OSMA 2021 Annual Meeting Resolution Committee Three
Online Testimony

Res.#	Comment by:	Representing	Position	Comments
26	Deepak Kumar, MD	Self	Oppose	I am in opposition to this resolution. The authors are only looking at one benefit of COMPACT but are overlooking all negative aspects of the compact (including increased cost, requirement of Board Certification and recertification and MOC).
26	Ken Christman, MD	Self	Oppose	 STRONGLY OPPOSE this resolution. Ohio's State Medical Board has very good reasons for rejecting the Interstate Medical Licensure Compact, an entity devised by the FSMB which curtails the jurisdiction of the OSMB, is costly, inefficient, and even more importantly, very difficult to leave. If one has read the requirements of joining this compact, provisions are in place for the FSMB to actually sue the State of Ohio, and leaving this Compact can be very expensive to taxpayers. Furthermore, there is nothing that prevents physicians from obtaining medical licenses in other states. NOTHING. There is no advantage to the IMLC, and in fact, for the State of Ohio, there are significant disadvantages. The IMLC may very well self-destruct in a few years, and Ohio has wisely stayed out of this potential disaster.
26	Herman Abromowitz, MD	Self	Oppose	Strongly Oppose!
26	Ellen Hott, MD	Self	Oppose	 Strongly oppose. I'm not surprised that this resolution was brought by an institution rather than actual physicians. Did the Ohio Hospital Association propose this?
26	Keith Reisinger-Kindle, DO, MPH	District 2	Oppose	 On behalf of District 2, we oppose this resolution due to general concerns around the lack of autonomy and authority this change would bring about for the Ohio State Medical Board.
26	Susan Hubbell, MD	Authors & District 3	Support	See below.

No conflict. The Interstate Medical Licensure Compact has evolved since it was created. IT IS NOT A NATIONAL LICENSE. If Ohio were a part of the Compact, an Ohio physician MUST go through the usual process through the State Medical Board of Ohio to obtain a license and pay the same fees that every physician pays to be licensed. That process does not change if Ohio were a part of the Compact. An Ohio physician must also maintain his or her license in the current method through the State Medical Board of Ohio. The Compact does not over rule the policies and procedures of the State Medical Board of Ohio. The Compact serves as a data base so that when a physician wants to be licensed in another state that is a part of the Compact his or her information such as verification of medical school graduation, verification of residency training, etc., is easily available and can be sent to the new state licensure board where he or she wants to become licensed. That medical board makes the final decision of who will be licensed and the medical board charges their usual licensure fees so it does not lose money. Many physicians now want licenses in more than one state for purposes of telemedicine, locums work, etc, where a license is

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required in the state where the patient lives in order for a physician to care for the patient. Ohio physicians who live near our state border may want to have an office in an adjoining state and participation in the Compact would make obtaining a license easier and faster. For an individual Board to independently verify all of the information necessary for licensure takes time and effort and delays licensure, sometimes indefinitely. Our American Medical Association House of Delegates voted to encourage states who are not members of the Compact to join and has model legislation that can be used in each state legislature to accomplish this.
The link below takes you to the web site for the Compact for further information. This Compact does not work the way the Nursing Compact does. 

https://www.imlcc.org/faqs

26	Ellen Hott, MD	Self	Oppose	See below.

Dr. Hubbell, can you address the following concerns? (I'd like to acknowledge the ideas and words of colleagues whose understanding and eloquence exceed my own, as I can't take credit for all of the following)

1) The compact is anti-trust. The compact is written in such a way that a physician is defined as someone who is compliant with the American Board of Medical Specialties Maintenance (ABMS) of Maintenance of Certification (MOC) Programs. The American Medical Association (AMA) has passed numerous resolutions that MOC compliance should not be a requirement to practice medicine (https://assets.ama-assn.org/sub/meeting/documents/i16-resolution-309.pdf). The compact would do facto make MOC compulsory even for states whose laws prohibit requiring MOC for licensure and credentialing.

MOC serves to increase the cost of healthcare, reduce patient access to healthcare, and contribute to physician burnout. As recently as May 28, 2020, the AMA has taken a public position that compulsory MOC participation contributes to physician burnout (https://www.ama-assn.org/practice-management/physician-health/12-factors-drive-physician-burnout). In addition, MOC compliance is discriminatory based on age, race, and gender, as time-unlimited certificate holders (grandfathered physicians) are excluded from participation, and are 80% white and 70% male (https://www.aamc.org/system/files/reports/1/factsandfigures2010.pdf). The danger here is that if the Interstate Compact is successful, national rather than state medical licensure may be on the horizon, which should not be tied to MOC compliance.

Furthermore, MOC is defined as participating by in the ABMS monopoly, as alternative board certifications (NBPAS, e.g.) are not recognized by the compact.

2) The compact requires board certification, thus younger physicians are ineligible until they have completed a residency.

3) The compact finishes due process. If you have a complaint in one state...you can lose your license in all those states before you have a chance to defend yourself.

4) The compact adds cost to licensure. It costs $700 in addition to the cost of each state's license.

5) The compact does not add value to existing services. It essentially merely expedites educational verification, a process already served by FCVS (which, as a personal note, is an inefficient, unresponsive organization which actually slowed my licensure by losing documents).

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6) The compact is a vehicle if enrichment for FSMB. It is designed to achieve a goal any medical credentialler can do, but it brings the service “in-house” keeping the fees for FSMB.				
26	John Corker, MD	YPS	Support	The IMLC has myriad potential benefits for our members, including but not limited to: those who practice LOCUMS, Telehealth and in border counties who practice across state lines. The train has left the station on this, and many states have already supported the IMLC. It is time for OSMA to align itself with current AMA policy in this regard and, in so doing, make the practice lives of so many of its members that much easier. Isn't that precisely our mission as a membership organization?
26	Anne Taylor, MD, MPH	Self	Support	See below.
I completely understand the concerns articulated. Just to clarify, if Ohio moves forward in joining the Interstate Medical Licensure Compact (IMLC) Ohio would continue to have complete control over its licenses holders. The Ohio State Medical Board will continue to have full autonomy to make its own rules for its license holders and are not beholden to any other state or outside entity. There are many different state compacts being considered for many different allied practitioners, and they all seem to be structured slightly different. All of the ones being debated in Ohio must comply with Ohio scope of practice laws. As you are probably aware the APRN Compact does not and would supersede Ohio scope laws. Luckily, the APRN compact is not being considering in Ohio at this time. According to Joe and Monica, the OSMA Government Relations team is aware of this and is monitoring all of the compact bills closely. The main IMLC purpose is to make a more streamline process for physicians who choose to be licensed in multiple states. This is accomplished by having physicians who wish to practice in multiple states apply through the IMLC rather than apply to each state individually. A physician who is applying for licensure in multiple states is routed through the IMLC, therefore making the overall process of gaining a license in multiple states more streamlined. Often times physicians are able to receive their license much faster with fewer burdens. An important note, licenses are still issued by individual states medical board, and they maintain full control in regulating their license holders, not the IMLC. Even if a state joins the IMLC it is completely voluntary for physicians to join. Applying for licenses through the ILMC is completely voluntary and if you choose to only be licensed in Ohio there would be no change in your application/renewal process. I would agree in keeping the Ohio State Medical Board to be able to govern and make the best decisions for its Ohio license holders and residents.				
26	Susan Hubbell, MD	Authors	Support	See below.
Speaking for the authors and responding to questions in the testimony: 1. The process for Ohio physicians to get an Ohio license would not change if Ohio joins the IMLC. 2. No Ohio physician has to participate in the IMLC. 3. If an Ohio physician wants to be licensed in another state, he or she can apply directly with that state's licensure board if he or she chooses to do so. 4. If an Ohio physician WANTS to participate in IMLC to get a license in other states, the physician must meet the IMLC criteria and pay a fee to IMLC which then gathers all of the necessary credentialing information and submits it to the other states. The physician pays each state's licensure fee. The idea is that the IMLC has a file with all of the physician's credentialing information which can then quickly be sent to the states where the physician wants to be licensed. 5. The IMLC has set a high bar for physicians to qualify to participate. Because of that, the states that participate in the Compact can feel confident about granting a license to physicians who apply for licensure through the Compact.				

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6. The State Medical Board of Ohio has authority over the physician's license just like it does now. 7. If a physician does not participate in MOC he or she can apply directly with the state where he or she wants to be licensed.				
27	Ken Christman, MD	Self	Oppose	 OPPOSE this resolution. What is the need to identify a behavior choice as a "medical condition"? There are, indeed, many behavior choices that can lead to a medical condition. Is tobacco use a behavior choice? Is it also a medical condition? What about dangerous behavior choices such as bungee jumping, white water rafting, parachute jumping, motorcycle riding. . . behavior choices are endless. While we sympathize we addictions of all types and as physicians, should do our best to help, in the final analysis, unless patients are caged, fed, and watered, they must ultimately bear the consequences of their own choices.
27	Jack Reifenberg and Kiersten Woodyard	Authors of Resolution	Support	Hello! Thank you for your comment. As physicians and future physicians, we hope to attempt to alleviate the plight of those experiencing consequences of the healthcare-industry precipitated Opioid Crisis in Ohio. When certain types of addictions, specifically alcoholism, have been questioned as medical conditions in the past, our OSMA (Policy 79, 1977) has responded by recognizing Alcoholism as a disease and resolved to support expansion of Alcoholism treatment and support coverage of Alcoholism treatment by insurance companies. Our OSMA resolved in 2017 that all Ohio Physicians should work diligently to find solutions to the multifactorial opioid epidemic that physicians have contributed to (Policy 20, 2017), as well as resolved to work with other state agencies to develop solutions to prescription drug abuse (Policy 18, 1983). In the wake of the Opioid Crisis, for which the Ohio-based patient suffering has been extensively documented, we hope to follow the lead of former OSMA policy writers by supporting those affected by addiction in Ohio by expanding treatment coverage, options, and accessibility.
27	Jocelyn Wray, MD	District 3	Oppose	Dr. Jocelyn Wray representing District 3. We oppose this resolution. No personal or financial disclosures.  As physicians, we absolutely support respectful treatment of all patients, including those individuals with substance use / abuse. We agree that access to treatment for individuals with health issues, including addiction, is important. However, it is the opinion of District 3 that it is not in our best interest to "support legislative change" as written in this resolution. It is particularly problematic to "support legislative changes...that de-incentivize the policing of substance users..." We would likely all agree that addiction is a very complex issue. For instance, what is the definition of "early intervention.?" It would be interesting to know how many individuals with addiction would seek

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				any intervention (early or otherwise) without an encounter with the legal system. The resolution as written is opposed by District 3.
27	Jack Reifenberg and Kiersten Woodyard	Authors of Resolution	Support	See below.

Hello! Thank you for your comment.

As Physicians and Future Physicians, we hope to alleviate the burden of the healthcare industry-precipitated Opioid Crisis in Ohio. In reference to supporting legislative change that de-incentivizes the policing of those experiencing substance use disorder, we hope to reduce the instance of legal punishment as a direct consequence of a medical condition, legal punishment which disproportionately affects patients of marginalized populations. The change in funding priorities could further expand current intervention programs in Ohio, such as Ohio START (Sobriety, Treatment and Reducing Trauma), which is a specialized service currently in 34 counties, with imminent expansion to 30 additional counties. The services of Ohio START include a family-focused approach where parents are assisted with a path from recovery to addiction, while their children receive intensive trauma counseling for parental substance abuse related events. The services provided by Ohio START are able to help avoid family separations and costly out-of-home placements. Another highly effective set of programs are the Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOP), which have the goal of prevention and early identification of adolescent drug use in urban minority populations, with subsequent referral for specialized intervention services. There are currently less than a dozen UMADAOPs in all municipalities across Ohio, even though there has been demonstrated need in many more. Please refer to the Budget of the State of Ohio for the Fiscal Years 2020-2021 for the Department of Mental Health and Addiction Services for more programs that would benefit from a fraction of the funding allotted to incarcerating patients experiencing SUD.

There, as well as on the Ohio Department of Mental Health and Addiction Services website, you will find opportunities to increase housing security, job placement, post-incarceration support, as well as veteran and military addiction support. In identifying potential and current initiatives that utilize early intervention, we use the OhioMHA framework for programs outlined in the RecoveryOhio Advisory Council Initial Report, which is built from the SAMHSA model to screen for substance abuse and mental illness in patient populations.

27	Keith Reisinger-Kindle, DO, MPH	District 2	Support	 On behalf of District 2, we support this resolution. The recognition of substance use disorder as a chronic medical condition with the need to prioritize treatment over penalization is a critically important evidence based approached to not only improving the care of individuals who to improving public health outcomes around substance use disorder.
27	Jack Reifenberg and Kiersten Woodyard	Authors of Resolution	Support	Thank you for your comment! With the wealth of literature on the impact of the Opioid Crisis and Substance Use Disorder on the health of Ohioans, we also believe that prioritization of treatment over penalization is an important tenet of the path forward for Ohio. Thank you for your support and your evidence-based approach to this issue.
27	Alan Levy, MD	Self	Support	Alan Levy MD speaking for myself in support of this resolution. Both federal and State parity legislation mandates that substance use disorders be regarded as medical conditions entitled to the same

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				insurance coverage offered for other medical illnesses. It is also clear that governments are increasingly offering "drug courts" to divert substance users to treatment rather than prison. We should advocate for the carefully considered dispositions of substance users who are arrested and who may be found to be more appropriately served by receiving treatment rather than jail. This reduces cost to society, keeps families together, and has a better chance of restoring a substance misuser to a more productive and healthier member of the community. Prison has proven to be a poor deterrent.
27	Jack Reifenberg and Kiersten Woodyard	Authors of Resolution	Support	Thank you for your comment! We whole-heartedly agree with your insight regarding the Mental Health Parity Act at the federal level and the proper implementation of its tenets at our Ohio state level. We appreciate your support and evidence-based approach to this issue.
27	Suzanne Sampang, MD	District 1	Support	Suzanne Sampang MD speaking on behalf of District 1 FOR the resolution. I do not have a personal or substantial financial interest. The Medical Student Section has put together a well-written, impactful resolution. It is finally widely accepted that substance use disorders are biologically-based, medical illnesses with significant morbidity and mortality. As such, they are deserving of the house of medicine's efforts at prevention, early detection, intervention and treatment. It is also well-established in the literature that diversion to treatment provides better outcomes than incarceration. Ohio is ground zero for the opioid epidemic and we need to be loud partners in advocating for affordable and accessible treatment.
28	Ken Christman, MD	Self	Oppose	 VERY STRONGLY OPPOSE this resolution. There is absolutely no need to further explore drugs that have already been shown to be dangerous. The Harvard Experiments of 5 or 6 decades ago adequately demonstrated the hazards of these drugs. They should be abandoned forthwith. Why would one wish to further experiment with known poisons?
28	Paul Nagib	MSS/Authors	Support	See below.
We appreciate your input! The Harvard Experiments were terminated in 1962 because the faculty investigators broke ethical standards. I wholeheartedly agree with you that the era of psychedelic research in question (50s-70s) should be carefully scrutinized. After all, the CIA's MK ULTRA experiments of the 50s-60s proved that a psychoactive drug combined with malintent, ignorance, or recklessness can be dangerous, just as you pointed out. But please keep in mind that the objective of MKULTRA was to weaponize a drug for use in intelligence. Besides LSD, the CIA also experimented with amphetamine, morphine, scopolamine, marijuana, and alcohol. The experiments only proved themselves dangerous, not the drugs. After all, these other substances are either prescribed as medication today or are otherwise legally obtained. Today, medical researchers globally are interested in promising preliminary clinical data which has already garnered millions of				

funding dollars, legislative changes, and even bipartisanship during the Trump administration. The quality and direction of today's psychedelic research explains why even the Navy SEAL Foundation funds and supports MDMA research to treat PTSD. The evidence speaks for itself.

The following medical institutions now have or are planning multimillion dollar centers dedicated to this field:
Mt Sinai (The Center for Psychedelic Psychotherapy and Trauma Research)Massachusetts General (Center for the Neuroscience of Psychedelics)Johns Hopkins University (Center for Psychedelic and Consciousness Research)UC Berkeley (Center for the Science of Psychedelics)NYU Langone (Center for Psychedelic Medicine)Imperial College of London (Imperial Centre for Psychedelic Research)

Even if the risk of these substances outweighed the potentiality of benefit, that should give more reason to study them. 32 million Americans reported recreational psychedelic use (2013) compared to 11.5 million Americans who reported illicit/recreational opioid use (2015). Why are 32 million Americans drawn to this non-addictive substance? Shouldn't we find out more about substances this widely used?

Ohio has world-class resources and talent to contribute to the inevitable research on psychedelics happening globally today. Please let me know if any other points come to mind. Thank you!

28	Ellen Hott, MD	Self	Oppose	 Oppose. FYI I am boarded in Psychiatry and Addiction Medicine.
28	Paul Nagib	MSS/Authors	Support	See below.

I would love to learn more about your perspective coming from addiction medicine. Addiction medicine is extremely relevant to the research of psychedelics. Several studies have shown that the insightful effects of psychedelic-assisted therapy (PAT) often accompany sobriety. In a recent study for example, 80% of participants had stopped smoking by the 6 month follow up after PAT, and 75% by the 2.5yr follow up. A similar experiment with alcohol-dependent participants showed similar promising results with PAT. Interestingly enough, Bill Wilson, decades after founding Alcoholic Anonymous, became a proponent of PAT after receiving it under medical supervision. (Johnson MW, Griffiths RR. Potential Therapeutic Effects of Psilocybin. Neurotherapeutics. 2017)

I do believe that the approach to PAT, like anything involving a psychoactive substance, should be based on evidence and should always prioritize safety. I understand that this realm of research might be questionable to some, especially professionals that see and treat substance abuses of all kinds. Why should the substance in question not be further researched, especially if its unregulated use causes concern while its clinical use has thus far shown promise?

In my response to Dr. Christman, I allude to the CIA's nonmedical and unethical experiments with several psychoactive drugs, including amphetamine. Amphetamines are highly addictive and cause a number of side effects ranging from appetite loss to motor dysfunction. Yet, they are well-studied and regulated in a way where the treatment it provides those who need supersedes the liability. Psilocybin, on the other hand, has no LD50 and is non-addicting. Consider the checklist provided by the FDA which determines the control of a substance according to the Controlled Substance Act:
1. Its actual or relative potential for abuse.
2. Scientific evidence of its pharmacological effect, if known.
3. The state of current scientific knowledge regarding the drug or other substance.
4. Its history and current pattern of abuse.
5. The scope, duration, and significance of abuse.
6. What, if any, risk there is to the public health.

7. Its psychic or physiological dependence liability.
8. Whether the substance is an immediate precursor of a substance already controlled.

Despite abuse potentiality appearing to be a major theme on this list, several dangerously addicting and potentially toxic substances have been ranked as more safe and of more therapeutic value by the CSA. For example, Desoxyn (methamphetamine) and fentanyl are both Schedule II, despite having been dangerously used outside of their regulated manner. Psilocybin, although much more safe pharmacologically, is still a Schedule I substance- deemed as most dangerous and unbeneficial despite evidence proving otherwise.

I am very interested in your perspective on this subject and what you think of the ongoing research with psilocybin for depression and MDMA for PTSD. I suppose I am most interested in how you see addiction potential as a factor in researching the therapeutic potential of substances, since there seem to be many contradictions in current scheduling laws. Thank you for your time!

28	Keith Reisinger-Kindle, DO, MPH	District 2	Oppose	On behalf of District 2, we oppose this resolution. The resolution authors have not provided enough information and evidence to support the statements in the resolved clauses and to identify the importance of increased attention on these two specific substances.
28	Paul Nagib	MSS/Authors	Support	See below.

I appreciate your time looking into this resolution. The following is the breakdown of how we derived the resolved clauses from the evidence cited throughout this resolution-

R1; There is ample evidence regarding the need for mental health services in the state of Ohio (lines 14-26). Mental health services are projected to be much more needed in the near future as depression becomes recognized as endemic. There is ample evidence that psilocybin has possibly efficacy in the populations needing these mental health services. Lines 28-43 cite the ample evidence to what has thus far proven to be an extremely efficacious and safe treatment for depression (with Psilocybin-Assisted Therapy) and PTSD (with MDMA-assisted therapy). Support from the OSMA would bring awareness to this research and combat long-lasting stigmas that might be in the way of medical progress.

R2: The United States created five “schedules” with the aim of organizing harmful substances from most to least dangerous (Schedule I-V) as part of the Comprehensive Drug Abuse and Control Act of 1970. In the last two decades, inconsistencies due to the lack of any clear pharmacologic, neuroscientific, or psychiatric evidence, have manifested themselves as several drugs scheduled in lower categories, such as benzodiazepines (Schedule IV), have been demonstrated to be extremely addictive and dangerous, yielding disasters such as the opioid crisis. In the meantime, several Schedule I compounds including psilocybin have shown therapeutic potential and low rates of misuse, addiction, or physical harm. It is for these reasons that we call for the OSMA to acknowledge that federal scheduling of substances should not interfere with or contribute to the stigma of psychedelic research.

R3: This resolved clause is self-explanatory. Patient safety comes before anything else. There is much less and weaker evidence for therapeutic benefits of marijuana than for either psilocybin or MDMA. Still, the state of Ohio (alongside many other states) deemed current evidence as sufficient before implementing state-based medical marijuana programs. Marijuana is a commercialized substance, so its expansion should come to no surprise. Big Pot lobbyists have influence that might unfortunately supersede the quality of evidence required by the FDA before medicalizing a substance. Consider that clinical

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trials with psilocybin and MDMA have been granted Investigational New Drug status by the FDA, meaning they are being investigated for a specific indication. Marijuana, which is being medically marketed in Ohio, has never been designated an IND. Thus, R3 calls for the OSMA to take control of the growing field of psychedelic research so that legislative decisions are solely evidence-based. It calls for further research and clear indications before allowing our communities to be exposed to any controlled substance. For these reasons, I believe that the resolved clauses are appropriate for the OSMA and are well supported by current evidence. Please let me know if there are specific changes you would like to see on this resolution, or if there are specific points I made above that you would like me to cite. Thank you!				
28	Michelle Knopp, MD	District 1	Support, in part	Michelle Knopp, Speaking on behalf of District One with substitute language for consideration by the authors. We proposed replacement of entire resolution with following language: "RESOLVED, that Our OSMA supports efforts enabling clinical research on schedule I drugs to help elicit possible medical benefit." While research has been done on some of these drugs in the past, more recent research has indicated potential of some of these drugs in various medical applications. Wanting to avoid specific language in policy of supporting certain formulations or drugs, we believe this amended language remains true to the authors hopes while providing broad policy for the OSMA to work on going forward in finding the best medical care for our patients.
28	Alan Levy, MD	Self	Support	Alan Levy MD speaking for myself in support of this resolution. While I would suggest Michelle Knopp's recommended amended language is a reasonable substitute, I see no reason not to support the language offered in this resolution. OSMA would NOT be advocating for the use of Schedule I drugs but rather acknowledging that the FDA is conducting experiments which have merit in examining the questions of whether any such-labeled drugs may have utility in the treatment of refractory psychiatric conditions. Of course, we physicians should be supporting pharmacologic research, even with schedule I drugs, which in micro-doses may have utility not previously appreciated.
28	Anne Worth, DO	YPS	Support, in part	Anne Worth DO, elected alternate delegate to the Young Physician's Section, speaking on behalf of the YPS: We support Resolved 1 and recommend removing Resolved 2 and 3; we feel Resolved 1 accomplishes the intended objective--researching these drugs for potential benefit for psychiatric conditions. Continued research will be necessary before further policy can be made.
29	Deepak Kumar, MD	Self	Support	Support for obvious reasons.
29	John Naveau, MD	District 3	Support, in part	No disclosures District 3 recommends that the word "sale" be changed to "resale" in both "Resolveds". If this change is made, District 3 supports the resolution.

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29	Alexander Pennekamp, DO	Self/Author	Support, in part	Author Comment: District 1 Resolution Discussion meeting yielded several changes that I see were echoed by District 3. I would graciously like to accept the suggested change of wording from "sale" to "resale" in both Resolved statements. In reading the posted comments as well as attending the District 1 Resolution Discussion meeting, I would be happy to accept friendly suggestions / changes from the Reference Committee. I have no personal disclosures related to this resolution. I have no financial interests in the resolution either.
30	Ken Christman, MD	Self	Oppose	OPPOSE this resolution as written. While I hope all physicians oppose forced sterilizations, there are already laws in place for requiring full informed consent for all medical and surgical procedures. Even without such laws, physicians have a duty and responsibility to each patient to apprise them of risks and benefits to prescription medications, surgical and nonsurgical procedures, vaccinations, etc., and full informed consent is paramount. This includes forced sterilization. There is no need for a resolution that calls for prohibition of something that is already prohibited.
30	Meghana Kudrimoti	Self/Author	Support	Thank you for taking the time to read and comment. As first author of the resolution, I'd like to clarify that this resolution does not move to prohibit or criminalize physicians who forcibly sterilize patients. As you've pointed out, this is already illegal since there are laws to ensure informed consent. However, despite these laws, forced sterilization continues to be a problem today (as recently as September 2020!) and unfortunately, the practice has been a dark part of our past (please see the resolution for historical instances in the US and Ohio). This resolution simply asks the OSMA to acknowledge forced sterilization is still a problem today by condemning it unequivocally. I believe this is an important first step the OSMA can take to rebuild trust with patients who have been forcibly sterilized or fear being forcibly sterilized by physicians.
30	Keith Reisinger-Kindle, DO, MPH	Self	Support	 As an OB/GYN this issue is particularly important to our specialty. While this resolution would be mostly symbolic, there is an important role to play in symbolic resolutions when so much distrusts exists in marginalized communities hurt by these previous practices. Having a

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				specific statement/OSMA policy on this would allow OSMA to clearly lobby/advocate in a way that would make it clear to our patients that the medical community has acknowledged our historical mistakes and that we want to work together with marginalized communities to move forward. This resolution is the least we can do.
30	Meghana Kudrimoti	Self/Author	Support	Thank you for the comment, Dr. Reisinger-Kindle! As first author of this resolution, I agree with what you've said. The OSMA should adopt this resolution as a first step to rebuilding trust with our marginalized patients.
30	Ellen Hott, MD	Self	Oppose	 This resolution has the potential risk to create confusion and legal challenges to both appropriate use of contraception authorized by legal guardians of person (“medical” guardians) and to appropriate use of anti-androgen therapy for problematic sexual behaviors. These appear to be outside the scope of the intention of the authors and the resolution, as worded, does not provide sufficient clarity.
31	Ken Christman, MD	Self	Oppose	OPPOSE this resolution as written. While it is unfortunate that there are many gullible patients who are easily persuaded by just about any wild claim on the outer edges of the internet, invoking the FDA, FTC, and any other government regulatory agency is perhaps not the best way to correct this situation. As physicians, our role should be to educate, inform, warn, etc. of the many real dangers associated with supplements and herbal remedies, falling short of regulatory endeavors. After all, one of the recurring mantras of this population is that organized medicine has "outlawed" some of these "beneficial" remedies. Endorsement of this resolution will certainly add fuel to those flames.
31	Keith Reisinger-Kindle, DO, MPH	District 2	Support	 On behalf of District 2, we support this resolution as it brings OSMA policy in line with AMA updated policy.
31	Brian Bachelder, MD, FAAFP	Self	Support	No conflicts. Testifying for myself. Agree with the resolution. Unfortunately the power of social media can drown out the advice of physicians. We need to continue our education efforts, but a multi-pronged approach is required.
32	Ken Christman, MD	Self	Oppose	OPPOSE this resolution. Free China Virus testing is already being done and is available to ALL, whether homeless or not. We all hope that this virus is transient, and who knows, perhaps it will not be an issue one or two years hence. If so, we do not want to see continued testing unless there is a very real need for it. This matter is best left to the public health authorities to determine current needs.

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32	Pragi Patel	Self/MSS/ Authors	Support	Thank you for your comment. Although the current Covid-19 pandemic may be transient, our resolution calls for infectious disease testing beyond that of the novel coronavirus. Through this, we can ensure proper testing for further infectious disease outbreaks such that we can ensure proper care for our homeless population.
32	Michelle Knopp, MD	District 1	Support, in part	Michelle Knopp, speaking on behalf of District One with alternative language. "RESOLVED, that Our OSMA supports efforts for access to prevention, testing and treatment of infectious diseases to patients residing in homeless shelters." We believe this would incorporate the authors' goals of this resolution while creating long standing policy for the OSMA in the future.
32	John Corker, MD	YPS	Support	John Corker MD, YPS Chair, speaking on behalf of the YPS in support of this resolution and the amended language offered by Dr. Knopp and District One. This is a common sense effort to address a severe public health threat for our most vulnerable patients.
33	Ken Christman, MD	Self	Oppose	OPPOSE this resolution, as it is not necessary for physicians to prescribe food. Such is readily available for purchase WITHOUT prescription. If there are cost problems, there are plenty of programs, including FOOD STAMPS to aid in payment. Furthermore, just because a physician prescribes fresh produce does not assure that they will be consumed. I might be persuaded to endorse this resolution if I could be assured that my doctor would prescribe generous portions of Graeter's Black Raspberry ice cream!
33	Hendrik Stegall	Self/MSS/ Authors	Support	I appreciate you taking the time to read our resolution and leave your thoughts. Unfortunately, many in the US have inadequate access to healthful foods even with the help of the Supplemental Nutrition Assistance Program (SNAP, aka "food stamps"). This is evidenced, in part, by the existence of numerous non-profit, non-government programs designed to supplement food stamps. Preliminary studies of food prescription programs are promising, and we believe that such programs, in combination with other efforts, could be very helpful in improving the health of our more vulnerable patient populations.
33	Deepak Kumar, MD	Self	Oppose	I oppose 2nd resolve as this unnecessarily puts burden on insurance industry to provide more coverage. By same logic insurance should cover for diabetic diet for diabetics.
33	Hendrik Stegall	Self/MSS/ Authors	Support	See below.
Thank you for taking the time to read and comment on our resolution! While I understand the concern about placing an increased burden on insurance companies, what is the purpose of health insurance if not to facilitate improved health? The burden of healthcare is moving from treatment to prevention, and a patient's access to healthful, nutritious food is a critical				

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aspect of preventive care for chronic diseases like hypertension, dyslipidemia and diabetes. Preliminary studies are showing some benefit of food prescription programs on weight loss and HbA1c; if insurance supplementing a patient's food budget can aid in long-term weight and blood sugar control, how is it any less important than insurance covering a patient's insulin or metformin? The goal of both diet supplementation and medication is to improve a patient's health and control of their disease in order to prevent disease worsening and complications, which are expensive for the patient and for insurance. Please feel free to respond with other thoughts!				
34	Deepak Kumar, MD	Self	Support	Support for reasons described in the resolution.
34	Ellen Hott, MD	Self	Support	 Support without reservation.
34	Keith Reisinger-Kindle, DO, MPH	District 2	Support	 District 2 supports this resolution and believes this would decrease costs for both applicants and residency programs.
34	Jonathan Markle	MSS/Author	Support	Jonathan Markle, OSMA-MSS NEOMED delegate, speaking on both the chapter's behalf and as lead author of this resolution.  I would like to thank everyone so far for their support! If anyone has any reservations or questions, please reach out to [email].
34	John Corker, MD	YPS	Support, in part	John Corker MD, YPS Chair, speaking on behalf of YPS in support of the spirit and intent of this resolution but with the following amendments/reasoning: 1.) Strike R1. The term "residency Match filters" is undefined and not universally applied. Thus, R1 cannot stand on its own as actionable policy. 2.) Amend the language of R2 to read: "That the OSMA WORK WITH APPROPRIATE STAKEHOLDERS TO create recommendations for increasing transparency of the residency application process, and disseminate THESE RECOMMENDATIONS to all Ohio residency programs." This amended language will achieve the intent of stricken R1, will reduce the fiscal note, promote a collaborative effort and increase the chances of meaningful progress on this important issue.
35	Keith Reisinger-Kindle, DO, MPH	Self	Support	 Support without reservation. This training is long overdue, and is but the smallest of steps to address the public health crisis of racism in medicine.

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35	Ellen Hott, MD	Self	Support	 Support without reservation.
35	Anne Worth, DO	YPS	Support, in part	 Anne Worth DO, elected alternate delegate to the Young Physician's Section, speaking on behalf of the YPS: We support this resolution with the following amendment to the language of Resolve 3: "Our OSMA encourages Ohio medical schools to utilize…"
36	Keith Reisinger-Kindle, DO, MPH	Self	Support	 Support without reservation.
36	David Miller, MD, FAAP	Self	Support	Support without reservation.
36	Keith Reisinger-Kindle, DO, MPH	District 2	Support	 On behalf of district 2, we strongly support this resolution.
36	Anne Worth, DO	YPS/Authors	Support	 Anne Worth DO, elected alternate delete to the Young Physician's Section, speaking on behalf of the YPS and as authors of this resolution: We encourage the OSMA to recognize the importance of the unique health care needs of LGBTQ individuals, and therefore support this training in medical education.
37	Ken Christman, MD	Self	Support	 VERY STRONGLY SUPPORT THIS VERY WELL WRITTEN RESOLUTION. Patients do indeed have the right to know. They should be fully aware, if they make an appointment with their physician, that they will not have a physician laying eyes on them. Those masquerading as physicians should be required to identify themselves for what they truly are. We need full disclosure.
37	Phillip Shaffer, MD	Self/Author	Support	I am the author. This proposal is, I think, non-controversial. Patients should and do have a right to know the capabilities of those caring for them. People have a right to know the terms of other contracts they sign in a very clear manner, such as for purchase of a car, obtaining a loan, etc. Agreeing to allow someone to affect your health should have an even higher bar. This resolution is similar to a law proposed in Texas, known as "Betty's law", named for a 7 year old girl who died hours after being seen by an NP. Her parents had believed the person was a fully capable physician. She was not. Betty did not have the chance to be saved, because the persons training was hidden from her parents. Obviously, this should never happen. https://www.kxan.com/investigations/bettys-law-pushing-for-transparency-inside-freestanding-ers-and-urgent-care-

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				clinics/?fbclid=IwAR3ZoKXdHDypn8wCzryk_G1hc867mrb2YyyBl1KU5D_0mJ4CB_3ZKwqpyAs
37	Ellen Hott, MD	Self	Support	FOR Resolution 37. I very strongly support this resolution. Many of my patients, family, and friends are unaware that they are not seeing a Physician for their medical care when they go to a doctor's office, urgent care, or emergency room. They do not understand the difference between a CRNA, AA, and an anesthesiologist. Truth in advertising should be law in Ohio.
37	Chris Paprzycki, MD	Self	Support, in part	See below.

Chris Paprzycki, MD speaking on behalf of myself, as a physician that works closely with two DNPs in my inpatient and outpatient practices. While I agree with the spirit of the first resolved, we must be careful with the language proposed. Whether you're a physician or own a doctorate degree in pharmacy, I believe you have earned to right to use the term "Doctor." Pharmacists, APPs, physician therapists, etc....they are crucial members of the team, and should be treated as such. We cannot continue to isolate and disparage non-physician health care providers, and expect them to continue to collaborate. But I don't believe that use of the word "Doctor" is the true concern here. I believe improved transparency is the overall intent of the authors, resulting in "Betty's Law," referenced below. Even if a non-physician did not use the term "Doctor," patients will often assume as such. All patients need full disclosure.

I agree with the second resolved, and suggest also that the collaboration agreement be publicly posted (if exists), or a placard saying no physician will be involved in your care.

I strongly agree with the 3rd resolved clause. This should be a routine portion of every patient encounter, not only for credentials, but experience, etc. For example, "My name is Dr Chris Paprzycki, and I am a board certified vascular surgeon. I have been in practice for four years, and I perform 150 of this surgery each year." Transparency o/disclosure of credentials and qualifications is an absolute patient right.

Support last resolved.

37	Johannes O. Olsen, MD	Self	Support	See below.

 Writing on behalf of myself I strongly support this resolution as written. Recognizing mine may be a simplistic approach, hospitals and physician oriented facilities have pretty strong credential committees. For example credentialed orthopedic surgeons are generally qualified for Orthopedic Surgery and not credentialed to practice Urology or Gastroenterology.

However Hospitals and facilities with physician credentialing committees often engage other ancillary medical personnel such as for example advanced practice nurses who do not go through the same credentialing process but may be considered an expert in cardiology one month and next month a renal expert and the next month an expert in breast care.

Several years ago our Ohio Medicare Director, Dr Berman, specifically commented to the Medicare Advisory Committee that he doesn't understand why physicians tolerate lesser trained personnel to be presented as medical experts practicing and claiming the same fees as highly trained physicians who have gone through a strict credentialing process and are generally

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more competent to practice in whatever specific area. He is the one who used the example of a nurse being declared an expert in a new area of practice every month. He offered a soft challenge that physicians should do something about this situation on a national level. This resolution is a step in the direction of defending the meaning of our hard earned credentials especially when the community might allow cheapening of the meaning of Doctor. I support that this resolution, after adoption, is referred to the AMA annual meeting.				
37	Alisha Reiss, MD	YPS	Oppose	See below.
Alisha Reiss, MD, YPS Councilor speaking on behalf of the Young Physicians Section. While we support the spirit of this resolution, we cannot support this as written. As the president of my medical staff and having done a recent bylaws review, I can tell you firsthand that degrees other than MD/DO have admitting privileges including DPM, DDS, and DMD. First, Ohio Revised Code defines "physician" as "an individual authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery." This resolution excludes the degree, DPM. Another example of providers who provide surgery would be our oral-maxillofacial colleagues. These individuals are be board certified by the ABOMS and can become members of the American College of Surgeons (using the title, FACS); however they may have credentials of DMD, DDS, or some dual-degree. These individuals are called "surgeon," but this resolution would ask that they not be permitted to be called "doctor." In its current form, we feel that this resolution is too simplistic in its current definition. Lastly, we are strongly opposed to legislating the informed consent process. While we totally agree this is a best-practice and should be part of informed consent, creating legislation to govern the process can have unintended consequences and may open up litigation if not followed to the letter of the law. As an organization, we have previously fought against legislating informed consent when it came to breast cancer consent for treatment. While the spirit of that legislation was well-intended, there were numerous unintended consequences that could have resulted from that legislation. We need to continue to educate on best-practices and encourage proper, full disclosure of credentials but be cautious on how we ask this to be mandated.				
37	Anne Taylor, MD, MPH	Self	Support, in part	 I am writing as an individual. I am in favor of the spirit of this resolution, and see similar fuzzy credentialing/ non-transparency of providers in my specialty. But as outlined by others, there are some details to be ironed out, before it can be adopted.
37	Morgan Hott, MD	Self	Support	I support this legislation. There is unfortunately great confusion on the part of patients as to who is treating them, and anything that can be done to clarify this should be. NPs and PAs serve a valuable role, but should be confused with or present themselves as doctors. The difference is meaningful, and this needs to be the law of the land.
37	Ellen Hott, MD	Self	Support	See below.
We, the undersigned physicians, strongly support Resolution 37. A 2018 survey commissioned by the American Medical Association's Scope of Practice Partnership (1) clearly shows that patients are unsure of who is a physician and that they prefer physician-led care. We appreciate the work OSMA is doing regarding scope of practice and patient safety. Sincerely yours, Ellen Hott, M.D. (OSMA Member) Nita Bhatt, M.D., M.P.H., FAPA Olufunke Fajobi, M.D.				

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Florence Kimbo, M.D. Irina Korobkova, M.D. Assadulla Khaishgi, M.D. Jera Barrett, M.D., J.D. Mohammed Mahboob Ahmed, M.D. Sujan Barua, M.D. Cortney A. Kohberger, M.D. Muhammad Awais Aftab, M.D. Vamshi K. Myneni, M.D, (1) https://linkprotect.cudasvc.com/url?a=https%3a%2f%2fwww.ama-assn.org%2fsystem%2ffiles%2f2018-10%2ftruth-in-advertising-campaign-booklet.pdf&c=E,1,lPj-L8OQkqML7azidgSorIv9mPNy7-afEsp3FvWzvZyXDrLpq2dEP33yCX2hwsCQmR6ycGJ883D7r8KHeMGYnNZeEr5y-fIPTaBgMV7wgdw,&typo=1				
37	Jeff Harwood, MD	Self	Oppose	Speaking for myself, in favor of the concept but none of the Resolved's as written are workable. So, I am in opposition to the Resolution as written. We must be careful in asking for others to be legislated as it catches us in the same net.
38	Ken Christman, MD	Self	Oppose	 Early childhood is not the time to be educating on these matters. There are many Ohio citizens who will likely object to these "enforced standards." Many parents will likely object to the usurpation of their responsibilities in this arena, and perhaps physicians should avoid engaging the educational system in these matters.
38	Keith Reisinger-Kindle, DO, MPH	Self	Support	 This resolution calls for "age-appropriate, evidence based, comprehensive health education in schools beginning in early childhood." Age appropriate is important language, that should not be overlooked. This is the standard not only in the educational literature but in the public health literature, and is directly tied to improved health outcomes not only for the children exposed to these curricula, but for the entire community. Some parents may not like this, but it is not my job as a physician and public health expert (or the job of OSMA) to tailor our professional and scientific advice to what will make parents happy. It is our job to advocate for the evidence based solutions that result in healthier patients and communities, and let parents decide whether or not it is appropriate for their individual students to participate.
38	Ellen Hott, MD	Self	Support	 I very strongly support this resolution. The authors have clearly cited the policies and research on the subject. We, as physicians, should

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				stand by the evidence-based recommendations of our national professional organizations.
38	Anne Worth, DO	YPS	Support	 Anne Worth DO, elected alternate delegate to the Young Physician's Section, speaking on behalf of the YPS: We support this resolution. Our medical organization should advocate for comprehensive sexual education in schools, a stance already supported by the AMA, as well as the American Academy of Pediatrics, among others. As physicians, we should promote researched, medically accurate, and inclusive sexual education.
38	Rebecca Glowinski	Self/Author	Support	 Rebecca Glowinski, speaking on behalf of myself as one of the authors of this resolution. The evidence on sexual education supports age-appropriate, comprehensive sex ed in grade schools as an effective approach to reducing adolescent sexual risk-taking behavior. As medical professionals, it is definitely within our purview to lobby on behalf of policies that will impact public health in Ohio, and implementing comprehensive sexual education in schools is such a policy. Additionally, while I recognize that many Ohio citizens will have strong feelings about this, the regulation of educational standards at the state level, including standards regarding sexual education, is a very common practice. We do not adjust our medical practices according to politics, but instead follow evidence and science. We should follow these same standards in determining what policies to lobby on behalf of. The fact that Ohio has such lax standards as to what must be taught regarding sex ed leaves many Ohio children subject to standards chosen by their school districts. These standards have no requirement to be evidence-based or to not push an agenda, and so not all children are able to receive comprehensive education. As a result, the public health in Ohio suffers. It is vital that we push our lawmakers to implement age-appropriate, scientifically accurate, and comprehensive sexual education standards so that all Ohio adolescents can make informed, safe decisions.
39	Keith Reisinger-Kindle, DO, MPH	Self	Support	 Support without reservation.
39	Deepak Kumar, MD	Self	-	I am not sure who runs this Minority Health Strike Force and how it is managed and funded. So this resolution needs to be amended to reflect that.

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39	Jonathan Markle	MSS/Author	Support	Jonathan Markle, OSMA-MSS Delagate, speaking as a co-author of this resolution. The MHSF is an executive branch advisory group tasked by Gov. DeWine to study and report on racial differences in COVID-19 and other disease outcomes in Ohio. I recommend reading a little about them here, if you are curious! https://coronavirus.ohio.gov/wps/portal/gov/covid-19/families-and-individuals/More-than-a-mask/More-than-a-mask I also recommend reading their Blueprint and Interim Report to get an idea of the work they have been doing.
39	Keith Reisinger-Kindle, DO, MPH	District 2	Support	 On behalf of District 2, we support the previously completed work of the Minority Health Strike Force and therefore support the resolution.
39	John Corker, MD	YPS	Oppose	John Corker, YPS Chair, speaking on behalf of the YPS in opposition to this resolution. While we applaud the work of the MHSF to date, We should not be endorsing specific non-OSMA programs (over which we have no control) in our permanent policy compendium. These external programs are organic and inevitably evolve. Monitoring this evolution and the appropriateness of our policy can be tedious and cumbersome, and this would set an untenable precedent. Rather, we should be focusing our policy pertaining to this and all important issue on timeless principles, and the YPS would be more than happy to work with the authors to this effect in anticipation of our next policy-making meeting.
39	Annamarie Beckmeyer	Authors/MSS	Support	I believe, in a personal capacity, that the spirit of the resolution is to ensure the Minority Health Strike Force does not disappear post-COVID. Having the OSMA support the implementation of a permanent Minority Health Task Force at the state level seems well within the scope of the organization. Would your concerns be addressed if the language were altered to more clearly support the continuation of the committee post-COVID? In my view, then, once that happened, this policy could be taken off the books, avoiding the continual monitoring you mention. It should also be noted we aren't completely without an OSMA voice as Dr. Armstrong is a member. 
39	Anthony Armstrong, MD, MPH, FACOG	Self	Support	See below.

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 Anthony Armstrong, delegate District 4, and President, OSMA. Speaking on behalf of myself. Naturally I'm in support of this resolution as I have special interest having been a member of the Strike force team. As COVID-19 Minority Health Strike Force advisers we worked with local/state leadership to provide feedback to address COVID-19 and its disproportionate impact on Ohioans of color. The blueprint was to provide actionable recommendations to both eliminate racial and ethnic disparities in COVID-19 and other health outcomes and improve overall well-being for communities of color. Taken verbatim from the purpose "this blueprint goes beyond the current crisis to establish a vision of Ohio as a model of justice, equity, opportunity, and resilience to withstand future challenges." The end result was 35 "recommendations" that span from Dismantling Racism to Advance Health Equity, Health Care and Public Health, Social and Economic Environment, Physical Environment and Data, Implementation, and Accountability. Although the depth and breadth of the Strike force mission was broad, the recommendations are concise and each one is able to stand on its own. Virtually all of them would require changes in policy, legislation and advocacy efforts at the community, local, state and even federal level. Funding of course would vary depending on the issue at hand. OSMA may choose to support all or none of these endeavors as they will very likely be addressed in the near future. With that said this was a task force and the business has such been concluded and therefore it is no longer in existence. It was our understanding that another committee could be formed in the future with similar responsibilities however to my knowledge this has not been done as of yet? I would hope that we could support such a committee, however I think it would be prudent to wait and see when and if that committee is formed, what Is their specific task(s) and does their mission / vision etc. align with ours. I believe what you are really looking for in the meantime is an amended resolved reading "broadening the Minority Health Strike Force recommendations?" Hope this is helpful 

39	Anthony Armstrong, MD, MPH, FACOG	Self	Support	Sorry for the last minute addition but I failed to add that I did mention the Strike Force blueprint in the open commentary for a resolution at the last AMA interim meeting. I'm not sure if it got any traction, but we could possibly consider re-introducing it at A 21 as a template for other states to follow if it were to meet "priority business "qualifications?
39	Rommel Morales	Authors/MSS	Support	Thank you so much for your input, insight, and efforts. As you eloquently stated previously, the aims of the Minority Health Strike Force were a comprehensive deployment of resources and engagement of key community stakeholders to address the racial and ethnic disparities highlighted by COVID-19. This resolution was written as an affirmation to ensure that these objectives would be preserved, not only for future challenges to our public health and healthcare infrastructure, but most importantly as a model of equity and justice to preserve the lives of Ohioans. Given that the Strike Force business has been concluded and is no longer in existence, we would gladly welcome support and collaboration by all commenters to pivot such that the timeless principles of this vision reach fruition.