitation, and

Whereas, Non-physician practitioner "collaboration" with a physician, may imply a lower degree of physician involvement in the care of the patient than physician supervision, inasmuch as, collaboration may imply mere consultation of the physician only when deemed necessary by the non-physician practitioner which is inadequate in the setting of acute medical care because non-physician practitioners have not been trained to the same extent[1], as have physicians, and cannot consistently recognize all acute emergency situations in which immediate physician care is required, and

Whereas, Every patient presenting to a facility in Florida which represents itself as a place where patients can seek emergency medical care should be under the direct real-time care of a licensed physician including the on-site and real-time supervision of non-physician practitioners, therefore, be it

RESOLVED, That the Florida Medical Association, in order to promote safety, truth and transparency in the services available to patients seeking emergency medical care, seek legislation or regulation requiring that all facilities in the state of Florida that bear the designation of Emergency Department, ED, Emergency Room, ER, or other title, facility logo or design implying provision of emergency medical care must have the real-time, on-site presence of, and supervision of non-physician practitioners, by a licensed physician with training and experience in emergency medical care, 24 hours a day, 7 days a week whose primary duty is dedicated to patients who seek emergency medical care in that specific ED, whether it serves the general population or a special population. Physician collaboration with a non-physician practitioner will not fulfill this requirement; further, be it

RESOLVED, That to fully promote truth and transparency, non-physician practitioners need to clearly state their credentials at the time of service in the Emergency Department; be it further

RESOLVED, That the adequate supervision of non-physician practitioners in the emergency department requires that the supervising physician may only supervise 1 (one) non-physician practitioner at a time, to provide true supervision and appropriate care to the emergency patient. At any given time, there cannot be a ratio exceeding 1:1 of real-time and on-site physicians to non-physician practitioners working in the emergency department; be it further

RESOLVED, That the Florida Medical Association advocate for similar legislation or regulation, promoting truth and transparency for patients, regarding availability and scope of emergency medical services at all health care facilities and seeking appropriate designations, at a Federal level with the American Medical Association.

Fiscal Note:

Description	Amount	Budget Narrative
305 staff hours	$45,350	Can be accomplished with current staff
Total	$45,350	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

References

(1) Proffitt Lavin, R PhD FNP-BC FAAN, et al. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation, Vol 12, Issue 4, P50-62, Jan 01, 2022. https://www.journalofnursingregulation.com/article/S2155-8256(22)00010-2/fulltext

Resolution 22-312
Home and Birth Center Safety
Emerald Coast Medical Association

Whereas, Pregnant patients in Florida may deliver in a hospital, a birthing center, or a home, and the practitioners may be physicians, certified nurse midwives, non-certified nurse midwives, or lay midwives, and that each have varying levels of educational requirements and capabilities; and

Whereas, High risk deliveries such as trial of labor with history of previous cesarean should not be attempted in the home or birthing center setting; and

Whereas, The location of which the patient receives prenatal care, delivery, and postpartum care may affect maternal and neonatal outcomes and be associated with various levels of safety protocols; and

Whereas, Current Florida law requires adverse events including but not limited to transfer to a higher level of care to be reported; and

Whereas, Current law requires midwives and other practitioners practicing in birthing centers to have a consulting obstetrician, however, there is no specification as to the involvement of the consulting physician in the care of the patient and no distance or time limit to the practicing midwife or practitioner; and

Whereas, Standalone birth centers are required to list a hospital where patients will be transported in emergency cases; and

Whereas, The Medicaid and CHIP managed care final rule, requires states to develop time and distance standards for multiple provider and service types, which includes primary care, adult and pediatric as well as obstetric and gynecologic providers; and

Whereas, The 2016 final rule also requires standards other than time and distance for providers who travel to the enrollees home or community residents, which is often the case for Medicaid and CHIP; and

Whereas, CMS stated that states are in the best position to understand the unique needs of their populations, and can best set criteria and standards; and

Whereas, As of 2013, 32 of the 33 states with risk based managed care plans have established standards for the maximum time and distance for travel-based care; and

Whereas, It has been established that perinatal outcome are better when all pregnancy related healthcare team members are working together in collaboration; and

Whereas, most states such as Georgia, Indiana, Nebraska, Colorado, New Jersey, and others have established standards for the distance for patients to be supervised and cared for by practitioners; and

Whereas, Florida statute section 2 Chapter 467.015 states “A midwife may provide collaborative prenatal and postpartum care to pregnant women not at low risk in their pregnancy, labor, and delivery, within a written protocol of a physician currently licensed under chapter 458 or chapter 459, which physician shall maintain supervision for directing the specific course of medical treatment;” therefore be it

RESVOLVED, That the Florida Medical Association support administrative change or legislation to establish that unsupervised or supervised midwives practicing independently at home or in birthing centers be required to have a consulting Board Certified Obstetrician by the American Board of Obstetricians and Gynecologists practicing within a 30 minutes of travel time and within a 30-50 mile radius to a receiving hospital where there is a written transfer agreement between the birthing center and midwife, and the physician has active medical staff privileges in Obstetrics.

Fiscal Note:

Description	Amount	Budget Narrative
100 staff hours	$15,000	Can be accomplished with current staff
Total	$15,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

Resolution 22-313
Electronic Prescribing Requirements
Melanie Cross, M.D.

Whereas, Florida Section 456.42(3), Florida Statutes, requires prescribing health care practitioners to electronically transmit prescriptions for medicinal drugs upon renewal of license or by July 1, 2021, whichever is earlier, unless a specific exception applies; and

Whereas, Mandated electronic prescribing allows many other eyes on the patient data than necessary, decreasing patient privacy since it is electronically transmitted allowing internet providers and others access to the data via electronic means (hacking, unauthorized access); and

Whereas, Mandated electronic prescribing may cause adverse economic consequences for physicians and medical practices due to hacking and other data breaches as well as cloud server companies denying or unable to provide service; and

Whereas, Mandated electronic prescribing allows insurance companies increased ability to dictate physician prescribing behavior; and

Whereas, Forcing electronic prescribing prevents physicians from choosing how they prescribe for patients, giving them very few alternatives, and forcing them to apply for exemptions, which is an additional administrative burden; and

Whereas, Increased regulatory burden would limit physicians to only electronic means, increasing costs; and

Whereas, The Florida Prescription Drug Monitoring Program (EFORSCE) provides a safeguard against controlled substance prescribing fraud while tamper-proof script pads provide additional safeguards for paper scripts; therefore be it

RESOLVED, That the FMA seek legislation that restores physicians' choice to prescribe in the manner they choose; and be it further

RESOLVED, That the FMA seek legislation that adds or restores options that traditionally exist for physicians to prescribe, including phone-in prescriptions and written or typed prescriptions in paper form.

Fiscal Note:

Description	Amount	Budget Narrative
300 staff hours	$45,000	Can be accomplished with current staff
Total	$45,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

Resolution 22-314

Opposition to License Free Gun Carry

Megan Core, MD, Florida Chapter Division of the American Academy of Emergency Medicine, and the Florida College of Emergency Physicians

Whereas, Gun violence has become a public health crisis in the United States and as of 2020, has become the leading cause of death of children and adolescents, surpassing motor vehicle accidents; and (1)

Whereas, The FMA already has policy advocating for a Public Health Response to Gun Violence (2); and

Whereas, The state of Florida currently requires a license to carry a concealed weapon or permit and licensure requirements include the completion of a certified safety and training course. It is currently a first degree misdemeanor in the state of Florida to carry a concealed weapon without a license (3); and

Whereas, It is also a requirement in the State of Florida to hold a license to cut hair or drive a car, requiring completion of a certified safety and training course in order to obtain licensure.

Whereas, Some Florida Legislators are pushing for legislation allowing for permitless gun carry laws, also known as constitutional carry. Such legislation seeks to remove any requirement for a license to a carry concealed firearm (4); and

Whereas, This type of legislation will eliminate any and all safety and training requirements for those who chose to carry firearms. Undoubtedly, this will lead to an increase in the number of accidental injury and death by firearms; therefore be it

RESOLVED, That the FMA actively and openly oppose any such legislation that would reduce or eliminate the current requirements to obtain a license in order to carry a concealed firearm weapon or firearm, with requirements for licensure to include formalized training in gun use and safety.

Fiscal Note:

Description	Amount	Budget Narrative
300 staff hours	$45,000	Can be accomplished with current staff
Total	$45,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

1. https://www.nejm.org/doi/full/10.1056/NEJMc2201761

2. https://www.flmedical.org/florida/Florida_Public/Docs/AM/PublicPolicyCompendium.pdf

3. http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0790/Sections/0790.01.html

4. https://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=73146

Resolution 22-315
Abortion Resolution
American College of Obstetricians and Gynecologists, District XII, Broward County Medical Society, Florida Society of Ophthalmology

Whereas, Abortion is considered a safe an effective medical procedure; and

Whereas, One in four women in the United States (U.S.) will obtain an abortion by the age of 45, with approximately 860,000 women seeking an abortion annually; and

Whereas, 45% of all pregnancies in the U.S. are unplanned;[1] and

Whereas, 60% of all unintended pregnancies result in induced abortion; [2] and

Whereas, 50,000 people in US experience severe pregnancy complications annually; and

Whereas, Risk of death associated with childbirth is 14x higher than with abortion; [3] and

Whereas, Average cost of delivery in U.S. is $4,500 (with insurance) and $11,000-33,000 (without insurance); [4] and

Whereas, There have been criminal charges and convictions against pregnant individuals suffering miscarriages or self-managed abortions despite federal protections against this; and

Whereas, States with restrictive abortion laws and restrictions on Medicaid coverage of abortion care have higher total maternal mortality and higher infant mortality rates; and

Whereas, The Supreme Court of the United States decision in "Roe v. Wade" in 1973 created the federal legal precedent that the 14th Amendment of the U.S. Constitution protects a pregnant person's liberty to choose to have an abortion without excessive government restriction; and

Whereas, Upon the overturning of Roe v. Wade, in the first year, there will be an estimated 50 more pregnancy-related deaths (up 7%) from before the ruling and in subsequent years, 140 more deaths (up 21%). For non-Hispanic, African-Americans, this will be a 12% increase in pregnancy-related deaths in first year and 33% in subsequent years; [5] and

[1] https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions

[2] https://www.who.int/health-topics/abortion#tab=tab_1

[3] Raymond, Elizabeth G. MD, MPH; Grimes, David A. MD The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, Obstetrics & Gynecology: February 2012 - Volume 119 - Issue 2 Part 1 - p 215-219 doi: 10.1097/AOG.0b013e31823fe923

[4] Michelle H. Moniz, A. Mark Fendrick, Giselle E. Kolenic, Anca Tilea, Lindsay K. Admon, and Vanessa K. Dalton. Out-Of-Pocket Spending For Maternity Care Among Women With Employer-Based Insurance, 2008–15. Health AffairsVol. 39, No. 1. https://doi.org/10.1377/hlthaff.2019.00296

[5] Amanda Jean Stevenson; The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant. Demography 1 December 2021; 58 (6): 2019–2028. doi: https://doi.org/10.1215/00703370-9585908

Whereas, Black market abortion services will likely emerge which, conservatively, will result in 30 out of 100,000 women dying in the U.S. from these services; [6] and

Whereas, The rates of abortion don't change whether such services are restricted or not when looking worldwide. The rate is 37 per 1000 women in countries where abortion is prohibited or restricted, 34 per 1000 women where not restricted. [2] Wealthy will travel internationally. Poorer and middle class will go to another state or self-induce risking their lives; and

Whereas, Legal restrictions on safe abortions do not reduce the incidence of abortions, and mortality and morbidity, including effects on future reproduction as a result of unsafe abortions, are essentially wholly preventable; and

Whereas, Bills in several states would criminalize abortion for the pregnant person and/or physician; and

Whereas, Such action interferes with the physician-patient relationship on matters of health, autonomy, justice, beneficence, and non-maleficence; and

Whereas, The Supreme Court of the United States, in its 2022 session, is likely to overturn federal protections of abortion through the 1973 ruling "Roe v. Wade" and 1992 ruling "Planned Parenthood v. Casey" based on verified court documents confirmed by the Chief Justice John Roberts in the case Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health v. Jackson Women's Health Organization ("Dobbs v. Jackson"); [6] and

Whereas, Upon the overturning of "Roe v. Wade", 21-29 states will outright ban abortion, many including in cases of rape, incest, or danger to life of mother which will result in the rise in maternal mortality; [1] and

Whereas , On May 5, 2022, in response to the leaked draft opinion for the "Dobbs v. Jackson", the President of the American Medical Association (AMA) released a statement condemning the intrusion into the physician-patient relationship and stated that "we strongly urge the Court to reject the premise of the draft opinion and affirm precedent that allows patients to receive the critical reproductive health care that they need;" and

Whereas, Current FMA policy P5.002 states "The Florida Medical Association supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities. Abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state. No physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case as long as the withdrawal is consistent with good medical practice"; and

[6] https://www.politico.com/news/2022/05/02/supreme-court-abortion-draft-opinion-00029473

Whereas, The American Medical Association[7], American College of Physicians[8,9], American Academy of Family Physicians, American Academy of Pediatrics, American Psychiatric Association, and American College of Obstetricians & Gynecologists[10,11,12,13] , and many other national medical societies have all written statements opposing restrictions to reproductive health care, including but not limited to abortion services, that undermine the relationship between a physician and patient; therefore be it

RESOLVED, That the Florida Medical Association reaffirm P5.002 and make a public statement stating such within 2 weeks of the official announcement of the 2022 Supreme Court of the United States decision on Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health v. Jackson Women's Health Organization ("Dobbs v. Jackson") should the draft majority opinion publicized on 3 May 2022 stand; and be it further

RESOLVED, That the Florida Medical Association support efforts by other medical societies to oppose actions by the Florida Legislature, now and in the future, to block abortion services, including but not limited to cases of rape, incest, or risk to the life of the pregnant person, to criminalize such pregnancy termination against the pregnant person and/or physician, and to interfere with the professional relationship between a physician and patient, the expertise and medical judgment of said physician, and the autonomy and justice of said patient; and be it further

RESOLVED, That the Florida Medical Association oppose any future legislation hindering or blocking the availability of FDA-approved treatments for pharmacological termination of pregnancy, regardless of whether used for termination or other unrelated indications, when this is a matter between the physician and patient.

Fiscal Note:

Description	Amount	Budget Narrative
256 staff hours	$38,290	Can be accomplished with current staff
Total	$38,290	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

[7] https://www.ama-assn.org/press-center/press-releases/ama-statement-draft-supreme-court-opinion

[8] https://www.acponline.org/acp-newsroom/internal-medicine-physicians-say-oklahoma-abortion-legislation-will-criminalize-health-care

[9] https://www.acponline.org/acp-newsroom/internal-medicine-physicians-say-idaho-abortion-legislation-will-harm-patient-physician-relationship

[10] https://www.acponline.org/acp_policy/statements/g6_statement_idaho_abortion_bill_2022.pdf

[11] https://www.acponline.org/acp_policy/letters/joint_letter_in_support_of_the_womens_health_protection_act_feb_2022.pdf

[12] https://www.acponline.org/acp-newsroom/leading-physician-groups-oppose-texas-legislation-that-threatens-access-to-reproductive-patient-care

[13] https://www.acog.org/news/news-releases/2022/05/acog-statement-on-reports-of-a-draft-opinion-in-dobbs-v-jackson

Reference Committee: III – Legislation & Miscellaneous

97

Resolution 22-316
Anti-Abortion
Diane Gowski, M.D.

Whereas, The United States' Supreme Court decision regarding the Dobbs case could send legislative decision making regarding abortion back to the state level; and

Whereas, FMA's input will be sought for FL legislative healthcare policy in a potential post-Roe world; and

Whereas, Abortion is not healthcare but the killing of unborn children; therefore be it

RESOLVED, That the FMA will support pro-life legislation to work toward banning the practice of abortion in the state of Florida.

Fiscal Note:

Description	Amount	Budget Narrative
100 staff hours	$15,000	Can be accomplished with current staff
Total	$15,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation & Miscellaneous

Reference Committee IV

Report D
of the Board of Governors

Douglas Murphy, M.D., President and Chair

The Board of Governors submits the following report to the House of Delegates. This report contains **one recommendation** and a summary of major Board actions taken on items relating to medical economics. This report also contains information items as presented by the Council on Medical Economics and Practice Innovation.

Recommendation D-1

Resolution 21-304
Pharmacies
Capital Medical Society

That substitute language be adopted in lieu of Resolution 21-304 Pharmacies from the 2021 House of Delegates.

RESOLVED, That the FMA supports legislation that would enhance communication, drug pricing transparency and software interoperability between payors, PBMs, and clinician EHRs.

~~RESOLVED, That the FMA supports legislation or regulatory action to require that in the event a patient cannot afford the medication prescribed, either because it is not on the formulary or it is priced higher than other medications on the formulary, the pharmacist must communicate to the prescriber a medication option in the same class prescribed with the lowest out-of-pocket cost to the patient.~~

Description	Amount	Budget Narrative
staff hours	$	Can be accomplished with current staff
		No Fiscal Impact.

Background: On August 1, 2021 the FMA House of Delegates referred Resolution 21-304 to the Board of Governors for study and report back to the 2022 House of Delegates.

Discussion: The Board of Governors reviewed this resolution and believed it to be an important goal of helping patients receive affordable and appropriate medications. However, there are several roadblocks to successfully implementing this proposal that are worth considering.

Implementing the resolution would likely increase the administrative burden of physicians and pharmacists without placing any additional requirements on the pharmacy benefit managers that ultimately have a greater say in the cost of drugs. In order for this resolution to fulfill its intended function, pharmacists would have to reliably inform physicians of the lowest cost medication available as described in this resolution and physicians would have to render decisions concerning whether to prescribe those medications. This would therefore result in a new, legally mandated administrative task that would affect both pharmacists and physicians. The additional time required by pharmacists and

physicians to act on these notifications could make this requirement very difficult to effectively operationalize in already-strained pharmacies and medical practices.

Additionally, the least expensive medication within a given class may not be a clinically appropriate option in the opinion of the prescribing physician. When such discrepancies exist, this could lead to confusion amongst patients who expect this new legal requirement to lower their costs and thereby have a potentially negative impact on the physician-patient relationship.

If this resolution were transformed into legislation, the onus to inform the patient of this information may be shifted towards physicians rather than pharmacists. In fact, such legislation has been attempted. This year, HB 947, which the FMA opposed, and which failed to pass the Florida Legislature, was introduced and would have legally required physicians to provide, upon the patient's request, "real-time, patient-specific information regarding prescription drug benefits, coverage, and costs in order to facilitate a discussion of benefit, coverage, and cost options…" Although this legislation would have also required insurers to provide this information to physicians in order to facilitate these discussions, physicians would have certainly incurred an increased administrative burden as a result of its enactment. Thus, advocating for legislation that would transform this resolution into law may inadvertently create an even greater, legally mandated administrative burden on prescribing physicians.

Finally, a resolution with identical language was previously submitted to the AMA House of Delegates in 2020. This resolution was referred for a report back that was published by the AMA Council on Medical Service at the 2021 AMA November meeting. The AMA analyzed this resolution and began by recognizing the untenable situation that physicians and patients find themselves in when dealing with incomplete information concerning the affordability of medications. The report notes that, at the point at which a prescription is issued, cost information is not universally available to the prescribing physician. The report notes that "In the absence of a technology tool, the only way to know which medications are on the formulary is for the physician, pharmacist, or patient to research the formulary and/or call the insurance plan or PBM."

The report goes on to state that "the ultimate decision regarding which medication is most appropriate for a patient is made directly between physicians and patients, requiring pharmacists to research patients' formularies and discuss their research with the physician unnecessarily adds burden to both physicians and pharmacists. Moreover, unnecessarily inserting pharmacists into the prescribing process may increase confusion among patients and scope of practice concerns as patients seek prescription guidance from their pharmacists. Rather than imposing burdensome new legal requirements on pharmacists, the goal of improved prescription drug price transparency at the point of prescribing could be accomplished via improved HIT." The report further explains that a physician's ability to access Real-Time Prescription Benefit (RTPB) technology depends on the business relationship between the physician's RTPB tool software provider and the patient's drug plan. The report notes that "some physicians may have access to RTPB tools for some patients, but physicians cannot yet access comprehensive benefit information across all prescription drug plans, and tools do not yet integrate with all EHRs prescribing systems. To achieve that level of universal access and transparency, a non-proprietary RTPB standard is required."

The report concludes by recommending that, in lieu of adopting the resolution, the AMA advocate to continue to support efforts to publish a RTPB standard that meets the needs of all physicians, to require payors to keep an up-to-date RTPB standard tool that integrates will all EHR vendors, and to take other actions that support the availability and understanding of RTPB technology.

Council on Medical Economics and Practice Innovation

Major Board Actions:

- Reviewed and approved recommendations to reaffirm public policies from 2014
  - (See Recommendation A-1)
- Adopted substitute language in lieu of original Recommendation D-2, Resolution 21-102, Initial Assessment and Treatment Recommendations by Specialists.

Board Recommendation D-2
Resolution 19-102, Initial Assessment and Treatment Recommendations by Specialists(2019 House of Delegates)

House Action: Refer to the Board of Governors for decision; substitute language adopted

RESOLVED, that the FMA request that the various primary care and specialty societies work collaboratively to develop and publish appropriate guidelines on the use of Advanced Practice Registered Nurses and Physician Assistants for referrals and evaluations.

Discussion: The 2021 House of Delegates referred Board Recommendation D-2, Resolution 19-102, Initial Assessment and Treatment Recommendations by Specialists to the Board of Governors for decision. The 2019 House of Delegates referred the original resolution, 19-102 to the Board of Governors for study and report back. The resolution was studied by both the Council on Medical Economics and Practice Innovation and the Council on Medical Education, Science, and Public Health. As a result of those studies, the Board of Governors proposed substitute language be adopted by the 2021 House of Delegates. The 2021 House of Delegates was divided on the proposed substitute language and referred Recommendation D-2 to the Board of Governors for decision. The Board agreed that a task force was needed to study this resolution and appointed a task force in October 2021. The task force felt that a single set of guidelines would not work for all specialties and felt that a collaborative approach would be best. The Board adopted the substitute language.

Reference Committee No. IV
Medical Economics

Saturday, August 6, 2022
10:00 a.m. – 11:30 a.m.

Members:

Aaron Sudbury, M.D., Chair	Manatee
Courtney Bovee, M.D.	Florida Society of Ophthalmology
David Dixon, M.D.	Capital
Vania Fernandez, M.D.	Broward
Ali Kasraeian, M.D.	Duval
Maribel Lockwood, M.D.	Capital
Kerry Schwartz, M.D.	Physicians Society of Central Florida

Agenda:
Board of Governors Report D

1. Board Recommendation D-1: Resolution 21-304

Resolutions:

22-401	EHR Refill Errors
22-402	Employed Physician Unionization
22-403	Tort Reform Strategy
22-404	FMA Stakeholder Engagement in First Coast Service Options
22-405	Medicaid Expansion
22-407	Uncompensated Care Reimbursement for Physicians
22-408	Physicians for Protecting Information
22-409	Fair Compensation for Supervised Residents

Resolution 22-401
Preventing EHR Refill Errors

Shawn Baca, M.D., Palm Beach County Medical Society, Broward County Medical Association

Whereas, One of the contributing factors to patient safety and to physician burnout is inefficiencies created by the use of the electronic health record EHR. In that many EHRs automatically generate medication refill requests without integrating updated medication orders, e.g., changes in dosage or even discontinuation, this contributes to patient safety and requires additional physician oversight, often completed manually, to ensure that prescription errors do not occur, thereby endangering patients. Furthermore, this creates additional physician stress and work when additional time is needed to prevent medical errors; and

Whereas, Traditionally patients obtained their medication prescriptions at a face-to-face encounters with their physicians, the new EHR technology pharmacies push out refill requests in far greater numbers, on a regular basis, regardless of whether a medical visit has taken place. With this automated refill process, the opportunity for a shared decision-making conversation of the physician and patient to fill, edit, or discontinue a prescription is denied; and

Whereas, EHR prescribing of medications is now expected by most insurers. The EHR is often programmed to transmit refill prescriptions to the patient's pharmacy of choice when the current supply is calculated to be exhausted. The EHR however is NOT programmed to review and recognize when a prescription has been modified or discontinued and notify the pharmacy accordingly. Thus, the pharmacies often receive electronic prescription refill requests that are in error and the prescribing physician, receiving no notification or request for final authorization for the refill, lacks the ability to scrutinize every prescription. This increases the risk of medical errors that could endanger patients; therefore be it

RESOLVED, That the FMA advocate for regulation that improves EHR operability thereby requiring that all EHR systems be programmed to review all prescription changes and updates and make any necessary revisions prior to transmitting the refill request, if and when appropriate, to the prescribing pharmacy, ensuring that all pharmacy records remain consistent with the patient's EHR chart; and be it further

RESOLVED, That the FMA establish an ad-hoc committee to investigate, work with pharmaceutical representatives and other interested parties, to investigate the extent and effect of EHR refill errors and make recommendations for remediation, and be it further resolved; and be it further

RESOLVED, That the FMA refer these recommendations to the Florida Delegation to the American Medical Association (AMA) to be drafted as a resolution to the brought to the House of Delegates for action.

Fiscal Note:

Description	Amount	Budget Narrative
320 staff hours	$47,900	Can be accomplished with current staff
Ad Hoc Committee	$ 3,750	Meeting Expenses, in person and virtual
Total	$51,650	$3,750 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

Resolution 22-402
Formation of Unions

Steven Babic, M.D., Palm Beach County Medical Society and Broward County Medical Association

Whereas, 75 percent of doctors in the United States are now employees of large organizations such as hospitals, government agencies, and corporate employers; and

Whereas, Physicians that are employed by government facilities and residents and house staff are allowed to unionize and collectively bargain with their employer; and

Whereas, Physicians who are employees by large organizations and hospitals have the same lack of "supervisor" roles as physicians who are employed by government facilities and residents and house staff; and

Whereas, Studies show employed physicians are more likely to be burnt out due to lack of autonomy. Physician wellness is directly tied to patient outcomes and patients benefit if physicians have more autonomy; and

Whereas, The Florida Medical Association supports the formation of bargaining units by physicians and the right to affiliate with established trade unions. P480.001; and

Whereas, Employers seek to prevent unionization of physicians by hiding behind Sherman Anti-Trust laws that label physicians as "supervisors" and therefore don't qualify for union protection. However, most employed physicians do not have the authority to hire, fire, or make managerial decisions, with hospitals, or corporate employers. Employed physicians are generally paid with a W2 form which identifies them as an employee. Employed physicians do not have the ability to profit share or deduct expenses on their taxes associated when working as an employed physician in contrast to actions that self-employed physicians may perform; and

Whereas, The "supervisor" status was found to not be valid in a Washington State case. There, doctors at 46 primary care clinics voted to be represented by the United Salaried Physicians and Dentists Union. The National Labor Relations Board sided with the doctors, concluding they could organize as they did not have authority to hire, fire or make managerial decisions which could be made by a "supervisor". This standard has been upheld in other cases, including in Arizona and New York; and

Whereas, If hospitals and large organizations allowed physician greater autonomy with true managerial roles, to supervise, hire and fire employees, engage in profit sharing or ownership of facilities physicians would not have the need to unionize; therefore be it

RESOLVED, That the FMA recognize that employed physicians are not "supervisors" and therefore employed physician unions are not in violation of anti-trust laws; and be it further

RESOLVED, That the FMA actively explore and facilitate the formation of a union for employed physicians for protection of our patients and fellow physicians.

Fiscal Note:

Description	Amount	Budget Narrative

101 staff hours	$17,040	Can be accomplished with current staff
Total	$17,040	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

Resolution 22-403

Strategy for Proactive Tort Reform Relief

Dade County Medical Association and Broward County Medical Association

Whereas, Medical liability insurance premiums remain higher in Florida than in most other states; and

Whereas, After a period of relatively stable insurance premiums, the medical liability insurance market is once again showing signs of hardening with insurance carriers posting loss ratios that are unsettling the market and justify the need to increase insurance premiums on physicians over the coming years; and

Whereas, Past efforts to pass meaningful tort reform in Florida have been overturned by the Florida Supreme Court; and

Whereas, Several developments in recent years including turnover on the Florida Supreme Court and an increase in Republican voter registration in the State of Florida, indicate a more favorable environment to pursue tort reform to stabilize the medical liability marketplace; therefore be it

RESOLVED, That the Florida Medical Association create a task force with interested stake holders to review the feasibility of filing legislation that would enact meaningful tort reform including: reinstating caps on non-economic damages; jury notification of settlements reached by other defendants; and a revision of the formula used to extrapolate future medical care that elevates monetary awards.

Fiscal Note:

Description	Amount	Budget Narrative
50 staff hours	$17,000	Can be accomplished with current staff
Task Force	$ 3,750	Meeting expenses, in person and virtual
Total	$20,750	$3,750 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

Resolution 22-404

FMA Stakeholder Engagement in First Coast Service Options (FCSO) Policy Processes

Florida Society of Rheumatology, Florida Academy of Dermatology, Florida Gastroenterologic Society

Whereas, Carrier Advisory Committees (CACs) and other stakeholders have played an important role in review of policy changes put forth by First Coast Service Options (FCSO); and

Whereas, The Local Coverage Determination (LCD) process historically has considered comment and input from a Carrier Advisory Committee, and, in most cases, LCDs require a 45-day comment period; and

Whereas, Florida specialty physicians have strong policy in support of robust FCSO processes for transparency and stakeholder engagement, including engagement of CACs, in reviewing Local Coverage Determinations (LCDs), and in support of local Medicare CACs in their role as policy advisers; and

Whereas, The 21st Century Cures Act included provisions intended to modernize and strengthen the LCD review process and ensure transparency and stakeholder engagement in Medicare Administrative Contractors (MACs) decision making processes, and the Medicare Program Integrity Manual Chapter 13 finalized requirements of the LCD modernization process; and

Whereas, The 21st Century Cures Act and related regulations demonstrate the intent of Congress and CMS to ensure processes for meaningful stakeholder review and input for substantive policy changes; and

Whereas, FCSO issuing changes in coverage policy through local coverage articles (LCAs) without issuing a proposed LCD are circumventing the notice-and-comment period required of LCDs and other substantive rulemaking, bypassing the stakeholder engagement and transparency in decision making that was intended by Congress; and

Whereas, LCAs are typically published by a local Medicare Administrative Contractor to provide coding/billing guidelines or other provider education that is complementary to an existing NCD or LCD.

Whereas, By issuing LCAs without associated LCDs, FCSO is denying stakeholders a meaningful opportunity to review data and decision making criteria, and to provide feedback on proposed changes in coverage policy, and are bypassing consultation with healthcare professional experts and professional societies; and

Whereas, The evidentiary requirements of LCDs are not required in an LCA, and LCAs unilaterally issued without LCDs lack transparency and also do not allow stakeholders to review data or decision criteria, or to submit formal requests for reconsideration of the coverage policy; and

Whereas, These actions by FCSO are counter to and not in the spirit of the transparency and increased stakeholder engagement and review intended by Congress in revising the LCD process by way of the 21st Century Cures Act, nor of CMS' improvements to the LCD process following stakeholder feedback to its Request for Information (RFI) in the CY 2018 Physician Fee Schedule; and

Whereas, The significant changes to LCD procedures stemming from the 21st Century Cures Act also allow FCSO to change their engagement with traditional CACs, and CACs are no longer being engaged by

FCSO to function in their roles in reviewing and commenting on proposed policy changes and therefore no longer have a meaningful function; therefore be it

RESOLVED, That our FMA opposes First Coast Service Option (FCSO) issuing Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes; and be it further

RESOLVED, That our FMA advocate and work with FCSO to ensure no LCAs that could have the effect of restricting coverage or access are issued by FMA without FCSO providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input processes, through the modernization requirement of the 21st Century Cures Act; and be it further

RESOLVED, That our FMA advocate to CMS that the agency immediately invalidate any LCAs that are identified as potentially restricting coverage or access and that were issued without the FCSO providing public data, decision criteria, and evidentiary review, or that were issued without an associated LCD and the required stakeholder processes, and that CMS require FCSO to restart those processes taking any such proposed changes through LCDs and associated requirements for stakeholder engagement, public data, and evidentiary review; and be it further

RESOLVED, That our FMA advocate that Congress consider clarifying legislative language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in 21st Century Cures Act that allowed local CACs to be left without a voice or purpose; and be it further

RESOLVED, That our FMA work with the AMA to clarify that AMA LCD, LCA, and CAC policies are being interpreted and followed correctly by the standards and policies within the CMS guidelines handbook.

Fiscal Note:

Description	Amount	Budget Narrative
staff hours	Unknown	Unable to determine staff hours related to 2nd resolve.
Total	Unknown	Unknown impact on the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

AUTHOR'S STATEMENT OF PRIORITY

Recent reforms to Local Coverage Determination (LCD) processes used by First Coast Service Options (FCSO) have increased transparency, clarity, and responsiveness to local clinical and coverage policy concerns. However, FCSO is still able to utilize Local Coverage Articles (LCAs) to unilaterally issue policy changes that may have the effect of restricting coverage or access, arguing they are only providing

billing instructions when instead the changes could reasonably be expected to have the effect of restricting coverage or access. Unlike with LCDs, by relying on LCAs, FCSO can make significant changes without any requirement that they provide data, scientific justification, or evidentiary review related to the decisions, any notice-and-comment period for stakeholder input, nor any opportunity for reconsideration. One example is FCSO' decisions to reimburse administration of certain highly complex biologics at Medicare's simple therapeutic administration rate, without having to provide stakeholders any scientific explanation of why only the simple therapeutic code is being allowed for those drugs and which decision criteria and data are being used by FCSO, and providing no opportunity for reconsideration, despite evidence-based considerations showing how these drugs' high complexity and safety risks meet the definitions for reimbursement under the complex chemotherapy codes. These changes have significant repercussions for practices' ability to provide treatment access to patients. Decisions like this are happening now without data or evidentiary review being provided and without reconsideration available to physicians. Urgent action is required to further reform these processes to protect physician practices and patient access to care.

73

Resolution 22-405
Medicaid Expansion
Hillsborough County Medical Association

Whereas, In 2013, the federal government approved an amendment for statewide expansion of Medicaid known as Managed Medical Assistance; and

Whereas, Florida is one of 12 states that has not expanded Medicaid eligibility and has repeatedly declined to do so since the option became available in 2014; and

Whereas, In consequence of Florida not expanding Medicaid, the newly insured population is not covered according to a normal state/federal split thereby losing over 6 billion dollars of federal money in 2022 according to Healthinsurance.org; and

Whereas, Florida's decision not to expand Medicaid leaves nearly 400,000 people in the state in the "coverage gap;" and

Whereas, Florida's economy is negatively impacted by not expanding Medicaid according to an analysis by the Robert Wood Johnson Foundation; and

Whereas, According to the Commonwealth Fund's 2019 Scorecard on State Health System Performance, Florida ranks near the bottom of all states on measures of access and affordability; and

Whereas, The Florida Medical Association is an advocate for its physicians and their patients to promote the public health; therefore be it

RESOLVED, that the Florida Medical Association seek legislation that will enable Florida to apply for statewide expansion of Medicaid under the Affordable Care Act.

Fiscal Note:

Description	Amount	Budget Narrative
500 staff hours	$75,000	Can be accomplished with current staff
Total	$75,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

Resolution 22-407
Uncompensated Care Reimbursement for Physicians
Northeast Florida Delegation

Whereas, The Low Income Pool (LIP) funds were provided for eligible providers to cover health care costs for which compensation was not available from other payors; and

Whereas, LIP provided government support for providers that furnished uncompensated care to the Medicaid, underinsured, and uninsured populations; and

Whereas, physicians are not included in LIP; and

Whereas, physicians are mandated by Federal Law (EMTALA) and State Law to provide emergency care to patients no matter their ability to pay; and

Whereas, physicians provide uncompensated care on a daily basis through hospitals across the state; therefore be it

RESOLVED, That the Florida Medical Association study and report back on how to compensate physicians for the provision of uncompensated care that is a result of EMTALA.

Fiscal Note:

Description	Amount	Budget Narrative
50 staff hours	$3,250	Can be accomplished with current staff
Total	$3,250	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

Resolution 22-408
Physicians for the Protection of Private Information
Northeast Florida Delegation

Whereas, The American Medical Association (AMA) holds a Physician Masterfile of virtually all physicians in the United States; and

Whereas, The AMA Physician Masterfile has expanded to include significant education, training and professional certification information on virtually all Doctors of Medicine (MD) and Doctors of Osteopathic Medicine (DO) in the United States, Puerto Rico, Virgin Islands and certain Pacific Islands; and

Whereas, The AMA began licensing its Physician Masterfile to external used more than 60 years ago; and

Whereas, The AMA has a policy that all physicians automatically participate in the Masterfile unless they opt out of the system; and

Whereas, Most physicians are not aware that such Masterfile exists and that the AMA distributes this information to industry; and

Whereas, The AMA has a physician Data Restriction Program which empowers physicians by allowing them to restrict pharmaceutical sales representatives from accessing their prescribing data; and

Whereas, The Do Not Release policy prohibits the AMA from releasing any Physician Masterfile information on the physician. If a physician instructs the AMA to flag his/her record as Do Not Release, AMA Database Licensees will no longer have the right to use Physician Masterfile information for the purpose of contacting the physician, which would include health hazard warnings and drug recalls. The Do Not Release flag will also prohibit release of Physician Masterfile information to state licensing boards and hospitals that use this information to verify credentials, unless the AMA has written permission from the physician to release his/her Physician Masterfile information to a specific organization; and

Whereas, The No Contact status on a Physician Masterfile record ensures that the physician's name will not be licensed for purposes of marketing to the physician via mail, telephone or fax; therefore be it

RESOLVED, That the Florida Medical Association make a request to the AMA to make participation in the Data Restriction Program more transparent as well as clarify the Do not Release Policy and The No Contact Status making them easier to work with and opt out off; and be it further

RESOLVED, The FMA educate physicians on the AMA's Masterfile via an article published through one of their newsletters. This article should include information on how their private information is used and how to opt out of this system via the Data Restriction Program if they are inclined to do so.

Fiscal Note:

Description	Amount	Budget Narrative
25 staff hours	$1,650	Can be accomplished with current staff

Total	$1,650	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics

Resolution 22-409
Fair Compensation for Resident's Work
Northeast Florida Delegation

Whereas, Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPS) are allowed to bill for services performed without immediate supervision; and

Whereas, Residents perform procedures, see patients in clinic or during consultation under supervision from attending physicians; and

Whereas, Attending physicians are still liable for services performed by Residents and Fellows; and

Whereas, There has been a current expansion in Telehealth services and billing options; and

Whereas, Adding a telehealth supervision option could improve care to rural areas; and

Whereas, Medicare pays for services furnished in teaching settings through the Medicare Physician Fee Schedule (PFS) if the services meet one of these criteria:

- They are personally furnished by a physician who is not a resident
- They are furnished by a resident when a teaching physician is physically present during the critical or key portions of the service or
- They are furnished by a resident under a primary care exception within an approved Graduate Medical Education (GME) Program; and

Whereas, The American Medical Association policy titled Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries H-390.999 states that when a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision; therefore be it

RESOLVED, That the Florida Medical Association (FMA) study and report back to determine if there is a need to change Florida Telehealth law to include and option for Attending physicians to use Telehealth while services are provided by Residents and Fellows so they can appropriately bill for these services without having to be physically present

Fiscal Note:

Description	Amount	Budget Narrative
20 staff hours	$3,400	Can be accomplished with current staff
Total	$3,400	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: IV – Medical Economics