Attention Delegates and Alternate Delegates:

There will be no printed copies of this Official Reports Book (ORB) at the House of Delegates this year. All meeting rooms will have WiFi, but due to the larger file size we recommend you print or save this ORB before arriving at the meeting. You will want to bring your computer or tablet to the meeting to access updates.

On Sunday, reference committee reports will be posted to www.pamedsoc.org/HOD to be accessed prior to the caucuses and opening of the House.

The ORB will be updated as we receive changes or additions. A date will appear at the top indicating when it has been updated. A * will mark revised sections.

To access this PDF offline you will need to save it to your computer. Click on the disk icon in the top left or select Save from the File menu. The ORB can easily be navigated using the table of contents or by turning on the bookmarks navigation panel from under View.

If you are on a tablet, we recommend you open this in a PDF reader application (i.e., iBooks, Amazon Kindle App, etc). Use the table of contents or your tablet’s bookmark feature to navigate the ORB.
Click on the links below to jump to that section:

- Schedule of Events
- Order of Business
- Reference Committee List
- Official Call
- Delegates and Alternate Delegates to the Pennsylvania Medical Society
- Seating Plan for the 2016 House
- Ex Officio Members
- Members Eligible for Election to the Judicial Council
- Pennsylvania Medical Society Presidents
- PAMED Membership Figures Map
- Board of Trustees List
- AMA Delegation List
- One-Page Election Guide
  - William R. Dewar, III, MD - VP Disclosure Statement
  - Danae M. Powers, MD - VP Disclosure Statement
- Memorial Resolutions:
  - Donald W. Spigner, MD, Walter I. Hofman, MD, Richard P. Whittaker, MD
  - Charles D. Hummer, JR., MD, John W. Mills, MD., Carmela F. deRivas, MD
- PMSA's Wellness Central & Boutique
- House of Delegates Procedures Book
- Parliamentary Procedure Chart

Information Reports

- Reports of Board of Trustees
  - BOT 1: 2015 House of Delegates Resolutions
  - BOT 7: Membership Dues
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  - Necrology Report

- Reports of Standing Committees
  - Nominate Delegates & Alternates to the AMA

- Reports of Officers
  - Auditor Report
  - Executive Vice President Report
  - Secretary Report
  - Speaker, House of Delegates
  - Treasurer’s Report

- Miscellaneous Reports
  - Pennsylvania Delegation to the AMA Report
  - Pennsylvania Medical Political Action Committee Report
  - Foundation of the Pennsylvania Medical Society Report

- Rules and Credentials
  - Late Resolutions Report
  - Standing Rules
Reference Committee Reports

Reference Committee A: Bylaws
Order of Business and Summary of Proposed Bylaw Amendments

Reference Committee B: Education & Science/Public Health
Res 16-201: Elimination of Tobacco Sales
Res 16-202: Further Addressing the Overdose Crisis
Res 16-203: Seeking Support of Pennsylvania Immunization Coalition
Res 16-204: Eliminating Barriers to Children Possessing and Using Sunscreen in School
Res 16-205: Transfer of Jurisdiction Over Required Clinical Skills Examinations to LCME Accredited and COCA-Accredited Medical Schools
Res 16-206: Pennsylvania Medical Society Support for a Moratorium on Fracking
Res 16-207: Promote Teen Health Week
Res 16-208: Support for Liability Protection in Administration of Naloxone in Schools
Res 16-209: Increase in Availability of Opioid Rescue Medication and Medication-Assisted Treatment
BOT 2, Res 15-201: Clinical Rotations in Pennsylvania Hospitals for Medical Students of International Medical Schools

Reference Committee C: Managed Care & Other Third Party Reimbursement
Res 16-301: Standardize Observation Status Among Insurers
Res 16-302: Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing
Res 16-303: Clinical Pathways
Res 16-304: Resolution revised, renumbered as 506 and referral changed to Reference Committee E BOT 3, Res 15-302: Informing Public of Hospital Revenue per Inpatient Day of Care

Reference Committee D: Mcare Fund/Tort Reform/other Legislation/Regulation
Res 16-401: Oppose Mandate to Mandated E-Prescribing
Res 16-402: Abolish the 30-Day Waiting Period for Tubal Sterilization for Medicaid Beneficiaries
Res 16-403: Fairness for Physicians Cleared of Wrongdoing by their State Licensing Board
Res 16-404: Comprehensive Women’s Reproductive Health Care
Res 16-405: Protect Confidentiality of Dependents of Insurance Policyholders
Res 16-406: Hepatitis C Screening Act and Discretion of Physician Practice
Res 16-407: The Pennsylvania Medical Society Recommend Legislation to Train and License Unmatched Residency Applicants as Independent Primary Care Providers in Areas of Pennsylvania with Physician Shortage
Res 16-408: Address and Petition CMS and Legislators to Allow for a Process of Appeal to Negative Statements and Reports to the National Practitioner Data Bank
Res 16-409: Support Closing Pennsylvania’s Private Sale Loophole for Long Guns by Requiring Background Checks for All Firearms Transfers
BOT 4, Res 15-404: Protect Physicians Who Wish to Terminate Futile Medical Care from Civil and Criminal Prosecution
Reference Committee E: Membership/Leadership/Subsidiaries
Res 16-501: Practicing Physician Declining Membership Analysis ....................................................
Res 16-503: Analysis of American Board of Internal Medicine (ABIM) Finances ................................
Res 16-504: Endorse National Board of Physicians and Surgeons (NBPAS) for Recertification .........
Res 16-505: Support Reform of the Maintenance of Certification (MOC) Process and Adopt a Position Favoring Acknowledgment of an Alternative Board, the National Board of Physicians and Surgeons (NBPAS), for Certification of Physicians Pursuing Lifelong Education ........................................................................................................

BOT 5, Res 15-503: The Education of Pennsylvania Physicians, Fellows, Residents, and Students to the Legislative Processes of Pennsylvania and How to Participate Therein ................................................................................................................................

BOT 6: Policy Sunset ................................................................................................................................

Reference Committee of the Whole:
Res 16-COW: Practice Options Initiative Concept and Funding ..........................................................
2016 House of Delegates & Annual Education Conference Schedule

*Events in RED are by Invitation ONLY*

**Thursday, October 20**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:30 pm</td>
<td>Finance Committee (Invite Only)</td>
<td>Cocoa 3 &amp; 4</td>
</tr>
<tr>
<td>6:00 pm</td>
<td>Dinner (Invite Only)</td>
<td>Cocoa 5</td>
</tr>
<tr>
<td>7:00 am – 8:30 pm</td>
<td>Registration</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>7:00 am – 8:30 pm</td>
<td>Exhibits</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>8:00 am</td>
<td>Executive Committee (Invite Only)</td>
<td>Wild Rose A</td>
</tr>
<tr>
<td>9:00 am</td>
<td><strong>Board of Trustees Meeting</strong></td>
<td><strong>Empire A-B-C-D</strong></td>
</tr>
<tr>
<td>8:00 am – 12:00 pm</td>
<td><strong>CME Education</strong> –</td>
<td>Trinidad</td>
</tr>
<tr>
<td>8:00 am – 12:00 pm</td>
<td><em>Be Smart, Be Safe, Be Sure: Approaches to Managing Your Patients with Chronic Pain</em></td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>12:00 pm</td>
<td>Educational Session Box Lunch</td>
<td>Forebay Lounge</td>
</tr>
<tr>
<td>12:00 pm</td>
<td>Board of Trustees Luncheon (Invite Only)</td>
<td>Magnolia A-B</td>
</tr>
<tr>
<td>12:30 pm – 3:30 pm</td>
<td><strong>CME Education</strong> –</td>
<td>Trinidad</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>PA AMA Delegation Caucus</td>
<td>Wild Rose A-B</td>
</tr>
<tr>
<td>3:45 pm – 5:15 pm</td>
<td><em>Pennsylvania Health Care Topics Debate</em></td>
<td>Trinidad</td>
</tr>
<tr>
<td>5:00 pm – 7:00 pm</td>
<td><strong>County Presidents’ and President Elects Meeting</strong></td>
<td><strong>Empire CD</strong></td>
</tr>
<tr>
<td>6:00 pm</td>
<td>Committee on Rules &amp; Credentials</td>
<td>Tower 1</td>
</tr>
<tr>
<td>6:00 pm – 7:00 pm</td>
<td>Young Physician Section Annual Meeting (YPs)</td>
<td>Crystal A</td>
</tr>
<tr>
<td>6:00 pm – 7:00 pm</td>
<td>Medical Student Section Meeting (MSS)</td>
<td>Magnolia B-C-D</td>
</tr>
<tr>
<td>6:00 pm – 7:00 pm</td>
<td>International Medical Graduates Meeting (IMG)</td>
<td>Wild Rose A-B</td>
</tr>
<tr>
<td>6:00 pm – 7:00 pm</td>
<td>Residents &amp; Fellows Annual Meeting (RFS)</td>
<td>Magnolia A</td>
</tr>
<tr>
<td>6:15 pm – 7:00 pm</td>
<td>Presidents’ Reception (Invite Only)</td>
<td>Empire A-B</td>
</tr>
<tr>
<td>7:00 pm – 8:30 pm</td>
<td>Presidents’ Dinner (Invite Only)</td>
<td>Empire A-B</td>
</tr>
<tr>
<td>7:00 pm – 8:30 pm</td>
<td>Information Session for Reference Committee of the Whole</td>
<td>Trinidad</td>
</tr>
<tr>
<td>8:00 pm – 9:00 pm</td>
<td>PAMPAC Social (Invite Only)</td>
<td>Trinidad</td>
</tr>
<tr>
<td>9:00 pm – 10:00 pm</td>
<td>PAMED Social (Open to ALL)</td>
<td>Trinidad</td>
</tr>
</tbody>
</table>

**Friday, October 21**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 pm – 7:00 pm</td>
<td>Clinically Integrated Network Overview and Q&amp;A</td>
<td>Trinidad</td>
</tr>
<tr>
<td>6:30 am – 7:30 am</td>
<td>Continental Breakfast</td>
<td>Confection Lobby</td>
</tr>
<tr>
<td>6:30 am – 7:00 pm</td>
<td>Registration</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>7:00 am – 5:00 pm</td>
<td>Exhibits</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>7:00 am</td>
<td>First District Caucus</td>
<td>Wild Rose A</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Second &amp; Fifth Districts Caucus</td>
<td>Magnolia B-C-D</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Third, Fourth, Seventh, Twelfth, Sixth, Eighth, Ninth, Tenth &amp; Eleventh Districts Caucus</td>
<td>Empire C-D</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Thirteenth District Caucus</td>
<td>Magnolia A</td>
</tr>
<tr>
<td>7:00 am</td>
<td>YPS Caucus</td>
<td>Empire A</td>
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<tr>
<td>7:00 am</td>
<td>MSS/RFS Caucus</td>
<td>Empire B</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Specialty Trustees/Specialty Delegates Caucus</td>
<td>The Forebay</td>
</tr>
<tr>
<td>7:15 am</td>
<td>Reference Committee Chairs’ Breakfast</td>
<td>Aztec/Nigerian</td>
</tr>
<tr>
<td>8:30 am</td>
<td>House of Delegates (HOD)</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>10:30 am – 11:00 am</td>
<td>AMA Delegation Candidates Speeches &amp; AMA Delegation Presentation</td>
<td>Aztec/Nigerian</td>
</tr>
<tr>
<td>11:00 am</td>
<td>Box Lunches</td>
<td>Aztec/Nigerian</td>
</tr>
<tr>
<td>11:30 am – 1:30 pm</td>
<td>Reference Committee of the Whole</td>
<td>Empire A</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee A</td>
<td>Wildrose A-B</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee B</td>
<td>Crystal A</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee E</td>
<td>Empire B-C</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee D</td>
<td>Magnolia A</td>
</tr>
<tr>
<td>2:00 pm – 4:00 pm</td>
<td>Elections</td>
<td>Cocoa 6</td>
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**Saturday, October 22**

<table>
<thead>
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<tbody>
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<td>Exhibits</td>
<td>Chocolate Lobby</td>
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<tr>
<td>7:00 am – 5:00 pm</td>
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<td>Chocolate Lobby</td>
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<tr>
<td>7:00 am</td>
<td>First District Caucus</td>
<td>Wild Rose A</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Second &amp; Fifth Districts Caucus</td>
<td>Magnolia B-C-D</td>
</tr>
<tr>
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<td>The Forebay</td>
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<td>Aztec/Nigerian</td>
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<tr>
<td>8:30 am</td>
<td>House of Delegates (HOD)</td>
<td>Chocolate Lobby</td>
</tr>
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<td>10:30 am – 11:00 am</td>
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</tr>
<tr>
<td>11:00 am</td>
<td>Box Lunches</td>
<td>Aztec/Nigerian</td>
</tr>
<tr>
<td>11:30 am – 1:30 pm</td>
<td>Reference Committee of the Whole</td>
<td>Empire A</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee A</td>
<td>Wildrose A-B</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee B</td>
<td>Crystal A</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee E</td>
<td>Empire B-C</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Reference Committee D</td>
<td>Magnolia A</td>
</tr>
<tr>
<td>2:00 pm – 4:00 pm</td>
<td>Elections</td>
<td>Cocoa 6</td>
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Saturday, October 22 (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>4:00 pm - 5:00 pm</td>
<td>CME Education – The Hitchhiker's Guide to the Health Care Galaxy</td>
<td>Magnolia B-C-D</td>
</tr>
<tr>
<td>4:30 pm</td>
<td>Catholic Church Service</td>
<td>Empire D</td>
</tr>
<tr>
<td>5:00 pm - 6:00 pm</td>
<td>Education – Evaluating Scientific Research: Resident &amp; Fellow Poster Reviews</td>
<td>Great Lobby</td>
</tr>
<tr>
<td>5:15 pm</td>
<td>Reception and AMES Fundraiser (Silent Auction)</td>
<td>Red &amp; White</td>
</tr>
<tr>
<td>6:00 pm - 9:00 pm</td>
<td>Inaugural Program &amp; Dinner (Election Results Announced)</td>
<td>Red &amp; White</td>
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Sunday, October 23

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>6:00 am</td>
<td>Re-Credentialing &amp; Registration</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>6:30 am</td>
<td>Continental Breakfast</td>
<td>Confection Lobby</td>
</tr>
<tr>
<td>7:00 am - 12:30 pm</td>
<td>Exhibits</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Elections (If Needed)</td>
<td>Cocoa 6</td>
</tr>
<tr>
<td>7:00 am</td>
<td>First District Caucus</td>
<td>Empire C-D</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Thirteenth District Caucus</td>
<td>Wild Rose A-B</td>
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<td>Empire B</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Specialty Trustees/Specialty Delegates Caucus</td>
<td>Cocoa 6</td>
</tr>
<tr>
<td>7:00 am</td>
<td>Elections (Any Run-Off Elections)</td>
<td>Aztec/Nigerian</td>
</tr>
<tr>
<td>8:00 am</td>
<td>House of Delegates (HOD)</td>
<td>Chocolate Lobby</td>
</tr>
<tr>
<td>10:00 am - 1:00 pm</td>
<td>Boxed Healthy Snack</td>
<td>Wildrose A-B</td>
</tr>
</tbody>
</table>

Following HOD Board of Trustees Reorganization Meeting

BOLD = Change
1. Call to Order by the Speaker—Martin D. Trichtinger, MD
2. Invocation—Carol E. Rose, MD
3. National Anthem and Pledge of Allegiance
4. Report of the Committee on Rules & Credentials—James W. Thomas, MD, Chair
5. Approval of Proceedings
7. Report of the Committee on Rules & Credentials (Late Resolutions)—James W. Thomas, MD, Chair
8. Address of the President—Scott E. Shapiro, MD, FACC, FACP, FCPP
9. Remarks by the Pennsylvania Medical Society Alliance President—Mrs. Caryl Schmitz
10. Address of the President Elect—Charles Cutler, MD, MACP
11. Remarks by the Chair of the Board, PAMPAC—John C. Wright, Jr., MD
12. Remarks by the Secretary of the Board, AMPAC—Vidya Kora, MD
13. Remarks by the Chair of the Board, Foundation of the Pennsylvania Medical Society—Raymond C. Truex, Jr., MD, FACS
14. Remarks by the PAMED Interim Executive Vice President—Heather A. Wilson, MSW, CFRE, Interim Executive Vice President, Pennsylvania Medical Society and Executive Director, Foundation of the Pennsylvania Medical Society
15. Nominations and/or Elections

(Note: All known nominees were published in the Official Call. According to Chapter X, Section 1 of the PAMED Bylaws: “Where candidates for offices are unopposed, except for the office of vice president, there will be no nominating speeches.”)

Vice President
Speaker
Vice Speaker
Trustees:

Second District
Ninth District
Tenth District
Thirteenth District
Primary Care (Pediatrics)
Psychiatry
International Medical Graduates Section
Residents & Fellows Section
Young Physicians Section
Medical Students Section

Delegates and Alternate Delegates to the AMA
Committee to Nominate Delegates & Alternates to the AMA
Judicial Council

16. Candidates’ Speeches for Contested Elections
17. Announcements
18. Recess

(The inauguration of Charles Cutler, MD, MACP as the 167th President of the Pennsylvania Medical Society will be held at 6:00 pm in the Red and White Rooms of the Hershey Lodge. Dinner will follow in the same room. The inaugural is being held in conjunction with the Alliance Medical Education Scholarship Fund (AMES) Fundraiser. Wine and hors d’oeuvres will be available at 5:15 pm. Silent Auction items will be available for viewing all afternoon in the Red and White Rooms.)
1. Call to Order by the Speaker—Martin D. Trichtinger, MD
2. Report of the Committee on Rules & Credentials—James W. Thomas, MD, Chair
3. Reports from Reference Committees of the House of Delegates
4. Remarks by the AMA Representative—Patrice A. Harris, MD, MA, Board Chair, American Medical Association (Introduction by James A. Goodyear, MD, Chair—Pennsylvania Delegation to the AMA)
5. New or Unfinished Business
6. Announcements
7. Adjournment
REFERENCE COMMITTEES

On Saturday, October 22, 2016, reference committees which have been designated and appointed by the Speakers of the House of Delegates will convene open hearings. (The Committee on Rules & Credentials will meet on Friday, October 21, 2016.) The committees and their members are as follows:

REFERENCE COMMITTEE A (Standing Committee on Bylaws)
JENNIFER L. LEWIS, MD, CHAIR (Washington County)
   Mark S. Friedlander, MD (Delaware County)
   Kevin O. Garrett, MD (Allegheny County)
   Cadence A. Kim, MD, FACS (Philadelphia County)
   Shyam Sabat, MD (Young Physicians Section)

REFERENCE COMMITTEE B (Education & Science/Public Health)
KINNARI PATEL, MD, CHAIR (Philadelphia County)
   Robert D. Barraco, MD (Lehigh County)
   Justin V. Chacko, DO (Residents & Fellows Section)
   Rajendra N. Seth, MD (Philadelphia County)
   Carol A. Westbrook, MD (Luzerne County)

REFERENCE COMMITTEE C (Managed Care & Other Third Party Reimbursement)
MARIA J. SUNSERI, MD, FAASM, CHAIR (Allegheny County)
   Patrick F. McSharry, MD, MBA, CHCQM (Dauphin County)
   Winslow W. Murdoch, MD (Chester County)
   Jay E. Rothkopf, MD (Young Physicians Section)
   Joseph J. Stemm, MD (Montour County)
   Adele L. Towers, MD (Allegheny County)

REFERENCE COMMITTEE D (Mcare Fund/Tort Reform/Other Legislation/Regulation)
SALVATORE A. LOFARO, MD, CHAIR (Delaware County)
   Ronald B. Anderson, MD (Delaware County)
   Timothy D. Pelkowski, MD (Erie County)
   Chand Rohatgi, MD, BS, FACS (Northampton County)
   Benjamin Schlechter, MD, FACS (Berks County)
   John P. Williams, MD (Allegheny County)

REFERENCE COMMITTEE E (Membership/Leadership/Subsidiaries)
WILLIAM R. DEWAR, III, MD, FACP, CHAIR (Wayne/Pike County)
   Aasta D. Mehta, MD (OB/GYN Specialty Society)
   Amelia A. Paré, MD, FACS (Allegheny County)
   Judith R. Pryblick, DO (Lehigh County)
   Warren L. Robinson, Jr., MD, FACP (Lycoming County)
   John M. Vasudevan, MD (Young Physicians Section)
REFERENCE COMMITTEE OF THE WHOLE (Clinically Integrated Networks)
DAVID A. TALENTI, MD, CHAIR (Chair, Executive Committee)
  John P. Gallagher, MD (Executive Committee)
  Scott E. Shapiro, MD (Executive Committee)
  Charles Cutler, MD (Executive Committee)
  Theodore A. Christopher, MD (Executive Committee)
  Karen A. Rizzo, MD (Executive Committee)
  Martin D. Trichtinger, MD (Executive Committee)
  F. Wilson Jackson, III, MD (Executive Committee)

COMMITTEE ON RULES & CREDENTIALS
JAMES W. THOMAS, MD, CHAIR (Montgomery County)
  George R. Green, MD (Montgomery County)
  Virginia E. Hall, MD, FACOG, FACP (Dauphin County)
    Tani Malhotra, MD (York County)
    Jill M. Owens, MD (McKean County)
    Timothy D. Welby, MD (Lackawanna County)

TELLERS/SERGEANTS-AT-ARMS
PHILLIP R. LEVINE, MD, CHIEF (Allegheny County)
  James A. Betler, DO (Allegheny County)
  Joseph B. Blood, Jr., MD (Bradford County)
  V. Hema Kumar, MD (Westmoreland County)
  Albert S. Kroser, DO (Philadelphia County)
  Deval M. Paranjpe, MD (Allegheny County)
  Suneel S. Valla, MD (Northampton County)
OFFICIAL CALL TO 2016 MEETING

The 2016 annual meeting of the House of Delegates of the Pennsylvania Medical Society (PAMED) will be called to order at the Hershey Lodge, Hershey, Pennsylvania, on Saturday, October 22nd at 8:30 am. The second session of the House is scheduled for Sunday, October 23rd at 8:00 am.

ELECTIONS

In accordance with Chapter XII, Section 1 of the PAMED Bylaws, “(t)he officers of this Society shall be a president, a president elect, a vice president, an immediate past president, a secretary, a treasurer, and a speaker and a vice speaker of the House of Delegates. There may be such assistant treasurers and assistant secretaries as may be designated by resolution by the Board of Trustees.”

Chapter XI, Sections 1-4 state that:

Elections shall be held in accordance with these bylaws and the Standing Rules of the House of Delegates.

All contested elections shall be by ballot and a majority vote shall be necessary to elect candidates except that delegates and alternates to the American Medical Association and to the Committee to Nominate Delegates and Alternates to the American Medical Association shall be elected by a plurality vote.

Election by acclamation shall be valid when there is no contest and therefore such positions need not be included on a ballot.

The speaker shall appoint tellers who shall be responsible to the speaker for a count on a vote in any session of the meeting of the House of Delegates. Tellers are also responsible for the counting of all ballots and reporting the results directly to the speaker.

In accordance with Chapter X, Section 1 of the Bylaws: “Nominations for all offices to be elected by the House of Delegates may be made by seated delegates from the floor of the House or published in the Official Call upon recommendation of the respective section or district. To be accepted by the House, nominees should possess the prescribed qualifications for the office for which they are nominated.”

Chapter X continues: “Nominees for officers and trustees, if known, will be published in the Official Call. Where candidates for offices are unopposed, except for the office of Vice President, there will be no nominating speeches. Nominations for delegates and alternates to the American Medical Association shall be made by the Committee to Nominate Delegates and Alternates to the American Medical Association and published in the Official Call. Nominations for the Judicial Council shall be made by the Board of Trustees at least thirty (30) days prior to the annual meeting. At least one qualified person shall be nominated for each expiring term. These names should be disseminated to the members of this Society via appropriate means as determined by the secretary. Nominations for district trustees shall be made from the floor of the House and only by seated delegates from their respective districts for which positions need to be filled. Nominations for a trustee from the specialties organized in Pennsylvania and recognized by the Pennsylvania Medical Society and the American Board of Medical Specialties shall be made by the seated delegates from those specialties in the House of Delegates. Nominations for special section trustees shall be made from the floor of the House and only by seated delegates from their respective special sections for which positions need to be filled.”
In accordance with Chapter XI of the Bylaws, the following elections shall be in order:

Vice President: William R. Dewar, III, MD (Wayne/Pike County) and Danae M. Powers, MD (Centre County) are seeking election.

Speaker, House of Delegates to succeed Martin D. Trichtinger, MD (Montgomery County): John J. Pagan, MD (Bucks County) is seeking election.

Vice Speaker, House of Delegates to succeed John J. Pagan, MD (Bucks County): Todd M. Hertzberg, MD (Allegheny County) and John W. Spurlock, MD (Northampton County) are seeking election.

Second District Trustee: Mark A. Lopatin, MD (Montgomery County)—who was appointed at the February 10, 2016 Board of Trustees meeting to fill the vacant 2nd District seat until the 2016 annual meeting—is eligible and is seeking election, and Chand Rohatgi, MD (Northampton County), who is seeking election.

Ninth District Trustee: Erick J. Bergquist, MD, PhD (Indiana County), who is eligible and is seeking re-election.

Tenth District Trustee: Donald C. Brown, MD (Westmoreland County), who is eligible and is seeking re-election.

Thirteenth District Trustee to succeed John F. Delaney, Jr., MD (Allegheny County), who is eligible but is not seeking re-election: Amelia A. Paré, MD (Allegheny County).

Primary Care (Pediatrics) Trustee: Steven A. Shapiro, DO (Montgomery County), who is eligible and is seeking re-election, and has been nominated by the Specialty Leadership Cabinet.

Psychiatry Trustee: Michael Feinberg, MD, PhD (Montgomery County), who is eligible and is seeking re-election, and has been nominated by the Specialty Leadership Cabinet.

International Medical Graduates Section Trustee: Bindukumar C. Kansupada, MD (Bucks County), who is eligible for re-election.

Residents & Fellows Section Trustee: Hans T. Zuckerman, DO (Lebanon County), who is eligible for re-election.

Young Physicians Section Trustee to succeed Kristen M. Sandel, MD (Berks County), who is not eligible for re-election: John M. Vasudevan, MD (Philadelphia County) is seeking election.

Medical Students Section Trustee to succeed John S. Trickett, Jr. (Lackawanna County), who is eligible but is not seeking re-election: Cicily Vachaparambil (Philadelphia County) is seeking election.

In accordance with Chapter X, Section 1 of the Bylaws, elections for Delegates and Alternate Delegates to the American Medical Association are in order. In accordance with Standing Rule Number 10, elections for Delegates will be held on Saturday afternoon, October 22, 2016, and elections for Alternate Delegates will be held on Sunday morning, October 23, 2016.
Delegates whose terms expire December 31, 2016 are:

1. James A. Goodyear, MD (Montgomery County)
2. Daniel B. Kimball, Jr., MD (Berks County)
3. Anthony M. Padula, MD (Philadelphia County)
4. John P. Williams, MD (Allegheny County)
5. Virginia E. Hall, MD (Dauphin County)

The Committee to Nominate Delegates and Alternates to the American Medical Association makes the following nominations for Delegates to serve for two (2) years commencing January 1, 2017 and expiring December 31, 2018:

1. James A. Goodyear, MD (Montgomery County)
2. Daniel B. Kimball, Jr., MD (Berks County)
3. Anthony M. Padula, MD (Philadelphia County)
4. John P. Williams, MD (Allegheny County)
5. Virginia E. Hall, MD (Dauphin County)

Alternate delegates whose terms expire December 31, 2016 are:

1. John P. Gallagher, MD (Mercer County)
2. Bruce A. MacLeod, MD (Allegheny County)
3. Jane A. Weida, MD (Berks County)
4. John M. Vasudevan, MD (Philadelphia County), who was appointed by the Board in May, 2016 to fill Dr. Virginia Hall’s seat when she was elevated from an Alternate to a Delegate

The Committee to Nominate Delegates and Alternates to the American Medical Association makes the following nominations for Alternate Delegates to serve for two (2) years commencing January 1, 2017 and expiring December 31, 2018:

1. John P. Gallagher, MD (Mercer County)
2. Bruce A. MacLeod, MD (Allegheny County)
3. Jane A. Weida, MD (Berks County)
4. John M. Vasudevan, MD (Philadelphia County)

The Committee to Nominate Delegates and Alternates to the American Medical Association has not yet received a nomination from the Residents and Fellows Section for one slotted position for Alternate Delegate for a one-year term commencing immediately following the conclusion of the 2016 House of Delegates’ annual meeting and expiring at the conclusion of the next annual meeting to replace Dane Scantling, DO (Philadelphia County) who is eligible for re-election.

The Committee to Nominate Delegates and Alternates to the American Medical Association has not yet received a nomination from the Medical Students Section for one slotted position for Alternate Delegate for a one-year term commencing January 1, 2017 and expiring December 31, 2017 to replace Michael Loesche (Philadelphia County) who is eligible for re-election.
Also to be elected will be two members for three-year terms to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. The term of Jonathan E. Rhoads, Jr., MD (York County) expires; he is eligible to serve and is seeking re-election. Charles Cutler, MD (Montgomery County) was appointed in 2016 by the Board to serve a term expiring at the conclusion of the 2016 House of Delegates. He is eligible to serve and is seeking election.

In accordance with Chapter XVI, Section 2 of the Bylaws, the Board of Trustees nominates the following member for a vacancy on the Judicial Council for a three-year term: For the office now held by Carol E. Rose, MD (Allegheny County), who is eligible to serve and is seeking re-election, the Board nominates Carol E. Rose, MD (Allegheny County).
2016 Delegates and Alternate Delegates to the Pennsylvania Medical Society
(Delegates are listed first, alternate delegates second)

Adams (2)
Dende, Paul F., DO, FACP

Allegheny (24)
Appasamy, Ragunath, MD
Betler, James A., DO
Carignan, Coleen A., MD
Clough, Douglas F., MD, FACP
Coppula, William F., MD
Daroski, M. Sabina, MD
Gabriel, George C.
Garrett, Kevin O., MD
Goldstein, Sharon L., MD
Hertzberg, Todd M., MD
John, Lawrence R., MD
Landay, Ronald A., MD
Levine, Phillip R., MD
Mechling, Courtney A., MD
Paranjpe, Deval M., MD
Paré, Amelia A., MD, FACS
Piñer, Gerald W., MD
Schmeltz, Ralph, MD, FACP, FACE
Straka, Matthew B., MD
Sunseri, Maria J., MD
Towers, Adele L., MD
Van Ham, Raymond
Wildor, Bruce L., MD, JD
Williams, John P., MD
Deitrick, David J., DO
MacLeod, Bruce A., MD
Pavignianiti, Joseph C., MD
Sirio, Carl A., MD
Varma, Rajiv R., MD
Zuniga-Penaranda, Nicolas

Beaver (3)
Wright, John C., Jr., MD

Berks (7)
Atwell, Margaret S., MD, FACP, FACOEM
Baxter, D. Michael, MD
Kimball, Daniel B., Jr., MD, MACP
Sachs, Rachel Vanessa, DO
Schlechter, Benjamin, MD, FACS
Trues, Raymond C., Jr., MD, FACS
Wilson, Gregory T., DO

Blair (3)
Blood, Joseph B., Jr., MD
Porter, Burdett R., MD, MMM, CPE, FAAPL

Bucks (8)
Alderfer, James Todd, MD
Butler, Sean, DO
Cavale, Arvind R., MD
Gallagher, John T., MD
Gallagher-Braun, Judith E., MD
Helmold, Karl W., MD, FACS
Levin, David A., DO
Snyder, Barry J., MD

Butler (3)

Cambria (3)
Csikos, David A., MD
Furigay, Rodolfo Lazo, MD
Swansiger, Robert J., MD

Centre (2)

Clarin (2)
Freenock, Thomas F., Jr., MD

Clearfield (2)

Clinton (2)
Greenberg, Michael R., MD, MBA

Columbia (2)

Crawford (2)

Cumberland (5)
Dauphin (9)
Anderson, Douglas, DO
Ettlinger, Robert A., MD
Goldman, John D., MD
Hall, Virginia E., MD, FACOG, FACP
McSharry, Patrick Feargal, MD, MBA
Parikh, Mukul L., MD
Poles, Gwendolyn A., DO
Sabat, Shyam, MD
Zale, Connor Lawrence
Altaker, Lawrence L., MD, DLFAPA
Anderson, Bryan E., MD
Bosak, Michael D., MD
Forney, John P., MD
Geraci, Leonardo Anthony, DO
Hills, Everett C., MD
Walker, Andrew R., MD

Delaware (7)
Anderson, Ronald B., MD
Clay, Stephen N., MD
Friedlander, Mark S., MD
Hollman, Fredric N., MD
Kroser, Joyann A., MD
Laskas, Joseph W., DO
Lofaro, Salvatore A., MD
Fohrer, Aviva, MD
Hannum, Christopher F., MD
Kotyo, John A., MD, FAAFP
Offutt, Laura A., MD

Erie (5)
Bhagwandien, Narendra S., MD
Kauffman, Mark K., DO
Pelkowski, Timothy D., MD
Wienecke, Kelli K., DO

Franklin (3)

Greene (2)

Huntingdon (2)

Indiana (2)
Ghate, Sharad B., MD
Lamantia, Joseph, DO

Jefferson (2)

Lackawanna (6)
Chacko, Justin Varghese, DO
Farrell, John S., MD
Gupta, Geetika
Minello, Christopher M., DO
Peters, Christopher A., MD
Severs, Gregg A., DO
Welby, Timothy D., MD

Lancaster (7)
Aichele, Robert K., Jr., DO
Denlinger, Stacey S., DO
Fisher, Laura H., MD
Kelly, James M., MD
Olin, Stephen T., MD
Shepherd, Rebecca M., MD
Simons, David J., DO

Lawrence (2)
Stoner, J. Fred, MD
Toca, Angel R., Jr., MD

Lebanon (3)
Lehigh (6)
Barraco, Robert D., MD
Hunt, Jonathan Thomas
Podlaski, Alexander Christian
Pryblick, Judith R., DO
Scaglotti, Charles J., MD, FACS

Luzerne (4)
Boonin, Alan, MD
McGraw, Joseph P., MD
Spring, Deborah A., MD
Westbrook, Carol Ann, MD
Ciotola, Thomas J., MD
English, Richard B., MD
Kowalski-McGraw, Michele, MD
Ramos, Julio A., MD

Lycoming (4)
Heilmann, Timothy M., MD
Robinson, Warren L., Jr., MD, FACP

Mercer (3)

Mifflin/Juniata (2)

Monroe (2)

Montgomery (11)
Becker, Frederic S., MD
Bothwell, William N., MD, FACS
Douglas, Scott R.
Goodyear, James A., MD, FACS
Green, George R., MD
Grisafi, Joseph L., MD
Johnson, Ahashta T., MD
Lorine, Jennifer, DO
Pyfer, Mark F., MD, FACS
Rothkopf, Jay Evan, MD
Thomas, James W., MD
Davis, Nicole, MD
Manstein, Carl H., MD

Montour (2)

Northampton (5)
Dippolito, Anthony D., MD, MBA, FACS
Nguyen, Minh Q., MD, FACC
Rohatgi, Chand, MD, BS, FACS
Singh, Vasu, MD
Valia, Sunee S., MD
Khalighi, Koroush, MD
Metzgar, Martha McGarey, DO

Northumberland (2)

Philadelphia (37)
Beaudoin, Jaret
Bianco, Lauryn Dominica
Brown, Martin Tucker
Chu, Brandon
DellaVecchia, Michael A., MD, PhD, FACS
Dempsey, Daniel T., MD, FACS
Friedrich, Sarah Anne
Gable, Christopher
Gash, Richard M., MD, FACS
Hernandez, Enrique, MD, FACOG, FACS
Jordan, Scott Eric, MD
Kim, Cadence A., MD, FACS
Kucejko, Robert Jon, MD
Lin, Henry C., MD
Loesche, Michael Austin
Maher, Lauren Rose, MD
Miyamoto, Curtis T., MD
Morgenstern, Ricardo, MD
Ortiz Torrent, Natalia, MD, FAPA, FAPM
Padula, Anthony M., MD, FACS
Patel, Kinnari, MD
Permut, Stephen R., MD, JD
Ray, Keval
Russo, Molly Elise
Saha, Anamika
Saka, Erik
Sanserino, Kathryn Ann, MD
Scantling, Dane, DO
Seth, Rajendra N., MD
Song, Angela
Thomas, Rachel Ann
Tumminello, Richard
Verghese, Danielle
Williams, Graeme Robert
Wolfé, Winifred
Yu, J. Q, Michael, MD
Cristol, James L., MD
Eskin, Bernard A., MD
Fleischer, Scott A., MD, DLFAPA
Habboushe, Christa P., MD
Habboushe, Fawzi P., MD, FACS
Kroser, Albert S., DO
Love, Carol A., MD
Mandel, Dale M., MD, FACS
Miceli, Kurt, MD
Wasserman, Kenneth E., MD

Potter (2)

Schuylkill (2)
Krewson, David P., DO

Somerset (2)

Tioga (2)

Union (2)

Warren (2)

Washington (3)
Anderson, Sheila M., DO
Lewis, Jennifer L., MD
O’Brien, Lauren C., MD

Wayne/Pike (2)
Dewar, William R., III, MD, FACP
Hoff, Nathan

Westmoreland (5)
Kumar, V. H., MD
Light, Wilma C., MD
Miranda, Ralph A., MD
Selip, Steven W., MD
Tymoczko, Robert G., MD
Wysomierski, David A., MD

York (6)
Harberger, Quincy, MD
Kehrl, Thompson, MD, FACEP
Kochert, Erik, MD, FACEP
Malhotra, Tani, MD
Rhoads, Jonathan E., Jr., MD, FACS
Vega, David D., MD, FACEP
Specialties

American College of Surgeons (Keystone Chapter, Metro-Philadelphia Chapter, Southwestern PA Chapter) (1)
Buzas, Christopher J., DO

PA Chapter, American College of Physicians (1)
Pollack, Evan Jay, MD

PA Section, American Congress of Obstetricians & Gynecologists (1)
Mehta, Aasta Dinesh, MD

Pennsylvania Academy of Dermatology and Dermatologic Surgery (1)
Brod, Bruce A., MD

Pennsylvania Academy of Otolaryngology - Head & Neck Surgery (1)
Soliman, Ahmed M.S., MD

Pennsylvania Allergy & Asthma Association (1)
DiPrimio-Kalman, Denise Angela, DO

PA Chapter, American College of Cardiology (1)
Waxler, Andrew R., MD

Pennsylvania Psychiatric Society (1)
Certa, Kenneth M., MD

Pennsylvania Society of Gastroenterology (1)
Ghanta, Ravi K., MD

Pennsylvania Society of Oncology & Hematology (1)
Heine, Marilyn J., MD FACP FACEP

Sections

Medical School Section (10)
Botejue, Mahesh
Bracken, Jennifer L.
Donches, Katherine
Giusto, Elisa
Koeneke, Ludwig
Kordick, Christopher
Penaranda, Ariel Leonardo
Shaik, Aleesha
Thadikonda, Kishan Mark
Urwin, John
Boghossian, Leigh Joan
Doan, Thanhnga
Eisenberg, David A.
Evans, Gretchen
Jurgielewicz, Piotr
Nguyen, Felix

Residents & Fellows Section (10)
Craner, Madushini Gunawardana, DO
Kirsch, Jordan Michael, DO
Kramer, Lauren, DO
Punch, Nicholas Rapheal, DO
Sakata, Lissa Christina, MD
Vu, Lyndsey Uyen, MD

Young Physicians Section (4)
Kalanuria, Atul Ashok, MD
Lutzkanin, Andrew, III, MD
Matta, Mark A., DO
Vasudevan, John Michael, MD
Fodeman, Jason, MD

International Medical Graduates Section (1)
Mehrotra, Deepak, MD
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<th>York</th>
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<td>Specialty Society Presidents</td>
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Hershey Lodge
Aztec/Nigerian Rooms

Platform

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2016
<table>
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<tr>
<th>Name</th>
<th>Position(s)</th>
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<tbody>
<tr>
<td>Domingo T. Alvear, MD</td>
<td>Former Trustee</td>
</tr>
<tr>
<td>A. Loren Amacher, MD</td>
<td>Former Trustee</td>
</tr>
<tr>
<td>Joseph F. Answine, MD</td>
<td>Trustee</td>
</tr>
<tr>
<td>Margaret S. Atwell, MD</td>
<td>Former Trustee</td>
</tr>
<tr>
<td>Terrence E. Babb, MD</td>
<td>Former Trustee</td>
</tr>
<tr>
<td>Edward P. Balaban, DO</td>
<td>Trustee</td>
</tr>
<tr>
<td>Richard T. Bell, MD</td>
<td>Former Trustee</td>
</tr>
<tr>
<td>Erick J. Bergquist, MD, PhD</td>
<td>Trustee</td>
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<tr>
<td>Sherry L. Blumenthal, MD</td>
<td>Trustee</td>
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<tr>
<td>Donald C. Brown, MD</td>
<td>Trustee</td>
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<tr>
<td>Frederick G. Brown, MD</td>
<td>Former Trustee</td>
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<tr>
<td>George F. Buerger, Jr., MD</td>
<td>Former Trustee</td>
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<tr>
<td>John B. Bulger, DO</td>
<td>Former Trustee</td>
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<tr>
<td>Paul N. Casale, MD</td>
<td>Former Trustee</td>
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<tr>
<td>Charles A. Castle, MD</td>
<td>Former Trustee</td>
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<tr>
<td>Kenneth M. Certa, MD</td>
<td>Former Trustee</td>
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<tr>
<td>Ashok Chaddah, MD</td>
<td>Former Trustee</td>
</tr>
<tr>
<td>Theodore A. Christopher, MD</td>
<td>Former Trustee; Vice President</td>
</tr>
<tr>
<td>Ronald J. Clearfield, MD</td>
<td>Former Speaker, House of Delegates</td>
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<td>Andrew W. Gurman, MD</td>
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Donald E. Harrop, MD  Former Speaker, House of Delegates; Past President
Marilyn J. Heine, MD  Past President
Enrique Hernandez, MD  Former Trustee
John H. Hobart, MD  Former Trustee; Past President
Christopher M. Hughes, MD  Former Trustee
Charles D. Hummer, III, MD  Former Trustee
F. Wilson Jackson, III, MD  Trustee
Bindukumar C. Kansupada, MD  Trustee
Daniel B. Kimball, Jr., MD  Former Trustee
Walter M. Klein, MD  Trustee
Joyann A. Kroser, MD  Former Trustee
William W. Lander, MD  Former Trustee; Past President; Judicial Council
Michael P. Levis, MD  Past President
Mark A. Lopatin, MD  Trustee
Lynn M. Lucas-Fehm, MD, JD  Trustee
Peter S. Lund, MD  Former Trustee; Past President
Stephanie A. Mackey, MD  Former Trustee
Heath B. Mackley, MD  Trustee
Bruce A. MacLeod, MD  Former Trustee; Past President
John A. Malcolm, Jr., MD  Former Trustee; Judicial Council
Camille J. Maravalli, MD  Former Trustee
Carol N. Maurer, MD  Former Trustee
Lee H. McCormick, MD  Former Trustee; Past President
Robert M. McNamara, MD  Former Trustee
Robert N. Moyers, MD  Former Trustee; Past President
John J. Pagan, MD  Vice Speaker, House of Delegates
Michael J. Paglia, MD, PhD  Trustee
Lewis T. Patterson, MD  Former Trustee
Kristine E. Perle, MD  Former Trustee
Mark A. Piasio, MD  Former Trustee; Past President
Danae M. Powers, MD  Trustee
Michael J. Prendergast, MD  Former Trustee
Sant Ram, MD  Former Trustee
James W. Redka, MD  Trustee
Jonathan E. Rhoads, Jr., MD  Former Speaker, House of Delegates
Andrew J. Richards, MD  Trustee
Karen A. Rizzo, MD  Former Trustee; Immediate Past President
Carol E. Rose, MD  Former Trustee; Past President, Judicial Council
Kristen M. Sandel, MD  Trustee
Joseph W. Sassani, MD  Trustee
Ralph Schmeltz, MD  Former Trustee; Past President
C. Richard Schott, MD  Former Trustee; Past President
Stephen L. Schwartz, MD  Former Trustee
Scott E. Shapiro, MD  Former Trustee, President
Steven A. Shapiro, MD  Trustee
Barbara Shelton, MD  Former Trustee
Jaan E. Sidorov, MD  Trustee
Carl A. Sirio, MD  Former Trustee
Barry J. Snyder, MD  Former Trustee
Ferdinand L. Soisson, Jr., MD  Former Trustee
Edward M. Stafford, MD  Trustee
Joseph J. Stemm, MD  Former Trustee
David A. Talenti, MD  Trustee
Adam Z. Tobias, MD  Former Trustee
Gerald P. Tracy, MD  Former Trustee
Martin D. Trichtinger, MD  Speaker, House of Delegates
John S. Trickett, Jr.  Trustee
William A. VanDecker, MD  Trustee
Chad P. Walker, DO  Trustee
Thomas J. Weida, MD  Former Trustee
William J. West, Jr., MD  Former Trustee
Irving Williams, III, MD  Former Trustee
Cathleen A. Woomert, MD  Trustee
James A. Yates, MD  Former Trustee
Hans T. Zuckerman, DO  Trustee

(Additionally, the presidents of component county medical societies are ex-officio members when they are not seated as delegates to the House.)
PAMED HOUSE OF DELEGATES MEMBERS ELIGIBLE FOR ELECTION TO THE JUDICIAL COUNCIL

CAPITAL LETTERS – Present members of the Judicial Council

This list includes members of committees, task forces and work groups. These individuals cannot serve as a member of the Judicial Council unless they resign their current office.

NOTE: The term of Carol E. Rose, MD (Allegheny County) expires this year; she is eligible for reelection.

<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Member’s County</th>
<th>Category of Eligibility</th>
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<td>Aber, Robert C.</td>
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Gordon, Adam J. Allegheny CountyTrustee
Grandon, Raymond C. Dauphin CountyPast President, Trustee
GRECO, VICTOR F. LUZERNE COUNTYJUDICIAL COUNCIL MEMBER
Green, Linda D. Delaware CountyTrustee
Gregory, Robert E. Allegheny CountyDelegate
Gurman, Andrew W. Blair CountyFormer Speaker
Habboushe, Christa P. Philadelphia CountyDelegate
Habboushe, Fawzi P. Philadelphia CountyDelegate
Haidet, Keith R. Lancaster CountyTrustee
Hall, Virginia E. Dauphin CountyDelegate
Hamilton, Robert W. Dauphin CountyDelegate
Hannum, Christopher F. Delaware CountyDelegate
Harrop, Donald E. Chester CountyPast President, Former Speaker
Heine, Marilyn J. Bucks CountyPast President
Heinle, Michael S. Beaver CountyDelegate
Hellman, Fredric N. Delaware CountyDelegate
Herbert, Anita J. McKean CountyDelegate
Hernandez, Enrique Philadelphia CountyTrustee
Hertzberg, Todd M. Allegheny CountyDelegate
Hetrick, William D. Allegheny CountyDelegate
Hills, Everett C. Dauphin CountyDelegate
Himmelreich, III, Lester L. Cumberland CountyDelegate
Hobart, John H. Northampton CountyDelegate
Hostetter, Abram M. Lebanon CountyDelegate
Hotmer, Dianne D. Chester CountyDelegate
Hudson, Jr., Howard E. Lehigh CountyDelegate
Hughes, Christopher M. Washington CountyTrustee
Hughes, Patrick H. Allegheny CountyDelegate
Hummer, III, Charles D. Delaware CountyTrustee
Hummer, Jr., Charles D. Delaware CountyDelegate
Ignocheck, Anthony R. Erie CountyDelegate
Jaeger, Robert M. Lehigh CountyDelegate
John, Lawrence R. Allegheny CountyDelegate
Johnston, Craig T. Erie CountyDelegate
Jones, Edward R. Philadelphia CountyDelegate
Jones, David B. York CountyDelegate
Kardish, Thomas J. Bucks CountyDelegate
Katalan, Maurice M. Philadelphia CountyDelegate
Katz, David L. Allegheny CountyDelegate
Kaye, Donald Philadelphia CountyDelegate
Kean, Herbert Philadelphia CountyDelegate
Kelly, James M. Lancaster CountyDelegate
Kemp, Robert M. Lancaster CountyDelegate
Kennedy, Richard P. Monroe CountyDelegate
Kim, Sun Y. Cumberland CountyDelegate
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Sturm, Patrick W.  Beaver County  Delegate
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Swansen, Harold E.  Allegheny County  Delegate
Swansen, Nancy M.  Allegheny County  Delegate
Teeple, Jr., Edward  Allegheny County  Delegate
Thomas, Bruce L.  Huntingdon County  Delegate
Thompson, Mark E.  Allegheny County  Delegate
Tobias, Adam Z.  Allegheny County  Trustee
Tracy, Gerald P.  Lackawanna County  Trustee
Truex, Jr., Raymond C.  Berks County  Delegate
Tymoczko, Robert G.  Westmoreland County  Delegate
Uroskie, Theodore W.  Lackawanna County  Delegate
Vaidya, Shailendra  Philadelphia County  Delegate
Varma, Rajiv R.  Allegheny County  Delegate
Vega, David D.  York County  Delegate
Vermeire, David A.  Mercer County  Delegate
Wasserman, Kenneth E.  Philadelphia County  Delegate
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West, Sr., William J.  Cumberland County  Delegate
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Williams, John P.  Allegheny County  Delegate
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Wood, Jr., Ernest M.  Lancaster County  Delegate
Woodings, Samuel G.  Mercer County  Delegate
Woods, Anne M.  York County  Delegate
Wright, Jr., John C.  Beaver County  Delegate
Yates, James A.  Dauphin County  Trustee
Yeasted, G. Alan  Allegheny County  Delegate
Yu, J. Q. Michael  Philadelphia County  Delegate
Zemel, Walter G.  Bucks County  Delegate
Zuckerman, Robert M.  Dauphin County  Delegate
Pennsylvania Medical Society Presidents

1982 ...... Raymond C. Grandon, MD .......... Dauphin County
1983 ...... Michael P. Levis, MD .......... Allegheny County
•1984 ...... John Y. Templeton III, MD ......... Philadelphia County
•1985 ...... D. Ernest Witt, MD ................. Columbia County
•1986 ...... R. William Alexander, MD ......... Berks County
•1987 ...... R. Robert Tyson, MD .............. Philadelphia County
1988 ...... Donald E. Harrop, MD .......... Chester County
•1989 ...... Gerald L. Andriele, MD ............ Luzerne County
1990 ...... J. Joseph Danyo, MD ............... York County
•1991 ...... Gordon K. MacLeod, MD .......... Allegheny County
1992 ...... Robert N. Moyers, MD .......... Crawford County
•1993 ...... Donald G. Ferguson, MD ............ Allegheny County
•1994 ...... Martin A. Murcek, MD ............ Westmoreland County
1995 ...... John H. Hobart, MD ............. Northampton County
1996 ...... Jonathan E. Rhoads Jr., MD ......... York County
1997 ...... Victor F. Greco, MD ............... Luzerne County
1998 ...... Lee H. McCormick, MD .......... Allegheny County
•1999 ...... John W. Lawrence, MD .......... Delaware County
•2000 ...... Donald H. Smith, MD .......... Northampton County
2001 ...... Carol E. Rose, MD ................. Allegheny County
•2002 ...... Howard A. Richter, MD .......... Delaware County
2003 ...... Edward H. Dench, Jr., MD ......... Centre County
2004 ...... Jitendra M. Desai, MD ............. Allegheny County
2005 ...... William W. Lander, MD .............. Montgomery County
•2006 ...... Lila S. Krosor, MD ................. Philadelphia County
2006-07 .. Mark A. Piasio, MD ................. Clearfield County
2008 ...... Peter S. Lund, MD ................. Erie County
2009 ...... Daniel J. Glunk, MD ............... Lycoming County
2010 ...... James A. Goodyear, MD .......... Montgomery County
2011 ...... Ralph Schmeltz, MD ................. Allegheny County
2012 ...... Marilyn Heine, MD ................. Bucks County
2013 ...... C. Richard Schott, MD .......... Delaware County
2014 ...... Bruce A. MacLeod, MD .......... Allegheny County
2015 ...... Karen A. Rizzo, MD ................. Lancaster County
2016 ...... Scott E. Shapiro, MD ................. Montgomery County
•Deceased
Pennsylvania Medical Society Membership Figures
(As of December 31, 2015)

[ ]—Delegation allocation, including secretary
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<td>2019</td>
<td>Yes 2019</td>
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<td>Second</td>
<td>Mark A. Lopatin, MD †</td>
<td>2016</td>
<td>Yes 2016 &amp; 2020</td>
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<td>Third</td>
<td>Chad P. Walker, DO</td>
<td>2019</td>
<td>Yes 2019</td>
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<td>Michael J. Paglia, MD</td>
<td>2019</td>
<td>Yes 2019</td>
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<td>Heath B. Mackley, MD</td>
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<td>Sixth</td>
<td>Danae M. Powers, MD</td>
<td>2018</td>
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<tr>
<td>Seventh</td>
<td>James W. Redka, MD</td>
<td>2017</td>
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<td>Eighth</td>
<td>John P. Gallagher, MD</td>
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<td>Ninth</td>
<td>Erick J. Bergquist, MD</td>
<td>2016</td>
<td>Yes 2016</td>
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<td>Tenth</td>
<td>Donald C. Brown, MD</td>
<td>2016</td>
<td>Yes 2016</td>
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<td>Eleventh</td>
<td>Edward M. Stafford, MD</td>
<td>2017</td>
<td>Yes 2017</td>
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<td>Twelfth</td>
<td>David A. Talenti, MD</td>
<td>2019</td>
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<td>Thirteenth</td>
<td>John F. Delaney, Jr., MD</td>
<td>2016</td>
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<td>Primary Care (Pediatrics)</td>
<td>Steven A. Shapiro, DO</td>
<td>2016</td>
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<td>Primary Care (Internal Medicine)</td>
<td>Jaan E. Sidorov, MD</td>
<td>2017</td>
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<td>Primary Care (Family Medicine)</td>
<td>Dennis L. Gingrich, MD</td>
<td>2019</td>
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<td>Medical Specialties</td>
<td>F. Wilson Jackson, III, MD</td>
<td>2019</td>
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<td>William A. VanDecker, MD</td>
<td>2019</td>
<td>No</td>
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<td>Hospital-Based</td>
<td>Cathleen A. Woomert, MD</td>
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<td>Joseph F. Answine, MD</td>
<td>2017</td>
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<td>Surgical Specialties</td>
<td>Joseph W. Sassani, MD</td>
<td>2019</td>
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<td>Surgical Specialties</td>
<td>Andrew J. Richards, MD</td>
<td>2018</td>
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<td>Eligible for Reelection</td>
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<td>Psychiatry</td>
<td>Michael Feinberg, MD</td>
<td>2016</td>
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<td>Obstetrics/Gynecology</td>
<td>Sherry L. Blumenthal, MD</td>
<td>2017</td>
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<td>At-Large Specialties</td>
<td>Walter M. Klein, MD</td>
<td>2017</td>
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<td>Edward P. Balaban, DO</td>
<td>2019</td>
<td>Yes 2019</td>
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<td>International Medical Graduates Section</td>
<td>Bindukumar C. Kansupada, MD</td>
<td>2016</td>
<td>Yes 2016</td>
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<td>Residents &amp; Fellows Section</td>
<td>Hans T. Zuckerman, DO</td>
<td>2016 (or upon completion of residency program)</td>
<td>Yes 2016 (as long as Dr. Zuckerman remains in a residency/fellowship program)</td>
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<td>Young Physicians Section</td>
<td>Kristen M. Sandel, MD</td>
<td>2016</td>
<td>No</td>
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<td>Medical Students Section</td>
<td>John S. Trickett, Jr.</td>
<td>2016</td>
<td>Yes 2016, 2017 (as long as Mr. Trickett remains in medical school)</td>
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† February 10, 2016 the Board of Trustees appointed Mark A. Lopatin, MD to fill the vacant 2nd District Trustee seat until the annual meeting in October 2016. Dr. Lopatin is be eligible for election in 2016 and re-election in 2020.
<table>
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<tr>
<th>Delegates</th>
<th>County</th>
<th>Total Years of Delegate Service</th>
<th>Term Expires</th>
<th>Prior Years of Delegate Service</th>
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<td>Marilyn J. Heine, MD</td>
<td>Bucks</td>
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<td>Daniel B. Kimball, Jr., MD</td>
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<td>Peter S. Lund, MD</td>
<td>Erie</td>
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<td>Judith R. Pryblick, DO</td>
<td>Lehigh</td>
<td>8</td>
<td>2017</td>
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<td>John W. Spurlock, MD</td>
<td>Northampton</td>
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<td>Martin D. Trichtinger, MD</td>
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<td>2017</td>
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<td>Theodore A. Christopher, MD</td>
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<td>Ralph Schmeltz, MD</td>
<td>Allegheny</td>
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<td>John P. Williams, MD</td>
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<td>Virginia E. Hall, MD</td>
<td>Dauphin</td>
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<td>Scott E. Shapiro, MD</td>
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<td>Michael A. DellaVecchia, MD</td>
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<td>Kevin O. Garrett, MD</td>
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<td>Jane A. Weida, MD</td>
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<td>Erick J. Bergquist, MD</td>
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<td>2017</td>
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<td>Mark S. Friedlander, MD</td>
<td>Delaware</td>
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<td>2017</td>
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<td>Dane Scantling, DO (Resident)</td>
<td>Philadelphia</td>
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<tr>
<td>Michael A. Loesche (Student)</td>
<td>Philadelphia</td>
<td>0</td>
<td>2016</td>
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VICE PRESIDENT  
*(Elect One/One-Year Term)*  
William R. Dewar, III, MD (Wayne/Pike County)  
Danae M. Powers, MD (Centre County)  

SPEAKER, HOUSE OF DELEGATES  
*(Elect One/One-Year Term)*  
John J. Pagan, MD (Bucks County)  

VICE SPEAKER, HOUSE OF DELEGATES  
*(Elect One/One-Year Term)*  
Todd M. Hertzberg, MD (Allegheny County)  
John W. Spurlock, MD (Northampton County)  

SECOND DISTRICT TRUSTEE  
*(Elect One/Four-Year Term)*  
Mark A. Lopatin, MD (Montgomery County)  
Chand Rohatgi, MD (Northampton County)  

NINTH DISTRICT TRUSTEE  
*(Elect One/Four-Year Term)*  
Erick J. Bergquist, MD, PhD (Indiana County)*  

TENTH DISTRICT TRUSTEE  
*(Elect One/Four-Year Term)*  
Donald C. Brown, MD (Westmoreland County)*  

THIRTEENTH DISTRICT TRUSTEE  
*(Elect One/Four-Year Term)*  
Amelia A. Paré, MD (Allegheny County)  

PRIMARY CARE (PEDIATRICS) TRUSTEE  
*(Elect One/Four-Year Term)*  
Steven A. Shapiro, DO (Montgomery County)*  

PSYCHIATRY TRUSTEE  
*(Elect One/Four-Year Term)*  
Michael Feinberg, MD, PhD (Montgomery County)*  

INTERNATIONAL MEDICAL GRADUATES SECTION TRUSTEE  
*(Elect One/Four-Year Term)*  
Nominee(s) not known at this time  

RESIDENTS & FELLOWS SECTION TRUSTEE  
*(Elect One/Two-Year Term)*  
Nominee(s) not known at this time  

YOUNG PHYSICIANS SECTION TRUSTEE  
*(Elect One/One-Year Term)*  
John M. Vasudevan, MD (Philadelphia County)  

MEDICAL STUDENTS SECTION TRUSTEE  
*(Elect One/One-Year Term)*  
Nominee(s) not known at this time  

AMA DELEGATES  
*(Elect Five/Two-Year Terms)*  
James A. Goodyear, MD (Montgomery County)*  
Daniel B. Kimball, Jr., MD (Berks County)*  
Anthony M. Padula, MD (Philadelphia County)*  
John P. Williams, MD (Allegheny County)*  
Virginia E. Hall, MD (Dauphin County)*  

AMA ALTERNATE DELEGATES  
*(Elect Four/Two-Year Terms)*  
John P. Gallagher, MD (Mercer County)*  
Bruce A. MacLeod, MD (Allegheny County)*  
Jane A. Weida, MD (Berks County)*  
John M. Vasudevan, MD (Philadelphia County)*  

AMA ALTERNATE DELEGATE SLOTTED RESIDENTS & FELLOWS POSITION  
*(Elect One/One-Year Term)*  
Nominee(s) not known at this time  

AMA ALTERNATE DELEGATE SLOTTED MEDICAL STUDENT POSITION  
*(Elect One/One-Year Term)*  
Nominee(s) not known at this time  

COMMITTEE TO NOMINATE DELEGATES & ALTERNATES TO THE AMA  
*(Elect Two/Three-Year Terms)*  
Charles Cutler, MD (Montgomery County)*  
Jonathan E. Rhoads, Jr., MD (York County)*  

JUDICIAL COUNCIL  
*(Elect One/Three-Year Term)*  
Carol E. Rose, MD (Allegheny County)*  

*Incumbent*
PENNSYLVANIA MEDICAL SOCIETY DISCLOSURE STATEMENT
(Please Print) or Type

To avoid the occurrence of potentially harmful conflicts of interest as I perform my duties as the President of the Pennsylvania Medical Society, I submit the following information:

1. All financial holdings of myself or spouse that constitute ten percent or more interest in a business, partnership, or corporation.

   NONE

2. All memberships on any other boards or committees.

   FOUNDATION BOARD

   DEVELOPMENT COMMITTEE OF THE FOUNDATION

3. All employment or contractual relationships for services with any health-related organization or any supplier of goods or services to PMS or its subsidiaries.

   NONE

4. Any other involvement where actions of the Society may result in material financial benefit to me or immediate family members.

   NONE

I agree that if any additional relationships, interests, or situations should arise in the future, I will promptly advise the Judicial Council.

[Signature]  [Date]

barrett/abm/DisclosureStatement
PENNSYLVANIA MEDICAL SOCIETY DISCLOSURE STATEMENT

(Please Print) or Type

To avoid the occurrence of potentially harmful conflicts of interest as I perform my duties as the President of the Pennsylvania Medical Society, I submit the following information:

1. All financial holdings of myself or spouse that constitute ten percent or more interest in a business, partnership, or corporation.

   Owner of My Medical Practice

2. All memberships on any other boards or committees.

   None Known

3. All employment or contractual relationships for services with any health-related organization or any supplier of goods or services to PMS or its subsidiaries.

   None Known

4. Any other involvement where actions of the Society may result in material financial benefit to me or immediate family members.

   None Directly Known

   Albeit to the extent that Medical Society Actions Impact Medical Practice, Business Insurance, Regulations, etc. that Affects Finances Across Stakeholders in the Health Care Arena

I agree that if any additional relationships, interests, or situations should arise in the future, I will promptly advise the Judicial Council.

Signature: Barrett

Date: Sept 29, 2016
MEMORIAL RESOLUTION FOR DONALD W. SPIGNER, MD

Introduced by: Gwendolyn Poles, DO on behalf of the Dauphin County Medical Society
Author: Gwendolyn Poles, DO

WHEREAS, Donald Wayne Spigner, MD peacefully departed this world on Saturday, October 31, 2015 at the age of 75, surrounded by his family and friends; and

WHEREAS, Dr. Spigner was a faithful member of the Pennsylvania Medical Society (PAMED) and the Dauphin County Medical Society (DCMS), serving as president of DCMS in 1984 and a long-time Board member and Delegate to the PAMED Annual Business Meeting; was a member of the Pennsylvania Academy of Family Physicians from 1989 to 1992; was a member for many years of the American Medical Association and the National Medical Association; and

WHEREAS, Dr. Spigner, a board-certified family physician, was on the medical staff of local hospitals (Polyclinic Hospital and Harrisburg Hospital—which became Pinnacle Health System) until the feasibility of maintaining a hospital and office-based practice became impossible; and

WHEREAS, Dr. Spigner was born in Tyler, Texas; moved to Los Angeles, California with his parents at the age of 5; and graduated from Susan Miller Dorsey High School prior to obtaining a Bachelor of Arts degree in zoology in 1962 at the newly established University of California at Riverside. He attended medical school at the University of California at San Francisco, graduating in 1966, and interned at the Los Angeles County General Hospital. Following his internship, he was assigned to the Peace Corps while serving as a commissioned officer in the U.S. Public Health Service. Stationed in Ibadan, he provided direct care to Peace Corps staff and volunteers, American foreign-service staff, and Nigerian nationals. After his discharge in 1969, he spent a year in Washington, D.C., where he manned the Peace Corps Desk and served as the Associate Medical Director of the African Regional Program; and

WHEREAS, Dr. Spigner began his civilian medical career in suburban Minneapolis, Minnesota as the Project Director of Pilot City Comprehensive Neighborhood Health Center, a practicing family physician, and an associate and adjunct professor at St. Paul Ramsey Hospital Family Practice Residency Program and the University of Minnesota School of Public Health, respectively; and

WHEREAS, In 1975, Dr. Spigner moved with his family to Harrisburg, PA, where he had been recruited by the Rev. Robert Bailey to head the newly established Hamilton Health Center in Harrisburg and to serve the City of Harrisburg as the City Health Officer (CHO). As his last act as Harrisburg CHO, he saw to the city’s health planning in response to the Three Mile Island nuclear crisis; and

WHEREAS, In Harrisburg he fostered and lived his passion: delivering quality healthcare to poor and minority urban communities. He headed Hamilton Health Center for a decade, and continued his work there even after entering private practice and until federal laws made doing so impossible; but the Center and the goal of improving the collective health of minority populations always occupied a special place in his heart. He was a founding physician of Community Medical Associates (CMA) where he practiced for over 30 years and helped to grow CMA into a well-respected, large, private family health practice; and

WHEREAS, In 1994, guided by a mission to bring cutting-edge care and services to children and families in the region affected by Sickle Cell, he helped found the South Central Pennsylvania Sickle Cell Council
WHEREAS, Dr. Spigner was named among 150 Highmark Living Legacies in 2009, recognized for his extraordinary local achievements. Dr. Spigner was the co-founder of the Harrisburg-based Martin Luther King, Jr. Leadership Development Institute. He has been credited for helping students of the Institute develop civil rights advocacy skills and interpersonal skills that would make them more successful in their careers; and

WHEREAS, Dr. Spigner leaves to mourn his wife, Carol Wilson Spigner; his two daughters, Nicole Adeyinka Spigner and Danielle Khadeja Spigner; two stepsons, Thomas Wilson Williams and Holman Andrew Williams; and two grandchildren, Shane Dorian Spigner-Wilford and Alexander Upton Williams; and

WHEREAS, Dr. Spigner will be greatly missed by family, friends, colleagues and the greater Harrisburg, PA community for his personal and professional dedication, his commitment to challenge injustice, his hearty and contagious laugh, his passion for music of all kinds, his sharp intellectual mind, his love for his garden and travel, and his tremendous energy and spirit; therefore, be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society observe a moment of silence, recognizing our appreciation for this dedicated and excellent physician; and be it further

RESOLVED, That this memorial resolution be recorded in the minutes of the 2016 House of Delegates and a copy be sent to his family.
MEMORIAL RESOLUTION FOR WALTER I. HOFMAN, MD

Introduced by: Jay E. Rothkopf, MD, President, Montgomery County Medical Society, on behalf of the Board of Directors

Author: Jay E. Rothkopf, MD, President, Montgomery County Medical Society

WHEREAS, Walter I. Hofman, MD, an expert in forensic pathology for more than fifty (50) years, passed away on Friday, February 19, 2016; and

WHEREAS, Dr. Walter I. Hofman, well-known throughout the United States as well as Canada, was the only board-certified forensic pathologist coroner in Pennsylvania; and

WHEREAS, Dr. Walter I. Hofman served as the Montgomery County coroner for eight years, oversaw some high-profile cases in Southeastern Pennsylvania, and prided himself in speaking for those who could no longer speak for themselves; and

WHEREAS, Dr. Walter I. Hofman was known for his authoritative testimony as an expert witness in more than two dozen Pennsylvania counties, as well as testifying in federal cases and cases in other states; and

WHEREAS, Dr. Walter I. Hofman, board-certified in anatomic, clinical and forensic pathology, personally performed more than 10,000 autopsies; issued more than 17,000 death certificates; and examined more than 20,000 bodies; and

WHEREAS, Dr. Walter I. Hofman was born in Berlin in 1936 and became a U.S. citizen in 1944. He earned a Bachelor of Science degree from Roosevelt University in Chicago in 1958, and a medical degree in 1965 from the University of Basel in Switzerland. He completed a pathology residency at the Boston University Medical Center, and a fellowship at the Maryland medical examiner's office; and

WHEREAS, Dr. Walter I. Hofman served in the Air Force Reserve from 1968 until 1992, holding the rank of lieutenant colonel and working as a forensic pathologist and lecturer; and

WHEREAS, Dr. Walter I. Hofman held positions at the University of Pennsylvania, the Pennsylvania State University, Harvard University Medical School, Roxborough Memorial Hospital, and others; and

WHEREAS, Dr. Walter I. Hofman faithfully served the Montgomery County Medical Society (MCMS) as its secretary, delegate to the Pennsylvania Medical Society Annual Business Meeting, and past chairman and member of the MCMS Medical Legal Committee; and

WHEREAS, Dr. Walter I. Hofman advocated for changes in Pennsylvania's system for electing coroners, arguing that politics should be removed and coroners should be subject to certification requirements; and

WHEREAS, Dr. Walter I. Hofman is survived by his wife of 52 years, Ethel, three children, and six grandchildren; and

WHEREAS, Dr. Walter I. Hofman’s dedication to his profession, patients and many friends will be greatly missed; therefore, be it
RESOLVED, That the House of Delegates of the Pennsylvania Medical Society observe a moment of silence, recognizing our appreciation for his many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That this memorial resolution be recorded in the minutes of the 2016 House of Delegates and a copy be sent to his family and to the Montgomery County Medical Society.
MEMORIAL RESOLUTION FOR RICHARD P. WHITTAKER, MD

Introduced by: Jay E. Rothkopf, MD, President, Montgomery County Medical Society, on behalf of the Board of Directors
Author: Jay E. Rothkopf, MD, President, Montgomery County Medical Society

WHEREAS, Richard P. Whittaker, MD, a well-known Pottstown physician and humanitarian, passed away on Friday, February 26, 2016; and

WHEREAS, Dr. Richard Whittaker, a longtime orthopedic surgeon known for his positive attitude and enthusiasm for life, was a Pottstown Memorial Medical Center board member. He served as the chairman of the hospital’s Board of Trustees since 2008; and

WHEREAS, Dr. Richard Whittaker served on the staff of Pottstown Memorial Medical Center for 39 years, retiring in 2013, and served as a medical staff representative on the Board of Directors from 2003-2008; and

WHEREAS, Dr. Richard Whittaker received his medical degree from the University of Pennsylvania in 1966 and completed a rotating internship and residency at Pennsylvania Hospital as well as a residency in orthopedic surgery at the Hospital of the University of Pennsylvania; and

WHEREAS, Dr. Richard Whittaker taught weekly at the University of Pennsylvania Medical School, and received a Dean’s Award for Excellence in Clinical Teaching and volunteered his services to the needy all over the world, traveling to Panama, Guatemala, the Dominican Republic, Nicaragua, Haiti, Thailand, Uganda and India. He served medical missions and provided medical aid following earthquakes and the 2004 tsunami and immunized children against polio; and

WHEREAS, Dr. Richard Whittaker served as a major in the U.S. Army Reserve and later moved to active duty status, serving as a staff orthopedic surgeon from 1971 to 1974 in Panama. Dr. Whittaker participated in Operation Desert Storm in 1991, serving as an orthopedic surgeon in Riyadh, Saudi Arabia; and

WHEREAS, Dr. Richard Whittaker was a longtime member of the Rotary Club of Pottstown and avid bicyclist who biked across Montgomery County to raise awareness about the importance of exercise. Additionally, he was active in the development and the maintenance of the Rotary Pavilion in Riverfront Park, selling bricks to finance its upkeep and working to maintain the gardens; and

WHEREAS, Dr. Richard Whittaker helped to develop the Helen and Robert Whittaker Memorial Trailhead Park, East Brandywine Township, Chester County, in memory of his parents; and

WHEREAS, Dr. Richard Whittaker served on the Pottsgrove School Board for six years and was a volunteer doctor for the Pottsgrove football team for 10 years, an elder at his church, assistant Girl Scout leader, member of the United Way Advance Gifts Solicitation Committee and volunteered with Habitat for Humanity; and

WHEREAS, Dr. Richard Whittaker faithfully served the Montgomery County Medical Society (MCMS) as a past president, member, leader in the Pennsylvania Orthopedic Society and delegate to the Pennsylvania Medical Society Annual Business Meeting; and
WHEREAS, Dr. Richard Whittaker is survived by his wife of 51 years, Peggy, four children, and 11 grandchildren, and a sister; and

WHEREAS, Dr. Richard Whittaker’s dedication to his profession, patients and many friends will be greatly missed; therefore, be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society observe a moment of silence, recognizing our appreciation for his many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That this memorial resolution be recorded in the minutes of the 2016 House of Delegates and a copy be sent to his family and to the Montgomery County Medical Society.
MEMORIAL RESOLUTION FOR CHARLES D. HUMMER, JR., MD

Introduced by: Ronald B. Anderson, MD, President, Delaware County Medical Society on behalf of the Board of Directors

Author: Ronald B. Anderson, MD, President, Delaware County Medical Society

WHEREAS, Charles DeWitt Hummer, Jr., MD, a well-known orthopaedic surgeon from Swarthmore, Delaware County, PA passed away on October 11, 2016 following a brief struggle with cancer; and

WHEREAS, Dr. Hummer was a lifelong resident of Swarthmore; and an athletic standout at Swarthmore High School; and

WHEREAS “Charlie” received his BA Degree from Amherst College in 1959 and his MD Degree from Hahnemann Medical College in 1963; and

WHEREAS, Dr. Hummer served in the US Air Force Reserve from 1966 to 1968, being honorably discharged with the rank of Captain; and

WHEREAS, He returned to Swarthmore and practiced orthopaedic surgery with Premier Orthopedics until the time of his retirement in 2012; and

WHEREAS, Dr. Hummer was deeply involved in his community serving as a School Board Member and also as Mayor of Swarthmore; and

WHEREAS, Charlie Hummer was an active advocate for his patients and his fellow physicians, he held numerous positions at the Crozer Chester Medical Center, and with the Delaware County and Pennsylvania Medical Societies; and

WHEREAS, Dr. Hummer also served in the leadership of the Pennsylvania Orthopedic Society and as Chairman of the Pennsylvania State Board of Medicine; and

WHEREAS, Dr. Hummer is survived by his son, Charles D. Hummer, III, MD, (Lisa), his daughters Katherine (Jean Paul), and Mai (Virgil), and his four grandchildren, Talley, Case, Jack and Cole; therefore be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society observe a moment of silence, recognizing our appreciation for Dr. Hummer’s many years of service to his community and his profession; and be it further

RESOLVED, That this memorial resolution be recorded in the minutes of the 2016 House of Delegates and that a copy be sent to Dr. Hummer’s family and to the Delaware County Medical Society.
MEMORIAL RESOLUTION FOR JOHN W. MILLS, M.D.

Introduced by: Ruth Woolcock, M.D., Past President, on behalf of the Indiana County Medical Society

Author: Ruth Woolcock, M.D.

WHEREAS, John Wuensch Mills, M.D., passed away May 15, 2016 at St. Andrews Village in Indiana, PA at the age of 90 with his family at his side; and

WHEREAS, Dr. Mills was on the medical staff of Indiana Regional Medical Center, a long-time member of the Indiana County Medical Society, the Pennsylvania Medical Society, the American College of Obstetrics and Gynecology (ACOG) and a Fellow of the American College of Surgeons. He was a strong supporter of organized medicine holding various positions in his county medical society, participated in various committees at the state level, was 9th District Trustee of PAMED from 1989 to 1998 and was editor of Pennsylvania Medicine for many years. He was a caring and compassionate physician who was much loved and respected by his family, his friends, his patients and his colleagues; and

WHEREAS, Dr. Mills graduated from the University of Rochester in 1949. He graduated from New York Medical College in 1953. Dr. Mills interned in McKeesport and completed his OB/GYN residency in Rochester, NY; and

WHEREAS, Dr. Mills worked in Indiana for almost all of his career, except for a short time when he worked for Mead Johnson Pharmaceuticals and served in the United States Air Force; and

WHEREAS, Dr. Mills was a long-standing member of Calvary Presbyterian Church, where he served as a ruling elder; and

WHEREAS, Dr. Mills enjoyed traveling with his wife, the former Jane Finch, gardening, working on his 1929 truck, and building televisions, radios and an organ from DIY kits. Dr. Mills was an avid model railroader and avid train lover. He was a founding member of the Indiana County Model Railroad Club. One of his greatest joys was completing a course to be a brakeman on the Pacific/SW Railway in Compo, California; and

WHEREAS, Dr. Mills is survived by four children, nine grandchildren, a sister and his sister-in-law; therefore be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society observe a moment of silence, recognizing our appreciation for his many years of service to the medical community, his patients, his family, and our county and state societies; and be it further

RESOLVED, That this memorial resolution be recorded in the Minutes of the 2016 House of Delegates and a copy be sent to his family and to the Indiana County Medical Society.
MEMORIAL RESOLUTION FOR CARMELA F. deRIVAS, MD

Introduced by: Jay E. Rothkopf, MD, President, Montgomery County Medical Society, on behalf of the Board of Directors

Author: Jay E. Rothkopf, MD, President, Montgomery County Medical Society

WHEREAS, Carmela Foderaro deRivas, MD, a board certified psychiatrist and Montgomery County healthcare facility administrator, passed away at her home on Thursday, Oct. 6; and

WHEREAS, Dr. Carmela F. deRivas was truly a woman before her times, an Italian immigrant who came to Philadelphia in 1935 and knew very little English. She defied odds by pursuing a career in medicine and becoming one of the first female physicians in Southeastern Pennsylvania; and

WHEREAS, Dr. Carmela F. deRivas earned a bachelor's degree at the University of Pennsylvania, followed by a medical degree in 1946 at the Women's Medical College of Pennsylvania. She completed her residencies at Chestnut Hill Hospital and Norristown State Hospital; and

WHEREAS, Dr. Carmela F. deRivas was a member of the Montgomery County Medical Society (MCMS) and Pennsylvania Medical Society (PAMED) for more than 60 years, served as a member of the MCMS Board of Directors, becoming its president in 1967, served as a longtime delegate of the PAMED House of Delegates and was president of the Pennsylvania Psychiatric Society; and

WHEREAS, Dr. Carmela F. deRivas combined her expertise in psychiatry and health care administration and became Norristown State Hospital’s first female superintendent in 1964. During her tenure, she treated more than 4,000 patients, managed 1,500 employees and oversaw the hospital’s 225-acre campus in Norristown; and

WHEREAS, Dr. Carmela F. deRivas, upon leaving the Norristown State Hospital as its administrator, continued serving her community as a psychiatrist for the Penn Foundation Mental Health Facility in Sellersville and then she signed on as the medical director of clinical services for adults at the Central Montgomery Mental Health/Mental Retardation Center in Norristown; and

WHEREAS, Dr. Carmela F. deRivas received many awards and accolades for being a trailblazer in psychiatric medicine and administration. In 1968, she was inducted into the South Philadelphia High School Hall of Fame and cited for excellence by the Women's Medical College of Pennsylvania and was named Woman of the Year by the Pennsylvania Federation of Business and Professional Women in 1979; and

WHEREAS, Dr. Carmela F. deRivas shared her passion for medicine with her husband and physician, the late Aureliano Rivas, MD, a urologist and one of the first Puerto Rican-born brigadier generals in the U.S. Army Reserve; and

WHEREAS, Dr. Carmela F. deRivas shared her passion for travel, classical music and gardening with her husband and four children, Carmen Rivas, Norma Rivas, Sandra Rivas-Hall and David Rivas, MD; and

WHEREAS, Dr. Carmela F. deRivas, is survived by her four children, one of which followed in his parents footsteps and became a physician, and three grandchildren; and
WHEREAS, Dr. Carmela F. deRivas’ dedication to her profession, patients and many friends will be greatly missed; therefore be it

RESOLVED, That the House of Delegates of the Pennsylvania Medical Society (PAMED) observe a moment of silence, recognizing our appreciation for her many years of service to the medical community, his patients, and our county and state societies; and be it further

RESOLVED, That this memorial resolution be recorded in the minutes of the 2016 House of Delegates and a copy sent to his family and the Montgomery County Medical Society.
Need to Relax and De-stress?

PMSA’s Wellness Central and Boutique in Cocoa Suite 5 is here for you throughout PAMED’s House of Delegates weekend!

Featuring:

Chair Massage & Reflexology Hand Massage (individual pricing)
Walk-ins welcome—Appointments recommended—Come in to schedule

Reiki — 15 Minute Sessions—$1 per minute
Walk-ins welcome—Appointments recommended—Come in to schedule

Aromatherapy with Essential Oils

Jewels By Donna
Handmade beaded jewelry

Mehry’s Boutique
Handmade costume jewelry featuring semi-precious stones, more

Vendors will donate a portion of proceeds to benefit the Alliance Medical Education Scholarship (AMES) Fund
Hershey Lodge’s beverage manager will share tips on pairing wine and chocolate—and we’ll sample FIVE delectable combinations! Then enjoy our Personal Wellness Forum at which we’ll learn about relaxation, meditation, aromatherapy, essential oils, burnout prevention and more. You can also visit PMSA’s Wellness Central and Boutique from 9 a.m. to 5 p.m. in Cocoa Suite 5—get a reflexology hand massage, chair massage, explore Reiki, sample essential oils, browse handmade jewelry and more! A portion of proceeds from Wellness Central and Boutique benefits the Alliance Medical Education Scholarship (AMES) Fund.

Print and return this form to PMSA before Oct. 14

Name: _________________________________ Email: _______________________________
Address: ______________________________ City: ______________ State/Zip: ____________
Phone: ___________________ Alt. Phone: ___________________ PMSA Member? ___Yes ___No

(Check all that apply)
□ Wine, Wellness and Chocolate Registration—$60
□ PMSA Membership (New Member Special) - $10

Make Checks Payable to: PMSA
Mail to: PMSA, 777 East Park Drive, Harrisburg, PA 17111

Credit Card Payment: _____VISA _____Master Card _____Discover  Total Authorized: $___________
Name on Card: ___________________ Billing Address: ________________________________
Card Number: ________________________ Exp. Date ___________ CV2 Code: ____________
Phone: ___________________________ Signature: _______________________________

Cancellation Policy: A written cancellation notice is required no later than October 15, 2016 for a full refund minus a $20 administrative fee. No refunds will be remitted after that date.
# PENNSYLVANIA MEDICAL SOCIETY

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PREFACE

The House of Delegates transacts its business according to a combination of rules imposed by its bylaws, established by tradition, decreed by its presiding officer, and generally pursuant to the dictates of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure. Parliamentary procedure serves to aid an assembly in orderly, expeditious, and equitable accomplishment of its desires.

The majority opinion of the House in determining what it wants to do and how it wants to do it should always remain the ultimate determinant. It is the obligation of the Speakers to sense this will of the House, to preside accordingly, and to hold their rulings ever subject to challenge from and reversal by the assembly. In accordance with this concept, the following outline of procedures is offered as a guide, subject to reasonable modification, in the hope that adherence to its principles will advance smoothness of operation by reducing confusion and misunderstanding.

Credentialing
Your first duty as a delegate at the annual meeting is to appear before the Credentialing Desk and receive your badge.

The Credentialing Desk, located in the Convention Center Lobby, will be open from 7:00 a.m. to 8:30 p.m. on Friday, October 21; from 6:30 a.m. to 6:00 p.m. on Saturday, October 22; and beginning at 7:00 a.m. on Sunday, October 23. After the staff at the Credentialing Desk have verified your credentials, they will record you as being seated as a member of the House and will give you your badge. A delegate whose credentials have been accepted by the Committee on Rules and Credentials shall be a seated delegate until final adjournment of the session. However, if such delegate is unable to be present, a certified alternate may take such delegate’s place during the period of absence.

Who Has a Vote?
The voting membership shall be the delegates duly seated, including the delegates seated from the International Medical Graduates Section; the Residents and Fellows Section; the Medical School Section; the Medical Students Section; the Young Physicians Section; alternates duly seated as delegates; and the secretaries of the component county medical societies in attendance or their duly-designated alternates.

Who Are the Ex Officio Members?
The ex officio members of the House without the right to vote are the president of each component society, if not an elected voting delegate; the Speaker; the Vice Speaker; the President; the Immediate Past President; the President Elect; the Vice President; the Secretary; the trustees; and the members of the Judicial Council. The presiding officer may vote only to break a tie on a business matter in the House of Delegates. The ex officio members with the right to vote are the past presidents; the past trustees; and the immediate past speaker of the State Society, unless they hold another office as provided in Chapter VIII, Section 3(b)(2) or 3(b)(3) of the Bylaws.
INTRODUCTION OF BUSINESS

Business comes before the House of Delegates in two ways:

1. Resolutions introduced by voting delegates or component societies or sections; and

2. Reports from the Board of Trustees, task forces or work groups, committees, and certain officials of the Society.

Recommendations from the President and the President Elect shall be referred to the Board of Trustees for report back to the House of Delegates.

Tradition governs a substantial portion of each formal session of the House of Delegates. Addresses by outgoing and incoming Presidents, remarks by the Speaker, recognition of distinguished guests, and the like are in this category. It is the prerogative of the Speakers to permit so many of these niceties as they may feel to be appropriate without unduly intruding upon the time necessary for the House to accomplish its regular business. In general, such items are scheduled in advance in the published order of business. Unscheduled presentations may be arranged either with the Speaker or by a request for unanimous consent of the House to hear them. It is to be recognized that the Speaker must usually discourage extraneous unscheduled presentations, not because of any lack of merit of the proposals, but because of the Speaker’s primary obligation to conserve the time of the House for its immediate deliberations.

Business is of two broad categories:

1. Informational, which will not affect the policy of the Society (e.g., the Auditor’s report); and

2. Policy statements such as resolutions or recommendations. Recommendations may be found in reports (which may also contain a great deal of information) and in the addresses of officers (which may also contain a great deal of information).

Disposition of an Item of Business

Items of business will ultimately be disposed of in one of six ways:

1. Adopt (with or without amendments);

2. Not adopt;

3. File;

4. Refer;

5. Refer for decision; or

6. Postpone (either to a definite time or temporarily tabled).
In general, purely informational items without recommendations should be filed. It is not appropriate to file resolutions and recommendations; they should be disposed of in one of the other ways.

REPORTS

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

RESOLUTIONS

Business is introduced into the House through the presentation of resolutions by voting delegates on behalf of their county medical society, specialty society, the Residents and Fellows Section, the Medical School Section, the Medical Students Section, the Young Physicians Section, or the International Medical Graduates Section, or as individuals.

Presentation of Resolutions
It is a standing rule of the House of Delegates that resolutions may be submitted thirty (30) days before a meeting of the House to become business of the House. Resolutions received after that date will be posted on the website prior to the meeting to the extent feasible. Once a resolution has been accepted as business of the House, it cannot be withdrawn at the discretion of its primary author. Resolutions submitted less than 30 days prior to a meeting, except those submitted by the special sections, will be posted on the website but will require a two-thirds (⅔) favorable vote of the House at the opening session in order to become the business of the House. Resolutions submitted after the Committee on Rules and Credentials has adjourned will require a three-fourths (¾) favorable vote to become the business of the House. All resolutions are to be submitted to the Secretary of the Society and should include the name of the sponsor(s).

Resolutions not prepared in advance should be delivered to the Society’s Control Desk located outside Cocoa 1.

The Committee on Rules and Credentials will review late resolutions and make recommendations to the House regarding their acceptance. (See page 5.)

Fiscal Note
All resolutions introduced in the House of Delegates whose implementation necessitates an expenditure of funds should include a fiscal note supplied by the sponsor. The following guidelines should be used in the development of appropriate fiscal information:

1. Resolutions requiring the expenditure of funds should show a specific dollar amount where possible.

2. The Executive Vice President’s office can assist sponsors with the development of financial information, but requests of this nature should be forwarded well in advance of the deadline for submitting resolutions.
3. Resolutions which call for the institution of legal action, the repeal of legislation, or similar action for which a precise cost estimate cannot be determined should indicate that a substantial commitment of resources may be necessary for implementation.

4. Resolutions which establish policy and do not require other specific action beyond that which would be covered by the Society’s routine work need not have fiscal notes appended to them by the authors. Society staff will provide the appropriate fiscal note.

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 a prefatory statement, or preamble, explaining the rationale of the resolution. This may also be accomplished by the time-honored mechanism of a series of “whereas” statements.

It is not necessary for a resolution to have such 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, advise the House as to the timeliness or urgency of the problem, the effect of the issue upon the Society, and indicate if the action called for is contrary to, or will revise, current Society policy.

It is a general principle of 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 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 “Resolveds”. It is time-consuming, unnecessary (except as indicated above), and therefore usually out of order to propose formal amendments to the wording of accessory statements, or to the language of the reference committee report in making its recommendations.

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 preamble or whereas statements should be checked for accuracy.

3. The Resolveds should stand alone and not refer back to the prefatory statements (i.e., “Resolved, that the Pennsylvania Medical Society support such programs or policies…” since the House adopts only the Resolveds and the Whereas clauses 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.
Late Resolutions
Late resolutions, as defined on page 3, will be distributed to the delegates. The Committee on Rules and Credentials will submit its recommendations on each late resolution. This committee will hold an open hearing to provide sponsors of late resolutions an opportunity to explain the reasons for lateness and the importance of the House considering the late resolution. The Committee on Rules and Credentials will make a recommendation to the House as to whether the late resolution should be the business of the House, and the House will then vote on the acceptance of each resolution. A two-thirds ($\frac{2}{3}$) favorable vote is required for acceptance as official business of the House.

Any resolution submitted after the Committee on Rules and Credentials has adjourned will require a three-fourths ($\frac{3}{4}$) favorable vote to become the business of the House.

Convention Committees
The Speakers have appointed committees necessary to the operation of the meeting. The Committee on Rules and Credentials is primarily responsible for the Order of Business for the meeting as delineated in the Standing Rules of the House of Delegates. The Committee also oversees the registration and credentialing of delegates and alternates. Tellers have been appointed to count votes when necessary during the meeting.

REFERENCE COMMITTEES

Reference committees are groups of at least four members (five members for Reference Committee A-Bylaws) selected by the Speakers to conduct open hearings on matters of business of the Society. Having heard discussion on the subject before it, the committee prepares a report with recommendations to the House for disposition of its items of business.

At each meeting of the House of Delegates, the Speakers assign to the previously-appointed reference committees resolutions, reports, and other matters within each committee’s jurisdiction. The Bylaws provide that the Speaker shall appoint such reference committees and clearly identify them as deemed necessary to expedite the business of the House. For the 2016 annual meeting, the Speakers have appointed the following reference committees:

A-Bylaws  
B-Education and Science/Public Health  
C-Managed Care & Other Third-Party Reimbursement  
D-Mcare Fund/Tort Reform/Other Legislation/Regulation  
E-Membership/Leadership/Subsidiaries

Reference committee hearings are open to all members of the Society, guests, official observers, interested outsiders, and the press. Any member of the Society is privileged to speak on the 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 the chair’s 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. The chair also has jurisdiction over such matters as photography, television filming, and the introduction of recording devices. If, in the chair’s estimation, such factors would be, or become, undesirable for the conduct of an orderly hearing, the chair may act to prohibit them. It is recommended that reference committee chairs not ask for an expression of the sentiments of those attending the hearing by an informal vote on particular items. The committee members may ask questions to be sure that they understand the opinions being expressed, or may answer questions if a member seeks clarification; however, the committee members should not enter into arguments with speakers or express opinions during the hearing. The committee listens carefully and evaluates all opinions presented so that it may provide the voting body with a carefully considered recommendation.

The reference committee hearing is the proper forum for discussion of controversial items of business. In general, delegates who have not taken advantage of such hearings for the presentation of their viewpoints or the introduction of evidence should be reluctant to do so on the floor of the House. It is recognized, however, that 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.

District, specialty and section caucuses should assign to each delegate responsibility for attending specific reference committees to carry the sentiment of the caucus and to report back.

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

Minority reports from reference committees are in order only if signed by two or more members of the committee.

REFERENCE COMMITTEE REPORTS

Reference committee reports on the official business consume much of the deliberations of the House of Delegates. They need to be constructed swiftly and succinctly after completion of the hearings in order that they may be processed and made available to the delegates as far in advance of formal presentation as possible.

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

Basically, at the time of the reference committee report, each report, resolution, or recommendation which has been accepted by the House as business is the matter which is before the House for disposition. The reference committee recommends a disposition such as adopt, not adopt, refer, or file. 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 a reference committee be reported to the House as follows:

1. Identify the resolution or report by number, title and sponsor;

2. State concisely the committee’s recommendations, and state what was called for in the resolution, report, or recommendation;

3. Comment on the testimony presented at the hearings; and

4. Incorporate supporting evidence of the recommendations of the committee.

**Waiver of Debate List**

Your Speakers suggest that the reference committee report *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 proposal 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, 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, making it clear that the reference committee has recommended a vote in the negative. The vote, however, is on the resolution—not on the reference committee’s recommendation.

3. The reference committee is reporting on a resolution or report which it feels should be referred for further consideration to the Board of Trustees, or through the Board to an appropriate council or committee, and it so recommends. The chair will put the motion on the recommendation of the reference committee “to refer”. If this fails to pass, the motion is again on the adoption of the 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 reference committee may prepare the amendment; if the amendment is accepted, the amended resolution or recommendation is presented to the House. 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 adopt the original resolution.

5. The reference committee is reporting on two or more similar 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
The Speakers have the option to present reference committee reports as a consent calendar and intend to do so.

Form of Action on Reports and Resolutions
As a member of the House, you should have a clear understanding of the precise effect of the language used in disposing of items of business. There has been variance in interpretation of such proposals as “to accept for information”, “to approve in principle”, or “to approve”, “accept”, or “adopt”.

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 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 regulation, or clarifies issues in a controversial matter, may be filed for information. This does not have the effect of placing the Society 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 Society responsible for the matter. In the interest of clarity, use of the terms “accept for information” and “approve in principle” should be avoided.

3. When the House does not wish to assume responsibility for the recommendations of a report in its existing form, it may take action to refer back to committee (recommit) or to refer elsewhere; to reject the report in its entirety or in specific part; or to adopt as amended (amend and adopt).
NOTE: A report or resolution is “received” when it is introduced as the business of the House at its opening session. The House may decline to receive the matter only by objecting to its consideration at the time of its introduction. For this reason, it is inappropriate to propose as final action that a matter be “received” or “received for information”.

PARLIAMENTARY PROCEDURE IN THE HOUSE

It is necessary in an assembly of over 300 delegates to insist that each individual speaking to an issue be recognized by the chair, be at a microphone, and be properly identified for the information of those who transcribe the proceedings.

As indicated in Standing Rule No. 18, the House is guided by the principles of the parliamentary authority designated in the Bylaws, which is the current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

A few comments regarding specific procedures may be helpful:

1. **The motion to REFER**: If it is desired that a matter receive more study, it can be referred. If a motion to REFER is applied to a subject which has pending amendments, the matter as it stands at the moment of the motion to REFER is referred.

2. **The motion to REFER FOR DECISION**: If it is desired that a matter be studied and acted upon prior to the next meeting of the House of Delegates, it can be referred for decision. If a motion to REFER FOR DECISION is applied to a subject which has pending amendments, the matter as it stands at the moment of the motion to REFER FOR DECISION is referred.

3. **The motion to RECONSIDER**: Roberts’ Rules of Order require that this motion be made by one who voted with the prevailing side in the prior action which is to be reconsidered. This is an impractical provision when applied to action taken by votes which are not individually recorded. Under AIP, a motion to RECONSIDER which has been seconded will generally be assumed by the chair to be in order. If the motion to RECONSIDER is sustained, the situation reverts to the exact position it occupied before it was voted on.

4. **The motion to VOTE IMMEDIATELY**: Sustaining such a motion requires a two-thirds ($\frac{2}{3}$) affirmative vote. 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.

The motion to vote immediately has the following rules:

• It requires a two-thirds ($\frac{2}{3}$) majority to pass.
• It may not be made by a delegate or alternate immediately following his or her own testimony on an issue.
• It will be assumed to apply to the last motion on the floor unless the maker of the motion specifies otherwise.
• It has been our custom to depart from The Standard Code of Parliamentary Procedure so that this motion will only apply to motions on which there has been both pro and con debate.
5. **WITHDRAWAL of resolutions**: Occasionally the sponsors of resolutions become persuaded that their resolutions are somehow inappropriate or inaccurate. At any time prior to the acceptance of the resolutions as the business of the House, with referral to reference committees, the sponsors may WITHDRAW their resolutions and they do not become the business of the House. After referral to reference committees, they are the business of the House. At the time of the reference committee hearings, the sponsors may become persuaded that they would like to WITHDRAW their resolutions, and may suggest to the reference committee that WITHDRAWAL would be preferable to other action. If the sponsor concurs, the reference committee may recommend in its report that leave to WITHDRAW be accorded by the House. The chair, having confirmed approval by the sponsor, places the question on granting LEAVE TO WITHDRAW. A majority vote in the affirmative accomplishes WITHDRAWAL.

6. **The motion to POSTPONE or DEFER CONSIDERATION of a question**: Such deferment may take two forms - (a) Postpone to a Definite Time or (b) Postpone Temporarily.

   a. **To postpone to a definite time** is of higher rank than referral, and a less 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. A simple majority vote is required for adoption.

   b. **To postpone temporarily** has the force of the former motion to "table", and is the highest ranking subsidiary motion to be applied to a main motion. It is not debatable. A simple majority vote is required for adoption.

7. **The motion to RESUME CONSIDERATION**: To resume consideration is equivalent to “take from the table”. The effect of the motion to resume consideration is that the original main motion, with any attached subsidiary motions, is before the House in exactly the same state it was when it was postponed. A simple majority vote is required for adoption.

**IF YOU WANT THE FLOOR**

If you wish to speak during a meeting of the House, go to the nearest microphone and wait to be recognized by the Speaker. Before making your statement, please identify yourself by name and county or section. Otherwise, the Speaker will interrupt you and request you to do so.

**ABOUT VOTING**

When the Speaker calls for a standing vote, the tellers assigned to specific sections of the House will be asked to make the count. Please, therefore, remain standing until you are sure that the teller in your part of the House has completed the count. Your cooperation will enable the sectional teller to report quickly and accurately to the chief teller, who in turn will report the total vote to the Speaker.
**SUGGESTIONS AND REMINDERS**

To help you prepare yourself for an efficient role as a member of the House of Delegates, here are a few additional suggestions and reminders.

1. Read the Bylaws of the Pennsylvania Medical Society so that you will have a good working knowledge of the organizational structure, rules, and procedures.

2. Familiarize yourself with parliamentary procedure, as detailed in the American Institute of Parliamentarians *Standard Code of Parliamentary Procedure*.

3. Study the various reports and resolutions in the Official Reports Book.

4. Familiarize yourself with all resolutions, proposals, or policies which your county or specialty society plans to present at the session.

5. Attend the district/section caucuses, usually held prior to the first session of the House, to review with your colleagues the business before the House.

**OBLIGATIONS AND TIME COMMITMENT OF THE PRESIDENCY**

Election to the office of Vice President is the first year of a four-year continuum. This is followed by automatic elevation to the offices of President Elect, President, and Immediate Past President. What follows is a brief description of the obligations and time commitment of these four years as compiled by several recent Presidents.

Note that all expenses of travel are reimbursed by the Society. Coach travel is expected.

**The Vice President:**

- Attends all meetings of the Medical Society Board of Trustees.
- Is a member of the Executive Committee which meets on an as-needed basis, generally four to five times per year. These meetings, if held in person, typically are at the Medical Society headquarters building in Harrisburg. Frequently, they are held by conference call if the issues are urgent, the meeting is expected to be short, and an in-person meeting is not feasible. The meetings are chaired by the Chair of the Board.
- Is an ex-officio member of all committees of the Medical Society. The Vice President will receive a copy of the agenda of all meetings in advance of the meetings, and is welcomed and encouraged to attend any of the meetings, though not necessarily expected to attend. These meetings take place in Harrisburg. Video conferencing may be an option depending on whether the meeting incorporates this feature, and in a location where the Vice President lives. Attendance at these meetings during the years leading up to the Presidency helps familiarize the Vice President with the members of the committees and aids in the process of committee appointments which are made by the incoming President a few months prior to taking office.
- Is invited to all meetings of the Finance Committee of the Board. These meetings are usually held in the daytime on Tuesdays prior to evening sessions of the Board.
- Will occasionally be called upon to attend meetings and functions related to the activities of the Medical Society when they are held nearby to the home or work location of the Vice President.
• Will occasionally be called upon to grant media interviews when local media wish to speak with an officer of the Society who is representative of their geographic area. The Vice President should plan to attend at least one or possibly more media spokesperson training sessions during this year if not previously done.

• Is often invited to county medical society and Alliance functions in nearby areas. These functions will most often be held during the evening or on weekends.

• May be asked to represent the Society at functions of other professional associations when the President or President Elect is unavailable, especially if these functions are held in nearby locations.

• Is assisted with the arrangements for the above responsibilities by the staff of the Medical Society. The assistant to the President keeps track of the appointments and travel arrangements for the Vice President if it is desired by the Vice President. Other staff who are available and very helpful will represent media relations, government relations, medical economics, the Alliance, membership, and the Foundation.

• Will be oriented to the staff and functions of the divisions of the Medical Society, if the Vice President has not previously been a member of the Board of Trustees, by a day-long orientation process.

The President Elect:

• Attends all meetings of the Medical Society Board of Trustees.

• Is first in line after the President to be spokesperson for the Medical Society if the President is unavailable.

• Continues with above activities and is expected to attend the council, commission and committee meetings more often as their work schedule allows.

• Will be called upon more often to contribute to media interviews, especially if the President is unavailable. Arrangements will be coordinated by Media Relations.

• Gives testimony to state House and Senate committees if the President is unavailable or if the committee issue is of particular interest or relates to specific expertise of the President Elect. In most cases these committee meetings are held in Harrisburg, but may also be held in locales near to the President Elect. Testimony is generally prepared by staff, but the officer has input into the contents of the testimony.

• Will be kept informed of visits to the area by various staff of the Medical Society, and will be invited to participate if appropriate.

• Fills in as representative of the Medical Society in various contiguous states at their annual meetings if the President is unavailable. These meetings usually occur over weekends. The spouse of the President Elect is generally invited to accompany the President Elect but is not obligated to do so. Expenses of the spouse are generally covered by the Medical Society.

• May be asked to host representatives of other professional societies as needed.

• May be asked to accompany Medical Society staff to meetings with other organizations. Examples may include: insurance companies, the Physician General, the Insurance Commissioner, offices of legislators, the Secretary of Health, editorial boards.

• May be asked to make presentations at hospital medical staff meetings as a spokesperson of the Medical Society. Society staff will accompany as needed or requested.

• Travel around the state increases during this year.

• Will be expected to register as a lobbyist in order to conform with state law. This relates to the fact that the President Elect receives a small stipend to offset a decreased income during this year.
The President:
- Depending on the hot button items of the year, the President may need to be away from his/her practice anywhere from 40% to 70% of the time. The stipend for this year increases.
- Attends all meetings of the Medical Society Board. May need to come early and stay late on a regular basis. Travel plans should be flexible.
- Attends council, commission and committee meetings as schedule allows.
- Becomes the chief spokesperson for the Society. Is obligated to represent the official policy of the Society as determined by the House of Delegates and the Board.
- Is involved in media interviews (radio, TV, local and national newspapers, and journals) which increase dramatically in number. Is assisted in arrangements by Media Relations.
- Travels extensively both in-state and out-of-state. Spends many weekends away from home, especially at other state society annual meetings, and meetings of other professional societies. Generally, the President’s spouse is invited but not obligated to attend.
- Travels around Pennsylvania to represent the Medical Society at county society and Alliance meetings. Is expected to give verbal updates of Society activities during these functions.
- Frequently offers testimony to state House and Senate committees. These may often be scheduled at the last minute, i.e., with just a few days notice.
- Accompanies staff to meetings with various government agencies, both state and federal, as appropriate.
- Will be asked to sign letters as President of the Society when it is appropriate. These may be to members, non-members, government agencies, media, and legislators. Medical Society staff will correspond with the President by email and will provided all background information. The correspondence will be composed by the staff, but the President is expected to have input into the content of the correspondence. Letters are sent out of Society headquarters; staff support is provided.
- Will be expected to attend at least the June meeting in Chicago if not already a member of the AMA Delegation. Will participate in the ceremonial inauguration of the new AMA President.

The Immediate Past President:
- Has markedly fewer time commitments.
- Continues as a member of the Board and the Executive Committee.
- Is last in line after President Elect and Vice President to represent the Medical Society at Society and public venues.
- May wish to continue activities related to a specific issue with the concurrence of the President.

(Note: Only active members of this Society are eligible to serve as officers. Members of the Society’s Board of Trustees must be either active or associate members.)

STANDING COMMITTEES

Committee on Bylaws
The Committee on Bylaws consists of five voting members of the House of Delegates appointed by the Speaker of the House of Delegates. This Committee serves as Reference Committee A at the annual House of Delegates meeting. Three members are appointed in odd-numbered years for two-year terms, and two members are appointed in even-numbered years for two-year terms. No member may serve more than two consecutive two-year terms unless elected Chair, in which case an additional year may
be served. The Bylaws Committee is charged with constantly studying the bylaws and recommending revisions and modifications necessitated by changing times, methods, or conditions.

**Committee to Nominate Delegates and Alternates to the American Medical Association**

Consists of five members elected by the House of Delegates to serve a term of three years. Nominations are made by seated delegates from the floor of the House. All committee members must be members in good standing of the AMA. The Immediate Past President and the Chair of the Board of Trustees serve as ex officio non-voting members. The Committee is charged with submitting to the House of Delegates a list of nominees for delegates and alternates to the AMA.

**CAMPAIGN GUIDELINES**

Resolution 80-33, Procedures to be Followed by Candidates Seeking Elected Positions in this Society, was adopted by the 1980 House of Delegates and established the following guidelines and campaign protocol for candidates running for elective office in the Pennsylvania Medical Society:

1. It is required that a concise summary of each candidate be produced, citing practice location and type; age; educational background; positions held in county, specialty, and state medical societies; and years of service in present elected positions if an incumbent.

2. It is appropriate for letters of intent or endorsement to be sent from the sponsoring county, specialty society, or district at times they deem appropriate. It is also permissible for candidates to make personal visits to hospitality rooms or suites. *Campaign materials (pins, brochures, stickers, etc.) and organized society events promoting candidates are considered inappropriate.*

*In lieu of candidates attending each of the caucuses, the Speakers provide a luncheon for candidates for the Pennsylvania Delegation to the American Medical Association, at which time each candidate is given a few minutes to speak.

In addition, the 1989 House of Delegates approved the Speaker’s report, amending the election guidelines to provide for candidates for the positions of Vice President, Speaker, Vice Speaker, and Trustee (in those years when there are multiple candidates) to address the House for a maximum of five minutes after their nomination; seconds **will not** be recognized.

If the district or section trustees wish to meet further with the delegates, they are encouraged to do so by personal invitation to their caucus or luncheon.
## BASIC RULES

### PRIVILEGED MOTIONS

<table>
<thead>
<tr>
<th>Order of precedence</th>
<th>Can interrupt?</th>
<th>Requires a second?</th>
<th>Debatable</th>
<th>Amendable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>Yes$^3$</td>
<td>Yes$^4$</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes$^3$</td>
<td>Yes$^4$</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

### SUBSIDIARY MOTIONS

<table>
<thead>
<tr>
<th>Order of precedence</th>
<th>Can interrupt?</th>
<th>Requires a second?</th>
<th>Debatable</th>
<th>Amendable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Table</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>6. Limit or Extend debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes$^3$</td>
<td>Yes$^2$</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes$^3$</td>
<td>Yes$^2$</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes$^3$</td>
<td>Yes$^2$</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes$^3$</td>
<td>Yes$^2$</td>
</tr>
</tbody>
</table>

### MAIN MOTIONS

10. a. The main motion
    b. Specific main motions
        - Adopt in-lieu-of
        - Amend a previous action
        - Ratify
        - Recall from committee
        - Reconsider
        - Rescind

### INCIDENTAL

### MOTIONS

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can interrupt?</th>
<th>Requires a second?</th>
<th>Debatable</th>
<th>Amendable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Suspend the rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

### REQUESTS

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can interrupt?</th>
<th>Requires a second?</th>
<th>Debatable</th>
<th>Amendable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Inquiries</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

---

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 undefeatable motion.

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

<table>
<thead>
<tr>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
<th>Renewable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes</td>
</tr>
<tr>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>2/3</td>
<td>Main motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>Majority</td>
<td>Rewordable motions</td>
<td>Amend, close debate, limit debate</td>
<td>No⁶</td>
</tr>
<tr>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Majority</td>
<td>Referred main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>Majority</td>
<td>Vote on main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>Same Vote</td>
<td>Adopted main motion</td>
<td>Subsidiary, except amend</td>
<td>No</td>
</tr>
</tbody>
</table>

## MOTIONS

<table>
<thead>
<tr>
<th>Vote required?</th>
<th>Applies to what other motion?</th>
<th>Can have what other motions applied to it?</th>
<th>Renewable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority⁷</td>
<td>Ruling of chair</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>2/3</td>
<td>Procedural rules</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Majority</td>
<td>Main motion or subject</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>None</td>
<td>Procedural error</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>None</td>
<td>All motions</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>None⁸</td>
<td>All motions</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>None⁸</td>
<td>Main motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>None⁸</td>
<td>Indecisive vote</td>
<td>None</td>
<td>No</td>
</tr>
</tbody>
</table>

⁵ Withdraw may be applied to all motions.
⁶ Renewable at the discretion of the presiding officer.
⁷ A tie or majority vote sustains the ruling of the presiding officer; a majority vote in the negative reverses the ruling.
⁸ If decided by the assembly, by motion, requires a majority vote to adopt.
Listed below are the resolutions considered by the 2015 House of Delegates. In the case of a referred or adopted resolution, the index refers to the specific report, which contains the details of the implementing actions.

Resolution 15-202: Defining Annual Wellness Visits as Provided by Community-based Primary Care Physicians (adopted as amended)—Called on PAMED to work to define the Medicare annual wellness visit as that which is provided by physicians or members of a community-based, physician-led team that will provide continuity of care to patients; also called on the AMA Delegation to consider taking a similar resolution to the AMA. Resolution was submitted to the AMA for its interim meeting in November 2015. The AMA’s Council on Medical Service will prepare a report for consideration by the AMA House of Delegates at the 2016 interim meeting in November.

Resolution 15-203: Recognizing National Board of Physicians and Surgeons Board Certification as an Equal Alternative to American Board of Medical Specialties Maintenance of Certification and Recertification Process (not adopted)—Called on PAMED to recognize certification by the National Board of Physicians and Surgeons (NBPAS) as equal to Maintenance of Certification (MOC) and recertification by the American Board of Medical Specialties (ABMS) and all its respective specialty boards; to make public this position to insurance companies, hospitals and on its website; and to promote this resolution to the AMA for consideration at its next meeting.

Resolution 15-204: Parity for International Medical Graduates with US Medical Graduates in Years of Graduate Medical Education Requirement for Licensure (adopted)—Called on PAMED to adopt a policy supporting parity in the number of years of Graduate Medical Education (GME) training required for International Medical Graduates (IMGs) and United States Medical Graduates (USMGs) to obtain state medical licensure, and to aggressively pursue, including by legislative means, parity in the number of years of GME training requirement for IMGs and USMGs for licensure, and report back the progress in two years. PAMED has discussed this issue with HAP. HAP is in favor of this resolution. PAMED will contact AMA for additional data/info. PAMED has asked Rep. Aaron Kaufer to sponsor legislation on the issue. Draft legislation has been drafted. PAMED will provide updates on this resolution as they occur.

Resolution 15-205: Universal Access for Vaccinations in Pennsylvania (adopted as amended)—Called on PAMED to advocate that all insurers should be required to pay for appropriate vaccines regardless of the point of service, and to advocate that when a vaccination is administered to an adult or minor, a record of this vaccination is registered in the Pennsylvania state vaccine registry and that communication of administration is passed back to the primary care providers. PAMED has been in touch multiple times with resolution author regarding research and communication with insurers and public. This issue was presented to members of the PAMED Medical Directors Forum at their May meeting to determine which payers are paying for vaccine administration to the pharmacist. Several of the payers do pay for this service. Several retail pharmacies in the author’s service area were contacted regarding their stocking of vaccines. We have compiled a spreadsheet outlining the pharmacies contacted and their vaccine supplies. We also talked with the PA DOH regarding PA SIIS reporting. We believe all of the Resolveds have been addressed.

Resolution 15-206: Reducing Healthcare Disparities for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients (adopted as amended)—Called on PAMED to advocate to expand access and eliminate disparities for LGBT Pennsylvanians; to advocate for future research efforts that are specifically designed to investigate LGBT health issues; and to make information on LGBT health issues available to Pennsylvania physicians. Task force met on 2/17/16, 3/30/16, and 7/6/16. The resolution’s author was invited to participate in these meetings. Each meeting focused on the three key resolves of the resolution: 1) advocate for future research efforts specifically designed to investigate LGBT health issues; 2) educate
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and inform Pennsylvania’s physicians, policymakers, and the public on issues that impact public health, patient care and the practice of medicine; and 3) make information on LGBT health issues available to Pennsylvania physicians. Areas of priority included support for the PA Fairness Act; discussion of proposed legislation, policies and procedures related to conversion therapy; the Healthcare Bill of Rights; insurance coverage for hormone replacement therapy, gender reassignment surgery and other LGBT healthcare concerns; mental health and substance use parity to include LGBT behavioral health needs; and elimination of anti-stigma and anti-discrimination in local, state and national policies/legislation. The March meeting focused on cultural and medical competency education for transgender, bisexual, lesbian and gay patients and their families of choice. The task force recommended mandated medical school curriculum on LGBT-specific health care disparities, cultural sensitivity and non-discrimination training. A list of clinical competency model training modules was compiled. The focus of the last meeting was to brainstorm educational needs for both the public at large and medical healthcare professionals. Attendees provided links to important healthcare initiatives occurring across the state and nation and list of organizations available to serve as resources for education, public service awareness, and physician training. Issues that should be part of a public service campaign include information on domestic violence, bullying, increased mental health needs (including high incidence of suicides, gun violence, and substance use) and cultural sensitivity. Although the official duties of the task force are complete, this group has expressed an interest in continuing to meet to complete its work.

Resolution 15-207: A Clearly Articulated Protocol for Sleep Facilities and/or Safe Transportation in All ACGME/AAOA-Approved Residencies (adopted as amended)—Called on PAMED to advocate that all physician residency programs in Pennsylvania offer the option of safe transportation home, as well as sleep facilities in their institution, for residents who may be too fatigued to safely return home after an overnight shift, and to ask all physician residency programs in Pennsylvania to create and make publicly available via the internet and in internal literature, such as resident physician program handbooks, a clearly articulated protocol for the use of their sleep facilities and transportation services for residents who have overnight shifts. PAMED has met internally to discuss strategy for advancing this resolution and had a conference call with HAP to discuss. HAP believes that the existing accreditation standards adopted by ACGME are adequate. PAMED provided update to resolution author via email. Letter sent to medical school deans to request clearer articulation of literature on transportation and sleeping arrangements and to make this information available to students. Letter sent to ACGME requesting that policy be changed to require schools to provide both transportation and sleeping arrangements for students instead of providing one or the other. PAMED will continue to monitor this situation as required.

Resolution 15-301: Improve Delivery of Peripheral Arterial Disease Care to Medicaid Beneficiaries at a Lower Cost to the State (adopted as amended)—Called on PAMED to urge the Pennsylvania Department of Human Services to cover and reimburse for in-office percutaneous peripheral arterial disease (PAD) therapies. PAMED contacted author for access to information and consultation on resolution. PAMED conducted research on Medicare payment amounts and drafted letter to CMO of DHS (Dr. Kelley) requesting physician office coverage. PAMED sent follow-up email to Dr. Kelley and received a response indicating that the Bureau of Planning and Policy is reviewing the resolution and they will apprise PAMED once that is complete. There has been follow-up with Dr. Kelley to determine status of evaluation. Preliminary report is DHS is considering covering some of the codes, but probably not all. Waiting for final response from DHS.

Resolution 15-401: Source Testing After Healthcare Worker Bloodborne Pathogen Exposure (adopted)—Called on PAMED to place Act 148 on its legislative agenda and to dedicate resources to lobbying for further amendment of Act 148, further eliminating barriers to prompt Source testing in the case of BBPE involving HCW, and to continue to lobby for amendment of Act 148, should it be unsuccessful, until the goal is attained. Resolution re-assigned from Angela Boateng to Hannah Walsh on 4/21/16. PAMED staff met with Resolution author to establish the criteria for the specific change(s) in the law that are being sought. This issue requires further research. Given PAMED’s legislative priorities, this has not been aggressively pursued.
Resolution 15-402: “Long White Coats” to Help Identify Physicians (not adopted)—Called on
PAMED to seek regulations from the appropriate state regulatory agency and/or legislation that restricts
the wearing of long white coats to physicians and PhDs when caring for patients to improve patients’ and
health care team members’ recognition of the individuals caring for patients.

Resolution 15-403: Medical Use of Cannabinoids (adopted substitute resolution as amended)—
Called on PAMED to oppose broad-based legalization of cannabis for medical use and adopt the
following principles:

1) The Pennsylvania Medical Society calls for further adequate and well-controlled studies of
marijuana and related cannabinoids in patients who have serious conditions for which preclinical,
anecdotal, or controlled evidence suggests possible efficacy and the application of such results to
the understanding and treatment of disease.

2) The Pennsylvania Medical Society urges that marijuana’s status as a federal Schedule I controlled
substance be reviewed with the goal of facilitating the conduct of clinical research and
development of cannabinoid-based medicines, and alternate delivery methods. This should not be
viewed as an endorsement of state-based medical cannabis programs, the legalization of
marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current
standards for a prescription drug product.

3) The Pennsylvania Medical Society urges the National Institutes of Health (NIH) to implement
administrative procedures to facilitate grant applications and the conduct of well-designed clinical
research into the medical utility of marijuana. This effort should include: a) disseminating
specific information for researchers on the development of safeguards for marijuana clinical
research protocols and the development of model informed consent on marijuana for institutional
review board evaluation; b) sufficient funding to support such clinical research and access for
qualified investigators to adequate supplies of marijuana for clinical research purposes; c)
confirming that marijuana of various and consistent strengths and/or placebo will be supplied by
the National Institute on Drug Abuse to investigators registered with the Drug Enforcement
Agency who are conducting bona fide clinical research studies that receive Food and Drug
Administration approval, regardless of whether or not the NIH is the primary source of grant
support.

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

5) The Pennsylvania Medical Society supports trials using cannabidiol oil to treat children with
seizure disorders, funding for the trials, and a patient registry.

Between 1/1/16 and 4/28/16: PAMED staff fielded a combined total of 55 media inquiries and news
conference contacts related to the medical use of cannabinoids, and 662 news clips on the issue.
PAMED also participated in a Media Call-In.

On multiple dates (3/7/16, 3/8/16, 3/14/16, 3/15/16, 3/23/16, 4/4/16, 4/5/16, 4/7/16, 4/11/16, 4/12/16, and
4/13/16), Advocacy staff advocated PAMED’s position to key legislators regarding SB3 and the need for
more research on medical uses of cannabinoids. Advocacy staff also worked to ensure that the
Pennsylvania Department of Health (DOH) would have an advisory committee to annually review
cannabinoid medical research being conducted and provide recommendations.

During the Executive Committee teleconference on 3/16/16, Advocacy staff provided an overview of the
political landscape as well as the multiple versions of SB3.

On 4/13/2016, PAMED released a statement from Dr. Shapiro regarding medical use of cannabinoids:
“The Pennsylvania Medical Society (PAMED) is encouraged that the recently-passed legislation
concerning marijuana for medical use contains provisions that recognize the benefit and need for
additional clinical research. In light of the passage of this legislation, it is our hope that
marijuana’s status as a federal Schedule I controlled substance is reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. While PAMED continues to have serious concerns about the efficacy of medical cannabis across a wide spectrum of disease states, it is our sincere hope that patients, especially children and their caring parents, experience positive clinical outcomes.”

On 4/15/16, PAMED created 4 Quick Consults regarding the recently-passed SB3 “Medical Marijuana Legislation”:

Quick Consult 1: General Information Regarding Medical Marijuana (a general overview for physicians; understanding the role and responsibilities of health care providers).

Quick Consult 2: Highlights of SB 3 - Medical Marijuana Legalization (a general overview for the public explaining which conditions are approved and what forms of cannabinoids may be administered).

Quick Consult 3: Physician Information for Medical Marijuana (a general overview of the provisions that impact physicians directly).

Quick Consult 4: Upcoming Process for Medical Marijuana (explains the process for physicians and patients to become “approved” by the DOH).

Resolution 15-405: The Pennsylvania Medical Society Aggressively Seek Legislation and/or Regulatory Action to End the Practice of Exclusive Contracts by Hospitals and Hospital Networks (existing policies 180.983 & 230.991 reaffirmed in lieu of resolution)—Called on PAMED to actively pursue actions and legislation to end the unfair practice of exclusive contracts by hospitals and hospital networks and support physicians who are impacted by these tactics; to aggressively seek enforcement of the “Community Benefit Standard” in respect to the restriction of physician access to non-profit hospitals and health networks through the closing of medical staff to independent physicians; and to lobby the Internal Revenue Service to enforce the “Community Benefit Standard” in reference to the restriction of private practice physicians’ access to non-profit hospitals and health networks.

Resolution 15-501: Regional Local Medical Societies (adopted)—Called on PAMED to create a task force to examine the feasibility of forming larger regional medical societies built upon existing county structures that will continue to provide appropriate representation of physicians’ local issues while providing increased member benefits though organizations with greater resources. PAMED created a task force to operate under direction of its Chair, Charles Cutler, MD, PAMED President Elect. Additional PAMED staff were assigned to this issue on 1/25/16. PAMED made contact with Sheri Jacobs, Consultant, to outline work plan and consulting needs. Consultant’s proposal received and reviewed with Task Force Chair. Finance Committee funding request completed; reviewed at 2/9/16 Finance Committee meeting. Funding request was approved by PAMED BOT; agreement signed with Consultant. Task Force participant names provided for consideration of appointment; letters sent and interested participants confirmed. Task force update on purpose completed and approved by Chair; shared with Executive Committee. First meeting was held on 4/8/16 to discuss the charge, author’s vision, and the end goal of creating tool kits for use by counties that provide expert legal and financial guidance for those interested in merging. The group spent time with Sheri Jacobs, Consultant, who was gathering data on membership value and associated dues with the end result of providing membership model recommendations. PAMED continued to work with experts on the financial and legal aspects necessary for the toolkits. A focus group was hosted for county medical society leaders who are considering the possibility of regionalization. The focus group yielded helpful feedback and guidance for the formation of the toolkit. Key themes included:

• regionalization is a decision directed by county medical society leadership;
• regionalization is completely optional and often emerges organically;
• regionalization can be as simple as coordinating advocacy efforts and as complex as merging boards and sharing financial resources;
• the state society has no authority and/or role in the regionalization process;
• regionalization within districts is the most feasible option because representation within the House of Delegates is determined through district boundaries;
• if regionalization occurs outside across district boundaries, the bylaws will need to be revised;
• the toolkit is not legal guidance—legal guidance must be secured by each county medical society;
• the toolkit will serve as a starting point and guide for key discussion points between county leadership.

During the process of research and discovery, Avenue M was commissioned to create and execute a survey to evaluate value relative to the cost of dues pricing at the county and state levels. The results of this survey will be made available in a report in September 2016. The assembly of the toolkit is currently underway and will be made available to all county medical society leadership before the 2016 House of Delegates. Key components of the toolkit include: governance, legal, financial and staffing considerations.

Resolution 15-502: Pennsylvania Medical Society Inclusion of Non-Physician Subject Matter Experts (adopted as amended)—Called on PAMED to seek and engage non-physician subject matter expert(s) to participate (in a non-voting capacity) on councils, committees or task forces charged to investigate, evaluate, review and/or implement policy, programs or legislation that may impact the physicians of the Commonwealth and their patients. PAMED will work with Board Chair and President to implement this policy as part of the 2017 Committee appointment process. There are currently several non-physician experts participating in various PAMED work groups and task forces, including the Payer Advocacy Task Force and the LGBT Task Force.

Resolution 15-504: The Education of Pennsylvania Physicians to the Legalities of Contracts (adopted as amended)—In order to assist and prepare the many Pennsylvania physicians, fellows and students who may be faced with contracts, this Resolution called on PAMED to establish a readily available (such as on the PAMEDSOC website) presentation, educating such individuals to the proper method of analyzing, questioning and entering into such contracts for their just and proper benefit. PAMED legal counsel is reviewing existing resources. Will determine whether or not 2014 HOD presentation, “Get What You Deserve, Save What You Get (Physician Employment Contracts)” will satisfy resolution.

Resolution 15-505: Streamlining Medical Student Membership Registration (adopted as amended)—Called on PAMED to explore avenues of having Pennsylvania medical schools facilitate access to and build awareness of free membership for all current students. Dr. Gallagher spoke with several medical students at the February 2016 Board meeting on this issue. Concern was expressed about automatically signing up all students as members. PAMED will reach out to Medical Student Section for further discussion.

STANDING COMMITTEES OF THE BOARD

Executive – The Executive Committee is comprised of the Board chair, Board vice chair, president, president elect, vice president, immediate past president, speaker of the House of Delegates and the chair of the Finance Committee. This year the Executive Committee held monthly telephone conferences and also met in person on the Monday evening immediately preceding the Board meetings in February, May, and August. A brief summary of actions taken during each teleconference and meeting are outlined below.

September 16, 2015—The Executive Committee took the following actions: 1) tentatively supported the PA Pharmacists Association’s opioid dispensing guidelines, with the caveat that PAMED staff would address with the pharmacists the issues raised regarding prescriber validation and oversight; 2) provided
direction to staff regarding a meeting scheduled for September 21st with the PA Insurance Department, as well as an insurance hearing scheduled for October 1st at which PAMED was asked to testify. Dr. Brad Klein, a neurologist and PAMED young physician member, would provide testimony; 3) approved PAMED endorsement of Kishan Thadikonda (University of Pittsburgh School of Medicine) to run for election as the Region VI Delegate from Pennsylvania and Gretchen Evans (Drexel University College of Medicine) to run for the Region VI Alternate Delegate from Pennsylvania; and 4) supported Dr. Daniel Glunk’s nomination to the American Board of Internal Medicine (ABIM).

October 23, 2015—The Executive Committee took the following actions: 1) approved the nomination of Patrick M. Reilly, MD to the PA Trauma Systems Foundation Board and directed staff to notify PTSF; and 2) approved the request of Congressman Charles Dent (PA-15-Lehigh) that PAMED support H.R. 3537, the Synthetic Drug Control Act of 2015. The Committee also discussed the following issues: POLST orders; guidelines for an effective medical staff; the current status of the Mcare refund process; interstate medical licensure compact; and medical marijuana.

November 18, 2015—The Executive Committee authorized Dr. Scott Shapiro and Dr. Charles Cutler to meet with Senator Toomey and his staff to begin working on addressing the issue of limiting the number of prescribers of opioids to one physician per patient. The Executive Committee heard additional updates regarding the Mcare refund process, POLST, and the child abuse clearances requirement in the Child Protective Services Law.

December 16, 2015—The Executive Committee began discussing the process that would be followed for appointing a PAMED member to fill the 2nd District Trustee vacancy created by Dr. John Pagan’s successful election to Vice Speaker. Additionally, the Committee took the following actions: 1) determined to conclude the work of the Endowment Fund Task Force; and 2) approved sending a co-authored letter from HAP and PAMED to Secretary Ted Dallas requesting clarification regarding child abuse clearances.

January 20, 2016—The Executive Committee continued discussions regarding the appointment of the 2nd District Trustee; received a request from the Philadelphia County Medical Society to sign on to a Declaration of Principles by Cease Fire, PA; and took the following actions: 1) voted to submit the names of two PAMED members to the Board of Trustees, for consideration at the February meeting, for one appointment to fill a vacancy on the Committee to Nominate Delegates and Alternates to the AMA. The appointment will end with a formal election held during the House of Delegates meeting in October; and 2) approved the creation of five new task forces for 2016. Additionally, the Committee discussed some housekeeping items.

February 8, 2016—The Executive Committee took the following actions: 1) approved support of mandatory opioid prescription CME legislation with the caveat that it would apply only to providers who have a DEA license and the CME would count for two (2) of the 10 hours per year required as patient safety hours of CME; further, any legislation would only apply to physicians who write at least one narcotic prescription per year; and 2) approved recommending to the Board of Trustees that PAMED investigate various options to support physician participation in value-based care initiatives, including potentially forming or affiliating with already formed, physician-led organizations such as an independent physician network and/or Accountable Care Organization, and that a feasibility study on options for supporting physician participation be presented to the PAMED Board of Trustees at the May 2016 meeting. The Committee also discussed PAMED’s endorsement agreement with NORCAL and a proposed legislative fix for the Child Protective Services Legislation.

February 17, 2016—The Executive Committee took the following actions: 1) approved sending a letter to the Pennsylvania Insurance Department addressing issues regarding out-of-network surprise billing practices; and 2) approved creation of a subgroup of the Executive Committee to develop parameters for a Governance and Nomination Committee. Additionally, the Committee discussed some housekeeping items.
March 16, 2016—The Executive Committee voted: 1) to present to the Board of Trustees in May a report regarding a vacancy in the alternate delegate position on the Pennsylvania Delegation to the AMA. The Board of Trustees is responsible for filling any alternate delegate vacancies; 2) to secure a law firm to explore the feasibility of any potential legal claim(s) against the ABIM; and 3) to authorize PAMED to support an AMA Call to Action regarding the nationwide opioid epidemic. The Executive Committee discussed several housekeeping items and was provided with updates on the status of the Mcare refund process; PAMED’s Regionalization Task Force; Highmark’s announced fee reduction; balanced billing; and Senate Resolution 267 (Establishment of an Advisory Committee to Study the Need, Availability and Access to Effective Drug Addiction Treatment in the Commonwealth).

April 27, 2016—The Executive Committee approved preparation of an amicus brief on Mcare informed consent requirement. Additionally, the Committee was advised by the LGBT work group that there was an urgency to support the PA Fairness Act. Based upon that information, the Executive Committee approved moving forward in support. The Committee also received updates on the following: 1) Highmark’s fee reduction; physician guilds/unions; PMSCO; practice options for physicians; and CRNP legislation.

May 16, 2016—The Executive Committee met preceding the Board of Trustees meeting in May. Discussion items included: 1) PAMED’s pension program; 2) state and county relations; 3) a review of the Board’s meeting agenda; and 4) PAMED’s membership numbers and financial figures.

June 22, 2016—The Executive Committee approved two actions during the June 22 teleconference: 1) authorized sending a letter to CMS regarding PAMED’s comments on MACRA; and 2) authorized staff to conduct fact-finding to explore costs and potential risks/rewards of filing an FTC complaint regarding over-concentrated health insurance markets. The Committee also discussed various topics which included: Pennsylvania rural health transformation; a Pennsylvania hospital’s exception request to add clinical psychologists to their hospital medical staff; resolution of litigation involving sanctions against a professional liability defense counsel; CRNP scope of practice (SB 717); PAMED’s position on organ donation (HB 30 / SB 180); PAMED’s Be Smart. Be Safe. Be Sure campaign on opioid abuse/addiction; feedback from the membership regarding the PA Fairness Act; and plans for preparation of the 2017 budget.

July 6, 2016—The Executive Committee held a phone conference to discuss the resignation of Michael Fraser, PAMED’s Executive Vice President (EVP). The Committee will involve the Board of Trustees in the candidate search and hiring process and, to that end, directed staff to prepare a webinar to inform the Board of the pros and cons of conducting an internal vs. an external candidate search. The Board will determine, during a special meeting on July 11, the process for conducting the EVP search.

July 20, 2016—The Executive Committee took the following actions during the July 20 teleconference: 1) approved a report from the Society’s Awards Committee; 2) approved sending a letter to the AMA Board of Trustees in support of Dr. Michael Suk’s nomination to the AMPAC Board; and 3) authorized filing an amicus brief for the Pennsylvania Supreme Court regarding the peer review protection act. The Committee also continued its discussion of physician practice options and received updates regarding a fiscal code amendment involving the Joint Underwriting Association (JUA); PAMED’s receipt of a contingency payment from KEPRO as a result of their award of a TRICARE contract; an update on the EVP search; and proposed changes to the PAMED Bylaws regarding membership dues categories.

August 15, 2016—The Executive Committee discussed several items in preparation for the Board of Trustees meeting on August 16-17: 1) review of the agenda for the Board meeting; 2) an update on the EVP search; and 3) received an overview of the 2017 budget.

Finance – The Finance Committee held meetings regularly during the past year for the purpose of reviewing the Society’s finances and making appropriate recommendations to the Board of Trustees. The
Committee kept the Board informed of the Society’s financial position by distributing financial statements at all regular Board meetings.

The Society’s investment consultant attended Committee meetings quarterly to review Society investments, to provide economic forecasts, and to offer performance comparisons. The Committee also met with the outside independent auditor to review the annual audited financial statements and any other matters the auditor deemed worthwhile.

The PAMED Finance Committee also reviewed the finances of The Foundation, PMSCO, PAMPAC and the Alliance.

The Society relies heavily on the Endowment Fund and dues revenue for Society operations. The use of proceeds from the Endowment Fund is determined annually through the application of a “spending rule.” Despite budgetary restraints, the Society has continued to effectively respond to the many issues we face in this challenging economic environment.

A member of the Finance Committee will be available during Reference Committee E to answer any questions with respect to Society financial matters.

PERMANENT COMMITTEES OF THE BOARD

Distinguished Service Awards Committee – This committee considers candidates nominated for the Pennsylvania Medical Society Distinguished Service Award, the Physician Award for International Voluntary Service (even-ending years), the Physician Award for Community Voluntary Service (odd-ending years), and the PAMED Grant for Healthy Living in Ethnic Communities. In addition, this committee recommends award recipients to the Board of Trustees.

This year, the Awards Committee recommended, and the Executive Committee of the Board of Trustees approved, the following: (1) that the 2016 Distinguished Service Award not be handed out; (2) that Baker Henson, DO, be the recipient of the Physician Award for International Voluntary Service in 2016; and (3) that Katallasso, nominated by the York County Medical Society, be awarded the 2016 Grant for Healthy Living in Ethnic Communities.

Members of the Distinguished Service Awards Committee are: C. Richard Schott, MD, Chair; Bruce A. MacLeod, MD; and Karen A. Rizzo, MD.

Awards Sub-Committee – This committee considers candidates nominated for the Pennsylvania Physician “40 Under 40” awards.

This year, this committee selected, and the Executive Committee of the Board of Trustees approved, forty-two (42) members to be named to the list.

The physicians selected are: Anastasia Shnitser, MD; Jennifer Stephens, DO; Cynthia Bartus, MD; Pamela Valenza, MD; Aaron George, DO; Thomas Jordan, MD; Katherine Lund, DO; Jorge Mercado, MD; Kelli Wenecke, DO; Maggie Biebel, DO; Atul Kalanuria, MD; Eric Griffin, DO; Daniel Schlegel, MD; Affif Kulaylat, MD; Lindsay Surace, MD; Ure Mezu-Chukwu, MD; Lyndsey Vu, MD; Andrew Batchelet, MD; Kristin Ondecko-Ligda, MD; Adam Biuckians, MD; Kristina Newport, MD; Marc Yester, MD; Elizabeth Ramsey, DO; Mark Matta, DO; Jason Neustadter, MD; Carlo Bartoli, MD, PhD; David Frankel, MD; Amanda Hu, MD; Priya Mitra, MD; Richard Month, MD; Dane Scantling, DO; Alexandra Tuluca, MD; Tamar Carmel, MD; Andrew Pogoelski, MD; Keith Stowell, MD; Micah Jacobs, MD; Nicole Velez, MD; Matthew Novak, MD; Ariane Conaboy, DO; John Vasudevan, MD; Diane Shih-Della Penna, MD; and Luis Garcia, MD.
Sub-Committee members include: Charles Cutler, MD; Kristen M. Sandel, MD; and Hans T. Zuckerman, DO.

Committee on Subsidiary and Foundation Relations – The members of this committee are as follows: Steven A. Shapiro, DO, Chair; John P. Gallagher, MD; Danae M. Powers, MD; James W. Redka, MD; Jaan E. Sidorov, MD; and Hans Zuckerman, DO.

PMSCO Board – Current members of the PMSCO Board are: Martin D. Trichtinger, MD, Chair; John J. Pagan, MD; Theodore A. Christopher, MD; Sally J. Dixon, Treasurer; John P. Furia, MD; and Martin Raniowski, PAMED Staff.

Foundation Board – Current members of the Foundation Board are: Joanne R. Bergquist; Erick J. Bergquist, MD, PhD; Kenneth M. Certa, MD; Paul F. Dende, DO; William R. Dewar, III, MD; Ravi Dukkipati, MD; Virginia E. Hall, MD; Peter S. Lund, MD; Kirk D. Tolhurst, MD; Raymond C. Truex, Jr., MD; and William J. West, Jr., MD.

eHealth & Health IT Task Force – The Task Force did not meet, as resources were devoted to final development and introduction of the PAMED Telemedicine Bill. After initial development by the PAMED Telemedicine Task Force, comprised of physicians representing a number of specialties and engaged in telemedicine, the draft was approved by the PAMED Board. After Board approval and the long process of seeking input and potential support by other stakeholders (including the Hospital & Healthsystem Association of Pennsylvania, the Health Information & Management System Society, health insurance plans, vendors, Pennsylvania providers engaged in telemedicine, and others), the language was finalized. The bill has been introduced as SB-1342 by the prime sponsor, Sen. Elder Vogel. A House sponsor has been identified. Next steps will be to seek passage of the bill during the remaining days of the 2016 legislative session.

Employed Physician Task Force – The Employed Physician Task Force has conducted four conference calls during 2016. The task force has focused efforts in three major areas: needs assessment; contract review; and physician bill of rights. PAMED staff conducted six employed physician focus groups across the Commonwealth. The focus groups revealed common issues and needs of employed physicians: 1) employment contracts; 2) employment working conditions; 3) leadership training; and 4) understanding employment transitions. The task force tasked staff with researching and drafting a physician bill of rights that will address and establish the standards for physicians in an employed setting. Staff has nearly completed the research and will present those finding to the task force. The Employed Physician Task Force will draft and then recommend to the Board of Trustees a Physician Bill of Rights. The task force also worked with PAMED staff to ensure that contract reviews were still available through PAMED partners like PMSCO. The task force will provide recommendations for marketing contract review services. The task force will also provide recommendations to PAMED education staff regarding specific needs for employed physicians’ leadership training.

Legislative Advocacy Task Force: On July 20, 2016, the Legislative Advocacy Task Force (LATF) conducted a conference call. Topics for discussion were Scope of Practice, Telemedicine, Retroactive Denial, and the Pennsylvania Prescription Drug Monitoring Program. The Task Force has asked Pennsylvania Medical Society (PAMED) staff going forward to continue to provide an overview of the legislation. However, in cases where PAMED may not fully agree with a piece of legislation, the Task Force asked PAMED staff to provide additional information so that the LATF could provide suggestions to the Board of Trustees to consider as counter proposals or amendment language.

LGBT Health Disparities Work Group: As a result of House Resolution 206-2015 (Reducing Healthcare Disparities for Lesbian, Gay, Bisexual and Transgender (LGBT), a task force was created to address the key components of this resolution. The task force included representatives from: Alder Health Services, the American Medical Association (AMA), Bradbury-Sullivan LGBT Community, a clinical sexologist in private practice, the Craig-Dalsimer Division of Adolescent Medicine, Equality...
Pennsylvania, the Gay and Lesbian Medical Association, Gender and Sexuality Development Clinical at the Children’s Hospital of Philadelphia (CHOP), LGBT Community Center, the Mazzoni Center, Metro Community Health Center, PA Department of Health (DOH), PAMED, Papillon Center, PA Psychiatry Society, Persad Center, Pinnacle Health Endocrinology Associates, and Temple University School of Medicine. Jarett Sell, MD, Hershey Medical Center and Alder Health Services, served as Chair of the task force. Michael Fraser, PhD, CAE and Deborah Ann Shoemaker served as staff liaisons.

The task force met on February 17th, March 30th and July 6th. The resolution’s author was invited to participate in these meetings. Each meeting focused on the three key resolves of the resolution: 1) advocate for future research efforts specifically designed to investigate LGBT health issues; 2) educate and inform Pennsylvania’s physicians, policymakers, and the public on issues that impact public health, patient care and the practice of medicine; and 3) make information on LGBT health issues available to Pennsylvania physicians.

During the advocacy meeting, areas of priority addressed included support for the PA Fairness Act; discussion of proposed legislation, policies and procedures related to conversion therapy; the Healthcare Bill of Rights; insurance coverage for hormone replacement therapy, gender reassignment surgery and other LGBT healthcare concerns; mental health and substance use parity to include LGBT behavioral health needs; and elimination of anti-stigma and anti-discrimination in local, state and national policies/legislation.

Our March meeting focused on cultural and medical competency education for transgender, bisexual, lesbian and gay patients and their families of choice. The task force recommended mandated medical school curriculum on LGBT-specific health care disparities, cultural sensitivity and non-discrimination training. Areas of concern to be addressed to reduce disparities include:

- the need to provide health needs assessments,
- the need to perform the Youth Behavioral Risk Survey and the Behavioral Risk Factor Surveillance System,
- develop/promote health care prevention in areas of known disparities,
- call for data to be included in all publicly-funded research areas,
- ensure that gynecological care is included for women who were female at birth, and
- the need for increased training on mental health, substance use, gun violence and domestic violence needs.

A list of clinical competency model training modules was compiled and available for future use.

The focus of the last meeting was to brainstorm educational needs for both the public at large and medical healthcare professionals. Attendees provided links to important healthcare initiatives occurring across the state and nation. Organizations discussed included the Centers for American Progress, the Centers for Disease Control, the LGBT Data Center at Drexel University, the Human Resources Services Administration, the Gay and Lesbian Medical Association, and the LGBT Center. Issues that should be part of a public service campaign include information on domestic violence, bullying, increased mental health needs (including high incidence of suicides, gun violence, and substance use) and cultural sensitivity. Attendees were provided with a list of organizations available to serve as resources for education, public service awareness, and training for physicians.

Although the official duties of the task force are complete, this group has expressed an interest in continuing to meet to complete our work.

**Medical Society Regionalization Task Force:** PAMED created a task force to examine the feasibility of forming larger regional medical societies built upon existing county structures that will continue to provide appropriate representation of physicians' local issues while providing increased member benefits.
though organizations with greater resources. The task force has been guided under the direction of Task Force Chair, Chuck Cutler, MD, PAMED President Elect.

The task force representing county leadership and executive staff met to discuss challenges and opportunities associated with regionalization. In addition, a focus group was hosted for county medical society leaders who are considering the possibility of regionalization. The focus group yielded helpful feedback and guidance for the formation of the toolkit. Key themes included:

- regionalization is a decision directed by county medical society leadership;
- regionalization is completely optional and often emerges organically;
- regionalization can be as simple as coordinating advocacy efforts and as complex as merging boards and sharing financial resources;
- the state society has no authority and/or role in the regionalization process;
- regionalization within districts is the most feasible option because representation within the House of Delegates is determined through district boundaries;
- if regionalization occurs outside across district boundaries, the bylaws will need to be revised;
- the toolkit is not legal guidance—legal guidance must be secured by each county medical society;
- the toolkit will serve as a starting point and guide for key discussion points between county leadership

During the process of research and discovery, Avenue M was commissioned to create and execute a survey to evaluate value relative to the cost of dues pricing at the county and state levels. The results of this survey will be made available in a report in September 2016. The assembly of the toolkit is currently underway and will be made available to all county medical society leadership before the 2016 House of Delegates. Key components of the toolkit include: governance, legal, financial and staffing considerations.

**Member Advisory Panel:** The Member Advisory Panel is a monthly online survey group of PAMED members who have volunteered to participate. Around the 15th of every month, an email is sent to the ninety-one (91) people currently on the panel asking them to answer 3-5 questions. These questions can be from any area or topic that is currently relevant to our membership. Recent examples include: MOC, MACRA, ICD-10, and Advocacy issues. PAMED evaluates the answers to the questions to better develop activities, communications, and even advocacy positions that better serve our membership-at-large. Marketing emails and materials continually go out promoting members to opt-in to participate on the Member Advisory Panel.

**Opioid Prescribing Guidelines Task Force:** The PAMED Opioid Advisory Task Force has met regularly by phone to discuss and plan initiatives related to opioid and heroin misuse, abuse and diversion.

Actions taken by the task force include:

1) Reconsideration of the PA-developed Clinical Guidelines for Opiate Prescribing for Non-Cancer Chronic Pain in light of newly released CDC Guidelines. The two sets of guidelines were compared point for point to find areas of consensus which were then incorporated into the revised Opiate Guidelines submitted to the state and endorsed by the PA State Board of Medicine.

2) Staff has attempted, without tangible success to date, to develop a grassroots advocacy program among the counties to propose full availability of Narcan in all high schools and police units to facilitate immediate response to opiate overdoses. Initial outreach was attempted to also develop a central clearinghouse for all county and specialty society activities on the opiate issue to develop a database of best ideas for general distribution to other interested stakeholders. Response to this effort was disappointing. Trial projects to implement these programs are being attempted in one
rural county (Mercer) which we hope will serve as the basis for projects in other counties across the Commonwealth.

3) On the educational front, a meeting of community stakeholders from Lancaster County was held on August 8th to address the Opioid/Heroin overdose crisis. The purpose of the meeting was to get community stakeholders to come together to develop education for students and faculty at both high school and middle schools. Included were school superintendents, local hospital officials & physicians, local law enforcement, the PA District Attorneys’ Association, the PA Department of Health, the PA Pharmacy Association, the PA Dental Association and the School Nurses’ Association. The goal is to create educational modules for schools and disseminate the program across the state via county medical societies and physician members.

4) A Task Force meeting for August 3rd was scheduled to review information on the ABC-MAP program, limited though it may still be, as well as to develop a Speakers’ Bureau to provide educational programs to interested counties, and to brainstorm how to move forward and implement the practice guidelines.

Staff has also reached out to other constituencies, including the PA District Attorneys’ Association, the Drug Enforcement Agency (DEA) and the PA Department of Health to develop networking opportunities that will advance PAMED’s agenda.

PA Physician Innovation Committee: Funds from the sale of KEPRO have been placed in a board-designated special purpose fund. The fund has three key areas of focus: Advocacy, The Foundation of the Pennsylvania Medical Society, and Innovation/Strategic Purpose Grant Funding. The Innovation Fund would allow PAMED to react nimbly to emerging issues or strategic opportunities in the medical community based on the results of periodic environmental scans. To date, a 2016 call for proposals has not been issued due to a lack of response to requests to serve on the Innovation Committee along with critical financial challenges presently facing the Pennsylvania Medical Society Board.

Finance Committee Chair, F. Wilson Jackson, MD, in coordination with the Innovation/Strategic Funding Grant Chair, John Pagan, MD, plan to convene the former KEPRO Innovation Fund Work group in the fall of 2016 to evaluate current innovation opportunities against the background of these new financial stressors impacting the financial needs/obligations of the Pennsylvania Medical Society.

Payer Advocacy Task Force: The Payer Advocacy Task Force met and focused their energies on insurer network adequacy in response to a legislative proposal by the Pennsylvania Insurance Commissioner to address “surprise” balance billing. The proposal by the Commissioner was not supported by PAMED and a number of specialty societies, including those representing emergency physicians, pathologists, radiologists, and anesthesiologists. The bill proposed in the Senate was a mirror image of the Insurance Department proposal. The bill did not gain any traction in the Senate. A number of studies have found that a primary root cause of surprise balance billing is lack of robust networks to begin with. This concept fueled the approach that PAMED took to address balance billing in general—network advocacy. Draft legislation was developed by the Task Force with input from those specialties most affected by the Insurance Department proposal. PAMED leadership met with the Insurance Commissioner several times on this issue. Our draft bill was presented to the Commissioner. Little support was shown for our bill. No further legislative activity has occurred on this issue.

Task Force on Continuous Professional Education: Recommendations made by the Task Force on Continuous Professional Education earlier in the year, and approved by the Board of Trustees in February, set in motion several subsequent activities that have established PAMED as the state medical society leading the national campaign in response to the lack of substantive positive changes brought forth by the ABIM.

Perhaps just as importantly, the same recommendations of the Task Force set the tone for PAMED’s continued leadership at the AMA level in the effort to address widely held concerns with Maintenance of Certification (MOC). In June, again as a result of leadership by PAMED, the AMA’s House of Delegates set new policy that will maintain a high level of meaningful and relevant life-long learning and
ongoing continuing medical education by all physicians as an important component of promoting patient safety, and health care quality and value.

Since the October 2015 meeting of the PAMED House of Delegates, the recommendations of the Task Force (which are listed below and which are ongoing) and the following activities undertaken at the national level during meetings of the AMA House of Delegates have resulted in significant progress with regard to both the ABIM and MOC:

November 2015 – PAMED convened a meeting of interested physicians during the 2015 Interim meeting of the AMA HOD that was attended by more than 100 individuals.

June 2016 – PAMED hosted a panel discussion during the 2016 Annual meeting of the AMA HOD featuring individuals who have been prominently engaged in the national discussion of the fiscal irregularities of the ABIM:

- Bonnie H. Weiner, MD – NBPAS Board Member, “Making MOC Work through a New Board Structure”
- Wes Fisher, MD – Cardiologist/Blogger, “Why MOC is Broken and How to Fix It.”
- Scott Shapiro, MD – PAMED President, “Steps Forward on MOC and Making Changes to MOC”

June 2016 – Aggressively and successfully supported adoption of Resolution 309 which established stronger AMA policy:

- Calling for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
- Directing that the AMA continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam.
- Directing that the AMA continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
- Directing that the AMA support a recertification process based on high quality, appropriate CME material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

July 2016 – Issued a Statement of No Confidence in the leadership of the ABIM and circulated to state medical societies a “sign on” letter, inviting them to join in the Statement of No Confidence. PAMED continues to explore possible collaborative legal action and initiated a discussion of relevant aspects of the issue in policy discussions with the Attorney General candidates from both parties in the November general election.

**Recommendations of the Task Force:**

1) Improve Continuous Professional Education/MOC through the deletion of some of the more onerous requirements (cost, hassle) and addition of others (continuous quality improvement, satisfaction, practicing physician oversight).
   a) Evaluate support from state medical societies, state and national specialty organizations, the AMA and other interested physician or relevant groups for a statement of “No Confidence” in the ABIM.
   b) Obtain legal advice relative to potential “class action” litigation.
   c) Review the options for state level legislation that will prohibit insurers and hospitals from requiring board certification.
2) Assess the availability of other options that also demonstrate professional expertise (such as NBPAS).
   a) Evaluate the potential for PAMED to initiate a program that would “franchise” board certification by entities meeting relevant standards.
   b) Evaluate and prepare for distribution an analysis report card comparing ABIM and NBPAS to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification (MOC)).
   c) Host a meeting with Paul Teirstein of the NBPAS.
3) Heighten and sustain exposure of the issue via bi-weekly emails and content in PAMED electronic communications vehicles.

David A. Talenti, MD
Chair
According to the bylaws, the Board of Trustees sets the membership categories every year prior to the next dues cycle. The Board has approved the attached membership dues categories for 2017 with extending the Group Dues Pilot through 2017 and removing the exception to the affiliate membership dues amount to be in alignment with the PAMED bylaws in which county medical society dues categories and the percentages of the full annual dues to be paid by each category must be in accord with the State Society’s categories and percentages.

PART I

MEMBERSHIP DUES

The full dues for 2017 are $395.

PART II

MEMBERSHIP DUES CATEGORIES

The following membership categories and dues for those categories will be in effect for 2017.

Membership Dues Categories

With the exception of the Group Dues Pilot Project rate for groups of 3-29 physicians (see b.6.(a) below), County Medical Society dues for each membership category are to be the same percentage of full dues as those of the State Society, although each County Society can decide to forego county dues for any membership category.

a. Students -- Persons who are enrolled in a medical school approved by this Society. Upon admission to membership, such members shall have the right to vote and hold office*. These members are dues exempt at the state and county levels.

b. Active -- Persons who hold the degree of Doctor of Medicine or Osteopathy or the equivalent from a recognized accredited medical school, and who hold or are eligible to hold an unrestricted license to practice medicine and surgery in PA, are eligible for active membership in the Society. Upon admission to membership, such members shall have the right to vote and hold office*. Active members pay the full annual assessment, except as follows.

(1) Residents – Persons serving in training programs approved by this Society are eligible for active membership. Upon admission to membership, such members shall have the right to vote and hold office*. These members are dues exempt at the state and county levels.

(2) First Year Practice -- An active member who pays 25 percent of the full annual assessment for the period between the completion of a training program and the end of the first full calendar year of practice.

(3) Second Year Practice -- An active member who pays 50 percent of the full annual assessment in the second full calendar year following completion of a training program.

(4) Third Year Practice -- An active member who pays 75 percent of the full annual assessment in the third full calendar year following completion of a training program.

(5) One-Time $95 Introductory Membership -- This discounted, once-in-a-lifetime dues offer is available to 1) new physician members and 2) former members who have been out of membership for two or more consecutive years who have not previously taken advantage of
the one-time offer. The member is assessed $50 for State Society dues and a maximum of $45 for County Society dues. Those County Societies whose dues are less than $45 continue to charge their normal rate.

(6) **Group Membership** – This pilot was originally scheduled to run for five years, through 2015. It has been extended through 2016. We will also continue to honor several multi-year agreements, containing different parameters, through the end of those agreements. See attached addendum for history of the group dues pilot program.

(a). **Groups of 3 – 29 physicians** with 100% membership will receive a 5% discount if they meet the designated criteria. The discount will apply to full Active members. This discount will be extended on State Society dues uniformly across the state; however, all county medical societies will have the option to extend the 5% discount on county medical society dues.

Criteria for group to receive the discount:
- Group must provide an updated roster of physicians once a year (July).
- Group must pay via a group dues invoice by January 15 (group will receive invoices in early October and December of previous year, as per current invoicing schedule).

(b). **Groups of ≥30 physicians** will receive the discounts outlined below if they meet the designated criteria. The discount will apply to full Active members; other discounts, such as the special introductory rate, will not be applied in addition to these discounts.

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Discount for 75% membership</th>
<th>Discount for 100% membership</th>
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</thead>
<tbody>
<tr>
<td>30 – 99</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>100 – 299</td>
<td>15%</td>
<td>30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Size</th>
<th>Discount for 50% Membership</th>
<th>Discount for 75% Membership</th>
<th>Discount for 100% Membership</th>
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</thead>
<tbody>
<tr>
<td>300 +</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Criteria for discount:
- Group must provide an updated roster of physicians twice a year (January and July).
- Group must provide three opportunities throughout the year for the Society to communicate with the physicians, at least one of which must be in person.
- Group must pay via a group dues invoice by January 15 (group will receive invoices in early October and December of previous year, as per current invoicing schedule).
- Group must provide all e-mail addresses and agree to receive all communications electronically.
We will continue to pursue corporate-sponsored group memberships, working with 80+ groups which have expressed interest. We will calculate the current revenue for all of the 80+ groups in our database to arrive at a per member figure which could be used to arrive at a group membership fee. The goal would be to increase membership while not decreasing revenue, but also to stem the downward trend in active membership and revenue. If we are successful in this approach and can put some corporate-sponsored group memberships in place, at the end of the pilot (or sooner), we could lower dues for all active members to this new figure. We would be using increased volume to achieve a lower per physician cost. The corporate membership agreement for each group would be subject to approval by all parties involved – the group, the State Society, and the County Society.

(7) **Special Status** -- Physicians earning $75,000 or less adjusted gross income shall receive a reduction of the full active dues. Physicians who are either on family leave, temporarily disabled/suffering from a chronic illness or going through a financial hardship are eligible. This category of membership is subject to approval of the county medical society on a case by case basis and reviewed yearly.

(8) **Disability** -- Active members unable to practice because of permanent illness or disability shall pay no annual assessment.

c. **Associate** -- An associate member shall be a physician who is 70 years of age or over (in the year of application) and has been an active member of this Society or an active member of a constituent association of the American Medical Association or an affiliate member who is engaged in missionary or philanthropic labors. Election and the revocation of election shall be made in such manner as determined from time to time by the Secretary of the Society. An associate member shall not be required to maintain a license, and shall not be required to pay any annual assessment except that if they elect to receive publications of the State Society, they shall pay 10 percent of the full annual assessment each year. Those physicians who have previously paid the lifetime membership will be grandfathered. Associate members who became such prior to January 1, 1983 shall pay no annual assessment.

d. **Affiliate** -- An affiliate member shall pay 10 percent of the annual assessment. Upon recommendation and certification by the county medical society and election by the Board of Trustees, any member of a component society not engaged in active practice within the jurisdiction of the county society may be an affiliate member of this Society and remain as such providing the individual is one of the following:

1. A physician who is a member of a national medical society of a foreign country;
2. An American physician who is engaged in missionary or philanthropic labors who may or may not have an unlimited license to practice medicine and surgery in Pennsylvania;
3. A full-time teacher of medicine or of the arts and sciences allied to medicine who does not have a license to practice medicine in Pennsylvania;
4. A physician who is engaged in research or administrative medicine in Pennsylvania who does not have an unlimited license to practice medicine and surgery in Pennsylvania;
5. A physician who is retired from active practice;
6. A physician who has moved out of Pennsylvania and concurrently maintains active membership in the state medical society and the county society in the new state of residence;
7. A physician who resides in a state other than Pennsylvania and concurrently maintains active membership in another state medical society.

An affiliate member may vote, hold office, or serve as a member of any workgroup or committee*. Affiliate members shall pay 10 percent of the full annual assessment.

e. **Administrative** – An administrative member may be a county medical society executive, a medical practice administrator, or a hospital medical staff coordinator.
(1) a county medical society executive -- A county medical society executive will be exempt from paying dues.

(2) a medical practice administrator -- A medical practice administrator may be admitted to membership if they meet the following criteria:
   - The administrator directly manages a medical practice and is not a consultant.
   - The administrator is employed directly by a physician, or the physician and practice administrator are employed by the same organization.
   - At least one physician in the practice must be a member.
   - Only one practice administrator per practice is eligible for membership, except that the administrator of a parent group may also be eligible if they meet the criteria.

A medical practice administrator will be exempt from paying dues, except for medical practice administrators from a practice with less than 50 percent physician membership, who shall pay 10 percent of the full annual assessment.

(3) a hospital medical staff coordinator -- A hospital medical staff coordinator may be admitted to membership if they are employed by a hospital (does not include nursing homes and ambulatory surgical facilities). A hospital medical staff coordinator shall pay 10 percent of the full annual assessment.

An administrative member may not vote or hold office, but may serve as a non-voting member of any workgroup or committee provided that the percentage of administrative members does not exceed 25 percent.

PART III
STUDENT LOAN ALLOCATION

Allocation to Support Student Loan Program -- Under the terms of Chapter IV, Section 3, the Bylaws of the Pennsylvania Medical Society, the Board of Trustees may allocate a portion of dues to the Medical Student Fund of the Foundation of the Pennsylvania Medical Society. The dues allocation for 2017 is $10.

The Foundation will make $450,000 available for medical loans in the 2016-2017 school year. The Board again commends the Foundation and its staff for its greatly expanded activities and efforts.

PART IV
STUDENT ASSESSMENT

As previously noted, the student assessment for 2017 will be $0.

David A Talenti, MD
Chair
ADDENDUM

Group Membership Pilot – Year 5 Report

Background
At the 2009 House of Delegates, a five-year group membership dues pilot (October 1, 2010 – September 30, 2015) was approved with specific discounts based on group size. The five-year pilot became effective on October 1, 2010, which was the beginning of the 2011 membership dues year.

Year 1 of Pilot
- PAMED laid groundwork (data gathering, meeting with target groups, etc..) and began to approach large groups using the discounts:

- At the time of the 2011 HOD, we had not been successful in obtaining a group membership using the discounts in the pilot. We knew, however, that the sales cycle for large groups would be long. It was recommended that we continue to work with group leaders, as well as individual physicians within each practice, knowing that it is critical that both see value.

Year 2 of Pilot
PAMED and the county medical societies were not effective in increasing membership to any substantial degree. However, in 2012 we began to see the value of the enhanced relationships created by the success of PAMED’s CEO Advisory Panel (comprised of the CEOs of every 80+ physician group in Pennsylvania -- roughly 27 groups). As PAMED worked closely with the administrative and physician leadership within several of these 80+ groups, many indicated an interest in a group membership. As we approached the 2012 House meeting, there were several 80+ groups who had invited PAMED to propose options for a group membership. At that time, a new approach for year three was proposed and approved.

- The approach was to first calculate the current revenue for all 80+ groups in Pennsylvania, then calculate the price per member at which 100% of the physicians within those 80+ groups could be members, without a decrease in revenue. With that figure as a basis, we could then arrive at a per member figure which would enhance current revenue to some extent. That per member figure would be used to calculate the group membership fee. So, the fee for each group would vary depending on the number of physicians, but the cost per physician would remain consistent.

Year 3 of Pilot
- After data analysis following the 2012 HOD, the cost per member for the 80+ groups was calculated at $250 per physician. Among the 80+ groups in Pennsylvania, this was the figure that would allow the state and county medical societies to increase membership while not decreasing revenue, and to stem the downward trend in active membership and revenue.

- The membership agreement for each group was subject to approval by all parties involved – the group, the State Society, and the County Society. PAMED worked with multiple county medical societies to target 80+ groups during 2013 and experienced some success with this approach.

- Prior to extending a proposal for $250 per physician dues, PAMED and CMS leaders agreed that because most of our costs are fixed and go into development of education, programs, newsletters and advocacy, it should be possible to take on these additional members without incurring significant costs. The incremental costs to serve each member would be low, and that members employed by 80+ practices do not utilize benefits to the extent of independent practitioners. Also integral to the agreement was the understanding that it is the individual physicians within the practice who will be members, rather than the corporate entity. Another factor considered by each of the county medical societies involved in making the decision was the substantial savings
in dues billing/collection because the group agreed to pay on one check prior to December 31 of each year.

Year 4 of Pilot
- PAMED and the applicable county medical societies retained the following practices through year four: Cardiology Consultants of Philadelphia, Excela Health Medical Group, Lancaster Radiology, Quantum Imaging, Pinnacle Cardiovascular Institute, Saint Vincent’s Medical Group, and Susquehanna Medical Group. Additionally, Primary Health Network joined through the pilot in 2014.

- At its February, 2014 meeting the Board of Trustees approved Allegheny County Medical Society’s recommendation to modify the pilot to allow for groups larger than 400 physicians to benefit from the pilot arrangement of $250 while requiring 80% membership as opposed to 100% membership.

Year 5 of Pilot
- PAMED and the applicable county medical societies have retained the following practices through the pilot: Cardiology Consultants of Philadelphia, Excela Health Medical Group, Lancaster Radiology, Pinnacle Cardiovascular Institute, Primary Health Network, Saint Vincent’s Medical Group, and Susquehanna Medical Group. Additionally, Butler Medical Providers and Intermountain Medical Group joined the pilot in 2015.
REPORT 8
BOARD OF TRUSTEES

County Medical Society Resources: Regionalization/County Governance Compliance Toolkits

Resolution 15-501: Regional Local Medical Societies – Resolution 15-501, called upon the Society to create a taskforce to examine the feasibility of forming larger regional medical societies built upon existing county structures that will continue to provide appropriate representation of physicians’ local issues while providing increased member benefits though organizations with greater resources.

REGIONALIZATION TOOLKIT
The resulting work product includes a Regionalization Toolkit, attached, as a starting point for counties interested in exploring regionalization. This toolkit is not intended to serve as legal guidance and all county leadership should seek official guidance from their financial and legal counsel and consultants, all of which an independent county medical society should have in place as a best practice.

The Task Force also reviewed the results of Avenue M’s membership survey, also attached, to look at member value/dues tiering, etc.

COUNTY GOVERNANCE COMPLIANCE TOOLKIT
Further discussion around county medical society compliance gave way to the County Governance Compliance Toolkit crafted to provide a helpful guide for county leadership and county executives to understand the annual compliance, reporting requirements and governance expectations to ensure protection for the organization and its volunteer leadership. Because each county is structured differently, not every component of the toolkit will apply. This toolkit is not intended to serve as legal guidance and all county leadership and executives should seek official guidance from their financial, legal and human resources counsel and consultants, all of which an independent county medical society should have in place as a best practice.

David A. Talenti, MD
Chair
Allegheny County - 24
Albo, Vincent C.
Amshel, Albert L.
Block, Robert C.
Cooper, Jeanne A.
Felgar, Raymond Eugene
Ferguson, Berrylin J.
Fitting, George M., Jr.
Haradin, Anthony R.
Hoysom, Gregory M.
Keddie, Roland T.
Krause, Seymoure
Kunschner, Alan J.
Kuwik, Richard J.
Maley, Richard H.
Miller, Clarence M., Jr.
Ripepi, Philip P.
Rittenhouse, Frank H.
Ryoo, In O.
Serafy, Michael M.
Sri-Vasagam, Narasimman
Tannenhill, Norman B.
Walsh, John J.
Weigel, John E., Jr.
Winter, Peter M.

Armstrong County - 2
Pitts, William H.
Yockey, Robert H.

Beaver County - 2
Gray, Herbert M.
Lehman, John W.

Bucks County - 4
Buttram, Harold E.
Clipp, Samuel W.
Connors, Earl K., Jr.
Flacco, Albert J.

Butler County - 1
Drennen, James K., Jr.

Cambria County - 1
Casale, Lawrence F.

Chester County - 4
Abbott, Joseph L.
Brown, Nathan
Krishna, Narendra
Lucine, Albert A., Jr.

Crawford County - 2
Dratler, M. Bruce
Kirkpatrick, David D., Jr.

Cumberland County - 4
Cho, Jay J.
Demuth, William E., Jr.
Urban, Donald G.
Yeager, James P.

Dauphin County - 2
Freedman, Donald B.
Spigner, Donald W.

Delaware County - 6
Alexander, Charles M.
Armitage, Harry V.
Brenner, Angus L.
Kurtz, Michael B.
Weinberg, Carroll A.
Yagnik, Rekha P.

Franklin County - 1
Harris, Albin W.

Indiana County - 1
Mills, John W.

Lackawanna County - 1
Simpson, Roy W.

Lancaster City & County - 5
Cooper, Emmett M.
Stuart, Thomas J.
Taylor, Fred R., Jr.
Wagner, Richard S., Jr.
Wolbach, Albert B., Jr.

Lawrence County - 3
Barszczowski, Peter J., Jr.
Uberti, Frederick G.
Vandrak, Robert S.

Lebanon County - 2
Hauer, Marlin L.
Rovinski, Helen T.

Lehigh County - 1
Klaassen, Johanna H.

Luzerne County - 1
Klein, Joseph M.

Mercer County - 1
Flamberg, Ira W.

Monroe County - 1
Dracos, Frank J.

Montgomery County - 4
Cochran, William C.
Hofman, Walter I.
Nowacki, Stanley M.
Whittaker, Richard P.

Northampton County - 3
Grassi, Joseph J.
Heimbach, George Z.
Orr, Ross M., Jr.

Philadelphia County - 4
Jaffari, Mohammed
Sembrot, William B.
Tzarnas, Chris D.
Yoos, Chung H.

Washington County - 2
Martin, John B.
Smith, Perry C., Jr.

Westmoreland County - 5
Aber, John M.
Barber, John V.
Blackburn, Lawrence F.
Pae, Dong W.
Shope, William B.

York County - 2
Delp, William T.
Gross, Donald R.
The Committee to Nominate Delegates and Alternates to the AMA consists of five members elected by the House of Delegates; additionally, the Medical Society’s Immediate Past President and the Chair of the Board of Trustees serve as ex-officio non-voting members. The Nominating Committee is charged in the bylaws with submitting to the House of Delegates a list of nominees for delegates and alternate delegates to the AMA House of Delegates.

The Nominating Committee is cognizant of the delegation’s term limits which were established by the Delegation in June 2011 and state:

I. d. The Pennsylvania Medical Society has established term limits for AMA delegates based on the following criteria:

- Six two-year terms as a delegate (alternate delegate term of service not included).
- Six cumulative two-year terms as an alternate delegate.
- If a decline in Pennsylvania’s delegate and alternate delegate allocation requires elimination of one or more delegate positions, the necessary decrease in alternate delegate positions will be based on seniority such that those alternate delegates with the greatest number of cumulative terms will not be listed for re-election by the Committee to Nominate.
- To conform with any reduced allocation of delegates, the selection of delegates to be recommended for nomination as alternate delegates will be suggested by the Delegation’s Executive Committee, in consultation with the Committee to Nominate, with due regard for the requirements of the Delegation.
- If a mid-term reduction in delegates is required due to decreased Pennsylvania members of the AMA, the decision regarding the selection of delegate(s) to be reclassified as alternate(s) is vested in the Delegation’s Executive Committee.
- The decision regarding any mid-term reduction in alternate delegates is vested in the Executive Committee of the Delegation.

The Pennsylvania Delegation is respected by the AMA House of Delegates. Our delegates know the policies of the Pennsylvania Medical Society and contribute to the reference committee hearings and the Delegation’s discussions. Pennsylvania should be proud of its AMA Delegation for its hard work during the year and its willingness to serve. This Committee is proud to report that at the June AMA Annual Meeting, Andrew W. Gurman, MD was inaugurated as President of the AMA. (See the report of the Pennsylvania Delegation to the AMA for further information on delegation activity.)

The Nominating Committee continues to recommend delegates and alternate delegates from throughout the state. The Committee’s recommended nominees for AMA delegate and alternate delegate positions can be found in the Official Call.

The Committee requests that anyone who identifies potential candidates for AMA delegate and alternate delegate positions forward that information to the Committee.

Committee Members:
George R. Green, MD – Chair
Richard T. Bell, MD
Kenneth M. Certa, MD
Charles Cutler, MD
Jonathan E. Rhoads, Jr., MD

Ex Officio, Non-Voting Members:
David A. Talenti, MD
Karen A. Rizzo, MD

2016 – Committee to Nominate Delegates & Alternates to the AMA
PENNSYLVANIA MEDICAL SOCIETY

Consolidated Financial Statements with Supplementary Information

December 31, 2015 and 2014
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**INDEPENDENT AUDITORS' REPORT**

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**SUPPLEMENTARY INFORMATION**
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Independent Auditors' Report

The Members and the Board of Trustees
Pennsylvania Medical Society
Harrisburg, Pennsylvania

We have audited the accompanying consolidated financial statements of the Pennsylvania Medical Society and its subsidiaries and affiliates, which comprise the consolidated statements of financial position as of December 31, 2015 and 2014, and the related consolidated statements of activities, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Pennsylvania Medical Society and its subsidiaries and affiliates as of December 31, 2015 and 2014, and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating statements of financial position and activities are presented for the purpose of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain other procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Kreischer Miller

Horsham, Pennsylvania
August 1, 2016
# Consolidated Statements of Financial Position

**December 31, 2015 and 2014**

## ASSETS

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
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<tr>
<td>Cash and cash equivalents (Note 2)</td>
<td>$6,398,098</td>
<td>$5,257,644</td>
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<tr>
<td>Accounts and reimbursements receivable, net</td>
<td>467,356</td>
<td>432,111</td>
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<tr>
<td>Prepaid expenses and advances</td>
<td>287,257</td>
<td>192,728</td>
</tr>
<tr>
<td>Investments (Notes 2 and 4)</td>
<td>176,758,501</td>
<td>181,185,883</td>
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<tr>
<td>Accrued interest receivable</td>
<td>147,797</td>
<td>154,500</td>
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<tr>
<td>Assets held in charitable remainder trust (Note 8)</td>
<td>108,055</td>
<td>120,714</td>
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<tr>
<td>Loans receivable (Note 5)</td>
<td>4,578,971</td>
<td>4,651,574</td>
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<td>Property and equipment, net (Note 2 and 6)</td>
<td>849,443</td>
<td>6,761,005</td>
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<tr>
<td>Beneficial interest in perpetual trust (Note 7)</td>
<td>675,062</td>
<td>706,614</td>
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<tr>
<td>Contributions receivable from split-interest agreements (Note 8)</td>
<td>108,892</td>
<td>105,985</td>
</tr>
<tr>
<td>Assets related to discontinued operations (Note 3)</td>
<td>1,902</td>
<td>94,690</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$190,381,334</strong></td>
<td><strong>$199,663,448</strong></td>
</tr>
</tbody>
</table>

## LIABILITIES AND NET ASSETS

### Liabilities:

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership dues collected in advance (Note 2)</td>
<td>$2,215,947</td>
<td>$2,326,145</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>357,388</td>
<td>464,695</td>
</tr>
<tr>
<td>Liabilities under split-interest agreement (Note 8)</td>
<td>198,833</td>
<td>212,736</td>
</tr>
<tr>
<td>Pension liability (Note 11)</td>
<td>16,940,202</td>
<td>15,520,318</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>2,342,658</td>
<td>2,028,341</td>
</tr>
<tr>
<td>Postretirement healthcare plan (Note 12)</td>
<td>441,019</td>
<td>509,187</td>
</tr>
<tr>
<td>Deferred revenue (Note 2)</td>
<td>438,422</td>
<td>-</td>
</tr>
<tr>
<td>Liabilities related to discontinued operations (Note 3)</td>
<td>4,928</td>
<td>18,908</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td><strong>22,939,397</strong></td>
<td><strong>21,080,330</strong></td>
</tr>
</tbody>
</table>

### Net assets:

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board designated endowment fund (Note 14)</td>
<td>117,431,909</td>
<td>124,551,573</td>
</tr>
<tr>
<td>Undesignated</td>
<td>46,410,210</td>
<td>50,312,981</td>
</tr>
<tr>
<td><strong>Total net assets</strong></td>
<td><strong>163,842,119</strong></td>
<td><strong>174,864,554</strong></td>
</tr>
</tbody>
</table>

## TOTAL LIABILITIES AND NET ASSETS

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
<td><strong>$190,381,334</strong></td>
<td><strong>$199,663,448</strong></td>
</tr>
</tbody>
</table>

See accompanying notes to consolidated financial statements.
PENNSYLVANIA MEDICAL SOCIETY

Consolidated Statements of Activities
Years Ended December 31, 2015 and 2014

Changes in unrestricted net assets:

<table>
<thead>
<tr>
<th>Revenues and other support:</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership dues and contributions</td>
<td>$3,268,957</td>
<td>$3,425,044</td>
</tr>
<tr>
<td>Contract revenue</td>
<td>640,110</td>
<td>713,463</td>
</tr>
<tr>
<td>Fees and payments for services</td>
<td>900,229</td>
<td>824,736</td>
</tr>
<tr>
<td>Rental income (Note 10)</td>
<td>296,448</td>
<td>466,709</td>
</tr>
<tr>
<td>Specialty Society Management Services</td>
<td>1,828,169</td>
<td>1,763,336</td>
</tr>
<tr>
<td>Physician Services</td>
<td>110,457</td>
<td>281,862</td>
</tr>
<tr>
<td>CME Certification/Accreditation</td>
<td>130,825</td>
<td>130,757</td>
</tr>
<tr>
<td>Interest income on loans</td>
<td>133,816</td>
<td>128,237</td>
</tr>
<tr>
<td>Interest income</td>
<td>11,985</td>
<td>13,048</td>
</tr>
<tr>
<td>Contributions, bequests, and fundraising</td>
<td>488,730</td>
<td>479,816</td>
</tr>
<tr>
<td>Creative services revenue</td>
<td>434</td>
<td>29,995</td>
</tr>
<tr>
<td>Endorsement agreement (Note 13)</td>
<td>250,000</td>
<td>425,000</td>
</tr>
<tr>
<td>County Medical Society Management Services</td>
<td>360,051</td>
<td>361,410</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>61,146</td>
<td>102,547</td>
</tr>
<tr>
<td></td>
<td>8,481,357</td>
<td>9,145,960</td>
</tr>
</tbody>
</table>

Expenses:

<table>
<thead>
<tr>
<th>Programs and services:</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Advocacy and Political Affairs</td>
<td>1,185,083</td>
<td>1,153,753</td>
</tr>
<tr>
<td>Specialty Society Management Services</td>
<td>1,861,383</td>
<td>2,043,901</td>
</tr>
<tr>
<td>Physician Leadership, Education and Practice Support</td>
<td>2,336,602</td>
<td>3,100,181</td>
</tr>
<tr>
<td>Organizational Performance and Operations</td>
<td>6,635,086</td>
<td>7,090,559</td>
</tr>
<tr>
<td>Executive Office</td>
<td>2,230,710</td>
<td>2,500,817</td>
</tr>
<tr>
<td>Physicians Health Program</td>
<td>806,347</td>
<td>819,985</td>
</tr>
<tr>
<td>Student Loan Program</td>
<td>241,916</td>
<td>216,839</td>
</tr>
<tr>
<td>Political Action Program</td>
<td>105,933</td>
<td>109,983</td>
</tr>
<tr>
<td>Alliance Program</td>
<td>583</td>
<td>592</td>
</tr>
<tr>
<td>Member Services Consulting</td>
<td>903,658</td>
<td>877,921</td>
</tr>
<tr>
<td>Other programs</td>
<td>159,808</td>
<td>223,011</td>
</tr>
<tr>
<td>Depreciation</td>
<td>289,953</td>
<td>425,064</td>
</tr>
<tr>
<td>Fundraising</td>
<td>174,867</td>
<td>189,774</td>
</tr>
<tr>
<td></td>
<td>16,931,929</td>
<td>18,752,380</td>
</tr>
</tbody>
</table>

Decrease in unrestricted net assets before income from investments and other changes

| (8,450,572) | (9,606,420) |

Income (loss) from investments (Note 4):

| Net realized and unrealized gains (losses) in fair value of investments | (6,695,853) | 1,709,439 |
| Interest and dividend income                                              | 3,771,119   | 2,861,601 |
| (2,924,734)                                                               | 4,571,040   |

Continued...
Consolidated Statements of Activities, Continued

Years Ended December 31, 2015 and 2014

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in unrestricted net assets before other changes</td>
<td>(11,375,306)</td>
<td>(5,035,380)</td>
</tr>
<tr>
<td>Other changes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net assets released from restrictions</td>
<td>269,394</td>
<td>303,292</td>
</tr>
<tr>
<td>Change in net assets from continuing operations</td>
<td>(11,105,912)</td>
<td>(4,732,088)</td>
</tr>
<tr>
<td>Discontinued operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on the sale of KePRO (Note 3)</td>
<td>-</td>
<td>13,718,466</td>
</tr>
<tr>
<td>Loss from operations of discontinued component KePRO (Note 3)</td>
<td>-</td>
<td>(234,910)</td>
</tr>
<tr>
<td>Loss from operations of discontinued components PMSCO (Note 3)</td>
<td>(349,001)</td>
<td>(342,545)</td>
</tr>
<tr>
<td>Gain (loss) from discontinued operations</td>
<td>(349,001)</td>
<td>13,141,011</td>
</tr>
<tr>
<td>Change in net assets before pension related changes other than net periodic pension costs</td>
<td>(11,454,913)</td>
<td>8,408,923</td>
</tr>
<tr>
<td>Pension related changes other than net periodic pension costs (Note 11)</td>
<td>432,478</td>
<td>(6,799,263)</td>
</tr>
<tr>
<td>Increase (decrease) in unrestricted net assets</td>
<td>(11,022,435)</td>
<td>1,609,660</td>
</tr>
<tr>
<td>Changes in temporarily restricted net assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>37,518</td>
<td>42,020</td>
</tr>
<tr>
<td>Grants</td>
<td>165,300</td>
<td>28,500</td>
</tr>
<tr>
<td>Realized and unrealized gains (losses), net income on long-term investments</td>
<td>(125,694)</td>
<td>26,983</td>
</tr>
<tr>
<td>Change in value of split-interest agreements</td>
<td>(13,763)</td>
<td>(132,624)</td>
</tr>
<tr>
<td>Net assets released from restrictions</td>
<td>(269,394)</td>
<td>(303,292)</td>
</tr>
<tr>
<td>Decrease in temporarily restricted net assets</td>
<td>(121,539)</td>
<td>(226,259)</td>
</tr>
<tr>
<td>Changes in permanently restricted net assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>34,345</td>
<td>32,742</td>
</tr>
<tr>
<td>Unrealized gain (loss) on beneficial trust</td>
<td>(31,552)</td>
<td>16,515</td>
</tr>
<tr>
<td>Increase in permanently restricted net assets</td>
<td>2,793</td>
<td>49,257</td>
</tr>
<tr>
<td>Increase (decrease) in net assets</td>
<td>(11,141,181)</td>
<td>1,432,658</td>
</tr>
<tr>
<td>Net assets, beginning of year</td>
<td>178,583,118</td>
<td>177,150,460</td>
</tr>
<tr>
<td>Net assets, end of year</td>
<td>$167,441,937</td>
<td>$178,583,118</td>
</tr>
</tbody>
</table>

See accompanying notes to consolidated financial statements.
Cash flows from operating activities, continuing operations:

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in net assets</td>
<td>$(11,141,181)</td>
<td>$1,432,658</td>
</tr>
<tr>
<td>Change in net assets from discontinued components, net of tax</td>
<td>349,001</td>
<td>(13,141,011)</td>
</tr>
<tr>
<td>Change in net assets from continuing operations</td>
<td>(10,792,180)</td>
<td>(11,708,353)</td>
</tr>
<tr>
<td>Adjustments to reconcile change in net assets from continuing operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>289,953</td>
<td>424,998</td>
</tr>
<tr>
<td>Net gain on sale of investments</td>
<td>(5,855,603)</td>
<td>(1,189,111)</td>
</tr>
<tr>
<td>Gain on assets held in charitable remainder trusts</td>
<td>12,659</td>
<td>5,025</td>
</tr>
<tr>
<td>Net loss on sale of property and equipment</td>
<td>105,873</td>
<td>2,795</td>
</tr>
<tr>
<td>Amortization of deferred gain on sales-leaseback transaction</td>
<td>(33,725)</td>
<td>-</td>
</tr>
<tr>
<td>Unrealized (gain) loss on investments</td>
<td>12,679,478</td>
<td>(555,590)</td>
</tr>
<tr>
<td>Unrealized (gain) loss on beneficial trust</td>
<td>31,552</td>
<td>(16,515)</td>
</tr>
<tr>
<td>Increase (decrease) in allowance for doubtful accounts</td>
<td>(65,314)</td>
<td>61,017</td>
</tr>
<tr>
<td>Change in assets and liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase) decrease in assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts and reimbursements receivable</td>
<td>30,069</td>
<td>290,715</td>
</tr>
<tr>
<td>Prepaid expenses and advances</td>
<td>(94,529)</td>
<td>6,354</td>
</tr>
<tr>
<td>Accrued interest receivable</td>
<td>6,703</td>
<td>16,161</td>
</tr>
<tr>
<td>Loans receivable</td>
<td>72,603</td>
<td>(40,127)</td>
</tr>
<tr>
<td>Contributions receivable from split-interest agreements</td>
<td>(2,907)</td>
<td>(6,261)</td>
</tr>
<tr>
<td>Increase (decrease) in liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership dues collected in advance</td>
<td>(110,198)</td>
<td>(222,839)</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>(107,307)</td>
<td>(321,454)</td>
</tr>
<tr>
<td>Liability under split-Interest agreement</td>
<td>(13,903)</td>
<td>115,911</td>
</tr>
<tr>
<td>Pension liability</td>
<td>1,419,884</td>
<td>6,088,992</td>
</tr>
<tr>
<td>Postretirement healthcare plan</td>
<td>(68,168)</td>
<td>38,448</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>472,147</td>
<td>-</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>314,317</td>
<td>190,555</td>
</tr>
<tr>
<td><strong>Net adjustments</strong></td>
<td><strong>9,083,584</strong></td>
<td><strong>4,889,074</strong></td>
</tr>
</tbody>
</table>

Net cash used in operating activities, continuing operations

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net cash used in operating activities, continuing operations</strong></td>
<td><strong>(1,708,596)</strong></td>
<td><strong>(6,819,279)</strong></td>
</tr>
</tbody>
</table>

Cash flows from operating activities, discontinued operations:

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Loss) gain from operations of discontinued components, net of tax</td>
<td>(349,001)</td>
<td>13,141,011</td>
</tr>
<tr>
<td>Adjustments to reconcile (loss) gain from operations of discontinued components, net of tax, to net cash used in operating activities of discontinued components:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on sale of KePRO (Note 3)</td>
<td>-</td>
<td>(13,383,556)</td>
</tr>
<tr>
<td>Decrease in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets related to discontinued operations</td>
<td>92,788</td>
<td>40,531</td>
</tr>
<tr>
<td>Decrease in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liabilities related to discontinued operations</td>
<td>(13,980)</td>
<td>(18,882)</td>
</tr>
<tr>
<td><strong>Cash used in operating activities, discontinued operations</strong></td>
<td><strong>(270,193)</strong></td>
<td><strong>(220,896)</strong></td>
</tr>
</tbody>
</table>

Net cash used in operating activities

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net cash used in operating activities</strong></td>
<td><strong>(1,978,789)</strong></td>
<td><strong>(7,040,175)</strong></td>
</tr>
</tbody>
</table>

Continued...
Consolidated Statements of Cash Flows, Continued
Years Ended December 31, 2015 and 2014

<table>
<thead>
<tr>
<th>Cash flows from investing activities:</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase of investments</td>
<td>(10,611,333)</td>
<td>(149,819,341)</td>
</tr>
<tr>
<td>Proceeds from sale of investments</td>
<td>8,214,840</td>
<td>133,542,645</td>
</tr>
<tr>
<td>Purchase of property and equipment</td>
<td>(687,000)</td>
<td>(424,190)</td>
</tr>
<tr>
<td>Proceeds from sale of property and equipment</td>
<td>6,202,736</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from sale of KePRO, net of related costs (Note 3)</td>
<td>-</td>
<td>22,329,121</td>
</tr>
<tr>
<td>Net cash provided by investing activities</td>
<td>3,119,243</td>
<td>5,628,235</td>
</tr>
</tbody>
</table>

Net increase (decrease) in cash and cash equivalents

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,140,454</td>
<td>(1,411,940)</td>
</tr>
</tbody>
</table>

Cash and cash equivalents, beginning of year

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,257,644</td>
<td>6,669,584</td>
</tr>
</tbody>
</table>

Cash and cash equivalents, end of year

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,398,098</td>
<td>$5,257,644</td>
</tr>
</tbody>
</table>

See accompanying notes to consolidated financial statements.
Principles of Consolidation and Organization

The accompanying consolidated financial statements include the Pennsylvania Medical Society (the Society) and its subsidiaries and affiliates: PennMed Member Services Company (PMSCO), the Foundation of The Pennsylvania Medical Society (the Foundation), Pennsylvania Medical Political Action Committee (PAMPAC), Pennsylvania Medical Society Political Action Committee – Federal (PAMSFAC), and Pennsylvania Medical Society Alliance (the Alliance), collectively referred to as the "Organization". Significant intercompany balances and transactions have been eliminated in consolidation.

On May 16, 2014, the Society completed the sale of its equity interest in Keystone Peer Review Organization, Inc. (KePRO) in accordance with the Stock Purchase Agreement dated May 2, 2014 (see Note 3.) As a result, PMSCO was reorganized as a wholly-owned subsidiary of the Society. PennMed, Inc. and KePro, formerly subsidiaries of the Society, discontinued operations on May 16, 2014.

**Pennsylvania Medical Society**

The Society, a professional membership organization of medical doctors and doctors of osteopathy, is the largest single medical professional organization in Pennsylvania. The Society is affiliated with county medical societies throughout Pennsylvania. Founded in 1848, the Society's mission is to be the voice of Pennsylvania's physicians, advancing quality patient care, the ethical practice of medicine and advocating for the patients they serve.

Wholly-owned subsidiaries and other affiliated entities included in these consolidated financial statements are as follows:

**The Foundation of the Pennsylvania Medical Society**

The Foundation was created to provide educational loans, scholarships and assistance to medical students and the Pennsylvania medical community. The Foundation provides programs and services for individual physicians and others that improve the well-being of Pennsylvanians and sustain the future of medicine. The Society's Board of Trustees appoints all members of the Foundation's Board of Trustees.

*Continued...*
Principles of Consolidation and Organization, Continued

The Foundation of the Pennsylvania Medical Society, Continued

The Foundation of the Pennsylvania Medical Society has existed as a Pennsylvania charitable trust (unincorporated entity) since January 18, 1955. Effective January 1, 2015, a new nonprofit corporation was created by the Society to improve the well-being of Pennsylvanians and sustain the future of medicine. This includes carrying on the program activities of the Foundation including providing monitoring services to impaired physicians, training for physicians who have left the practice of medicine for a period of time, and providing low cost student loans to those attending medical school. The new incorporated entity has been formed under the same name – The Foundation of the Pennsylvania Medical Society. The existing charitable trust will operate under the name the Pennsylvania Medical Society Charitable Trust (the Trust). Beginning on January 1, 2015, program activities and all relating assets and liabilities were moved from the unincorporated trust to the newly formed incorporated entity. The Trust holds the Physicians' Health Programs (PHP) Endowment Fund and is dedicated to advancing the culture of philanthropy and supporting excellence across programs and services provided by the Foundation of the Pennsylvania Medical Society. The Trust is controlled by the Trustees of the Foundation who serve as the Directors of the Trust. The newly created entity, The Foundation of the Pennsylvania Medical Society, is organized as a wholly-owned subsidiary of the Society.

The Medical Legacy Fund (the Fund) is controlled by the Trustees of the Foundation who serve as the Directors of the Fund. It is organized for the exclusive benefit of the Foundation for the purpose of implementing a planned giving program to solicit, accept, and administer funds from donors.

PennMed Member Services Company

PMSCO provides a full range of healthcare consulting services to physicians, physician networks, hospitals and other healthcare organizations. PMSCO's primary market is Pennsylvania with a presence in the Mid-Atlantic region. In addition, PMSCO offers insurance products and services to physicians and medical practices.

Pennsylvania Medical Political Action Committee

PAMPAC was established to encourage all individuals to take a more active part in political affairs, disseminate unbiased information on political issues and candidates, and make the voice of medicine a more important factor in government. PAMPAC solicits money for the purpose of making contributions on behalf of candidates for nomination or election to public office. At any given time, 40% of PAMPAC's Board of Directors have been appointed by the Society's Board of Trustees.

Continued...
(1) Principles of Consolidation and Organization, Continued

_Pennsylvania Medical Society Political Action Committee - Federal_

PAMSPAC was established to encourage all Pennsylvania Medical Society members to take a more active part in political affairs, disseminate unbiased information on political issues and candidates and make the voice of medicine a more important factor in government. PAMSPAC solicits money for the purpose of making contributions to candidates for nomination or election to public office. At any given time, at least 40% of PAMSPAC's Board of Directors have been appointed by the Society's Board of Trustees.

_Pennsylvania Medical Society Alliance_

The Alliance was established to assist the programs of the Society and to improve the health and quality of life for all people. The Society normally provides 70% - 80% of the funding of the Alliance, by providing all staffing requirements and significant other costs. The Executive Committee of the Board of Trustees of the Society serves as the liaison to the Board of Directors of the Alliance.

(2) Summary of Significant Accounting Policies

_Basis of Accounting_

These consolidated financial statements are in accordance with generally accepted accounting principles promulgated in the United States of America (U.S. GAAP) for Not-for-Profit Organizations. Revenues are reported as increases in unrestricted net assets unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets unless their use is restricted by explicit donor stipulation or by law.

_Financial Statement Presentation_

Financial statement presentation follows the recommendations of the Financial Accounting Standards Board (FASB) _Accounting Standards Codification_ (ASC) 958, _Not-for-Profit Entities_. Under FASB ASC 958, the Society is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.
(2) Summary of Significant Accounting Policies, Continued

Financial Statement Presentation, Continued

These are defined as follows:

Unrestricted net assets – Net assets that are not subject to donor-imposed stipulations.

Temporarily restricted net assets – Net assets subject to donor-imposed stipulations that may or will be met, either by actions of the Society and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions. If the restriction expires during the reporting period in which the support is recognized, then the support is reported as an increase in unrestricted net assets.

Permanently restricted net assets – Net assets subject to donor-imposed stipulations that they be maintained permanently by the Organization.

Recent Accounting Pronouncement

In May 2015, FASB issued Accounting Standards Update (ASU) No. 2015-07 (ASU 2015-07), Fair Value Measurement (Topic 820): Disclosure for Investments in Certain Entities That Calculate Net Asset Value (NAV) per Share (or Its Equivalent). ASU 2015-07 removes the requirement to categorize, within the fair value hierarchy (Note 2), all investments for which fair value is measured using the NAV per share practical expedient. However, sufficient information must be provided to permit reconciliation of the fair value of assets categorized within the fair value hierarchy to the amounts presented in the statement of financial position. The amendments also remove the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the NAV per share practical expedient. The amendments in this update are effective for fiscal years beginning after December 15, 2016. Early adoption is permitted. Upon adoption, the amendments shall be applied retrospectively to all periods presented.

The Organization has elected to forego early adoption of ASU 2015-07 for the year ended December 31, 2015.
(2) Summary of Significant Accounting Policies, Continued

Fair Value Measurements

FASB ASC 820, *Fair Value Measurements and Disclosures*, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

- **Level 1:** Quoted market prices in active markets for identical assets or liabilities.
- **Level 2:** Observable market based inputs or unobservable inputs that are corroborated by market data.
- **Level 3:** Unobservable inputs that are not corroborated by market data.

In determining the appropriate levels, the Organization performed a detailed analysis of the assets and liabilities that are subject to FASB ASC 820. All assets and liabilities for which the fair value measurement is based on significant unobservable inputs are classified as level 3.

Following is a description of the valuation methodologies used for assets and liabilities measured at fair value. There have been no changes in the methodologies used at December 31, 2015 and 2014.

Certain international equity mutual funds are valued at the net asset value of shares held by the Organization at year end based on the underlying investments of the fund as determined by the fund's audited financial statements. Commodities are valued based on similar assets which are traded in active markets.

The fair value of the charitable remainder trust assets and liabilities is the aggregation of all future cash flows discounted to present value at prevailing market returns. The fair value of the beneficial interest in perpetual trusts is based on the fair value of the assets held by the trust.

Private equity investments and hedge funds are valued based on the audited financial statements of the underlying funds when available, and other information from independent third parties including information provided by the fund managers, the general partners and research performed by the fund's management.

Continued...
### Fair Value Measurements, Continued

<table>
<thead>
<tr>
<th>Description</th>
<th>December 31, 2015</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>Investments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash equivalents</td>
<td>$ 17,387,005</td>
<td>$ 17,387,005</td>
<td>-</td>
<td>$ -</td>
</tr>
<tr>
<td>U.S. equity mutual funds</td>
<td>34,791,897</td>
<td>34,791,897</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fixed income mutual funds</td>
<td>49,377,093</td>
<td>49,377,093</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>International equity mutual funds</td>
<td>18,866,143</td>
<td>9,758,065</td>
<td>9,108,078</td>
<td>-</td>
</tr>
<tr>
<td>Emerging markets mutual funds</td>
<td>9,926,628</td>
<td>9,926,628</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Private equity funds</td>
<td>15,270,478</td>
<td>-</td>
<td>-</td>
<td>15,270,478</td>
</tr>
<tr>
<td>Commodities</td>
<td>3,758,043</td>
<td>-</td>
<td>3,758,043</td>
<td>-</td>
</tr>
<tr>
<td>Hedge funds</td>
<td>27,391,214</td>
<td>-</td>
<td>-</td>
<td>27,391,214</td>
</tr>
<tr>
<td>Total investments</td>
<td>176,758,501</td>
<td>121,250,688</td>
<td>12,846,121</td>
<td>42,661,692</td>
</tr>
<tr>
<td>Beneficial interest in perpetual trusts</td>
<td>675,062</td>
<td>-</td>
<td>-</td>
<td>675,062</td>
</tr>
<tr>
<td>Charitable remainder trust assets</td>
<td>216,947</td>
<td>-</td>
<td>-</td>
<td>216,947</td>
</tr>
<tr>
<td>Total assets</td>
<td>$ 177,650,510</td>
<td>$ 121,250,688</td>
<td>$ 13,063,068</td>
<td>$ 43,336,754</td>
</tr>
<tr>
<td>Liabilities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charitable gift annuities liability</td>
<td>$ 114,680</td>
<td>-</td>
<td>$ 114,680</td>
<td>-</td>
</tr>
<tr>
<td>Charitable remainder trust liability</td>
<td>44,302</td>
<td>-</td>
<td>44,302</td>
<td>-</td>
</tr>
<tr>
<td>Planned gift liability</td>
<td>39,851</td>
<td>-</td>
<td>39,851</td>
<td>-</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>$ 198,833</td>
<td>-</td>
<td>$ 198,833</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>December 31, 2014</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>Investments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash equivalents</td>
<td>$ 48,495,421</td>
<td>$ 48,495,421</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>U.S. equity mutual funds</td>
<td>33,307,709</td>
<td>33,307,709</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fixed income mutual funds</td>
<td>15,472,288</td>
<td>15,472,288</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>International equity mutual funds</td>
<td>18,930,241</td>
<td>9,793,864</td>
<td>9,136,377</td>
<td>-</td>
</tr>
<tr>
<td>Emerging markets mutual funds</td>
<td>11,655,037</td>
<td>11,655,037</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Private equity funds</td>
<td>21,458,935</td>
<td>-</td>
<td>-</td>
<td>21,458,935</td>
</tr>
<tr>
<td>Commodities</td>
<td>5,013,813</td>
<td>-</td>
<td>5,013,813</td>
<td>-</td>
</tr>
<tr>
<td>Hedge funds</td>
<td>26,852,439</td>
<td>-</td>
<td>-</td>
<td>26,852,439</td>
</tr>
<tr>
<td>Total investments</td>
<td>181,185,883</td>
<td>118,724,319</td>
<td>14,150,190</td>
<td>48,311,374</td>
</tr>
<tr>
<td>Beneficial interest in perpetual trusts:</td>
<td>706,614</td>
<td>-</td>
<td>-</td>
<td>706,614</td>
</tr>
<tr>
<td>Charitable remainder trust assets</td>
<td>226,699</td>
<td>-</td>
<td>226,699</td>
<td>-</td>
</tr>
<tr>
<td>Total assets</td>
<td>$ 182,119,196</td>
<td>$ 118,724,319</td>
<td>$ 14,376,889</td>
<td>$ 49,017,988</td>
</tr>
<tr>
<td>Liabilities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charitable gift annuities liability</td>
<td>$ 119,536</td>
<td>-</td>
<td>$ 119,536</td>
<td>-</td>
</tr>
<tr>
<td>Charitable remainder trust liability</td>
<td>52,588</td>
<td>-</td>
<td>52,588</td>
<td>-</td>
</tr>
<tr>
<td>Planned gift liability</td>
<td>40,612</td>
<td>-</td>
<td>40,612</td>
<td>-</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>$ 212,736</td>
<td>-</td>
<td>$ 212,736</td>
<td>-</td>
</tr>
</tbody>
</table>

Continued...
Summary of Significant Accounting Policies, Continued

Fair Value Measurements, Continued

The following table sets forth a summary of changes in the fair value of the Organization's level 3 assets and liabilities for the years ended December 31, 2015 and 2014:

<table>
<thead>
<tr>
<th></th>
<th>Private Equity</th>
<th>Hedge Funds</th>
<th>Beneficial Interest in Perpetual Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as of December 31, 2013</td>
<td>$24,331,918</td>
<td>$21,139,201</td>
<td>$690,099</td>
</tr>
<tr>
<td>Total realized gains included in changes in net assets</td>
<td>2,064,694</td>
<td>1,013,238</td>
<td>-</td>
</tr>
<tr>
<td>Total unrealized gains for assets held at year end included in changes in net assets</td>
<td>499,409</td>
<td>-</td>
<td>16,515</td>
</tr>
<tr>
<td>Purchases</td>
<td>315,000</td>
<td>4,700,000</td>
<td></td>
</tr>
<tr>
<td>Settlements</td>
<td>(5,752,086)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Balance as of December 31, 2014</td>
<td>$21,458,935</td>
<td>$26,852,439</td>
<td>$706,614</td>
</tr>
<tr>
<td>Total realized gains included in changes in net assets</td>
<td>3,027,626</td>
<td>538,775</td>
<td>-</td>
</tr>
<tr>
<td>Total unrealized losses for assets held at year end included in changes in net assets</td>
<td>(2,042,795)</td>
<td>-</td>
<td>(31,552)</td>
</tr>
<tr>
<td>Settlements</td>
<td>(7,173,288)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Balance as of December 31, 2015</td>
<td>$15,270,478</td>
<td>$27,391,214</td>
<td>$675,062</td>
</tr>
</tbody>
</table>

Cash and Cash Equivalents

For the purposes of the consolidated statements of cash flows, the Organization considers all accounts that are not subject to withdrawal restrictions or penalties, and all investments in highly liquid debt instruments with original maturities of three months or less to be cash equivalents.

Investments

The Organization's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.
(2) Summary of Significant Accounting Policies, Continued

Investments, Continued

The Organization periodically reviews its investments in equity securities for impairment and adjusts these investments to their fair value when a decline in market value is deemed other than temporary. See Note 4 for further information on investments.

Property and Equipment

Property and equipment are stated at cost. Depreciation is calculated using the straight-line and accelerated methods over the estimated useful lives of the assets. Certain office furniture components and equipment which have not yet been placed in service are carried at cost, and are not being depreciated.

Pension Plan

The Organization accounts for pension costs relating to the Pension Plan of the Pennsylvania Medical Society, a defined benefit plan, in accordance with FASB ASC 715, Compensation – Retirement Benefits.

Postretirement Healthcare Plan

The Society accounts for the costs of postretirement healthcare plan other than pensions (health insurance) on the deferred recognition basis in accordance with FASB ASC 715.

Revenue Recognition

Revenue from contracts at PMSCO is recognized as services are performed. Estimated subcontract costs incurred in connection with providing services are accrued as the related revenue is earned. Fees collected in advance of performing services are recorded as other liabilities.

Membership dues for the Society are recorded in the applicable membership period. Membership dues paid in advance are recorded as deferred revenue.
(2) Summary of Significant Accounting Policies, Continued

Contributions and Promises to Give

Contributions, including unconditional promises to give, are recognized as revenues in the period received. Conditional promises to give are not recognized until they become unconditional, that is when the conditions on which they depend are substantially met. Contributions of assets other than cash are recorded at their estimated fair value. Unconditional promises to give that are expected to be collected within one year are recorded at net realizable value. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of the estimated cash flows and are discounted at an appropriate discount rate commensurate with the risks involved. Amortization of discounts is recorded as additional contribution revenue in accordance with donor-imposed restrictions, if any, on the contributions. An allowance for uncollectible contributions receivable is provided based upon management's judgment including such factors as prior collection history, type of contribution and nature of the fund-raising activity.

Income Taxes

Prior to May 16, 2014, KePRO and PMSCO filed a consolidated federal income tax return with PennMed. In accordance with the tax sharing agreement, the current income tax expense or benefit was allocated on the basis of the calculated tax liability or benefit of each member. On May 16, 2014, PMSCO was reorganized as a wholly-owned subsidiary of the Society.

PMSCO's income taxes in the accompanying financial statements were computed in accordance with the FASB ASC 740, Income Taxes. This standard requires an asset and liability method of accounting for income taxes. Under this method, deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between book and tax basis of assets and liabilities, as well as the estimated future tax consequences attributable to net operating loss and tax credit carryforwards. A valuation allowance is established if, based upon all available information, it is deemed more likely than not that a portion or all of a deferred tax asset will not be realized.

The Society is subject to unrelated business income tax as a result of insurance income. The Society, the Foundation, PAMPAC, PAMSPAC, and the Alliance are otherwise exempt from income taxes under Sections 501(c) and 527 of the Internal Revenue Code (IRC) and file Form 990, Return of Organization Exempt from Income Tax, on an annual basis.

Continued...
(2) Summary of Significant Accounting Policies, Continued

Income Taxes, Continued

With few exceptions, the Organization is no longer subject to U.S. federal or state income tax examinations by tax authorities for years before 2012. It is difficult to predict the final timing and resolution of any particular tax position. Based on the Organization's assessment of many factors, including past experience and judgments about future events, the Organization does not currently anticipate significant changes in its tax positions over the next 12 months.

Allocations of Expenses

The costs of providing various programs and activities have been summarized on a functional basis in the statements of activities. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

Use of Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities and net assets. These estimates and assumptions also include the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenues and expenses including contributed services and functional allocations during the reporting period. Accordingly, actual results could differ from those estimates.

Concentrations of Credit Risk

Financial instruments that potentially subject the Organization to concentrations of credit risk consist principally of cash and cash equivalents, accounts receivable, investments, split interest agreements (Note 8) and loans receivable (Note 5). The Organization places its cash and temporary cash investments with financial institutions. At times, such balances may be in excess of the FDIC insurance limits. The Board of Trustees has implemented investment guidelines intended to mitigate the investments' interest rate, market, and credit risks. The Organization maintains a reserve for potential credit losses associated with its accounts receivable and such losses have been within management's expectations.

Subsequent Events

The Organization has performed an evaluation of subsequent events through August 1, 2016, which is the date the consolidated financial statements were available to be issued.
(3) Discontinued Operations

On both December 31, 2015 and 2014, PMSCO discontinued certain lines of business. The major categories of discontinued operations for the years ended December 31, 2015 and 2014, were as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>$1,877</td>
<td>$94,665</td>
</tr>
<tr>
<td>Other assets</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>Total current assets</td>
<td>$1,902</td>
<td>$94,690</td>
</tr>
<tr>
<td>Total assets</td>
<td>$1,902</td>
<td>$94,690</td>
</tr>
<tr>
<td>Current liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>$4,851</td>
<td>$10,218</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>$77</td>
<td>$8,690</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>$4,928</td>
<td>$18,908</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>$4,928</td>
<td>$18,908</td>
</tr>
<tr>
<td>Revenues</td>
<td>$19,530</td>
<td>$527,679</td>
</tr>
<tr>
<td>Expenses</td>
<td>(368,531)</td>
<td>(876,929)</td>
</tr>
<tr>
<td>Income tax benefit</td>
<td>(349,001)</td>
<td>(349,250)</td>
</tr>
<tr>
<td>Loss from operations of discontinued component, net of tax</td>
<td>$(349,001)</td>
<td>$(342,545)</td>
</tr>
</tbody>
</table>

Sale of Subsidiary

On May 16, 2014, the Society completed the sale of the equity interest in KePRO in accordance with the Stock Purchase Agreement dated May 2, 2014. As of December 31, 2014, there are no carrying amounts of the major classes of assets and liabilities included as part of discontinued operations in the accompanying consolidated financial statements.
(4) Investments

The Organization's investments are stated at fair value. See *Fair Value Measurements* in Note 2 for further information on investments.

At December 31, 2015 and 2014, total investments held in a bylaw-designated endowment fund are $117,431,909 and $124,551,573, respectively.

Unrestricted investment (loss) income for the years ended December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest and dividends</td>
<td>$ 3,771,119</td>
<td>$ 2,861,601</td>
</tr>
<tr>
<td>Realized and unrealized</td>
<td>(6,695,853)</td>
<td>1,709,439</td>
</tr>
<tr>
<td>gains (losses), net</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ (2,924,734)</td>
<td>$ 4,571,040</td>
</tr>
</tbody>
</table>

In August 2005, the Society began investing in Portfolio Advisors (Offshore) Private Equity Fund III, L.P., a Cayman Islands exempted limited partnership. This fund is a "menu-driven" fund of funds that was formed to provide institutional investors the opportunity to participate in high quality managed fund investments in the private equity asset class. Portfolio Advisors, LLC, the Investment Manager, seeks to develop a diversified portfolio of primary fund investments in each Sector. Commitments will be made primarily to North American and European based funds in each of its three Sectors – Buyouts, Venture Capital, and Special Situations. The Society has a total capital commitment of $10,000,000, of which $5,000,000 is allocated to Buyouts, $2,500,000 to Venture Capital, and $2,500,000 to Special Situations. As of December 31, 2015, there is a remaining capital commitment of $1,200,000 and inception-to-date distributions are $9,238,605.

In October 2007, the Society began investing in Metropolitan Real Estate Partners Global, LLC, a Delaware limited liability company. This company is a real estate fund-of-funds investing approximately sixty percent (60%) of all capital commitments in Metropolitan Real Estate Partners Fund V, L.P. (Fund V) and approximately forty percent (40%) of all capital commitments in Metropolitan Real Estate Partners International II, L.P. (International II). Both funds are Delaware limited partnerships which invest in certain real estate funds, selected by the Manager, that were formed generally for the purpose of investing in office, retail, apartment, industrial or other commercial real estate, or in real estate-related securities. Fund V invests primarily within the United States whereas International II invests primarily within Europe, with a secondary focus on properties located within certain Asian markets. The Society has a total capital commitment of $15,000,000. As of December 31, 2015, there is a remaining capital commitment of $1,165,981 and inception-to-date distributions are $10,636,537.
(4) Investments, Continued

In March, 2008, the Society began investing in Siguler Guff Distressed Opportunities Fund III, LP, a Delaware limited partnership. This fund is a fund of funds formed to assemble a diversified portfolio of investment funds investing in securities of companies undergoing financial distress, operating difficulties or restructuring, as well as allocate capital to direct investment opportunities in similar situations. The Society has a total capital commitment of $4,500,000. As of December 31, 2015, there is a remaining capital commitment of $135,000 and inception-to-date distributions are $4,735,715.

In March, 2008, the Society began investing in Siguler Guff BRIC Opportunities Fund II, LP, a Delaware limited partnership. The BRIC Opportunities Fund is a fund of funds formed to assemble a diversified portfolio of investment funds in the large and dynamic emerging economies of Brazil, Russia, India and China, with a primary emphasis on India and China. The fund expects to take advantage of the many opportunities in industries that result from the expanding middle class and growth in per capita gross domestic product (GDP) of these emerging economies. The Society has a total capital commitment of $4,500,000. As of December 31, 2015, there is a remaining capital commitment of $472,500 and inception-to-date distributions are $881,152.

The Society's investments in private investment companies are subject to the terms of their private placement memoranda and other governing agreements. The investments in such private investment companies are also subject to management and performance fees as specified in their agreements.

The Society invests in various investment securities that are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect account balances and the amounts reported in the statements of financial position.
(5) Loans Receivable

Loans are issued and maintained by the Foundation. Individuals who are United States citizens and Pennsylvania residents for at least twelve months prior to registering as a medical student in an accredited United States medical school are eligible to receive student loans for a maximum of $7,000 per year with an aggregate of $21,000 per student. The student loans are uncollateralized. The loans bear interest at the 91-day Treasury Bill rate at June 1 plus 3.5% (not to exceed 6%) until student graduates. Upon graduation, loans may be deferred from repayment for up to five years, during completion of internship, residency and fellowship training. Deferment interest is annually adjusted using the 91-day Treasury Bill rate at June 1 plus 3.5% (not to exceed 6%). Repayment terms begin on July 1, after the completion of training, and loans are generally repaid over a ten-year period. Repayment interest is calculated on the 91-day Treasury Bill rate plus 4.5% (not to exceed 8%) as of the preceding June 1 and remains fixed throughout the repayment period. Interest earned on loans is recognized in the consolidated statements of activities.

(6) Property and Equipment

Property and equipment consist of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
<th>Depreciable Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$</td>
<td>-</td>
<td>$ 1,620,000</td>
</tr>
<tr>
<td>Building</td>
<td>-</td>
<td>15,054,840</td>
<td>40 years</td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>4,351,077</td>
<td>4,296,647</td>
<td>5-10 years</td>
</tr>
<tr>
<td>Other</td>
<td>384,022</td>
<td>177,810</td>
<td>various</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>(3,885,656)</td>
<td>(14,388,292)</td>
<td></td>
</tr>
<tr>
<td>Net book value</td>
<td>$ 849,443</td>
<td>$ 6,761,005</td>
<td></td>
</tr>
</tbody>
</table>

Depreciation expense for 2015 and 2014 amounted to $289,953 and $424,998, respectively.

On January 29, 2015, the Society entered into a sale-leaseback agreement with a third party to sell its office building. Gain on the sale, of approximately $470,000, is deferred and will be amortized over the term of the lease (see Note 15).
(7) Beneficial Interest in Perpetual Trust

The Foundation has a one-fourth beneficial interest in a split interest perpetual trust. The split interest perpetual trust is recorded on the consolidated statements of financial position as a permanently restricted asset with a fair value at December 31, 2015 and 2014 of $675,062 and $706,614, respectively. The income distribution from the split interest perpetual trust has no donor-imposed restrictions and is included in unrestricted investment income.

(8) Split-Interest Agreements

A donor established a charitable remainder trust with a bank naming the Foundation as a partial beneficiary. The trustee shall pay the donor and his wife during their lifetimes an amount equal to 5% of the net fair value of the trust assets determined as of the first business day of each taxable year. At the time of the donors' deaths, the trust is to terminate, and the remaining trust assets are to be distributed. The Foundation has recorded a contribution receivable from the remainder trust based on the present value of future benefits expected to be received. Changes in the fair value of the Foundation's beneficial interest, using a discount rate of 7%, are recognized as change in value of split-interest agreements in the accompanying consolidated statements of activities.

A donor established a charitable remainder trust with the Fund naming the Foundation as a beneficiary. The trustee shall pay to the donor and his wife during their lifetimes an amount equal to 7% of the net fair value of the trust assets determined as of the first business day of each taxable year. At the time of the donors' deaths, the trust is to terminate, and the remaining trust assets are to be distributed. The Fund has recorded an asset in the amount of the fair value of the gift and a liability at the present value of the estimated future payments discounted at 7%, to be distributed over the donors' expected lives.

The Fund received title to a plot of land located near Harrisburg, Pennsylvania. In return, the Fund shall pay an amount equal to 7.5% of the appraised value of the land at December 9, 2002, to the donor and his spouse each year during their lifetimes. During 2003, the land was sold, and the cash received was recognized as temporarily restricted. A related annuity liability is recorded at the present value of the estimated future payments, discounted at 7%, to be distributed over the donors' expected lives.
(9) Income Taxes

PMSCO files a Form 1120, *U.S. Corporation Income Tax Return*, on an annual basis.

Income tax expense is reported on the consolidated statements of activities within the program which generated the taxable income. Income taxes include income taxes deferred because of temporary differences between the financial statement and tax bases of assets and liabilities.

The tax effects of temporary differences at December 31 are presented below:

<table>
<thead>
<tr>
<th>Deferred tax assets (liabilities):</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowance for doubtful accounts</td>
<td>$12,034</td>
<td>$38,159</td>
</tr>
<tr>
<td>State net operating loss carryforwards</td>
<td>777,121</td>
<td>700,833</td>
</tr>
<tr>
<td>Federal net operating loss carryforwards</td>
<td>501,103</td>
<td>239,102</td>
</tr>
<tr>
<td>Prepaid insurance</td>
<td>(4,747)</td>
<td>(4,624)</td>
</tr>
<tr>
<td>Pension liability</td>
<td>449,357</td>
<td>452,709</td>
</tr>
<tr>
<td>Other</td>
<td>43,710</td>
<td>4,431</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,778,578</strong></td>
<td><strong>1,430,610</strong></td>
</tr>
</tbody>
</table>

| Valuation allowance                                      | (1,778,578) | (1,430,610) |
| Deferred tax assets                                      | $-           | $-          |

The net change in the valuation allowance for the years ended December 31, 2015 and 2014 was an increase of $347,968 and $799,310, respectively.

The estimated state net operating loss carryforwards expire from 2019 through 2035.

(10) Rentals, Unrelated

Unrelated rental income recognized was $296,448 and $466,709 for the years ended December 31, 2015 and 2014, respectively.
(11) Retirement Plans

Pension Plan

The Society has a noncontributory defined benefit pension plan that previously covered all eligible employees meeting service and age requirements. Effective January 1, 2007, the Society amended its defined benefit plan to freeze participation in the plan. Any employee hired after December 31, 2006, was no longer eligible to participate in the plan. Effective January 1, 2015, the Society amended its defined benefit plan such that no additional benefits will accrue for employees under the plan. As a result of the amendment, a curtailment gain was recognized in the consolidated statement of activities for the year ended December 31, 2014. Annual contributions are made to the plan equal to amounts allowable under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. Effective December 31, 2006, PMSCO froze participation and accruals for its employees. No new PMSCO participant may enter the plan after December 31, 2006 and no PMSCO participant will earn benefits for service after December 31, 2006.

The following table sets forth the plan's funded status and amounts recognized in the accompanying consolidated statements of financial position as of December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit obligation</td>
<td>$ (37,341,556)</td>
<td>$ (37,527,425)</td>
</tr>
<tr>
<td>Plan assets at fair value</td>
<td>20,401,354</td>
<td>22,007,107</td>
</tr>
<tr>
<td>Funded status</td>
<td>$ (16,940,202)</td>
<td>$ (15,520,318)</td>
</tr>
<tr>
<td>Liability included on consolidated statements of financial position</td>
<td>$ (16,940,202)</td>
<td>$ (15,520,318)</td>
</tr>
</tbody>
</table>

The measurement date of the pension obligation is December 31, 2015. As of December 31, 2015 and 2014, the accumulated benefit obligation is $37,341,556 and $37,527,425, respectively.

Continued...
(11) Retirement Plans, Continued

Pension Plan, Continued

Net periodic benefit costs recognized in the consolidated statements of activities for the years ended December 31, were as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service cost</td>
<td>$</td>
<td>$ 406,463</td>
</tr>
<tr>
<td>Interest cost</td>
<td>1,484,360</td>
<td>1,487,713</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(1,706,840)</td>
<td>(1,695,738)</td>
</tr>
<tr>
<td>Amortization of prior service costs</td>
<td>-</td>
<td>26,366</td>
</tr>
<tr>
<td>Amortization of net loss</td>
<td>1,101,774</td>
<td>283,569</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$879,294</td>
<td>$508,373</td>
</tr>
</tbody>
</table>

Immediate recognition of prior service cost due to curtailment

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>-</td>
<td>$70,461</td>
</tr>
</tbody>
</table>

Immediate recognition of special termination benefits

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>$993,878</td>
<td>$</td>
<td>-</td>
</tr>
</tbody>
</table>

Other changes in plan assets and benefit obligations recognized previously in changes in unrestricted net assets:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net loss for the period</td>
<td>$2,337,664</td>
<td>$755,728</td>
</tr>
<tr>
<td>Change due to change in assumptions</td>
<td>(1,668,368)</td>
<td>9,464,551</td>
</tr>
<tr>
<td>Amortization of prior service cost</td>
<td>-</td>
<td>(26,366)</td>
</tr>
<tr>
<td>Amortization of net loss</td>
<td>(1,101,774)</td>
<td>(283,569)</td>
</tr>
<tr>
<td>Curtailment gain</td>
<td>-</td>
<td>(3,088,475)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ (432,478)</td>
<td>$ 6,821,869</td>
</tr>
</tbody>
</table>

Amounts recognized as changes in unrestricted net assets but not yet included in net periodic benefit costs related to net loss is $12,255,012 and $12,687,490 as of December 31, 2015 and 2014, respectively.

The estimated net loss that is expected to be amortized from net assets into net periodic benefit cost in the next fiscal year is $1,180,445.

Continued...
(11) Retirement Plans, Continued

Pension Plan, Continued

Weighted average assumptions used by the Society in the determination of pension plan information consist of the following as of December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate</td>
<td>4.19 %</td>
<td>4.00 %</td>
</tr>
<tr>
<td>Rate of increase in compensation levels</td>
<td>N/A %</td>
<td>3.00 %</td>
</tr>
<tr>
<td>Expected long-term rate of return on assets</td>
<td>8.00 %</td>
<td>8.00 %</td>
</tr>
</tbody>
</table>

The Society's Board's Finance Committee (the Committee) is responsible for developing and overseeing the investments of the plan. Investment recommendations of the plan's consultant must be approved by the Committee before transactions are made. It is the Committee's expectation that equity securities will outperform debt securities over the long-term. Accordingly, for 2015, the Committee has targeted an allocation of 80% equity securities and 20% debt securities.

Pension plan assets, allocated based on relative fair values, consist of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>Percentage of Plan Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015</td>
</tr>
<tr>
<td>Equity securities</td>
<td>78 %</td>
</tr>
<tr>
<td>Debt securities</td>
<td>20 %</td>
</tr>
<tr>
<td>Cash</td>
<td>2 %</td>
</tr>
<tr>
<td>Total</td>
<td>100 %</td>
</tr>
</tbody>
</table>

Continued...
(11) Retirement Plans, Continued

Pension Plan, Continued

The fair value of the Organization's pension plan assets are as follows:

<table>
<thead>
<tr>
<th></th>
<th>December 31, 2015</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>Money market</td>
<td>$ 412,716</td>
<td>$ 412,716</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>103-12 investment entity</td>
<td>2,568,618</td>
<td>-</td>
<td>2,568,618</td>
<td>-</td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income fund</td>
<td>4,044,933</td>
<td>4,044,933</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth fund</td>
<td>2,491,844</td>
<td>2,491,844</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value fund</td>
<td>2,292,450</td>
<td>2,292,450</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hedge fund</td>
<td>4,289,674</td>
<td>-</td>
<td>-</td>
<td>4,289,674</td>
</tr>
<tr>
<td>Emerging markets fund</td>
<td>1,763,546</td>
<td>1,763,546</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>International fund</td>
<td>2,537,573</td>
<td>2,537,573</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total registered investment companies</td>
<td>17,420,020</td>
<td>13,130,346</td>
<td>-</td>
<td>4,289,674</td>
</tr>
<tr>
<td></td>
<td>$ 20,401,354</td>
<td>$ 13,543,062</td>
<td>$ 2,568,618</td>
<td>$ 4,289,674</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>December 31, 2014</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>Money market</td>
<td>$ 545,688</td>
<td>$ 545,688</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>fund</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>103-12 investment entity</td>
<td>2,485,267</td>
<td>-</td>
<td>2,485,267</td>
<td>-</td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income fund</td>
<td>3,906,467</td>
<td>3,906,467</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth fund</td>
<td>2,333,886</td>
<td>2,333,886</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value fund</td>
<td>3,753,860</td>
<td>3,753,860</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hedge fund</td>
<td>4,175,086</td>
<td>-</td>
<td>-</td>
<td>4,175,086</td>
</tr>
<tr>
<td>Emerging markets fund</td>
<td>2,070,103</td>
<td>2,070,103</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>International fund</td>
<td>2,736,750</td>
<td>2,736,750</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total registered investment companies</td>
<td>18,976,152</td>
<td>14,801,066</td>
<td>-</td>
<td>4,175,086</td>
</tr>
<tr>
<td></td>
<td>$ 22,007,107</td>
<td>$ 15,346,754</td>
<td>$ 2,485,267</td>
<td>$ 4,175,086</td>
</tr>
</tbody>
</table>

Money market funds are valued at the net asset value (NAV) of shares held by the plan at year end.

Continued...
(11) Retirement Plans, Continued

Pension Plan, Continued

The 103-12 investment entity's investments are valued at the NAV of shares held by the plan at year end as determined by the audited financial statements of the fund.

Level 1 registered investment companies are valued at the closing price reported on the active market on which the individual securities are traded.

Level 3 registered investment companies are valued based on the audited statements of the underlying funds when available, and other information from independent third parties including information provided by the fund managers, the general partners and research performed by the fund's management.

The following table sets forth a summary of changes in the fair value of the Society's level 3 pension plan assets for the years ended December 31, 2015 and 2014:

<table>
<thead>
<tr>
<th></th>
<th>Hedge Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as of December 31, 2013</td>
<td>$ 3,990,087</td>
</tr>
<tr>
<td>Unrealized gain on assets held at year end</td>
<td>184,999</td>
</tr>
<tr>
<td>Balance as of December 31, 2014</td>
<td>4,175,086</td>
</tr>
<tr>
<td>Unrealized gain on assets held at year end</td>
<td>114,588</td>
</tr>
<tr>
<td>Balance as of December 31, 2015</td>
<td>$ 4,289,674</td>
</tr>
</tbody>
</table>

The plan made benefit payments of $1,248,909 and $1,094,344 for the years ended December 31, 2015 and 2014, respectively. The estimated future benefit payments reflecting expected future service are as follows:

<table>
<thead>
<tr>
<th>Year Ending December 31,</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$ 1,367,155</td>
</tr>
<tr>
<td>2017</td>
<td>$ 1,471,723</td>
</tr>
<tr>
<td>2018</td>
<td>$ 1,568,563</td>
</tr>
<tr>
<td>2019</td>
<td>$ 1,634,883</td>
</tr>
<tr>
<td>2020</td>
<td>$ 1,794,419</td>
</tr>
<tr>
<td>2021-2025</td>
<td>$ 10,085,678</td>
</tr>
</tbody>
</table>

Continued...
(11) Retirement Plans, Continued

Pension Plan, Continued

The Organization contributed $20,810 and $1,241,250 to the plan for the years ended December 31, 2015 and 2014, respectively, and expects to contribute $732,920 to the pension plan for the year ending December 31, 2016.

Deferred Salary Plans

The Society sponsors a defined contribution plan for all employees meeting certain eligibility requirements. The Foundation participates in the Society's plan. Eligible participants may defer 1% to 50% of annual compensation. The employer matching percentage is determined each year by the employer at its own discretion. Matching contributions to the plan aggregated $311,891 and $304,165 in 2015 and 2014, respectively.

Effective January 1, 2015 employees will receive an employer contribution of 5% of annual compensation, plus 5% of compensation in excess of the social security taxable wage base; previously this benefit only applied to employees hired after December 31, 2006. Society contributions to the plan aggregated $301,760 and $96,169 in 2015 and 2014, respectively.

PMSOCO participates in the Society's 401(k) Retirement Savings Plan. The plan covers all employees who work at least 1,000 hours or more annually. Eligible participants may defer 1% to 50% of annual compensation. PMSCO makes a matching contribution to the plan on behalf of each participant equal to 100% of eligible employee contributions up to a maximum of 5% of annual compensation. Employer contributions were $25,005 and $39,461 for the years ended December 31, 2015 and 2014, respectively.

As a result of freezing the noncontributory pension plan as noted above, effective January 1, 2007, all PMSCO's participants receive a profit sharing contribution of 5% of annual compensation, plus 5% of compensation in excess of the social security taxable wage base. Employer contributions were $153,740 and $45,454 for the years ended December 31, 2015 and 2014, respectively.

(12) Postretirement Healthcare Plan

The Society sponsors a postretirement healthcare plan that covers premiums for health and basic dental insurance for eligible retirees and their spouses, as of January 1, 1995. Plan participation has been frozen as of January 1, 1995. The postretirement healthcare plan is not funded. At December 31, 2015 and 2014, a liability for contingent benefits in the amount of $441,019 and $509,187, respectively, has been recorded.
(13) Royalty and Endorsement Agreements

The Society agreed to endorse PMSLIC as a carrier of choice for medical professional liability insurance in Pennsylvania. PMSLIC was permitted to use the Society's endorsement to market medical professional liability insurance in Pennsylvania. The Society signed a nonexclusive endorsement agreement with PMSLIC for $425,000 on an annual basis. For the years ended December 31, 2015 and 2014, the Society received $250,000 and $425,000, respectively, per the terms of the agreement.

(14) Board Designated Net Assets

The Society follows FASB Staff Position 117-1, *Endowments of Not-for-Profit Organizations: Net Asset Classification of Funds Subject to an Enacted Version of the Uniform Prudent Management of Institutional Funds Act (UPMIFA) and Enhanced Disclosures for All Endowment Funds* now incorporated in FASB ASC 958. The Commonwealth of Pennsylvania has not yet adopted the provisions of the UPMIFA, but the Society is required by FASB ASC 958 to disclose certain matters associated with its Endowment Fund. Endowment funds subject to FASB ASC 958 include board designated net assets.

The following is the activity associated with the Board Designated Endowment Fund for the years ended December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of year</td>
<td>$124,551,573</td>
<td>$125,609,339</td>
</tr>
<tr>
<td>Dividends and interest</td>
<td>2,593,673</td>
<td>2,364,336</td>
</tr>
<tr>
<td>Realized and unrealized gains (losses), net</td>
<td>(4,743,748)</td>
<td>1,634,371</td>
</tr>
<tr>
<td>Appropriations for expenditure</td>
<td>(4,969,589)</td>
<td>(5,056,473)</td>
</tr>
<tr>
<td>End of year</td>
<td>$117,431,909</td>
<td>$124,551,573</td>
</tr>
</tbody>
</table>

*Risk Tolerance*

The Society recognizes that the primary fiduciary obligation regarding the Endowment Fund is to maximize the inflation-adjusted principal value of the assets to meet current and future needs and obligations of the Society. Assets of the Endowment Fund are to be diversified to protect against large investment losses and to reduce the probability of excessive performance volatility. The Society recognizes the likelihood of periodic market declines and is willing to accept the possibility of some short-term declines in market value in order to achieve potentially higher long-term investment returns. Asset allocation will be structured to minimize downside volatility while maximizing return at an acceptable risk level.

*Continued*
(14) Board Designated Net Assets, Continued

Temporarily Restricted Net Assets

Temporarily restricted net assets are available for medical education and physicians' health programs in the amount of $930,364 and $1,051,903 at December 31, 2015 and 2014, respectively.

Permanently Restricted Net Assets

Permanently restricted net assets consist of donor restricted endowments for which income is restricted for the purpose of supporting medical education and physicians' health programs in the amount of $2,669,454 and $2,666,661 at December 31, 2015 and 2014, respectively.

Investment Strategy

The Endowment Fund utilizes specialist managers (i.e., who manage portfolios oriented to one asset class, such as equities) within each asset class and investment style. Investment managers selected will have demonstrated strong performance within their investment style as well as organizational stability and consistent investment philosophy and process. The Society's asset allocation for the Board Designated Endowment Fund targets a composition of equity investments of 35% to 70% (with up to 35% international equities), fixed income 5% to 20% and alternative investments 15% to 45%.

Spending Policy

The Society uses a spending rule to determine the amount of the Endowment Fund to be allocated to operations. The spending rule, which is subject to review and approval by both the Society's Finance and Executive Committees, was revised in 2011. A hybrid method, two part calculation, is now used. Part one, Banded Inflation, takes the prior year's spending value, inflates it by the Consumer Price Index (CPI), but with a minimum of three percent and a maximum of six percent. Part two, Moving Average Asset, calculates four percent of the average Endowment Fund values of the preceding twenty calendar quarters ending June 30 of the year prior to the year of distribution. The results of the two calculations are weighted, 80% for part one and 20% for part two, and added together to determine the total amount to be distributed. The amount distributed shall pay all Endowment Fund administrative expenses first, before being used to pay other Society expenses.

For the years ended December 31, 2015 and 2014, $4,750,000 and $4,675,000, respectively, of the funds were withdrawn and used by the Society for operations.
(15) Commitments

During 2015, the Society sold the building housing its corporate headquarters and operations. As a part of the sale terms, the Society leases a portion of the building for a period of seven years with an option to renew, at the Society's choice, for one additional two year period. The agreement also includes leasing terms for a second portion of the building for a term of five years with an option to renew, at the Society's choice, for an additional two periods of two years each. Lease terms commenced in June of 2015. As of December 31, 2015, monthly rentals are for $61,699 and escalate by 3% on an annual basis. The Society is also responsible for maintaining certain levels of commercial general liability insurance. Future minimum lease payments are as follows:

<table>
<thead>
<tr>
<th>Year Ending December 31</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$ 751,435</td>
</tr>
<tr>
<td>2017</td>
<td>$ 774,049</td>
</tr>
<tr>
<td>2018</td>
<td>$ 797,412</td>
</tr>
<tr>
<td>2019</td>
<td>$ 821,348</td>
</tr>
<tr>
<td>2020</td>
<td>$ 547,344</td>
</tr>
<tr>
<td>Thereafter</td>
<td>$ 399,644</td>
</tr>
</tbody>
</table>

(16) Litigation

The Organization is involved in litigation as part of its ordinary course of business. Management believes that the probable resolution of such contingencies will not materially affect the financial position, statements of activities, or cash flows of the Organization.

(17) Subsequent Event

In 2016, two separate investment funds, in which the Society held interests at December 31, 2015 were liquidated. The funds were redeemed in 2016 for $11,370,996.
SUPPLEMENTARY INFORMATION
# CONSOLIDATING STATEMENTS OF FINANCIAL POSITION

**December 31, 2015**

<table>
<thead>
<tr>
<th>Description</th>
<th>Pennsylvania Medical Society</th>
<th>Pennsylvania Medical Political Action Committee</th>
<th>Pennsylvania Medical Society Political Action Committee</th>
<th>Pennsylvania Medical Society Alliance</th>
<th>PennMed Member Services Company</th>
<th>The Foundation of the Pennsylvania Medical Society Combined</th>
<th>Eliminating Entries</th>
<th>Consolidated Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents (Note 2)</td>
<td>$ 5,677,270</td>
<td>$ 47,684</td>
<td>$ 1,969</td>
<td>$ 88,579</td>
<td>$ 110,258</td>
<td>$ 472,338</td>
<td>$ -</td>
<td>$ 6,398,098</td>
</tr>
<tr>
<td>Accounts and receivables, net</td>
<td>297,060</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>15,177</td>
<td>191,360</td>
<td>(261)</td>
<td>487,850</td>
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<tr>
<td>Prepaid expenses and advances</td>
<td>255,249</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>27,959</td>
<td>4,425</td>
<td>-</td>
<td>287,829</td>
</tr>
<tr>
<td>Investments (Notes 2 and 4)</td>
<td>170,922,422</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6,236,079</td>
<td>-</td>
<td>176,158,491</td>
</tr>
<tr>
<td>Accrued interest receivable</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>147,777</td>
<td>147,777</td>
</tr>
<tr>
<td>Assets held in charitable remainder trust (Note 8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>108,005</td>
<td>108,005</td>
</tr>
<tr>
<td>Loans receivable (Note 5)</td>
<td>4,578,370</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,578,370</td>
</tr>
<tr>
<td>Property and equipment, net (Note 2 and 6)</td>
<td>811,498</td>
<td>-</td>
<td>-</td>
<td>21,705</td>
<td>16,240</td>
<td>-</td>
<td>-</td>
<td>849,443</td>
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<tr>
<td>Beneficial interest in perpetual trust (Note 7)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>675,062</td>
<td>675,062</td>
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<tr>
<td>Contributions receivable from split-interest agreements (Note 8)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>108,892</td>
<td>108,892</td>
</tr>
<tr>
<td>Net assets of controlled not-for-profit organizations</td>
<td>10,211,215</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(10,211,215)</td>
<td>-</td>
</tr>
<tr>
<td>Due from related party</td>
<td>39,589</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,768</td>
<td>(56,645)</td>
</tr>
<tr>
<td>Assets related to discontinued operations (Note 3)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,902</td>
<td>1,902</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>$ 187,774,303</td>
<td>$ 47,684</td>
<td>$ 1,969</td>
<td>$ 88,579</td>
<td>$ 193,923</td>
<td>$ 12,542,997</td>
<td>(10,268,121)</td>
<td>$ 190,581,334</td>
</tr>
</tbody>
</table>

## LIABILITIES AND NET ASSETS

### Liabilities:
- Membership dues collected in advance (Note 2) | $ 2,205,277 | - | - | $ 10,670 | - | - | - | $ 2,215,947 |
- Accounts payable and accrued expenses | 243,573 | - | - | - | 95,135 | 20,660 | - | 357,388 |
- Liabilities under split-interest agreement (Note 8) | - | - | - | - | - | - | 198,833 | 198,833 |
- Pension liability (Note 11) | 13,880,656 | - | - | - | 1,233,392 | 1,932,954 | - | 16,946,902 |
- Due to affiliated company | 6,868 | 173 | 424 | - | 5,199 | 12,416 | (56,906) | - |
- Other liabilities | 2,073,383 | - | - | 1,000 | - | 268,275 | - | 2,341,658 |
- Postretirement healthcare plan (Note 12) | 441,019 | - | - | - | - | - | - | 441,019 |
- Deferred revenue (Note 2) | 438,622 | - | - | - | - | - | - | 438,622 |
- Investment in subsidiary | 1,081,968 | - | - | - | - | - | (1,043,968) | - |
- Liabilities related to discontinued operations (Note 3) | - | - | - | - | - | 4,928 | - | 4,928 |

**Total Liabilities** | 20,332,366 | 173 | 424 | 16,869 | 1,235,991 | 2,452,548 | (1,096,874) | 22,959,397 |

### Net assets / stockholder’s deficit:
- Stockholder’s deficit: | - | - | - | - | 1,100 | - | - | (1,100) |
- Additional paid-in capital | - | - | - | - | 8,832,840 | - | (8,832,840) | - |
- Accumulated deficit | - | - | - | - | (6,971,577) | - | - | (6,971,577) |
- Accumulated other comprehensive loss | - | - | - | - | - | - | 904,331 | 904,331 |
- **Total stockholder’s deficit** | - | - | - | - | (1,043,968) | - | - | (1,043,968) |

### Net Assets:
- Unrestricted: | 117,431,909 | 47,531 | 1,545 | 71,710 | - | 2,965,958 | (2,965,958) | 117,431,909 |
- Board designated endowment fund (Note 14) | 46,410,210 | - | - | - | - | 3,601,273 | (3,601,273) | 46,410,210 |
- Undesignated | 133,862,119 | 47,531 | 1,545 | 71,710 | - | 6,508,031 | (6,629,697) | 163,842,419 |
- Temporarily restricted: | 930,364 | - | - | - | - | 912,065 | (912,065) | 930,364 |
- Permanently restricted: | 2,669,454 | - | - | - | - | 2,669,454 | (2,669,454) | 2,669,454 |
- **Total net assets** | 163,641,977 | 47,531 | 1,545 | 72,710 | - | 10,093,449 | (10,215,215) | 163,441,937 |

**Total Liabilities and Net Assets** | $ 187,774,303 | $ 47,684 | $ 1,969 | $ 88,579 | $ 193,923 | $ 12,542,997 | (10,268,121) | $ 190,381,334 |

### Notes:
- **Note 2**: Cash and cash equivalents include cash, cash equivalents, and investments, all of which are held in short-term, highly liquid investments.
- **Note 3**: Net assets related to discontinued operations are reported as a separate component of equity.
- **Note 7**: Beneficial interest in perpetual trust includes an agreement for the perpetual payment of a charitable gift.
- **Note 8**: Contributions receivable from split-interest agreements represent contributions received in cash or in-kind with the expectation of receipt in a future period.

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*Schedule 1*
## Consolidating Statements of Activities
### Year Ended December 31, 2015

### Schedule II

<table>
<thead>
<tr>
<th>Changes in unrestricted net assets:</th>
<th>Pennsylvania Medical Society</th>
<th>Pennsylvania Medical Society Political Action Committee</th>
<th>Pennsylvania Medical Society Alliance</th>
<th>PennMed Member Services Company</th>
<th>The Foundation of the Pennsylvania Medical Society Combined</th>
<th>Eliminating Entries</th>
<th>Consolidated Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership dues and contributions</td>
<td>$3,091,818</td>
<td>$164,297</td>
<td>$ - - $12,842</td>
<td>$ - - $768,444</td>
<td>$ - - $891,274</td>
<td>$(138,334)</td>
<td>$3,248,957</td>
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<tr>
<td>Contract revenue</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Fees and payments for services</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rental income (Note 19)</td>
<td>367,165</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(70,717)</td>
<td>296,448</td>
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<tr>
<td>Specialty Society Management Services</td>
<td>1,828,169</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,828,169</td>
</tr>
<tr>
<td>Physician Services</td>
<td>110,657</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>110,657</td>
</tr>
<tr>
<td>CME Certification/Accreditation</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>130,825</td>
</tr>
<tr>
<td>Interest income on loans</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest income</td>
<td>11,995</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11,995</td>
</tr>
<tr>
<td>Contributions, bequests, and fundraising</td>
<td>30,870</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(922,244)</td>
<td>488,750</td>
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<td>Creative services revenue</td>
<td>434</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>434</td>
</tr>
<tr>
<td>Royalty income - insurance</td>
<td>148,599</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(148,599)</td>
<td>-</td>
</tr>
<tr>
<td>Endorsement agreement (Note 13)</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>250,000</td>
</tr>
<tr>
<td>County Medical Society Management Services</td>
<td>360,051</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>360,051</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>59,326</td>
<td>104</td>
<td>-</td>
<td>1,216</td>
<td>-</td>
<td>-</td>
<td>61,146</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,356,829</strong></td>
<td><strong>164,401</strong></td>
<td><strong>8,955</strong></td>
<td><strong>45,428</strong></td>
<td><strong>768,444</strong></td>
<td><strong>1,105,194</strong></td>
<td><strong>669,894</strong></td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td><strong>6,356,829</strong></td>
<td><strong>164,401</strong></td>
<td><strong>8,955</strong></td>
<td><strong>45,428</strong></td>
<td><strong>768,444</strong></td>
<td><strong>1,105,194</strong></td>
<td><strong>669,894</strong></td>
</tr>
<tr>
<td>Programs and services:</td>
<td><strong>6,356,829</strong></td>
<td><strong>164,401</strong></td>
<td><strong>8,955</strong></td>
<td><strong>45,428</strong></td>
<td><strong>768,444</strong></td>
<td><strong>1,105,194</strong></td>
<td><strong>669,894</strong></td>
</tr>
<tr>
<td>Physician Advocacy &amp; Political Affairs</td>
<td><strong>1,185,083</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>1,185,083</strong></td>
</tr>
<tr>
<td>Specialty Society Management Services</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>1,861,383</strong></td>
</tr>
<tr>
<td>Physician Leadership, Education &amp; Practice Support</td>
<td><strong>2,356,602</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>2,356,602</strong></td>
</tr>
<tr>
<td>Organizational Performance and Operations</td>
<td><strong>6,325,167</strong></td>
<td><strong>59,629</strong></td>
<td><strong>9,051</strong></td>
<td><strong>56,977</strong></td>
<td><strong>264,205</strong></td>
<td><strong>289,617</strong></td>
<td><strong>541,560</strong></td>
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<td>Executive Office</td>
<td><strong>2,352,710</strong></td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>2,352,710</strong></td>
</tr>
<tr>
<td>Physicians Health Program</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>806,347</td>
<td><strong>806,347</strong></td>
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<tr>
<td>Student Loan Program</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>241,916</td>
<td><strong>241,916</strong></td>
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<tr>
<td>Political Action Program</td>
<td>-</td>
<td><strong>101,933</strong></td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>101,933</strong></td>
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<td>Alliance Program</td>
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<td>-</td>
<td><strong>583</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>583</strong></td>
</tr>
<tr>
<td>Member Services Consulting</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>963,658</td>
<td><strong>2,288,142</strong></td>
<td><strong>126,334</strong></td>
<td><strong>1,059,008</strong></td>
</tr>
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<td>Other programs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>13,916</strong></td>
<td><strong>4,191</strong></td>
<td>-</td>
<td><strong>178,867</strong></td>
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<td>Depreciation</td>
<td><strong>271,846</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>271,846</strong></td>
</tr>
<tr>
<td>Fundraising</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,600,791</strong></td>
<td><strong>143,562</strong></td>
<td><strong>9,051</strong></td>
<td><strong>59,560</strong></td>
<td><strong>1,181,779</strong></td>
<td><strong>1,050,063</strong></td>
<td><strong>669,894</strong></td>
</tr>
<tr>
<td>Increase (Decrease) in unrestricted net assets before income from investments and other changes</td>
<td><strong>(8,044,962)</strong></td>
<td><strong>18,839</strong></td>
<td><strong>(96)</strong></td>
<td><strong>(14,132)</strong></td>
<td><strong>(413,335)</strong></td>
<td><strong>114</strong></td>
<td><strong>(8,650,572)</strong></td>
</tr>
<tr>
<td>Income from investments (Note 4):</td>
<td><strong>(6,475,045)</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(222,808)</td>
<td><strong>(6,697,853)</strong></td>
</tr>
<tr>
<td>Net realized and unrealized losses in fair value of investments</td>
<td><strong>3,975,511</strong></td>
<td>7</td>
<td>-</td>
<td>-</td>
<td><strong>195,601</strong></td>
<td>-</td>
<td><strong>3,771,110</strong></td>
</tr>
<tr>
<td>Interest and dividend income</td>
<td><strong>(2,897,534)</strong></td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(27,207)</td>
<td><strong>(2,924,741)</strong></td>
</tr>
</tbody>
</table>

Continued...
## Consolidating Statements of Activities, Continued

Year Ended December 31, 2015

<table>
<thead>
<tr>
<th></th>
<th>Pennsylvania Medical Society</th>
<th>Pennsylvania Medical Political Action Committee</th>
<th>Pennsylvania Medical Society Alliance</th>
<th>PennMed Member Services Company</th>
<th>The Foundation of The Pennsylvania Medical Society Combined</th>
<th>Eliminating Entries</th>
<th>Consolidated Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase (decrease) in unrestricted net assets before other changes</td>
<td>(10,935,496)</td>
<td>18,839</td>
<td>(89)</td>
<td>(14,132)</td>
<td>(413,335)</td>
<td>(22,095)</td>
<td>(11,375,356)</td>
</tr>
<tr>
<td>Other changes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity in losses of subsidiary</td>
<td>(684,878)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>684,878</td>
<td>-</td>
</tr>
<tr>
<td>Net assets released from restriction</td>
<td>261,899</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>240,894</td>
<td>265,394</td>
<td></td>
</tr>
<tr>
<td>Change in unrestricted net assets of controlled not-for-profit organizations</td>
<td>(394,479)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>240,894</td>
<td>422,979</td>
<td>269,394</td>
</tr>
<tr>
<td>Change in net assets from continuing operations</td>
<td>(11,333,975)</td>
<td>18,839</td>
<td>(89)</td>
<td>(14,132)</td>
<td>(413,335)</td>
<td>213,801</td>
<td>(11,105,912)</td>
</tr>
<tr>
<td>Discontinued operations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss from operations of discontinued components (Note 3)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(349,001)</td>
<td>-</td>
<td>(349,001)</td>
</tr>
<tr>
<td>Change in net assets before pension related changes other than net periodic pension costs</td>
<td>(11,333,975)</td>
<td>18,839</td>
<td>(89)</td>
<td>(14,132)</td>
<td>(762,336)</td>
<td>213,801</td>
<td>(11,454,913)</td>
</tr>
<tr>
<td>Pension related changes other than net periodic pension costs (Note 11)</td>
<td>331,640</td>
<td>-</td>
<td>-</td>
<td>77,458</td>
<td>43,480</td>
<td>432,678</td>
<td></td>
</tr>
<tr>
<td>Increase (decrease) in unrestricted net assets</td>
<td>(11,022,435)</td>
<td>18,839</td>
<td>(89)</td>
<td>(14,132)</td>
<td>(684,878)</td>
<td>257,281</td>
<td>(11,022,435)</td>
</tr>
<tr>
<td>Changes in temporarily restricted net assets:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
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<td></td>
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<td></td>
<td></td>
<td>37,518</td>
<td>37,518</td>
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<tr>
<td>Grants</td>
<td>18,500</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>147,000</td>
<td>165,500</td>
</tr>
<tr>
<td>Realized and unrealized losses, net income on long-term investments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(125,694)</td>
<td>-</td>
<td>(125,694)</td>
</tr>
<tr>
<td>Change in value of split-interest agreements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>84,494</td>
<td>-</td>
<td>84,494</td>
</tr>
<tr>
<td>Net assets released from restrictions</td>
<td>(28,500)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(240,694)</td>
<td>-</td>
<td>(269,394)</td>
</tr>
<tr>
<td>Change in temporarily restricted net assets of controlled not-for-profit organizations</td>
<td>(111,339)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>111,339</td>
<td>-</td>
</tr>
<tr>
<td>Decrease in temporarily restricted net assets</td>
<td>(121,339)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(111,339)</td>
<td>111,339</td>
<td>(121,339)</td>
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<tr>
<td>Changes in permanently restricted net assets:</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Contributions</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>34,345</td>
<td>-</td>
<td>34,345</td>
</tr>
<tr>
<td>Unrealized loss on beneficial trust</td>
<td>2,793</td>
<td>-</td>
<td>-</td>
<td>(2,793)</td>
<td>(2,793)</td>
<td>-</td>
<td>(2,793)</td>
</tr>
<tr>
<td>Change in permanently restricted net assets of controlled not-for-profit organizations</td>
<td>2,793</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,793</td>
<td>2,793</td>
</tr>
<tr>
<td>Increase in permanently restricted net assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase (decrease) in net assets</td>
<td>$ (11,141,181)</td>
<td>$ 18,839</td>
<td>$(89)</td>
<td>$(14,132)</td>
<td>$(684,878)</td>
<td>$ 148,735</td>
<td>$ 531,525</td>
</tr>
</tbody>
</table>
“Change” is the word that most use when describing the transformations in the Pennsylvania Medical Society over the past few years. I prefer to describe the process of transformation as an “evolution”. The Pennsylvania Medical Society has always served as the leading voice for physicians across the Commonwealth, however, the manner in which we execute our mission has evolved. We have introduced new tactics, technologies and approaches, sustained and enhanced core activities that are essential to our work and mission, and challenged the activities that really don’t add value to the membership experience. We have many accomplishments to be proud of and the opportunities ahead are stimulating and inspiring.

This report summarizes some of our major accomplishments over the past year and highlights areas for continued growth and opportunity in the year to come. As always, I invite your comments, feedback, questions and suggestions at any time. Shortly after this report we will announce a new Pennsylvania Medical Society Executive Vice President. As the Interim EVP, let me assure you that the next EVP will want to engage with you to advance our collective mission…… Until that time, please feel free to reach out with comments/questions at hwilson@pamedsoc.org or 717-558-7816.

2015-2016 In Review

Continued Implementation of PAMED’s Strategic Plan
It is easy to become side-tracked with the tyranny of the urgent when considering the challenges impacting Pennsylvania physicians. The 2014 strategic plan has served as a grounding force to focus PAMED leadership and staff on the key priorities and essence of each decision that executes our strategic plan and measures that work through the monitoring of goals and data measurements.

Areas where we have been successful on the advocacy and regulatory front, include the completion the MCARE rebates and assessment relief. Even though the Commonwealth enacted the medical marijuana law, our advocacy team was able to ensure that the bill contained essential funding for medical marijuana research. Another major win for PAMED is that (SB717) the CRNP bill stayed a bill and didn’t become law. The credentialing bill (HB1663) was introduced and has passed the house health committee. Telemedicine and prior authorization bills have been introduced and are being discussed by legislators. PAMED is also founding member of a new tort reform coalition.

Our suite of tools and educational offerings has expanded to meet the needs of both independent and employed physicians. Our Payer Relations team has provided a comprehensive outline on MACRA and continues to prepare our physician members and their practices for reporting requirements that will impact future reimbursement. As we continue to offer new tools and resources on the web and mobile app, we are continually striving to implement current technologies that enable PAMED operations to function in a manner that meets the needs of today’s busy physician.

Addressing Membership
PAMED experienced a decrease in membership in 2016. Overall, we were down 220 members (16,890 compared to 17,110). While our active membership was 235 physicians lower than last year, we had an increase of 8.8% in employed physicians, a 4.2% increase in female physicians and a 2.3% increase in the pediatric specialty.

When considering renewals, we had an overall increase of 2.9% in active members compared to last year (7,577 compared to 7,362). The greatest areas of increase included: employed physicians (16.2%), physicians who are under 40 years of age (2.4%) and 40-49 years old (1.7%), female physicians (9.9%) and multiple specialty areas.
New members were down from last year (624 compared to 678), but we did see an increase in employed physicians (19.9%), female physicians (6.6%), and physicians who are in hospital based (12.6%) and medical specialties (3.0%).

Staff are working diligently and in new ways to demonstrate PAMED’s value to Pennsylvania’s physicians and encourage more physicians to join us. Membership campaigns, including “MyPAMED/YourPAMED” have helped with recruitment activities. Our communications strategies have put PAMED in members’ inboxes on a weekly basis. Our advocacy agenda was reviewed and prioritized by the Board and the Physician ADVOCATE newsletter helps us describe PAMED’s role as the premiere advocate for all physicians.

A Task Force of the Board spent 2016 examining the concept of regionalization at the county level. The goal was to examine the feasibility of forming larger regional medical societies built upon existing county structures that will continue to provide appropriate representation of physician’s local issues while providing increased member benefits through organizations with greater resources. A comprehensive study was completed by Avenue M to look at member value and willingness to pay. In addition, a toolkit was created to help counties approach the concept of regionalization. See Board Report 8 for more information.

Increasing the Visibility of PAMED

In an effort to respond to member feedback and emphasize the activity that members express they value most, PAMED News shifted to the Physician Advocate. The shift was designed to provide a more frequent and focused vehicle to sharing our work at the local, state and national level. Our presence in the media continued to expand as our physician leadership spoke with authority on issues like Zika, marijuana, ACA, telemedicine, team-based care, and the opioid crisis. Our leaders conveyed PAMED positions on a host of issues by participating on PA Newsmakers, the most broadly viewed newsmakers television show in Pennsylvania.

In addition to our media activities and communication efforts, PAMED staff have traveled to and participated in many conferences and meetings statewide to highlight PAMED’s work and increase our visibility among the membership. To the counties who have extended a true hand of partnership and authentic collaboration, I express the state society’s appreciation for the opportunity to join in shared work that benefits our collective membership.

Connecting with Key Partners and Stakeholders in Harrisburg and Across the State

In addition to outreach to county and specialty groups, PAMED has continued to build strong relationships with partner organizations and government agencies. We have met with the Governor and his team and participated in several major initiatives, most notable is our work regarding the opioid crisis. We have come together with key partners including the Hospital and Healths ystem of Pennsylvania (HAP), the Pennsylvania Pharmacists Association, the Pennsylvania Dental Association, the Pennsylvania District Attorneys Association, local law enforcement and school districts to address the opioid crisis. We continue to work on shared activities with the Pennsylvania Health Care Cost Containment Council, Pennsylvania Association of Community Health Centers, Pennsylvania Health Care Association, Pennsylvania Homecare Association, and many others. We have a staff presence at all major State Board meetings including Medicine, Nursing, Osteopathic and the Patient Safety Authority.

Opioids Day

The opioid crisis has affected many – including our membership. On May 15, 2016, PAMED leadership swarmed the state capital to share materials with legislators on the opioid crisis. Our “Be Safe, Be Smart, Be Sure” Campaign provided front-line education for legislators and provided them with materials for their constituency that answered basic questions like, “what is an opioid and should I take one?” PAMED held a press conference to share the work of physicians and key stakeholders across the state. During the afternoon a symposium was held for members, PAMED physician leaders and Specialty Leadership cabinet members to share what programs and services are available to help physicians respond to the crisis. Representatives from the Ohio State Medical Society shared lessons learned, Secretary Lauren Hughes spoke about the Pennsylvania PDMP, General Rachel Levine and Secretary Gary Tennis gave voice to the statistics and sense
of urgency across the Commonwealth, and the Foundation outlined their intensive controlled substance and
opioid prescribing course. The day ended with a powerful dramatization of a “warm handoff”. Through this
re-enactment, Dr. Charles Barbera from Reading Hospital brought each physician back to the core of the
physician patient relationship and reminded each attendee that it is essential to be human, kind and
compassionate to those who are suffering from addiction. The ripple effect of the day continues in the
ongoing work of the Opioid Task Force and our grassroots efforts at the local level with the District
Attorney’s Association and other key stakeholders.

**Practice Options Initiative**

During 2016 the board diligently researched the feasibility of creating and providing resources to help
independent physicians who have an interest in learning about creating an independent practice network. The
culmination of this work has resulted in the landmark Committee of the Whole at the 2016 House of
Delegates. While independent physicians are a distinct subset of our membership, this opportunity offers
independent and employed physicians the option of employment setting choice for future practice.

**Maintenance of Certification (MOC)**

Our leadership worked throughout the year to build momentum and collective buy-in from key
constituencies including other state and specialty societies to release a “no Confidence” statement in the
ABIM. PAMED’s position includes improving continuous Professional Education/MOC through the deletion
of some of the more onerous requirements including cost and time; and advocates for improvements
including continuous quality improvement and career-long learning. The PAMED board met with Dr.
Permut, Chair of the AMA Board to discuss AMA’s actions and position regarding MOC. This work will
continue into 2017.

**Top Priorities for 2017**

As we look toward 2017, I am looking forward to progress in several areas. Here are a few of those:

1. **Membership increases.** PAMED is making a concerted effort to recruit and retain members early in
   their career. The Future Med Project which extends free membership to residents to a new initiative that
   should yield strong results in 2017.

2. **Continued Leadership on Opioid Abuse and the “Be Safe, Be Smart, Be Sure” campaign.** Our
   continued leadership on opioid abuse issues will include advocacy work regarding proposed legislation
   and input to prescribing guidelines. We will continue to offer a CME product on PA opioid prescribing
   guidelines, the use of Naloxone, the state’s controlled substance database (ABC-MAP), and the “warm
   hand-off” on referrals to treatment.

3. **Strengthen Connections with Counties and Specialty Societies.** We invest a tremendous amount of
   resource in partnering with county and specialty groups and working together to demonstrate member
   value. I expect to continue to cultivate these relationships and build trust to advance our collective
   strategic goals in 2017.

4. **Build and Strengthen Relationships with Health Plans and Payers.** As a key group that impacts
   physician practice, we need to build on our connections with health plans and payers and hold some
   strategic conversations about how to best influence policy decisions on behalf of physicians and patients.

5. **Refreshed Advocacy Priorities.** We will continue to follow our PAMED priority issues and share
   updates routinely via the Physician Advocate, the Dose, the mobile app and a new weekly advocacy
   roundup. In 2017, look for web-based communications that track key bills and share the status of
   priority areas. Immediate key issues will include CRNP scope of Practice (SB 717) which is expected to

6. **New EVP Announcement.** We anticipate the hiring of the next PAMED EVP in December 2016. I trust
   that the individual selected will desire to connect with many critical constituencies including county
   leaders and members across the state. I thank you in advance for opening your doors and sharing your
   thoughts that will inform our new leader as he outlines his plan to lead PAMED into the future.

These are just a few highlights of the work to come. I would be remiss if I didn’t take a moment to express
profound gratitude to the current PAMED Senior Team (Martin Raniowski, Angela Boateng, and Tami
Brehm). Their commitment to advancing PAMED through critical challenges this year has been nothing short of spectacular. Their commitment to transparency, honesty and keeping the member at the center of our work has afforded PAMED and its staff the opportunity to thrive in the environment of continual evolution. For the privilege to serve in this temporary capacity as the Interim EVP, I express my humblest appreciation and gratitude to our staff and our membership. There are so many moments during this season of change when members of PAMED and County leadership extended a hand of assistance and a voice of truth and authenticity. For those who were heard loudly and those who whispered quietly – I extend my deepest respect and gratitude.

Heather A. Wilson, MSW, CFRE
Interim Executive Vice President
The Secretary's Office performed the assignments of serving as ex officio to the House of Delegates as well as Secretary to the PAMED Board of Trustees and the Judicial Council. The Secretary is an ex officio member of the Committee on Bylaws, whose activities are reported separately.

**Proceedings of the 2015 House of Delegates** -- The Secretary's Office made available to all Society members a copy of the Proceedings via the PAMED website (https://www.pamedsoc.org/hod).

**Board of Trustees** -- The Secretary attended the meetings of the PAMED Board of Trustees and provided minutes of those meetings.

**Judicial Council** -- The Secretary serves as Secretary to the Judicial Council. Among other duties, the Secretary transmits requests for interpretations of issues, and becomes a voting member of the Judicial Council when the need for a quorum arises.

I am honored to have been able to serve the Society in this capacity.

Erick J. Bergquist, MD, PhD

Secretary
Resolution 03-511: Recognizing PAMPAC Membership at the House of Delegates Annual Meeting —
Resolution 03-511, introduced at the 2003 annual meeting and adopted by the House of Delegates,
called for the House to be informed about delegates and alternate delegates, by county and specialty,
who are PAMPAC members. That information is appended to this report.

Martin D. Trichtinger, MD                      John J. Pagan, MD
Speaker, House of Delegates                  Vice Speaker, House of Delegates

Attachment

orb/misc/2016 speakers' pampac report
PAMAPAC MEMBERS PENNSYLVANIA MEDICAL SOCIETY
2016 DELEGATES AND ALTERNATES BY COUNTY
AS OF OCTOBER 7, 2016

Allegheny
Patricia L. Dalby, MD
Sharon L. Goldstein, MD
Todd M. Hertzberg, MD
Lawrence R. John, MD
Amelia A. Pare, MD, FACS
Ralph Schmeltz, MD, FACP, FACE
Maria J. Sunseri, MD
John P. Williams, MD

Beaver
John C. Wright, MD

Bucks
James T. Alderfer, MD
Sean Butler, DO
Judith E. Gallagher-Braun, MD
Marilyn J. Heine, MD, FACP, FACEP
David A. Levin, DO
Barry J. Snyder, MD

Berk
Margaret S. Atwell, MD, FACP, FACOEM
Daniel B. Kimball, Jr., MD, MACP
Benjamin Schlechter, MD, FACS

Bradford
Joseph B. Blood, Jr., MD
Burdeett R. Porter, MD, MMM, CPE, FAAPL

Chester
Bruce A. Colley, DO

Clarion
Thomas F. Freenock, Jr., MD

Dauphin
Robert A. Ettlinger, MD
John D. Goldman, MD
Virginia E. Hall, MD, FACOG, FACP
Patrick F. McSharry, MD, MBA, CHCQM

Delaware
Stephen N. Clay, MD
Denise A. DiPrimio-Kalman, DO
Christopher F. Hannum, MD
John A. Kotyo, MD, FAAFP
Joseph W. Laskas, DO

Lancaster
David J. Simons, DO
Bruce A. Brod, MD

Lehigh
Judith R. Prybick, DO

Luzerne
Thomas J. Ciotola, MD

Lycoming
Warren L. Robinson, MD, FACP

Montgomery
William N. Bothwell, MD, FACS
James A. Goodyear, MD, FACS
George R. Green, MD
James W. Thomas, MD

Northampton
Suneel S. Valla, MD

Philadelphia
James L. Cristol, MD
Michael A. DellaVecchia, MD, PhD, FACS, FICS
Scott A. Fleischer, MD, DLFAPA
Enrique Hernandez, MD, FACOG, FACS
Michael A. Loesche
Kurt Miceli, MD
Anthony M. Padula, MD, FACS
John M. Vasudevan, MD

Washington
Jennifer L. Lewis, MD

Wayne/Pike
William R. Dewar, III, MD, FACP

Westmoreland
Steven W. Selip, MD
Robert G. Tymoczko, MD

York
Erik Kochert, MD, FACEP
# PAMPAC Members Pennsylvania Medical Society
## 2016 Delegates and Alternates by Specialty
### As of October 7, 2016

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Delegates/Alternates</th>
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<tr>
<td><strong>Allergy &amp; Immunology</strong></td>
<td>Denise A. DiPrimio-Kalman, DO</td>
</tr>
<tr>
<td><strong>Anesthesiology</strong></td>
<td>Patricia L. Dalby, MD; Burdett R. Porter, MD, MMM, DPE, FAAPL; David J. Simons, DO; John P. Williams, MD</td>
</tr>
<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td>James T. Alderfer, MD; Thomas J. Ciotola, MD</td>
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<tr>
<td><strong>Dermatology</strong></td>
<td>Bruce A. Brod, MD; Joseph W. Laskas, DO</td>
</tr>
<tr>
<td><strong>Diagnostic Radiology</strong></td>
<td>Todd M. Hertzberg, MD</td>
</tr>
<tr>
<td><strong>Emergency Medicine</strong></td>
<td>Erik Kochert, MD, FACEP</td>
</tr>
<tr>
<td><strong>Endocrinology, Diabetes &amp; Metabolism</strong></td>
<td>Ralph Schmeltz, MD, FACP, FACE</td>
</tr>
<tr>
<td><strong>Family Medicine</strong></td>
<td>Bruce A. Colley, DO; Robert A. Ettlinger, MD; Lawrence R. John, MD; John A. Kotyo, MD, FAAFP; Patrick F. McSharry, MD, MBA, CHCQM; Judith R. Pryblic, DO; Steven W. Selip, MD; Robert J. Swansiger, MD</td>
</tr>
<tr>
<td><strong>General Surgery</strong></td>
<td>William N. Bothwell, MD, FACS; Sharon L. Goldstein, MD; James A. Goodyear, MD, FACS; Anthony M. Padula, MD, FACS</td>
</tr>
<tr>
<td><strong>Gynecological Oncology</strong></td>
<td>Enrique Hernandez, MD, FACOG, FACS</td>
</tr>
<tr>
<td><strong>Gynecology</strong></td>
<td>John C. Wright, Jr., MD</td>
</tr>
<tr>
<td><strong>Hematology/Oncology</strong></td>
<td>Marilyn J. Heine, MD, FACP, FACEP</td>
</tr>
<tr>
<td><strong>Infectious Disease</strong></td>
<td>John D. Goldman, MD</td>
</tr>
<tr>
<td><strong>Internal Medicine</strong></td>
<td>Joseph B. Blood, Jr., MD; Stephen N. Clay, MD; David A. Csikos, MD; William R. Dewar, III, MD, FACP; George R. Green, MD; Christopher F. Hannum, MD; Daniel B. Kimball, Jr., MD, MACP; Jennifer L. Lewis, MD; Robert G. Tymoczko, MD</td>
</tr>
<tr>
<td><strong>Medical Oncology</strong></td>
<td>Warren L. Robinson, Jr., MD, FACP</td>
</tr>
<tr>
<td><strong>Obstetrics &amp; Gynecology</strong></td>
<td>Virginia E. Hall, MD, FACOG, FACP</td>
</tr>
<tr>
<td><strong>Occupational Medicine</strong></td>
<td>Margaret S. Atwell, MD</td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>James L. Cristol, MD; Michael A. DellaVecchia, MD, PhD, FACS</td>
</tr>
<tr>
<td><strong>Orthopedic Surgery</strong></td>
<td>Barry J. Snyder, MD</td>
</tr>
<tr>
<td><strong>Otolaryngology</strong></td>
<td>Judith E. Gallagher-Braun, MD</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td>Timothy D. Welby, MD</td>
</tr>
<tr>
<td><strong>Physical Medicine &amp; Rehabilitation</strong></td>
<td>Sean Butler, DO; Thomas F. Freenock, Jr., MD; John M. Vasudevan, MD</td>
</tr>
<tr>
<td><strong>Plastic Surgery</strong></td>
<td>Amelia A. Paré, MD, FACS; Benjamin Schlechter, MD, FACS</td>
</tr>
<tr>
<td><strong>Psychiatry</strong></td>
<td>Scott A. Fleischer, MD, DLFAPA; Kurt Miceli, MD</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td>David A. Levin, DO; James W. Thomas, MD</td>
</tr>
<tr>
<td><strong>Sleep Medicine</strong></td>
<td>Maria J. Sunseri, MD; Suneel S. Valla, MD</td>
</tr>
<tr>
<td><strong>Student</strong></td>
<td>Michael A. Loesche</td>
</tr>
</tbody>
</table>
The annual examination of the Society's financial records for the year ending December 31, 2015 was performed by Kreischer Miller, Certified Public Accountants. A copy of the audit is included separately in this “Official Reports Book.” This is the consolidated audit with “parent company only” information starting on page 32.

The annual assessment of our members who pay full state dues was $395 for 2015.

As of December 31, 2015, the Society reported property and equipment with a net book value of $811,498, long-term investments with a market value of $170,522,422 and cash of $5,677,270. In June 2015, the Society’s headquarters building was sold for $7,050,000. After sale expenses the net proceeds were placed in the Special Purpose Fund to offset future occupancy needs. In May, 2014, our equity interest in our subsidiary, KEPRO was sold. The amount of the final consideration is pending results of certain financial benchmarks. The cash received is now held in the long-term investments of the Society. As a result of the KEPRO sale, the remaining subsidiary, PMSCO is carried as a liability in the amount of $1,041,968 and the net assets of controlled organizations were $10,211,215. Among the liabilities of the Society was membership dues collected in advance of $2,205,277 and long term liabilities of $18,127,089 which includes the PMSCO liability. The total net assets of the Society were $167,411,937.

During 2015, revenue for the Society, not including investment activity, amounted to $6,358,929 of which $3,091,818 was dues. Net realized and unrealized losses in the fair value of investments were $6,473,045 and investment income was $3,575,511. Expenses for 2015 totaled $14,400,791. In order to meet the expenses of the Society, $4,750,000 was transferred from the Endowment Fund by way of the spending rule. The Society ended the year with a decrease in unrestricted net assets before other changes of $11,141,181.

F. Wilson Jackson III, MD
Treasurer
PENNSYLVANIA DELEGATION TO THE AMA

The Pennsylvania Delegation to the AMA actively represented this House at the Interim 2015 and Annual 2016 meetings of the AMA House of Delegates. This report contains a summary of our activities since our last report to this House.

RESOLUTIONS UPDATE

AMA Interim Meeting 2015 (I-15)

Three resolutions—one from this House and two authored by the Pennsylvania Delegation—were submitted for consideration at the AMA Interim meeting in November 2015:

- Defining Annual Wellness Visits as Provided by Community-based Primary Care Physicians (Resolution 15-202): This resolution called on the AMA to advocate for clear definition of the Centers for Medicare and Medicaid Services’ (CMS’) Medicare Annual Wellness Visit as one that is provided only by physicians or members of a community-based, physician-led team that will provide continuity of care to those patients. The AMA House of Delegates referred the resolution; a report is expected at the 2016 Interim meeting.

- Maintenance of Certification Advocacy by our American Medical Association: The AMA House of Delegates adopted the following: RESOLVED, That our American Medical Association oppose those maintenance of certification programs administered by the specialty board of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification (AMA Policy D-275.954).

- Burdensome Paperwork for Breast Pumps: The AMA House of Delegates adopted this resolution as AMA Policy H-185.928: Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.

AMA Annual Meeting 2016 (A-16)

One resolution—authored by the PAMED Board of Trustees—was submitted to the AMA Annual meeting in June:

- Specialty Board Report Cards: This resolution called on the AMA to: 1) evaluate and prepare for distribution to the House of Delegates by the June 2017 meeting an analysis report card comparing ABIM and NBPAS to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification); and 2) that each succeeding year the AMA evaluate and annually prepare for distribution to the House of Delegates an Analysis Report Card comparing two separate and additional specialty boards, to be selected on a rotating and inclusive basis, from those Specialty Boards operating under the auspices of the American Board of Medical Specialties (ABMS) to the standards codified within AMA Policy H-275.924 (AMA Principles on Maintenance of Certification). The resolution was not adopted by the AMA House of Delegates.

Additionally, Pennsylvania signed onto a resolution authored by Florida, and adopted by the AMA House of Delegates, which called on the AMA to: 1) call for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure recertification examination; 2) continue to support requirement of CME and ongoing, quality assessments of physicians, where such CME is proved to be cost-effective and shown by evidence to improve quality of care for patients; 3) continue to
work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam; and 4) support a recertification process based on high quality, appropriate CME material directed by the AMA-recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

DELEGATION ACTIVITY

Delegation members participated in three meetings since our last update to the PAMED House:

AMA Interim Meeting 2015 (I-15)

Pennsylvania ably represented this House of Delegates at the 2015 Interim meeting in Dallas, Texas. In addition to testifying on the myriad issues before the AMA House, highlights of the November meeting included:

- Great Lakes States Coalition reference committee reviews via teleconference prior to the Interim meeting and an onsite review on Sunday morning;
- Thorough review of the reports and resolutions during delegation caucus sessions, to include all business items submitted from the AMA sections (OMSS, IMG, YPS, RFS, MSS);
- The delegation held elections for Chair, Vice Chair, Secretary, Delegate-at-Large and Alternate Delegate-at-Large. Dr. James Goodyear was re-elected Chair; Dr. Stephen Clay was re-elected Vice Chair; Dr. Judith Prybick was re-elected Secretary; Dr. John Spurlock was re-elected Delegate-at-Large; and Dr. Virginia Hall was elected as Alternate Delegate-at-Large. Their terms expire December 31, 2017.

Spring Telephone Conference 2016

The delegation held its 2016 spring teleconference on April 26 to prepare for the AMA Annual meeting in June. We reviewed the Annual meeting schedule, discussed our responsibilities as host of the Great Lakes States Coalition (Illinois, Indiana, Michigan, New York, Ohio and Pennsylvania) for 2016 and learned highlights of the plans for Dr. Andrew Gurman’s inauguration as AMA President.

AMA Annual Meeting 2016 (A-16)

Pennsylvania expertly represented the PAMED House of Delegates at the AMA’s Annual meeting in June. In addition to the success achieved on the MOC issue, highlights of the meeting included:

- Joint Great Lakes States Coalition reference committee reviews held prior to the meeting via an electronic process and an onsite review during the meeting;
- Great Lakes States Coalition interviews for AMA Officer, Trustee and Council positions;
- Great Lakes States Coalition networking breakfast for delegates, alternates, and staff;
- Thorough review of the reports and resolutions during delegation caucus sessions, to include all business items submitted from the AMA sections (OMSS, IMG, YPS, RFS, MSS);
- Great Lakes States Coalition reception honoring its endorsed candidates for AMA office;
- The delegation held a special election for the Alternate Delegate-at-Large position on the Executive Committee. Dr. Virginia Hall was previously elected to serve as the Alternate Delegate-at-Large; however, due to an increase in the total allotment of delegates and alternates for 2016, she was elevated to delegate, thereby vacating the Alternate...
Delegate-at-Large position. Dr. Michael DellaVecchia was elected by the delegation to fill this position with a term expiration of December 31, 2017.

- Dr. Andrew Gurman was inaugurated as the 171st President of the AMA on Tuesday, June 14—Congratulations, Andy!

** RETIREMENTS FROM THE DELEGATION **

The delegation has expressed its overwhelming and sincere appreciation to the members who retired at the end of 2015. The AMA recognized these individuals at the 2015 Interim meeting:

- John E. Demko (AMA Region 6 Alternate Delegate)
- Jana L. Ebbert, DO (Resident Alternate Delegate)
- Sage Green (AMA Region 6 Delegate)
- Andrew W. Gurman, MD (Delegate and Alternate Delegate)
- Diana Huang (Student Alternate Delegate)
- Evan J. Pollack, MD (Alternate Delegate)
- Thomas J. Weida, MD (Alternate Delegate)
- Bruce L. Wilder, MD (Alternate Delegate)

James A. Goodyear, MD

Chair
PAMPAC
The Physicians’ Voice in Politics

MISSION

PAMPAC, through its political and educational endeavors, strengthens the voice of physicians in the political arena.

VISION

• PAMPAC members actively participate in the political process by supporting pro-physician candidates for elected office.
• PAMPAC disseminates unbiased information on current political issues and candidates for elected office and conducts other political activities of an informative and impartial nature.
• PAMPAC participates actively in election campaigns of pro-physician candidates by soliciting money for political purposes, making contributions to and expenditures on behalf of candidates for nomination or election to public office, and any other election activities permitted by law and regulation.
• PAMPAC assists physicians and Alliance members in organizing themselves for more effective political action.
• PAMPAC is recognized in the political arena as the representative for all physicians, regardless of specialty or stage in career.

Invest in our future, together we are stronger!

More specifically, the focus of the PAMPAC Board is to recruit members from among our fellow PAMED and Alliance members and use those contributions to strategically support viable candidates. PAMPAC is committed to supporting candidates that are aligned with PAMED policies based on their policy positions and past voting records. It is also important for PAMPAC supported candidates to be accessible to the physician community so that PAMED representatives will have the opportunity to discuss our views and concerns on key issues to physicians and patients in Pennsylvania.

Until 2016, the past several years have been a time of transition and improvement for PAMPAC. During this time, PAMPAC began to reverse a downward trend in membership and had hired its first full-time Executive Director. However, securing sufficient financial contributions to allow PAMPAC to provide appropriate support for deserving candidates continues to be our most significant challenge.

Data detailing the current status of PAMPAC membership and collected revenues for 2015 and 2016 reflects a short term trend that will hopefully be reversed in 2017. Year to date we have seen a decrease in PAMPAC membership of 217 members. There remain a significant number of 2015 contributors that have not joined this year and the retention of these donors will be
critical to growth in total PAMPAC membership this year. It is our hope that many of these individuals will renew their 2016 membership at this year’s House of Delegates meeting in Hershey.

<table>
<thead>
<tr>
<th></th>
<th>Commonwealth Club $1,000</th>
<th>Capitol $500</th>
<th>Keystone $300</th>
<th>Total PAMPAC Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 (full year)</td>
<td>39</td>
<td>61</td>
<td>91</td>
<td>641</td>
</tr>
<tr>
<td>2015 (full year)</td>
<td>36</td>
<td>56</td>
<td>98</td>
<td>670</td>
</tr>
<tr>
<td>2016 (9/30/2016)</td>
<td>34</td>
<td>36</td>
<td>68</td>
<td>453</td>
</tr>
</tbody>
</table>

Since the 2009 House of Delegates, these words in amended resolution 09-408: “That PAMPAC be applauded for re-affirming its policy to carefully scrutinize political leaders’ voting record/scorecards prior to distributing PAC funds to qualified candidates” have been a continuing standard for PAMPAC candidate contribution decisions. It is important that PAMPAC contributors, whether they are members of the House of Delegates or not, know that they remain as the standard for the PAMPAC Board.

2016 Election Preview

PAMPAC supported candidates across the Commonwealth repeatedly emerged as the winners in key races during the May 2016 primary election.

Congress
Even with what has been characterized as one of the most unusual presidential elections in U.S. history dominating the media, the contest for the U.S. Senate in Pennsylvania is one of a handful that will decide which party controls the U.S. Senate next year. Katie McGinty (D) is challenging incumbent U.S. Senator Pat Toomey (R) in the general election. AMPAC and PAMPAC announced their support for Sen. Toomey.

Philadelphia Congressman Chaka Fattah (D – 2nd District) was the only incumbent who lost in the primary election and he will almost certainly be replaced by current State Rep. Dwight Evans (D). In the general election, Congressman Bill Shuster (R – 9th District) has a rematch with Art Halvorson, who lost the GOP primary but simultaneously secured the Democratic nomination. AMPAC and PAMPAC are supporting Shuster.

The two open PA congressional seats are also key races in the eyes of state and national political party leaders. State Rep. Steve Santarsiero (D) and Brian Fitzpatrick (R) are separated by a thin margin in the 8th district (Bucks & Montgomery) while Christina Hartman (D) and State Sen. Lloyd Smucker (R) are waging a battle to win the 16th district (Berks, Chester & Lancaster). AMPAC and PAMPAC are supporting Fitzpatrick and Smucker. Those seats are now held by Mike Fitzpatrick (R–8th) and Joe Pitts (R–16th).

State Senate
Like their counterparts in the House of Representatives, Senate Republicans have a commanding majority, outnumbering Democrats by a 31-19 margin. This year’s primary election stage was set early when three senators announced their plans to retire, with a fourth, Sen. John Wozniak, making his decision to “hang it up” shortly after he won his primary. Interestingly, four
incumbent Democrat senators successfully fought off primary challengers while Republicans battled over four open seats. No incumbent Republican was challenged.

PAMPAC engaged in two of the four open Republican primaries, throwing support to Scott Martin (Lancaster) and State Rep. Mike Regan (Cumberland), both whom sailed to victory.

In the November general election, thirteen senators are running unopposed, with only a few expected to have formidable opponents. While it is always difficult to predict whether the Senate Republicans will maintain their existing majority, a number of political pundits expect the GOP to pick up another seat.

State House

With the balance of power in the House of Representatives currently favoring Republicans by a 119-84 margin, it’s safe to say that the chamber will remain in Republican control next legislative session. This year, 15 members of the House of Representatives—8 Republicans and 7 Democrats—announced that they would not seek re-election. Of those retiring from the House, two are seeking other elected offices, with Rep. Steve Santarsiero (D-Bucks) running for Congress and Rep. Mike Regan (R-Cumberland) looking to relocate across the rotunda to replace retiring State Sen. Pat Vance.

This year’s primary election saw 164 lawmakers running unchallenged while four saw the end of their legislative careers. Turning to the November general election, 98 of the House’s 203 members will not face opposition, with 51 Republicans and 47 Democrats getting a “free ride.”

PAMPAC Success

In the current 2015-2016 election cycle, PAMPAC contributed nearly $200,000 to legislative candidates.

2016 Election Activities

In addition to direct financial support, PAMPAC often engages in election outreach by encouraging PAMPAC member physicians and their family and friends to vote for specific legislative candidates. This activity typically involves targeted letters and other direct mail that informs physicians why PAMPAC favors a particular candidate and is most often executed to help an identified incumbent candidate. As in the past, PAMPAC will be engaged this fall in this level of political advocacy.

New PAMPAC Officers & Board Members

The PAMPAC Board met by conference call in December 2015 and elected the following officers and board members for 2016. The custom is to provide for continuity during the two-year election cycle.

Chair                John Wright, MD
Vice Chair            Timothy Welby, MD
Asst. Treasurer       Jennifer Lewis, MD
Secretary          Donna Rovito
Executive Comm.     Bruce MacLeod, MD
Executive Comm.     Robert Richards, Jr., MD

At-Large:

Joanne Bergquist (Alliance – Westmoreland)
Bruce MacLeod, MD (Allegheny)
Peter Daloni, MD (Mercer)
Jim Thomas, MD (Montgomery)
Jaan Sidorov, MD (Dauphin)
Michael DellaVecchia, MD (Philadelphia)

Later in 2015, John Pagan, MD and Aaron George, DO were both elected to fill at-large
vacancies on the board. The PAMPAC Board will once again meet in December of this year to
elect officers for 2017.

House of Delegates PAMPAC Reception

In recognition of PAMPAC members attending the Medical Society’s House of Delegates, we
will once again host the popular PAMPAC reception on Friday night, Oct. 21. As in previous
years, we will open the second hour of the event to all delegates and emphasize the importance
of joining PAMPAC to those who are not yet 2016 members.

In Appreciation

John Wright, MD, Theodore Christopher, MD, Michael Abdul-Malek, MD, Ameila Pare, MD,
and Alliance representative Donna Rovito will conclude their service on the PAMPAC Board in
2016. Their collective talent, time, insight and thoughtful contributions will be missed.
2016 PAMPAC Board of Directors

*Member of the PAMPAC Executive Committee

First District   Theodore A. Christopher, MD
Second District  Mark Lopatin, MD
Third District   Timothy Welby, MD*..............................Vice Chair
Fourth District  Cathleen Woomert, DO
Fifth District   Robert N. Richards, Jr., MD*
Sixth District   Neil A. Kaneshiki, MD
Seventh District Carmen Spinney, MD
Eighth District  Michael E. Abdul-Malak, MD
Ninth District   Erick Bergquist, MD, PhD
Tenth District   John C. Wright, Jr., MD*........................Chair
Eleventh District Jennifer Lewis, MD* ..........................Assistant Treasurer
Twelfth District Burdett R. Porter, MD
Thirteenth District Brahma Sharma, MD

At-Large        Mrs. Joanne Bergquist
At-Large        Peter Daloni, MD
At-Large        Michael DellaVecchia, MD
At-Large        Aaron George, DO
At-Large        John Goldman, MD
At-Large        Bruce MacLeod, MD*
At-Large        Philip Mandato, MD
At-Large        John Pagan, MD
At-Large        Amelia A. Pare, MD
At-Large        Ralph Schmeltz, MD
At-Large        Jaan Sidorov, MD
At-Large        Alexis Smith, DO
At-Large        James Thomas, MD

Student         Leanne Woiewodski
Resident        Hans Zuckerman, DO

Alliance        Mrs. Cynthia Richards
Alliance        Mrs. Donna Baver Rovito*.......................Secretary
Alliance        Mrs. Caryl Schmitz

PAMPAC Staff    Ms. Katie Thiemann..............................Director
PAMPAC Staff    Ms. Janet Minnier ..............................Treasurer
Mission: The Foundation of the Pennsylvania Medical Society provides programs and services for individual physicians and others that improve the well-being of Pennsylvanians and sustain the future of medicine.

The Board of Trustees and staff of the Foundation are proud to serve as your philanthropic partner, and we are grateful for your generous support.

2015-2016 Accomplishments

Priority Area: Education – Student Financial Services

Student Loans: figures as of 12/31/2015

- Active Loan Accounts: $4,659,006 for 439 accounts as of 12/31/2015
- Default Rate: .19%  Delinquent Rate: .48%
- Loans: $432,500 to 79 medical students for the 2015-2016 academic year as of 12/31/2015
- Loan Amounts: Individual awards ranged from $3,000-$7,000, maximum aggregate loan amount per student was $21,000
- Disbursement: As of December 2015, the Foundation has disbursed more than $19.6 million in loans and scholarships to nearly 4,500 medical and allied health students (Appendix A)

Scholarships

- Nine Scholarships: The Foundation manages funds for nine medical student scholarships.
- In 2015, 19 scholarships were awarded totaling $48,000
- Allegheny County Medical Society Medical Student Scholarship: 2015—Awarded a $4,000 scholarship to Diana Huang, Lewis Katz School of Medicine at Temple University. 2016—one recipient of a $4,000 scholarship will be selected in December. Eligibility criteria includes: student applicants must be from Allegheny County and attend a Pennsylvania medical school as a third- or fourth year student.
- Alliance Medical Education Scholarship: April 2016—The committee selected seven recipients to receive awards from this fund—six students will each receive a $2,500 scholarship, including one student who received the William J. West Jr., MD, Award and one student who received the Barbara Prendergast Award; one student will receive a $3,000 scholarship from the Robert and Arlene Oyler Award. The Alliance will present the awards during the Annual Business Meeting in October.
- Endowment for South Asian Students of Indian Descent: 2015—awarded a $2,000 scholarship to Anup Bhattacharya, Lewis Katz School of Medicine at Temple University. 2016—one recipient of a $2,000 scholarship will be selected in December. Eligibility criteria includes: student applicants must be of South Asian Indian heritage and attend a Pennsylvania medical school as a second-, third-, or fourth-year student.
- Lehigh County Medical Auxiliary’s Scholarship and Educational Fund: 2015—Two students were selected to receive a total of $5,000 from this fund. $2,500 scholarships were awarded to Ahmed Kashkoush, University of Pittsburgh School of Medicine, and Adria Simon, New York University School of Medicine. 2016—one recipient of a $2,500 scholarship will be selected in December. Eligibility criteria includes: student applicants must be residents of Lehigh County.
• **Lycoming County Medical Society Scholarship Fund**: 2015—Three students were selected to receive a total of $9,000 from this fund. $3,000 scholarships were awarded to Laura Anderson, The Commonwealth Medical College, Ian Eisenhauer, University of Colorado School of Medicine, and Paige Robinson, Philadelphia College of Osteopathic Medicine. 2016—two recipients will be selected to receive $3,000 scholarship awards by December. Eligibility criteria includes: student applicants must be residents of Lycoming County and 2015 scholarship winners are ineligible to reapply for 2016 award.

• **Montgomery County Medical Society Scholarship**: 2015—Two students were selected to receive a total of $5,000 from this fund. $2,500 scholarships were awarded to Quan Chen, The Commonwealth Medical College and Gregory Woods, University of Michigan Medical School. 2016—one recipient will be selected to receive a $1,000 award by December. Eligibility criteria includes: student applicants must be a first-year student and a resident of Montgomery County at time of high school graduation or four years prior to entering medical school.

• **Myrtle Siegfried, MD, and Michael Vigilante, MD, Scholarship Fund**: 2015—awarded a $1,000 scholarship to Shenel Franklin, Philadelphia College of Osteopathic Medicine. 2016—will award one $1,000 scholarship by December. Eligibility criteria includes: student applicants must be Berks, Lehigh, or Northampton County residents and first-year students.

• **Scott A. Gunder, MD, DCMS Presidential Scholarship Fund**: May 2016—awarded a $1,500 scholarship to Emily Galli, Penn State College of Medicine.

• **Blair County Medical Society Scholarship Fund**: 2015—no recipient selected as no applications were received. 2016—will award one $1,000 scholarship by December. Eligibility criteria includes: student applicants must be a resident of Blair County and a second-, third- or fourth year medical student.

**PRIORITY AREA: PHYSICIAN HEALTH & WELLNESS – PHYSICIANS’ HEALTH PROGRAM**

The Physicians’ Health Program (PHP) assists physicians and other eligible health care professionals to understand, accept and cope with the physical, emotional, spiritual and mental conditions which impair or threaten to impair their health and well-being, and thus help them to meet the usual and high standards of medical care required of licensed physicians/others in the Commonwealth of Pennsylvania. The PHP is able to provide those who suffer from addiction, mental health disorders or behavioral concerns that impact their ability to practice medicine, with support and advocacy services needed by compiling documentation that accurately reflects their participation and compliance with their monitoring agreement. Participants in long-term recovery, mentor and support physicians/others in early recovery through sharing their experience, strength and hope.

- **Active Caseload**: 486 participants were in active agreements in 2015.
- **Referrals**: 277 referrals were received in 2015.

**PRIORITY AREA: PHYSICIAN CLINICAL COMPETENCY – LIFEGUARD®**

Lifeguard® provides physicians with an unbiased seamless pathway for re-entry into the workforce and provides remediation for those who may have fallen behind in clinical skills or continuing education, or about whom quality concerns have arisen through a peer review process. Lifeguard utilizes the medical model as its basis and a case management approach to provide components of the program as needed.

- **PMSCO continues to provided case management services for LifeGuard through a sub-contractor relationship with the Foundation of the Pennsylvania Medical Society (Foundation) through March 2016. In March 2016, all the LifeGuard program moved formally back under the Foundation of the Pennsylvania Medical Society providing services to physicians in and out of state.**
• LifeGuard has a dedicated website: http://www.lifeguardprogram.com/
• 56 Pennsylvania participants have completed LifeGuard since February of 2011.

**PRIORITY AREA: PHILANTHROPY & COMMUNICATIONS**

Philanthropy and communications are the undergirding tools to advance the mission and programs of the Foundation. Why is support for the Foundation important? Simply put, **every program at the Foundation exists for the sole benefit of Pennsylvania physicians**. We help future physicians obtain their medical education. We encourage the impaired physician to get help when they are suffering with addiction and we provide monitoring to ensure that they are safe and certain when practicing in their medical community. We provide fair assessment and efficient and effective remediation when clinical skills are called into question. The Foundation offers programs that speak to improving the human condition of the physician regardless of the political and economic influences that impact the practice of medicine.

**Philanthropy**

• **House of Delegates Honor Gift for the Outgoing PAMED President:** You currently have the opportunity to honor Scott Shapiro, MD, for his service as the PAMED president. The Foundation has a goal of raising $10,000. [Click here to make a gift in honor of our outgoing President](#)
  
  - Gifts received in honor of the past PAMED Presidents include:
  - In 2015, 67 gifts were received totaling $8,825, with an average gift of $132 to honor Karen Rizzo, MD.
  - In 2014, 89 gifts were received totaling $11,640, with an average gift of $131 to honor Bruce MacLeod, MD.
  - In 2013, 69 gifts were received totaling $8,593, with an average gift of $125 to honor Richard Schott, MD.
  - In 2012, 78 gifts were received totaling $7,267, with an average gift of $93 to honor Marilyn Heine, MD.

The Foundation thanks all of the delegates who have contributed to our PAMED Honor Campaign over the years. In the last four years more than $36,000 has been raised in support of our physician–driven programs.

• **Physicians Health Program - 30 years of Change – Transforming Lives Campaign** – In honor of the 30th anniversary of the PHP an Endowment Campaign was launched in January. The campaign goal is $60,000. We are honored that one dedicated physician pledged $30,000 as a “matching gift” which will be received in full as long as an additional $30,000 is raised. As of 7/31/2016 we are less than $3,000 away from making this important goal! To learn more about the PHP and our transformational stories of change or to make a gift please [Click here](#).

• **Annual Hospital Giving to the PHP** as of 7/31/2016 $207,526 from 137 hospitals has been raised compared to $185,670 from 114 hospitals at this same time last year. The PHP remains the single most effective system to ensure that an impaired physician is sober, safe and certain.

• **Face Ratio:** The Foundation maintained a 26% FACE ratio for 2015. The ratio of fundraising and administration costs to total expenditure (FACE) is frequently used as a benchmark to measure the efficiency of charities. The national standard is 35% or less.

• **Foundation’s Fundraising ROI:** Is 4.87 – for every dollar we invest in fundraising, we receive 4 times that amount

• **990 Program Spending Ratio:** The IRS threshold is 65% program spending/35% overall, the Foundation programmatic spending is at 75%.
• Total funds raised as of 7/31/2016 is $616,522, compared to $530,287 last year at this time.
The 2016 overall fundraising goal for all programs is: $829,000.

Communications
• The 2015 Annual Report was released in electronic format and print, to see a copy of the 2015
  Annual Report please go on line to www.foundationpamedsoc.org or pick up a hard copy at the
  Foundation table at the House of Delegates.

FINANCIAL INFORMATION
Appendix B contains a review of the Foundation’s financial information for 2015. Audited reports are
prepared each year by the accounting firm of Kreischer Miller. A copy is available through the
Foundation’s office of the Executive Director.

2015 BOARD OF TRUSTEES

Raymond C. Truex Jr., MD, FAANS, FACS, Chair
Donald E. Parlee, MD, FACR, Vice Chair
Virginia E. Hall, MD, FACOG, FACP, Treasurer
Paul F. Dende, DO, FACP, Assistant Treasurer
Heather A. Wilson, MSW, CFRE, Secretary
Erick J. Bergquist, MD, PhD
Kenneth M. Certa, MD

William R. Dewar III, MD, FACP
Ravi Dukkipati, MD
Michael Fraser, PhD, CAE, FCPP
Peter S. Lund, MD, FACS
Kirk D. Tolhurst, MD
William J. West Jr., MD

Attachments: Appendix A
            Appendix B
Appendix A
The Foundation of the Pennsylvania Medical Society

Student Financial Aid Statistics
(As of December 31, 2015)

<table>
<thead>
<tr>
<th>Statistics on active student loans:</th>
<th>Amount of Aid</th>
<th>Number of Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Paying Loans</td>
<td>$ 1,832,254</td>
<td>221</td>
</tr>
<tr>
<td>Active Non-paying Loans (in-school/residency)</td>
<td>2,826,752</td>
<td>218</td>
</tr>
<tr>
<td><strong>Total Active Loans</strong></td>
<td><strong>$ 4,659,006</strong></td>
<td><strong>439</strong></td>
</tr>
</tbody>
</table>

*The average default rate for 2015 was 0.19%*

<table>
<thead>
<tr>
<th>Total student aid awarded since 1948:</th>
<th>Amount of Aid</th>
<th>Number of Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Student Loans</td>
<td>$ 17,180,078</td>
<td>3,225</td>
</tr>
<tr>
<td>Residency Relocation Loans</td>
<td>394,600</td>
<td>*</td>
</tr>
<tr>
<td>(Extension of Medical Student Loan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health &amp; Miscellaneous Student Loans</td>
<td>948,319</td>
<td>580</td>
</tr>
<tr>
<td>Loans for Children of Deceased or Disabled Physicians</td>
<td>282,417</td>
<td>96</td>
</tr>
<tr>
<td>Scholarships</td>
<td>849,477</td>
<td>589</td>
</tr>
<tr>
<td><strong>Total, Student Aid Since 1948</strong></td>
<td><strong>$ 19,654,891</strong></td>
<td><strong>4,490</strong></td>
</tr>
</tbody>
</table>

*Number of persons is not given because these borrowers also received medical student loans and are accounted for in the medical student loan total. As a matter of information, 392 of these loans have been awarded since 1991, when the program was initiated.
## ASSETS

<table>
<thead>
<tr>
<th>Item</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>472,338</td>
<td>230,077</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>195,148</td>
<td>85,808</td>
</tr>
<tr>
<td>Investments (Notes 1 and 3)</td>
<td>6,236,079</td>
<td>6,445,431</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>4,415</td>
<td>5,644</td>
</tr>
<tr>
<td>Loans receivable, net of allowance for uncollectible loans of $82,114 in 2015 and 2014 (Note 4)</td>
<td>4,578,971</td>
<td>4,651,574</td>
</tr>
<tr>
<td>Accrued interest receivable</td>
<td>147,797</td>
<td>154,500</td>
</tr>
<tr>
<td>Office equipment, net of accumulated depreciation of $156,173 in 2015 and $156,730 in 2014 (Note 1)</td>
<td>16,240</td>
<td>8,844</td>
</tr>
<tr>
<td>Split-interest agreements (Note 5):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets held in charitable remainder trusts</td>
<td>108,055</td>
<td>120,714</td>
</tr>
<tr>
<td>Beneficial interest in perpetual trust</td>
<td>675,062</td>
<td>706,614</td>
</tr>
<tr>
<td>Contributions receivable from split-interest agreements</td>
<td>108,892</td>
<td>105,985</td>
</tr>
</tbody>
</table>

**Total Assets:**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 12,542,997</td>
<td>$ 12,515,191</td>
</tr>
</tbody>
</table>

## LIABILITIES AND NET ASSETS

<table>
<thead>
<tr>
<th>Item</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable</td>
<td>52,486</td>
<td>186,875</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>81,642</td>
<td>83,512</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>10,435</td>
<td>6,445</td>
</tr>
<tr>
<td>Agency funds</td>
<td>176,198</td>
<td>197,916</td>
</tr>
<tr>
<td>Liability under split-interest agreements (Note 5)</td>
<td>198,833</td>
<td>212,736</td>
</tr>
<tr>
<td>Pension liability (Note 9)</td>
<td>1,932,954</td>
<td>1,885,993</td>
</tr>
</tbody>
</table>

**Total Liabilities:**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,452,548</td>
<td>2,573,477</td>
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**Net assets:**

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<thead>
<tr>
<th>Subcategory</th>
<th>2015</th>
<th>2014</th>
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</thead>
<tbody>
<tr>
<td>Unrestricted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board designated</td>
<td>2,906,958</td>
<td>2,971,056</td>
</tr>
<tr>
<td>Undesignated</td>
<td>3,601,973</td>
<td>3,280,594</td>
</tr>
<tr>
<td>Temporarily restricted</td>
<td>912,065</td>
<td>1,023,404</td>
</tr>
<tr>
<td>Permanently restricted</td>
<td>2,669,453</td>
<td>2,666,660</td>
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</table>

**Total Net Assets:**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,090,449</td>
<td>9,941,714</td>
</tr>
</tbody>
</table>

**Total Assets and Liabilities:**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 12,542,997</td>
<td>$ 12,515,191</td>
</tr>
</tbody>
</table>

See accompanying notes to combined financial statements.
THE FOUNDATION OF THE PENNSYLVANIA MEDICAL SOCIETY

Combined Statements of Activities
Years Ended December 31, 2015 and 2014

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unrestricted</td>
<td>Temporarily Restricted</td>
<td>Permanently Restricted</td>
<td>Total</td>
</tr>
<tr>
<td>Revenues and other support:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Interest income from loans</td>
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<td>Administrative grants (Note 8)</td>
<td>233,264</td>
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<td>Increase (decrease) in net assets before income from investments and pension related changes other than net periodic pension costs</td>
<td>241,008</td>
<td>(56,376)</td>
<td>34,345</td>
<td>218,977</td>
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<td>Income from investments:</td>
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<td>Net realized and unrealized (losses) gains on investments (Note 3)</td>
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<td>-</td>
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<td>(31,552)</td>
<td>(113,722)</td>
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<td>Increase (decrease) in net assets before pension related changes other than net periodic pension costs</td>
<td>213,801</td>
<td>(111,339)</td>
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<td>Pension related changes other than net periodic pension costs</td>
<td>43,480</td>
<td>-</td>
<td>-</td>
<td>43,480</td>
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<td>Increase (decrease) in net assets</td>
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<td>2,793</td>
<td>148,735</td>
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<td>Net assets, beginning of year</td>
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<td>1,023,404</td>
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<td>Net assets, end of year</td>
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See accompanying notes to combined financial statements.
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<td>(473,562)</td>
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<td>$9,941,714</td>
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</table>

-3-
Mr. Speaker, members of the House of Delegates, the Committee on Rules and Credentials has considered all the items in the above index.

Resolutions must be submitted 30 days before the scheduled opening of the House to be timely and automatically accepted as business. This year’s resolution deadline was September 22, 2016. The Rules and Credentials Committee meets the day before the House opens to recommend whether resolutions submitted after the deadline should be accepted as business. The final decision is made by the House. A late resolution may be added to the House’s business only if the House votes to accept it as business by either a two-thirds vote in the case of a late resolution submitted prior to adjournment of the committee or a three-quarters vote in the case of a late resolution submitted after the committee’s adjournment. The committee does not address the merits of the late resolutions – only whether there is sufficient basis to waive the resolution deadline.

1. Late Resolution A: Supporting County Medical Societies

Mr. Speaker, your Committee on Rules and Credentials recommends that
Late Resolution A not be accepted for business of the House.

This resolution articulates the concern that the original funding for the creation of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) in 1976 included an all-member assessment for all county and state medical society members. In addition, the resolution expresses the concern that many of the county medical societies are at risk of exhausting or have exhausted their reserves while maintaining an active role in their communities and in service to their members.

The resolution recommends that the Pennsylvania Medical Society (PAMED) reiterate its support for county medical societies throughout Pennsylvania as essential local organizations, and work together with leadership and staff of the county medical societies as equal partners to develop programs which meet the needs of local communities and the general membership of the societies.

The resolution also recommends that the House of Delegates approve a plan to allocate up to $4 million from the PAMED endowment fund to be used to assist financially struggling component societies in establishing their own modest reserves and to be able to deal with their ongoing costs without a complete reliance on dues as the primary source of income for the societies.

The resolution was submitted late because when the representative from the International Medical Graduate (IMG) section attempted to present the resolution, the representatives were told that there would be no time to discuss the resolution.
The resolution is necessary because the county medical societies are struggling with their reserves and counties will play a critical component in the implementation of the clinical integrated network (CIN). As potential marketers of this initiative to the medical community at the local level, counties will need financial support to do the work required to engage members in the CIN.

The committee does not recommend that Resolution A be accepted for business of the House. Although the resolution meets the requirement for lateness, the urgency articulated did not rise to the level of a compelling need for the House to consider the resolution at this meeting.

2. Late Resolution B: Using the Endowment Funds to Lower Dues

Mr. Speaker, your Committee on Rules and Credentials recommends that Late Resolution B not be accepted for business of the House.

This resolution articulates the concern that efforts of state and county medical society leadership and staff to recruit and retain members are stymied by the high cost of combined dues for the state and county societies. The resolution further states that special membership dues discounts for new members and discounted rates for group practice members have had an impact on county medical societies and, as a result, they are no longer able to rely on membership dues as sole sources of revenue.

The resolution recommends that PAMED along with representatives of the county medical societies coordinate and implement a plan to apply funds from the PAMED reserves and offer all members affordable dues at the rate no greater than $300 per year/per member, to include both county and state society dues.

The resolution also recommends that PAMED fully subsidize all county societies for all county society revenue lost due to the new dues levels.

The resolution was submitted late because when the representative from the International Medical Graduate (IMG) section attempted to present the resolution, the representatives were told that there would be no time to discuss. The resolution is necessary because the county medical societies are struggling with their reserves and, based on the data received from the Avenue M report commissioned by PAMED, the time to implement this initiative is now.

The committee does not recommend that Resolution B be accepted for business of the House. Although the resolution meets the requirement for lateness, the urgency articulated did not rise to the level of a compelling need for the House to consider the resolution at this meeting—lowering dues in not a new issue and does not satisfy that the requirement for a late resolution.
Respectfully submitted,

____________________________________________  
George R. Green, MD

____________________________________________  
Mark Friedlander, MD

____________________________________________  
Tani Malhorta, MD

____________________________________________  
Timothy D. Welby, MD

____________________________________________  
Virginia E. Hall, MD, Chair
Mr. Speaker, The Committee on Rules and Credentials recommends the following consent calendar:

Recommended for Continuation without Amendment

1. Standing Rules Nos. 1-18

Mr. Speaker, members of the House of Delegates, the Committee on Rules and Credentials has considered all the items in the above index.

The Standing Rules establish procedures for the orderly transaction of business at meetings of the House of Delegates. The rules in effect as of the most recent meeting remain in effect unless altered or rescinded by the House of Delegates by a two-thirds favorable vote of the seated delegates. The Committee on Rules and Credentials is responsible for proposing necessary or desirable changes to the rules.

1. STANDING RULES NOS. 1-18

Mr. Speaker, your Committee on Rules and Credentials recommends that Standing Rules Nos. 1 through 18 of the House of Delegates, as published in the 2016 Official Reports Book, remain in effect with no amendments.

There was no discussion regarding Standing Rules Nos. 1-18 and the committee agreed that they should remain in effect.
Respectfully submitted,

__________________________
George R. Green, MD

__________________________
Mark Friedlander, MD

__________________________
Tani Malhorta, MD

__________________________
Timothy D. Welby, MD

__________________________
Virginia E. Hall, MD, Chair
STANDING RULES OF THE HOUSE OF DELEGATES

Standing Rule No. 1
Order of Business, Annual Meeting
(Revised October 21, 1983; Editorially Revised October 27, 1995)

The order of business, as published in the Official Reports Book, shall be the official order of business for all sessions of the House of Delegates. This may be revised by the Speaker to expedite the business of the House, subject to any objection sustained by the House.

Standing Rule No. 2
Procedure for Submitting Resolutions
(Revised Nov. 6, 1981; Oct. 23, 1987; October 19, 1990; October 23, 1992; October 27, 2001; October 19, 2002; October 16, 2005; and October 23, 2010; Editorially Revised October 27, 1995)

Resolutions may be submitted at any time prior to thirty (30) days before a meeting of the House of Delegates to become the business of the House. Resolutions received after that date will be posted on the website prior to the meeting to the extent feasible. Those resolutions submitted later than 30 days prior to a meeting shall be posted on the website, but to become the business of the House shall require a two-thirds favorable vote of the House members present and voting at the first session. Resolutions requiring a vote of the House are to be accompanied by an explanation for lateness. Such resolutions will be reviewed by the Committee on Rules and Credentials, which will recommend to the House whether they should be accepted or rejected as House business. Authors may be present at the Committee on Rules and Credentials meeting to explain their resolution. The foregoing rule shall not apply to substitute resolutions. Any resolution submitted after the Committee on Rules and Credentials has adjourned will require a three-fourths favorable vote of the members of the House present and voting to become the business of the House.

All resolutions must be introduced by a member of the House of Delegates either acting as an individual or as a representative for a component society, specialty, or section.

Resolutions emanating from a business meeting of an officially-recognized section of the Pennsylvania Medical Society may be presented for consideration by the House of Delegates at any time before the close of business at the opening session of the House. Discretion is urged in the number and timeliness of the subjects of the resolutions introduced.

Resolutions emanating from, and approved by, the Board of Trustees may be submitted directly to the House of Delegates at any time prior to or during the meeting at the discretion of the Speaker.

All resolutions are to be submitted to the Secretary of this Society and are to include the names of the author and the introducer.

The Speaker of the House of Delegates, during the meeting of the House, shall have the right to declare any resolution out of order in accordance with the principles of the parliamentary authority designated in the bylaws.

Standing Rule No. 3
Procedure for Review of Reference Committee Reports
(Revised October 23, 1972; Editorially Revised Nov. 6, 1981 & October 27, 1995)

The Speaker, Vice Speaker, legal counsel, and the executive vice president of this Society, or their designated representatives, shall review with the reference committee chair each reference committee report. This rule shall not prevent a reference committee from submitting any reports that it deems proper.
Standing Rule No. 4

Actions of House in Effect Until Altered by House
(Adopted October 15, 1961; Editorially Revised October 27, 1995)

Any resolution or other action of this House of Delegates shall remain in effect until
countermanded or altered by the House of Delegates unless otherwise specified in the original action
taken by the House of Delegates.

Standing Rule No. 5

Voting Procedure of the House
(Revised October 23, 1972; & October 19, 1990; October 19, 2002;
Editorially Revised Nov. 6, 1981 & October 27, 1995)

To expedite the work of the House, voting will be held during a recess of the House at a time or
times designated by the Speaker. Each delegate seated as of and including the second session of the
House will, during such recess, be certified by a member of the Committee on Rules and Credentials as a
delegate at a location which will be announced by the Speaker. At that time, the delegate will vote. The
opening and closing times of the polls will be announced by the Speaker.

Standing Rule No. 6

Procedure Regarding the Report of the Committee to Nominate
Delegates and Alternates to the AMA and Elections of
Delegates and Alternates
(Revised October 23, 1972; October 19, 1990; October 27, 2001;
Editorially Revised Nov. 6, 1981; Revised October 21, 1994; Editorially Revised October 27, 1995)

The report of the Committee to Nominate Delegates and Alternates to the AMA shall be supplied to
the delegates in their Official Reports Book material at the opening session. Nominating speeches may
only be one minute in length for any nominee who does not speak at the Luncheon to Meet the AMA
Delegate and Alternate Delegate Candidates. There will be no seconding speeches. All names on the
ballot shall be listed alphabetically with an asterisk denoting those being nominated by the nominating
committee.

Standing Rule No. 7

Procedure Regarding the Bullet Ballot
(October 18, 1991; Revised October 19, 2002)

The 1991 House of Delegates, following an open hearing of the Reference Committee on Rules and
Credentials, approved the recommendation that the bullet ballot will, henceforth, be discontinued. It is
required that if there are multiple candidates for positions of equal rank, a vote for every position must
be cast. Failure to vote for all positions will invalidate the ballot.

Standing Rule No. 8

(Editorially Revised October 27, 1995; Revised October 16, 2005)

The Speaker shall not recognize the motion to vote immediately or terminate debate as being “in
order” unless both sides of a pending item of business have been heard.

Standing Rule No. 9

Election Rules for Offices Requiring a Majority Vote
(Adopted October 22, 1982; Editorially Revised October 27, 1995)

When a majority vote is not obtained by any one candidate on the first ballot, the names of the two
candidates receiving the most votes will remain on the ballot for the second vote if their combined total
is 50 percent of those voting. If the first two candidates do not have at least 50 percent of the votes, the
candidate who received the third-higher vote will be added to the ballot.
Standing Rule No. 10

Procedures for Nominating Delegates and Alternate Delegates to the AMA
(Adopted October 22, 1982; Revised October 21, 1994, and October 27, 2001;
Editorially Revised October 17, 1995; Amended October 20, 2007)

The election of delegates and alternate delegates to the AMA shall allow a delegate who is
defeated to be a candidate for an alternate delegate seat, and an alternate who is defeated as a
candidate for delegate to be a candidate for an alternate delegate seat. In order to accomplish this, the
election of delegates will take place before the second session of the House. Alternate delegates who
have not completed year one of their two-year term and who wish to run for delegate must resign from
their unexpired term as alternate delegate. Election of alternate delegates will also occur before the
final scheduled session of the House.

Standing Rule No. 11

(Adopted October 21, 1994; Editorially Revised October 27, 1995; Amended October 17, 1997, and
October 16, 1998)

The Speaker shall appoint a sufficient number of delegates to act as Sergeants-at-Arms to maintain
security. The Sergeants-at-Arms shall also serve as the Tellers.

Standing Rule No. 12

(Adopted October 21, 1994)

There shall be a three-minute limit on debate per speaker from the House Floor.

Standing Rule No. 13

(Adopted October 18, 1996)

Members of the House of Delegates who have a substantial financial interest in a commercial
enterprise, which interest will be materially affected by a matter before the House of Delegates, must
publicly disclose that interest before:
- testifying at a reference committee on the matter, or
- speaking on the floor of the House of Delegates on the matter.

Standing Rule No. 14

(Adopted October 18, 1996)

All amendments five words or more in length must be handed to the Speaker in writing; however, it
is preferred that the amendment be taken to the Control Desk to be typed. This should be done in
advance of the amendment being proposed from the floor, when possible. To the extent feasible,
amendments five words or more will be made available to the House either on paper or electronically.

Standing Rule No. 15

(Adopted October 17, 1997)

The Speaker shall have the option to present reference committee reports as a consent calendar.

Standing Rule No. 16

(Adopted October 13, 2000)

The business of the House and its reference committees shall not be interrupted by the use of
electronic devices or the distribution of any materials or information unapproved by the Speaker during
the conduct of its business. All pagers, cellular telephones, and other electronic devices must be placed
in silent mode (e.g., vibrate or inactivated).


Standing Rule No. 17

Referral of Items of Business to the Board

(Adopted October 21, 2006)

Two subsidiary motions to refer items of business from the House of Delegates to the Board of Trustees shall be in order. A motion to “Refer for Study” shall outrank a motion to amend, and a motion to “Refer for Decision” shall outrank the motion to amend and the motion to refer for study. These motions require a second; are debatable; are amendable; and require a majority vote for adoption. The maker of these motions may not interrupt one who has the floor.

Standing Rule No. 18

Parliamentary Authority for October 22-23, 2016 House of Delegates

American Institute of Parliamentarians Standard Code of Parliamentary Procedure shall be the parliamentary authority of the Pennsylvania Medical Society House of Delegates for the October 22-23, 2016 annual meeting.
ORDER OF BUSINESS

Reference Committee A
Jennifer L. Lewis, MD, Chair

Saturday, October 22, 2016
2:00 PM

1. **Subject 1: Membership:** Medical Students
2. **Subject 2: Membership:** Component Societies
3. **Subject 3: Membership:** Affiliate Members—Out of State Physicians
4. **Subject 4: Membership:** Expansion of Affiliate Member Category to Include Physicians 70 Years of Age or Older
5. **Subject 5: Membership:** Administrative Members
6. **Subject 6: Component Societies:** Membership Dues
7. **Subject 7: Component Societies:** Choice of Membership
8. **Subject 8: Dues:** Payment of Dues
9. **Subject 9: Special Sections:** Proposed Name Change from Young Physicians Section to Early Career Physicians Section
10. **Subject 10: House of Delegates:** Composition and Apportionment—Voting Delegates and Alternate Delegates, Medical Schools
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 1—MEMBERSHIP: Medical Students

Currently, the bylaws indicate that medical students are not required to be members of the county medical society. This, however, is not current practice.

The proposed revision would require medical students to be members of a component medical society, as is currently required of all Active members of PAMED.

SUBJECT 2—MEMBERSHIP: Affiliate Members—Component Societies

Currently, the bylaws indicate that PAMED Affiliate Membership is contingent upon the direct application or recommendation and certification by a component society. The bylaws also require the prospective applicant to be an existing member of a component society.

This amendment removes the component medical society certification requirement, and the requirement that the applicant be an existing member of a component medical society to qualify for affiliate membership.

SUBJECT 3—MEMBERSHIP: Affiliate Members—Out of State Physicians

Currently, the bylaws make a distinction between “physicians who have moved out of Pennsylvania and concurrently maintain active membership in the state medical society in the new state of residence” and physicians “who live in a state other than Pennsylvania and concurrently maintains active membership in another medical society.” There does not appear to be a difference between the described characteristics.

To eliminate the redundancy, this amendment deletes the language “physicians who have moved out of Pennsylvania and concurrently maintain active membership in the state medical society in the new state of residence.”

SUBJECT 4—MEMBERSHIP: Expansion of Affiliate Member Category to Include Physicians 70 Years of Age or Older

Currently, the bylaws have a separate category of membership for Associate members: these are physicians who are 70 years of age or over (in the year of application) and have been an active member of PAMED or an active member of a constituent association of the American Medical Association. These members are not required to pay annual dues and are not required to maintain a license.

Additionally, the Associate members are currently split into two categories: Associate members with mail and Associate members with no mail. Individuals in the ‘Associate members with mail’ category pay 10 percent of the full annual assessment each year and continue to receive PAMED communications. Individuals in the ‘Associate members with no mail’ category do not pay dues and do not receive PAMED communications.

This amendment proposes to eliminate the Associate member category. Physicians who are 70 years of age or over (in the year of application) and choose to receive PAMED mail would be moved to the Affiliate category. These individuals would still pay 10 percent of the full annual assessment of state dues; dues payment for the component medical society would be at the component medical societies’ discretion.
Physicians who are 70 years of age or over (in the year of application) and choose not to receive PAMED mail would be grandfathered into the proposed iteration of the bylaws; these individuals would retain the “Associate member” title and would neither pay dues nor receive PAMED communications.

Since the Associate member category would be eliminated, this membership option and title would no longer be available for prospective members.

**SUBJECT 5—MEMBERSHIP: Administrative Members**

Currently, administrative members are exempt from paying dues, if 50% or more of the physicians in their practice were members of PAMED in the preceding membership year. This amendment proposes to change the dues exemption so that it is only applicable to administrative members who have 50% or more of their practice’s physicians in the current membership year.

**SUBJECT 6—COMPONENT SOCIETIES: Membership Dues**

Currently, the bylaws state that “[t]he executive vice president or the secretary or treasurer of each component society shall…render an annual dues statement to each member of said component medical society….” In practice, only PAMED disseminates the dues statements and collects dues for the component medical societies. The monies are then distributed twice a month to each component society.

This amendment proposes to remove the language that refers to the secretary/treasurer of a component medical society rendering annual dues statements and submitting said dues statements to the Society.

**SUBJECT 7—COMPONENT SOCIETIES: Choice of Membership**

Currently, the bylaws give physicians a choice of membership, allowing those who either (1) live near a county line, or (2) living in one county and maintaining an office in another, to choose to hold membership in the component medical society most convenient to them, on permission of the trustee of the district in which the physician member resides.

In practice, the Society also allows physicians who live in one county and are affiliated with a hospital in another county to choose to hold membership in the component medical society most convenient to them. The proposed amendment would reflect this current practice.

**SUBJECT 8—DUES: Payment of Dues**

Currently, the bylaws state that “annual dues shall be paid to [t]he executive vice president of this Society or to the member’s component society.

In practice, annual dues are paid only to the Society. The monies are then distributed twice a month to each component society.

To reflect practice, this amendment proposes to remove the language that refers to the member’s component society as part of the dues collection process.

**SUBJECT 9—SPECIAL SECTIONS: Proposed Name Change from Young Physicians Section to Early Career Physicians Section**

The Young Physicians Section (YPS) would like to change its section name to the Early Career Physicians Section (ECPS) as a result of member input and trend analysis. The age at which students are entering medical school has increased throughout the United States and physicians who are entering practice are not necessarily “young” in the traditional context of the word.
Individuals may begin their medical careers at all different ages and referring to them as “Early Career” versus “Young” demonstrates a recognition of and respect for the changing demographic.

The proposed amendment would remove all references in the bylaws to the Young Physicians Section (YPS) and replace with the name the Early Career Physicians Section.

**SUBJECT 10—HOUSE OF DELEGATES: Composition and Apportionment—Voting Delegates and Alternate Delegates, Medical Schools**

Currently, voting delegates and alternate delegates include medical school students who are designated by their medical school dean and are active members of the Pennsylvania Medical Society.

To keep medical students engaged at the county level, the proposed amendment would require that medical students designated by their medical school dean (as a voting delegate or an alternate voting delegate) be an active member of the Pennsylvania Medical Society and their county medical societies.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 1—MEMBERSHIP: Medical Students

Currently, the bylaws indicate that medical students are not required to be members of the county medical society. This, however, is not current practice.

The proposed revision would require medical students to be members of a component medical society, as is currently required of all Active members of PAMED.
Amend the bylaws as follows:

CHAPTER I
MEMBERSHIP

SECTION 3 - Membership Categories

a. Active Member

1. Persons who hold the degree of Doctor of Medicine or Osteopathy or the equivalent from a recognized accredited medical school, and who hold or are eligible to hold an unrestricted license to practice medicine and surgery in Pennsylvania, are eligible for active membership in this Society. Upon admission to membership, such members shall have the right to vote and hold office in this Society.

2. Residents and fellows serving in residency or fellowship programs approved by this Society are eligible for active membership in this Society. Upon admission to membership, such members shall have the right to vote and hold office in this Society.

3. Medical students enrolled in a medical school approved by this Society are eligible for active membership in this Society. They shall make application directly to this Society. Such students are entitled to all rights and privileges of membership. Medical student active members shall pay such amount as is fixed each year by the Board of Trustees.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 2—MEMBERSHIP: Affiliate Members—Component Societies

Currently, the bylaws indicate that PAMED Affiliate Membership is contingent upon the direct application or recommendation and certification by a component society. The bylaws also require the prospective applicant to be an existing member of a component society.

This amendment removes the component medical society certification requirement, and the requirement that the applicant be an existing member of a component medical society to qualify for affiliate membership.
Subject 2: Delete language which requires applicant to be certified by a component medical society to qualify for affiliate membership. Delete language which requires applicant to be an existing member of a component medical society to qualify for affiliate membership.

Amend the bylaws as follows:

CHAPTER I
MEMBERSHIP

b. Affiliate Member

Upon direct application or recommendation and certification by a component society, a member of a component society physician not engaged in active practice within the jurisdiction of the component society may be an affiliate member of this Society and remain as such providing the individual is one of the following: (1) a physician who is a member of a national medical society of a foreign country; (2) an American physician who is engaged in missionary or philanthropic labors who may or may not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (3) a full-time teacher of medicine or of the arts and sciences allied to medicine who does not have a license to practice medicine and surgery in the Commonwealth of Pennsylvania; (4) a physician who is engaged in research or administrative medicine in Pennsylvania who does not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (5) a physician who is retired from active practice; (6) a physician who has moved out of Pennsylvania and concurrently maintains active membership in the state medical society in the new state of residence; or (7) a physician who resides in a state other than Pennsylvania and concurrently maintains active membership in another state medical society.

An affiliate member may vote, hold office, and serve as a member of any workgroup or committee on the state and county levels.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 3—MEMBERSHIP: Affiliate Members—Out of State Physicians

Currently, the bylaws make a distinction between “physicians who have moved out of Pennsylvania and concurrently maintain active membership in the state medical society in the new state of residence” and physicians “who live in a state other than Pennsylvania and concurrently maintains active membership in another medical society.” There does not appear to be a difference between the described characteristics.

To eliminate the redundancy, this amendment deletes the language “physicians who have moved out of Pennsylvania and concurrently maintain active membership in the state medical society in the new state of residence.”
Amend the bylaws as follows:

**CHAPTER I**

**MEMBERSHIP**

**SECTION 3 - Membership Categories**

... 

b. **Affiliate Member**

Upon direct application or recommendation and certification by a component society, any member of a component society not engaged in active practice within the jurisdiction of the component society may be an affiliate member of this Society and remain as such providing the individual is one of the following: (1) a physician who is a member of a national medical society of a foreign country; (2) an American physician who is engaged in missionary or philanthropic labors who may or may not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (3) a full-time teacher of medicine or of the arts and sciences allied to medicine who does not have a license to practice medicine and surgery in the Commonwealth of Pennsylvania; (4) a physician who is engaged in research or administrative medicine in Pennsylvania who does not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (5) a physician who is retired from active practice; (6) a physician who has moved out of Pennsylvania and concurrently maintains active membership in the state medical society in the new state of residence; or (7) a physician who resides in a state other than Pennsylvania and concurrently maintains active membership in another state medical society.

An affiliate member may vote, hold office, and serve as a member of any workgroup or committee on the state and county levels.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 4—MEMBERSHIP CATEGORIES: Expansion of Affiliate Member Category to Include Physicians 70 Years of Age or Older

Currently, the bylaws have a separate category of membership for Associate members: these are physicians who are 70 years of age or over (in the year of application) and have been an active member of PAMED or an active member of a constituent association of the American Medical Association. These members are not required to pay annual dues and are not required to maintain a license.

Additionally, the Associate members are currently split into two categories: Associate members with mail and Associate members with no mail. Individuals in the ‘Associate members with mail’ category pay 10 percent of the full annual assessment each year and continue to receive PAMED communications. Individuals in the ‘Associate members with no mail’ category do not pay dues and do not receive PAMED communications.

This amendment proposes to eliminate the Associate member category. Physicians who are 70 years of age or over (in the year of application) and choose to receive PAMED mail would be moved to the Affiliate category. These individuals would still pay 10 percent of the full annual assessment of state dues; dues payment for the component medical society would be at the component medical societies’ discretion.

Physicians who are 70 years of age or over (in the year of application) and choose not to receive PAMED mail would be grandfathered into the proposed iteration of the bylaws; these individuals would retain the “Associate member” title and would neither pay dues nor receive PAMED communications.

Since the Associate member category would be eliminated, this membership option and title would no longer be available for prospective members.
Subject 4: Add physicians who are 70 years of age or over to the Affiliate member category. Delete the Associate member category.

Amend the bylaws as follows:

CHAPTER I
MEMBERSHIP

SECTION 3 - Membership Categories

b. Affiliate Member

Upon direct application or recommendation and certification by a component society, any member of a component society not engaged in active practice within the jurisdiction of the component society may be an affiliate member of this Society and remain as such providing the individual is one of the following: (1) a physician who is a member of a national medical society of a foreign country; (2) an American physician who is engaged in missionary or philanthropic labors who may or may not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (3) a full-time teacher of medicine or of the arts and sciences allied to medicine who does not have a license to practice medicine and surgery in the Commonwealth of Pennsylvania; (4) a physician who is engaged in research or administrative medicine in Pennsylvania who does not have an unlimited license to practice medicine and surgery in the Commonwealth of Pennsylvania; (5) a physician who is retired from active practice; (6) a physician who has moved out of Pennsylvania and concurrently maintains active membership in the state medical society in the new state of residence; or (7) a physician who resides in a state other than Pennsylvania and concurrently maintains active membership in another state medical society or (7) a physician who is 70 years of age or over.

An affiliate member may vote, hold office, and serve as a member of any workgroup or committee on the state and county levels.

c. Associate Member

An associate member shall be a physician who is 70 years of age or over (in the year of application) and has been an active member of this Society or an active member of a constituent association of the American Medical Association. An associate member shall not be required to pay any annual dues and shall not be required to maintain a license.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 5—MEMBERSHIP: Administrative Members

Currently, administrative members are exempt from paying dues, if 50% or more of the physicians in their practice were members of PAMED in the preceding membership year. This amendment proposes to change the dues exemption so that it is only applicable to administrative members who have 50% or more of their practice’s physicians in the current membership year.
Subject 5: Change the dues exemption for administrative members so that the exemption is only applicable to administrative members who have 50% or more of their practice’s physicians in the current membership year.

Amend the bylaws as follows:

CHAPTER I
MEMBERSHIP

SECTION 3 - Membership Categories

... e. Administrative Member

An administrative member shall be (1) a county society executive, who may or may not be a physician, (2) an administrator from a practice with at least one physician member, or (3) a hospital medical staff coordinator who meets the State Society’s membership guidelines. An administrative member shall be exempt from paying dues except for medical practice administrators from a practice with less than a 50 percent physician membership level, as of the preceding current membership year. An administrative member may not vote or hold office, but may serve as a non-voting member of any workgroup or committee provided that the percentage of administrative members does not exceed 25 percent.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 6—COMPONENT SOCIETIES: Membership Dues

Currently, the bylaws state that “[t]he executive vice president or the secretary or treasurer of each component society shall…render an annual dues statement to each member of said component medical society….” In practice, only PAMED disseminates the dues statements and collects dues for the component medical societies. The monies are then distributed twice a month to each component society.

This amendment proposes to remove the language that refers to the secretary/treasurer of a component medical society rendering annual dues statements and submitting said dues statements to the Society.
Subject 6: Remove the language that refers to the secretary/treasurer of a component medical society rendering annual dues statements and submitting said dues statements to the Society.

Amend the bylaws as follows:

CHAPTER II
COMPONENT SOCIETIES

SECTION 7 - Membership Dues

The executive vice president of this Society or the secretary or the treasurer of each component society shall, prior to January 1 of each year, render an annual dues statement to each member of said component society, indicating the date that payment is due to this Society, and the date it will be considered delinquent. The Board of Trustees shall set the delinquent and termination dates for non-payment of dues. The executive vice president may provide for installment payment of dues. New members shall be notified by a similar statement from the executive vice president of this Society or the component society that the annual dues are payable before final acceptance into membership. The secretary or treasurer of the component society shall promptly remit all dues of this Society to the office of the executive vice president.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 7—COMPONENT SOCIETIES: Choice of Membership

Currently, the bylaws give physicians a choice of membership, allowing those who either (1) live near a county line, or (2) living in one county and maintaining an office in another, to choose to hold membership in the component medical society most convenient to them, on permission of the trustee of the district in which the physician member resides.

In practice, the Society also allows physicians who live in one county and are affiliated with a hospital in another county to choose to hold membership in the component medical society most convenient to them. The proposed amendment would reflect this current practice.
Subject 7: Amend bylaws to allow physicians who live in one county and are affiliated with a hospital in another county to choose to hold membership in the component medical society most convenient to them.

Amend the bylaws as follows:

CHAPTER II
COMPONENT SOCIETIES

...  

SECTION 9 - Choice of Membership

A physician living near a county line or living in one county and maintaining an office or affiliated with a hospital in another county may hold membership in the component society most convenient on permission of the trustee of the district in which the member resides. No person may concurrently hold membership in more than one component society, except that a member who has full membership in one county medical society in Pennsylvania may be eligible to hold affiliate membership in any other county medical society in the state.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 8—DUES: Payment of Dues

Currently, the bylaws state that “annual dues shall be paid to [t]he executive vice president of this Society or to the member’s component society.

In practice, annual dues are paid only to the Society. The monies are then distributed twice a month to each component society.

To reflect practice, this amendment proposes to remove the language that refers to the member’s component society as part of the dues collection process.
Subject 8: Remove the language that refers to the member’s component society as part of the dues collection process.

Amend the bylaws as follows:

CHAPTER III

DUES

SECTION 4 - Payment of Dues

The annual dues shall be paid to the executive vice president of this Society or to the member’s component society. The Board of Trustees shall set the delinquent and termination dates for non-payment of dues. The executive vice president may provide for installment payment of dues. A special assessment shall be paid directly to the executive vice president prior to the due date of any special assessment.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 9—SPECIAL SECTIONS: Proposed Name Change from Young Physicians Section to Early Career Physicians Section

The Young Physicians Section (YPS) would like to change its section name to the Early Career Physicians Section (ECPS) as a result of member input and trend analysis. The age at which students are entering medical school has increased throughout the United States and physicians who are entering practice are not necessarily “young” in the traditional context of the word. Individuals may begin their medical careers at all different ages and referring to them as “Early Career” versus “Young” demonstrates a recognition of and respect for the changing demographic.

The proposed amendment would remove all references in the bylaws to the Young Physicians Section (YPS) and replace with the name the Early Career Physicians Section.
Subject 9: Remove all references in the bylaws to the Young Physicians Section and replace with the name the Early Career Physicians Section.

Amend the bylaws as follows:

CHAPTER VIII

HOUSE OF DELEGATES

a. Voting delegates shall be:

... 

4. One delegate from each medical school in Pennsylvania, who is a member of the medical student section and is elected by that section; ten delegates from the residents and fellows section; four delegates from the young physicians section early career physicians section; and one delegate from each medical school in Pennsylvania, who is an active member of the Pennsylvania Medical Society, who is designated by the dean.

d. Alternate Delegates - Component societies are entitled to elect two alternate delegates for each delegate. Alternates may be seated as determined by the chair of the delegation of each component society, or in the absence of a chair, the secretary of the county society, or in the absence of either person, by the Committee on Rules and Credentials. A delegation chair may not unseat a delegate involuntarily.

Each specialty shall be entitled to elect one alternate who shall be an active or associate member in good standing of this Society.

Each special section shall be entitled to elect alternates who also are members of that section as follows: one medical student from each medical school in Pennsylvania; ten from the residents and fellows section; four from the young physicians section early career physicians section; and one alternate from each medical school in Pennsylvania, who is an active member of the Pennsylvania Medical Society, who is designated by the dean.

...

CHAPTER XIV

THE BOARD OF TRUSTEES

SECTION 3 - Composition

The Board of Trustees shall consist of the following: Officers: the president, the president elect, the vice president, the immediate past president, the speaker of the House of Delegates, the vice speaker of the House of Delegates. Districts: one trustee who is an active or associate member in good standing of this Society from each district. Special Sections: one trustee to represent resident and fellow physicians who is an active member in good standing of this Society and who, at the time of election, is a resident or fellow
... 

SECTION 5 - Nomination and Election of Trustees

Nomination for a district trustee shall be made from the floor of the House by voting members of the House from the district to be represented, or shall be published in the Official Call. Nominations for the residents and fellows trustee, medical student trustee, young early career physicians trustee, and international medical graduates trustee shall be made from the floor of the House only by seated delegates from the residents and fellows, medical student, young early career physicians, or international medical graduates section respectively, or published in the Official Call upon recommendation of the respective section or district. Nominations for the thirteen specialty trustees shall be made from the floor of the House only by seated specialty delegates, or published in the Official Call. Initial nominations for specialty trustee candidates shall be for both the position and initial terms and shall be made by the individual specialty organizations and submitted to the Specialty Leadership Cabinet, who shall consider all nominations and submit their final nominees to the House of Delegates through seated specialty delegates. The Specialty Leadership Cabinet is an advisory group to the Pennsylvania Medical Society’s Board of Trustees comprised of the current presidents (or their designees) of medical specialty organizations which are organized in Pennsylvania and recognized by the Pennsylvania Medical Society and the American Board of Medical Specialties. Functions of the Cabinet include (1) acting as the nominating body for specialty trustees; (2) serving as a forum for collaboration/networking among specialty leadership and Pennsylvania Medical... 

SECTION 6 – Terms

Each trustee, except the residents and fellows, medical student, and young early career physicians trustees, shall be elected for a term of four years. The term of the residents and fellows trustee shall be the lesser of two years or so long as the residents and fellows trustee continues to serve in a residency or fellowship program approved by the Society. Provided, however, if the residents and fellows trustee ceases to serve in a residency or fellowship program less than one hundred twenty days before an annual meeting of the House, then said trustee's term shall expire at the expiration of that annual meeting of the House. The term of the medical student trustee shall be one year with eligibility for reelection so long as the medical student trustee continues to be enrolled in an approved medical school. Provided, however, if the medical student trustee ceases to be enrolled in an approved medical school as a result of graduation, the term of the trustee shall expire at the conclusion of the next annual meeting of the House. The term of the young early career physicians trustee shall be one year so long as the young early career physicians trustee is under 40 years of age or in the first five (5) years of professional endeavor after residency and fellowship training programs at the time of election.
CHAPTER XVIII
SPECIAL SECTIONS

SECTION 3 - Young Physicians Early Career Physicians Section

The purpose of the Young Early Career Physicians Section is to increase involvement of young early career physicians in organized medicine and provide a direct means for young early career physician members of the Pennsylvania Medical Society to participate in Society activities and policymaking. Membership in this section shall include all active physician members of the Pennsylvania Medical Society who are under 40 years of age or in the first five (5) years of professional endeavor after residency and fellowship training programs.

The section shall elect from among its members (a) a chair, vice chair, and two members-at-large, and (b) one or more qualified nominees for the position of young physicians trustee to the Society’s Board of Trustees who shall be placed in nomination at the annual meeting of this Society’s House of Delegates by a delegate of the section. The governing council of the section will consist of the chair, vice chair, trustee, and two members-at-large. The immediate past chair of the governing council will serve as an ex officio member. Delegates to the AMA Young Physicians Section and this Society’s House of Delegates will be chosen by the council from among the governing council and from among other young early career physicians who volunteer. The section is entitled to four delegates. The trustee may not serve as a delegate to this Society’s House of Delegates. Terms and duties of officers are as follows: Chair – one-year term with no term limits. Duties include presiding over governing council meetings, assigning tasks to governing council members, and overseeing reports to the Board of Trustees. Vice Chair -- one-year term with no term limits. Duties include chairing meetings in the absence of the chair, and coordinating programs and projects as assigned. Members-at-large -- one-year term with no term limits. Two members-at-large shall be elected and will undertake programs and projects as assigned. The period of time between the conclusion of one annual meeting of the House of Delegates and the conclusion of the next annual meeting shall be considered the term of office. Trustee – serves as Young Early Career Physicians Section trustee of this Society Board and participates in and advises the governing council. The term of office is as set forth in Chapter XIV, Section 6 of these bylaws. The section shall hold an annual business meeting in conjunction with the annual meeting of this Society's House of Delegates. All young physician members of this Society are eligible to attend and participate in the meeting. County and specialty societies will be encouraged to send interested young early career physicians, particularly if they are attending this Society’s annual meeting.
SUMMARY OF PROPOSED BYLAW AMENDMENTS

SUBJECT 10—HOUSE OF DELEGATES: Composition and Apportionment—Voting Delegates and Alternate Delegates, Medical Schools

Currently, voting delegates and alternate delegates include medical school students who are designated by their medical school dean and are active members of the Pennsylvania Medical Society.

To keep medical students engaged at the county level, the proposed amendment would require that medical students who are designated by their medical school dean (as a voting delegate or an alternate voting delegate) be an active member of the Pennsylvania Medical Society and their county medical societies.
Amend the bylaws as follows:

CHAPTER VIII

HOUSE OF DELEGATES

…

SECTION 3 - Composition and Apportionment

The House of Delegates shall be composed of voting delegates and ex officio persons without the right to vote.

a. Voting delegates shall be:

…

4. One delegate from each medical school in Pennsylvania, who is a member of the medical student section and is elected by that section; ten delegates from the residents and fellows section; four delegates from the young physicians section; and one delegate from each medical school in Pennsylvania, who is an active member of the Pennsylvania Medical Society and their county medical society, who is designated by the dean.

d. Alternate Delegates - Component societies are entitled to elect two alternate delegates for each delegate. Alternates may be seated as determined by the chair of the delegation of each component society, or in the absence of a chair, the secretary of the county society, or in the absence of either person, by the Committee on Rules and Credentials. A delegation chair may not unseat a delegate involuntarily.

…

Each special section shall be entitled to elect alternates who also are members of that section as follows: one medical student from each medical school in Pennsylvania; ten from the residents and fellows section; four from the young physicians section; and one alternate from each medical school in Pennsylvania, who is an active member of the Pennsylvania Medical Society and their county medical society, who is designated by the dean.
RESOLUTION 16-201

(Referred to Reference Committee B)

Subject: Elimination of Tobacco Sales

Introduced by: Jonathan E. Rhoads, Jr., MD, on behalf of the York County Medical Society

Author: Jonathan E. Rhoads, Jr., MD

WHEREAS, Tobacco products, especially cigarettes, are widely recognized as risk factors or etiologic agents for cancers arising from many organs, although lung cancer is most frequent and best documented; cancers in organs remote from the lungs such as bladder, pancreas, and breast occur more frequently in individuals who smoke; and

WHEREAS, Other diseases such as emphysema and atherosclerosis leading to coronary artery disease, stroke, and peripheral vascular disease are generally considered in part to be caused by tobacco smoke; and

WHEREAS, Because of its etiologic role in causing these many diseases, tobacco use shortens the lives of its users and causes much morbidity, this author considers it to be Public Health Enemy Number one; and

WHEREAS, Prevention is cheaper and more effective than cure; and

WHEREAS, President Obama has authorized a major government program to combat cancer called the Cancer Moonshot, and placed Vice President Biden in charge of it; and

WHEREAS, A panel from that program is calling physicians to obtain “more tailored data from individual patients”, and to develop more immunotherapies; and

WHEREAS, Such approaches are scientifically exciting, and are surely expensive, but have yet to achieve impressive outcomes; therefore, be it

RESOLVED, That it be the policy of PAMED to oppose the sale of tobacco products in the United States and its territories; and be it further

RESOLVED, That our AMA be asked to adopt this position; and be it further

RESOLVED, That our AMA ask Vice President Biden to use the resources of the Cancer Moonshot program to eliminate the sale of tobacco products in the United States and its territories.

Fiscal Note:

Relevance to Strategic Plan

201
RESOLUTION 16-202

(Referred to Reference Committee B)

Subject: Further Addressing the Overdose Crisis

Introduced by: Fredric N. Hallman, MD, on behalf of the Delaware County Medical Society

Authors: Board of Directors, Delaware County Medical Society

WHEREAS, The use and abuse of prescription medications, primarily opioids, benzodiazepines, antidepressants and other illegal drugs have become so pervasive as to be considered a public health epidemic; and

WHEREAS, The number of overdose deaths in our country was 30% greater last year (2015) than the previous year (2014), and preliminary data for 2016 indicates it will surpass 2015; and

WHEREAS, The Pennsylvania Medical Society and many component county medical societies have taken a leadership role in education and advocacy to address this crisis; and

WHEREAS, Many very significant barriers continue to exist for patients who are in need of appropriate and sometimes immediate treatment; therefore, be it

RESOLVED, That the Pennsylvania Medical Society work together with other statewide stakeholders to identify and rectify existing barriers for patients seeking care for addiction; and be it further

RESOLVED, That the Pennsylvania Medical Society work together with the county medical societies to identify and rectify barriers at the local level.

Fiscal Note:

Relevance to Strategic Plan

202
RESOLUTION 16-203

(Referred to Reference Committee B)

Subject: Seeking Support of Pennsylvania Immunization Coalition

Introduced by: Robert D. Barraco, MD, MPH, on behalf of the Lehigh County Medical Society

Author: Scott M. Brenner, MD

WHEREAS, Preventive care and population health are increasingly becoming a primary focus of healthcare in the United States; and

WHEREAS, Immunizations are the single most effective resource available to prevent common and often devastating infectious diseases; and

WHEREAS, There is a need for increased awareness and utilization of available immunizations across the State of Pennsylvania; and

WHEREAS, Only approximately half of all counties in Pennsylvania have local immunization coalitions to do this work with varying levels of funding including some with no funding; and

WHEREAS, The Pennsylvania Immunization Coalition serves as an overarching organization to coordinate, promote and advocate for immunization education and increased administration across the state; and

WHEREAS, Any incremental increase in immunization will lead to a significant decrease in healthcare expenses required for caring for patients who acquire vaccine preventable diseases; therefore, be it

RESOLVED, That the State of Pennsylvania provide $200,000 in annual funding for the administration and activities of the Pennsylvania Immunization Coalition to increase awareness and compliance with recommended immunization practices to improve the health of all Pennsylvanians.

Fiscal Note:

Relevance to Strategic Plan

203
RESOLUTION 16-204

(Referred to Reference Committee B)

Subject: Eliminating Barriers to Children Possessing and Using Sunscreen in School

Introduced by: Bruce Brod, MD, on behalf of the Pennsylvania Academy of Dermatology and Dermatologic Surgery

Author: Bruce Brod, MD

WHEREAS, National news media outlets have reported that children in some school districts have been inhibited from using sunscreen in schools without a prescription because of broad reaching ‘medication’ bans and fears of medico-legal exposure; and

WHEREAS, Despite an excellent safety profile, sunscreen is not allowed in many schools without physician authorization; and

WHEREAS, In these cases, sunscreen is usually required to be stored in a locked cabinet in the nurse’s office; and

WHEREAS, The Centers for Disease Control and Prevention believes that school policies that prohibit hats or student possession of sunscreen can create barriers to the use of important sun protection methods; and

WHEREAS, Even one blistering sunburn during childhood or adolescence can nearly double a person’s chance of developing melanoma later in life, while 5 or more blistering sunburns in late adolescence increases one’s melanoma risk by 80 percent and non-melanoma risk by 68 percent; and

WHEREAS, No published studies show that sunscreens that meet FDA standards are toxic to humans or hazardous to human health; and

WHEREAS, The incidence of skin cancer can be reduced by the use of sunscreen and sun-protective clothing; therefore, be it

RESOLVED, That the Pennsylvania Medical Society lobby to allow students to bring and possess sunscreen and sun-protective clothing, including hats, at school and youth camps without requiring physician authorization.

Fiscal Note:

Relevance to Strategic Plan:

204
RESOLUTION 16-205

(Referred to Reference Committee B)

Subject: Transfer of Jurisdiction Over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society

Author: Michael A Loesche, Medical Student, Philadelphia County Medical Society

WHEREAS, The USMLE Step 2 Clinical Skills (CS) exam was previously administered under a different name to assess English language skills of international medical graduates; and

WHEREAS, In 2004, the Step 2 CS exam was modified and appended on to the existing multiple choice Step 2 exam, better known now as “Step 2 Clinical Knowledge (CK)”; and

WHEREAS, Because states’ laws already specified prior to 2004 that physicians pass “Step 2” for licensure, adding “Step 2 CS” as a required part of Step 2 automatically incorporated such exam as a state licensure requirement; and

WHEREAS, Over 90% of all U.S. and Canadian medical schools currently administer an Objective Structured Clinical Examination (OSCE) or variant on this principle, and 74% of all U.S. and Canadian medical schools require a passing score for graduation; and

WHEREAS, Registration fees for USMLE Step 2 CS exam have increased from $1,120 in 2011 to $1,200 in 2013 to $1,250 in 2015; and

WHEREAS, Current costs incurred by medical students to complete the USMLE Step 2 CS exam include a registration fee of $1,275 and all expenses for travel/lodging to visit one of the only five cities in which the exam is administered; and

WHEREAS, Registration fees for COMLEX Level 2-PE have increased from $1,095 in 2009 to $1,150 in 2011 to $1,210 in 2013 to $1,245 in 2015; and

WHEREAS, Current costs incurred by osteopathic medical students to complete the COMLEX Level 2-PE include a registration fee of $1,290 and all expenses for travel/lodging to visit one of the only two cities in which the exam is administered; and

WHEREAS, In 2014, 19,801 medical students took the Step 2 CS exam, amounting to over $25 million in exam fees alone, or up to $36.2 million when including interest rates on medical student loans; and

WHEREAS, A recent study suggested that the true cost for detecting a single “double failure,” a student who failed the Step 2 CS 2-3 times and failed to graduate from medical school, may be as high as $1.1M, which does not include the cost of travel, lodging, or preparation materials; and

WHEREAS, Recent studies found weak correlations between Step 2 CS scores and end-of-year evaluations of internal medicine interns’ communications skills, without controlling for other effects such as school-required clinical skills; and
WHEREAS, Studies have demonstrated clinical skills scores added no additional predictive value beyond the written USMLE exams\textsuperscript{14,15}; and

WHEREAS, The Massachusetts and Michigan State Medical Societies have recently passed their own policies regarding the elimination of Step 2 CS\textsuperscript{16,17}; and

WHEREAS, The American Medical Association recently passed policy supporting the elimination of the USMLE Step 2 CS and COMLEX Level 2 PE examinations; and

WHEREAS, The USMLE Step 2 CS exam and the COMLEX Level 2-PE exam are extraneous financial burdens and unnecessary redundancies for students; therefore, be it

RESOLVED, That the Pennsylvania Medical Society, work with the American Medical Association, the Federation of State Medical Boards (FSMB), and our state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school-administered, clinical skills examination; and be it further

RESOLVED, That the PAMED advocate for medical schools and medical licensure stakeholders to create standards for clinical skills examination that would be administered at each Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school in lieu of United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) and Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) and that would be a substitute prerequisite for future licensure exams.

Fiscal Note: $2000

Relevance to Strategic Plan

205

References:


RESOLUTION 16-206

(Referred to Reference Committee B)

Subject: Pennsylvania Medical Society Support for a Moratorium on Fracking

Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society

Author: Walter Tsou, MD, Philadelphia County Medical Society

WHEREAS, As physicians of Pennsylvania, we care first and foremost about the health of our community and believe that when an activity raises potential harm to human health, precautionary measures should be taken until cause and effect relationships are fully established scientifically; and

WHEREAS, Act 13 (Impact Fee) of 2012 includes a provision that allows disclosure of proprietary chemicals after a physician places a request in writing, but prohibits further disclosure of the chemicals to other doctors or written into medical records, even if needed to properly care for a patient; and

WHEREAS, Hydraulic fracturing, or fracking, is a method of oil and gas removal that involves blasting between 4-6 million gallons of water, sand and chemicals under high pressure deep into the earth to break up the Marcellus Shale to allow oil and gas extraction; and

WHEREAS, The Marcellus Shale covers about 60% of Pennsylvania and much of the mineral rights have been leased to gas drilling companies; and

WHEREAS, The gas drilling industry has identified around 60 chemicals regularly used in fracking and hundreds that could potentially be used; and

WHEREAS, The gas drilling industry has many “proprietary” chemicals which are trade secrets so there is no way to ascertain their toxicity, but fracking routinely employs numerous toxic chemicals, including benzene and other volatile organic compounds; and can also expose humans to harm from lead, arsenic, and radioactivity brought back to the surface with fracking flowback fluid; and

WHEREAS, The gas industry has lobbied to exempt their industry from federal regulations of many important environmental laws, including the Safe Drinking Act, the Clean Air Act, the Clean Water Act, National Environmental Policy Act, Resource Conservation and Recovery Act, and CERCLA (the Superfund Act) hampering any federal oversight of the industry; and

WHEREAS, Many fracking chemicals and the radioactive isotopes of flowback fluid are known carcinogens and evidence is mounting throughout the country that these chemicals are making their way into aquifers and drinking water; and

1http://www.palivablefuture.org/content/statement-commonwealth-supreme-court-hearing-oral-argument-controversial-health-professional
3 Ibid.
4 https://en.wikipedia.org/wiki/Exemptions_for_hydraulic_fracturing_under_United_States_federal_law
WHEREAS, Water quality can be further threatened by methane contamination tied to drilling\(^6\) and the fracturing of rock formations, and highlighted by footage of people in fracked areas setting fire to methane-laced water from kitchen faucets; and

WHEREAS, The Delaware River water basin, which provides the water supply for 15 million people\(^7\) including those in Eastern Pennsylvania, would be put at risk if a fracking accident occurred; and

WHEREAS, About 9% of gas wells leak methane directly into the atmosphere\(^8\), a greenhouse gas which is 86 times more potent than carbon dioxide as a contributor to global warming\(^9\); and

WHEREAS, The impoundment ponds of fracking flowback are subject to leakage and spillovers of toxic chemicals and radioactivity, the disposal of fracking fluid in waste injection wells can cause earthquakes; and

WHEREAS, Many individuals and families have had nosebleeds, dermatological, respiratory, neurological and GI symptoms\(^10\), and the industry has denied any wrongdoing but has forced non-disclosure agreements in exchange for fresh water and money; and

WHEREAS, Pennsylvania’s legislature has refused to create a health registry, collect data, or study the health effects of fracking, essentially obstructing the scientific study of this industry; and

WHEREAS, The August 2016 EPA science advisory board criticized the June 2015 EPA study on hydraulic fracturing noting “that the EPA did not support quantitatively its conclusion about lack of evidence for widespread, systemic impacts of hydraulic fracturing on drinking water resources, and did not clearly describe the system(s) of interest (e.g., groundwater, surface water), the scale of impacts (i.e., local or regional), nor the definitions of ‘systemic’ and ‘widespread’”\(^11\); and

WHEREAS, Many communities who were financial beneficiaries of the shale gas extraction “boom” are now experiencing the environmental damage created by hydraulic fracturing as gas drilling has ceased due to lower oil prices; and

WHEREAS, after careful consideration and using the precautionary principle, the States of New York, Maryland\(^12\), and Vermont\(^13\) have enacted bans or moratoriums on fracking; therefore, be it

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\(^6\) [http://www.pnas.org/content/108/20/8172.full.pdf+](http://www.pnas.org/content/108/20/8172.full.pdf+)

\(^7\) [http://www.delawareriverkeeper.org/delaware-river](http://www.delawareriverkeeper.org/delaware-river)

\(^8\) [http://www.nrel.gov/docs/fy16osti/62820.pdf](http://www.nrel.gov/docs/fy16osti/62820.pdf)


\(^11\) [https://yosemite.epa.gov/sab/sabproduct.nsf/LookupWebReportsLastMonthBOARD/BB6910FEC10C01A18525800C00647104/$File/EPA-SAB-16-005+Unsigned.pdf](https://yosemite.epa.gov/sab/sabproduct.nsf/LookupWebReportsLastMonthBOARD/BB6910FEC10C01A18525800C00647104/$File/EPA-SAB-16-005+Unsigned.pdf)

\(^12\) [http://www.greenpeace.org/usa/where-fracking-was-banned-this-year/](http://www.greenpeace.org/usa/where-fracking-was-banned-this-year/)

RESOLVED, That the Pennsylvania Medical Society urge and support a moratorium on new natural gas extraction using high-volume hydraulic fracturing in Pennsylvania; and be it further

RESOLVED, That the Pennsylvania Medical Society urge the state legislature to fund an independent health registry and commission research studies on the health effects of fracking.

Fiscal Note: $2000

Relevance to Strategic Plan

206
RESOLUTION 16-207

(Referred to Reference Committee B)

Subject: Promote Teen Health Week
Introduced by: Michael DellaVecchia, MD, Philadelphia County Medical Society
Authors: Laura Offutt, MD and the Board of Directors of the Delaware County Medical Society; Michael DellaVecchia, MD and the Board of Directors of the Philadelphia County Medical Society

WHEREAS, The rapid physical and emotional growth of adolescence differs from the needs of children and adults and often includes deleterious, life-affecting choices of interpersonal relationships, diet, exercise, self-harm, substance use, and violence; and

WHEREAS, Health behaviors resulting in adult morbidity and mortality are initiated in adolescence and occur because teenagers are not exposed to positive activities which nurture better health choices; and

WHEREAS, There are observances for specific teen health issues (e.g., Teen Dating Violence Prevention Month, Teen Pregnancy Prevention Month, and Youth Violence Prevention Week) but none for overall Teen Health; and

WHEREAS, The second annual Pennsylvania Teen Health Week (January 9 – 13, 2017) has been organized by representatives of the Delaware County Medical Society, the Philadelphia College of Physicians, the Pennsylvania Department of Education, and the Philadelphia County Medical Society, and has been promoted by the SE PA Area Health Education Center; and

WHEREAS, A Teen Health Week Toolkit has been developed to assist schools and other groups in promoting active teen involvement in this effort; and

WHEREAS, the 2017 Teen Health Week includes publicized kick-off events at the State Capitol with emphasis throughout the week on nutrition & fitness; violence prevention; mental health; sexual health and substance abuse; and

WHEREAS, Pennsylvania Teen Health Week remains the only statewide such observance in the country; therefore, be it

RESOLVED, that The Pennsylvania Medical Society actively promote Teen Health Week and encourage county and specialty associations across the state to join with their local schools to adopt, promote and participate in Teen Health Week; and be it further

RESOLVED, that the Pennsylvania Delegation to the American Medical Association present this resolution to the upcoming interim meeting of the AMA (I-2016) for national adoption.

Fiscal Note: $2000

Relevance to Strategic Plan

207
RESOLUTION 16-208

(Referred to Reference Committee B)

Subject: Support for Liability Protection in Administration of Naloxone in Schools

Introduced by: Frederic S. Becker, MD

Author: Frederic S. Becker, MD

WHEREAS, Opioid-related overdoses are increasing at all age levels, including school-age children; and

WHEREAS, According to the most recent data compiled by the Centers for Disease Control and Prevention (CDC), Pennsylvania ranks #1 in overdose deaths for males age 12-24 and #8 overall in overdose deaths; and

WHEREAS, According to CDC research, almost 1 in 4 teens nationwide reported abusing or misusing a prescription drug at least once, with 16% reporting doing so in the last year; and

WHEREAS, School districts are in a unique position to save lives by providing naloxone to qualified employees of the school district; and

WHEREAS, Pennsylvania schools have been provided with free doses of Naloxone to be administered in cases of suspected opioid overdose; and

WHEREAS, Pennsylvania Act 139 of 2014 provides certain immunity to licensed health care professionals who, acting in good faith prescribe or dispense naloxone for such prescribing or dispensing or any outcomes resulting from the eventual administration of naloxone; and

WHEREAS, Act 139 provides certain immunity to laypersons for the administration of naloxone to a person whom the layperson believes to be suffering an opioid-related overdose; and

WHEREAS, Act 139 does not provide certain immunity to organizations other than law enforcement agencies, fire companies and fire departments; and

WHEREAS, Act 139 does not address nor mandate naloxone education or administration in schools; and

WHEREAS, A majority of school districts in PA presently have not agreed to allow their nurses, teaching staff or administrators permission to use this medication, due to these groups not specifically being named in Act 139 that provides “Good Samaritan” protection to first responder individuals who opt to administer this medication in suspected overdose situations; therefore, be it

RESOLVED, That the Pennsylvania Medical Society seek an amendment to Act 139 to provide specific immunity for school districts and their employees to include school nurses, teachers and administrators for the administration of naloxone on students while on school property with the same Good Samaritan protection provided to other first responders to overdose situations.

Fiscal Note:

Relevance to Strategic Plan
RESOLUTION 16-209

(Referred to Reference Committee B)

Subject: Increase in Availability of Opioid Rescue Medication and Medication-Assisted Treatment

Introduced by: Harry L. Haus, MD, JD, on behalf of the Mercer County Medical Society

Author: Harry L. Haus, MD, JD

WHEREAS, The FDA has issued a warning that opioids can cause addiction, overdoses, and even death; therefore, be it

RESOLVED, That the Pennsylvania Medical Society request that all pharmacies that sell opioids also sell naloxone (Narcan), the rescue drug for opioids and buprenorphine/naloxone, the medication-assisted treatment drug for opioid use disorder.

Fiscal Note: Minimal since these medications are already FDA-approved and covered by insurance.

Relevance to Strategic Plan:
This helps the Pennsylvania Medical Society plan to use naloxone to fight overdoses and the American Medical Association’s position that medication-assisted treatment can help fight the opioid epidemic.

209
Resolution 15-201: Clinical Rotations in Pennsylvania Hospitals for Medical Students of International Medical Schools – Resolution 15-201, introduced at the 2015 annual meeting and referred for study to the Board of Trustees, called on the Society to work with the State Board of Medicine and any other regulatory body to change the current regulation that defines an accredited medical school to include schools accredited by the Liaison Committee on Medical Education (LCME) and any other international medical school meeting the accreditation standard required for Educational Commission for Foreign Medical Graduates (ECFMG) certification.

LEGISLATIVE & REGULATORY BACKGROUND

Under current law and regulations, Pennsylvania does not permit medical students of non-accredited medical schools to complete clinical rotations in Pennsylvania hospitals. This prohibition is due to a combination of legislative and regulatory provisions found in the Medical Practice Act of 1985 (Act) and the State Board of Medicine’s regulations, respectively.

The Act differentiates between “accredited” and “unaccredited” medical colleges. Under section 2 of the Act, 63 P.S. § 422.2, an accredited medical college is defined as “an institution of higher learning which has been fully accredited, by any accrediting body recognized by the board, as an agency to provide courses in the art and science of medicine and surgery and empowered to grant academic degrees in medicine. Any accrediting bodies recognized by the board on the effective date of this act shall continue to serve in that capacity unless and until the board recognizes a successor.” An unaccredited medical college is defined as “an institution of higher learning which provides courses in the art and science of medicine and surgery and related subjects, is empowered to grant professional degrees in medicine, is not accredited by any accrediting body recognized by the board and is listed by the World Health Organization, its successors or assigns, or is otherwise recognized as a medical college by the country in which it is situated. Any accrediting bodies recognized by the board on the effective date of this act shall continue to serve in that capacity unless and until the board recognizes a successor.”

Specifically, as it relates to clinical rotations, the Act uses the term “clinical clerk.” Clinical clerk is defined as “an undergraduate student in good standing in an accredited medical college who is assigned to provide medical services in a hospital by the medical college and the hospital.”

Based upon the definitions of “accredited medical college,” “unaccredited medical college,” and “clinical clerk,” clinical rotations within the Commonwealth are only available to medical students of an accredited medical school. Under the Act, the State Board of Medicine was given the authority to recognize accreditation boards through the regulatory process. Currently, the Board only recognizes the Liaison Committee on Medical Education (LCME) under its definition of “accredited medical college” at 49 Pa. Code § 16.1, which is defined as “an institution of higher learning accredited by the Liaison Committee on Medical Education to provide courses in the arts and sciences of medicine and related subjects and empowered to grant professional and academic degrees in medicine.”

In sum, there is not an outright prohibition on students of international medical schools from performing clinical rotations in Pennsylvania hospitals. If the international medical school is accredited by the LCME (such as medical schools in Canada), then this prohibition does not apply. Therefore, a change in statute would not be required. The most-straightforward path to having the ECFMG become an accredited entity is for the ECFMG to petition the State Board for recognition as an accrediting entity.
RESEARCH ON NEIGHBORING STATES

PAMED researched three border states to determine if those states permit students of international medical schools to perform clinical rotations in those states’ hospitals and what requirements, if any, are placed on those students. In performing this research, PAMED focused on Ohio, New York, and New Jersey. In those states, there is no state law or regulation that prohibits students of international medical schools to perform clinical rotations at hospitals. However, in those states, it is left up to each hospital and/or health system to accept students of international medical schools for these clinical rotations. Hospitals enter into agreements with international medical schools to allow those schools’ medical students to complete clinical rotations within those hospitals. As such, it varies by state which international medical schools have what is in essence privileges at those hospitals that allow students to complete clinical rotations.

Specifically, as to New York, an article was written pertaining to allowing foreign medical students to complete their clinical rotations and/or clerkships in their state. Jo Wiederhorn is president and CEO of the Associated Medical Schools of New York, which represents all 16 medical schools in the state. Wiederhorn has reported and researched New York’s medical school curriculum versus the international medical school(s) curriculum. Through research, the article states and explains how and why foreign medical curriculums do not meet the standards and expectations as it relates to medical training and clinical knowledge here in the United States. New York medical schools believe their students should fill all clinical rotation slots and should not have to compete with foreign medical students due to lack of slots across the state already.

The Society also researched Texas. At this time, Texas does not permit international medical students to complete their clinical rotations in Texas facilities. Research indicates two reasons for this stance: the number of slots available for medical students and accreditation of schools outside the country. Caribbean medical schools have proposed to Texas to allow bringing third and fourth year students for clinical training in Texas and provide schools with a certificate of authority to do this. This proposal includes a provision that only students who have graduated from within the state of Texas would be eligible, but there was no mention of the schools’ accreditation or standards. The state’s nine medical schools oppose this proposal because they believe the influx of foreign medical school students will displace students at Texas medical schools from required training slots that are in short supply and that were designed to fit the accreditation criteria for Texas medical schools.

Texas, like many states, is facing a physician shortage due to population growth and available student slots. Subsequently, Texas is working to increase the number of medical school student slots. However, many hospitals have had to downsize and are therefore unable to increase the available slots. With the capacity and bed space down, it has affected the ability of Texas hospitals to slot students into rotations. In addition, the nine medical schools are concerned that they could wind up in bidding wars with the for-profit international medical schools by having to pay more to hospitals for additional slots, which could result in higher tuition to cover the cost. The Texas Higher Education Coordinating Board has delayed any action until more research is done to understand these issues more fully.

STATE BOARD OF MEDICINE

For clinical rotation purposes, the State Board of Medicine’s position is that it is required by statute to only recognize medical schools that have been accredited by an accrediting body recognized by the State Board. Therefore, under current law, the State Board would need to approve any entity, as it did with the LCME, that wishes to become an approved accrediting body. In order to do so, the Board will require that the entity make a request to give a presentation before the State Board at a public meeting. The applicant would have to show that its standards are equivalent or better than the standards of the LCME. Based on this information, PAMED would not be able to petition the State Board on its own to recognize entities in addition to the LCME. The applicant-accrediting body would have to make its own
presentation and be the primary participant. PAMED would, however, be able to provide its views on any
petition filed with the State Board in support of (or if the circumstances warrant, in opposition of) an
accrediting body’s application.

PROS & CONS FOR THIS ISSUE

PROS

1. More medical students will be available to hospitals for clinical rotation spots.
2. The Hospital & Healthsystem Association of Pennsylvania (HAP) supports this resolution.
3. Pennsylvania residents who are attending an international medical school would have the
   opportunity to return to the Commonwealth for clinical rotations.
4. Hospitals and health systems that may have trouble filling its slots would benefit from having
   additional students eligible for clinical rotation spots.
5. Allowing international medical students from non-LCME accredited schools to do clinical
   rotations in Pennsylvania may help address the increasing demand for physicians in Pennsylvania
   because some of those students may choose to practice in Pennsylvania upon licensure.
6. International Medical Schools will compensate healthcare systems which will create higher
   revenues for the hospitals and/or institutions.

CONS

1. Fewer clinical rotation spots will be available to students of Pennsylvania medical schools.
2. Concerns from legislators and/or State Board members that non-accredited medical schools do
   not have the same standards as accredited medical schools.
3. The ability of international medical schools to monitor their students’ performance from a
   distance.
4. International medical schools often pay more money to hospitals for their students to obtain
   clinical rotation experience versus American medical schools. If there are fixed and limited
   numbers of clerkship slots, it could result in a "bidding war" between PA medical schools and
   international medical schools to pay for slots to allow their medical students to secure clinical
   rotations. As an example, in New York, critics of this system have argued that selection for
   medical school rotations will move from a merit-based system to one driven by a financial
   incentive.
5. There is no guarantee that international medical students who secure clinical rotations in
   Pennsylvania will seek residency programs in the Commonwealth or ultimately seek to practice
   in Pennsylvania.
6. Hospitals and/or systems have to approve international medical school students to complete their
   clinical rotations. It is hospital dependent across all states.
7. If medical schools are not supportive of this concept, it could impact PAMED’s relationship with
   medical school programs and, subsequently, hurt membership.
8. International graduate medical school programs do not correlate with the United States medical
   school programs. Not all international medical school curriculums meet the standards of the
   LCME’s education and/or instruction.

CONCLUSION

Given the research performed and information provided, it is recommended that this resolution not be
adopted by the House of Delegates. While a laudable goal, the following facts are problematic in having
the House support this resolution:

• Concern that this resolution will alienate medical schools and their deans in Pennsylvania.
• Concern that PA medical schools will get into a bidding war with for-profit international medical schools and will be unable to compete with them on an ongoing basis. It would be difficult to have any legislation be enacted to cap the amount of money that medical schools and hospitals could negotiate, as this would be impairing the right to contract, which is guaranteed in the Pennsylvania Constitution.

• The fact that there is no indication that the ECFMG is trying to become an accrediting body in Pennsylvania. As stated by counsel for the State Board, the ECFMG would have to be an entity that would apply for accreditation and not PAMED.

PAMED does need to weigh the pros of opening up clinical rotations for students of international medical schools with the cons of possibly being at odds with Pennsylvania medical schools. There are a limited number of clinical rotation spots within Pennsylvania, and adding additional students to the rotation pool will likely result in medical students from Pennsylvania schools being left out of Pennsylvania-based clinical rotation spots. In addition, adding more supply than demand could lead to bidding wars between international medical schools and Pennsylvania medical schools, where schools will essentially be required to pay higher prices to secure clinical rotation spots.

Due to the concerns raised, the fact that at this time no entity has requested PAMED’s assistance to gain accreditation status, and the fact that PAMED will be unable to act on its own to obtain accreditation status for a third-party such as the ECFMG, it is recommended that this resolution not be approved.

RECOMMENDATION

1. The Board of Trustees recommends that this report be adopted in lieu of Resolution 15-201.

David A. Talenti, MD
Chair
RESOLUTION 16-301

(Referred to Reference Committee C)

Subject: Standardize Observation Status Among Insurers

Introduced by: Amelia A. Paré, MD, Chair, and Sharon L. Goldstein, MD, Vice Chair, on behalf of the Allegheny County Medical Society

Author: Lawrence R. John, MD

WHEREAS, Patients experiencing symptoms of an illness that they believe to be serious and life-threatening present at hospital emergency departments; and

WHEREAS, Patients are treated for their reported symptoms; and

WHEREAS, The patients’ insurers may later make a determination that the patients will be considered to have been in observation status rather than to have been admitted; and

WHEREAS, The determination by the patients’ insurers that they were “observation status” rather than “admitted” means that their insurance coverage will not provide the level of financial coverage that the patients believed they had; and

WHEREAS, This can result in significant and unexpected financial expenses to patients; and

WHEREAS, The use of observation status was created by CMS for the Medicare program, and was then adopted by private insurance carriers; and

WHEREAS, Pennsylvania passed legislation that requires hospitals to advise patients that they may be in observation status but the determination is made by insurers and not by physicians or hospital staff; and

WHEREAS, Every carrier uses different criteria that they claim are “proprietary” and are not available to patients, physicians or hospital staff; and

WHEREAS, Patients, some with serious medical conditions, may leave the hospital due to concerns over insurance coverage; therefore, be it

RESOLVED, That the Pennsylvania Medical Society seek through enactment of legislation or regulation the requirement that all insurers or their agents make publicly available the criteria that are used to determine observation status; and be it further

RESOLVED, That a determination of observation or admitted be made by the insurer at the time the patient presents for treatment based upon the information available to the attending physician and nursing staff; and be it further

RESOLVED, That the Pennsylvania Medical Society and the Commonwealth seek that the criteria used to determine observation status be standardized across insurers; and be it further

RESOLVED, That a clear and rapid process of appeal and review that includes the recommendations of the attending physician be defined and implemented.
Fiscal Note:

Relevance to Strategic Plan

301
RESOLUTION 16-302

(Referred to Reference Committee C)

Subject: Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing

Introduced by: Gwendolyn Poles, D.O., Dauphin County Medical Society

Author: Gwendolyn Poles, DO

WHEREAS, Insurers often retrospectively refuse payment for studies and testing that do not routinely require prior authorization; and

WHEREAS, Insurers use Medical Policies that are not routinely updated to reflect the ever-changing practice guidelines; and

WHEREAS, Insurers use medical codes as a method to limit and deny payment for services that otherwise would be covered; and

WHEREAS, Many rare and uncommon disease states require testing and studies otherwise reserved for populations in which screening is the standard of care; and

WHEREAS, An example of denied coverage referenced in the aforementioned is: osteopenia and osteoporosis are well documented complications of Sickle Cell Disease (SCD); and

WHEREAS, Many studies have shown that DEXA scans are necessary to diagnose, follow up on, and treat osteopenia and osteoporosis in children and adults with SCD; and

WHEREAS, The Medical Policies of most insurers do not include SCD as an approved indication for DEXA scan coverage; and

WHEREAS, Insurers, based on these incomplete Medical Policies, continue to deny coverage for DEXA scans in children and adults with SCD; and

WHEREAS, Physicians, hospital systems and other health care professionals spend an inordinate amount of time and resources resubmitting, appealing and/or going through other unnecessary processes to secure payment for many studies and testing appropriately prescribed and indicated for rare and uncommon disease states; and

WHEREAS, Many hospital systems are forced to “write off” the costs of these studies and tests due to insurers’ denial of payment based on flawed Medical Policies; therefore, be it

RESOLVED, That the Pennsylvania Medical Society advocate for legislation to require that insurers update their Medical Policy documents at least annually to reflect medically acceptable studies and treatments for relatively rare and uncommon diseases; and be it further

RESOLVED, That the Pennsylvania Medical Society advocate for legislation to require Pennsylvania insurers to put in place a streamlined process for exceptions for rare or uncommon disease states; and be it further
RESOLVED, That the Pennsylvania Medical Society advocate for legislation to prohibit insurers from using medical coding for the primary purpose of denying medical services, studies and testing; and be it further

RESOLVED, That the Pennsylvania Delegation to the AMA take this issue forward to the American Medical Association at the next feasible opportunity.

Fiscal Note:

Relevance to Strategic Plan

302
RESOLUTION 16-303

(Referred to Reference Committee C)

Subject: Clinical Pathways

Introduced by: Marilyn J. Heine, MD, FACP, FACEP, FCPP, on behalf of the Pennsylvania Society of Oncology & Hematology, the Pennsylvania Society of Gastroenterology, the Pennsylvania Rheumatology Society, and the Pennsylvania Academy of Dermatology and Dermatologic Surgery

Author: Marilyn J. Heine, MD, FACP, FACEP, FCPP

WHEREAS, A properly designed clinical pathway can provide a tool to help manage the quality of care as it standardizes care processes and promotes value through detailed protocols for delivering evidence-based healthcare services for specific patient presentations; and

WHEREAS, Clinical pathways should promote the best possible evidence-based care in a manner that is updated continuously to reflect the rapid development of new scientific knowledge; and

WHEREAS, Clinical pathways are increasingly being used by institutions, clinicians, commercial organizations, payers and other health systems as a way to improve patient care as they limit undesirable variability and reduce cost while providing for the optimal course of healthcare services for a patient’s specific diagnosis and co-morbid conditions; and

WHEREAS, With the growing use of clinical pathways, significant concerns have surfaced regarding their development and revision, including, but not limited to conflicts of interest, degree of transparency, extent of practicing physician input, influence of cost considerations and consistency with scientific literature; and

WHEREAS, Due to the variability among clinical pathways being utilized by different payers, administrative burdens are increased for healthcare providers who must track and manage their patients while keeping current on differences among the unmanaged proliferation of clinical pathways; and

WHEREAS, Clinical pathways should recognize medical variability among patients and individual patient autonomy, and all stakeholders must recognize that 100 percent concordance with clinical pathways is unreasonable, undesirable and potentially unsafe; therefore, be it

RESOLVED, That the Pennsylvania Medical Society advocate that clinical pathways be developed transparently and collaboratively and that they: (a) promote access to evidence-based care for patients; (b) recognize the medical variability among patients and individual patient autonomy; (c) promote access to clinical trials; (d) are continuously updated to reflect the rapid development of new scientific knowledge; and (e) are implemented in ways that promote administrative efficiencies for physicians, other healthcare providers, and payers; and be it further

RESOLVED, That the Pennsylvania Medical Society advocate that clinical practice guidelines, when used by health plans, must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care, and should include a statement of their limitations and restrictions; and be it further
RESOLVED, that the Pennsylvania Medical Society advocate that formal procedures be adopted to minimize the potential for undue financial or other interests from influencing the development of clinical guidelines including required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; with the disclosures of panel members’ conflicts of interest relating to specific recommendations published with the guidelines or otherwise made public.

Fiscal Note:

Relevance to Strategic Plan

GOAL 1: Improve the health of patients, families and communities as we advocate for physicians and their patients.

OBJECTIVE 1.1 – Develop and advocate for policies and programs that promote the appropriate patient-centered, physician-led team-based care as determined by patient need and available resources and position physicians as the ultimate champions of safety quality and value in patient care.

OBJECTIVE 1.4 – Build alliances with county, state and specialty societies, PAMED subsidiaries and other key stakeholders from across the Commonwealth, in order to promote shared goals and collaboratively advance PAMED’s advocacy agenda.

OBJECTIVE 1.5 – Represent the interests of physicians and their patients in legislative initiatives, legal proceedings, and insurer and regulatory processes; strategically communicate that perspective in discussion of health care transformation, health reform, and other matters that impact the practice of medicine in Pennsylvania.
Resolution 15-302: Informing Public of Hospital Revenue per Inpatient Day of Care—Resolution 15-302, introduced at the 2015 annual meeting and referred to the Board of Trustees for study, calls on PAMED to work with the Pennsylvania Department of Health (DOH) and the Pennsylvania Health Care Cost Containment Council (PHC4) to inform patients and families of the average daily cost of hospitalization at each hospital (Net Patient Revenue per Inpatient Day of Care). It also calls on PAMED to work to have the PHC4 publish an addendum to their 2014 Financial Analysis that reports Net Patient Revenue per Inpatient Day of Care for each hospital and region, and include Net Patient Revenue per Inpatient Day of Care in all future annual Financial Analysis reports. Lastly, it calls on PAMED to work with the PA DOH to establish policy that requires each hospital to post prominently its most recent Average Daily Cost for Hospitalization (Net Patient Revenue per Inpatient Day of Care), along with the averages for the state and region.

Background

The author is concerned about the lack of education and transparency of cost data in particular for patients to make informed healthcare purchasing decisions. The amounts charged and collected by hospitals for services vary significantly and therefore should be available to patients prior to making their decision about which hospital to use. The information to be posted by each hospital includes the average daily cost of hospitalizations. The author also desires the PHC4 to include this information in their yearly Financial Analysis of hospitals.

Discussion

An initial contact was made to the CEO of the Hospital and Healthsystem Association of Pennsylvania (HAP) to determine their view on the Resolution requests. The HAP CEO responded “We are concerned that this resolution proposes a very vague metric—average daily cost of hospitalization—that would not provide actionable information to policy makers or the public. The average cost of hospitalization is significantly affected by many factors, including the patient mix, the type of hospital, the geographic location, the acuity level of patients, etc. In addition, hospitals are reacting to market forces and the transition to value-based purchasing by providing much more price transparency, and this trend will continue. Finally, the Commonwealth is exploring this issue through the SIM process.” A follow-up conversation was also had with the HAP VP of Research as to whether the AHRQ Monarch data base, which HAP is using for their member hospitals, might be a source of data if the PHC4 route is not productive.

Next steps included several conversations with the Executive Director and other staff of PHC4 to determine what financial data they have and or willing to collect and whether PHC4 had the ability to produce the requested data to be included in their Financial Analysis reports. The author was communicated with and asked to attend the May PHC4 Council meeting after PHC4 agreed to add this issue to their meeting agenda. Additionally, staff contacted the two physician representatives on the PHC4 and asked them for their support of this issue at the Council meeting.

The author was able to attend the May PHC4 meeting to present his ask. Talking points were developed by the Resolution author to present to the members of the Council. Members of the Council did express some concerns about the cost comparisons not reflecting additional factors such as procedure type or type of hospital facility, some of the same concerns expressed by the HAP CEO. The Council determined to refer the issue to its Data Committee to review the Resolution ask in greater detail. The Data Committee has not met to discuss further.
RECOMMENDATION

1. The Board of Trustees recommends that staff continue to pursue the asks embedded in Resolution 15-302 by bringing this issue to the PHC4 Data Committee at their next meeting and to brief the author so that he might attend.

David A. Talenti, MD
Chair
RESOLUTION 16-401

(Referred to Reference Committee D)

Subject: Oppose Mandate to Mandated E-Prescribing

Introduced by: Amelia A. Paré, MD, Chair, and Sharon L. Goldstein, MD, Vice Chair, on behalf of the Allegheny County Medical Society

Author: Lawrence R. John, MD

WHEREAS, Many organizations are moving to support and encourage electronic prescribing; and

WHEREAS, Many physicians prefer to be able to write prescriptions using paper and pen; and

WHEREAS, This may create undue pressure and concern for many physicians; and

WHEREAS, A reliance on electronic prescriptions may present logistical difficulties when there are problems with the underlying technology; therefore, be it

RESOLVED, That the Pennsylvania Medical Society actively preserve the ability of physicians to physically write prescriptions and oppose any mandate to require or mandate all electronic prescribing.

Fiscal Note:

Relevance to Strategic Plan

401
RESOLUTION 16-402
(Referred to Reference Committee D)

Subject: Abolish the 30-Day Waiting Period for Tubal Sterilization for Medicaid Beneficiaries

Introduced by: Kathryn Sanserino, MD, Philadelphia County Medical Society

Author: Kathryn Sanserino, MD, Philadelphia County Medical Society

WHEREAS, Current Pennsylvania code requires that an individual requesting tubal sterilization give written informed consent at least 30 days, but not more than 180 days, before the sterilization procedure;

and

WHEREAS, Elective tubal sterilization is one of the most common and effective forms of contraception in the United States1,2; and

WHEREAS, Immediate postpartum sterilization offers the advantage of one-time hospitalization which offers ease and convenience for women3; and

WHEREAS, Women who did not receive a desired postpartum tubal sterilization were more likely than those who did not request permanent sterilization to be discharged from the obstetric service without contraception4; and

WHEREAS, Consequences of not performing desired sterilization for women who cannot present evidence of having met the 30-day requirement can be severe. Nearly half of those who never intended to become pregnant again do so, and nearly 20% within one year5, 6; and

WHEREAS, The mandatory 30-day waiting period violates health care principle of justice because it reduces access to a procedure differently based on the source of payment and gender, and entails increased clinical risks of unwanted pregnancy based on source of payment; therefore, be it

RESOLVED, That the Pennsylvania Medical Society recommend to the Pennsylvania Department of Human Services a revision to the current Medicaid regulations by abolishing the mandatory 30-day waiting period for elective tubal sterilization.

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6 ACOG Committee Opinion Number 530 July 2012 “Access to Postpartum Sterilization.”
1  Fiscal Note:  $2,000
2
3  Relevance to Strategic Plan
4
5  402
RESOLUTION 16-403

(Referred to Reference Committee D)

Subject: Fairness for Physicians Cleared of Wrongdoing by Their State Licensing Board

Introduced by: D. Michael Baxter, MD, on behalf of the Berks County Medical Society

Author: D. Michael Baxter, MD

WHEREAS, Any individual or entity may file a formal complaint against a physician licensed by the State Board of Medicine or Board of Osteopathic Medicine for alleged unprofessional conduct; and

WHEREAS, The Pennsylvania Department of State receives all complaints concerning licensees and registrants of professional and occupational licensing boards and commissions regulated by the Bureau of Professional and Occupational Affairs and is charged with reviewing information filed within each complaint to determine whether a violation of the licensing law has occurred; and

WHEREAS, If the Department completes an initial investigation into a complaint and there is no evidence to warrant the filing of a disciplinary action, the case is closed and the subject of the complaint is notified of such; and

WHEREAS, If a case is closed without disciplinary action, a physician is not provided any information regarding the specifics of the complaint, evidence gathered during review and investigation, or the reasoning that led to the decision made; and

WHEREAS, Despite a lack of knowledge of the complaint filed, physicians who have been investigated must subsequently report to a host of entities that they have been the subject of a licensing board investigation in the past, regardless of whether there was any merit in the complaint, for the purposes of obtaining professional liability coverage or professional credentialing or affiliation; and

WHEREAS, It is unfair that a physician must continually disclose that he or she has been the subject of an investigation that was closed without disciplinary action; and

WHEREAS, Due to the confidential and privileged nature of complaints and any ensuing investigation, a physician is unable to effectively defend himself or herself when disclosing this information; therefore, be it

RESOLVED, That the Pennsylvania Medical Society seek a remedy for physicians who must repeatedly disclose the fact that they have been the subject of an investigation by their licensure board due to a complaint which was filed against them, found to be without merit, and closed without action; and be it further

RESOLVED, That the Pennsylvania Medical Society propose legislation, if necessary, that eliminates a physician’s obligation to report complaints which have been filed against him or her and which have been closed without disciplinary action by his or her licensure board after initial review by the Department of State.

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RESOLUTION 16-404

(Referred to Reference Committee D)

Subject: Comprehensive Women’s Reproductive Health Care

Introduced by: Jay E. Rothkopf, MD, on behalf of the Montgomery County Medical Society

Author: Jay E. Rothkopf, MD, Montgomery County Medical Society

WHEREAS, Comprehensive health care during a woman’s reproductive life benefits public health; and

WHEREAS, Congress defeated a bill to provide Zika virus funding because an amendment was attached to the bill to defund Planned Parenthood; and

WHEREAS, "If we’re serious about addressing the Zika threat, we must fully fund comprehensive reproductive healthcare — so that all at-risk women who would like to avoid or delay their pregnancy may do so,” said U.S. Surgeon General Vivek Murthy, MD and American Congress of Obstetricians and Gynecologists (ACOG) President Tom Gelhaus, MD; and

WHEREAS, While Florida, for example, is ground-zero for the Zika crisis in the United States, in 2016 Florida Gov. Rick Scott signed a law that would block access to birth control, health education, and other screenings — the same services that are critical to combat Zika. The Aedes Egyptii mosquito is predicted to be present in Pennsylvania by 2017 according to the Centers for Disease Control and Prevention (CDC); and

WHEREAS, The American Medical Association (AMA) has filed amicus briefs in several cases involving restrictive legislation limiting reproductive health care for women; and

WHEREAS, These clinics provide medical care, counseling about contraception, provision of contraception, sexually-transmitted disease screening and prevention, and cancer screening and prevention in millions of insured, underinsured, and uninsured women. Closing free-standing women’s health clinics will prevent millions of women from receiving appropriate, affordable reproductive health care; and

WHEREAS, Although the Affordable Care Act (ACA) mandates provision of contraception included in all insurance plans, private insurance plans outside the ACA may not cover contraception and some religious groups are exempt from providing contraception coverage, even to employees who have other religious beliefs. Some insurance plans do not cover all forms of contraception, for example long-acting reversible contraception, recommended by ACOG as the most reliable form; and

WHEREAS, Zika virus infection in pregnancy has been proven to cause significant neurological damage to the fetus (best estimates as high as 13.2 percent) and can result in severe anomalies such as, but not limited to, microcephaly. There is the potential for long-term neurological sequelae in childhood; and

WHEREAS, The best prevention of Zika virus in pregnancy is contraception and prevention of sexual transmission (virus may be present in semen up to six months according to latest CDC data); and

WHEREAS, Effective contraception decreases unplanned pregnancy and Zika-affected pregnancies; and
WHEREAS, Free-standing non-profit clinics perform many valuable health services for women, including
contraception, that are often unavailable elsewhere; and

WHEREAS, Women should have the right to access FDA-approved methods of contraception according to
their own moral and ethical beliefs; and

WHEREAS, The Pennsylvania Medical Society has agreed to work to prevent legislation that interferes with
the physician-patient relationship and with the practice of medicine; therefore, be it

RESOLVED, That the Pennsylvania Medical Society oppose legislative interference with facilities that
provide medically-accepted standard of care reproductive services for women including contraception;
screening for and prevention of sexually transmitted infections; screening for female cancers; and
education to prevent unplanned pregnancy.

Fiscal Note:

Relevance to Strategic Plan:

404
RESOLUTION 16-405

(Referred to Reference Committee D)

Subject: Protect Confidentiality of Dependents of Insurance Policyholders

Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society

Author: Elisa Giusto, Medical Student, Philadelphia County Medical Society

WHEREAS, Healthcare providers, insurers, and healthcare systems have a legal and ethical obligation to protect patients’ privacy and ensure the confidentiality of their health information; and

WHEREAS, Healthcare providers, insurers, and healthcare systems have not implemented adequate policies, procedures, nor technical safeguards needed to protect the confidentiality of healthcare information related to the minor patients and young adults who are insured as dependents; and

WHEREAS, Explanation of benefits (EOBs) forms are sent by health insurance companies to policyholders after anyone covered under their policy, known as dependents, obtains care; with such forms identifying who received care, the date care was provided, the name of the healthcare provider, and the type of care provided; and

WHEREAS, Policyholders have virtually unfettered access to dependents’ healthcare information making it all but impossible for minor patients and young adults who are insured as dependents to obtain confidential care regarding sexual and reproductive health, mental health, and substance use; and

WHEREAS, Since March of 2016, 6.1 million uninsured young adults ages 19 to 25 have gained health insurance coverage because of the Affordable Care Act’s provision allowing them to be listed as dependent under their parent’s health insurance plan, affecting 27% of women of reproductive age and 20% of men of the same age; and

WHEREAS, Privacy concerns have a substantial impact on patients’ willingness to access healthcare services, as nearly 20% of women obtaining care at a family planning center do not plan on using their insurance coverage because of confidentiality concerns, 32% of minors and 24% of young adults did not use their insurance coverage to obtain contraceptive services due to confidentiality concerns, 60% of adolescents girls would forgo some or all sexual health services in the event of parental notification for prescribed contraceptives, and 14.3% of minor girls and 10.5% of minor boys have forgone needed healthcare due to confidentiality concerns; and

WHEREAS, 6 states (California, Colorado, Maryland, Massachusetts, Oregon, Washington) allow dependents to request confidential communications from their insurance provider via a written request; and

WHEREAS, 3 states (Massachusetts, New York, Wisconsin) allow insurers to mail an EOB directly to the patient instead of the policyholder and do not require insurers to send an EOB to the policyholder if there is no balance due; and

WHEREAS, 4 states (California, Connecticut, Delaware, Florida) have specific protections for minors seeking sexually transmitted infection treatment by not issuing an EOB; therefore, be it
RESOLVED, That the Pennsylvania Medical Society seek legislation to require insurers to communicate
directly and confidentially with dependents of a parent or guardian's insurance policy who receive any
medical services or treatment without parental or guardian consent as authorized by law, including but
not limited to the EOBs.

Fiscal Note: $2000 or determined by staff

Relevance to Strategic Plan
1.5 Represent the interests of physicians and their patients in legislative initiatives, legal proceedings, and
insurer and regulatory processes; strategically communicate that perspective in discussions of health care
transformation, health reform, and other matters that impact the practice of medicine in Pennsylvania.

PAMED Policy

190.997 Patient Confidentiality by Third Party Payers
The Society advocates for the imposition of sanctions against third party payers that breach the
confidentiality of patient information provided to them by a treating or consulting physician. Sanctions
should be legally imposed against third party payers that demand, for approval of or payment for medical
services, the provision of information that would conflict with HIPAA regulations. Additional penalties
should be imposed against a third party payer that inflicts onerous actions or sanctions against a provider
who has declined to submit information that would violate HIPAA regulations. (Res. 410, H-2005)

190.998 Electronic Explanation of Benefits
The Society encourages the Health Care Financing Administration to include in its Medicare electronic
claims submission program the reverse flow of electronic explanation of benefits to the provider. (Res.
36, H-88)

185.981 Disclosure of Health Care Benefits by Insurers
The Society shall use all means appropriate to ensure that insurers provide adequate information to
consumers regarding their health plan coverage and its limitations. The Society shall continue to monitor
and participate whenever possible in patient and subscriber education. (Res. 314, H-2002)

References:
1. English, Abigail, and Julie Lewis. Privacy Protection in Billing and Health Insurance
2. Anoshiravani A, Gaskin GL, Groshek MR, Kuelbs C, Longhurst CA. Special requirements for
   Guttmacher Institute, 1 July 2016.
   Coverage Because of the Affordable Care Act, New Estimates Show. 3 Mar. 2016.
5. Gold, Rachel. A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals
6. Frost JJ, Gold RB and Bucek A, Specialized family planning clinics in the United States: why women
   choose them and their role in meeting women’s health care needs, Women’s Health Issues, 22.6.

RESOLUTION 16-406

(Referred to Reference Committee D)

Subject: Hepatitis C Screening Act and Discretion of Physician Practice
Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society
Author: Kurt Miceli, MD, Philadelphia County Medical Society

WHEREAS, On July 20, 2016, Pennsylvania Governor Tom Wolf signed the Hepatitis C Screening Act (“Act 87”) into law; and

WHEREAS, Act 87 took effect on September 18, 2016 and requires each individual born between 1945 and 1965 who receives health services as an inpatient in a hospital or who receives primary care services in an outpatient department of a hospital, health care facility, or physician’s office, to be offered a hepatitis C screening test or hepatitis C diagnostic test; and

WHEREAS, The Pennsylvania Medical Society seeks clarification on Act 87 from Pennsylvania’s Department of Health (“DOH”); and

WHEREAS, The specific concerns of the Pennsylvania Medical Society include the following:

• Who is considered a primary care service provider under Act 87?
• Which facilities constitute providing primary care services under Act 87?
• Act 87 exempts the offering of hepatitis C screening services for an individual who has previously been offered or has been the subject of a hepatitis C screening test. However, there is no timeframe on this exemption. What is the timeframe for this exemption to apply?
• Is there a requirement that physicians have to explain to eligible patients that insurance may not cover the test?
• Act 87 states that "the offering of hepatitis C screening tests under this Act shall be culturally and linguistically appropriate in accordance with regulations promulgated by the department." What constitutes "culturally and linguistically appropriate?"
• Does asking the patient if they are interested in being screened and then providing those who answered 'yes' with an order or prescription meet Act 87's mandate?1; and

WHEREAS, Act 87 subverts clinical judgment by imposing a blanket mandate on physicians; and

WHEREAS, The Hippocratic Oath states that a physician “will use treatment to help the sick according to [the physician’s] ability and judgement,” not according to government mandate; and

WHEREAS, the continued intrusion of government into the doctor-patient relationship erodes the professional bond which exists between the two; and

WHEREAS, it is unclear what legal ramifications either intentional or unintentional violation of Act 87 may have; and

WHEREAS, a physician could face licensure sanctions before the Pennsylvania State Board of Medicine for failing to comply with Act 87; therefore, be it

1 https://www.pamedsoc.org/tools-you-can-use/topics/compliance/general/HepatitisCTesting (accessed 2 Sept 2016)
RESOLVED, That the Pennsylvania Medical Society seek legislative amendment to Act 87 which shall not impose any liability, criminal or civil penalty, or licensure sanctions before any applicable State board for failure by a physician, health care practitioner, health care provider, hospital, health care facility, or physician’s office to comply with Act 87.

Fiscal Note: $2000

Relevance to Strategic Plan

406
RESOLUTION 16-407

(Referred to Reference Committee D)

Subject: The Pennsylvania Medical Society Recommend Legislation to Train and License Unmatched Residency Applicants as Independent Primary Care Providers in Areas of Pennsylvania with Physician Shortage

Introduced by: Winifred M. Wolfe, Medical Student, Philadelphia County Medical Society

Author: Winifred M. Wolfe, Medical Student, Philadelphia County Medical Society

WHEREAS, The U.S. Health Resources and Services Administration has identified 155 areas of Pennsylvania lacking adequate primary care, including parts of Schuylkill County and Philadelphia; and

WHEREAS, Existing AMA policy recognizes the existing shortage of physicians (H-200.954) and will work with members of the Federation of Medicine (state, county, and specialty medical societies represented in the American Medical Association) and national and regional policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties (D-200.991); and

WHEREAS, The Pennsylvania Joint State Government Commission released a report on April 20, 2015 recommending strategies to address projected physician shortages, including increasing the number of residency positions in order to train more physicians in Pennsylvania²; and

WHEREAS, In the 2014 NRMP match, 5.6% of 17,374 US Allopathic Medical School Seniors (972 physicians in training) went unmatched and 25% of 34,270 active NRMP match applicants (8,567 applicants) went unmatched¹; and

WHEREAS, A 2012 JAMA article cites that there is a substantial waste in the education and training of U.S. physicians and years of training have been added without evidence that the additional time enhances clinical skills or quality of care; and

WHEREAS, Missouri, another state with primary care physician shortage, enacted legislation in 2014 to train and license unmatched senior student physicians with an Assistant Physician Licensure Program, Statutes 334.036 and 334.038, enabling unmatched residency applicants to enroll in a six-month supervised medical training program where, upon completion, “Assistant Physicians” serve as independent primary care providers in areas of state shortages³; therefore, be it

RESOLVED, That the Pennsylvania Medical Society address physician shortages by urging the state to enact legislation enabling unmatched residency applicants to become licensed to independently deliver primary care in areas of Pennsylvania requiring family physicians.

Relevant PAMED Policy

200.999 Enlisting Physicians to Practice in Underserved Areas
The Society should propose legislation which would seek to enlist the services of established health care personnel, as well as the commitment of students, to practice in medically underserved areas. The program should provide for fair remuneration of all participants, be easily administered, have enforceable penalties for violation of contract, and be developed in conjunction with the American Medical Students
Association, the state’s schools of medicine and osteopathy, and the affected local communities. Collectively, these would assure adequate health care to underserved areas of the Commonwealth. (Res. 29, H-78) (Retained in part, H-98)

200.998 Physician Population in Pennsylvania
The Society determined that the analysis of physician population and distribution in Pennsylvania should continue to be examined by PMS but should be broadened to include discussions with the state’s medical schools, recognized experts on Pennsylvania’s health manpower needs, and members of the state legislature. These discussions were to be undertaken through a PMS-sponsored or jointly sponsored program. It was stated that manpower discussions must take into account foreign medical graduates. Issues of physician distribution for underserved areas were to be discussed with the state legislature. (Report F, Board of Trustees, H-87)

200.995 Improving the Medical Practice Climate in Pennsylvania
The Society shall collaborate with other stakeholders (government, business, insurers, patient groups, etc.) in creating and prioritizing ideals for the climate of practice in Pennsylvania. The Society shall work with the Residents and Fellows Section to obtain data to assess the goals and desires of current resident physicians to seek ways to retain and attract sufficient recent resident graduates to practice in our state. This data will be included in future editions of the Society’s State of Medicine report. (Res. 401, H-2008)

200.996 Training of Family Physicians a Concern of Medicine
The Society considers the training of physicians in family practice to be a proper role for Pennsylvania medical schools; and further, it encourages the state-related and state-assisted medical schools of the Commonwealth to develop and execute training programs geared to producing family physicians. (Res. 23, H-73)

RELEVANT AMA and AMA-MSS Policy

US Physician Shortage H-200.954
1. Our AMA: 1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US; 3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;

The Physician Workforce: Recommendations for Policy Implementation D-200.991

2. Our AMA: will work with members of the Federation and national and regional policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

References:


Fiscal Note: As determined by staff.
RESOLUTION 16-408

(Referred to Reference Committee D)

Subject: Address and Petition CMS and Legislators to Allow for a Process of Appeal to Negative Statements and Reports to the National Practitioner Data Bank

Introduced by: Anthony Dippolito, MD, MBA, on behalf of the Northampton County Medical Society

Author: Anthony Dippolito, MD, MBA, Northampton County Medical Society

WHEREAS, The mission and intention of the National Practitioner Data Bank (NPDB) has been corrupted and abused; and

WHEREAS, The NPDB is being used by hospital systems and health care networks as a device to control and manipulate health care practitioners; and

WHEREAS, The NPDB was devised by Congress to restrict the ability of incompetent physicians and dentists to move from state to state without disclosure or discovery of the physician’s previous damaging or incompetent performance; and

WHEREAS, Hospitals have used and are using the NPDB to destroy physicians’ reputations at their discretion; and

WHEREAS, Hospital systems and networks are using the NPDB to manipulate and dissuade physicians from application to their medical staffs; and

WHEREAS, Hospital systems and networks are using the NPDB to threaten and skirt their legal responsibility pursuant to the “Community Benefit Standard” allowing “all qualified practitioners” to apply to their medical staffs; and

WHEREAS, There is no due process and physicians have no recourse to appeal, have their reputations restored, or have their names removed from the NPDB once submitted; and

WHEREAS, Hospital systems and networks are not and cannot be penalized for wrongly using the NPDB against physicians; and

WHEREAS, There is no oversight over the hospital systems and networks to prevent abuse of the NPDB process; therefore, be it

RESOLVED, That the Pennsylvania Medical Society adopt a position on and defend physicians against those who use The National Practitioner Data Bank to ruin their reputations in an effort to manipulate and dissuade them from application and/or participation on their medical staffs; and be it further

RESOLVED, That the Pennsylvania Medical Society take action through its delegation to the AMA to address and petition CMS and legislators to allow for a process of appeal to negative statements and reports to the data bank; and be it further

RESOLVED, That the Pennsylvania Medical Society pursue avenues legal and political to guarantee due process and to protect physicians from abuse of the NPDB.
Fiscal Note

Relevance to the Strategic Plan

408
RESOLUTION 16-409

(Referred to Reference Committee D)

Subject: Support Closing Pennsylvania’s Private Sale Loophole for Long Guns by Requiring Background Checks for All Firearms Transfers

Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society

Author: Michael DellaVecchia, MD

WHEREAS, Reducing gun violence is a responsibility we all share; and

WHEREAS, The most effective way to reduce gun violence is to keep guns out of the hands of people who should not have them; and

WHEREAS, Federal and Pennsylvania law in combination prohibit the sale to or possession of firearms by certain dangerous “Prohibited Purchasers” including convicted felons, domestic abusers, and people with specific kinds of mental health histories; and

WHEREAS, Background checks are a commonsense and effective measure that require sellers to first ascertain whether a buyer is listed on a database of Prohibited Purchasers before completing a firearms transfer; and

WHEREAS, Federal law only pertains to federally licensed firearms dealers whose business is selling firearms, who must conduct background checks for all of their firearm sales; and

WHEREAS, It is left to States to regulate sales of firearms by Private or Unlicensed Sellers, and Pennsylvania law only requires background checks for handgun sales by such sellers; and

WHEREAS, This creates a dangerous loophole in Pennsylvania whereby Private Sellers may legally sell long guns, including shotguns, rifles, and semi-automatic assault-type weapons without conducting a background check; and

WHEREAS, Private sales represent a large number of firearms sales and occur through many venues including gun shows, yard sales, and private arrangements made through the internet; and

WHEREAS, Long guns have been used in 50% of the fatal shootings of PA law enforcement officers since 2008, are used disproportionately in the killing of women by their domestic partners, and account for at least 10% of crime guns; and

WHEREAS, Background checks are effective and have already prevented over 2.4 million firearms sales to Prohibited Purchasers nationwide; and

WHEREAS, Background checks are convenient and fast and do not infringe upon the constitutional rights of law abiding gun owners; therefore, be it

RESOLVED, That the Pennsylvania Medical Society reaffirm support for HB 1010 or similar legislation that closes Pennsylvania’s private sale loophole for long guns by requiring background checks for all firearms transfers.
Fiscal Note: $2,000

Relevance to Strategic Plan
1.3 Educate and inform Pennsylvania physicians, policymakers, and the public on issues that impact the public’s health, patient care and the practice of medicine.
1.4 Build alliances with county, state and specialty societies, PAMED subsidiaries and other key stakeholders from across the Commonwealth, in order to promote shared goals and collaboratively advance PAMED’s advocacy agenda.

PAMED Policy
145.000 Firearms: Safety and Regulation

145.996 Gun Violence
The Society was directed to (1) issue a statement recognizing gun violence as a significant public health problem, and urge politicians and the public to support further research into the epidemiology of risks related to gun violence in the state of Pennsylvania; and (2) present, in writing, its position statement recognizing gun violence as a significant public health concern and its support of research into the epidemiology of risks related to gun violence in the state of Pennsylvania to the Pennsylvania Department of Health, Violence, and Injury Prevention for consideration. The Pennsylvania Delegation to the AMA was directed submit a resolution to the AMA House of Delegates, urging U.S. legislators to support further research into the epidemiology of risks related to gun violence on a national level. (Res. 206, H-2013)

145.997 Promotion of Firearms Safety
The Society shall partner with other stakeholders in an effort to promote firearms safety. (Res. 406, H-2007)

145.998 Firearms Safety Programs for Children
The Society supports AMA Policy 145.990: Prevention of Firearm Accidents in Children which (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearms safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; and (2) encourages state medical societies to work with other organizations to increase public education about firearm safety.

The Society also supports recently adopted AMA policy encouraging "organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children." (Report 2, Board of Trustees, H-2000)

145.999 Health Consequences of Firearms
The Society advocates funding of scientific research on firearm related injury and death by appropriate national groups, like the Centers for Disease Control. (Res. 50, H-86)
CLOSE PENNSYLVANIA’S LONG GUN LOOPHOLE FOR BACKGROUND CHECKS!

What is the Long Gun Loophole?

- Federal law requires that licensed firearms dealers conduct background checks on all firearms sales. But regulation of unlicensed, private sales is left to the states. This leaves a large gap where unlicensed sellers can peddle guns online, at gun shows, in parking lots, or anywhere else, without running background checks.
- Pennsylvania has partially closed the loophole by requiring that all handgun sales – whether by licensed or unlicensed/private sellers – undergo background checks. However, PA allows the private sales of long guns – shotguns, rifles or semi-automatic assault weapons like the one used at Newtown, CT – without a check.
- Result: prohibited purchasers who aren’t allowed to buy guns, including violent felons, domestic abusers and the seriously mentally ill, flock to unregulated private sales, including online and parking lot sales, where they can buy guns with no background checks, and no questions asked.

We Should Treat Private Sales of Long Guns the Same as Private Sales of Handguns.

- Although handguns are used more frequently in crimes, long guns in the wrong hands are deadly. Long guns are used in approximately 10.5% of gun murders.
- Long guns are used disproportionately by domestic abusers to kill women.
- Long guns are also used frequently by criminals against law enforcement officers. Since 2008, at least half of the Pennsylvania law enforcement officers killed with guns were killed with long guns.
- Requiring background checks on all gun sales will help keep guns out of the hands of those who should not have them. Closing this loophole will save lives.

Background Checks Work!

- The Pennsylvania background checks (PICS) system has blocked approximately 140,000 prohibited purchasers since its inception.
- Nationwide, background checks have prevented more than 2.4 million sales of firearms to prohibited purchasers since 1994.

Background checks are easy and convenient.

- Background checks typically take only a few minutes, and 99.97% of Pennsylvanians live within 10 miles of a licensed dealer who can perform a background check.

How Can Pennsylvania Close this Loophole?

By Enacting HB 1010 and SB 1049: The Pennsylvania Background Check Bills.

These companion House and Senate bills close the loophole by deleting the exemption for private sales of long guns. Firearms transfers between direct relatives, allowed under current law, are not affected.
These bills have bipartisan support from across the Commonwealth. The text and cosponsors of each bill are available online: HB 1010; SB 1049.
Resolution 15-404: Protect Physicians Who Wish to Terminate Futile Medical Care from Civil and Criminal Prosecution – Resolution 15-404, introduced at the 2015 annual meeting and referred for study to the Board of Trustees, called on the Society to petition the state legislature to enact a law in the state of Pennsylvania that will protect physicians who wish to terminate futile medical care from civil and criminal prosecution, thereby empowering physicians to follow the dictates of evidence-based medicine and act within the standard of care without fear of legal recourse.

LEGISLATIVE BACKGROUND
Resolution 15-404 references Texas’ Advanced Directives Act as an example of the type of protection sought by the resolution:

“The state of Texas enacted the Texas Advanced Directives Act of 1999…which gives physicians the ability to terminate life-sustaining treatment if the treating medical team determines that the care is futile care, and protects both the health care facility and the individual physicians involved from civil and criminal prosecution.”

After review of the Texas law, it appears that Pennsylvania and Texas offer the same protections. The Texas law, however, includes additional requirements of the physician and the health care facility.

Texas
Under the Texas law, a physician who fails to carry out a patient’s advanced health care directives is not civilly or criminally liable, or subject to review or disciplinary action by the applicable licensing board, if the physician’s decision is reviewed by an ethics or medical committee. While the physician’s decision is being reviewed by the committee, the patient must be given life sustaining treatment. If the attending physician, the patient or surrogate does not agree with the decision reached during the review process, the physician must make a reasonable effort to have the patient transferred to a physician who is willing to comply with the directive.

If the patient or surrogate is requesting life sustaining treatment, despite the physician’s decision and the committee’s affirmation that such treatment is medically inappropriate, the patient must be given available life-sustaining treatment pending transfer.

Unless a court authorizes additional time as requested by the patient or surrogate, the attending physician, any other responsible physician, and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after the patient or surrogate receives the committee’s written decision and the patient’s related medical record. The patient must, however, receive artificially administered nutrition and hydration, unless doing so would speed up the patient’s death; be medically contraindicated; result in substantial pain not outweighed by the benefit of treatment; be medically ineffective in prolonging life; or, be contract to the patient’s or surrogate’s wishes.

1. V.T.C.A, Health & Safety Code Sec. 166.045(c) and 166.046(a).
2. Id.
3. Id. at 166.046(d).
4. Id. at 166.046(e).
Pennsylvania’s Advanced Health Care Directives Law (20 Pa. C.S.A. 5421 et seq.) contains a liability provision, which offers protection to health care providers who, in good faith, are unable or refuse to comply with a patient’s advanced health care directives.

Under Pennsylvania law, a health care provider may not be subject to criminal or civil liability, discipline for unprofessional conduct or administrative sanctions and may not be found to have committed an act of unprofessional conduct for refusing to comply with a decision of an individual based on a good faith belief that compliance with the decision would be unethical or, to a reasonable degree of medical certainty, would result in medical care having no basis in addressing any medical need or condition of the individual.5

To receive this protection, the health care provider must inform the patient (if the patient is competent) or the patient’s surrogate (if the patient is incompetent) of the health care provider’s inability to comply with the living will or the decision of a surrogate.6

The attending physician or health care provider must make every reasonable effort to assist in the transfer of the patient to another physician or health care provider who will comply with the living will or the health care decision of the surrogate.7

CONCLUSION

Pennsylvania’s Advanced Health Care Directives Law (20 Pa. C.S.A. 5421 et seq.) already contains a liability provision that protects physicians from criminal or civil liability. The Texas law referenced in the resolution offers the same protection as the Pennsylvania law, along with additional requirements for the physician and health care facility.

RECOMMENDATION

1. The Board of Trustees recommends that this report be adopted in lieu of Resolution 15-404.

David A. Talenti, MD
Chair

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5 20 Pa CSA 5431(a)(6).
6 Id.
7 20 Pa CSA 5424(b).
RESOLUTION 16-501

(Referred to Reference Committee E)

Subject: Practicing Physician Declining Membership Analysis

Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society

Author: Kurt Miceli, MD, Philadelphia County Medical Society

WHEREAS, The total number of U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) increased from 741,495 in December 2010 to 797,645 in December 2015; and

WHEREAS, The total number of non-AMA U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) increased from 622,991 in December 2010 to 685,784 in December 2015; and

WHEREAS, U.S. physicians in Life Stage categories “Mature” and “Senior” (based on the AMA Physician Masterfile) represent the majority of practicing physicians (specifically 63.29% of all U.S. physicians and medical students); and

WHEREAS, The American Medical Association’s (“AMA’s”) membership for physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) declined from 118,504 in December 2010 to 111,860 in December 2015; and

WHEREAS, The percentage of total U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) who were members of the AMA in December 2010 was 15.98%; and

WHEREAS, The percentage of total U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) who were members of the AMA in December 2015 declined to 14.02%; and

WHEREAS, Membership dues for the AMA from 2014 to 2015 decreased from $40.4 million to $39.5 million; and

WHEREAS, The AMA states that it advocates on behalf of physicians and aims to be the voice of physicians; and

WHEREAS, The AMA has as its mission to “promote the art and science of medicine and the betterment of public health”;

4 http://www.ama-assn.org/ama
6 http://www.ama-assn.org/ama/pub/about-ama.page
WHEREAS, The AMA has supported physician membership drive campaigns in the past noting that “Together We are Stronger;” and

WHEREAS, A clear discrepancy exists between declines in AMA membership for the majority of practicing physicians and the AMA’s intent to be the voice of physicians; and

WHEREAS, Reasons for this discrepancy need to be understood and acted upon so that membership declines in practicing physicians can be reversed for the strength and financial health of the organization as well as the larger voice of physicians in the country; and

WHEREAS, It is in the interest of any membership organization to represent a substantial proportion of the individuals it claims to represent; therefore, be it

RESOLVED, That the Pennsylvania Medical Society petition the AMA to study the reasons for membership decline among practicing physicians in Life Stage categories “Mature” and “Senior” by proportionally surveying both members and non-members in these categories as to the reasons why or why not individuals are members; and be it further

RESOLVED, That any such survey examine a variety of concerns physicians may have with regard to the AMA, its attention to its mission, its adequacy in advocating for physicians, any political bias which may be dissuading individuals from remaining or becoming members, and possible solutions for the foregoing concerns; and be it further

RESOLVED, that this survey be undertaken immediately by an independent consulting company with expertise in membership engagement and reported to the AMA House of Delegates at the 2017 Annual Meeting and made available to the AMA membership at large at that time.

Fiscal Note: $2000

Relevance to Strategic Plan
RESOLUTION 16-502

(Referred to Reference Committee E)

Subject: Participation of Physicians on Healthcare Organization Boards

Introduced by: Mukul Parikh, MD, Dauphin County Medical Society

Author: Jaan E. Sidorov, MD

WHEREAS, The Pennsylvania Medical Society advances quality patient care, advocates for patients and promotes physician leadership; and

WHEREAS, Not-for-profit and for-profit healthcare corporations, organizations and other entities provide medical services, insurance, information technology services, devices, pharmaceutical products and other products and services that contribute close to 20% of the United States Gross Domestic Product; and

WHEREAS, Health organization governance boards are comprised of leaders who are ultimately responsible to establish the policies, make the strategy and oversee the activities and the performance that determine healthcare value; and

WHEREAS, Health organization boards select the Chief Executive Officer and monitor his or her progress; and

WHEREAS, There is significant evidence that the participation of physicians in the governance of many healthcare organizations is associated with higher business performance, clinical quality and social outcomes; and

WHEREAS, Physicians have special expertise with complex clinical outcomes data, can add to a board’s cognitive diversity, have a reputation for altruism and can offer special competitive insights; therefore, be it

RESOLVED, That the Pennsylvania Medical Society advocate for and promote the membership of physicians on the boards of healthcare organizations including, but not limited to, acute care providers, insurance entities, medical device manufacturers, health technology service organizations; and be it further

RESOLVED, That the Pennsylvania Medical Society promote educational programs that prepare and enable physicians to participate on health organization boards; and be it further

RESOLVED, That the Pennsylvania Medical Society provide existing healthcare boards with resources that increase their awareness of the value of physician participation in governance matters; and be it further

RESOLVED, That the Pennsylvania Delegation to the AMA take this issue forward to the American Medical Association at the next feasible opportunity.

References


Fiscal Note:

Relevance to Strategic Plan

502
RESOLUTION 16-503

(Referred to Reference Committee E)

Subject: Analysis of American Board of Internal Medicine (ABIM) Finances

Introduced by: Jennifer Lorine, DO, on behalf of the Montgomery County Medical Society

Author: Jennifer Lorine, DO, Montgomery County Medical Society

WHEREAS, The American Board of Internal Medicine (ABIM), a 501-C3 organization, used $56 million of diplomats’ money to form another 501(c)(3) corporation known as the ABIM Foundation; and

WHEREAS, The ABIM Foundation uses the income of the $56 million for internal salaries, dubious research which consistently publishes data in support of MOC, and approximately $500,000 a year for high-end retreats at the county’s most expensive resorts; and

WHEREAS, The ABIM paid its President $2,774,000 for her final 30 months of employment (an annualized salary of $1.1 million dollars); and

WHEREAS, The ABIM President gave her First Assistant a raise of $103,000/year in 2011, $83,000/year in 2014, and a bonus of $313,000 in 2011 for total earnings well in excess of $500,000; and

WHEREAS, The ABIM purchased a condominium for $2.3 million and sold it for $1.7 million losing $600,000 in cash along with real estate sales and transfer fees adding another loss of approximately $200,000, and chose to house its out-of-town guests in the most expensive per square foot real estate in the city of Philadelphia as well as provide a chauffeur-driven limousine for their use; and

WHEREAS, The top employees at the ABIM are receiving retirement contributions of 18 percent per year (fully funded by the ABIM with no employee contributions) in contrast to the industry average of 5 percent; and

WHEREAS, There may well be many more undiscovered excessive expenses at the ABIM; therefore, be it

RESOLVED, That the Pennsylvania Medical Society (PAMED) petition the American Medical Association (AMA), through its delegation to the AMA, to analyze the finances of the American Board of Internal Medicine (ABIM) and its Foundation; and be it further

RESOLVED, that PAMED request the results of this analysis be shared with our AMA House of Delegates and our membership at large.

Fiscal Note:

Relevance to Strategic Plan

503
RESOLUTION 16-504

(Referred to Reference Committee E)

Subject: Endorse National Board of Physicians and Surgeons (NBPAS) for Recertification

Introduced by: Amelia A. Paré, MD, Chair, and Sharon L. Goldstein, MD, Vice Chair, on behalf of the Allegheny County Medical Society

Author: Coleen A. Carignan, MD

WHEREAS, Maintenance of Certification (MOC) is a highly controversial and onerous program established and administered by the American Board of Medical Subspecialties (ABMS) and affiliated subspecialty boards and sold at great cost to previously Board certified physicians; and

WHEREAS, MOC is costly in time and money and is estimated to cost physicians between $16,725 to $40,495 over a 10-year period and 32.7 million physician hours over a 10-year period (Ann. Inter. Med. 2015;163(6):401-408; and

WHEREAS, There is no scientific evidence to show that MOC improves the quality of patient care (JAMA 2014, 312 (22):2348-57); and

WHEREAS, The current MOC process is opposed by numerous medical societies and legislative bodies including the Pennsylvania Medical Society (PAMED), the American Association of Physicians and Surgeons (AAPS), the American Association of Clinical Endocrinologists (AACE), American Society of Nephrology (ASN), the American College of Cardiology (ACP), American Gastroenterological Association (AGA), the Oklahoma State Legislature and the State of Kentucky; and

WHEREAS, Finances of the American Board of Internal Medicine (ABIM) and the salaries of its officers, the majority of which come directly from physicians through MOC fees, has been called into question (Eichenwald, Kurt. (2015, June 5) “Medical Mystery Making Sense of ABIMS Financial Report,” Newsweek); and

WHEREAS, PAMED does not desire to support such dubious practices; and

WHEREAS, PAMED wishes to support the continuing medical education and recertification of our fellow physicians in a manner that is not onerous, prohibitive to their practice of medicine, and preserves its integrity; and

WHEREAS, The National Board of Physicians and Surgeon (NBPAS) was created by physicians from prominent academic centers and medical societies (www.NBPAS.org); and

WHEREAS, The NBPAS is a newly formed organization which provides a viable, cost and time effective alternative for Board recertification; and

WHEREAS, The NBPAS supports initial certification through ABMS and its affiliated subspecialty boards and requires its participants to be previously board certified; and

WHEREAS, NBPAS recertification is based on attaining CME provided by a recognized provider of ACCME and the CME must be related to the specialty in which the candidate is applying; and
WHEREAS, The NBPAS is now supported by 30 medical centers and numerous medical societies such as the AACE, the West Virginia State Medical Society (WVSMS), and the Washington State Medical Society (WSMS); therefore, be it

RESOLVED, That the Pennsylvania Medical Society recognizes and supports recertification by the NBPAS as a viable alternative to recertification through the ABMS/AOA; and be it further

RESOLVED, That the Pennsylvania Medical Society supports the position that NBPAS equally fulfills all requirements by insurance companies, hospital bylaws and employment contracts that require MOC for participation; and be it further

RESOLVED, That the Pennsylvania Medical Society also be willing to review alternative boards for recertification; and be it further

RESOLVED, That the Pennsylvania Medical Society Delegation to the AMA bring this resolution to the AMA for consideration at its next scheduled meeting.

Fiscal Note:

Relevance to Strategic Plan

504
RESOLUTION 16-505

(Referred to Reference Committee E)

Subject: Support Reform of the Maintenance of Certification (MOC) Process and Adopt a Position Favoring Acknowledgment of an Alternative Board, the National Board of Physicians and Surgeons (NBPAS), for Certification of Physicians Pursuing Lifelong Education

Introduced by: Anthony Dippolito, MD, MBA, on behalf of the Northampton County Medical Society

Author: Anthony Dippolito, MD, MBA, Northampton County Medical Society

WHEREAS, The American Board of Internal Medicine (ABIM) has violated the confidence entrusted to that organization as evidenced by the American Medical Association (AMA) and Pennsylvania Medical Society (PAMED) votes of no confidence for financial irregularities; and

WHEREAS, The MOC examination has not been shown to improve the quality of patient care; and

WHEREAS, No exam can guarantee practitioner competency and improve the delivery of healthcare; and

WHEREAS, The ABMS & ABIM have had no oversight and have allowed groups like the AHA to sit on any Board associated with physician certification; therefore, be it

RESOLVED, That the NBPAS be accepted as an alternative certifying organization; and be it further

RESOLVED, That no hospital or insurance company use MOC examination to exclude physicians from participating in their organizations; and be it further

RESOLVED, That no organization with “Conflict of Interest” as presented in the PAMED “Conflict of Interest and Disclosure Policy” be allowed to sit on any board associated with Physician certification; and be it further

RESOLVED, That PAMED seek endorsement through the PAMED Delegation to the AMA for physician certification through the NBPAS.

Fiscal Note:

Relevance to Strategic Plan

505
RESOLUTION 16-506

(Referred to Reference Committee E)

Subject: Support Physician-Driven, Free Market-Based Healthcare Payment Model
Creation and the Restoration of the Patient-Physician Relationship through
Innovative Consumer-Driven Healthcare Financing and Delivery Solutions

Introduced by: Anthony Dippolito, MD, MBA, on behalf of the Northampton County Medical
Society Board of Directors

Authors: Arvind Cavale, MD, Bucks County Medical Society; Herb Kunkle, MD and Winslow
Murdoch, MD, Chester County Medical Society; Anthony Dippolito, MD, MBA,
Northampton County Medical Society; Jim Thomas, MD, Montgomery County
Medical Society; Ahmed Haasan, MD, Carbon County Medical Society; and
Oscar Morphi, MD, Lehigh County Medical Society

WHEREAS, The intrusion of multiple counterproductive intermediaries into the healthcare equation has
injured the patient-physician relationship; and

WHEREAS, Artificial regulatory constructs have added excessive waste into the healthcare equation; and

WHEREAS, This has caused soaring costs which make healthcare less affordable and unsustainable for our
patients; and

WHEREAS, Value to our patients can be restored via innovative free market healthcare solutions; and

WHEREAS, Healthcare reform solutions are being proposed through a collaborative patient-physician-
business healthcare network; and

WHEREAS, A new delivery system that will restore the healthcare promise of physicians to their patients
by providing affordable coverage with high-quality care through a new patient coverage paradigm is
urgently needed; and

WHEREAS, This proposed coverage plan will not be devoted to the rules, regulations, and policies that do
not provide value to the patient-physician relationship; and

WHEREAS, The mission of the Pennsylvania Medical Society (PAMED) is synergistic with creating such a
coverage plan as patient advocates striving to provide value to the patient-physician relationship; and

WHEREAS, PAMED, by supporting such a coverage plan, will benefit and strengthen its membership and
mission by supporting the physicians and patients in Pennsylvania; therefore, be it

Resolved, That the Pennsylvania Medical Society endeavor to aid in the creation of, and partner with,
a stand-alone comprehensive and innovative healthcare initiative; further, ask the Board of Trustees to
create a loan that may be released incrementally up to $5 million for a stand-alone comprehensive and
innovative healthcare initiative; and be it further
Resolved, That the Pennsylvania Medical Society anticipate that this endeavor be marketed and
promulgated through the county medical societies throughout the state of Pennsylvania; and be it
further

Resolved, That the Pennsylvania Medical Society partner with and provide administrative, secretarial
and county resources to this innovative physician-led plan and support physician-developed processes
to manage quality, utilization and cost through a patient- and physician-driven, free market-based
healthcare system; and be it further

Resolved, That the Pennsylvania Medical Society support patient centric and physician facilitated, free
market-based healthcare reform as an alternative to government or commercial insurance-devised
payment models.

Supporting Documents Attached: THA-SupportingDocument_A2016, THA_SupportingDocument2016_B,
THA-SupportingDocument2016_C

Fiscal Note:

Relevance to Strategic Plan

506
Resolution 15-503: The Education of Pennsylvania Physicians, Fellows, Residents, and Students to the Legislative Processes of Pennsylvania and How to Participate Therein – Resolution 15-503, introduced at the 2015 annual meeting and referred for study to the Board of Trustees, called on the Society to establish a readily available multimedia presentation educating Pennsylvania physicians on the legislative process.

The Pennsylvania Medical Society (PAMED) has increased its communication to Pennsylvania physicians — in a variety of formats and mediums — regarding the legislative process, as well as the Society’s advocacy efforts.

When a bill is introduced that may impact Pennsylvania physicians, PAMED communicates this with members via several communications channels, such as the all-member email, mobile app, social media, blogs, etc. Our regular communications walk Pennsylvania physicians through the bill’s movement in the Pennsylvania General Assembly.

Part of educating physicians on the legislative process is also increasing awareness of PAMED’s advocacy efforts. This has included:

- **Quick Consult documents on new laws and programs**, such as the state’s medical marijuana law and new prescription drug monitoring program (PDMP).
- **Increased advocacy-related content in PAMED’s all-member email, mobile app, and other communications.** PAMED’s new mobile app, launched in May 2016, focuses on the latest news and advocacy, giving Pennsylvania physicians the ability to easily connect with their legislators on important issues.
- **Increased awareness of PAMED’s advocacy efforts** — In May 2016, PAMED launched a new print publication — *Physician Advocate* — designed to help keep members up to date on PAMED’s advocacy efforts, the legislative process, and how new laws and regulations may impact them.
- **Media call-ins** when awareness/education is needed on particular issues, such as medical marijuana.
- **Voter Voice calls to action** — When legislators need to hear the physician voice on a particular issue, such as streamlining physician credentialing and prior authorization reform, PAMED sends a call to action to ALL Pennsylvania physicians explaining the issue and providing talking points. For example, in May/June 2016, Pennsylvania physicians received three calls to action from PAMED to take action and contact their legislators in opposition to the CRNP bill.
- **Online education** — When new laws or regulations become a reality, PAMED ensures that members have the resources to understand and comply. For example, one of the modules in our multi-part opioids CME series focuses on the state’s PDMP, provider and dispenser reporting requirements, and user access. We’ve also broken down the 962-page MACRA proposed rule into three *Quick Consults* and are working on an online video series which breaks the rule down into bite-sized, easily-digestible segments.
- **Magazine issues focused on advocacy** — In the fall of 2014, PAMED’s quarterly magazine, *Pennsylvania Physician*, sent to all Pennsylvania physicians (as well as legislators and media), focused on advocacy, and the fall 2016 issue will have a similar theme. All issues have advocacy-related content, such as a legislative affairs spotlight column, which are written by internal subject matter experts. We’ve also featured state officials – such as Physician General Rachel Levine, MD, and Secretary of Drug and Alcohol Programs Gary
Tennis – and legislator Q&As with Sen. Jake Corman and Rep. Gene DiGirolamo, that provide insight into how physicians can get involved in the legislative process and physician advocacy.

- **New customizable website** — PAMED launched a new website in April 2016. It features the ability for users to customize the content they see by article type (blog, article, etc.), bills we support, oppose, or have no position on, etc. We also have the ability to highlight key stories on the homepage, including a banner when there is a call to action on an important advocacy issue. The homepage also features a social media feed and latest news, which often contain advocacy updates.

In development for 2017 are a webinar and informational sheet on how legislation moves through the state legislature, real-time bill tracking on PAMED’s website, and more interactivity on PAMED’s website and mobile app regarding advocacy.

**RECOMMENDATION**

1. The Board of Trustees recommends that this report be adopted in lieu of Resolution 15-503.

David A. Talenti, MD
Chair
Policy Sunset - Resolution 89-9, Ten Year Sunset Provision for PMS Policy, directed that all Society policies adopted prior to 1981 be reviewed and presented to the House of Delegates for readoption; in subsequent years, all policies adopted by the Society be reviewed and presented to the House for similar action on the tenth anniversary of their adoption. All policies reviewed but not readopted automatically expire at the conclusion of that House of Delegates meeting. The Board implements this resolution by overseeing the sunset process and bringing a report with recommendations to the House each year.

The process employed is as follows: Once identified, the policy actions subject to sunset are sent to the relevant unit of the Society for review and a decision on whether the policy should be retained, rescinded, or retained in part. In instances where the recommendation is to rescind or retain in part, the reviewing unit is directed to indicate the reason for that decision. In addition, Society legal counsel reviews all policies for anti-trust ramifications. Policies are then submitted to the Board for recommendation to the House for action.

This year, this procedure was followed for policies for 1966, 1976, 1986, 1996, and 2006. The Board acted on these at its August meeting. These policies are now presented to the House for its consideration and action. Each item has a recommendation approved by the Board.

RECOMMENDATION:

1. The Board of Trustees recommends that the action indicated be adopted for each policy item.

David A. Talenti, MD
Chair
Attachment
<table>
<thead>
<tr>
<th>Policy Number &amp; Title</th>
<th>Retain</th>
<th>Retain in Part</th>
<th>Rescind</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.999-Testifying Before State Legislature (Res. 7, H-82; revised, Res. 210, H-96)</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>10.997-Motorcycle Helmet Law (Res. 404, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
<td>The Pennsylvania law that removed the requirement that motorcyclists wear protective head gear has been in effect since September 2003. While PAMED should maintain its public endorsement that motorcycle helmets reduce or eliminate the severity of potential injuries, repealing the law as a “high priority” should be abandoned given the lack of any legislative interest in doing so.</td>
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<tr>
<td>15.996-Mandatory Use of Seat Belts (Res. 23, H-86)</td>
<td></td>
<td>X</td>
<td></td>
<td>Manadatory seat belt laws have been on the books in Pennsylvania for some time. While the penalty for not using vehicular seatbelts is considered a secondary offense, the law requires adults and children to be belted. Unless PAMED wants to pursue elevating the penalty to a “primary” offense, this policy should be rescinded.</td>
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<tr>
<td>35.987-Advertising by Non-Physician Health Care Providers . (Res. 412, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>35.988-Department of Transportation Physical Examinations by Chiropractors (Res. 401, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
<td>This has been part of the Vehicle Code and in effect for over ten (10) years. There is not enough support in the legislature to repeal this provision. Because this is law, regulations and judicial means are not possible methods for rescinding.</td>
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<tr>
<td>35.999-Direct Reimbursement of Nurse Anesthetists (Res. 40, H-86)</td>
<td>X</td>
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<tr>
<td>70.999-Uniform Disease and Procedural Coding (Res. 53, H-86)</td>
<td></td>
<td>X</td>
<td></td>
<td>This is being accomplished through ICD-10 for uniform disease coding and CPT for procedural coding.</td>
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<td>115.997</td>
<td>Prescription Drug Expiration Dates (Res. 409, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>135.999</td>
<td>Air Pollution (Res. 10, H-66)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>140.994</td>
<td>Physician Advertising (Res. 504, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>140.998</td>
<td>Restrictive Covenants in Medicine (Report 6, Board of Trustees, H-96)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>145.999</td>
<td>Health Consequences of Firearms (Res. 50, H-86)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>160.982</td>
<td>Health Care Services to the Underserved (Report 6, Board of Trustees, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>160.983</td>
<td>Access to Health Care (Res. 403, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>160.988</td>
<td>Access to Quality Medical Care (Res. 508, H-96)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>160.989</td>
<td>Health Care Delivery Models (Report 3, Board of Trustees, H-96)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>180.988</td>
<td>Reimbursement for Services Related to Obesity Diagnosis (Res. 306, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>180.989</td>
<td>Reimbursement for Services Related to Tobacco Abuse Diagnosis (Res. 305, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>185.975</td>
<td>Reimbursement for HPV Vaccination (Res. 309, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Even with passage of the Affordable Care Act and the development of marketplaces and the expansion of Medicaid as well as mental health parity, there continue to be individuals in the commonwealth that are underserved including the LGBT population. PAMED is very engaged in the new value-based health care delivery models and are making efforts to educate physicians on these as well as business opportunities to further assist physicians in succeeding in these new models. Most, if not all, insurance companies reimburse for services related to smoking cessation and other services related to tobacco-related diseases. This is an important public health issue and needs continued support from PAMED. Most, if not all, insurance companies reimburse for the HPV vaccine. This is an important public health issue and needs continued support from PAMED.
<table>
<thead>
<tr>
<th>Code</th>
<th>Topic</th>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>185.977</td>
<td>Physician Phone Appeals for Denied Procedures (Res. 303, H-2005; reaffirmed, H-2006)</td>
<td>X</td>
<td>PAMED continues to advocate for reforms in the pre-authorization process and has introduced legislation to remediate various aspects of pre-authorization process.</td>
</tr>
<tr>
<td>185.992</td>
<td>Denial of Care (Res. 510, H-96)</td>
<td>X</td>
<td></td>
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<tr>
<td>185.993</td>
<td>Emergency Room Precertification (Res. 403, H-96)</td>
<td>X</td>
<td></td>
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<tr>
<td>230.993</td>
<td>Linkage of Academic Privileges and Hospital Privileges (Res. 402, H-96; revised, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>230.994</td>
<td>Effect of Changes in Hospital Character Upon Medical Staff Credentialing (Res. 616, H-96)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>230.999</td>
<td>Exclusive Contracts (Hospital Medical Staff Section Report, H-86)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>255.999</td>
<td>Clinical Clerkships (Res. 18, H-86)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>260.996</td>
<td>Specimen Handling Fee (Res. 6, H-86)</td>
<td>X</td>
<td>This is an ongoing issue to seek a “reasonable” drawing and handling fee as operating costs continue to increase for the physician practice.</td>
</tr>
<tr>
<td>260.999</td>
<td>Alpha Fetoprotein Testing (Report H, Board of Trustees, H-86; policy retained in part, H-96)</td>
<td>X</td>
<td>Pennsylvania Medicaid reimburses for this service.</td>
</tr>
<tr>
<td>280.998</td>
<td>Mandated Laboratory Testing of Nursing Home Patients (Res. 507, H-96)</td>
<td>X</td>
<td>Federal and state regulations for laboratory testing of nursing home patients continues to evolve, so it is important to continue to monitor.</td>
</tr>
<tr>
<td>285.986</td>
<td>Managed Care Organization Reimbursement Formulas (Res. 304, H-96)</td>
<td>X</td>
<td>Severity of illness adjustments especially as it pertains to risk are being used in the new value-based payment methodologies.</td>
</tr>
<tr>
<td>285.987</td>
<td>Managed Care Organization Termination of Participation (Res. 306, H-96)</td>
<td>X</td>
<td>Network adequacy has become a major discussion item at the federal and state level. Increased scrutiny has been applied by regulators as evidence show many provider directories contain incorrect information regarding their participating providers.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Status</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>290.995</td>
<td>Parity Between Outpatient Departments and Physicians’ Offices (Res. 4, H-76)</td>
<td>X</td>
<td>Activity is occurring at the Federal level to create parity between physician offices and outpatient departments.</td>
</tr>
<tr>
<td>290.996</td>
<td>Low Physician Fee Schedule Deters Physician Participation (Res. 22, H-76; revised, H-2006)</td>
<td>X</td>
<td>Although most of Medicaid is now delivered through managed care where fee schedules are negotiable, the starting point is generally the fee-for-service fee schedule. Increasing fees could help in the negotiation process.</td>
</tr>
<tr>
<td>310.996</td>
<td>Parity for International Medical Graduates (Res. 203, H-2006)</td>
<td></td>
<td></td>
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<tr>
<td>350.996</td>
<td>Statement of Principles for Cultural Competency (Report 8, Board of Trustees, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>385.965</td>
<td>Reimbursement for Immunizations (Res. 314, H-2005; reaffirmed, H-2006)</td>
<td>X</td>
<td>Adequate reimbursement for immunizations is important as costs to purchase, store, and administer the immunizations continue to increase. Immunizations are a major public health concern so patients need access to providers providing them.</td>
</tr>
<tr>
<td>385.986</td>
<td>Third Party Reimbursement for Services Rendered by Physician (Report 25, Board of Trustees, H-96)</td>
<td>X</td>
<td>The importance of this policy cannot be understated. We just experienced a scenario where Highmark unilaterally cut ACA marketplace reimbursement by 4.5%.</td>
</tr>
<tr>
<td>405.996</td>
<td>Protecting Patient’s Right to Know Who is Treating Them (Res. 410, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>435.969</td>
<td>Delinkage of Medical Liability Insurance to Physician Licensure (Res. 407, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>435.990</td>
<td>Tort Reform/CAT Fund Reform 10-Point Action Plan (Report 27, Board of Trustees, H-96)</td>
<td>X</td>
<td>The action plan articulated in the policy is outdated and should be updated. House should consider developing updated policy.</td>
</tr>
<tr>
<td>435.991</td>
<td>CAT Fund Premium and Surcharge (Res. 408, H-96)</td>
<td>X</td>
<td>CAT Fund no longer in existence; now Mcare. Policy should be updated to reflect current state of affairs.</td>
</tr>
<tr>
<td>Code</td>
<td>Title</td>
<td>X</td>
<td>Description</td>
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<tr>
<td>440.975</td>
<td>Safe Treatment of Head Lice Infestation (Res. 204, H-2006)</td>
<td>X</td>
<td>This was accomplished by submission of a resolution to the AMA Annual meeting in June 2007 (Res 432-A-07). However, Resolution 432 was not adopted by the AMA House of Delegates.</td>
</tr>
<tr>
<td>440.976</td>
<td>Air Pollution Caused by Diesel Trucks (Res. 201, H-2006)</td>
<td>X</td>
<td>In 2008, the general assembly approved legislation limiting diesel truck idling to 5 minutes. As a result, PAMED’s policy to reduce diesel-related air pollution should be rescinded.</td>
</tr>
<tr>
<td>440.977</td>
<td>Health Impact of High Fructose Syrup (Report 2, Board of Trustees, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>440.978</td>
<td>Healthy Choices in Hospital Cafeterias (Res. 207, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>440.979</td>
<td>Promotion of HPV Vaccine (Res. 309, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>440.993</td>
<td>Standards for Blood Donors (Report 18, Board of Trustees, H-96)</td>
<td>X</td>
<td></td>
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<tr>
<td>440.994</td>
<td>Antibiotic Resistance Surveillance Network (Res. 216, H-96)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>445.999</td>
<td>Community Committees (Address of the President, H-86)</td>
<td>X</td>
<td>This policy remains pertinent and enables CMS’ to further define their role within the community as a voice of physicians.</td>
</tr>
<tr>
<td>480.999</td>
<td>Telemicine (Report 29, Board of Trustees, H-96)</td>
<td>X</td>
<td>In our recently introduced telemedicine legislation, this is a very important component of the legislative language.</td>
</tr>
<tr>
<td>490.998</td>
<td>Ban on Smoking in Hospitals (Res. 24, H-86)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>490.999</td>
<td>Ban Distribution of Cigarettes and Smokeless Tobacco (Res. 25, H-86)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>530.995</td>
<td>Forums (Report of Ad Hoc Committee on House Representation)</td>
<td>X</td>
<td>These forums are no longer utilized.</td>
</tr>
<tr>
<td>530.996</td>
<td>Mainstreaming Underrepresented Physician Groups (Report of Ad Hoc Committee on House Representation, H-96)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>545.995</td>
<td>Time of House of Delegates Meeting (Report 14, Board of Trustees)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>545.996</td>
<td>Appendixes to Resolutions (Res. 96-609)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>555.995</td>
<td>Medical Student Dues (Ad Hoc Committee on House Representation, 11-96; revised, H-2006)</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
RESOLUTION 16-COW

(Referred to Reference Committee of the Whole)

Subject: Practice Options Initiative Concept and Funding

Introduced by: PAMED Board of Trustees

Author: PAMED Board of Trustees

Whereas, Most experts have concluded that the traditional fee-for-service payment mechanisms created incentives to over treat, over prescribe, and over spend. The result was an economically unsustainable health care delivery and financing system that did not provide a commensurate level quality of care; and

Whereas, The Affordable Care Act was enacted in 2010 and its provisions included value-based care initiatives; and

Whereas, Many payers, public and private have enacted or are testing value-based payment mechanisms such as shared savings, bundled payments, episodes of care, and patient centered medical homes; and

Whereas, Congress doubled down on value-based reimbursement by enacting the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, parts of which are effective in 2017; and

Whereas, In January 2015, the Department of Health and Human services announced new goals for value-based payments and Advanced Practice Models in Medicare to include that 30 percent of all Medicare payments be tied to quality or value through alternative payment models by the end of 2016 and 50 percent by the end of 2018 and that 85 percent of Medicare fee-for-service payments are tied to quality or value by the end of 2016 and 90 percent by the end of 2018; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) promulgated a proposed rule in 2016 to implement MACRA. In that rule, CMS stated that under the MACRA Quality Payment Program, 87 percent of solo practitioners and nearly 70 percent of those practices of 2-9 physicians will receive a negative payment adjustment in 2019; and

Whereas, MACRA will impose decreased per patient fees for half the practicing physicians; and

Whereas, To avoid decreased physician payment physicians will need to begin data aggregation by the end of 2017; and

Whereas, A recent survey by Deloitte & Touche found that half of non-pediatric physicians have never heard of MACRA. Just 21% of self-employed or small group physicians and 9% of physicians employed by hospitals or larger groups were only somewhat familiar with the pending reimbursement changes. The survey also found that 58% of respondents said they would join a larger organization to diminish their financial risks and 80% expected MACRA to prompt physicians to join larger organizations or networks; and

Whereas, In 2010 the Pennsylvania Medical Society House of Delegates approved a strategic blueprint “Get In The GAME: Why Physicians Must Engage in This Era of Change” that included a Statement of
Principles. These principles included; “For decisions that are imbued with clinical care significance, it is imperative that physicians have substantial and direct participation with real power to influence the outcome. In many cases this requires that we lead the initiative”; and

Whereas, The PAMED Board of Trustees in that Blueprint document recommended “The Pennsylvania Medical Society must position physicians to lead and shape health care delivery to assure that the evolving system provides quality and value;” and

Whereas, It is stated that the general purpose of the Endowment Fund of the Pennsylvania Medical Society is “created and shall be operated exclusively for the benefit of PAMED in carrying out its mission...;” and

Whereas, The mission of PAMED is stated as: Pennsylvania Medical Society is the voice of Pennsylvania’s physicians and the patients they serve. We advance quality patient care and the ethical practice of medicine. We promote physician leadership, education, professional satisfaction, practice sustainability, and the public’s health; and

Whereas, The PAMED Board of Trustees voted at their August 16, 2016 meeting by the required simple majority to support the concept of the PAMED Practice Options Initiative; and

Whereas, The PAMED Board of Trustees voted at their October 21, 2016 meeting by the required super majority vote of 75 percent to recommend to the House of Delegates their approval to withdraw up to $15 million from the $115 million principle to be used to develop the PAMED Practice Options Initiative; and therefore be it

Resolved, that the PAMED House of Delegates support the concept and development of the PAMED Practice Options Initiative; and be it further

Resolved, That the PAMED House of Delegates authorize the PAMED Board of Trustees to access up to $15 million from the PAMED Endowment Fund principle of $115 million to be used to actualize the PAMED Practice Options Initiative.

Fiscal Note: $15 million

COW
The Pennsylvania Medical Society would like to thank the following supporters for their participation in helping us with our 2016 House of Delegates and Annual Education Conference in October at the Hershey Lodge, Hershey, PA.

Thank you to:

Carnegie Mellon University  
First Healthcare Compliance  
The Glatfelter Agency  
Operation Medical  
MD Advantage

Prescription Advisory Systems & Technology
Medical Professional Liability Coverage
Occurrence and Claims-Made Policies Available

Complimentary Supreme Advantage® Coverage
The following three claims-made coverages are automatically provided as one endorsement to each physician’s medical professional liability policy providing a combined single limit of $50,000 (subject to policy terms and conditions):

- Employment Practices Liability Insurance (EPLI)
- Privacy and Data Security Insurance (PDSI)
- Medical Practice Administration Insurance (MPAI)

Premium Discount Opportunities

- Education Discount – 3% (up to $1,000)
- Electronic Medical Records – 3%

- Electronic Prescription Writer – 2%
- PeriCALM Shoulder Screen (OB/GYN) – 5%
- Advanced Fetal Monitoring Course (OB/GYN) – 5%
- Synergy discount for OB/GYNs (PeriCALM + Fetal Monitoring Course) – 5%
- Computer Aided Detection (Radiology) – 5%
- New practice discount (75% in Year 1, 20% in Year 2 and 10% in Year 3)

Additional Coverage Options

- Part-time coverage
- Corporate/partnership professional liability coverage
- Prior acts coverage

Please contact your broker for more information on which coverages are available in your particular situation. If you do not have a broker, you may contact our Policyholder Services Department directly at 888-355-5551.

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