2023 House of Delegates
April 21-22, 2023

Meeting Material
Friday, April 21, 2023

2:30 pm * Welcome and Announcements – Ronnie Dowling, MD
Introduce Dr. Thompson, 2023-2024 – Jennifer Hartmark-Hill, MD
In Memoriam Presentation

2:45 pm* Business of the House
- Report of Committee on Credentials
- Report of the Committee on Standing Rules
- Adoption of the Agenda
- Approval of Minutes from April 21, 2022 (distributed electronically)
- Reference Committee on Resolutions & Amendments – Marc Leib, MD, Chair

4:00 pm* Break

4:15 pm * Business of the House Continues

5:30 pm * Recess House of Delegates

Saturday, April 22, 2023

8:00 am * Welcome and Announcements – Ronnie Dowling, MD
Presidential Inaugural Address – William C. Thompson, IV, MD

8:30 am * Business of the House Resumes
- Reference Committee on Resolutions & Amendments – Marc Leib, MD, Chair

10:00 am * Break
- ArMPAC Update – Gretchen Alexander, MD
- AMPAC Update – Ricardo Correa, MD

10:30 am* Business of the House Continues

11:10 am* New Business

11:20 am* Welcome to New Board Members; Outgoing Board Recognition – William Thompson, MD

11:30 am * Adjourn Sine Die – Ronnie Dowling, MD

*times are approximated
YOUR PRESIDENTS

William C. Thompson, IV
2023-2024

Jennifer Hartmark-Hill, MD
2022-2023
2023 House of Delegates
April 21-22, 2023

Official Meeting Notices
2022 Meeting Minutes
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NOTICE OF ANNUAL MEETING

TO: THE ELECTED BOARD OF DIRECTORS AND HOUSE OF DELEGATES MEMBERS OF THE ARIZONA MEDICAL ASSOCIATION, INC.
A NON-PROFIT ARIZONA CORPORATION

Notice is given that the Annual Meeting of the membership of the Arizona Medical Association, Inc., will be held on Sunday, January 8, 2022, at the hour of 11:00 a.m. at its offices at 2401 W. Peoria Ave, Suite 130 Phoenix, AZ, at which time a motion will be entertained to adjourn the meeting until Friday, April 21, 2023, at 2:30 p.m., at which time all business that may properly come before the meeting will be considered.

DATED this first day of November 2022.

Jason Jameson, M.D.
Secretary
HOUSE OF DELEGATES - ANNUAL MEETING

January 8, 2023

The regular Annual Meeting of the House of Delegates of the Arizona Medical Association, Inc. was scheduled to be held in its offices, 2401 W. Peoria Avenue, Suite 130, Phoenix, Arizona, on the first Sunday of January the eighth, 2023, at eleven o'clock in the morning.

The following members appeared at the time and place set for the meeting:

    Jason Jameson, M.D., Secretary

No quorum being present, the meeting was duly adjourned to the twenty first day of April 2023, at 2:30 pm.

THE ARIZONA MEDICAL ASSOCIATION, INC.

Jason Jameson, M.D.
Secretary
1. All ArMA Delegates must sign-in so that their attendance may be certified each day.

2. All delegates will wear badges to identify them and their voting eligibility.

3. When addressing the meeting delegates must introduce themselves by name and by affiliation.

4. Only members of the house are eligible to vote.

5. Non-delegate ArMA members may speak with a majority vote of the HOD.

6. All cell phones should be on vibrate or silent.

7. These House of Delegates Standing Rules may be suspended or amended after adoption by a two-thirds vote of the Delegates.
The 2022 meeting of the House of Delegates of the Arizona Medical Association, Inc (ArMA) was held virtually with Ronnie Dowling, MD, Speaker of the House, presiding. The meeting was called to order at 8:00 am.

**Credentials**

Ms. Carleen Cuevas, Committee on Credentials Chair, reported a quorum present and the House duly constituted. There are 52 delegates entitled to vote and will constitute the Roll; these Delegates include:
- 4 Past Presidents
- 30 Board Members
- 5 At-Large Delegates
- 2 Maricopa County Delegates
- 1 Pima County Delegates
- 1 Rural County Delegates
- 1 Resident Physician
- 1 Medical Student
- 7 Specialty Society Delegates

**Standing Rules**

Mr. Timothy Durr, Committee on Standing Rules Chair, moved the follow rules be adopted:
- All ArMA Delegates and guests shall be registered and connected through the electronic software being used for this ArMA 2022 House of Delegates Meeting. Delegates joining and leaving the meeting will be identified by the same electronic software.
- The presence of a quorum shall be established based on the Credentials Committee Report.
- ArMA Delegates in good standing who have complied with the registration requirements shall be eligible to vote.
- Only credentialed Delegates shall be able to speak to an issue.
- The "Raise Hand" feature will be used to request permission to speak.
- Delegates when addressing the House of Delegates must identify themselves by name and affiliation.
- All votes taken at this meeting shall be taken by electronic voting or by unanimous consent.
- Members shall not speak more than once to a question until all others desiring to speak the first time have done so; speeches shall be limited to two minutes.
- The names of those making motions will not be recorded in the minutes.
- Delegates will keep their audio muted until recognized to speak unless they have an interrupting motion. Guests will also keep their audio muted.
- Non-delegate ArMA members may only speak with permission by an affirmative majority vote of the Delegates.
- Each attendee is responsible for his or her electronic connection.
- These House of Delegates Standing Rules may be suspended or amended after adoption by a two-thirds vote of the Delegates.

With no objections, the Rules were adopted.

**Agenda**

With no objections, the Agenda was adopted.

**Minutes**

The Minutes of the meeting of the House of Delegates held April 17, 2021, were distributed electronically. A member of the House asked for clarification on Arizona Revised Statutes Section 10-3708 reference in A02-21. The statute in question was researched and it was determined that the statute referenced was accurate. Following the clarification, the Minutes of the meeting were approved as distributed.
The ArMA 2022 leadership elections were conducted via an electronic, online vote that concluded on Friday, April 22. The following members were elected to positions and terms as indicated:

**ArMA 2022 Elected Leadership Results**

- **President-elect (2022-23)**: William Thompson, IV, MD
- **Secretary (2022-24)**: James Jameson, MD
- **At-Large Member, Executive Committee (2022-24)**: Timothy Beger, MD
- **At-Large Member, Executive Committee (2022-23)**: Sarah Coles, MD
- **Maricopa Director (2022-25)**: Ricardo Correa, MD
- **Maricopa Director (2022-25)**: Corrina Saldanha, DO
- **Pima Director (2022-25)**: Robert Aaronson, MD
- **Pima Director (2022-24)**: Christopher Bailey, MD
- **Rural Director (2022-25)**: Nadeem Kazi, MD
- **Early Career Director (2022-2025)**: Sarah Patel, MD
- **Resident Physician (2022-23)**: David Baltazar, DO
- **Resident Physician (2022-23)**: Jacquelyn Hoffman, MD
- **Medical Student (2022-23)**: Ms. Olufunmilola Adeleye
- **Medical Student (2022-23)**: Mr. Spencer Bayless
- **Speaker of the House (2022-24)**: Ronnie Dowling, MD
- **Delegate to the AMA (1/1/2023-12/31/24)**: Ronnie Dowling, MD
- **Delegate to the AMA (1/1/2023-12/31/24)**: Michael Hamant, MD
- **Delegate to the AMA (1/1/2023-12/31/24)**: Marc Leib, MD
- **Alternate Delegate to the AMA (1/1/2023-12/31/24)**: Adam Brodsky, MD
- **Alternate Delegate to the AMA (1/1/2023-12/31/24)**: Timothy Fagan, MD
- **Alternate Delegate to the AMA (1/1/2023-12/31/24)**: Jennifer Hartmark-Hill, MD

### 2022 Bylaw Amendments

#### 2022 Bylaws Resolution Adopted

**Resolution A02-22, Forty-Year Club Membership**

Chapter III, Section 3. Class of Membership

(B) Forty-Year Club Members

Members who have practiced medicine for forty (40) years or longer, at least half of that time in Arizona, and are age 70 or older, may be honored by elevation to the Forty-Year Club at the discretion of the Board. Forty-Year Club membership, once granted, shall be deemed a lifetime privilege, regardless of continuation of licensure or status of practice, unless revoked by action of the Board of Directors.

**Privileges.** Forty-Year Club members shall enjoy all of the privileges of Active members but shall not be required to pay Association dues and shall be exempted from assessments.

#### 2022 Bylaws Resolution Referred to the Bylaws Committee

**Resolution A01-22, ArMA Bylaws Requirement for Active Membership**

Resolved that The Arizona Medical Association requirement for Active membership and to hold elected office is that the individual not have a "revoked" license by action of the Arizona Medical Board, and be it further

Resolved that Retired physicians with an inactive medical license may choose Active membership status in the Association and can hold elected office.

_The House directed the Bylaws Committee to report back at the 2023 Meeting._

#### 2022 Bylaw Resolutions Not Adopted

**Resolution A03-22 ArMA-AMA Delegation Representation on the ArMA Board of Directors**

Resolved, that the Arizona Medical Association Bylaws be amended to state that all of the ArMA-AMA Delegates (that are allocated to Arizona by the AMA) will be full voting members of the Board of Directors of the Arizona Medical Association and that all ArMA-AMA Alternate Delegates will receive all Board communications and meeting invitations (as non-voting members).
RESOLUTION A04-22 NOMINATING COMMITTEE COMPOSITION
Resolved, in Chapter VIII Section 3. (f) of ArMA’s Bylaws, that paragraph two be substituted to read:

"The Nominating Committee, two of whom shall be Maricopa Directors, two Pima directors, two At-Large Directors and two Rural Directors, shall be elected by the Board of Directors. The Nominating Committee shall elect a chair from among its own members."

2022 NEW RESOLUTIONS

2022 RESOLUTION REFERRED TO A TASK FORCE TO BE SET UP BY THE ArMA PRESIDENT WITH A REPORT TO THE BOARD OF DIRECTORS EVERY SIX MONTHS

RESOLUTION 14-22 REMOVE OPPOSITION TO MEDICAL AID IN DYING
Resolved, that the Arizona Medical Association remove its opposition and take a neutral position in regards to the practice of Medical Aid in Dying, indicating it is a compassionate end-of-life care option for mentally capable, terminally ill adults and that it should be legally authorized as one of the end-of-life care options available for Arizonans, and that physicians who participate in the practice of Medical Aid in Dying are adhering to their professional, ethical obligations as are physicians who decline to participate. This position would allow for, respect, and support the diverse views of the ArMA membership, and it will improve the end-of-life care for people with advancing life-limiting illnesses in Arizona.

2022 RESOLUTIONS NOT ADOPTED

RESOLUTION 2-22 FREE SCIENTIFIC DEBATE AND PHYSICIAN PRESCRIBING
Resolved: That ArMA supports the following:
1) the right and duty of physicians to prescribe according to their own best judgment, with the commitment to do no harm to anyone, and defends this right in its positions on legislation, regulation, hospital medical staff bylaws, or licensure board actions.
2) ArMA promotes free and open discussion on its forums.
3) ArMA shall, in town halls, meetings, webinars, and other events, allow input from participants in real time, as, at a minimum, through a “chat” or “question and answer” feature that ALL participants can view and, if possible oral exchanges.

RESOLUTION 19-22 EMPLOYMENT DISCRIMINATION OF FORMERLY INCARCERATED INDIVIDUALS
Resolved, that ArMA supports policies and practices that prevent employers from discriminating against formerly incarcerated individuals.

RESOLUTION 28-22 SUPPORTING RESIDENT WELLNESS AND MENTAL HEALTH (Not adopted in lieu of Readopting 41-22 Physician Well-being - Originally 08-18)
Resolved, that ArMA supports education about and the promotion of research into improving resident wellness, and specifically the mental health of resident physicians.

2022 RESOLUTIONS ADOPTED WITHOUT AMENDMENT

RESOLUTION 06-22 ADDRESSING THE HEALTH CARE NEEDS OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER POPULATIONS
Resolved, that ArMA affirm the importance of a physician’s ability to support the health needs of lesbian, gay, bisexual, transgender, or queer (LGBTQ+) patients by recognizing their identities in a non-judgmental manner; and be it further
Resolved, that ArMA supports access to high-quality care for LGBTQ+ patients by encouraging medical educational entities (such as medical school, residency programs, continuing medical education, etc.) to provide education regarding best practices in meeting the unique healthcare needs of LGBTQ+ individuals.

RESOLUTION 08-22 GENDER INCLUSIVE MEDICAL CARE
Resolved, that the Arizona Medical Association (ArMA) supports Gender-affirming care as an essential component of patient-centered medical care.
RESOLUTION 09-22 DIRECT CONTRACTING ENTITIES
Resolved that the Arizona Medical Association write a letter to Health and Human Services Secretary, Xavier Becerra and President Biden requesting that the Direct Contracting Entities program be terminated; and be it further
Resolved, that physicians be informed about this program through educational resources so that they can make intelligent decisions about participation.

RESOLUTION 11-22 ISOLATED CONFINEMENT IN PRISONS
Resolved, that the Arizona Medical Association oppose the use of solitary confinement except for extraordinary circumstances when an individual is at acute risk of harm to self or others, in which cases confinement be used for as short a time as possible; and be it further
Resolved, that ArMA opposes the use of solitary confinement for disciplinary purposes in correctional facilities; and be it further
Resolved, that ArMA supports efforts to ensure that the mental and physical health of all individuals placed in solitary confinement is routinely monitored by licensed medical professionals; and be it further
Resolved, that ArMA supports evidence-based legislation aimed at reducing the negative physical and mental health impacts of isolated confinement.

RESOLUTION 12-22 CO-PAYMENTS IN PRISONS
Resolved, That ArMA advocates for the prohibition of the use of copayments to access healthcare services in correctional facilities.

RESOLUTION 17-22 ACCESS TO FEMININE HYGIENE PRODUCTS
Resolved, that ArMA recognizes the adverse physical and mental health consequences of limited access to feminine hygiene products; and be it further
Resolved, that ArMA supports the distribution of menstrual products and inclusion of menstrual product disposal systems in educational institutions.

RESOLUTION 18-22 DECREASING FOOD INSECURITY IN ARIZONA
Resolved, that ArMA supports the 2025 Phoenix Food Action Plan and encourages the development of similar local and state-level initiatives throughout Arizona, and be it further
Resolved, that ArMA supports efforts that increase access to affordable, healthy, and culturally appropriate food for people living in Arizona, such as, but not limited to, the implementation of food pharmacies and other similar efforts.

RESOLUTION 20-22 ENCOURAGING DISTRIBUTION OF NALOXONE TO PATIENTS AT RISK FOR OPIOID OVERDOSE IN THE EMERGENCY DEPARTMENT
Resolved, that ArMA encourages emergency department staff to routinely offer a naloxone rescue kit to all patients at risk for opioid overdoses upon discharge from the emergency department; and be it further
Resolved, that ArMA encourages emergency departments staff to offer information on naloxone and its use, Medication-Assisted Treatment, and the Opioid Assistance and Referral Line to patients at risk for opioid overdose upon discharge from the emergency department.

RESOLUTION 21-22 EQUAL PAY FOR PHYSICIANS
Resolved, that ArMA opposes pay gaps in medicine that exist based on identities, including, but not limited to race, gender, or ethnicity.

RESOLUTION 22-22 EXPANDING DERMATOLOGIC MEDICAL EDUCATION TO SPECIFICALLY INCLUDE PRESENTATIONS WITH SKIN OF COLOR
Resolved, that ArMA encourages Arizona medical educators to provide comprehensive education by including patient presentations of dermatologic pathologies (including melanoma) specifically in skin of color.

RESOLUTION 23-22 TRANSDERMAL CONTRACEPTIVE PATCH COLOR VARIABILITY
Resolved, that ArMA increases awareness of the limited color availability of the current transdermal contraceptive patch and its associated barriers to women of all skin colors in order to drive future investigation and development of transdermal contraceptive patch color variability.
RESOLUTION 24-22 INCREASE COMMUNITY EDUCATION ON SPEECH DELAY AND OPPORTUNITIES TO IMPROVE LANGUAGE ACQUISITION DURING THE COVID-19 ERA
Resolved, that ArMA supports increased community education on early detection of speech delay and on readily available resources for therapeutic interventions that may be performed by both families and certified therapists.

RESOLUTION 25-22 INCREASING POSITIONS FOR GRADUATE MEDICAL EDUCATION TO ADDRESS PHYSICIAN SHORTAGES
Resolved, that ArMA supports policy and other measures in favor of increasing the number of GME positions in Arizona, particularly in underserved areas most affected by a lack of access to physician services, in order to address physician shortages.

2022 RESOLUTIONS AMENDED AND ADOPTED

RESOLUTION 03-22 ACCESS TO RESOURCES FOR FAMILY PLANNING IN CONTRACEPTION DESERTS
Resolved, that ArMA supports legislation and implementation of health policy that increases access to contraception in areas without adequate coverage throughout Arizona.

RESOLUTION 04-22 FAMILY PLANNING FOR MEDICAL STUDENTS AND GME PROGRAMS
Resolved, that ArMA encourages medical schools and GME programs to create informative resources addressing parenthood and the path to parenthood; and be it further

Resolved, that ArMA encourages medical schools and GME programs to provide easily accessible information to prospective and current students, residents, and fellows regarding family planning at their institution including policies on parental leave and relevant make up work, education on options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and be it further

Resolved, that ArMA supports the development of comprehensive requirements for medical and GME programs regarding guidelines and resources for family leave and parenthood; and be it further

Resolved, that ArMA supports medical schools and GME programs providing parental leave for medical students, residents, and fellows of all genders, and medical school or broader licensure-related policies that allow for students, residents, and fellows to take leave without academic or disciplinary penalties, and be it further

Resolved, that ArMA encourages medical schools and GME programs to formulate, and make readily available, concrete plans for each year of schooling such that continuous weeks of parental leave may be flexibly incorporated into the curriculum; and be it further

Resolved, that ArMA opposes discrimination against students, residents, and fellows who take family/parental leave; and be it further

Resolved, that ArMA encourages medical schools and GME programs to make these formal policies transparent and easily accessible for both current and prospective students, residents, and fellows.

RESOLUTION 05-22 PREVENTING DISCRIMINATION AND REDUCING RISK OF SUICIDE IN THE TRANSGENDER POPULATION
Resolved, that ArMA supports legislation and public health policy that is inclusive and supportive and prevents discrimination and neglect towards the transgender population to reduce the risk for suicide and adverse outcomes.

RESOLUTION 07-22 COMPREHENSIVE SEXUAL EDUCATION
Resolved, that ArMA supports improvement of overall health by expanding access to comprehensive sexual education that is medically accurate, evidence-based, age and developmentally appropriate, in primary and secondary education settings.

RESOLUTION 10-22 TRANSPARENCY BY ORGANIZATIONS THAT PROVIDE PRENATAL OR PREGNANCY SERVICES, INCLUDING CRISIS PREGNANCY CENTERS
Resolved, that ArMA encourages any organization offering prenatal or pregnancy services to offer evidence-based health information, or to fully inform the patient that any non-evidence-based information is not proven as safe or is experimental, and be it further

Resolved, that ArMA supports policies which require facilities that offer prenatal or pregnancy services to disclose the educational background, affiliations, financial disclosures, medical licensure, or lack thereof, and training or lack thereof of its staff and volunteers to patients at the time of service.
RESOLUTION 13-22 REPRODUCTIVE HEALTH
Resolved, that the Arizona Medical Association affirms that reproductive health care is essential to people’s overall health. Pregnancy termination is an essential component of reproductive health care, especially in cases of rape, incest, or danger to the life of the mother, and should not be criminalized.

RESOLUTION 16-22 RECOGNIZING THE IMPACT OF CLIMATE CHANGE ON HUMAN HEALTH
Resolved, that ArMA acknowledges the data-driven scientific consensus that the adverse effects of global climate change negatively impact public health, with disproportionate impacts on vulnerable populations, including children, the elderly, people experiencing poverty and homelessness, etc, and be it further

Resolved, ArMA support efforts to mitigate the negative effects of climate change on patient health.

RESOLUTION 26-22 PROMOTING A CULTURE OF DIVERSITY AND INCLUSION WITHIN ArMA
Resolved, that ArMA will create a Diversity, Equity, and Inclusion Committee, to promote a culture of inclusion and an appreciation for diversity within ArMA.

RESOLUTION 27-22 SUPPORT OF OSTEOPATHIC PHYSICIANS
Resolved, that ArMA recognizes the qualifications and contributions of physicians trained in osteopathic medicine, and be it further

Resolved, that ArMA discourages discrimination against medical students, residents, fellows, or physicians, by institutions and programs based on osteopathic or allopathic training, and be it further

Resolved, that ArMA encourages membership on committees, the Board of Directors, and the Executive Committee in a manner that reflects a representation of physicians from both osteopathic and allopathic training backgrounds.

READOPTION OR OTHER ACTION TAKEN ON PREVIOUS ARMA RESOLUTIONS

2017-2018 RESOLUTIONS READOPTED WITHOUT AMENDMENT

RESOLUTION 29-22 PROHIBITION ON THE HERBAL SUPPLEMENT KRATOM (ORIGINALLY 10-18)
Resolved, That ArMA supports the conduct of ethically and scientifically sound research to evaluate beneficial or harmful effects of Kratom and its pharmacologically active derivatives, and be it further

Resolved, That ArMA supports prohibition of the sale or distribution of Kratom or its derivatives in Arizona until it is deemed safe by the FDA.

RESOLUTION 30-22, GRADUATE MEDICAL EDUCATION FUNDING (ORIGINALLY 5-14, READOPTED 12-18)
Resolved, That ArMA supports increased GME funding in Arizona and is strongly opposed to any proposed funding cuts; since cuts will undoubtedly result in further physician shortages and be detrimental to medical education in this country; and be it further

Resolved, That ArMA supports preserving physician residency programs in Arizona as a focus for a long term solution that will maintain access to care for Americans and help to diminish upcoming physician shortages; and be it further

Resolved, That ArMA will pursue these goals by all means possible, including legislation.

RESOLUTION 31-22 PEER REVIEW; BEST PRACTICES (ORIGINALLY 13-10; READOPTED 15-14, 15-18)
Resolved, That ArMA work to ensure that hospital peer review be unbiased so that it shall only be used to make valid clinical decisions that improve patient care.

RESOLUTION 32-22 HEALTH SYSTEM REFORM (ORIGINALLY 14-94; READOPTED 36-98, 30-02, 26-06, 28-10, 24-14, 18-18)
Resolved, That ArMA supports health reform with a pluralistic, competitive system which includes fee-for-service, managed care organizations, and any other systems which can provide competent, scientific medical care to the citizens of Arizona.

Resolved, That ArMA supports medical licensure by examination or reciprocity based on documented adequate medical education, knowledge, skill and competency; and be it further
Resolved, That ArMA opposes discrimination in medical licensure, hospital staff appointments, and re-credentialing of privileges based upon graduation from a medical school outside the United States and Canada; and be it further

Resolved, That ArMA opposes any legislative policies or actions that foster discrimination based on graduation from a medical school outside the United States and Canada. (21.100)

RESOLUTION 34-22 DISCHARGE FROM ACUTE CARE INSTITUTIONS TO NON-ACUTE CARE FACILITIES (ORIGINALLY 14-98; READOPTED 21-02, 35-06, 34-10, 29-14, 21-18)
Resolved, That ArMA strongly endorses the position that no transfer from an acute care institution to a non-acute care facility be considered appropriate or allowed without a legible discharge summary and proof of acceptance from the receiving attending physician.

RESOLUTION 35-22 PROTECTING PHYSICIANS’ DUE PROCESS RIGHTS (ORIGINALLY 2-06, READOPTED 38-10, 32-14, 24-18)
Resolved, That ArMA declare that physicians shall refrain from enabling any process that deprives a colleague of procedural or substantive due process and that engaging in sham peer review shall constitute unethical conduct.

RESOLUTION 36-22 ELIMINATION OF INTRUSION INTO THE DOCTOR/PATIENT RELATIONSHIP AND PROTECTION OF PATIENT CONFIDENTIALITY (ORIGINALLY 15-98; READOPTED 22-02, 20-06, 26-10, 22-14; AMENDED 28-18)
Resolved, That ArMA strongly:
  • Supports the sanctity of the doctor/patient relationship;
  • Believes no physician should ever be compelled to betray the private trust inherent in this relationship;
  • Believes medical records should remain private and inviolate;
  • Believes medical information should never be shared outside of the physicians engaged in direct patient care without the written consent of the patient.

RESOLUTION 37-22 COMMITMENT TO AND SUPPORT OF ArMPAC (ORIGINALLY 6-82; READOPTED 19-86, 22-90, 28-94, 46-98, 36-02, 30-06, 31-10, 27-14; AMENDED 29-18)
Resolved, That ArMA reaffirm its support of the Arizona Medical Political Action Committee and encourage robust participation and giving from all ArMA members to ArMPAC.

2017-2018 RESOLUTIONS AMENDED AND READOPTED

RESOLUTION 38-22 TESTOSTERONE THERAPY (ORIGINALLY 8-14; AMENDED 26-18)
Resolved, That ArMA encourage appropriate healthcare providers to review the most recent American Urological Association Guidelines and the Endocrine Society Guidelines regarding Testosterone Therapy in Adult Men with testosterone deficiency. A thorough discussion of the risk versus benefit of testosterone therapy should be discussed between the provider and patient and documented.

RESOLUTION 39-22 ACTION ON PRIOR AUTHORIZATION DELAYS AND TRANSPARENCY (ORIGINALLY 27-98; READOPTED 26-02, 23-06, 45-10, 35-14; 30-18)
Resolved, That ArMA ensure that the prior authorization process does not hinder patient care, the practice of medicine, or the doctor/patient relationship; and be it further

Resolved, That ArMA works to ensure that the prior authorization process is transparent, efficient, fair and enforceable.

RESOLUTION 40-22 EXPERT WITNESS TESTIMONIAL ABUSE (ORIGINALLY 2-05, READOPTED AS 16-09, AMENDED 42-13; READOPTED 34-17)
Resolved, That ArMA continue to support the development of standards of professionalism that encompass guidelines for (1) impartial and fair testimony, (2) reasonable compensation for that testimony and (3) professional relations with colleagues.

RESOLUTION 41-22 PHYSICIAN WELL-BEING (ORIGINALLY 08-18)
Resolved, That ArMA pledge a continuing commitment to physician and physician trainee wellbeing to ensure the best possible patient care and medical education environments; and be it further

Resolved, That ArMA supports education about and the promotion of research into improving physician and physician trainee wellness, and specifically the mental health of physician and physician trainees.

RESOLUTION 42-22 PROTECTION AGAINST GUN VIOLENCE (ORIGINALLY 09-18)
Resolved, That ArMA support evidence-based interventions to reduce gun violence; and be it further
Resolved, that ArMA support full background checks for all firearm purchases.

RESOLUTION 43-22 GUIDELINES FOR ADMINISTRATION OF SUBCUTANEOUS IMMUNOTHERAPY (ORIGINALLY 9-14, 13-18)
Resolved, That ArMA will educate its members that, per the Agency for Healthcare Research & Quality guidelines, subcutaneous allergen immunotherapy should be administered in a setting that permits the prompt recognition and management of adverse reactions, except in proven clinical safe or rare and exceptional cases when allergen immunotherapy cannot be administered in a medical facility and withholding this therapy would result in a serious detriment to the patient’s health.

RESOLUTION 44-22 COLLEGE OF MEDICINE INCREASES (ORIGINALLY 14-02; READOPTED 18-06, 24-10, 20-14, 16-18)
Resolved, That ArMA work to minimize tuition increases for Arizona medical students in order to keep student education debt low enough that students will stay and practice in all Arizona locations, metropolitan and rural; and be it further

Resolved, That ArMA work with the legislature to create incentives to encourage medical students to remain in Arizona or return to Arizona after post-graduate training.

Resolved, That ArMA endorses legislation:
- Eliminating pre-existing condition exclusions that permit insurers to exclude artificial “communities” of the healthy for insurance coverage;
- Advocating for multiple options or pathways that will help low-income families purchase medical insurance;
- Promoting freedom of individual choice by encouraging access to multiple options for healthcare coverage; and
- Guaranteeing rights of physicians and patients to contract privately.

RESOLUTION 46-22 PREVENTING MEDICATION REGIMEN CHANGE (ORIGINALLY 6-10; AMENDED 37-14; READOPTED 25-18)
Resolved, That ArMA support legislation prohibiting changes in a medication regimen due to change in the patient’s health insurance company or pharmacy benefit manager or formulary change without written notification to both the patient and prescribing physician; and be it further

Resolved, That any changes in a medication regimen due to change in the patient’s health insurance company or pharmacy benefit manager or formulary change not be effective for at least 90 days after such notification.

RESOLUTION 47-22 CHILDHOOD OBESITY (ORIGINALLY 14-10; READOPTED 16-14; AMENDED 27-18)
Resolved, That ArMA support efforts to:
- Follow American Academy of Pediatrics guidelines for assessment of children for obesity and its medical complications and employ preventive strategies such as 5-2-1-0 counseling (5 servings of fruits and vegetables–2 or fewer hours screen time–1 hour of physical activity–no sweetened beverages daily) as part of routine pediatric care;
- Encourage schools and child care facilities to adopt best practices aligned with expert recommendations for nutrition and physical activity;
- Advocate for insurance companies to provide adequate coverage and payment for services provided by physicians and other healthcare professionals that support the expert recommendations for prevention, assessment and management of childhood obesity;
- Cover nutrition/dietician services for children;
- Maintain a sufficient nutrition/dietician network skilled in working with children and youth.
- Support funding, programming, and educational efforts to reduce and prevent childhood obesity;
- Support mental health services and trauma-informed care approaches to reduce and prevent childhood obesity.

2017-2018 RESOLUTIONS NOT READOPTED

- RESOLUTION 31-17 ArMA’s POSITION ON ABORTION (ORIGINALLY 03-97; READOPTED 25-01; AMENDED 37-05; READOPTED 36-09, 38-13, 31-17)
- RESOLUTION 02-18 PAYMENT FOR ADVANCE CARE PLANNING
- RESOLUTION 03-18 SCOPE OF PRACTICE EXPANSION ADVOCACY & IMPACTS ON PHYSICIANS & MEDICAL STUDENTS
- RESOLUTION 04-18 ALL PAYER GRADUATE MEDICAL EDUCATION FUNDING
- RESOLUTION 06-18 PAYMENT FOR PALLIATIVE CARE
- RESOLUTION 07-18 TRAMADOL CHANGE FROM DEA SCHEDULE IV TO SCHEDULE III
- RESOLUTION 11-18 NALOXONE ON COMMERCIAL AIRLINES
NEW BUSINESS

As a result of adopting 13-22 Reproductive Health, it was moved that ArMA engage the AMA and ACOG in helping to craft messaging in response to questions that will arise from the public and media, due to our change of policy regarding pregnancy termination and that this issue be referred to the Executive Committee. The motion was seconded and unanimously approved.

Having no other business before the House, the meeting adjourned sine die at 6:35 pm

Jason Jameson, MD
Secretary
### Membership Rates

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>Practicing Physician</td>
<td>$350</td>
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<tr>
<td>Government Physician</td>
<td>$105</td>
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<tr>
<td>Retired Physician</td>
<td>$60</td>
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<tr>
<td>Resident, Fellow, and Medical Students</td>
<td>Free</td>
</tr>
</tbody>
</table>

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### Benefits

- **Continued Medical Education (CME):**
  In-person events, virtual events, webinars, seminars, and conferences within Maricopa County.

- **Patient Referrals:**
  Find a Physician Directory connects patients with a physician that best meets their medical needs.

- **Professional Referrals:**
  Vetted private companies, government organizations and business professionals.

- **Networking Events:**
  Business, educational, and social events.

- **Maricopa County Marketplace:**
  Physician members can place advertisements for their practices, job openings for all levels of medical professionals and office staff.

- **Partner Program:**
  Simplifying prior authorizations, modernizing revenue cycle management, reviewing your employment contracts, and protecting your assets.

- **Policy Advocacy:**
  MCMS member physicians at the Arizona Legislature to promote positive change in health policy.

- **Arizona Physician Media:**
  A quarterly print magazine that is circulated to over 12,600 physicians in Maricopa County, the nation’s fifth largest concentration of physicians.
2023 House of Delegates
April 21-22, 2023

Delegates
Board of Directors
Past Presidents
HOD Committees
FINANCIAL PLANNING STRATEGIES FOR PHYSICIANS AND PHYSICIAN BUSINESS OWNERS

TAX STRATEGIES
MAXIMIZING DEDUCTIONS
FINANCIAL ORGANIZATION
INVESTMENT PORTFOLIO OPTIMIZATION
BUSINESS PLANNING

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Joshua Brown | 520.591.5729
joshua.d.brown@westpacwealth.com

Bryan Martinka | 623.210.2314
bryan.x.martinka@westpacwealth.com
<table>
<thead>
<tr>
<th>REPRESENTING</th>
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<tbody>
<tr>
<td>At-Large Delegates</td>
<td>Ms. Blessing Atanmo</td>
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<tr>
<td></td>
<td>Ms. Carleen Cuevas</td>
</tr>
<tr>
<td></td>
<td>David Horwitz, MD</td>
</tr>
<tr>
<td></td>
<td>Mr. Eshaan Kashyap</td>
</tr>
<tr>
<td></td>
<td>Kenneth Knox, MD</td>
</tr>
<tr>
<td></td>
<td>Marla Rejbi, MD</td>
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<tr>
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<td>Amish Shah, MD</td>
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<tr>
<td></td>
<td>Duane Whitaker, MD</td>
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<tr>
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<tr>
<td>Maricopa County Medical Society</td>
<td>Jane Lyons, MD</td>
</tr>
<tr>
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<tr>
<td>Pima County Medical Society</td>
<td>Wendy Huempfner, MD</td>
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<tr>
<td>(3)</td>
<td>Anil Prasad, MD</td>
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<tr>
<td>Rural County Delegates</td>
<td>William Waldo, MD</td>
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<tr>
<td>Medical Students</td>
<td>Ms. Jennifer Codd</td>
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<tr>
<td>(2)</td>
<td>Ms. Fathima Haseefa</td>
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<td>Resident Physicians</td>
<td>Elizabeth Braunreuther, MD</td>
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<tr>
<td>(2)</td>
<td>Viktorya Tannenbaum, MD</td>
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<tr>
<td>American Academy of Pediatrics, AZ Chapter</td>
<td>Pamela Murphy, MD</td>
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<tr>
<td>American Congress of Obstetricians &amp;</td>
<td>Ilana Addis, MD</td>
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<td>Victoria Fewell, MD</td>
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<td>William Thrift, MD</td>
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<td>Society</td>
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<td>Arizona Society of Pathologists</td>
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<tr>
<td>Arizona Society of Physical Medicine &amp; Rehabilitation</td>
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<tr>
<td>Arizona Society of Plastic Surgeons</td>
<td>(1)</td>
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<tr>
<td>-----------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Arizona Urological Society</td>
<td>(1)</td>
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</tbody>
</table>
Guests

Ronald Fischler, MD
Ms. Melissa Pelkey, Medical Student
Mr. Adam Thompson, Medical Student

Libby McDannell, Chief Executive Officer, Arizona Medical Association

Leighann Wilson, AMA Federation Relations for Arizona
EXECUTIVE COMMITTEE
President - Jennifer Hartmark-Hill, MD
President-Elect - William Thompson, IV, MD
Treasurer - James Nachbar, MD
Secretary - Jason Jameson, MD
Immediate Past President - Miriam Anand, MD
At Large EC Member - Timothy Beger, MD
At Large EC Member - Sarah Coles, MD
AMA Delegation Chair - Ronnie Dowling, MD
Chair ArMA L&G Committee – Ross Goldberg, MD

OTHER DIRECTORS
Robert Aaronson, MD – Pima Director
Ms. Olufunmilola Adeleye – Medical Student Director
Gretchen Alexander, MD – Chair, ArMPAC
Arash Araghi, DO – At-Large Director
Christopher Bailey, MD - Pima Director
David Baltazar, DO – Resident Director
Spencer Bayless – Medical Student Director
Ajay Bhatnagar, MD – Rural Director
Kathryn Coan, MD – At-Large Director
Jennifer Conn, MD – Rural Director
Ricardo Correa, MD – Maricopa Director
Katherine Glaser, MD – Rural Direct
Timothy Graham, MD – Rural Director
Dale Guthrie, MD – At-Large Director
Jacquelyn Hoffman, MD – Resident Director
M. Zuhdi Jasser, MD – AMA Delegate
Nadeem Kazi, MD – Rural Director
Lee Ann Kelley, MD – Maricopa Director
Laura Mercer, MD – At-Large Director
May Mohty, MD – Maricopa Director
Sarah Patel, MD – Early Career Director
Corinna Saldanha, DO – Maricopa Director
Ricardo Verdiner, MD – At-Large Director
### Past Presidents Who Are Current Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Years</th>
<th>Location</th>
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<tbody>
<tr>
<td>Gretchen Alexander, MD*</td>
<td>2016–2017</td>
<td>Phoenix</td>
</tr>
<tr>
<td>Miriam Anand, MD*</td>
<td>2021–2022</td>
<td>Tempe</td>
</tr>
<tr>
<td>Bruce A. Bethancourt, MD</td>
<td>2003–2004</td>
<td>Paradise Valley</td>
</tr>
<tr>
<td>Henri R. Carter, MD</td>
<td>2008–2009</td>
<td>Yuma</td>
</tr>
<tr>
<td>Jacqueline A. Chadwick, MD</td>
<td>1992–1993</td>
<td>Phoenix</td>
</tr>
<tr>
<td>Richard L. Collins, MD</td>
<td>1988–1989</td>
<td>Paradise Valley</td>
</tr>
<tr>
<td>Richard Dale, MD</td>
<td>2002–2003</td>
<td>Tucson</td>
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<tr>
<td>Ronnie K. Dowling, MD*</td>
<td>2001–2002</td>
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<tr>
<td>Robert J. Dunn, MD</td>
<td>1996–1997</td>
<td>Scottsdale</td>
</tr>
<tr>
<td>R. Screven Farmer, III, MD</td>
<td>2007–2008</td>
<td>Tucson</td>
</tr>
<tr>
<td>Gary R. Figge, MD</td>
<td>2010–2011</td>
<td>Tucson</td>
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<tr>
<td>Ross Goldberg, MD*</td>
<td>2020–2021</td>
<td>Phoenix</td>
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<tr>
<td>Ronald A. Goodsite, MD</td>
<td>2000–2001</td>
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<tr>
<td>Michael Hamant, MD</td>
<td>2017–2018</td>
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<tr>
<td>Joseph W. Hanss, Jr., MD</td>
<td>1990–1991</td>
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<tr>
<td>Gary L. Henderson, MD</td>
<td>1985–1986</td>
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<td>M. Zuhdi Jasser, MD*</td>
<td>2006–2007</td>
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<tr>
<td>Philip E. Keen, MD</td>
<td>2004–2005</td>
<td>Phoenix</td>
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<tr>
<td>Nathan Laufer, MD</td>
<td>2015–2016</td>
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<tr>
<td>Marilyn K. Laughead, MD</td>
<td>1995–1996</td>
<td>Scottsdale</td>
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<tr>
<td>Marc L. Leib, MD</td>
<td>1997–1998</td>
<td>Phoenix</td>
</tr>
<tr>
<td>Jeffrey T. Mueller, MD</td>
<td>2014–2015</td>
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<tr>
<td>John E. Oakley, MD</td>
<td>1982–1983</td>
<td>Prescott</td>
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<tr>
<td>Robert R. Orford, MD</td>
<td>2011–2012</td>
<td>Fountain Hills</td>
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<td>J. Michael Powers, MD</td>
<td>1998–1999</td>
<td>Phoenix</td>
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<tr>
<td>Traci Pritchard, MD</td>
<td>2018–2019</td>
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<tr>
<td>Beth A. Purdy, MD</td>
<td>2009–2010</td>
<td>Phoenix</td>
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<tr>
<td>Thomas C. Rothe, MD</td>
<td>2013–2014</td>
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<td>Paul L. Schnur, MD</td>
<td>1994–1995</td>
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<td>John J. Standifer, MD</td>
<td>1972–1973</td>
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<td>William J. Thrift, MD</td>
<td>2012–2013</td>
<td>Prescott</td>
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<tr>
<td>Susan M. Whitely, MD</td>
<td>2019–2020</td>
<td>Phoenix</td>
</tr>
</tbody>
</table>

*Currently on ArMA’s Board of Directors*
COMMITEES OF REFERENCE FOR THE 2023 ANNUAL MEETING

COMMITTEE ON CREDENTIALS
Katherine Glaser, MD
Pamela Murphy, MD

COMMITTEE ON RESOLUTIONS AND AMENDMENTS
Marc Leib, MD, Chair
Ricardo Correa, MD
Laura Mercer, MD
William Thrift, MD

COMMITTEE ON STANDING RULES & Tellers
Ms. Blessing Atanmo
Sarah Patel, MD
IN MEMORIAM 2022-2023

Arizona physicians who have passed away in the last year. For convenience, a link to their obituary has been provided.

Julian E. Ballesteros, MD, Tucson, passed away on July 4, 2022.
James C. Brown, MD, Phoenix, passed away on August 13, 2022.
Robert B. Cairns, MD, Tucson, passed away on September 14, 2022.
Paul E. Clinco, MD, Tucson, passed away on May 1, 2022.
Mary E. Collins, MD, Tucson, passed away on September 9, 2022.
Carleton E. Dangremond, Jr., MD, Fountain Hill, passed away on November 4, 2022.
David R. Ewing, MD, Tucson, passed away on February 11, 2023.
Brian Fairfax, MD, Phoenix, passed away on August 9, 2022.
Diane S. Fordney, MD, Tucson, passed away in November 2022.
Clifford Goodman, Jr, MD, Chandler, passed away on May 29, 2022.
David Gralnek, MD, Phoenix, passed away on February 28, 2023.
Wilbur A. Haak, MD, Globe, passed away on September 7, 2022.
Craig E. Hoffbauer, DO, Cottonwood, passed away on December 8, 2022.
Edward S. Levy, MD, Scottsdale, passed away on March 10, 2023.
Max D. Lind, MD, Scottsdale, passed away on July 8, 2022.
Jan Mangalat, MD, Phoenix, passed away on October 20, 2022.
Larry I. Mann, MD, Tucson, passed away on January 21, 2023.
Frank I. Marcus, MD, Tucson, passed away on December 21, 2022.
Harold Margolis, MD, Tucson, passed away on November 25, 2022.
Bert McKinnon, MD, Flagstaff, passed away on December 9, 2022.
IN MEMORIAM 2022-2023

William E. Miller, Jr., MD, Tucson, passed away on May 12, 2022.
Thomas F. Moore, MD, Phoenix, passed away on February 20, 2023.
Luis A. Munoz, MD, Payson, passed away on July 30, 2022.
John W. Pettit, MD, Nogales, passed away in October 2022.
John C. Racy, MD, Tucson, passed away on September 14, 2022.
Paul Reinholtz, MD, Mesa, passed away on July 2, 2022.
Phyllis S. Reuss, MD, Paradise Valley, passed away on December 31, 2022.
Larry Rumans, MD, Tucson, passed away on July 6, 2022.
Stuart J. Salasche, MD, Tucson, passed away in July 2022.
Darrell L. Scheetz, DO, Yuma, passed away on June 29, 2022.
Phon D. Sutton, MD, Payson, passed away in March 2023.
Beverly S. Tozer, MD, Paradise Valley, passed away on April 22, 2022.
Vernon C. Urich, MD, Oro Valley, passed away on October 19, 2022.
C. Harold Willingham, MD, Tucson, passed away on November 14, 2022.
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2023 House of Delegates
April 21-22, 2023

Reports
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mark.austin@carr.us

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2023 REPORTS

- 2023 Approved ArMA Budget
- President's Report
- ArMA Bylaws Committee Report
- Medical Aid in Dying Task Force Report
- June 2022 AMA Delegation Report
- November 2022 AMA Delegation Report
- 2023 Leadership Elections
### 2023 Budget

#### Revenue:

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<tr>
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<td>Dues</td>
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<tr>
<td>MICA Sponsorship</td>
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<td>Affiliate Partner Program</td>
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<td>Advertising</td>
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<td>Healthcare Coalition Management</td>
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<td>AMPAC Admin Fees</td>
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<td>Grant Revenue</td>
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<td>AMA Annual Meeting</td>
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<td>AMA Meetings</td>
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<td>Interest</td>
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#### Expense:

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<td>Marketing &amp; Promotional resources</td>
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<td>Strategic Planning</td>
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<td>Physician/Resident Guides</td>
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<td>Adolescent Guide</td>
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<td>Professional/Team Development</td>
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<td>HAWC Initiative Expense</td>
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<tr>
<td>Presidential Budget</td>
<td>25,000</td>
</tr>
<tr>
<td>Total</td>
<td>2,130,258</td>
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#### Operating Net Margin

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (USD)</th>
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<tbody>
<tr>
<td>Foundation Profit/(Loss)</td>
<td>22,515</td>
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<tr>
<td>Unrealized Gain/Loss on Investments</td>
<td>24,153</td>
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<tr>
<td>Realized Gain/Loss on Investments</td>
<td>29,521</td>
</tr>
<tr>
<td>Gain/Loss on Disposal of Assets</td>
<td>-</td>
</tr>
<tr>
<td>Net Margin</td>
<td>24,146</td>
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</table>
Over the past year, the Arizona Medical Association (ArMA) worked diligently to actively support physicians and patients on multiple fronts, achieving momentous wins along the way. From developing a robust 3-year strategic plan for success, to tackling key strategic objectives, ArMA’s efforts have been thoughtful, well-balanced, and focused on both our internal strength and external influence.

It is my pleasure to highlight a few of our many accomplishments during my presidential term.

**Reproductive Health** – ArMA has been a leading voice in efforts to affirm that reproductive health care is essential to people’s overall health. In accordance with our policies, we have continued to fight for appropriate access to care and against the criminalization of our physician community. Over the past year, ArMA has taken significant action to improve access to reproductive health care in our state. This included issuing a public call to action, filing a lawsuit requesting our state courts harmonize the laws regulating access to reproductive health care, and convening a stakeholder coalition with more than 50 representatives from Arizona’s health care community to develop a joint statement on behalf of our member organizations. ArMA remains committed to protecting your freedom to deliver care that is in the best interest of your patients.

**Destigmatizing Mental Health** – At the end of the 2022 Legislative Session, ArMA’s signature legislation, HB2429, reached the ultimate milestone, passing the AZ State Legislature with nearly unanimous support and being signed into law by Governor Ducey. This new statute supports the well-being of Arizona’s physicians and nurses by encouraging the seeking of timely confidential mental health care.

In conjunction with common sense changes to the reporting requirements on the medical licensure application and ArMA’s very own DOC2DOC AZ peer support program, these efforts send a clear message to our physician community that seeking timely mental health treatment is essential to whole-person health.

**Addressing Healthcare Workforce Shortages** – While there has been long-standing awareness regarding the serious impacts of the ongoing shortage of healthcare workforce personnel in Arizona, there has not been, until this past year, a coordinated approach taken to address this important issue. Thusly, ArMA has stepped up to take a leadership position on this need. With funding and support from the Arizona Department of Health Services (ADHS), ArMA has convened a Healthy Arizona Workforce Coalition (HAWC) that is meeting monthly to explore short-, mid-, and long-term solutions to the workforce crisis. This work is critical to ensuring that our healthcare workforce is able to meet the demands of Arizona’s unique and growing population.

**Physician Leadership** – ArMA is committed to helping each of our members develop their leadership skills, something that is not adequately addressed in our training. As part of those efforts, ArMA hosted a 4-part webinar series titled “4 Physician Perspectives on Transformative Leadership” last summer. That series was
followed by ArMA’s inaugural Physician Leadership Course, a virtual, 10-week leadership development workshop. In addition to those sessions, we are pleased to be highlighting physician leadership during our 2023 Annual Meeting with a theme of “More Than a LeaDr.” and including 3 hours of CME credit on the topic of physician leadership.

Social Determinants of Health – One of our main goals over the past year has been to bring awareness to the social determinants of health (SDOH) impacting patient populations. As physicians, knowing how to efficiently and effectively screen for and address SDOH for our patients can drastically improve health outcomes. ArMA was one of 5 organizations across the U.S. to receive grant funding that will enhance our capacity to help physicians optimize the integration of SDOH into their practices in a way that enhances patient health and increases value of care. Not only will this grant make the generation and compilation of resources possible, but it will also give our professional association the means to organize integration efforts and collect meaningful data. As the work on this grant is ongoing, ArMA has been highlighting members each month who are exemplars of incorporating SDOH into practice. These efforts make a difference, and deserve to be recognized!

Modernizing ArMA Governance – ArMA’s Bylaws Committee has taken on the extensive responsibility of reviewing our governance structure and considering how to make it nimbler and more inclusive of our membership. The Committee has done a great job of developing a proposal to modernize ArMA’s House of Delegates in a way that addresses policy setting, leadership elections, and bylaw amendments. With this proposal, ArMA would move to a year-round process for considering new policy resolutions. In addition, the entire membership would have more opportunities for engagement on policy proposals and the ability to elect the leadership of our society. These concepts have already been adopted by a majority of other state medical associations, and we are learning from their success. The final proposal will be presented for approval at the 2023 House of Delegates meeting.

A Focus on the Future – ArMA’s continued success is dependent on meeting the needs of our members. Earlier this year, we conducted a survey of all ArMA members and convened focus groups as part of the planning process for the development of our 3-year strategic plan. The results of that member engagement show that ArMA provides its members with the value they expect from a professional association, and our members are overwhelmingly satisfied with their membership. Armed with this data and other information, our leadership developed and approved a new three-year plan that aims to address healthcare needs strategically and proactively in Arizona. Our strategic focus will direct the association’s resources and efforts toward a clearly defined future in which ArMA continues to serve as the largest organization representing physicians throughout our state.

Thank you for playing a vital and valued role in our organization. Your leadership and the outstanding work you do matter and are greatly appreciated!

Sincerely,

Jennifer Hartmark-Hill, MD
ArMA President
In accordance with ArMA House Policy, a report is prepared to the House on proposed bylaw amendments and resolutions that have been referred; below is a summary of actions taken on bylaw amendments referred by the 2022 ArMA House of Delegates:

At the April 2022 ArMA House of Delegates meeting, Resolution A01-22, “ArMA Bylaws Requirements for Active Membership”, was introduced and debated. This resolution requested the following bylaw amendments be approved:

Resolved that The Arizona Medical Association requirement for Active membership and to hold elected office is that the individual not have a "revoked" license by action of the Arizona Medical Board.

Resolved that Retired physicians with an inactive medical license may choose Active membership status in the Association and can hold elected office.

The proposed bylaw amendments were not approved by the HOD and instead were referred to the Bylaws Committee for further consideration and evaluation.

The ArMA Bylaws Committee discussed the 2022 Referred Amendment during several of its meetings over the past year.

After thorough discussion as well as consultation with the Arizona Medical Board, the Committee agreed on the following with regards to the first Resolved and clarifying requirements for Active Membership.

- Members will be eligible for this category of membership if they hold an active, unsuspended license to practice medicine in the state of Arizona.

Per the AZ Medical Board, an active license is defined as one that is not revoked or surrendered.

Discussion on the 2\textsuperscript{nd} Resolved included agreement that retired members, especially long-time members, can make significant contributions. As such, it was recommended that an Emeritus Category be created to recognize long-standing ArMA members. Within that category of membership, criteria would include eligibility to hold elected office if the member is within their first five years of discontinuation of active practice. The Committee discussed the importance of elected leaders being practicing physicians, noting that the decisions made will directly impact them. After reviewing the Associate Member category criteria, there was consensus that this was appropriate for retired physicians who are not eligible for the 40 Year Club or Emeritus Membership.

The proposed amendments to the membership category criteria have been submitted to the 2023 House of Delegates for approval.
In accordance with ArMA House Policy, a report is prepared to the House on resolutions that have been referred; below is a summary of actions taken on the topic of medical aid in dying (MAID):

At the April 2022 ArMA House of Delegates meeting, Resolution 14-22, “Remove Opposition to Medical Aid in Dying” was introduced and debated. This resolution requested the following be approved:

**Resolved**, that the Arizona Medical Association remove its opposition and take a neutral position in regards to the practice of Medical Aid in Dying, indicating it is a compassionate end-of-life care option for mentally capable, terminally ill adults and that it should be legally authorized as one of the end-of-life care options available for Arizonans, and that physicians who participate in the practice of Medical Aid in Dying are adhering to their professional, ethical obligations as are physicians who decline to participate. This position would allow for, respect, and support the diverse views of the ArMA membership, and it will improve the end-of-life care for people with advancing life-limiting illnesses in Arizona.

The proposed resolution was not approved by the HOD; it was referred to a task force to be established by the ArMA President. The taskforce was charged with reporting back to the Board of Directors every six months.

The taskforce was established in October 2022 and convened in November 2022. It is comprised of the following members:

Dr. Gretchen Alexander, *ArMA Past President and Chair*
Dr. Jennifer Hartmark-Hill, *ArMA President*
Dr. Bill Thompson, *ArMA President-Elect*
Dr. Patricia Bayless, *Chair of AZ Bioethics Network*
Dr. Jasleen Chhatwal, *AZ Psychiatric Society Past President*
Dr. Robert Orford, *ArMA Past President*
Dr. Sarah Patel, *neurology trained ArMA board member representing early career physicians*
Dr. Michael Powers, *ArMA Past President and Chair of Previous Medical Ethics Taskforce*

The taskforce reported on its activities to the ArMA Board of Directors in December 2022 and March 2023 as follows:

- Detailed review of previous work done on this topic including ArMA’s 1997 Report on Physician Assisted Suicide, Recommendations from 2018 ArMA Medical Ethics Committee, 2018 Report from ArMA End of Life Task Force
- Detailed review of the 2018 Arizona Physician Survey on End of Life Issues and discussion of member concerns regarding this survey
- Analysis of AMA and other state medical society positions on MAID
• Creation of an ArMA member survey to evaluate membership opinions of MAID

During the March 2023 Board of Directors meeting, clarification of the Task Force’s mission was requested of the BOD and the following motion was passed: “To charge the Task Force with making recommendations for the process that ArMA should follow regarding MAID.”

At this time, the Task Force recommends that the House of Delegates support an ongoing process to determine member opinions of ArMA’s position on MAID, including active support of and participation in the current survey.

A further recommendation is that matters to be considered in a thoughtful process should include not only the question of whether to change ArMA’s position from opposed to neutral, but whether the position, if changed to neutral, should outline specific safeguards, as some other state medical societies positions on MAID have done.
Report of the Arizona Medical Association American Medical Association Delegation

June 2022 Meeting

Our ArMA AMA delegation was well represented at the June 2022 AMA House of Delegates meeting (HOD). The meeting was the first in-person AMA meeting in two years and had a backlog of resolutions that had been held over from the virtual meetings, necessitating a longer than usual timeline that was unusually packed with concurrent group meetings.

An overview of many important topics follows, and specific resolutions the delegation felt should be outlined are found starting on page 4. Please feel free to contact any of the delegates for further clarification or sign onto the AMA website using this link.

A Recovery Plan for Physicians was unveiled at the meeting as physician health is a major concern. Key points included:

- **Supporting telehealth** to maintain coverage and payment.
- **Reforming Medicare payment** to promote thriving physician practices and innovation.
- **Stopping scope creep** that threatens patient safety.
- **Fixing prior authorization** to reduce the burden on practices and minimize care delays for patients.
- **Reducing physician burnout** and addressing the stigma around mental health.

There is an active state and federal legislative movement on the issue of physician health. Delegates amended existing policy directing the AMA to work with the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop model state legislation or legislative guidelines addressing the design and implementation of physician health programs. These model guidelines may include – but are not limited to - the allowance for safe-haven or nonreporting of physicians to a licensing board or acceptance of physician health program compliance as an alternative to disciplinary action when public safety is not at risk, especially for physicians who voluntarily self-report their physical, mental, and substance-use disorders, engage with a physician health program, and successfully complete the terms of participation.

AMA delegates responded to concern over workplace retribution or retaliation against both employed and independent-contractor physicians who voice their concerns regarding patient safety and quality of care. The AMA was directed to "develop a model state legislative template and principles for federal legislation to protect physicians from corporate, workplace, or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities."

Scope of practice issues and the cost of providing health care by non-physician providers were extensively discussed.

The delegates took action to better support physician-led team-based care and more effectively push back against the inappropriate unsupervised practice of non-physician health providers, based on a study by the Hattiesburg Clinic physicians published in the *Journal of the Mississippi State Medical Association*. The Hattiesburg physician leaders examined Centers for Medicare & Medicaid Services 2017–2019 cost data on the operation of their organization’s Accountable Care Organization. The data revealed care provided by non-physician health professionals working on their own patient panels was more expensive than care delivered by doctors.
Fueled by this data, the Hattiesburg Clinic redesigned its care model to eliminate unsupervised practice by physician assistants and nurse practitioners—and also successfully opposed state legislation that would have allowed independent practice by these non-physician clinicians.

Following this example, delegates directed the AMA to:

- Encourage and support studies to determine the cost and quality impact of non-physician unsupervised practice on all patients.
- Develop model state legislation that opposes enactment of legislation and supports the reversal of such legislation, if present, that would authorize the independent practice

Firearm violence was again discussed as a Public Health crisis.

The 2022 AMA Annual Meeting was preceded by mass shootings at a school in Uvalde, Texas, and a grocery store in Buffalo, New York. The delegates adopted a new policy to support regulating homemade weapons known as "ghost guns," research warning labels on ammunition packages, and consider the mental health of schoolchildren as they engage in active-shooter drills.

Physicians themselves have not been spared in the recent carnage. Stephanie Husen, DO, and Preston Philips, MD, were shot and killed at their offices in Tulsa, Oklahoma; and John Cheng, MD, was killed while attending church in Orange County, California.

"This cannot be our new normal," said AMA Immediate Past President Gerald E. Harmon, MD, "Gun violence is out of control. Enough is enough."

Responding to the growing threat of over-policing and surveillance of reproductive health services, the nation's physicians and medical students at the 2022 AMA Annual Meeting in Chicago adopted a policy recognizing that it is a violation of human rights when government intrudes into medicine and impedes access to safe, evidence-based reproductive health services, including abortion and contraception.

In accordance with the new policy, the AMA will seek expanded legal protections for patients and physicians against government systems of control and punishment that criminalize reproductive health services. The new policy also calls for AMA to seek legal protections for patients who cross state lines to receive reproductive health services, as well as legal protections for physicians and others who support or provide reproductive health services or referrals to patients who cross state lines.

Existing AMA policy supporting the survivors of sexual assault was amended to include advocacy for immediate processing of sexual assault examination kits, an action which would reinforce the importance of testing to help catch perpetrators, protect survivors, and ensure that the statute of limitations does not pass before testing takes place, according to a resolution from the AMA Medical Student Section.

Specifically, delegates directed the AMA to advocate at the state and federal levels for:

- The timely processing of all sexual examination kits upon patient consent.
- Timely processing of "backlogged" sexual examination kits with patient consent.
- Additional funding to facilitate the immediate testing of sexual assault evidence kits.
Climate change and fossil fuels were also topics of intense debate. Delegates adopted a policy to "recognize the health, safety and climate risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas."

Additionally, delegates directed the AMA to:

- Educate its members and, to the extent possible, health care professionals and the public, about the health, safety, and climate risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas.
- Advocate to the appropriate government agencies such as the Environmental Protection Agency, the Department of Energy, and federal legislative bodies regarding the health, safety, and climate risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas.

Resolutions were passed to encourage health insurers to divest of their investments in fossil fuels, and the AMA has already done so.

Throughout the COVID-19 pandemic, disinformation has been of the utmost concern. This has led to what some describe as a secondary "infodemic," where permanent harm may be done to the trust in institutions due to the sheer volume of disinformation spread in a rapidly changing and sensitive environment.

"Physicians are a trusted source of information for patients and the public alike, but the spread of disinformation by a few has implications for the entire profession and causes harm. Physicians have an ethical and professional responsibility to share truthful information, correct misleading and inaccurate information, and direct people to reliable sources of health information," said AMA President Gerald E. Harmon, MD. "The AMA is committed to confronting disinformation, and we need to address the root of the problem.

"We must ensure that health professionals spreading disinformation aren't able to use far-reaching platforms, often benefitting them financially, to disseminate dangerous health claims," Dr. Harmon added. "While we are unlikely to undo the harms caused by disinformation campaigns during the COVID-19 pandemic, we can act now to help prevent the spread of disinformation in the future."

The AMA delegates worked to educate physicians and patients on the new 988 mental health hotline, boost training on laboratory testing in medical school, address childcare for medical students and residents, stop insurance coverage losses when the public health emergency ends, and help private practice build their part in new payment models.

It should be recognized that the new Physician Private Practice Section, chaired by Dr. Jasser, had nine of its resolutions pass the HOD. Dr. Dowling served as Parliamentarian of the Section and was also elected President of the Organization of State Medical Association Presidents.

The ArMA AMA Delegation thanks all ArMA AMA members for the opportunity to represent them and encourages active participation in both ArMA and the AMA to help keep our profession strong and protect the patients we serve.
Report of the Arizona Medical Association American Medical Association Delegation

June 2022 Meeting

Of note, several partial travel scholarships for medical students had no applicants and were not awarded. The deadline to apply for a travel grant for the November meeting is September 1, 2022, and the application can be found at this link.

Also, there is intense activity on creating more "gold card" states wherein a physician who achieves >90% positive result on preauthorization requests over six months then gets a "bye" for either that particular procedure/code (some states) or any subsequent authorizations that particular physician requests (other states) for a designated period of time. This is huge, and ArMA leadership is aware of the process and hopefully will work to achieve this in Arizona.

Respectfully Submitted,

Ronnie Dowling, ARMA AMA Delegation Chair

Council on Constitution & Bylaws Report, by Timothy Fagan, MD
This CC&B meeting was unlike any I have previously attended. Usually, the topics are dry and related to changes in procedures and wording. This meeting was almost entirely related to current medical and ethical issues. I have selected 3 of the adopted Resolutions, but I was very impressed by many others. The information on these Resolutions below is self-explanatory.

Resolution 003 – Gender Equity and Female Physician Work Patterns During the Pandemic
This resolution directs the AMA to take action by advocating for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality (Directive to Take Action); and that the AMA collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic.

Resolution 007 – Equal Access to Adoption for the LGBTQ Community
This resolution directs the AMA to advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation and to encourage the allocation of government funding to licensed child welfare agencies that offer adoption services.

Resolution 023 – Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options
This resolution directs the AMA to advocate for business models in long-term care for the elderly which incentivize and promote the ethical use of resources to maximize care quality, staff and resident safety, and resident quality of life and which hold patients' interests as paramount over maximizing, and in collaboration with other stakeholders, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care.

Reference Committee A – Medical Service, by Daniel Aspery, MD
Council on Medical Service (CMS) Report 4: Parameters of Medicare Drug Price Negotiation
This CMS report sought to outline specific principles for the use of international price indices and averages in determining the price and payment for drugs. These principles would help guide Medicare in drug price negotiations. In addition, this report sought to encourage the AMA to seek the development of voluntary models under the CMS Innovation Center to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs. In summary, this CMS report sought to expand the AMA’s efforts in helping lower the cost of drugs for Medicare beneficiaries.

Resolution 113: Prevention of Hearing Loss-Associated Cognitive Impairment through Earlier Recognition and Remediation
This resolution asks that the AMA promote awareness to physicians and the public of hearing impairment as a potential contributor to the development of cognitive impairment or dementia in later life and that the AMA promote that other pertinent stakeholders conduct and accelerate the research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment or dementia and are amenable to correction. Given the aging U.S. population and the healthcare burdens of cognitive decline and dementia, hearing loss's impact on these healthcare problems should be addressed. Still, the need for research for a better definition and role of hearing loss in cognitive decline and dementia development also needs to be addressed.

Resolution 116: Reimbursement of School-Based Health Centers
Given the role that school-based health centers play in access to care for large numbers of children and adolescents, this resolution asks the AMA to support the implementation, maintenance, and equitable expansion of physician-led, school-based, or school-linked health centers for the comprehensive management of childhood and adolescence health conditions. This resolution also seeks to study claims data from Medicaid and other payers for research and quality improvement purposes to improve the quality of care from these school-based health centers where so many children and adolescents access their care.

Resolution 118: Caps on Insulin Co-Payments for Patients with Insurance
Although the AMA has a policy on affordable medications, including insulin, this resolution sought to be more specific on the pricing and market competition regarding insulin and encouraged the FTC and DOJ to investigate insulin pricing and market competition. It also sought to support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin. The ultimate out-of-pocket expenses include co-payments and deductibles, but also rising insurance premiums due in part to rising drug costs. This resolution sought to protect patients from increases in all of these expenses.

Reference Committee B – Legislation, by Marc Leib, MD
Resolution 219—Due Process and Independent Contractors
The HOD adopted this resolution, which directs the AMA to develop model state legislative template and principles for federal legislation to protect physicians from corporate, workplace, and/or employer retaliation when they report concerns regarding safety, harassment, or fraud.

Resolution 212—Medication for Opioid Use Disorder in Physician Health Programs
Existing AMA Policy was modified to clarify that the AMA will work with the Federation of State Medical Boards (FSMB) as well as the Federation of State Physician Health Programs (FSPHP) to promote effective physician
health treatment programs. In addition, the policy is modified to include development of model state legislation or guidelines to include inclusion of medications to treat opioid use disorders while maintaining safe havens and non-disciplinary actions against physicians availing themselves of these programs when patients are not at risk, especially for physicians who voluntarily self-report substance use disorder and engage with a Physician Health Program.

**Resolution 254—Stakeholder Engagement in Medicare Administrative Contractor Policy Processes**
Directs AMA to work with CMS to prevent MACs from issuing Local Coverage Articles (LCAs) that could potentially restrict care without disclosing the data and evidentiary review underlying those LCAs and publishing accompanying Local Coverage Determinations (LCDs) with stakeholder input. Also requests that CMS invalidate any existing LCAs that could restrict access to care published without public disclosure of data and evidence and an accompanying LCD with appropriate input. In addition, state medical associations and specialty societies should also identify existing LCAs that restrict care issued without disclosing underlying data and evidence supporting such restrictions.

A number of resolutions were referred to the Board of Trustees for either a report back to the HOD or for decision.

**Reference Committee C – Medical Education, by Jacque Hoffman, MD**

**Council on Medical Education (CME) Report 4: Protection of Terms Describing Physician Education and Practice**
This CME report sought to clarify the use of the terms "residency" and "fellowship" in regards to physician training programs and directed the AMA to work with other academic institutions who train non-physicians in health care careers to create alternative nomenclature for their training programs in order to reduce confusion among the public about the types of training programs that physicians and non-physician health care workers receive. This report also directs the AMA to advocate that all health professionals in a clinical health care setting clearly and accurately communicate to patients and relevant others their qualifications; to seek legislation for implementation of this clear and accurate communications; and, to expand efforts in educational campaigns that addresses the differences in education, training and licensure/certification requirements and the differences in the role of physicians in health care compared to non-physicians.

**Council on Medical Education (CME) Report 5: Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician**
This CME report instructs the AMA to support inter-professional education programs and to intervene when medical education programs are being adversely impacted by clinical training programs of non-physicians. This report furthers the AMA support of physician training and healthcare roles and the potential adverse effects of non-physician training and clinical roles on physicians.

**Resolution 319: Senior Living Community Training for Medical Students and Residents**
Given the growing population of senior patients and the growing number of senior patient living in senior living facilities, this resolution directs the AMA to encourage the development of opportunities for medical students and resident/fellow physicians to train in senior living communities based on the educational objectives of their educational programs.
Resolution 327: Leadership Training Must Become an Integral Part of Medical Education
This resolution calls for a study by the AMA of the impact of current AMA policy on elective curriculums in medical educational programs. It also promotes the expansion of the AMA's efforts to use the tenets of health systems science to prepare trainees for leadership roles and to address prevalent challenges in the practice of medicine and public health. Physicians' roles as leaders continues to grow and expand. There is little preparation for this role in medical education and this resolution seeks to promote this type of education in medical education programs, while at the same time trying to understand the overall impact on the currently heavy medical education curriculums.

Reference Committee F – Finance, by Ronnie Dowling, MD
Resolution 601 - Development of Resources on End-of-Life Care
This resolution calls for the AMA to work with interested stakeholders to provide educational resources for medical students, physicians, and allied healthcare professionals as well as patients and their families on end-of-life care.

Resolution 607 - AMA Urges Health and Life Insurers of Divest from Investments in Fossil Fuels
AMA urges health and life insurers to divest from investments in fossil fuel. Called for building on the strong precedent of existing AMA policy as it pertains to the tobacco industry, the resolution calls for the ama to encourage all life and health insurance companies/HMOs to end all financial investments that generate the majority of their income from the exploration for, production of or sale of fossil fuels.

Resolution 615 - Anti-Harassment Training
This resolution calls for all AMA elected and appointed members to national and regional positions to complete AMA Code of Conduct and anti-harassment training.

Resolution 621 - Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence Based, Appropriate Care Is Banned or Restricted
The resolution addresses the mounting restrictions associated with reproductive health care threaten the patient physician relationship with unexpected consequences of bans of appropriate treatment restrict patient access to care, exacerbate health inequities and worsen health outcomes. The task force will have multiple objectives. Many of the other resolutions targeted the climate crisis, the focus and priorities of the AMA House of Delegates and modernization of the meetings as well as a resolution calling for candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence.

Reference Committee G – Medical Practice, by Zuhdi Jasser, MD
A number of resolutions were passed in Reference Committee G that shaped AMA policy in a way relevant to the vast majority of physicians in practice. The following are the highlights. Please note that Dr Jasser served as Chair of the Private Practice Physicians' Section and that in the first Annual meeting as a section 9 resolutions ultimately passed the House of Delegates. A few are identified here.

Resolution 702- Health System Consolidation
This resolution has asked the AMA to urgently study the current state of nationwide health systems and hospital consolidation "in order to assist policy makers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation. This study and report will be very timely and will hopefully expose the realities for many physicians on the frontlines of this threat.

**Resolution 701 – Fair Reimbursement for Administrative Burdens**

This resolution passed asking the AMA to continue strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduce the overall volume of PA for physician practices. The AMA will continue partnering with patient advocacy groups in PA reform efforts to reduce patient harms including care delays, treatment abandonment and negative clinical outcomes. The AMA will also oppose the inappropriate payer policies that deny or delay medically necessary drugs and medical services. Most importantly this called for fair reimbursement of time and burdens related to services provided.

The AMA will also oppose inappropriate payer policies that deny or delay medically necessary drugs and medical services. Most importantly this called for fair reimbursement of time and burdens related to services provided in order to complete.
The AMA Interim meeting concluded on November 15, 2022. The Interim sessions are limited to those issues addressing advocacy.

Five ArMA AMA delegates and three alternates attended the meeting. This report attempts to summarize those issues which our delegates and alternates felt were most pertinent to Arizona physicians. A full summary can be found on the AMA website.

Of paramount importance to every physician who accepts Medicare are the looming cuts proposed by Congress. The course of Congressional inaction to stop these cuts will result in heightened financial hardship to physician practices already reeling from the impact of the pandemic and the fact that physicians are the only providers whose Medicare payments do not automatically get an annual inflation increase. Medicare payments have declined 22% over the last twenty years when adjusted for inflation. The AMA organized a letter that all 50 medical associations signed and sent to House and Senate leaders. A second letter, signed by more than 100 specialty societies, was also generated. This was accomplished by the AMA HOD passing a multitude of resolutions asking for AMA leadership action on this topic. Almost all Arizona physicians will benefit from this action should it result in Congress denying the cut in Medicare payments.

Physician burnout, which has soared from 38% to 63% from 2020 to 2021, affects most Arizona physicians. Two in five practicing physicians nationwide plan to retire or move to part-time within the next two years. The AMA has developed several programs which deal with physician burnout, including methods recommended to help avoid/alleviate the condition and urging health systems and academic institutions to remove questions that might prevent medical students and physicians from seeking care for mental health and wellness. Anyone interested can access these on the AMA website. It should be noted that in 2022, the AMA advocated for new laws in AZ which sought to protect physicians who sought care for mental illness and substance abuse from punitive actions.

Scope of practice, which affects all physicians, was the subject of more than a few resolutions, as was asking for continuing opposition to the Improving Care and Access to Nurses Act which would expand the scope of practice for non-physician practices in both the Medicare and Medicaid programs.

Fixing prior authorization, another issue affecting most physicians in Arizona, was addressed in several resolutions, as was the continued support for enacting the Improving Seniors’ Timely Access to Care Act, which would streamline the prior auth processes in Medicare Advantage plans across the state and country.

One resolution, 313, co-sponsored by Arizona, asked that the AMA work to delay the implementation of a proposed change affecting any state Medical Association accreditation program with less than 20 programs a year. The new guidelines would greatly affect ArMA and 19 other states from creating or maintaining any ACCME-accredited CME programs. This resolution could potentially preserve the monies ArMA makes through our accreditation program.

Medical education and consideration of quality of life for those still in training resulted in three different but related resolutions passing, which better defined ama policies regarding parental, family, and medical necessity leave for MS and residents. Others dealt with GME funding and expansion.

The AMA HOD also passed resolutions (805, 811) to improve coverage and reimbursement for vaccines and encourage health plans to recognize that physicians incur costs associated with procurement beyond current
reimbursement. Also, the AMA HOD passed a resolution recommending that third-party pharmacy benefit administrators that contract be included in existing PBM regulatory frameworks and statutes and be subject to the same licensing, registration, and transparency reporting requirements (811). This affects many of our patients.

A Council on Medical Services report acknowledged that the corporate practice of medicine may create a conflict of interest between profit and best practices in residency and fellowship training. They highlighted that each physician should have the ultimate decision for medical judgment in patient care and medical care processes, including using mandated patient care algorithms or supervising non-physician practitioners.

The following are resolutions and reports thought to be important to Arizona physicians, physicians in training, and the patients they care for, which the AMA HOD passed:

Board of Trustee Report 1 Opposition to Requirements for Gender-Based Treatment for Athletes. Athletes have been subjected to procedures as invasive as genital exams; Testosterone levels do not reliably predict performance, and gender-altering operations do not predict performance. Individuals should be allowed to compete according to the gender with which they identify.

Board of Trustee Report 4 Preserving Access to Reproductive Health Services. Adopted as amended. Abortion and other reproductive services are a right, and access must be preserved.

Resolution 8 Support for Physicians Practicing Evidence-Based Care. Doctors must be able to practice evidence-based care and not be limited by what Legislators think should be done.

Resolution 809 mandated that Medicare Advantage Plans be required to post all components of Medicare covered in all plans and also have an accurate, up-to-date list of physicians and their associated plans.

Resolution 826 called for "leveling the playing field" and producing a report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades and factoring in inflation. Resolution 824 called for the AMA to advocate for appropriate payment for multiple services (two or more) to be performed during a single patient encounter.

Three resolutions concerning the youth were adopted: Resolution 926, limiting pornography viewing by minors; Resolution 919, decreasing access to E-cigarettes by minors; and Resolution 905, designed to make 14 the minimum age for juvenile criminal justice intervention.

Four resolutions concerning gun violence were adopted: Resolution 907, directed toward research to mitigate the effect of gun violence, Resolution 909, to reduce gun suicides, Resolution 921, to increase firearm violence research data availability, and Resolution 923, to increase physician education on firearm safety.

Passage of Resolutions 302, 303, and 308 with amendments to expand and better define AMA policies and provide additional recommendations for medical schools, residencies, and training hospitals regarding parental, family, and medical necessity leaves of absence to define times guaranteed, encourage paid leave where able, define the time needed to be made up or not, and expand to include bereavement for family losses of all kinds including loss of pregnancy. These affect all ARIZONA medical students.
Council on Medical Education Report 1 asks to study, better define and guarantee funding and expansion of GME spots and prevent or have a plan to place individuals in case of hospital/program closures and to include corporate and Medicare funding possibilities aid in this endeavor.

Resolution 313: that AMA works to delay implementation of any changes to the state medical society accreditor program until such a time that a mutual agreement can be reached as current changes to be implemented soon will greatly affect ArMA and other smaller state societies from realistically creating or maintaining any ACCME accredited CME programs.

Resolution 316: requests certain recommendations for consideration and for the AMA to study criteria for recognition and inclusion of certain subspecialty certifications seemingly worthy by all recognition criteria and yet to be ABMS certified.

Resolution 201: AMA to advocate for direct reimbursement to physicians for providing mandated interpretive services, including sign language interpreters. These payments would be provided by Medicare (including Medicare Advantage plans), Medicaid (including Medicaid managed care plans), Tricare, Veterans Administration, and commercial health insurers.

Resolution 202: Directs AMA to advocate for increased State funding for GME programs to increase the number of programs available beyond those funded by the Medicare program. This is important for the long-term stability of the number of physicians in the US healthcare system as an increasing number of physicians retire over the next 10 years.

Resolution 205: AMA to advocate for federal and state legislation to prohibit waiver of due process in physician employment contracts and to declare any existing provisions void. This would apply to any entity that employs physicians to prevent coercion of physicians concerned about patient safety or other issues whom such employers dismiss without recourse for due process protections.

Resolution 206: Investigate whether the increase in Nurse Practitioner programs has negatively affected the number of bedside nurses available to care for patients.

Resolution 223: The AMA will advocate for legislation to prevent the criminalization of pregnancy loss due to healthcare treatments for conditions resulting in unintended pregnancy loss for physicians and patients.

Resolution 227: AMA will oppose restrictions on prescribing, distributing, or dispensing methotrexate for the treatment of medical conditions based on its potential off-label use for pregnancy termination.

Public Health Issues which affect all of us and which were addressed at the meeting are as follows:

An annual update from the Council of Science and Public Health will be done on the drug shortages with added support for additional HHS and FTC oversight.

Recognition of Climate Change as a public health crisis with added actions to include additional funding for evidence-based policies and programs to protect vulnerable and minoritized populations
Report of the Arizona Medical Association American Medical Association Delegation

November 2022 Meeting

Resolution 911 called for the critical need for National Emergency Cardiac Care Systems (ECC) to ensure individualized State wide care for ST-segment elevation myocardial infarction (STEM) cardio genie shock and out-of-hospital arrest. The new AMA policy encourages states to designate hospitals as ECC centers.

Resolution 915 spoke to the awareness of the reduced accuracy of pulse oximeters in patients with increased skin pigmentation. The discussion included the margin of error for pulse oximeters in general.

Resolution 935, which pertained to Government manufacturing of Generic Drugs to address Market Failures, was deferred to the annual AMA meeting as one of the CA delegates is also a state senator who introduced the CA bill to address drug shortages.

The Delegation thanks all our ArMA members for allowing us to represent you and our patients at the AMA and for the continued support, ArMA gives the delegation.

Respectfully submitted for the Delegation,

Ronnie Dowling, MD
Delegation Chair.
## 2023 Leadership Elections
### FINAL BALLOT

#### BOARD OFFICER POSITIONS

<table>
<thead>
<tr>
<th>Open Position</th>
<th>Term</th>
<th>Candidate</th>
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<tbody>
<tr>
<td>President-Elect</td>
<td>2023-2024</td>
<td>Nadeem Kazi, MD</td>
</tr>
<tr>
<td>Treasurer</td>
<td>2023-2025</td>
<td>James Nachbar, MD</td>
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#### BOARD AT-LARGE MEMBERS OF EXECUTIVE COMMITTEE

<table>
<thead>
<tr>
<th>Open Position</th>
<th>Term</th>
<th>Candidate</th>
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<tbody>
<tr>
<td>At-Large Member of EC</td>
<td>2023-2025</td>
<td>Timothy Graham, MD</td>
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#### OTHER BOARD POSITIONS

<table>
<thead>
<tr>
<th>Open Position</th>
<th>Term</th>
<th>Candidate</th>
</tr>
</thead>
<tbody>
<tr>
<td>At-Large Director</td>
<td>2023-2026</td>
<td>David Baltazar, DO</td>
</tr>
<tr>
<td>Maricopa Director</td>
<td>2023-2026</td>
<td>Brenda Gentz, MD</td>
</tr>
<tr>
<td>Rural Director</td>
<td>2023-2025</td>
<td>Sarah Coles, MD</td>
</tr>
<tr>
<td>Rural Director</td>
<td>2023-2025</td>
<td>Katherine Glaser, MD</td>
</tr>
<tr>
<td>Resident Director</td>
<td>2023-2025</td>
<td>Elizabeth Braunreuther, MD</td>
</tr>
<tr>
<td>Resident Director</td>
<td>2023-2024</td>
<td>Viktorya Tannenbaum, MD</td>
</tr>
<tr>
<td>Medical Student Director</td>
<td>2023-2024</td>
<td>Carleen Cuevas</td>
</tr>
<tr>
<td>Medical Student Director</td>
<td>2023-2024</td>
<td>Eshaan Kashyap</td>
</tr>
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#### AMA DELEGATION

<table>
<thead>
<tr>
<th>Open Position</th>
<th>Term</th>
<th>Candidate</th>
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<tbody>
<tr>
<td>AMA Delegate</td>
<td>1/1/24-12/31/25</td>
<td>Gary Figge, MD</td>
</tr>
<tr>
<td>AMA Delegate</td>
<td>1/1/24-12/31/25</td>
<td>M. Zuhdi Jasser, MD</td>
</tr>
<tr>
<td>AMA Alternate Delegate</td>
<td>1/1/24-12/31/25</td>
<td>Ilana Addis, MD**</td>
</tr>
<tr>
<td>AMA Alternate Delegate</td>
<td>1/1/24-12/31/25</td>
<td>David Baltazar, DO</td>
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<tr>
<td></td>
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<td>Jacquelyn Hoffman, MD (Select 2)</td>
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#### HOUSE OF DELEGATES

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<thead>
<tr>
<th>Open Position</th>
<th>Term</th>
<th>Candidate</th>
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<tbody>
<tr>
<td>Vice Speaker of the House</td>
<td>2023-2025</td>
<td>Ross Goldberg, MD</td>
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**Denotes floor nomination. All other candidates listed are Nominating Committee recommendations**
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* Keane, D; Walker, J; Kennedy, B; Sabbagh, M. “Development, application, and results from a precision/medically platform that personalizes multi-modal treatment plans for mild Alzheimer’s disease and at-risk individuals.” Current Aging Science, 2018

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2. Analysis
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3. Delivery
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providerrelations@goldkidney.com
480-903-8502 ext. 299
2023 House of Delegates
April 21-22, 2023

Amendments & Resolutions
Madam Speaker and Members of the House of Delegates, after reviewing the online comments on April 13, 2023, the Reference Committee on Resolutions and Amendments offers the following report. All of the Committee recommendations have been incorporated into the full body of the original resolutions within this document.

The full report can be found at this [link](#).

Madam Speaker, this concludes the report of the Reference Committee on Resolutions & Amendments. I wish to express my appreciation to Drs. Correa, Dowling, Mercer, and Thrift for their participation and thoughtful deliberations, and Susan Brown and Libby McDannell for their administrative support.
### Consent Calendar 1: Review of 2019 Resolutions

Your Reference Committee recommends the following consent calendar #1 for acceptance:

- **Resolutions Recommended to Not Be Readopted**
  - 02-19 Discriminatory Questions on Application for Medical Licensure
  - 07-19 Arizona Medical Association House of Delegates Annual Meeting
  - 14-19 Promoting Quality Continuing Medical Education
  - 16-19 Indoor Tanning Regulation
  - 26-19 Standardize Managed Care Contracts
  - 40-19 Social Security Number
  - 44-19 Request for Contributions
  - 47-19 Referred House of Delegate Resolution Updates

- **Resolutions Recommended to be Readopted Without Amendment**
  - 06-19 Health Protections Against the Introduction of Contagious Diseases Due to Population Migration
  - 08-19 Education and Public Awareness on Vaccine Safety and Efficacy
  - 09-19 Preservation of Arizona’s Sunrise Process
  - 10-19 Allowing Ama Discussion Regarding Health Care Reform to Include Single Payer (Medicare for All) Proposals
  - 13-19 Provider Orders for Life-sustaining Treatment (POLST)
  - 15-19 Firearm Harm Reduction
  - 18-19 Hospitalists
  - 19-19 Patient Confidentiality; Electronic Information Exchanges
  - 20-19 Prior Authorization Payments to Physicians
  - 23-19 Anesthesia Services
  - 24-19 Food Safety Concerns
  - 27-19 Disaster Planning
  - 28-19 Arizona Medical Association Support for Reducing Air Pollution
  - 29-19 Tissue and Organ Donors
  - 30-19 Corporate Compliance Resolution
  - 31-19 Reinstatement of Mandatory Helmet Laws
  - 32-19 Medical Staff Responsibility for Patient Care
  - 33-19 Physician Supervision of Paramedical Specialists
  - 34-19 Open Staff Policy in Arizona Hospitals
  - 37-19 Optometrists and the Use of Drugs
  - 38-19 Tax Credits and Other Incentives to Disadvantaged Area Medical Practices
  - 39-19 Antivivisection Legislation
  - 41-19 Physician Members on Boards of Directors of Hospitals
  - 42-19 Principles of Patient-centered Formularies
  - 43-19 Payment for Physicians’ Services
  - 46-19 Managed Care Responsibility for Follow-up Care After Emergency Department Consultation
- Resolution Recommended to be postponed to a time certain, and that time certain is following the discussion and decision on Resolution 17-19 Criminalizing Medical Practice.
  - 11-19 Opposition to Rhetoric Equating Legal Medical Practice to Criminal Conduct

- Resolutions Recommended to be Readopted with Amendments
  - 17-19 Criminalizing Medical Practice
  - 21-19 Fail First Insurance Step Therapy Protocol Mandates
  - 22-19 Increasing J-1 Primary Care Physician Workforce For Physicians Holding Valid Working Visas
  - 25-19 Direct Physician Payment for Non-Contracted Emergency Service
  - 35-19 Mandatory Full Disclosure by Insurance
  - 36-19 Food and Drug Administration
  - 45-19 HIV/AIDS, Hepatitis C, and Other Blood-Borne Pathogens

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Consent Calendar #2: 2023 Proposed Bylaw Amendments

Your Reference Committee recommends the following consent calendar #2 for acceptance:

- Amendments Recommended to be Referred to the Bylaws Committee
  - A01-23ArMA Bylaws Revisions, Chapter III Membership

- Resolutions with Bylaw Amendments Deemed Out of Order
  - 02-23 Proposal to Pilot Process for Membership Voting on Leadership Elections and Bylaw Amendments
  - 03-23 Proposal to Pilot Process for Membership Voting on Policy Resolutions

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Consent Calendar #3: 2023 New Resolutions

Your Reference Committee recommends the following consent calendar #3 for acceptance:

- Recommended to be Adopted without Amendments
  - 07-23 Silicosis from Work with Engineered Stone
  - 08-23 Creating an AMA Task Force Dedicated to The Alignment of Specialty Designations for Advanced Practice Providers with Their Supervising Physicians
  - 09-23: Medical Aid in Dying
  - 17-23 Recognizing and Supporting Voting Access as A Social Determinant of Health
  - 18-23 Recognizing Housing as A Social Determinant of Health
  - 20-23 Treating Traumatic Injury Survivorship as A Chronic Disease
- **Recommended Not to be Adopted.**
  - 10-23 Use of Precise Language
  - 11-23 “Gender-Affirming Care”
  - 12-23 Medical Ethics
  - 13-23 Medical Freedom
  - 14-23 Reproductive Health and Covid Vaccination

- **Recommended to be Adopted with Amendments.**
  - 04-23: Substance Use and Pregnant or Postpartum People
  - 06-23 Workforce, Burnout by Administrative Burdens And Maintenance Of Certification
  - 15-23 ACO Realizing Equity, Access, and Community Health (ACO-REACH)
  - 19-23: Destigmatizing and Endorsing Equitable Treatment of The Disease of Obesity
  - 21-23 Eliminate Mandatory Medicare Budget Cuts
  - 23-23 Expanding The Revolutionary Use Of Entheogenic Research For Integrative Psychiatric Treatments, Supporting Novel And Emerging Research for Psychiatric Treatment

- **Recommended Referring to the Executive Committee**
  - 05-23 Insurance Payments

- **Recommended Not to be Adopted in Lieu of Revised 15-23**
  - 16-23 ACO-REACH
### 2019 Resolutions

<table>
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<tr>
<th>Resolution</th>
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<tr>
<td>Consent-Not ReAdopt</td>
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<td>Consent-ReAdopt</td>
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<tr>
<td>Discussion</td>
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<tr>
<td>Postpone</td>
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</table>
The resolutions listed below have been accomplished or are no longer applicable and, in the interest of time, will not be discussed individually unless someone requests it:

RESOLUTION 02-19, DISCRIMINATORY QUESTIONS ON APPLICATIONS FOR MEDICAL LICENSURE (1st Resolve)
This has been completed with work done by AMB and DO Licensing Board

RESOLVED, that the Arizona Medical Association (ArMA) recommend that decisions about physician licensure, credentialing, and recredentialing be based on professional performance.

RESOLUTION 07-19, ARIZONA MEDICAL ASSOCIATION HOUSE OF DELEGATES ANNUAL MEETING
We understand the importance of holding the ArMA meeting before the AMA, and recommend not readopting, and add to the ArMA internal policies and procedures for the annual meeting.

RESOLVED, that the Arizona Medical Association Annual House of Delegates meeting be held at least four weeks in advance of the American Medical Association Annual House of Delegates meeting.

RESOLUTION 14-19 PROMOTING QUALITY CONTINUING MEDICAL EDUCATION (ORIGINALLY 11-15)
An active licensed physician is required to complete 40 credit hours of continuing medical education (AMA PRA Cat.1) during the two calendar years preceding biennial registration.

RESOLVED, That the Arizona Medical Association take necessary action to update the current Arizona licensure requirement for continuing medical education to include a minimum of 20 hours of AMA PRA Category 1 or equivalent credit over the biennial registration term.

RESOLUTION 16-19 INDOOR TANNING REGULATION (ORIGINALLY 14-15)
The administrative code requires an operator to prevent the use of tanning equipment by anyone under 18 unless the person has written permission from a parent or guardian.

RESOLVED, That ArMA work with a coalition of organizations to seek legislative reform that raises the age of consent for indoor tanning to 18 years of age.

RESOLUTION 26-19 STANDARDIZE MANAGED CARE CONTRACTS (ORIGINALLY 17-07; READOPTED 33-11, 29-15)
RESOLVED, That the Arizona Medical Association work to achieve the use of a standardized contract format by all payers for physician services including the introduction of legislation if necessary

RESOLUTION 40-19 SOCIAL SECURITY NUMBER (ORIGINALLY 13-76; READOPTED 52-91, 43-95, 44-99, 40-03, 47-07; 51-11, 44-15)
RESOLVED, That Arizona Medical Association oppose the use of the Social Security Number as a universal identifier.

RESOLUTION 44-19 REQUEST FOR CONTRIBUTIONS (ORIGINALLY 1-83; READOPTED 25-87, 34-91, 33-95, 31-99, 49-03, 56-07, 56-11, 49-15)
This is a resolution that is not external policy but rather procedural. We recommend sunsetting and moving to the internal policies and procedures.

RESOLVED, That the Arizona Medical Association will not make contributions to organizations outside the federation of medicine (county societies, specialty societies and the AMA), which policy may be altered at the discretion of the Arizona Medical Association’s Executive Committee.
RESOLUTION 47-19 REFERRED HOUSE OF DELEGATE RESOLUTION UPDATES (ORIGINALLY 12-07; AMENDED AND READOPTED 60-11; READOPTED 53-15)

This is a resolution that is not external policy but rather procedural. We recommend sunsetting and moving to the internal policies and procedures.

RESOLVED, That resolutions that are referred during the Arizona Medical Association House of Delegates are subject to report back to the following year’s House of Delegates.
It is recommended that the resolutions listed below be readopted without amendment. In the interest of time, they will not be discussed individually unless someone requests it:

1. **RESOLUTION 06-19, HEALTH PROTECTIONS AGAINST THE INTRODUCTION OF CONTAGIOUS DISEASES DUE TO POPULATION MIGRATION**

   RESOLVED, That the Arizona Medical Association work with state officials and other appropriate stakeholders to ensure that all migrants, refugees, and asylum seekers coming to Arizona are provided with appropriate health screenings for diseases including but not limited to chronic, infectious, and psychiatric disease; and be it further

2. **RESOLUTION 08-19, EDUCATION AND PUBLIC AWARENESS ON VACCINE SAFETY AND EFFICACY**

   RESOLVED, the Arizona Medical Association oppose legislation that would have the intended or actual effect of increasing or promoting vaccine hesitancy.

3. **RESOLUTION 09-19, PRESERVATION OF ARIZONA’S SUNRISE PROCESS**

   RESOLVED, the Arizona Medical Association work to ensure that the Arizona Sunrise Process be utilized when considering the licensing and regulation of health care professions and oppose legislation that circumvents the Sunrise Process as outlined in statute.

4. **RESOLUTION 10-19, ALLOWING AMA DISCUSSION REGARDING HEALTH CARE REFORM TO INCLUDE SINGLE PAYER (MEDICARE FOR ALL) PROPOSALS**

   RESOLVED, That the ArMA American Medical Association delegation will continue to support discussion of all health care options.

5. **RESOLUTION 13-19 PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) (ORIGINAL 3-15)**

   RESOLVED, That the Arizona Medical Association is supportive of Provider Orders for Life-Sustaining Treatment (POLST) in Arizona.


   RESOLVED, That the Arizona Medical Association encourage the renewal of federal funding to the Centers for Disease Control for gun violence research.

7. **RESOLUTION 18-19 HOSPITALISTS (ORIGINAL 33-06; REFERRED TO EXECUTIVE COMMITTEE 6/5/2010; AMENDED AND ADOPTED AS 3-11, READOPTED 18-15)**

   RESOLVED, That the Arizona Medical Association:

   - Strongly support the rights of qualified physicians to see their patients in all settings and to bill for their services;
   - Support the right of patient choice of hospitalists as appropriate when requested by the attending physician or the patient.
RESOLUTION 19-19 PATIENT CONFIDENTIALITY; ELECTRONIC INFORMATION EXCHANGES
(ORIGINALLY 7-11, READOPTED 19-15)
RESOLVED, That the Arizona Medical Association shall encourage physicians to educate their patients about the drawbacks as well as the advantages of participation in health information exchanges.

RESOLUTION 20-19 PRIOR AUTHORIZATION PAYMENTS TO PHYSICIANS (ORIGINALLY 9-11; READOPTED 21-15)
RESOLVED, That the Arizona Medical Association pursue any channels available in order to ensure that whenever a physician or other medical provider is required to obtain prior authorization, the provider is entitled to bill and be paid, similar to any other service provided.

RESOLUTION 23-19 ANESTHESIA SERVICES (ORIGINALLY 27-11; READOPTED 25-15)
RESOLVED, Anesthesia services, including interventional pain medicine, are the practice of medicine; and be it further
RESOLVED, Anesthesia services should be personally performed by a physician or occur under the immediate supervision of a physician.

RESOLUTION 24-19 FOOD SAFETY CONCERNS (ORIGINALLY 3-07; READOPTED 28-11, 26-15)
RESOLVED, That the Arizona Medical Association encourage the promotion of physician and public education concerning food safety and food borne illness, including food selection, storage, handling and preparation and, be it further
RESOLVED, That the Arizona Medical Association Committee on Public Health continue to work with appropriate agencies, such as Arizona Department of Health Services, to promote food safety.

RESOLUTION 27-19 DISASTER PLANNING (ORIGINALLY 18-07; READOPTED 34-11, 30-15)
RESOLVED, That the Arizona Medical Association continue to develop and refine readily available information for office-based physicians as to their role in various disaster situations.

RESOLUTION 28-19 ARIZONA MEDICAL ASSOCIATION SUPPORT FOR REDUCING AIR POLLUTION
(ORIGINALLY 10-61; READOPTED 38-91, 35-95, 32-99, 29-03; AMENDED, RETITLED AND ADOPTED 60-07; READOPTED 37-11, 31-15)
RESOLVED, That the Arizona Medical Association support finding effective solutions to air pollution.

RESOLUTION 29-19 TISSUE AND ORGAN DONORS (ORIGINALLY 4-82; READOPTED 19-86, 20-90, 26-94, 42-98, REFERRED 40-02, AMENDED AND READOPTED 3-03; READOPTED 30-07, 38-11, 32-15)
RESOLVED, That the Arizona Medical Association encourage education of physicians, hospital personnel, lay groups and the general public to improve the donation of tissue and organs for transplant.

RESOLUTION 30-19 CORPORATE COMPLIANCE RESOLUTION (ORIGINALLY 15-99, READOPTED 0-03, 32-07, 40-11, 33-15)
RESOLVED, That the Arizona Medical Association oppose any requirement that physicians sign hospital corporate compliance policies in order to obtain hospital privileges.

RESOLUTION 31-19 REINSTATEMENT OF MANDATORY HELMET LAWS (ORIGINALLY 20-87; READOPTED 29-91, 30-95, 28-99, 26-03, 35-07, 41-11, 34-15)
RESOLVED, That the Arizona Medical Association actively support the passage of a mandatory helmet law in Arizona.
RESOLUTION 32-19 MEDICAL STAFF RESPONSIBILITY FOR PATIENT CARE (ORIGINALLY 7-83; READOPTED 23-87, 32-91, 31-95, 29-99, 27-03, 36-07, 42-11, 35-15)
RESOLVED, That the Arizona Medical Association continue to support the concept of the medical staff having responsibility for quality of care of patients in the hospital.

RESOLUTION 33-19 PHYSICIAN SUPERVISION OF PARAMEDICAL SPECIALISTS (ORIGINALLY 10-83; READOPTED 24-87, 33-91, 32-95, 30-99, 28-03, 37-07, 43-11, 36-15)
RESOLVED, That the Arizona Medical Association continue to support the concept that a physician be involved in the supervision of all professionally related paramedical specialists.

RESOLUTION 34-19 OPEN STAFF POLICY IN ARIZONA HOSPITALS (ORIGINALLY 23-67; READOPTED 46-91, 39-95, 33-99, 30-03, 38-07, 44-11, 37-15)
RESOLVED, That the Arizona Medical Association records its opposition to any action by any community hospital or group of hospitals, which would, by action or implication, interfere with the present successful “open staff” policy in effect in the community hospitals of Arizona; and be it further
RESOLVED, That the Arizona Medical Association continue to support the programs of hospitals practicing the “open staff” policy.

RESOLUTION 37-19 OPTOMETRISTS AND THE USE OF DRUGS (ORIGINALLY 4-77; READOPTED 46-91, 52-95, 40-99, 36-03, 43-07, 47-11, 40-15)
RESOLVED, That the Arizona Medical Association actively oppose any legislation the purpose of which is to directly or indirectly extend to optometrists the authority to practice medicine or surgery.

RESOLUTION 38-19 TAX CREDITS AND OTHER INCENTIVES TO DISADVANTAGED AREA MEDICAL PRACTICES (ORIGINALLY 4-73; READOPTED AS 49-91, 40-95; 34-99; 31-03, 44-07, 48-11, 41-15)
RESOLVED, That the Arizona Medical Association actively support national legislation to grant federal income tax credit and other incentives to medical practices established in disadvantaged communities and areas of critical physician need; and be it further
RESOLVED, That the Arizona Medical Association actively support state legislation to grant state income tax credit and other incentives to physicians who establish medical practices in disadvantaged communities and areas of critical physician need.

RESOLUTION 39-19 ANTVIVISECTION LEGISLATION (ORIGINALLY 36-95; READOPTED 42-99, 38-03, 45-07, 49-11, 42-15)
RESOLVED, That the Arizona Medical Association is supportive of medical research, including animal models with appropriate safeguards, to further medical knowledge.

RESOLUTION 41-19 PHYSICIAN MEMBERS ON BOARDS OF DIRECTORS OF HOSPITALS (ORIGINALLY 15-66; READOPTED 43-91, 37-95, 43-03; COMBINED WITH 51-95 IN 1999 AND READOPTED 47-99; READOPTED 43-03, 50-07, 53-11, 46-15)
RESOLVED, That the Arizona Medical Association urge the governing boards of all Arizona hospitals to provide voting membership on the governing board to the chief or president of the medical staff and additional staff physicians as appropriate.

RESOLUTION 42-19 PRINCIPLES OF PATIENT-CENTERED FORMULARIES (ORIGINALLY 19-99; READOPTED 45-03, 52-07, 54-11, 47-15)
RESOLVED, That the Arizona Medical Association support the development of a unified process for rational, patient-centered formulary management.
RESOLUTION 43-19 PAYMENT FOR PHYSICIANS’ SERVICES (ORIGINALLY 20-99; READOPTED 46-03, 53-07, 55-11, 48-15)
RESOLVED, That the Arizona Medical Association work to convince, or seek legislation to require, health plans to offer actuarially sound payments to physicians.

RESOLUTION 46-19 MANAGED CARE RESPONSIBILITY FOR FOLLOW-UP CARE AFTER EMERGENCY DEPARTMENT CONSULTATION (ORIGINALLY 23-99; READOPTED 48-03, 55-07; AMENDED AND READOPTED 59-11; READOPTED 52-15)
RESOLVED, That the Arizona Medical Association continue to seek legislation and/or regulation clearly defining the responsibility of managed care plans and state health agencies to approve and compensate for both immediate and necessary follow up care provided by non-contracted providers caring for patients acquired through emergency department consultation and/or in situations where a contracted provider cannot be secured in a timely manner regardless of the health-care setting.

RESOLUTION 48-19 SHAM PEER REVIEW EDUCATION (ORIGINALLY 15-07; AMENDED AND READOPTED 61-11; READOPTED 54-15)
RESOLVED, That the Arizona Medical Association continue to educate physicians about the existence, characteristics and legal implications of sham peer review and how physicians can make the peer review system function in a fair and just manner.

RESOLUTION 49-19 PAYMENT TERMINOLOGY (ORIGINALLY 19-07; AMENDED AND READOPTED 62-11; READOPTED 55-15)
RESOLVED, That the Arizona Medical Association continue to support the use of the term “payment” for physician compensation, rather than the term “reimbursement”.

RESOLUTION 50-19 ROUTINE CHILDHOOD IMMUNIZATIONS (ORIGINALLY 21-99; READOPTED 47-03, 54-07; AMENDED AND READOPTED 65-11; READOPTED 56-15)
RESOLVED, That the Arizona Medical Association continue to work to ensure that all insurers, health maintenance organizations and managed care companies that cover immunizations for children provide and pay at a reasonable rate, in a timely manner, for routine childhood immunizations in compliance with the annual Recommended Childhood Immunization Schedule.

RESOLUTION 51-19 HEALTH INFORMATION SHARING (ORIGINALLY 6-11; AMENDED AND READOPTED; RETITLED, AMENDED & ADOPTED 57-15)
RESOLVED, That the Arizona Medical Association support the collaboration between methods of health information sharing into a common method.

RESOLUTION 52-19 BOARD CERTIFICATION – TRUTH IN ADVERTISING (ORIGINALLY 12-11; AMENDED AND READOPTED 58-15)
RESOLVED, That the Arizona Medical Association will continue to work to broaden the awareness of physicians who advertise that they are “board certified” without listing the agency, organization or entity granting this standing, that they are at risk of penalty or investigation by the Arizona Medical Board for unprofessional conduct.

RESOLUTION 53-19 OPPOSITION TO COMPULSORY USE OF GENERIC DRUGS (ORIGINALLY 1 & 5-67, READOPTED 44-91, 38-95, 43-99, 39-03, 46-07, 50-11, 43-15)
RESOLVED, That Arizona physicians go on record as opposing mandatory generic prescribing as not always in the best interest of good patient care.

RESOLUTION 54-19 IMPROVING CHILDHOOD VACCINATION RATES IN ARIZONA THROUGH PARENTAL EDUCATION (ORIGINALLY 9-15)
RESOLVED, That the Arizona Medical Association (ArMA) supports adopting requirements that parents (or guardians) who do not wish to have their children vaccinated shall receive public health-approved counseling that provides scientifically accurate information about the childhood diseases, the available vaccines, the potential adverse outcomes from catching the disease, the risks unvaccinated children pose to children who cannot be vaccinated for medical reasons, the risks of vaccine side effects, and the procedures that are implemented to exclude unvaccinated children if an outbreak of disease occurs in the area administered by the local or state public health agency, and be it further RESOLVED, That ArMA supports adopting requirements that parents annually must sign an affirmative statement that acknowledges the risks they are accepting for their own children and the children of others by claiming a personal exemption from mandatory vaccination requirements, and be it further RESOLVED, That ArMA work with the Arizona Department of Health Services to include in the affirmative statement an acknowledgement of the risk to other children, pregnant females, and immunosuppressed individuals.

RESOLUTION 55-19 SUPPORTING VALLEY FEVER AWARENESS, EDUCATION, AND FUNDING (ORIGINALLY 10-15)
RESOLVED, that the Arizona Medical Association (ArMA) take the following actions to accomplish Valley Fever awareness, education funding:
• Use ArMA media such as its website, its magazine, and press releases to promote Coccidioidomycosis visibility, its importance as a public health problem, and how its members could improve their clinical practices to the benefit of their patients;
• Ally itself with the Arizona Osteopathic Medical Association; the Arizona Lung Association; the Arizona Academy of Family Practice; the Arizona Chapter of the American Lung Association; the American College of Physicians, Arizona Chapter; the American Academy of Pediatrics, Arizona Chapter; the Arizona Infectious Diseases Society, any other appropriate stakeholders; and jointly take a public position that Coccidioidomycosis is an important public health issue.
• Encourage (but not mandate) ongoing physician education on Coccidioidomycosis, especially for physicians seeking an Arizona license who have not been trained in Arizona.
• Work with the deans of the medical schools in Arizona to encourage the teaching of Coccidioidomycosis in their curriculum.
• Work with the directors of residency and fellowship programs to emphasize the importance of teaching about Coccidioidomycosis. Refer the tutorial on Valley Fever jointly sponsored by ArMA and freely distributed by the Valley Fever Center for Excellence.

RESOLUTION 56-19 RESTRICTIONS ON THE USE OF HAND-HELD DEVICES WHILE DRIVING (ORIGINALLY 12-15)
RESOLVED, That the Arizona Medical Association (ArMA) encourage physicians to educate their patients regarding the public health risks of text messaging and all other uses of hand-held devices while operating motor vehicles or machinery.

RESOLUTION 57-19 DEATH INVESTIGATION/CERTIFICATION (ORIGINALLY 15-15)
RESOLVED, That ArMA supports changes to the Medical Examiner Act (ARS 11-594b) that will require any death meeting the criteria of a Medical Examiner Death Case (ARS11-593) must be seen by a pathologist.

RESOLUTION 58-19 SUPPORT INCREASED ACCESS TO CARE (ORIGINALLY 11-07; READOPTED 31-11, 28-15)
RESOLVED, That the Arizona Medical Association work with state efforts to develop a plan to improve access to care for all residents of the state.
Upon adoption of the Consent Calendars 1 & 2 for Resolution 01-23, the resolution(s) listed below will be discussed individually:

**RESOLUTION 17-19 CRIMINALIZING MEDICAL PRACTICE (ORIGINALLY 2-11, READOPTED 17-15)**

After reviewing Resolution 11-19 and 17-19, the Committee recommends incorporating 11-19 into Resolution 17-19, and not readopting 11-19.

To Read:

RESOLVED, That the Arizona Medical Association oppose any attempt by the Congress or the Arizona Legislature to enact laws which place a criminal penalty on the legitimate practice of medicine; AND BE IT FURTHER

RESOLVED, THAT ArMA OPPOSE RHETORIC THAT LABELS OR EQUATES LEGAL MEDICAL PRACTICE WITH CRIMINAL CONDUCT.

**RESOLUTION 21-19 FAIL FIRST INSURANCE MANDATES (ORIGINALLY 10-11; READOPTED 22-15)**

The name of the Arizona Department needs to be updated.

RESOLVED, That the Arizona Medical Association actively work with the Arizona Legislature and the Arizona Department of Insurance AND FINANCIAL INSTITUTIONS to limit routine Fail First policies.

**RESOLUTION 22-19 INCREASING J-1 PRIMARY CARE PHYSICIAN WORKFORCE FOR PHYSICIANS HOLDING VALID WORKING VISAS (ORIGINALLY 19-11; READOPTED 23-15)**

The Committee reviewed this Resolution and found it to be inaccurate and recommends it be amended and retitled to remove reference to specific Federal visa designations.

To Read:

RESOLVED, That the Arizona Medical Association work with Federally Qualified Health Centers, other interested entities and the Arizona Medical Board to DECREASE THE TIME REQUIREMENTS FOR LICENSURE FOR ANY PHYSICIAN HOLDING A VALID WORKING VISA—modify Arizona statutes or their interpretation to allow an earlier licensure and subsequent insurance company credentialing so J-1 primary care physicians can start work in underserved Arizona locations after completion of a U.S. residency program—

**RESOLUTION 25-19 DIRECT PHYSICIAN PAYMENT FOR NON-CONTRACTED EMERGENCY SERVICE (ORIGINALLY 9-07; READOPTED 30-11, 27-15)**

The name of the Arizona Department needs to be updated.

RESOLVED, That the Arizona Medical Association work with the Arizona Department of Insurance AND FINANCIAL INSTITUTIONS to ensure direct payment to physicians providing non-contracted emergency care.

**RESOLUTION 35-19 MANDATORY FULL DISCLOSURE BY INSURANCE COMPANIES (ORIGINALLY 10-74; READOPTED 50-91, 41-95, 35-99, 32-03, 39-07, 45-11, 38-15)**

The name of the Arizona Department needs to be updated.

RESOLVED, That the Arizona Medical Association recommend that the Arizona Department of Insurance AND FINANCIAL INSTITUTIONS more closely monitor mandatory full disclosure of coverage in terms of cost, compliance of coverage and relationship of coverage to current medical and hospital costs so that the patient clearly understands his coverage.
RESOLUTION 36-19 FOOD AND DRUG ADMINISTRATION (ORIGINALLY 13-74; READOPTED 51-91, 42-95, 36-99, 33-03, 40-07, 46-11, 39-15)

Since this is from 1974, the Reference Committee recommends this be amended to state “continue to urge” instead of “be urged”?

RESOLVED, That the Arizona congressional delegation be urged CONTINUE TO URGE to support legislation to ensure adequate input by practicing physicians into all Food and Drug Administration regulations.

RESOLUTION 45-19 HIV/AIDS, HEPATITIS C AND OTHER BLOOD BORNE PATHOGENS (ORIGINALLY 8-03; READOPTED 57-07, 57-11, 50-15)

The Reference Committee recommends amending this Resolution to include a reference to 1) treatment and 2) mitigating the spread of disease rather than refraining from engaging in high-risk activities and readopt it.

RESOLVED, That the Arizona Medical Association recognizes that HIV/AIDS, Hepatitis C and other blood borne pathogens present a serious health threat in Arizona and elsewhere; and be it further

RESOLVED, That the Arizona Medical Association encourage its members to (a) recommend early screening AND TREATMENT for the HIV/AIDS and Hepatitis C viruses whenever any patient engages in high-risk activities and (b) recognize the public health risks of these diseases and encourage their patients to MITIGATE THE SPREAD OF THESE DISEASES WHEN refrain from engaging in high-risk activities.
Upon adoption of the Consent Calendars 1 & 2 for Resolution 01-23, the resolution(s) listed below will be discussed individually:

1. **RESOLUTION 11-19, OPPOSITION TO RHETORIC EQUATING LEGAL MEDICAL PRACTICE TO CRIMINAL CONDUCT**

   After reviewing Resolution 11-19 and 17-19, the Committee recommends incorporating it into Resolution 17-19, and not readopting 11-19.

2. **RESOLVED**, That ArMA oppose rhetoric that labels or equates legal medical practice with criminal conduct.
## Proposed Bylaw Amendments

<table>
<thead>
<tr>
<th>Proposed Bylaw Amendments</th>
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<tbody>
<tr>
<td>A01-23 Bylaws Revisions-Chapter III</td>
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<tr>
<td>02-23 Proposal to Allow ArMA Members to Vote in Elections and for Bylaw Amendments</td>
</tr>
<tr>
<td>03-23 Proposal for Year-Round Policy Resolution Submission</td>
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Whereas, the ArMA Membership Committee and the ArMA Committee on Articles of Incorporation and Bylaws have reviewed the membership categories as outlined in the bylaws and are recommending revisions that strive to:

1. Ensure the membership categories are clear and concise;
2. Provide a membership pathway for individuals who have been granted a transitional training permit (within Affiliate Membership Category);
3. Add an additional category of membership for Emeritus Members to honor long-time ArMA members; and
4. Keep the language in the membership categories consistent throughout.

Summary of Proposed Edits in Bylaw Chapter III Membership

Section 3: Classes of Membership – Added reference to the new Emeritus category and added one overarching statement referencing current ArMA practice that the Board annually will determine payment of dues and assessments.

Section 3A: Active Members – Provided clarifying language that to be considered an Active Member a member must have an active, unsuspended license.

Section 3B: 40-Year Club – Added eligibility requirement that members in this category must have been ArMA members for at least 5 years. This category of membership may hold elected office if they are actively practicing medicine (ie receiving remuneration) and hold an active, unsuspended license to practice medicine.

Section 3C: Service Members – Moved Service category to before Associate Members since they have the same privileges as Active Members. Kept language about privileges consistent with other categories of membership

Section 3D: Associate Members – Added reference to the Emeritus Category in the options for Associate Membership.

Section 3E and 3G: Affiliate Members / Honorary Members – Kept language about privileges consistent with other categories of membership. Added in a membership pathway within the Affiliate Membership Category for individuals who have been granted a transitional training permit with the criteria that they are currently under contract with an MD / DO supervising physician, reside in the state of AZ, and are currently working in AZ.
Section 3F: Emeritus Members – Created new category of membership to honor long-time ArMA members who are retired. Criteria includes having been a member for 20 years or more and are currently retired / no longer actively practicing medicine (ie receiving remuneration).

Therefore, be it

RESOLVED, that the ArMA Bylaws be amended by **insertion** and **deletion** to read:

**Chapter III Membership**

**Section 1. General Requirements:** — Any person, when becoming a member, shall agree to abide by the Articles of Incorporation and Bylaws of the Association and by any changes which from time to time may be made. The member further agrees to abide by the Principles of Medical Ethics of the American Medical Association.

**Section 2. Voting Members:** — The voting members of the Association shall consist of the Delegates plus the members of the Board and all Past Presidents. The voting members shall represent the membership at-large and shall have such powers and duties as hereinafter described.

**Section 3. Classes of Membership:** — The Association shall consist of members in the following classes: Active, Forty-Year Club, Service, Associate, Affiliate, **EMERITUS**, and Honorary. **ALL MEMBERS SHALL BE REQUIRED TO PAY DUES AND ASSESSMENTS AS DETERMINED BY THE BOARD OF DIRECTORS AND MEET THE QUALIFICATIONS AS OUTLINED IN EACH MEMBERSHIP CLASS.**

**(A) Active Members**

The qualifications for Active membership (other than for residents and medical students) shall be that the individual must (1) hold a degree of Doctor of Medicine or its equivalent or Doctor of Osteopathic Medicine and (2) hold an **unrevoked ACTIVE, UNSUSPENDED** license to practice medicine and surgery or osteopathic medicine and surgery in **THE STATE OF** Arizona, subject only to the provisions for loss of membership (Chapter III, Section 4).

Residents and Fellows who are licensed or registered with the Arizona Medical Board or the Arizona Osteopathic Board of Examiners shall be eligible for Active membership.

Full-time students in Arizona who are pursuing a course of study leading to the degree of Doctor of Medicine or Doctor of Osteopathic Medicine in an accredited school of medicine or osteopathic medicine shall be eligible for Active membership in the Association.

**Duties and Privileges.** Active members shall have all the duties and privileges of the Association as herein provided, and shall be required to pay such dues and assessments as may be determined by the Board. Members seventy years of age or older in active practice may be required to pay such dues as may be determined by the Board and shall be exempted from assessments. Resident and student members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.
(B) Forty-Year Club Members

Members who have practiced medicine for forty years or longer, at least half of that time in Arizona, and are age 70 or older, AND HAVE BEEN ARMA MEMBERS FOR AT LEAST FIVE YEARS, may be honored by elevation to the Forty-Year Club at the discretion of the Board. Forty-Year Club membership, once granted, shall be deemed a lifetime privilege, regardless of continuation of licensure or status of practice, unless revoked by action of the Board of Directors.

Privileges. Forty-Year Club members shall enjoy all of the privileges of Active members. ARE ELIGIBLE TO HOLD ELECTED OFFICE IF THEY ARE ACTIVELY PRACTICING MEDICINE IN ARIZONA* AND HOLD AN ACTIVE, UNSUSPENDED MEDICAL LICENSE; AND HAVE THE RIGHT TO SERVE AS A DELEGATE; but shall not be required to pay Association dues and shall be exempted from assessments.

(D) (C) Service Members

Service membership may be granted by the Association to regularly commissioned medical officers and commissioned medical officers of the reserve component on extended active duty with the Armed Forces of the United States and the United States Public Health Service who hold the degree of Doctor of Medicine or equivalent or Doctor of Osteopathic Medicine. The full-time physicians employed by the Veterans Administration who reside in Arizona also shall be eligible for Service membership.

Duties and Privileges. Service members shall have all the duties and privileges of Active members. Service members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.

(C) (D) Associate Members

Associate membership may be granted by the Association to Doctors of Medicine or Osteopathic Medicine who (1) are permanently disabled and unable to practice, (2) are retired from active practice and are not eligible for Forty-Year Club OR EMERITUS membership, (3) have left practice in the State of Arizona for temporary military service or further training, (4) are duly accredited in foreign countries and are engaged in medical missionary and similar educational and philanthropic work in Arizona, or (5) are physicians who reside in another state or country. MEMBERS MAY CHOOSE TO APPLY FOR ASSOCIATE MEMBERSHIP STATUS IF THEY MEET ANY OF THE ABOVE CRITERIA.

Duties and Privileges. Associate members shall have all the duties and privileges of Active members except the right to serve as a Delegate or to hold elected office. Associate members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.

(E) Affiliate Members

Affiliate membership may be granted by the Association to (1) Arizona dentists who are members in good standing of their state association, (2) Arizona pharmacists who are active members of their state association, (3) teachers of medicine and allied sciences in Arizona who are not otherwise eligible for membership in the Association and (4) those persons certified as physicians’ assistants who reside in Arizona, AND (5) INDIVIDUALS WHO HAVE BEEN GRANTED A TRANSITIONAL TRAINING PERMIT BY THE ARIZONA MEDICAL BOARD, ARE UNDER CONTRACT WITH AN MD/DO SUPERVISING PHYSICIAN, who IS A resident in the state of Arizona, AND ARE CURRENTLY WORKING IN THE STATE OF ARIZONA.
Duties and Privileges. Affiliate members shall enjoy the privileges of attending meetings of the Association, but shall ARE not ELIGIBLE TO HOLD ELECTED OFFICE OR have the right to serve as Delegates or to hold elected office. Affiliate members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.

(F) EMERITUS MEMBERS
EMERITUS MEMBERSHIP MAY BE GRANTED BY THE ASSOCIATION TO HONOR LONG-TIME DOCTORS OF MEDICINE OR OSTEOPATHIC MEDICINE WHO (1) ARE RETIRED FROM ACTIVELY PRACTICING MEDICINE* IN ARIZONA and (2) HAVE BEEN AN ARMA MEMBER FOR AT LEAST 20 YEARS.

PRIVILEGES. EMERITUS MEMBERS SHALL HAVE THE RIGHT TO SERVE AS A DELEGATE AND ARE ELIGIBLE TO HOLD ELECTED OFFICE WITHIN THE FIRST FIVE (5) YEARS OF DISCONTINUATION OF ACTIVE PRACTICE OF MEDICINE*.

(F) (G) Honorary Members
The House may elect at any annual meeting as Honorary members of this Association, Doctors of Medicine or other persons who are distinguished for their services or who have risen to preeminence in the profession of medicine and surgery, provided the candidate for membership has performed meritorious service for the public, the physician community, or the Association.

Duties and Privileges. Honorary members shall enjoy the privileges of attending meetings of the Association and will have the right to serve as Delegates. Honorary members shall not be required to pay Association dues and may be exempt from assessments.

* ACTIVE PRACTICE IS DEFINED AS "PRACTICE PERFORMED FOR REMUNERATION WHILE HOLDING AN ARIZONA MEDICAL LICENSE."
WHEREAS, In 2013, a resolution was passed by the ArMA House of Delegates to “… undertake a study to evaluate alternative forms of governance including the House of Delegates, Board of Directors and Executive Committee …”. This resolution was readopted in 2017 and 2020; and

WHEREAS, the Strategic Plan completed in April 2019 also identified a focus on the governance structure as an organizational goal; and

WHEREAS, in 2021, the Bylaws Committee began a deep dive review of ArMA’s House of Delegates. The Committee has surveyed other states and noted that a majority of state medical associations have transitioned away from a House of Delegates structure to something that is more nimble and engages a larger portion of their membership; and

WHEREAS, currently the House of Delegates is the body that annually elects ArMA leadership and approves bylaw amendments; and

WHEREAS, the House of Delegates comprises <3% of the ArMA membership, and participation in this entity is shrinking over time; and

WHEREAS, there is a robust nominations process undertaken each year by the Nominating Committee, and a ballot is produced that is voted upon by delegates; and

WHEREAS, the ArMA Nominating Committee issues an annual Call for Leadership Nominations, thoroughly vets all candidates for leadership positions, and recommends a final slate for consideration; and

WHEREAS, the Bylaws Committee has come to agreement on principles for modernizing ArMA’s House of Delegates that address leadership elections and bylaw amendments; therefore, be it

RESOLVED, that ArMA pilot a process by which members will serve as the voting body that elect the leadership positions and approve bylaw amendments; and be it further

RESOLVED, that the voting body of membership be comprised of the following membership categories: active members, 40-year club members, service members, emeritus members, and honorary members; and be it further
RESOLVED, that ArMA leadership elections be piloted for a period of 2 years (the “Test Period”), ending on June 30, 2025 (the “Sunset Date”) under the following parameters beginning with the 2024 election cycle:

- Leadership terms will be on the academic calendar year (July 1 – June 30)
- Online voting will be sent to all eligible voting categories of membership as defined in the bylaws and be conducted using plurality voting
- Floor nominations will be eliminated with all candidates being required to submit an application and be vetted appropriately by the Nominating Committee
- The ArMA Board has the authority to appoint replacements for any vacancies in office – appointees will serve until the next leadership election, at which time they must be ratified by the voting membership.

Leadership Elections Proposed Timeline

<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>Feb. 15</td>
<td>Call for Nominations</td>
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<tr>
<td>Mar. 30</td>
<td>Open Nomination Period Ends</td>
</tr>
<tr>
<td>Apr. 1 - 30</td>
<td>Nominating Committee vets all candidates and recommends final ballot to BOD</td>
</tr>
<tr>
<td>May 15</td>
<td>Ballot disseminated to full membership; online voting period opens. Separate ballots for AMA members</td>
</tr>
<tr>
<td>May 10</td>
<td>Ballot disseminated to full membership; online voting period opens. Separate ballots for AMA members</td>
</tr>
<tr>
<td>June 8</td>
<td>Election results announced by President</td>
</tr>
<tr>
<td>June 10</td>
<td>Election results announced by President</td>
</tr>
</tbody>
</table>

; and be it further

RESOLVED, that ArMA pilot a process with regards to bylaw amendments for a period of 2 years (the “Test Period”), ending on June 30, 2025 (the “Sunset Date”) beginning with the 2024 voting cycle as follows:
; and be it further

RESOLVED, that the ArMA bylaws be amended to remove language related to House of Delegates and its functions during the Test Period as ArMA pilots this membership voting process for leadership elections and bylaw amendments; and be it further

RESOLVED, that the Bylaws of ArMA, as amended, be the Bylaws of ArMA during the Test Period (the “Test Period Bylaws”); and be it further

RESOLVED, that upon the Sunset Date, unless otherwise extended by the membership, the Bylaws as they exist as of the date hereof be reinstated as the ArMA Bylaws, and the Test Period Bylaws be rescinded, null, void, and of no force and effect.
WHEREAS, In 2013, a resolution was passed by the ArMA House of Delegates to “… undertake a study to evaluate alternative forms of governance including the House of Delegates, Board of Directors and Executive Committee …”. This resolution was readopted in 2017 and 2020; and

WHEREAS, the Strategic Plan completed in April 2019 also identified a focus on the governance structure as an organizational goal; and

WHEREAS, in 2021, the Bylaws Committee began a deep dive review of ArMA’s House of Delegates. The Committee has surveyed other states and noted that a majority of state medical associations have transitioned away from a House of Delegates structure to something that is more nimble and occurs more than once a year; and

WHEREAS, the House of Delegates is a body that comprises <3% of the ArMA membership, and participation in this entity is shrinking annually; and

WHEREAS, there is growing frustration with “process” vs. substantive policy discussions at the House of Delegates; and

WHEREAS, the Bylaws Committee has come to agreement on principles for modernizing ArMA’s governance in the area of policy setting; and

WHEREAS, this proposal for policy resolutions has been vetted thoroughly within ArMA’s committee structure, with the ArMA Board of Directors, and with the full membership; therefore, be it

RESOLVED, that ArMA pilot a process for a period of two years (the “Test Period”) through June 30, 2025 (the “Sunset Date”) by which members can submit resolutions year-round with a Call for Resolutions issued quarterly, allowing for increased engagement and ArMA to be nimble when considering policy resolutions; and be it further

RESOLVED that ArMA members serve as the voting body on policy resolutions during the Test Period, with a robust process for review, comment, and voting on all resolutions submitted as outlined in the enclosed proposal; and be it further

RESOLVED, that the ArMA bylaws be amended to remove language related to the ArMA House of Delegates and its functions during the Test Period as ArMA pilots this policy resolution process.
Members can submit resolutions year-round, allowing for increased engagement and ArMA to be nimble when considering new policy positions.

Call for Resolutions will be issued quarterly to the membership.

There is a 12-week process for review, comment, and voting on all resolutions submitted.

Quarterly Resolution Pathway

1. Year-Round (quarterly)
   - Membership Call for Resolutions
   - Any ArMA member can submit resolution for consideration

2. 11 weeks out
   - Submitted resolution is reviewed internally for formatting / clarity and prepared for member comment

3. 10 weeks out
   - Resolution posted to online membership forum for comments

4. 7 weeks out
   - Online commenting period ends. Comments are sent to Reference Committee.

5. 6 weeks out
   - Ref Com meets to review online comments

6. 5 weeks out
   - Resolution is submitted to membership for voting approval / opposition with inclusion of any comments from the reference committee

7. 2 weeks out
   - Membership voting period ends. All votes are tallied.

8. Board Meeting
   - Board reviews action of membership on policy resolution. If 2/3 of Board are NOT supportive of membership action taken, membership will be asked for reconsideration during next open resolution period.

9. 1 week post BOD meeting
   - Action on resolution shared with all members.

Additional Details

- The membership will have final decision-making authority on proposed new resolutions.
- If the Board of Directors is not supportive of the action taken by membership on a policy resolution, it will require a 2/3 board vote to send it back to the membership for reconsideration during the next online voting period.
- The results of the membership vote will dictate whether the resolution is approved.
AMENDED AND RESTATED BYLAWS

Date of Adoption: April 23, 2022

ORGANIZED IN 1892
Amended and Restated Bylaws of The Arizona Medical Association, Inc.

Chapter I Definitions
Except where the context otherwise requires, as hereinafter used:

“Articles” means the Articles of Incorporation of the Association.

“At-Large Member” means an Association member practicing in Maricopa or Pima County or a non-practicing physician residing in Maricopa or Pima County, who may or may not be a County society member.

“Association” means The Arizona Medical Association, Inc.

“Board” means the Board of Directors of the Association.

“County society member” means an Association member who is also a member of a county society.

“Director” means a member of the Board of Directors.

“Electronic communication” means communication via teleconference, video conference, or email in compliance with applicable state laws.

“Maricopa member” means an Association member who is also a member of the Maricopa County Medical Society.

“Pima member” means an Association member who is also a member of the Pima County Medical Society.

“Rural member” means an Association member, practicing or residing in counties other than Maricopa and Pima.

Deleted: “Delegate” means a member of the House.

Chapter II General

Section 1. Name—The name of this corporation shall be The Arizona Medical Association, Inc., henceforth known as “Association.”

Section 2. Purpose—On behalf of member physicians, the Association promotes leadership in the art and science of medicine and advocates for economically sustainable medical practices, the freedom to deliver care in the best interests of patients, and health for all Arizonans.

Chapter III Membership

Section 1. General Requirements:—Any person, when becoming a member, shall agree to abide by the Articles of Incorporation and Bylaws of the Association and by any changes which from time to time may be made. The member further agrees to abide by the Principles of Medical Ethics of the American Medical Association.

Section 2. Voting Members:—The voting members of the Association shall consist of Delegates plus the members of the Board and all Past Presidents. The voting members shall represent the membership at-large and shall have such powers and duties as hereinafter described.

Section 3. Classes of Membership:—The Association shall consist of members in the following classes: Active, Forty-Year Club, Associate, Service, Affiliate, and Honorary.

(A) Active Members

The qualifications for Active membership (other than for residents and medical students) shall be that the individual must (1) hold a degree of Doctor of Medicine or its equivalent or Doctor of Osteopathic Medicine and (2) hold an unrevoked license to practice medicine and surgery or osteopathic medicine and surgery in Arizona, subject only to the provisions for loss of membership (Chapter III, Section 4).

Residents and Fellows who are licensed or registered with the Arizona Medical Board or the Arizona Osteopathic Board of Examiners shall be eligible for Active membership.

Full-time students in Arizona who are pursuing a course of study leading to the degree of Doctor of Medicine or Doctor of Osteopathic Medicine in an accredited school of medicine or osteopathic medicine shall be eligible for Active membership in the Association.

Duties and Privileges. Active members are eligible to hold elected office, have the right to vote, and shall be required to pay such dues and assessments as may be determined by the Board. Members seventy years of age or older in active practice may be required to pay such dues as may be determined by the Board and shall be exempted from assessments. Resident and student members shall be required to pay such dues as may be determined by the Board and shall be exempted from assessments.

(B) Forty-Year Club Members

Members who have practiced medicine for forty years or longer, at least half of that time in Arizona, and are age 70 or older, may be honored by elevation to the Forty-Year Club at the discretion of the Board. Forty-Year Club membership, once granted, shall be deemed a lifetime privilege, regardless of continuation of licensure or status of practice, unless revoked by action of the Board of Directors.

Privileges. Forty-Year Club members are eligible to hold office and have the right to vote but shall not be required to pay Association dues and shall be exempted from assessments.
(C) Associate Members
Associate membership may be granted by the Association to Doctors of Medicine or Osteopathic Medicine who (1) are permanently disabled and unable to practice, (2) are retired from active practice and are not eligible for Forty-Year Club membership, (3) have left practice in the State of Arizona for temporary military service or further training, (4) are duly accredited in foreign countries and are engaged in medical missionary and similar educational and philanthropic work in Arizona, or (5) are physicians who reside in another state or country.

Duties and Privileges. Associate members are not eligible to hold elected office or to vote. Associate members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.

(D) Service Members
Service membership may be granted by the Association to regularly commissioned medical officers and commissioned medical officers of the reserve component on extended active duty with the Armed Forces of the United States and the United States Public Health Service who hold the degree of Doctor of Medicine or equivalent or Doctor of Osteopathic Medicine. The fulltime physicians employed by the Veterans Administration who reside in Arizona also shall be eligible for Service membership.

Duties and Privileges. Service members are eligible to hold elected office and have the right to vote. Service members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.

(E) Affiliate Members
Affiliate membership may be granted by the Association to (1) Arizona dentists who are members in good standing of their state association, (2) Arizona pharmacists who are active members of their state association, (3) teachers of medicine and allied sciences in Arizona who are not otherwise eligible for membership in the Association and (4) those persons certified as physicians’ assistants who reside in Arizona.

Duties and Privileges. Affiliate members are not eligible to hold elected office or to vote. Affiliate members shall be required to pay such dues as may be determined by the Board and may be exempted from assessments.

(F) Honorary Members
The Board may elect Honorary members of this Association, Doctors of Medicine or other persons who are distinguished for their services or who have risen to preeminence in the profession of medicine and surgery, provided the candidate for membership has performed meritorious service for the public, the physician community, or the Association.

Privileges. Honorary members are not eligible to hold elected office but have the right to vote. Honorary members shall not be required to pay Association dues and may be exempt from assessments.

(G) Emeritus Member
Emeritus membership may be granted by the Association to honor long-time doctors of medicine or osteopathic medicine who (1) have retired from actively practicing medicine* in Arizona and (2) have been an ArMA members for at least 20 years.

Privileges. Emeritus members have the right to vote and are eligible to hold elected office within the first five (5) years of discontinuation of active practice of medicine*.

*Active practice is defined as “practice performed for remuneration while holding an Arizona Medical license.”
Section 4. Disciplinary Actions: —

(A) Active, Associate, Service, or Affiliate membership in the Association shall be terminated by:
   (1) action of the Board; with a two-thirds vote of the total membership of the Board being required to expel;
   (2) revocation of the member’s license to practice in Arizona;
   (3) termination of enrollment in medical school of student Active members;
   (4) failure to pay Association dues and assessments within six months of the date such become payable, unless such failure is exempted as otherwise outlined in the bylaws.

(B) Active, Associate, Service, or Affiliate membership in this Association shall be suspended by:
   (1) action of the Board;
   (2) failure to pay the annual dues and assessments before the delinquency date determined by the board, unless such failure is exempted as otherwise outlined in the bylaws.

(C) Honorary membership in the Association may be withdrawn upon a two-thirds vote of the total membership of the Board.

(D) Any physician refused membership in the Association or who is suspended or loses membership may appeal to the Board for reconsideration. The Board may affirm, modify, or change its decision in its discretion.
Chapter IV Officers and Directors

Section 1. The following shall be officers and directors of the Association with terms as outlined. All leadership terms shall commence of July 1 and conclude on June 30 of the year in which the term ends:

Board Officers:

<table>
<thead>
<tr>
<th>Officer position</th>
<th>Term</th>
<th>Officer Position</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>1 year</td>
<td>Immediate Past President</td>
<td>1 year</td>
</tr>
<tr>
<td>President-elect</td>
<td>1 year</td>
<td>AMA Delegation Chair</td>
<td>N/A</td>
</tr>
<tr>
<td>Secretary</td>
<td>2 years, elected in alternate year as Treasurer</td>
<td>Chief Executive Officer</td>
<td>N/A</td>
</tr>
<tr>
<td>Treasurer</td>
<td>2 years, elected in alternate years as Secretary</td>
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<td></td>
</tr>
</tbody>
</table>

With the exception of the Chief Executive Officer, all officers shall be voting members of the Board. In addition, the Board of Directors shall be comprised of the following positions, all of whom are voting members except as otherwise noted.

<table>
<thead>
<tr>
<th>Board Position</th>
<th>Number of Positions</th>
<th>Term</th>
<th>Board Position</th>
<th>Number of Positions</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Committee At-Large Members</td>
<td>2</td>
<td>2 years, staggered</td>
<td>Resident Physician Director</td>
<td>2</td>
<td>1 year</td>
</tr>
<tr>
<td>AMA Delegate</td>
<td>2**</td>
<td>2 years</td>
<td>Medical Student Director</td>
<td>2</td>
<td>1 year</td>
</tr>
<tr>
<td>At-Large / Rural Director</td>
<td>4</td>
<td>3 years, staggered</td>
<td>ArMA Foundation Chair *</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Maricopa Director</td>
<td>4</td>
<td>3 years, staggered</td>
<td>ArMPAC Chair *</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Pima Director</td>
<td>2</td>
<td>3 years, staggered</td>
<td>Legislative &amp; Government Affairs Committee Chair</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>Early Career Director</td>
<td>1</td>
<td>3 years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Non-voting board position
** Includes AMA Delegation Chair and one additional representative from the ArMA AMA Delegation, selected by the Delegation.

The entire ArMA AMA delegation, and all Arizona medical school deans who are ArMA members will be invited to attend the Board of Directors meetings as non-voting guests.

Section 2: Officer & Board Position Descriptions:

(A) Immediate Past President: The Immediate Past President, aside from specific duties otherwise herein assigned, shall, upon the President’s request, advise and counsel the President in the discharge of the office of the President and aid the President by accepting such special assignments as may become appropriate.
(B) President: — The President shall be chief officer of the Association and Chair of the Board and shall exercise general supervision over its members and affairs.

(C) President-Elect: — Aside from specific duties otherwise herein assigned, the President-Elect shall prepare for the office of President by assisting the President in the discharge of the President’s duties. The President-Elect shall be Vice-Chair of the Board and shall preside at any meeting in the absence of the President.

(D) Secretary: — The Secretary shall keep minutes of all official meetings of the Association, its board, and its committees. The Secretary shall see that all notices are duly given in accordance with the provisions of law and these Bylaws, and shall keep the membership records of the Association and be custodian of all contracts, assignments and other legal documents and records. In general, the Secretary shall perform all the duties incident to the office of Secretary of a corporation.

(E) Treasurer: — The Treasurer shall have charge of and be responsible for all funds, securities, receipts and authorized disbursements of the Association; shall deposit or cause to be deposited, in the name of the Association, all money or other valuable effects in such banks or other depositories as shall from time to time be selected by the Board; shall render to the president and to the Board, whenever requested, an account of the financial condition of the Association; and shall report annually to the membership on Association finances. In general, the Treasurer shall perform all duties incident to the office of Treasurer of a corporation.

(F) AMA Delegation Positions: — The AMA Delegation Chair, along with one other senior delegate to the American Medical Association, shall serve as liaisons between the Board and the AMA delegation.

(G) Appointed Board Positions: — The Chairs of ArMA’s Legislative & Government Affairs Committee, Foundation, and ArMPAC Board shall be appointed to the board of directors based upon their role.

(H) Constituent Directors: — The remaining Directors shall be chosen by the entire voting membership of the Association to fill the seats reserved to At-Large, Maricopa, Pima, Rural, Early Career, Resident Physician, and Medical Student Board members. Each Director shall represent the entire Association and carry out his or her duties in a manner they believe to be in the best interests of the Association as a whole and not limited to their specific constituency.

Section 3. Directors and Officers Liability Insurance: The Board shall procure Directors and Officers Liability Insurance, Errors and Omissions Insurance, and such other insurance, of the types and in the amounts as the Board deems necessary to protect the persons serving as Directors and Officers (including, where applicable, management employees) from unreasonable liability arising from their service to the Association.
Chapter V  Leadership Elections

Section 1.  Voting:— The voting members shall elect all board members and other elected positions either through electronic or in person means, as determined in advance by the Board. If the Board, by majority vote, determines to conduct elections by electronic means, then the Association shall conduct such election via an online voting system that complies with the requirements of Arizona Revised Statutes Section 10-3708 (or any successor statute that sets forth requirements for electronic voting), including the alternative of a paper ballot as set forth in subsection G of such Section 10-3708. If an election takes place in-person, it shall be by secret ballot unless candidates are unopposed.

Only those voting members of the Association who are members in good standing with the American Medical Association shall be eligible to vote for AMA Delegates and AMA Alternate Delegates. The Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the bylaws of the American Medical Association. If the Association shall be entitled to more than one Delegate, the terms will be staggered, as determined by the Board. Any nominee for Delegate (an “AMA Delegate”) or Alternate Delegate (“Alternate AMA Delegate”) to the American Medical Association shall also be a member of the American Medical Association.

Any candidate who receives a plurality of the votes cast shall be elected.

Section 2. Elected Positions and Transition:— All elected officers and directors automatically shall become members of the Board on July 1 of the year in which they are elected. The President and the Immediate Past President shall not be elected but shall assume their offices in the year next following their terms as President-Elect and President.

Any other appointed positions shall assume office on July 1 of the year in which they are appointed.

The Delegates and Alternate Delegates to the American Medical Association shall take office on January first of the year following election, or in conformity with any revised rules of the American Medical Association.

Section 3. Nominations:— Nominations for elected offices to be filled shall be solicited by the Nominating Committee from the membership.

Section 4. Term limits:— With the exception of medical student and resident directors, each elected board member shall serve no longer than six (6) consecutive years in a particular position. For medical student and resident directors, the term limit shall be two (2) years in a particular position. Board members are eligible to serve in other roles if they reach the term limit in their current position. Board members who term out can re-apply for the same position after three (3) years. The AMA delegate board positions will not be subject to term limits.
Chapter VI Board of Directors

Section 1. Operational Responsibilities: — The Board shall be vested with the control and management of the affairs of the Association, subject only to directives from the membership, The Articles of Incorporation, and these Bylaws. The Board may adopt and revise policies relating to conflicts of interest, confidentiality, incurring of expenses, and other matters reflecting on the integrity and financial health of the Association.

Section 2. Removal from Office: —
(A) In the event any officer does not carry out the responsibilities and duties of that office, the Board shall have the authority to remove such officer and replace such officer with an appointee from the existing Board of Directors, which appointee shall serve until the next general election.

(B) If a Board member fails to attend three consecutive Board meetings, the Board shall have the authority to remove such Board member from office and appoint a replacement, taking into consideration the constituency that Board member represents.

Section 3. Vacancies: — The Board shall have the authority to appoint replacements for any vacancies in office and in its membership, such replacements to serve until the next annual election. In the event of a temporary inability upon the part of any officer or director to perform the duties of that office, the Board may appoint any other officer or director to perform the function of said office without the office being vacated, such appointment to be limited to the period of inability and, in no event, to extend beyond the date of the next election. In the event the President’s position is required to be filled, the Board shall select a replacement from the members of the Executive Committee. A vacancy in a Director’s seat designated for a particular constituency shall be filled, if at all, by another person who satisfies the requirements for election to that position.

Section 4. Finances; Budget; Accounting; Vote Required for Non-Budgeted Expenses; Use of Funds; Investments: — The Board shall adopt an annual budget providing for the necessary expenses of the Association. The Board shall be responsible for the proper accounting and auditing of all funds and accounts of the Association. The Board shall also have the authority to establish and utilize appropriate reserves, establish policies for dealing with the receipt and utilization of funds derived other than from member dues and assessments, establish foundations and subsidiaries and capitalize them, to cause the Association to guarantee the indebtedness of any such foundations, and otherwise to deal with money and property that may be received by the Association.

Section 5. Time of Meetings; Who May Call: — The Board shall meet at least twice a year and at such other times as it deems necessary, subject to call of the Chair, or on petition of three members of the Board. In addition, meetings of the Board may be held by electronic communication in compliance with applicable state laws.

Section 6. Quorum; Vote: — A majority of the Board shall constitute a quorum for any meeting and, unless specified, a majority vote of the members present, and voting shall be required for action.

Section 7. Chief Executive Officer; Offices: — The Board shall employ a Chief Executive Officer, who need not be a physician, to manage and direct the activities of the Association and to perform the duties commonly required of the Chief Executive Officer of a corporation. The Chief Executive Officer shall be under the direction of the President and the Board, but shall supervise all other employees. The Chief Executive Officer shall be an officer of the Association, but shall not be a member of the Board of Directors or the Executive Committee.
Chapter VII Sections
The Board may establish sections that provide learning and networking opportunities for physicians, fellows / residents, and medical students at different stages in their careers or with similar interests and background. The sections shall be permitted to adopt internal operating policies that govern their internal affairs. Such internal operating policies shall not be in conflict with the Bylaws of the Association and must be approved by the Board of Directors to become effective.

Chapter VIII Standing and Other Committees
Section 1. Appointment; Ex-officio Members — There shall be standing committees as hereinafter specified. Unless otherwise provided for, the President-Elect shall appoint, with the advice and consent of the Board, the chair and members of each committee who will serve during his or her presidency. Vacancies in membership of a committee shall be filled by appointment by the President, with the advice and consent of the Board. The chair or any committee member may be removed by the President, with the advice and consent of the Board. The President, President-Elect and Secretary shall be ex-officio members of all committees in addition to the appointed members. Meetings of all committees may be held by electronic communication.

Section 2. Term: — The term of appointment for committee members and committee chairs shall be prescribed by the Board.

Section 3. Standing Committees and Functions: — The standing committees and their functions shall be:
(A) Articles of Incorporation and Bylaws: — The functions of the Committee on Articles of Incorporation and Bylaws shall be to serve as a fact-finding and advisory committee pertaining to the Articles of Incorporation and Bylaws and to recommend such changes as it deems appropriate for action by the voting members, or the Board, as applicable.

(B) Executive: — The Executive Committee shall consist of the physician officers, the Legislative & Government Affairs Committee Chair, and the two At-Large Members. The functions of the Executive Committee shall be to (1) review and summarize routine matters and correspondence for Board action; (2) develop policy positions and alternatives for consideration and decision by the Board; (3) develop affirmative plans for the Association to consider and be acted upon by the Board; (4) act as advisor to the Chief Executive Officer and conduct an annual review of his/her performance and make adjustments to compensation as deemed appropriate; and (5) study and make recommendations concerning long range and strategic objectives for the Association.

(C) Finance: — The Treasurer shall serve as chair of the Committee on Finance. The Committee on Finance shall act in an advisory capacity in budgetary and financial matters.

(D) Legislative & Government Affairs (L&G) Committee: The functions of the L&G Committee shall be to examine issues of concern to physicians, health care organizations and patients. This Committee is responsible for establishing the positions that the Association takes in negotiating or advocating on those particular issues.

(E) Public Health Committee: Consisting of physicians and public health professionals, this Committee discusses medical issues related to public health in our state. The Committee is intended to be the arena in which the Association’s public health professionals have the opportunity to champion issues that need attention and evoke positive changes for Arizona’s citizens.

(F) Nominating Committee: — The functions of the Nominating Committee shall be to (1) solicit nominations for
the elected positions and (2) finalize a slate of candidates, for recommendation to the voting members.

The Nominating Committee shall consist of the last three Past Presidents, who are still residing in Arizona, with the most immediate of these serving as chair, plus eight members appointed by the Executive Committee, with approval of the Board, from the existing Board of Directors, two of whom shall be At-Large, two of whom shall be Maricopa, two of whom shall be Pima and two of whom shall be Rural. Any deviations from this composition must be approved by the Board.

(G) Resolutions Committee: — The functions of the Resolutions Committee shall include: (1) on request, assist in writing resolutions based on issues, if presented by members of the Association, committees, counties, specialty societies and other ArMA constituencies; (2) consider, recommending readoption or non-readoption, current Association policy; (3) present its own resolutions to the voting members for consideration and debate; and (4) give its opinion relative to resolutions, changes in operations, bylaws and rules and regulations.

Section 4. Appointment of Other Committees: — All other committees as deemed necessary or appropriate shall be appointed by the President and exist at the pleasure of the Board of Directors, for one or more purposes and for a time period to be determined when the committee is established.
Chapter IX. House of Delegates

Section 1. Composition of House; Meetings:—The House shall constitute the voting body of the Association and shall be composed of Delegates from the following: At-Large and Rural members, Maricopa and Pima county societies, specialty and subspecialty societies, resident physicians and medical students. With the exception of medical student Delegates, all Delegates must be physician members of the Association. Members of the Board and all Past Presidents of the Association shall be voting members of the House.

The House shall meet at least once a year at the time of the Annual Meeting. In addition, special meetings of the House may be held at any time upon notice thereof to the Delegates, at the call of the Board, or upon the call of twenty Delegates. Meetings (including the Annual Meeting) and business of the House may be held by electronic communication in compliance with applicable state laws.

Section 2. Number of Delegates:—

(A) At-Large Members:— At-Large Members shall be entitled to representation in the House by ten (10) delegates, at least half of whom are not county society members.

(B) Maricopa and Pima Members:— The Maricopa members shall be entitled to representation in the House by five (5) delegates who are members of the Maricopa County Medical Society. The Pima members shall be entitled to representation in the House by three (3) delegates who are members of the Pima County Medical Society.

(C) Rural Members:— Rural members shall be entitled to representation in the House by three (3) delegates.

(D) Specialty and Subspecialty Societies:— A specialty or subspecialty society with 250 or fewer members shall be entitled to representation in the House of Delegates by one delegate and a specialty or subspecialty society with more than 250 members shall be entitled to 2 delegates if (1) the specialty or subspecialty is recognized by the American Board of Medical Specialties; (2) the specialty or subspecialty society has a minimum of twenty members practicing in Arizona; (3) the specialty or subspecialty society maintains an existing organization or structure with a slate of periodically elected officers, a constitution and bylaws and a frequency of meeting at least once a year; and (4) by a vote of the House it shall be deemed to be in the best interests of the Association. Specialty or subspecialty society delegates shall be the society president or designee(s) who shall be members of the Association.

(E) Resident Physician Members; Medical Student Members:— Resident physicians and medical students shall each be entitled to representation in the House by two delegates who must be Active members of the Association.

Section 3. Election of Delegates; List Thereof:—Sufficiently in advance of the Annual Meeting the Maricopa and Pima County Medical Societies and each specialty and subspecialty society shall designate delegates to represent them in the House and shall send to the Secretary of the Association a list of such elected delegates. Delegates must be current in their ArMA dues to serve in this role.

Section 4. Committees of the House:— At or before each Annual Meeting the Speaker, in consultation with the President-Elect, shall appoint such committees which may expedite the business of the House of Delegates. These may include Committees on Credentials, Resolutions, Amendments, and such other committees as the Speaker may designate. If there is a conflict, the speaker selection shall prevail.

Resolutions may be proposed by: (1) the Board, (2) any member of the House, (3) any county society, (4) any committee or section of the Association, (5) the Resolutions Committee, or (6) by any ArMA member.
Any resolution, other than those which amend the Bylaws, adopted by the House of Delegates shall become null, void and of no effect if not re-adopted within four years from the effective date of the adoption or re-adoption of the resolution.

At the discretion of the Speaker and President-Elect, more than one Committee on Resolutions may be appointed.

Section 5. Quorum; Minimum Requirements for Vote: — Twenty Delegates shall constitute a quorum and, unless otherwise specified herein, a majority vote of the quorum shall be required for action.

Section 6. Participation by Nondelegates in Meetings of the House: — All meetings of the House, except its executive sessions, shall be open to members of the Association; nondelegate members may participate in such meetings upon an affirmative majority vote of the House.

Section 7. Powers and Duties of the House: — The House shall:

(A) elect all officers and directors of the Association except officers or trustees of the American Medical Association;

(B) vote on all memorials and resolutions presented to it;

(C) instruct the Board on its wishes respecting the operations of the Association; and

(D) when necessary, amend the Articles and Bylaws.
Chapter X Dues and Assessments

Section 1. Fixing of Annual Dues; Payments; Reinstatements; Collections; Enforcement:

(A) The amount of annual dues shall be determined by the Board of Directors.

(B) The annual dues and the dues and assessments of the Association shall be payable January first of the year for which it is due.

Section 2. Fixing of Assessments; Payment; Collection; Enforcement:

(A) Assessments may be levied by the Board, subject to approval by the voting members.

(B) Assessments shall be payable thirty days after notice of such has been mailed and, subject to Section (C) hereof, shall be delinquent sixty days after that date.

(C) The Board of Directors may permit extension of time for payment of any assessment for good cause shown, but in no event longer than four years from the date of the initial assessment.

Section 3. Equality Within Membership Categories of Dues and Assessments:

While the amount of dues or assessments may vary as between classifications of membership (except as to certain classes upon which none may be levied), they shall be uniform within each classification, except for Service, Resident Physician and Medical Student members (Chapter III, Section 3) and new members. Discounts may be offered, including tiered pricing, for subsets of members, including groups.

Chapter X Parliamentary Authority

Section 1. Governing Rules:

The rules contained in the latest revised edition of Robert’s Rules of Order Newly Revised shall govern the Association in all cases to which they are applicable and in which they are not inconsistent with the Bylaws.

Section 2. Parliamentarian:

A Parliamentarian may be appointed by the President. The Parliamentarian shall provide advice and guidance to the officers and the Board as requested.

The Parliamentarian shall be present during the House to provide advice and guidance to the Speaker and to members of the House.

A Parliamentarian who is a credentialed delegate shall have a vote.
Chapter XI - Amendments

Section 1. Who May Propose Amendments: — Amendments to these Bylaws may be proposed by (1) the Board, (2) any county or specialty society, (3) any committee or section of the Association, or (4) any 25 or more ArMA members. Proposed amendments shall be delivered to the Secretary on or before March 1 each year.

Section 2. Notice of Proposed Amendments: — All proposed amendments shall be shared with the membership for feedback, comment, and questions prior to voting.

Section 3. Introduction of Proposed Amendments: — All proposed amendments shall be disseminated for formal vote at the same time as voting for leadership elections occurs.

Section 4. Vote Required: — An affirmative vote of two-thirds of the voting members who cast ballots shall be required for the adoption of an amendment to the Bylaws.

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Deleted: the Resolutions Committee, or (6) any ArMA member or ArMA constituency.

Deleted: at least six weeks prior to the meeting of the House at which the same will be considered.

Deleted: Written copies of all proposed amendments shall be distributed by the Secretary to all members of the House at least four weeks before the meeting at which the same will be considered. Written notice may be transmitted electronically.

Deleted: introduced at the Annual Meeting, referred to the Reference Committee on Amendments and voted upon at that meeting. A special meeting of the House may be called to consider duly proposed amendments.

Deleted: Delegates present and voting, or an affirmative vote of a majority of the entire membership of the House, whichever is the lesser.
# 2023 New Resolutions
Recommended to be Adopted without Amendments

<table>
<thead>
<tr>
<th>Year-23</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-23</td>
<td>Silicosis From Work with Engineered Stone</td>
</tr>
<tr>
<td>08-23</td>
<td>AMA Taskforce Creating an AMA Task Force Dedicated to The Alignment of Specialty Designations for Advanced Practice Providers with Their Supervising Physicians</td>
</tr>
<tr>
<td>09-23</td>
<td>Medical Aid in Dying</td>
</tr>
<tr>
<td>17-23</td>
<td>Voting Access</td>
</tr>
<tr>
<td>18-23</td>
<td>Recognizing Housing As A Social Determinant of Health</td>
</tr>
<tr>
<td>20-23</td>
<td>Traumatic Injury Survivorship</td>
</tr>
<tr>
<td>22-23</td>
<td>Pediatric Feeding Disorder</td>
</tr>
</tbody>
</table>
WHEREAS, Exposure to silica dust is a health hazard for workers who manufacture, finish, and install natural and engineered stone countertop products, causing silicosis, which is a progressive, debilitating, incurable, and sometimes fatal occupational disease; and

WHEREAS, Close to 100,000 workers are employed in the manufacture, finishing, and installation of natural and engineered stone countertop products in the United States; and

WHEREAS, Clusters of silicosis cases have been reported nationally and internationally among stone countertop fabrication workers, including cases in California and Texas; and

WHEREAS, Silicosis is a disease related to long-term exposure, usually appearing after many years of exposure, unlike workplace injuries; and

WHEREAS, Workers exposed to engineered stone are often employed in several different companies over time, some of which may go out of business; therefore, be it

RESOLVED, That the Arizona Medical Association should encourage physicians, including pulmonologists, radiologists and pathologists, as well as other health-care professionals, to report all diagnosed or suspected cases of silicosis in accordance with OSHA guidance. [https://www.cdc.gov/niosh/topics/surveillance/ords/statesurveillance/reportingguidelinesilicosis.html]; and be it further

RESOLVED, That ArMA should advocate for the establishment of preventive measures to reduce exposure of workers to silica levels above the OSHA permissible exposure level (PEL) for respirable crystalline silica, which is a time-weighted average (TWO) of 50 micrograms per cubic meter (µg/M 3) of air; and be it further

RESOLVED, That ArMA should advocate for the establishment of a registry of cases of silicosis to be maintained for workers diagnosed with silicosis resulting from engineered stonework or from other causes, either by the Arizona Department of Health Services or the Arizona Division of Occupational Safety and Health (ADOSH); and be it further

RESOLVED, That ArMA should advocate for the establishment of a fund by the State of Arizona to compensate workers who have been diagnosed with silicosis resulting from their work with silica, to recognize the progression and the need for increasing levels of compensation over time; and be it further
RESOLVED, That ArMA should bring this resolution to the attention of the American Medical Association, with the recommendation that other State Medical Associations should take similar actions with respect to the prevention of silicosis and to the recognition and compensation of affected workers.
INTRODUCED BY: M. Zuhdi Jasser, MD
SUBJECT: Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians

Whereas, Advanced Practice Providers (APP’s: PA’s and NP’s) have an established scope of practice directly determined by the specialty of their supervisory physician and their practice site; and

Whereas, Advanced Practice Providers in collaboration with their supervisory physicians provide care commensurate with the specialty training and board certification of the physician; and

Whereas, currently Advanced Practice Providers do not have any established standard for a residency or apprenticeship requirement or specialization process after graduation that aligns them with the specialty training of their supervisory physicians; and

Whereas, this absence of specialty designation for Advanced Practice Providers creates the following harms to the practice of medicine and the quality of care for our patients:

1. Advanced Practice Providers can completely change their professional specialty focus overnight creating major training requirements and costs for the practice that hires them.
2. Lower income physician specialties like primary care are disproportionately impacted by the frequent departure of APP’s for higher income specialties.
3. Costly training periods for APP’s can take a minimum of one year, for example, for primary care based specialties.
4. The current “non-specialty designated” APP system creates a financially exploitative system. Specialties with higher physician salaries unfairly lure away APP’s from the practices of lower salaried physicians. Those practices are unable to compete with salaries offered by disparate higher income specialties.
5. Primary care practices, for example, are thus left with untenable training cost losses and exponentially high turnover in an already volatile and predatory market; and

Whereas, if residency and specialty training makes sense for physicians, some type of established apprenticeship training program within established specialties must also make sense for APP’s; and

Whereas, current severe healthcare workforce shortages in the setting of an inflationary economy and reduced physician payments for our services, makes an alignment of APP salary and specialty competition particularly critical; therefore, be it

RESOLVED, that the Arizona Medical Association (ArMA)-AMA delegation ask that the American Medical Association (AMA) create a national taskforce that will make recommendations for the best process for Advanced Practice Providers (APP’s) to develop specialty designations and an associated apprenticeship process that is parallel to the specialties of the physicians that supervise them; and be it further
RESOLVED, that the ArMA-AMA delegation ask that the AMA work with appropriate stakeholders to
insure that the new specialty designations for APP’s developed by the AMA taskforce, after an appropriate
transition period, become an established practice expectation for APP collaboration with their supervisory
physicians of the same or similar specialty.
INTRODUCED BY:  Tom Fitch, MD
SUBJECT:  Medical Aid in Dying

Whereas, while the advances in Palliative Medicine and Hospice Care in the U.S. have been meaningful and gratifying, agonizing deaths still occur far too often. Fifty percent of deaths witnessed by Arizona physicians were described as “not good deaths”, per a survey of Arizona physicians by the ArMA/AOMA Task Force on End of Life Care 2016-2018. \(^{1,2,3,4,5,6,7,8,9}\); and

Whereas, care of patients with advancing life-limiting, serious illness should include discussions and information regarding advance directives and end-of-life care options - including palliative and hospice care, stopping disease directed care, withdrawing or withholding advanced care support, discussions of hydration and nutrition, voluntarily stopping eating and drinking, palliative sedation, and also medical aid in dying; and

Whereas, a majority of physicians and the public support Medical Aid in Dying as a compassionate end-of-life care option. Fifty-five percent of physicians in the U.S. support medical aid in dying, only 28% oppose, and a survey of Arizona physicians conducted by the ArMA/AOMA Task Force on End-of-Life Care in 2017, 53% of respondents supported Medical Aid in Dying and 27% opposed; 74% of U.S. residents support ending terminal patients’ lives by painless means and in a recent survey of Arizona residents 60% of respondents (64% of seniors) supported Medical Aid in Dying and 13% opposed. There was majority support within all demographic groups including gender, age, political party, political ideology, ethnicity, major religion, level of education, income level, and geographic areas of the state.\(^{1,10,11}\); and

Whereas, medical aid in dying is now available as a legal end-of-life care option in 10 states (Oregon, Washington, Montana, Maine, Vermont, New Jersey, New Mexico, Colorado, California, Hawaii) and Washington DC – available to over 72 million people, 1 in 5 U.S. citizens. \(^{12}\); and

Whereas, in the 70+ years of combined experience in the U.S. with Medical Aid in Dying, there has been no substantiated incidents of abuse or coercion and no indication of a heightened risk for vulnerable populations such as the elderly, the poor, racial or ethnic minorities, the less educated, physically disabled, or people with mental illness. And, there has been no evidence that legalization of aid in dying results in higher suicide rates. In fact, suicide rates tended to decline in states which passed authorized medical aid in dying and experience has demonstrated that authorizing medical aid in dying helps prevent suicide among the terminally ill. \(^{13,14,15,16}\)

Whereas, quality metrics for end-of-life care have improved in states where Medical Aid in Dying is available. \(^{17,18,19,20}\); and

Whereas, in June 2019, a new policy position was recommended by the American Medical Association’s Council on Ethical and Judicial Affairs. For the first time, the AMA affirmed that physicians can provide medical aid in dying “according to the dictates of their conscience without violating their professional
obligations.” The AMA established that physicians who participate in medical aid in dying are adhering to their professional, ethical obligations as are physicians who decline to participate. This position allows for, respects and supports the diverse views of the AMA’s membership. \(^{(21)}\); and

Whereas, six other national medical organizations have taken positions supporting medical aid in dying including the American College of Legal Medicine, American Medical Student Association, American Medical Women’s Association, American Public Health Association, GLMA: Healthcare Professionals Advancing LGBT Equality, and the National Student Nurses’ Association. Six other medical organizations have adopted neutral positions including the American Academy of Family Physicians, American Academy of Neurology, American Academy of Hospice and Palliative Medicine, American Nurses Association, American Pharmacists Association, American Society for Health System Pharmacists, and the National Association of Social Workers. \(^{(22)}\); and

Whereas, the state medical associations in many of the jurisdictions with authorized medical aid in dying have neutral/no position or a supportive position on medical aid in dying including Oregon, Washington, Maine, Vermont, New Mexico, Colorado, California, Hawaii, and the District of Columbia; other states have dropped their opposition including Maryland, Massachusetts, New York, Connecticut, Delaware, Minnesota, Nevada, and Rhode Island; additionally the Academy of Family Physicians in Washington, New York, California, and Arizona have taken a neutral position on medical aid in dying. \(^{(22)}\); therefore, be it

**Resolved**, that the Arizona Medical Association take a neutral position in regards to the practice of Medical Aid in Dying, an end-of-life care option for mentally capable, terminally ill adult Arizonans who are in their last six months of life; and be it further

**Resolved**, that physicians who participate in the legal practice of Medical Aid in Dying are adhering to their professional and ethical obligations, as are physicians who decline to participate.

Reference:

1. ArMA/ AOMA Task Force on End of Life Care, Final Report. 2018
9. Fitch T. 35 Years of Personal Experience as a Physician Caring for People with Cancer.


20. There's an Unforeseen Benefit to California's Physician-Assisted Death Law. Los Angeles Times (2017) [https://drive.google.com/file/d/1eHytFoU00JszAWxXlgANiwXYu8XH4q/view?usp=sharing](https://drive.google.com/file/d/1eHytFoU00JszAWxXlgANiwXYu8XH4q/view?usp=sharing)


23. Budget impact to ArMA. None
WHEREAS, the American Medical Association has a strong policy recognizing voting as a social determinant of health, with support for “safe and equitable access to voting as a harm-reduction strategy to safeguard public health” and supports collaboration to further show a relationship between voter participation and health outcomes,

WHEREAS, a study comparing state level voting inequality (defined as voter turnout rates compared across socioeconomic status), showed states with higher voting inequality had lower self-rated health (self-reported level of health chosen from 5 categories: excellent, very good, good, fair, and poor), even when controlling for income inequality and state median household income,

WHEREAS, the negative effects of low household income on self-rated health was greatest in states with the highest voting and income inequality,

WHEREAS, across 44 countries, including the United States, high voter participation was associated with higher self-reported health even when adjusted for individual demographics and country characteristics,

WHEREAS, the American Academy of Pediatrics encourages pediatricians to advocate for patients and families not only with their own voice but by encouraging civic engagement in their patients and families. Specifically, they advise “offering families affirmation on the importance of voting”,

WHEREAS, a large study has shown vulnerable populations, such as low-income families, racial minorities, and young people, are more likely to be affected by laws which place barriers to and restrictions on voting access as well as less likely to have health insurance in states with higher voting restrictions in place,

WHEREAS, some of the policies which restrict voting access for the aforementioned vulnerable populations are voter ID laws, inflexible voting hours, polling place closures, and voter registry purges, as well as gerrymandering which is done by both major political parties and lowers the value of votes,

WHEREAS, politicians are more responsive to constituents who vote, and healthier individuals are more likely to vote, and it has been shown “state electorates with disproportionately higher rates of healthy voter participation saw less health spending and less generous Medicaid programs, reinforcing disparities in health care coverage”,

WHEREAS, ArMA’s only current policy on voter registration supports physicians educating patients on the importance of voting and having access to voter registration materials from a nonpartisan
standpoint, but does not explicitly recognize voting as a social determinant of health or support an equitable voting process; therefore, be it

RESOLVED, ArMA recognizes voting as a social determinant of health and supports efforts to study and understand the relationship between voter participation and health outcomes; and be it further

RESOLVED, ArMA supports safe and equitable voting access as a means of improving community and individual health, including opposing gerrymandering, inflexible voting hours, polling place closures, and voter registry purges.

REFERENCES:
Whereas, in Arizona, there are approximately 9,026 individuals experiencing homelessness, representing an increase of 22% compared to 2020¹, and

Whereas, a study looking at census data showed 40% of middle-class Americans are one lost paycheck or unexpected financial disruption away from poverty and potential homelessness, and housing costs, both renting or owning a home, have far outpaced the growth of median income², and

Whereas, there is heightened concern for the health and well-being of individuals experiencing homelessness due to their increased rates of health inequities across a range of health conditions and a mortality rate of 3-4 times higher than that of the general population³,⁴,⁵, and

Whereas, individuals experiencing homelessness in Western countries are more likely to have alcohol and drug dependencies, as well as psychiatric illnesses and personality disorders⁶, and

Whereas, almost one-third of emergency room visits are made by people with chronic homelessness and a person experiencing chronic homelessness can cost the taxpayer an average of $35,578 per year⁶,⁷,⁸, and

Whereas, people experiencing homelessness often prioritize provision for basic human needs, such as shelter and food, over seeking and receiving healthcare⁹, and

Whereas, implementation of Housing First, which is the rapid housing of individuals not conditional upon sobriety have been shown to “reduce homelessness and non-routine health service use without an increase in problematic substance use”¹⁰,¹¹,¹²,¹³,¹⁴,¹⁵, and

Whereas, cities such as Houston have implemented a Housing First-based policy with a 62% decrease in the homeless population over the past 10 years. Their “The Way Home” plan, has guiding principles to “include extensive coordination among governments, nonprofit providers, and the private sector; the identification and dismantling of systematic racism; coordination of intensive outreach and crisis services; reduction in barriers to accessing needed services and care; ongoing open communication among partners; and the engagement of people with lived experience of homelessness in solving problems associated with homelessness”¹¹,¹²,¹³,¹⁶, and

Whereas, Medical Respite Care is an option for post-acute care for persons experiencing homelessness who are too ill to recover on the streets but not ill enough to remain admitted in a hospital. In a systematic review, this option “reduced future hospital admissions, inpatient days, and hospital readmissions. They also resulted in improved housing outcomes”¹⁴,¹⁵, and

Whereas, the cost of housing individuals first is similar to that of current practices including shelters, hospital emergency departments, drug and alcohol rehabilitation centers, and transitional housing, and as such is potentially warranted from an economic standpoint¹⁷, and
Whereas, “permanent supportive housing and income assistance interventions were effective in reducing homelessness and achieving housing stability” which has the potential to improve health\(^\text{18}\), and

Whereas, there is a lack of research done with the homeless population at large especially in the area of Housing First and its potential impact on long-term health outcomes\(^\text{18,10}\), and

Whereas, Street Medicine groups are physician-led groups that travel to unhoused individuals to provide healthcare and connections with social services, as one strategy for providing health services when and where people experiencing homelessness need them\(^\text{19}\), and

Whereas, many people experiencing homelessness also experience stigma from healthcare providers, which impacts general health and willingness to access care\(^\text{20}\), and

Whereas, the National Coalition to End Homelessness, the National Low-Income Housing Coalition, and the United States Department of Housing and Urban Development (HUD) support a Housing First approach\(^\text{21,22,23}\), and

Whereas, the Maricopa Association of Governments (MAG) Regional Council recently approved a resolution to join House America, a national initiative led by HUD to address the issue of homelessness by calling for a Housing First approach including, but not limited to: “rapid re-housing, permanent supportive housing, housing vouchers or subsidies, and federal, state, local, or philanthropic sources of financial assistance” for “any person or family who is residing in an emergency shelter, including a non-congregate shelter, or in an unsheltered location such as an encampment or vehicle”\(^\text{24,25}\), and

Whereas, AMA policy H-160.903 recognizes homelessness as a medical concern and supports a Housing First approach without mandated therapy or compliance with services\(^\text{26}\), and

Whereas there is no specific focus in current ArMA policy addressing homelessness\(^\text{27}\); therefore, be it

Resolved, ArMA recognizes housing as a social determinant of health and supports efforts to understand the relationship between homelessness and health outcomes; and be it further

Resolved, ArMA will support physician education about the distinct healthcare and social needs of patients experiencing homelessness in order to reduce stigma and implicit bias and promote improved interactions between individuals experiencing homelessness and the healthcare system; and be it further

Resolved, ArMA will encourage interdisciplinary collaboration between physicians, insurance companies, social service organizations, governmental agencies, stakeholders, hospitals and health systems to develop policies and plans to address the needs of patients experiencing homelessness; and be it further
Resolved, ArMA recognizes that stable, affordable housing, without mandated therapy or compliance with services, is critical to the health of patients, families, and communities and supports evidence-based plans, such as the Housing First approach, to eradicate homelessness; and be it further

Resolved, ArMA will support effective, evidence-based research and plans to implement and evaluate Medical Respite Care for patients experiencing homelessness; and be it further

Resolved, ArMA will encourage support, expansion, and funding of physician-led, team-based Street Medicine programs; and be it further

Resolved, ArMA will support legislation and initiatives that protect the human rights of individuals experiencing homelessness while opposing those that criminalize vital activities that are carried out in public spaces (i.e. eating or resting) when a private space is not available as an alternative location for these activities; and be it further

Resolved, ArMA recognizes that homelessness is a spectrum unique to each individual and supports the use of adaptive strategies based on personal, regional, and community variations and characteristics with an understanding that state and local resources are necessary to address the deep-rooted health and social complexities associated with homelessness.

References


WHEREAS, in 2020 the Center for Disease Control and Prevention reported that unintentional injury was the fourth leading cause of death in all age groups. Traumatic injury has increased social burden beyond death. The most significant social burden is in terms of disability and future quality of life of traumatic injury survivors;

WHEREAS, Patient with severe (injury severity score <25) or life threatening (injury severity score >25) injuries are most likely to become a traumatic injury survivor as case fatality rates are only 5% and 20% respectively;

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

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

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

WHEREAS, Livingston et al. in a 2019 study with over one hundred traumatic injury patients found that survivors experience high rates of Post-Traumatic Stress Disorder (PTSD) and depression, 32% for each and 23% for both PTSD and depression;

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

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

WHEREAS, Multidisciplinary outpatient “trauma quality of life clinic,” which (comprised of a nurse practitioner or surgeon (physician), psychologist, social worker, and physical therapist), reported improvement reported improvement in no-show rates as compared to the standard care visit with an advanced practitioner or surgeon, with no show rates for standard of care visits being 40% compared to 22% for trauma quality of life clinics. This suggests that that among patients with high-risk of developing...
PTSD or chronic pain, there is greater engagement in comprehensive multidisciplinary trauma follow-up care; and

WHEREAS, Patients undergoing follow-up care at a multidisciplinary “trauma quality of life clinic” completed 23 psychology visits in addition to their appointment with the multidisciplinary team versus one psychology visit at a standard of care follow-up clinic (p < 0.01); and

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

RESOLVED, that ArMA supports the view that traumatic injury survivorship is a chronic disease in which survivors should receive comprehensive outpatient follow-up aimed at improving the quality of life in all domains of traumatic injury survivorship (independence for activities of daily living, PSTD, depression, and chronic pain) via the use of multidisciplinary care (physician or advanced practitioner, psychologist, social worker, and physical therapist); and be it further

RESOLVED, that ArMA collaborates with other appropriate stakeholders to support legislation that addresses comprehensive care and improved quality of life for traumatic injury survivors.

REFERENCES:
2. A national trauma care system: Integrating military and civilian trauma systems to achieve zero preventable deaths after injury. national academy of science, engineering and medicine.
WHEREAS, Pediatric Feeding Disorder (PFD) was defined in 2019 as impaired oral intake that is not age-appropriate, is in the absence of eating disorders, and is associated with dysfunction in one or more of the following four domains: medical, nutritional, feeding skill, and/or psychosocial; and

WHEREAS, The prevalence of PFD in children with public insurance in Arizona state has steadily increased over an eight year period from 10 per 1000 children to 33 per 1000, exceeding the prevalence of autism spectrum disorder and both anorexia and bulimia nervosa; and

WHEREAS, Pediatric Feeding Disorder was not listed as an ICD-10-CM code until 2021 and historically relied of the evaluation and management by Speech Language Pathologists (SLPs) and Occupational Therapists (OTs); and

WHEREAS, Primary Care Physicians are best positioned to identify children with PFD, though currently lack tools to reliably distinguish these patients from those with transient feeding concerns; and

WHEREAS, Patient questionnaire and screening methods are found to be effective in distinguishing patients with PFD and could be implemented by Pediatricians in the primary care setting; and

WHEREAS, The purpose of screening by pediatric primary care offices is to identify patients with PFD, who are at risk for feeding challenges, dysphagia, and/or aspiration and to expedite the referral to SLPs and OTs for management of care; and

WHEREAS, Earlier detection and treatment of children with PFD could prevent long-term developmental consequences and aspiration events, as well as the incidence of comorbidities that negatively impact cognitive, physical, emotional, and social development; therefore be it

RESOLVED, that ArMA share education with its members on Pediatric Feeding Disorder (PFD), and, be it further

RESOLVED, that ArMA work with the AZ Chapter of the American Academy of Pediatrics to support further research on PFD including effective screening techniques and impact on morbidity and mortality.

REFERENCES
### 2023 New Resolutions Recommended to Not be Adopted

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Whereas, language is the tool we use for thinking; and

Whereas, precise definitions are required for mathematical and scientific work; and

Whereas, perversion of language, as in Orwell’s 1984 “doublespeak,” is a tool of totalitarianism; and

Whereas, confusing, euphemistic language enables enactment of duplicitous proposals that many might oppose if they were understood; and

Whereas, patients cannot give fully informed consent unless procedures (risks, benefits, and alternatives) are clearly described; therefore, be it

Resolved, that ArMA insist on precise, transparent language in its advocacy. Examples: (1) Use the word “abortion” when that is the main concern, not “reproductive health care,” which implies prenatal care, safe childbirth, fertility treatment, vasectomy reversal, and other measures that promote the outcome of a living child rather than a dead fetus. (2) Use terms like “puberty suppression,” “cross-sex hormones,” “bilateral mastectomy,” or “castration,” rather than vague expressions like “gender affirming care,” “top surgery,” or “bottom surgery.”

Budget impact: none
Whereas, physicians are under increasing pressure to provide treatment that they believe to be unethical or harmful; and

Whereas, sex is irreversibly determined at conception based on whether an X-sperm or a Y-sperm fertilizes the ovum—not “assigned at birth”; and

Whereas, a bedrock principle of medical ethics is the need for fully informed consent; and

Whereas, the long-term consequences of hormonal or surgical treatment intended to alter primary or secondary sexual characteristics are unknown and irreversible; and

Whereas, there is no scientific basis for the belief in a “gender identity” that is somehow “attached to the wrong body; therefore, be it

RESOLVED, that ArMA opposes any means of coercing or pressuring physicians to perform, participate in, or condone treatments that they believe to be unethical or harmful, including those for patients who identify with a gender different from their sex; and be it further

RESOLVED, that ArMA oppose treatment of minors with chemical or surgical procedures intended to interfere with normal development or to remove or mutilate healthy body parts; and be it further

RESOLVED, that ArMA advocate extending the statute of limitations for litigation related to transgender therapy to several years past the time at which the brain is fully matured, in the mid-twenties.

Budget impact: none
INTRODUCED BY: Jane Orient, MD
SUBJECT: Medical Ethics

Whereas, physicians' duty is to the patients who entrust their care to them, not to the collective, the third party's bottom line, or the goals of governmental or quasi-governmental entities (e.g., the UN's “sustainable development” goals); and

Whereas, no patient's well-being may ethically be sacrificed to attempt to right historic injustice, or to achieve greater “equity,” or to theoretically alter the earth's climate; and

Whereas, patients are harmed by elevating “diversity, equity, and inclusion” over standards of competence; therefore, be it

Resolved, that ArMA reaffirm the duty to “do no harm,” and reject any oaths, codes, or policies that tend to undermine patient care.

Budget impact: none
Whereas, persons do not forfeit their God-given inalienable rights, or the protections in the Bill of Rights in the U.S. Constitution, by obtaining a medical degree or a license to practice; and

Whereas, government administrative agencies, including licensure boards, FDA, CDC, and public health departments; hospitals; third-party payers; specialty boards; and pharmacists are neither qualified nor legally authorized to practice medicine; and

Whereas, these agencies are neither infallible nor accountable to individual patients; and

Whereas, mandates imposed for COVID-19 response have harmed untold numbers of persons, denied potentially beneficial and life-saving FDA-approved but “off-label” treatment, and coerced millions to receive a novel vaccine without having been informed of potential harm; and

Whereas, physicians who had an alternative view were intimidated into silence or suffered severe reputational and financial harm; and

Whereas, clinical practice guidelines are mostly consensus statements of selected experts, most of whom are financially linked to industry, and should thus not be held out as an enforceable standard of care; therefore, be it

RESOLVED, that ArMA support the right and duty of physicians to advise and prescribe according to the best of their ability and judgment, oppose censorship of information that does not follow the official narrative, encourage and provide a forum for open debate, and support limitations on governmental emergency powers.

Budget impact: none
INTRODUCED BY: Jane Orient, MD
SUBJECT: Reproductive Health and COVID Vaccination

1 Whereas, ArMA, all physicians, and the public are deeply concerned about the safety of the developing fetus
2 and successful pregnancy outcomes; and
3
4 Whereas, an alarming increase in fetal death, coincident with the rollout of COVID vaccines in pregnant
5 women, has been reported by whistleblowers in labor and delivery facilities; and
6
7 Whereas, a comparison of adverse event reports to the Vaccine Adverse Event Reporting System (VAERS) for
8 COVID and influenza vaccine shows a highly significant safety signal for stillbirth, fetal growth restriction,
9 placental thrombosis, and other adverse events associated with COVID in contrast to influenza vaccines; and
10
11 Whereas, pregnancy has traditionally been considered a contraindication to new therapies prior to
12 extensive long-term testing; therefore, be it
13
14 Resolved, that ArMA call for an immediate moratorium on the administration of COVID vaccines to anyone
15 who is or who might become pregnant.
16
17 Budget impact: none
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INTRODUCED BY: Arizona Section of the American College of Obstetricians and Gynecologists

SUBJECT: Substance Use and Pregnant or Postpartum People

Whereas, the Arizona Department of Health Services’ Maternal Mortality Review Committee determined that in 38.1% of pregnancy associated deaths, substance use was a contributing factor; and

Whereas, the Arizona Department of Health Services has additionally determined that 98% of pregnancy associated deaths related to mental health and substance use were preventable; and

Whereas, the Arizona Department of Health Services has additionally determined that 98% of pregnancy associated deaths related to mental health and substance use were preventable; therefore, be it

Resolved, that legislation and local and state initiatives for pregnant and postpartum people who are experiencing substance use promote harm reduction strategies, reduce stigma, and increase resources for family support and that such programs implement evidence-based practices; and be it further

Resolved, that the Arizona Medical Association actively support legislation that promotes such programs and oppose legislation that penalizes pregnant people with criminal consequences.

Budget impact: None
INTRODUCED BY: Kenneth Knox, MD
SUBJECT: Workforce, Burnout and Maintenance of Certification

Whereas, maintenance of certification (MOC) is proprietary, costly, time consuming, relies on narrowly focused test questions that are often not relevant to specialized practice, and has not shown to be of significant benefit to the public, and

Whereas, over 10 thousand US-trained physicians have been disenfranchised by traditional MOC offerings, prompting them to seek MOC through alternate, CME-based boards that align with their schedules, practice and life-learning philosophy, and

Whereas, several states and the national boards themselves have discouraged healthcare organizations from using MOC as a sole criterion for granting hospital privileges, and

Whereas, compulsory MOC, at a time when physician burnout is high and a large percentage of the workforce is retiring, will contribute to further attrition and worsening of access to care for patients; therefore, be it

Resolved, that ArMA pledge a continuing commitment to preventing physician burnout, including reducing the mental, emotional and time burden imposed every month by hospitals mandating maintenance of certification (MOC) to maintain privileges, and be it further

Resolved, that ArMA call on local and state healthcare systems to take action to eliminate MOC as a sole criteria for maintaining hospital privileges, by adopting clear criteria that take into account comparable competencies, equivalent experiences, teaching prowess, national recognition, etc.
WHEREAS, a new program started under the Biden administration allows people on Traditional Medicare to be moved into a profit-centric model without their full knowledge or consent using the program known as Accountable Care Organizations (ACO) Realizing Equity, Access, and Community Health (REACH), which essentially allows private companies to act as middlemen that receive a monthly capitated payment from Centers for Medicare & Medicaid Services (CMS) for covering all or some defined portions of each enrollee’s expenses; and

WHEREAS, ACO-REACH is very similar to the previous CMS program known as Direct Contracting Entities (DCEs), a program that ArMA opposed (Resolution 09-22) due to concerns regarding violations of patient and physician autonomy, restriction of patient care, abuse and corruption, and the endangerment of the entire Medicare program; and

WHEREAS, ACO-REACH claims to by increasing equity, but in fact only requires collection of demographic data with no actual provision of services to marginalized communities; and

WHEREAS, like DCEs, ACO-REACH allows for the enrollment of Medicare beneficiaries in the program without their full knowledge or consent, and also incentivizes this via a fee paid directly to the plan provider for each underserved patient enrolled therefore continuing to violate patient autonomy; and

WHEREAS, like DCEs, ACO-REACH does not necessarily allow an individual physician to choose to not be part of the program as they may find themselves part of ACO-REACH if their practice is acquired or if their corporate owner signs a ACO-REACH agreement, therefore continuing to violate physician autonomy; and

WHEREAS, like DCEs, if a physician or a patient finds themselves part of ACO-REACH and wishes to disenroll, their only option is to leave their group practice or change their PCP, respectively, therefore continuing to violate both patient and physician autonomy; and

WHEREAS, like DCEs, ACO-REACH allows third party organizations such as insurance companies and private equity firms to keep as profit and overhead a significant amount of revenue (currently over 25%), which is revenue that is generated by denying care and contracting with as few providers as possible, giving them a dangerous financial incentive to reduce payment to physicians and limit care to Medicare beneficiaries, therefore restricting patient care; and

WHEREAS, like DCEs, ACO-REACH does not provide sufficient oversight to prevent fraudulent up-coding by insurance companies to maximize profit—a problem that has already resulted in CMS suing DCEs for hundreds of millions of dollars—therefore continuing to allow abuse and corruption; and

WHEREAS, like DCEs, ACO-REACH lacks congressional oversight, and the absence of such a regulatory mechanism fails to protect against the concerns outlined above, therefore resulting in the endangerment of the entire Medicare program; and
WHEREAS, ACO-REACH is essentially a rebranding of the DCE program, and furthermore upon termination of the DCE program most participating entities were grandfathered into the ACO-REACH program without re-application, increasing the urgency to oppose ACO-REACH; therefore, be it

RESOLVED, that the Arizona Medical Association send a letter within one year of this resolution being adopted to Health and Human Services Secretary, Xavier Becerra, and President Biden requesting that the Accountable Care Organizations (ACO) Realizing Equity, Access, and Community Health (REACH) and similar programs be terminated; and be it further

RESOLVED, that ArMA opposes the Accountable Care Organizations (ACO) Realizing Equity, Access, and Community Health (REACH) and similar programs.

REFERENCES:
1. ACO REACH - by U.S. Centers for Medicare & Medicaid Services
2. ACO REACH Request for applications - by Centers for Medicare and Medicaid Services
3. Global and Professional Direct Contracting (GPDC) Model - by U.S. Centers for Medicare & Medicaid Services
4. The biggest threat to Medicare you’ve never heard of - by Rep. Pramila Jayapal and Dr. Susan Rogers
WHEREAS, the National Health and Nutrition Examination Survey found the prevalence of US adulthood obesity to be 41.9%, and the prevalence of US childhood and adolescent obesity to be 19.7% between 2017 - March 2020, with the estimated annual medical cost of obesity to be $173 billion in 2019 dollars\(^1,2\); and

WHEREAS, the Behavioral Risk Factor Surveillance System reports that, in Arizona, adulthood obesity has incrementally increased from 25.1% in 2011 to 31.3% in 2021, and adolescent obesity has increased from 11.1% in 2003 to 13.3% in 2019\(^3\); and

WHEREAS, obesity pathogenesis is multifactorial and involves the intrinsic, genetic causes of impaired energy balance regulation\(^3\) and the dysregulation of adipogenesis, lipid storage, insulin signaling, and the endocrine function of adipocytes\(^4,5,6\); and

WHEREAS, extrinsic causes of obesity include both the epigenetic changes occurring at critical developmental periods in life that are responsible for maladaptive responses later in life, as well as social determinants such as the globalization of the western diet and lifestyle choices and circumstances\(^4,7\); and

WHEREAS, a joint international consensus statement was published by an expert panel in April 2020 with unanimous consensus that obesity is characterized not as a condition, but as a disease, with specific signs and/or symptoms, distinct pathophysiology, reduced quality of life, and increased risk of complications/mortality\(^8\); and

WHEREAS, AMA policy H-440.842 recognizes obesity as a disease with a complex pathophysiology which requires a multifactorial approach to prevention and treatment\(^9\); and

WHEREAS, pharmacological interventions are FDA-approved for use in patients with a body mass index greater or equal to 30 kg/m\(^2\) or greater or equal to 27 kg/m\(^2\) with comorbid conditions and includes the newest treatment, semaglutide, as of June 2021\(^10\); and

WHEREAS, bariatric surgical interventions are appropriate treatments for obesity, especially for patients with comorbid metabolic conditions such as type 2 diabetes\(^11\); and

WHEREAS, the American Academy of Pediatrics published a clinical practice guideline in January 2023 that highlights the “urgency of providing immediate, intensive obesity treatment to each patient as soon
as they receive the diagnosis of obesity”, including intensive health behavior and lifestyle treatment,
weight loss pharmacotherapy, and bariatric surgery as indicated\textsuperscript{12}; and

WHEREAS, obesity stigma can lead to explicit and implicit weight bias, weight bias internalization,
weight-based stereotypes, and weight discrimination, and whereas obesity stigma is itself costly to the
patient and society\textsuperscript{13,14,15}; and

WHEREAS, obesity stigma is associated with mental health morbidity, social isolation, substance use,
unhealthy eating and weight-control behaviors, lower levels of physical activity, higher exercise
avoidance, and public health efforts have historically embraced stigmatization of individuals with obesity
with the incorrect assumption that shame is a motivator for improved health behavior\textsuperscript{8,16}; and

WHEREAS, obesity stigma is pervasive throughout medical culture which causes avoidance of treatment,
variations in time spent with patients, differences in treatment options offered, and negative attitudes
towards obese individuals\textsuperscript{17,18}; and

WHEREAS, it is unethical to permit differential treatment and management of health conditions despite
awareness of the existing underlying social stigma entrenched in those practices; and

WHEREAS, AMA policy H-440.821 states “Our AMA (1) encourages the use of person-first language
(patients with obesity, patients affected by obesity) in all discussions, resolutions, and reports regarding
obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding
patients affected by obesity including weight and unhealthy weight, and discourage the use of
stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers
on the importance of person-first language for treating patients with obesity; equipping their health
care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and
having patients weighed respectfully”\textsuperscript{19}; and

WHEREAS, ArMA policy 19.106 states “ArMA resolves to advocate for insurance companies to provide
adequate coverage and payment for services provided by physicians and other healthcare professionals
that support the expert recommendations for prevention, assessment and management of childhood
obesity”\textsuperscript{20}, therefore, be it

RESOLVED, ArMA advocates for the use of person-first language (patients with obesity), encourages the
use of preferred terms (weight, unhealthy weight), and discourages stigmatizing terms (obese, morbidly
obese, fat) in all discussions with patients, between healthcare professionals, and in legislation; and be it
further
RESOLVED, ArMA supports public health interventions addressing obesity that avoids stigmatizing language and shame as a motivator for improved health behavior, and acknowledges the multifactorial pathogenesis of obesity; and be it further

RESOLVED, ArMA encourages the implementation of weight-inclusive policies in clinical practice and research, including weight-inclusive facilities, furniture, equipment, and clothing; and be it further

RESOLVED, ArMA encourages medical schools, residency programs, and employers of physicians within Arizona to include education on the harms of obesity stigma, explicit and implicit weight bias, and weight-inclusive practices within their diversity and inclusion curriculum; and be it further

RESOLVED, ArMA works with AHCCCS to ensure insurance coverage is comprehensive and complete for all evidence-based treatment of obesity, including glucagon-like peptide-1 agonists and bariatric surgery, through education, negotiation, regulation, or other appropriate means to achieve this goal.

REFERENCES:


WHEREAS, the 2023 Medicare payments are to cut physician pay, and
WHEREAS, Medicare payments to physicians has not been consistent with inflation and has not increased in 20 years\(^1\), and
WHEREAS, practice costs and consumer prices have increased during that time frame, and
WHEREAS, Medicare physician payments have declined 22\% over the last 2 decades when adjusted for inflation,\(^2\) therefore, be it

RESOLVED, that ArMA reach out to all physician representative organizations to engage as a larger advocacy group in order to Advocate against physician pay cuts and for medicare physician payment reform; and be it further

RESOLVED, that ArMA reach out to the Arizona Congressional delegation to advocate for new legislation on medicare physician payment reform; and be it further

RESOLVED, that the ArMA AMA delegation ask the AMA to advocate for new legislation on medicare physician payment reform at or before the next AMA annual meeting.

References:
Whereas, global acceptance and expansion of entheogenic research has reigned in the medical community in the United States, it is time for Arizona to consider legalizing the use of entheogenic research for psychiatric treatment; and

Whereas, despite the revolutionary therapeutic potential, psychedelic-assisted psychotherapy is not a part of standard medical care yet; and

Whereas, self-medicating without harm-reduction education with psychedelics can produce unfavorable results, however, an increasing number of people feel stagnant with the efficacy of the current legal treatments and turn to criminalized medicine; and

Whereas, the goal of entheogenic research of harm reduction and the ability for mental health experts to use this as a means for a more targeted, integrative approach, considering that Arizona is a global hub for integrative medicine, home to the world renowned Andrew Weil Center for Integrative Medicine, however, Arizona also designates psychedelics as dangerous. “Many non-marijuana products, like hallucinogenic mushrooms, lysergic acid diethylamide (LSD), mescaline, and other drugs containing these or related substances, are categorized as dangerous drugs; and

Whereas, despite the criminalization of potential medicine, the fiery nature of the emerging integrative medical community is bringing this treatment modality back to the forefront. “In both Tempe and Tucson, there are two major organizations fighting to decriminalize psychedelics. Modern Spirit, a non-profit organization, and Amanda Ryskowski’s student organization are currently leading the charge in Tempe. Ryskowski created the Entheogenic Research Awareness group as a firstyear medical student at the Southwest College of Naturopathic Medicine. The organization seeks to raise awareness of the therapeutic potential of entheogenic substances among healthcare professionals and the general public. She is now working to legitimize the decriminalization of psilocybin and other natural psychedelics.” Therefore, be it

Resolved, as the Arizona Medical Association’s (ArMA) foundation dedicated to promoting public health initiatives, supporting medical education, and increasing patients' access to medicallyappropriate care, ArMA must stand to the call to increase access to entheogenic research for psychiatric treatment with higher, more sustainable results in Arizona.
2023 New Resolution
Recommend Referral to Executive Committee

05-23 Insurance Payments
INTRODUCED BY:  Julie Wendt, MD
SUBJECT:  Insurance Payments

1 Whereas, the insurance industry has seized control over the field of medicine, effectively making provision
2 of medical services more expensive and physicians are subject to the same yearly inflation and executives
3 in the insurance industry have given themselves raises to a near-ludicrous level but have cut insurance
4 payments year after year, and
5
6 Whereas, much of the cost of medicine, which requires physicians and physicians' offices to employ
7 numerous administrative employees that do not participate in care but ensure that their patients can get
8 the needed care, this resolution seeks to create a single portal whereby prior authorizations are process and
9 limit the time of first and final response by insurance, and
10
11 Whereas, the insurance industry requires cumbersome lengths to obtain eligibility and benefits of its
12 patients (specialty codes require a call; personnel that call are frequently on hold for hours; the calls are
13 frequently disconnected, requiring physician offices to call repeatedly; when a physician's office does
14 connect with the insurance, most insurance companies limit the number of patients about which they will
15 quote eligibility and benefits; and insurance is the only contract that does not have to stand behind its rates,
16 even when quoted), and
17
18 Whereas, insurance companies have initiated publicizing physicians that are "average" in cost in a negative
19 light which undermines the careers and reputation at the expense of physicians that are "much less than
20 average" but may not be delivering excellent healthcare and may not be board-certified in their field of
21 practice and whereas some physicians take patients that are potentially more challenging to treat and
22 therefore more expensive, the insurance industry is prohibited from discriminating and publicly damaging
23 physicians based on cost to them; therefore, be it
24
25 Resolved, that ArMA seeks to tie the minimum increase in insurance payments to doctors to the rate of
26 inflation; and be it further
27
28 Resolved, that ArMA seeks formation of a review board consisting of half general practitioners and half
29 specialists, voted into the committee by peers, that can be invoked in cases of abuse by insurance, that can
30 assess fines of the insurance industry; and be it further
31
32 Resolved, that ArMA seeks to require that all insurance companies to post all eligibility and benefits online
33 in a central portal for all potential services; for uncommon services, a request for quote can be entered
34 into a central portal and the answer must be delivered to the submitting physician's office within 48
35 hours. Any abuse can also be submitted to the committee of Clause 2.
2023 Resolutions Recommended to Not be Adopted in Lieu of 15-23

16-23 ACO-REACH
WHEREAS, Resolution 09-22 concerning the CMS program Direct Contracting Entities (DCE) was passed by the House of Delegates in April 2022, which required that ArMA send a letter to the HHS Secretary asking for the program be terminated for multiple reasons; and

WHEREAS, the letter to CMS was never sent as the DCE program was rebranded to ACO-REACH on 1/1/2023, although DCE and ACO-REACH are very similar, and this was known and discussed at the ArMA HOD at the time of the 2022 annual meeting; and

WHEREAS, a new Resolution is being submitted to the 2023 HOD by the MSS/RFS which specifically asks for a letter be written to the HHS Secretary asking that the ACO-REACH program be terminated, and

WHEREAS, the issues regarding the ACO-REACH program are critical and timely, therefore a letter needs to be sent as soon as possible; and

WHEREAS, a draft letter for the BOD to review per Resolution 09-22 was not prepared until January 2023, a letter has been prepared and included below for the 2023 HOD to consider; therefore, be it

Resolved, that the Arizona Medical Association send the attached letter which asks for the termination of the ACO-REACH program to the HHS Secretary within 30 days.

Dear Secretary Becerra,

We, the members of ArMA, write to you as an organization that has acted as a voice for its members, patients, and the people of Arizona for the past 130 years. In its long history, ArMA has advocated for economically sustainable medical practices, the freedom to deliver care in the best interests of patients, and health for all Arizonans. We write to you concerned for all three of these values.

Our concern has led us to ask for the termination of the Global and Professional Direct Contracting (GDPC)/Direct Contracting Entities (DCEs) and Accountable Care Organizations (ACO) Realizing Equity, Access, and Community Health (REACH) models.

Recently, the DCEs program, which ArMA strongly opposes, was rebranded as ACO-REACH. Former “DCEs” were simply renamed “ACOs” without any distinct or new application process.

ACO-REACH claims to increase equity, but its vague descriptions and inherent lack of enforceability give it unbridled control over patient coverage and care. For example, ACO-REACH plans will be paid (subsidized by government funding) to collect demographic and socioeconomic data on their patients. This is marketed as a way to help underserved communities, but historically this data has been used to non-consensually modify patients’ risk profiles, which are then used to deny care. In
the name of equity, ACO-REACH further pays ACOs per underserved patient they enroll. Both of
these financially reward ACOs without any strings attached—there is no requirement for care to be
provided, and no oversight for this system. ACOs are also able to retain as profit more than 25% of
the amount they save in medical expenses. In this system, ACOs (DCEs) will always be incentivized to
avoid the only thing they exist for: paying for patient care. No matter the name, ArMA’s opposition
to this economically nonviable program—one that pays for improved care while providing the
opposite—remains consistent.

Similar to its predecessor program, ACO-REACH does not represent the interests of patients. In fact,
it undercuts the quality of care, autonomy, and economic best interests of patients. ACO-REACH
enrolls Medicare beneficiaries without their consent or knowledge. Contrary to the claims that ACO-
REACH provides “accountable” care to underserved communities, this organization is not in fact
accountable in registering patients or in oversight. In fact, CMS fined multiple DCE programs
hundreds of millions of dollars for fraudulent billing, upcoding, and false advertising to seniors about
out of network availability and cost during the last year. By its very nature, ACO-REACH is a program
that doesn’t respect the values of ArMA in providing all patients care in their best interests, nor does
it respect patient autonomy in enrollment.

Nor does ACO-REACH afford physicians the voice and independence ArMA has advocated for so
long. Primary Care Provider’s (PCP’s) corporate owners have the ability to sign a ACO-REACH
agreement on behalf of physicians. This means that, without their consent or even knowledge, both
PCPs and their patients can be enrolled into this program. Not only is this failing to sustain the
practice of independent medicine, it actively challenges it. ACO-REACH does nothing to foster the
sacred bond between practitioner and patient nor does it promote the values physicians hold. The
program claims that physicians have a voice through holding 75% board membership along with
patients. However, there is no accountability yet again in this system as there are no protective
measures against conflicts of interest nor is there any requirement that practices, regions, or patient
populations be equally represented on the board. How can they represent physician voices when it’s
inherent to the program that physicians are enrolled without their consent? Because of this, there is
no reason to believe that ACO-REACH can represent the voices of physicians as a whole.

Furthermore, it is a pressing, widely held concern that US healthcare spending is out of control. The
US does not provide the level of care that other countries do, while spending much more. But ACO-
REACH programs only exacerbate this issue without providing meaningful benefit to physicians or
patients. As stated previously, DCE programs were fined for fraudulent billing and upcoding,
practices which only increased the spending and economic difficulties the healthcare system faces
while placing a difficult burden on patients. While ACO-REACH/DCE programs claim to benefit
underrepresented and disadvantaged populations, these economic burdens actively harm this
patient population. Our healthcare system is already facing large economic challenges, and ACO-
REACH will exacerbate these trends.

ArMA wants to highlight once again that we represent not only current physicians, but also medical
students and residents—the future healers of our state. We are united in our strong opposition to
programs like DCEs and ACO-REACH that further restrict our freedoms as physicians and our
patients’ freedoms and quality of care while harming the economic state of our country. This is
absolutely not the kind of program we want to be forcibly enrolled to work under. We, as a coalition
of physicians and future healthcare practitioners who hope to serve this country, ask that you
unequivocally terminate the ACO-REACH program altogether, not rebrand it, as its foundational
structure cannot be salvaged.

Sincerely,
Arizona Medical Association (ArMA)

Budget impact: none
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Thank you for your support!