2022 OSMA Annual Meeting
Resolution Committee One
Resolutions 1-15 and Policy Sunset Report

#1 - Create Guidelines for Sections, Create an International Medical Graduate Section

#2 - Change the Ratio of Representation for Medical Specialties in the HOD

#3 - Meeting Code of Conduct

#4 - Establish an OSMA Women Physicians Section

#5 - Establish an OSMA Senior Physician Section

#6 - OSMA Task Force on Pandemic Preparedness and Response

#7 - Addressing the Roles of Health Professionals in Preventing Public Health Misinformation

#8 - Supporting Legislation for Researching the Neurological and Psychological Effects of Covid-19

#9 - Access to Standard Care for Nonviable Pregnancy

#10 - Supporting Expectant Mothers on Medicaid Seeking Tubal Ligations During Cesarean Sections

#11 - Addressing Weight Stigma Among Healthcare Workers

#12 - Divestment from Fossil Fuels

#13 - Curbing Opioid-Related Deaths in Ohio Through Medication-Assisted Treatment and Harm Reduction Services

#14 - Eliminating Parking Costs for Patients

#15 - Opposing the Criminalization of Self-Managed Medication Abortion

OSMA Policy Sunset Report

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 01 – 2022

Introduced by: OSMA Council

Subject: Create Guidelines for Sections and create an International Medical Graduate Section

Referred to: Resolutions Committee No. # 1

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WHEREAS, the House of Delegates adopted Resolution 12-2021 directing the creation of an International Medical Graduate Section; and

WHEREAS, the OSMA Council recommends adoption of criteria for the creation of Sections within the OSMA governing structure, **therefore be it**

RESOLVED, that the OSMA Constitution and Bylaws be amended as follows (showing only affected sections):

ARTICLE IV
HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) Delegates selected by the Active and Retired Members residing or working within designated OSMA districts; (2) Officers of this Association enumerated in Article VI; (3) Delegates and Alternate Delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without the right to vote unless such Delegate, Alternate Delegate or Past President be a duly elected Delegate or a duly elected officer of this Association; and (4) such representatives of other medical groups as may be determined by the House of Delegates, including the following:

The Medical Student Section shall have ~~seven (7) representatives~~ ONE (1) DELEGATE AND ONE (1) ALTERNATE DELEGATE SELECTED FROM EACH OF THE MEDICAL OR OSTEOPATHIC COLLEGES IN THE STATE OF OHIO to the House of Delegates, said Delegates to be selected in accordance with the Bylaws of the Medical Student Section; provided that the Bylaws of the Medical Student Section have been approved by Council. For purposes of representation in the House of Delegates, Student Members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Student Members of each Ohio medical and osteopathic medical school elect their own Delegate.

The Organized Medical Staff Section shall have one (1) ~~representative~~ DELEGATE AND

ONE (1) ALTERNATE DELEGATE to the House of Delegates, said Delegate to be selected in accordance with Bylaws of the Organized Medical Staff Section; provided that the Bylaws of the Organized Medical Staff Section have been approved by Council.

The Resident and Fellows Section shall have five (5) ~~representatives~~ DELEGATES AND TWO (2) ALTERNATE DELEGATES to the House of Delegates who must be Members in Training of this Association, said ~~representatives~~ DELEGATES to be selected in accordance with the Resident and Fellows Section Bylaws; provided that the Bylaws of the Resident and Fellows Section have been approved by Council. For purposes of representation in the House of Delegates, Members in Training shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Members in Training elect their own Delegates.

The Young Physician Section shall have ~~five (5)~~ ONE (1) ~~representatives~~ DELEGATE AND ONE (1) ALTERNATE DELEGATE to the House of Delegates who must be physician~~s~~ in active practice and under the age of forty or in the first eight years of practice after residency and fellowship training. The Young Physician Section Delegate~~s~~ shall be selected in accordance with the Young Physicians Section bylaws; provided that the bylaws of the Young Physician Section have been approved by Council.

THE INTERNATIONAL MEDICAL GRADUATES SECTION SHALL HAVE ONE (1) DELEGATE AND ONE (1) ALTERNATE DELEGATE TO THE HOUSE OF DELEGATES. THE INTERNATIONAL MEDICAL GRADUATE SECTION DELEGATES SHALL BE SELECTED IN ACCORDANCE WITH THE INTERNATIONAL MEDICAL GRADUATE SECTION BYLAWS; PROVIDED THAT THE BYLAWS OF THE INTERNATIONAL MEDICAL GRADUATE SECTION SHALL HAVE BEEN APPROVED BY THE OSMA COUNCIL.

The primary medical specialties and subspecialties listed by the American Board of Medical Specialties are eligible to have one Delegate and one Alternate Delegate for every 100 specialty or subspecialty members who are also OSMA voting members to be selected in accordance with Chapter 5, Section 4 of the Bylaws of this Association.

The medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members are eligible to have a Delegate and Alternate Delegate to be selected in accordance with Chapter 4, Section 3 of the Bylaws of this Association.

BYLAWS

CHAPTER 5

THE HOUSE OF DELEGATES

Section 2. OSMA District Delegates Ratio of Representation. Each OSMA district shall be entitled to one (1) Delegate and one (1) Alternate Delegate in the House of Delegates for each fifty (50) Active Members and Retired Members working or residing in the district as of December 31st of the preceding year. If the total number of Active Members and Retired Members in the district is not evenly divisible by fifty (50), that district shall be entitled to one

(1) additional Delegate in the House of Delegates. The names of such Delegates and Alternate Delegates shall be submitted to the Association prior to the opening of the House of Delegates.

IN ADDITION TO THE DISTRICT DELEGATES RATIO OF REPRESENTATION STATED IN THIS SECTION, EACH OSMA DISTRICT SHALL BE ENTITLED TO ONE ADDITIONAL DESIGNATED DELEGATE AND ONE ADDITIONAL ALTERNATE DELEGATE WHO REPRESENTS A SECTION APPROVED BY THE HOUSE OF DELEGATES, EXCEPT THAT MEMBERS IN TRAINING AND MEDICAL STUDENTS ARE REPRESENTED SOLELY BY THEIR SEPARATELY SEATED SECTIONS. THESE ADDITIONAL DESIGNATED DELEGATES SHALL BE SELECTED BY THE DISTRICT.

Members in Training and Students are represented through separately seated sections of the House of Delegates and shall not be included in the member count/ratio of representation of OSMA districts for purposes of determining representation in the House of Delegates.

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Section 5. SECTIONS

(A) MISSION OF THE SECTIONS. A SECTION IS A FORMAL GROUP OF PHYSICIANS OR MEDICAL STUDENTS DIRECTLY INVOLVED IN POLICYMAKING THROUGH A SECTION DELEGATE AND REPRESENTING UNIQUE INTERESTS RELATED TO PROFESSIONAL LIFECYCLE, PRACTICE SETTING, OR DEMOGRAPHICS. SECTIONS SHALL BE ESTABLISHED BY THE HOUSE OF DELEGATES FOR THE FOLLOWING PURPOSES:

(1) INVOLVEMENT. TO PROVIDE A DIRECT MEANS FOR MEMBERSHIP SEGMENTS REPRESENTEDIN THE SECTIONS TO PARTICIPATE IN THE ACTIVITIES, INCLUDING POLICY-MAKING, OF THE OSMA.

(2) OUTREACH. TO ENHANCE OSMA OUTREACH, COMMUNICATION, AND INTERCHANGE WITH THE MEMBERSHIP SEGMENTS REPRESENTED IN THE SECTIONS.

(3) COMMUNICATION. TO MAINTAIN EFFECTIVE COMMUNICATIONS AND WORKING RELATIONSHIPS BETWEEN THE OSMA AND ORGANIZATIONAL ENTITIES THAT ARE RELEVANT TOTHE ACTIVITIES OF EACH SECTION.

(4) MEMBERSHIP. TO PROMOTE OSMA MEMBERSHIP GROWTH.

(5) REPRESENTATION. TO ENHANCE THE ABILITY OF MEMBERSHIP SEGMENTS REPRESENTED IN THE SECTIONS TO PROVIDE THEIR PERSPECTIVE TO THE OSMA AND THE HOUSE OF DELEGATES.

(6) EDUCATION. TO FACILITATE THE DEVELOPMENT OF INFORMATION AND EDUCATIONAL ACTIVITIES ON TOPICS OF INTEREST TO THE MEMBERSHIP SEGMENTS REPRESENTED IN THE SECTIONS.

(B) INFORMATIONAL REPORTS. EACH SECTION MAY SUBMIT TO THE HOUSE OF DELEGATES AT THE ANNUAL MEETING AN INFORMATIONAL REPORT DETAILING

THE ACTIVITIES AND PROGRAMS OF THE SECTION DURING THE PREVIOUS YEAR. THE REPORT(S) SHALL BE SUBMITTED TO THE HOUSE OF DELEGATES THROUGH THE COUNCIL. THE COUNCIL MAY MAKE SUCH NON-BINDING RECOMMENDATIONS REGARDING THE REPORT(S) TO THE SECTIONS AS IT DEEMS APPROPRIATE, PRIOR TO TRANSMITTING THE REPORT(S) TO THE HOUSE OF DELEGATES WITHOUT DELAY OR MODIFICATION BY THE COUNCIL. THE COUNCIL MAY ALSO SUBMIT WRITTEN RECOMMENDATIONS REGARDING THE REPORT(S) TO THE HOUSE OF DELEGATES.

(C) GOVERNING COUNCIL. THERE SHALL BE A GOVERNING COUNCIL FOR EACH SECTION TO DIRECT THE PROGRAMS AND THE ACTIVITIES OF THE SECTION. THE PROGRAMS AND ACTIVITIES SHALL BE SUBJECT TOTHE APPROVAL OF THE COUNCIL. EACH SECTION SHALL ADOPT RULES GOVERNING THECOMPOSITION, ELECTION, TERM, AND TENURE OF ITS GOVERNING COUNCIL.

(D) QUALIFICATIONS. MEMBERS OF EACH SECTION GOVERNING COUNCIL MUST BE MEMBERSOF THE OSMA AND OF THE SECTION. EACH SECTION SHALL DEFINE THE QUALIFICATIONS FOR MEMBERSHIP IN THE SECTION. ANY OSMA MEMBER MEETING THE QUALIFICATIONS SHALL BE A MEMBER OF THE SECTION UNLESS THE MEMBER OPTS OUT OF SECTION MEMBERSHIP.

(E) VOTING. MEMBERS OF EACH SECTION GOVERNING COUNCIL SHALL BE ELECTED BY THE VOTING MEMBERS OF THE SECTION PRESENT AT THE BUSINESS MEETING OF THE SECTION,UNLESS OTHERWISE PROVIDED IN THE SECTION BYLAWS.

(F) OFFICERS. EACH SECTION SHALL SELECT A CHAIR AND VICE CHAIR OR CHAIR-ELECT AND OTHER NECESSARY AND APPROPRIATE OFFICERS. EACH SECTION SHALL ADOPT RULES GOVERNING THE TITLES,DUTIES, ELECTION, TERM, AND TENURE OF ITS OFFICERS.

(1) QUALIFICATIONS. OFFICERS OF EACH SECTION MUST BE MEMBERS OF THE OSMA AND OFTHE SECTION.

(2) VOTING. OFFICERS OF EACH SECTION SHALL BE ELECTED BY THE VOTING MEMBERS OF THESECTION, UNLESS OTHERWISE PROVIDED IN THE SECTION BYLAWS.

E) DELEGATE AND ALTERNATE DELEGATE. EACH SECTION, EXCEPT FOR THE RESIDENT AND FELLOWS SECTION AND THE MEDICAL STUDENT SECTION, SHALL ELECT ONE (1) DELEGATE AND ONE (1) ALTERNATEDELEGATE TO REPRESENT THE SECTION IN THE HOUSE OF DELEGATES.

(F) BUSINESS MEETING. THERE SHALL BE A BUSINESS MEETING OF MEMBERS OF EACH SECTION. THE BUSINESS MEETING SHALL BE HELD PRIOR TO EACH ANNUAL MEETING OF THE HOUSE OF DELEGATES.

(1) PURPOSE. THE PURPOSES OF THE BUSINESS MEETING SHALL BE TO: HEAR SUCH REPORTS AS MAY BE APPROPRIATE; CONSIDER OTHER BUSINESS AND VOTE UPON SUCH MATTERS AS MAY PROPERLY COME BEFORE THE MEETING; ADOPT RESOLUTIONS FOR SUBMISSION BY THE SECTION TO THE HOUSE OF DELEGATES; HOLD ELECTIONS.

(2) THE BUSINESS MEETING SHALL BE OPEN TO ALL MEMBERS OF THE OSMA. ONLY DULY SELECTED REPRESENTATIVES WHO ARE OSMA MEMBERS SHALL HAVE THE RIGHT TO VOTE AT THE BUSINESS MEETING. THE BUSINESS MEETING SHALL BE CONDUCTED PURSUANT TO RULES OF PROCEDURE ADOPTED BY THE GOVERNING COUNCIL. THE RULES OF PROCEDURE MAY SPECIFY THE RIGHTS AND PRIVILEGES OF SECTION MEMBERS, INCLUDING ANY LIMITATIONS ON PARTICIPATION OR VOTE.

(G) RULES. ALL RULES, REGULATIONS, AND PROCEDURES ADOPTED BY EACH SECTION SHALL BE SUBJECT TOTHE APPROVAL OF THE COUNCIL.

(H) ESTABLISHMENT OF NEW SECTIONS. AN OSMA MEMBER COMPONENT GROUP SEEKING SECTION STATUSSHALL SUBMIT A PROPOSAL TO THE OSMA COUNCIL. UPON APPROVAL OF THE OSMA COUNCIL, THE COUNCIL SHALL SUBMIT A RESOLUTION SEEKING SUCH NEW SECTION STATUS TO THE HOUSE OF DELEGATES.

(I) SECTION STATUS REVIEW. EACH SECTION SHALL RECONFIRM ITS QUALIFICATIONS FOR CONTINUED EXISTENCE AND REPRESENTATION IN THE HOUSE OF DELEGATES BY DEMONSTRATING AT LEAST EVERY 5 YEARS THAT IT CONTINUES TO MEET THE REQUIREMENTS IN THIS SECTION AND THE BYLAWS ADOPTED BY THE SECTION. THE HOUSE OF DELEGATES MAY ESTABLISH, BY ADOPTION OF A RESOLUTION, ADDITIONAL CRITERIA FOR CONTINUED EXISTENCE OF SECTIONS.

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Section 7. ~~Representative of~~ Organized Medical Staff Section. The Organized Medical Staff Section shall have one (1) Delegate and one (1) Alternate Delegate who must be voting members of this Association. In case a Delegate or Alternate Delegate is unable to serve, the Chair of the Section may at any time certify to the Chair of the Committee on Credentials the name of a voting member of this Association to serve in place of the absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate. The Organized Medical Staff Section Delegate shall have all rights, privileges and duties of other Delegates. The Delegate AND ALTERNATE DELEGATE will be SEPARATELY seated in the House of Delegates with ~~the councilor district in which that Delegate's county is represented~~ OTHER APPROVED SECTIONS.

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Section 9. Young Physician Section. The Young Physician Section shall have ~~five (5)~~ ONE (1) Delegate~~s~~ and ~~two (2)~~ ONE (1) Alternate Delegate~~s~~ who must be physicians in active practice and under the age of forty or in the first eight years of practice after residency and fellowship training AND WHO ARE ALSO OSMA VOTING MEMBERS. The Young Physician Section Delegate~~s~~ AND ALTERNATE DELEGATE shall have all the rights, privileges, and duties of other Delegates. The Young Physician Section Delegate~~s~~ AND ALTERNATE DELEGATE will be SEPARATELY seated in the House of Delegates ~~as a separate section~~ WITH OTHER APPROVED SECTIONS.

SECTION 10. INTERNATIONAL MEDICAL GRADUATE SECTION. THE INTERNATIONAL MEDICAL GRADUATE SECTION SHALL HAVE ONE DELEGATE AND ONE ALTERNATE DELEGATE WHO ARE ALSO OSMA VOTING MEMBERS. THE

INTERNATIONAL MEDICAL GRADUATE SECTION DELEGATE AND ALTERNATE DELEGATE SHALL HAVE ALL THE RIGHTS, PRIVILEGES, AND DUTIES OF OTHER DELEGATES. THE INTERNATIONAL MEDICAL GRADUATE SECTION DELEGATE AND ALTERNATE DELEGATE WILL BE SEPARATELY SEATED IN THE HOUSE OF DELEGATES WITH OTHER APPROVED SECTIONS.

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Section 16. Resolutions. Except as otherwise provided, every resolution to be presented to the House of Delegates for action shall be filed with the Chief Executive Officer of this Association at least ~~sixty (60)~~ FORTY-FIVE (45) days prior to the first (1st) day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Chief Executive Officer shall prepare and transmit a copy thereof to each member of the House of Delegates. Each resolution which, if adopted, would require expenditure of funds by this Association, shall have attached a statement of the amount of the estimated annual expenditure. The Chief Executive Officer shall cause to be published in advance of such meeting of the House of Delegates such resolutions as the President or the Council may designate.

No resolution may be presented or introduced at any meeting of the House of Delegates, unless the foregoing requirements for filing and transmittal shall have been complied with, or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. Late submission is only justified when events giving rise to the resolution occur after the filing deadline for resolutions. This special committee shall consist of the chairs of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the ~~sixty (60)~~ FORTY-FIVE (45) day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than twelve (12) hours prior to the opening session of the House of Delegates. If the committee votes unfavorably, the House may override the committee's recommendation by an affirmative vote of four-fifths (4/5) of the Delegates voting.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution is presented or introduced at the opening session of the meeting of the House of Delegates. However, a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session may be introduced at a later session with the consent of at least four-fifths (4/5) of the Delegates present. Upon its introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report. The Committee on Resolutions shall have the right to amend any such resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as the resolution or resolutions introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates. The House of Delegates shall have the right to adopt any such amended, composite or substitute resolution.

Any resolution adopted by the House of Delegates four (4) or more years prior to each Annual Meeting will be reviewed by the Council for purposes of recommending whether to retain each policy. The House of Delegates will be notified of those resolutions subject to review prior to the Annual Meeting at which they will be considered. Any resolution not retained by

House action on the report submitted by the Council becomes null, void and of no effect.

~~**Section 15. Organized Medical Staff Section Resolutions.** A maximum of five (5) resolutions, directly related to issues of concern to physicians on hospital medical staffs and matters of immediate importance, adopted by and presented from the business meeting of the Organized Medical Staff Section representative assembly, as provided in their Bylaws, may be presented for consideration by the House of Delegates at any time before the opening of the House of Delegates. All other resolutions adopted by and presented from the business meeting of the Representative Assembly of the Organized Medical Staff Section shall be submitted in report form to the House of Delegates at the Annual Meeting of the House of Delegates for the purpose of filing.~~

Fiscal Note: $ 10,000 (Sponsor)
$ 10,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 02 – 2022

Introduced by: OSMA Council

Subject: Change the ratio of representation for medical specialties in the House of Delegates

Referred to: Resolutions Committee No. # 1

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WHEREAS, the House of Delegates previously changed the ratio of representation for delegates in each OSMA District; and

WHEREAS, the OSMA Council recommends changing the ratio of representation for medical specialties in the House of Delegate to match the ratio of representation for delegates in the Districts, **therefore be it**

RESOLVED, that the OSMA Constitution and Bylaws be amended as follows (showing only affected sections):

ARTICLE IV
HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) Delegates selected by the Active and Retired Members residing or working within designated OSMA districts; (2) Officers of this Association enumerated in Article VI; (3) Delegates and Alternate Delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without the right to vote unless such Delegate, Alternate Delegate or Past President be a duly elected Delegate or a duly elected officer of this Association; and (4) such representatives of other medical groups as may be determined by the House of Delegates, including the following:

The Medical Student Section shall have seven (7) representatives to the House of Delegates, said Delegates to be selected in accordance with the Bylaws of the Medical Student Section; provided that the Bylaws of the Medical Student Section have been approved by Council. For purposes of representation in the House of Delegates, Student Members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Student Members of each Ohio medical and osteopathic medical school elect their own Delegate.

The Organized Medical Staff Section shall have one (1) representative to the House of Delegates, said Delegate to be selected in accordance with Bylaws of the Organized Medical Staff Section; provided that the Bylaws of the Organized Medical Staff Section have been approved by Council.

The Resident and Fellows Section shall have five (5) representatives to the House of Delegates who must be Members in Training of this Association, said representatives to be selected in accordance with the Resident and Fellows Section Bylaws; provided that the Bylaws of the Resident and Fellows Section have been approved by Council. For purposes of representation in the House of Delegates, Members in Training shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Members in Training elect their own Delegates.

The Young Physician Section shall have five (5) representative~~s~~ to the House of Delegates who must be physician~~s~~ in active practice and under the age of forty or in the first eight years of practice after residency and fellowship training. The Young Physician Section Delegate~~s~~ shall be selected in accordance with the Young Physicians Section bylaws; provided that the bylaws of the Young Physician Section have been approved by Council.

The ~~primary~~ medical specialties ~~and subspecialties~~ listed by the American Board of Medical Specialties are eligible to have one Delegate and one Alternate Delegate for every ~~100~~ 50 specialty ~~or subspecialty~~ members who are also OSMA voting members to be selected in accordance with Chapter 5, Section 4 of the Bylaws of this Association.

~~The medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members are eligible to have a Delegate and Alternate Delegate to be selected in accordance with Chapter 4, Section 3 of the Bylaws of this Association.~~

BYLAWS

CHAPTER 5
THE HOUSE OF DELEGATES

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Section 4. Representation of Medical Specialties. All ~~primary~~ medical specialties listed by the American Board of Medical Specialties are eligible for representation in the House of Delegates. ~~All medical subspecialty societies whose members hold such subspecialty certificates approved by the American Board of Medical Specialties with 100 or more members in Ohio and, of whom, at least 50% are OSMA members, are eligible for representation in the House of Delegates. An OSMA member may be represented by only one subspecialty organization in the OSMA House of Delegates.~~

A medical specialty ~~or subspecialty~~ society seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the specialty society qualifies for representation.

Each medical specialty ~~and subspecialty~~ society approved by the OSMA House of Delegates shall have one (1) Delegate and one (1) Alternate Delegate for every ~~100~~ 50 specialty ~~or subspecialty~~ members who are also voting members of this Association. Each specialty society will certify to this Association at least sixty (60) days prior to the Annual Meeting

both the names of the Delegates and Alternate Delegates selected who must also be voting members of the OSMA. The OSMA will verify OSMA membership of the names submitted. In case a Delegate or Alternate Delegate is unable to serve, the President of the recognized medical specialty society may at any time certify to the Chair of the Committee on Credentials the name of a voting member of this Association to serve in place of the absent Delegate or absent Alternate Delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place of such absent Delegate or Alternate Delegate. A medical specialty ~~or subspecialty~~ society Delegate shall have all rights, privileges and duties as other Delegates. The~~ Delegate~~ MEDICAL SPECIALTY SOCIETY DELEGATES will be seated in the House of Delegates ~~with the councilor district in which that Delegate's county is represented~~ AS A SEPARATE SECTION OF MEDICAL SPECIALTIES.

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Fiscal Note: $ 500 (Sponsor)
$ 500 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 03 – 2022

Introduced by: OSMA Council

Subject: Meeting Code of Conduct

Referred to: Resolutions Committee No. # 1

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WHEREAS, the House of Delegates adopted Policy 03-2020 requiring OSMA meeting attendees to adhere to respectful, professional and collegial behavior during all OSMA meetings; and

WHEREAS, Policy 03-2020 directs the OSMA to further refine the meeting code of conduct policy and submit recommendations to the House of Delegates; **therefore be it**

RESOLVED, that the OSMA adopts the following Meeting Code of Conduct:

Policy 03-2020 of the Ohio State Medical Association (OSMA) directs all attendees of OSMA hosted or sponsored meetings, events and other activities to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such OSMA hosted or sponsored meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants and should disclose any conflicts of interest related to an issue under consideration.

Any type of harassment of any attendee of an OSMA hosted sponsored meeting, event or other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an OSMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The OSMA is committed to a zero tolerance policy for harassing conduct at all locations where OSMA business is conducted. This zero tolerance **policy** also applies to meetings of all OSMA sections, committees, and task forces. The purpose of the policy is to protect participants from harm.

Harassment

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of interfering with an individual's participation in meetings or proceedings of the HOD or any OSMA hosted or sponsored event; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed at the site of any OSMA meeting or circulated in connection with any OSMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes: 1. making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and 2. creating an intimidating, hostile or offensive environment or otherwise interfering with an individual's participation in meetings or proceedings of the HOD or any OSMA hosted or sponsored meeting.

Sexual harassment may include, but is not limited to, such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Complaint process

Any attendee or participant in an OSMA hosted or sponsored event who believes they have experienced or witnessed a violation of this policy may file a complaint with the OSMA Council, the OSMA President, President-Elect, or Past President or the OSMA Chief Executive Officer who shall inform the Council. All complaints brought under this policy will be promptly and thoroughly investigated. To the fullest extent possible, the OSMA will keep complaints and the terms of their resolution confidential.

The Council may investigate, conduct a hearing and decide the matter or refer the matter to an internal committee appointed by the President or to an external entity qualified to investigate and recommend to the OSMA Council a resolution of the matter. If the complaint implicates a member of the OSMA Council, the complaint shall be referred to a committee of Past Presidents assigned by the OSMA President on an ad hoc basis or to an external entity qualified to investigate and recommend to the Council a resolution of the matter.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden and shall be investigated in the same manner as outlined for complaints.

Related documents:

OSMA Council Conflict of Interest Policy (requires annual signed disclosure statements)
OSMA AMA Delegation Conflicts of Interest Policy
OSMA's Human Resources Policies:
Conflict of Interest Policy (requires annual signed disclosure statements)
Harassment Prevention Policy
Social Media Policy.

Fiscal Note: $ (Sponsor)
$500 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 04 – 2022

Introduced by: The Academy of Medicine of Lima and Allen County

Subject: Establish an Ohio State Medical Association Women Physicians Section

Referred to: Resolutions Committee No. # 1

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WHEREAS, as of December, 2021, our Ohio State Medical Association (OSMA) has 2296 members who are identified as women which is 25 % of the total membership; and

WHEREAS, 45% of resident and fellow members and 61% of student members are women; and

WHEREAS, women have unique interests related to professional lifecycle, practice setting, demographics, and so forth; and

WHEREAS, outreach and communication to this group of physicians is important to the future of our OSMA; and

WHEREAS, representation in our OSMA House of Delegates will enhance the ability of women to provide their perspective to our OSMA; **therefore be it**

RESOLVED, that our OSMA form a section of the OSMA known as the OSMA Women Physicians Section; and, **be it further**

RESOLVED, that appropriate Bylaws changes be accomplished to establish the OSMA Women Physicians Section.

Fiscal Note: $2,000 (Sponsor)
$2,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 05 – 2022

Introduced by: The Academy of Medicine of Lima and Allen County

Subject: Establish an Ohio State Medical Association Senior Physician Section

Referred to: Resolutions Committee No. # 1

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WHEREAS, as of December 2021, Ohio State Medical Association (OSMA) has 3887 members who are 65 years of age or older which is 42 % of the total membership; and

WHEREAS, 20 % of active members and 96 % of retired members are 65 or over; and

WHEREAS, senior physicians have unique interests related to professional lifecycle, practice setting, demographics, and so forth; and

WHEREAS, outreach and communication to this group of physicians is important to our OSMA; and

WHEREAS, representation in the OSMA House of Delegates will enhance the ability of senior physicians to provide their perspective to the OSMA; **therefore be it**

RESOLVED, that our OSMA form a Section of the OSMA known as the OSMA Senior Physicians Section, to include all members age 65 and above, either active or retired; and, **be it further**

RESOLVED, that appropriate Bylaws changes to establish the Senior Physicians Section be accomplished.

Fiscal Note: $2,000 (Sponsor)
$2,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 06 – 2022

Introduced by: OSMA Council

Subject: OSMA Task Force on Pandemic Preparedness and Response

Referred to: Resolutions Committee No. # 1

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WHEREAS, we have been experiencing an unprecedented global pandemic due to the SARS-CoV-2 virus and COVID-19 illness since 2020, and

WHEREAS, in the coming months, various public and private bodies will be reviewing the strengths, weakness and opportunities identified based on the local, state and national response to this pandemic in order to better prepare for potential future pandemics, and

WHEREAS, the OSMA will be invited to participate in and partner with other organizations during these pandemic review activities, and

WHEREAS, having a focused task force within OSMA to determine our organization's position on a variety of issues related to the preparedness for and response to potential future pandemics will be critical to effectively participating in these pandemic review activities, **therefore be it**

RESOLVED, that the OSMA will create the Focused Task Force (FTF) on Pandemic Preparedness and Response to ensure that the organization is prepared to collaborate with other public and private bodies on the preparedness for and response to potential future pandemics; and, **be it further**

RESOLVED, that the FTF on Pandemic Preparedness and Response shall, be appointed by the OSMA President to include OSMA members from a variety of specialties and geographic areas of the state, but with a majority of the FTF members being those with special expertise in infectious diseases, public health, emergency medicine, critical care, emergency preparedness, public policy and other areas of emphasis critical to the assessment and implementation of pandemic preparedness and response initiatives; and, **be it further**

RESOLVED, that the FTF on Pandemic Preparedness and Response may invite non-OSMA member physicians and non-physicians with special expertise in pandemic preparedness and response to attend as non-voting participants in FTF meetings at the discretion of the FTF Chair; and, **be it further**

RESOLVED, that the FTF on Pandemic Preparedness and Response provide recommendations to the OSMA Council and the OSMA House of Delegates regarding the following issues:

1) Changes to local, state and federal public health measures to effectively prevent or reduce the impact of potential future pandemics

2) Changes to state or federal laws, regulations, administrative rules, and accreditation/certification standards to improve local, state or federal preparedness for and response to potential future pandemics
3) Changes to state or federal laws, regulations, administrative rules, and accreditation/certification standards to improve the ability of physicians, hospitals, and other healthcare entities to prepare for and maintain safe, high-quality, patient-centered, accessible, and equitable clinical practice/clinical operations during potential future pandemics
4) Local, regional and statewide efforts to improve the collaboration and coordination of clinical care in ambulatory, outpatient, inpatient, post-acute and other congregate care settings with regard to hospital capacity, nursing facility capacity, vaccination, prevention, and treatment of pandemic-related illnesses
5) Local, regional and statewide efforts to coordinate public and private entities to maintain the effective and equitable distribution of medical supplies, medications, and other scarce medical resources during potential future pandemics
6) Creation of effective networks and systems for the dissemination of accurate, evidence-based information related to preparedness for and response to potential future pandemics for physician practices, medical staffs, hospitals, nursing facilities, medical schools and GME training programs as well as the general public
7) Enhancements to the educational curricula for medical schools, GME training programs and CME programs related to pandemic preparedness and response
8) Programs to effectively provide professional and behavioral health support for physicians and other frontline healthcare personnel during potential future pandemics
9) Changes in the OSMA constitution, bylaws, policies and procedures to effectively maintain the operations of the organization during potential future pandemics

Fiscal Note: $ 75,000 (Sponsor)
$ 75,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 07 – 2022

Introduced by: OSMA Medical Student Section

Subject: Addressing the Roles of Health Professionals in Preventing Public Health Misinformation

Referred to: Resolutions Committee No. # 1

WHEREAS, misinformation is defined as any false information that is spread, regardless of whether there was an intent to mislead[1]; and

WHEREAS, the ethical principle of non-maleficence derived from the Hippocratic Oath is the obligation of health professionals to do no harm, and healthcare professional spread of misinformation contradicts this principle[2]; and

WHEREAS, misinformation is present within various platforms including social media and the Ohio legislature, and covers a variety of topics including abortion, vaccines, and COVID-19[1,3]; and

WHEREAS, past proposed OH HB182 introduced misinformation about the treatment of ectopic pregnancies, indicating the false possibility of reimplantation into the pregnant woman's uterus[3]; and

WHEREAS, proposed OH HB421 would require physicians to advise women considering abortion that the procedure could lead to breast cancer, despite a lack of evidence[4,5]; and

WHEREAS, in 2019, our American Medical Association (AMA) joined with the Center for Reproductive Rights in opposition of a law requiring physicians to tell patients that a medication abortion can be reversed[6]; and

WHEREAS, proposed OH HB378 similarly proposes that physicians misinform their patients about a medication abortion reversal method, which is clinically unproven[7–9]; and

WHEREAS, COVID-19 is the first pandemic in history in which technology and social media are being used to keep people safe, informed, and connected[10]; and

WHEREAS, public health misinformation has been shown to increase COVID-19 vaccine hesitancy[11]; and

WHEREAS, proposed OH HB 248 intends to eliminate all vaccine mandates in the state of Ohio, and our Ohio State Medical Association (OSMA) and its members strongly oppose this bill[12]; and

WHEREAS, a licensed Ohio physician used testimony in support of HB 248 to spread misinformation regarding the COVID-19 vaccines and subsequently had her license automatically renewed[13,14]; and

WHEREAS, a 2021 study conducted by the Federation of State Medical Boards found that only 21% of state medical boards took disciplinary action against a physician for disseminating misleading information[15]; and

WHEREAS, the Federation of State Medical Boards, the American Board of Medical Specialties, the American Board of Emergency Medicine, the American Board of Family Medicine, the American Board of Internal Medicine, and the American Board of Pediatrics have all released statements indicating that the spread of misinformation by physicians may lead to disciplinary action and potential suspension or revocation of one's medical license or board certification[16–18]; **therefore be it**

RESOLVED, that our OSMA oppose legislation requiring healthcare professionals to provide information without sufficient evidence to support; and, **be it further**

RESOLVED, that our OSMA collaborate with licensing bodies and specialty boards to utilize incentives and punitive measures, including but not limited to, the suspension or revocation of one's medical license or board certification; and to amend the current process of automatically renewing medical licenses for physicians undergoing investigation for disseminating misinformation, in order to promote the betterment of public health; and, **be it further**

RESOLVED, that our OSMA adopt an adapted version of AMA policy D-440.915: Our OSMA: 1) Will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and 2) will work with public health agencies and professional societies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information and address misinformation that undermines public health initiatives.

Fiscal Note: $ (Sponsor)
$50,000 (Staff)

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RELEVANT OSMA POLICY

RELEVANT AMA AND AMA-MSS POLICY

Medical and Public Health Misinformation in the Age of Social Media D-440.915
Our AMA: (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but

not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy expert[1] [2] s; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Protecting Social Media Users by Updating FDA Guidelines D-105.995

Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 08 – 2022

Introduced by: OSMA Medical Student Section

Subject: Supporting Legislation for Researching the Neurological and Psychological Effects of SARS-CoV-2 and the Covid-19 Pandemic

Referred to: Resolutions Committee No. # 1

WHEREAS, on October 28th the American congress proposed the Brycen Gray and Ben Price COVID-19 Neurological Impact Act, H.R. 5772 to provide federal grant money for the specific purpose of studying the psychological and neurological effects of Covid-19[1]; and

WHEREAS, the Center for Diseases Control has acknowledged that individuals with mental health disorders are at a higher risk for developing severe Covid-19 infections[2]; and

WHEREAS, individuals with a prior psychiatric diagnosis have a higher mortality rate following SARS-CoV-2 infection than those with no prior psychiatric diagnosis[3]; and

WHEREAS, it is accepted that infection, viral neurotropism, and the environmental stress of the pandemic can lead to the exacerbation, or even development, of psychiatric pathologies such as major depressive disorder, bipolar disorder, psychoses, obsessive compulsive disorder, and post-traumatic stress disorder[4]; and

WHEREAS, the Covid-19 pandemic has increased self-isolation, and other behaviors associated with suicide and poor mental health[6–8]; and

WHEREAS, suicide rates have increased for certain demographics groups during the pandemic, including young people, and people of color[9]; and

WHEREAS, the Covid-19 pandemic has had an especially negative effect on the mental health of women causing an increase in depression, anxiety and post-traumatic stress symptoms[10]; and

WHEREAS, the American Medical Association (AMA) has stated its commitment to publicly call attention to the escalating mental health crisis in children and adolescents in the United States of America in the wake of the Covid-19 crisis[11]; and

WHEREAS, it is an open question as to whether Covid-19 survivors are at an increased risk for suicide[12]; **therefore be it**

RESOLVED, our Ohio State Medical Association supports legislation that aims to address the need for research into the neurological and psychological effects of SARS-CoV-2 infection and the Covid-19 pandemic overall.

Fiscal Note: $ (Sponsor)
$ 20,000 (Staff)

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 09 – 2022

Introduced by: OSMA Medical Student Section

Subject: Access to Standard Care for Nonviable Pregnancy

Referred to: Resolutions Committee No. # 1

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WHEREAS, a pregnancy is nonviable if it cannot result in a liveborn baby, including but not limited to ectopic pregnancy, molar pregnancy, and miscarriage[1]; and

WHEREAS, ectopic pregnancies are the leading cause of maternal death in the first trimester, accounting for up to 9% of all pregnancy-related deaths, often due to lack of proper medical intervention[2,5,6]; and

WHEREAS, an untreated ectopic pregnancy leads to rupture of the uterine tube in 15-20% of cases, which is associated with risk of hemorrhage, loss of tubal structure and function, loss of ovary, infertility, and death[5,7]; and

WHEREAS, the accepted standard treatment of ectopic pregnancy includes methotrexate or surgical intervention and despite previously proposed Ohio HB 413, an ectopic pregnancy cannot move or be moved to the uterus, so it always requires treatment[2,8-11]; and

WHEREAS, molar pregnancy occurs at a rate of about 1 per every 1,000 pregnancies with standard treatment of molar pregnancy including immediate dilation and curettage followed by human chorionic gonadotropin monitoring[12,13]; and

WHEREAS, an estimated 26% of all conceptions end in miscarriage, standard treatment of miscarriage including prompt dilation and curettage or vaginally administered misoprostol or mifepristone, and lack of treatment increasing risk of progression to sepsis[14,16,17]; and

WHEREAS, the Ethical and Religious Directives for Catholic Health Care Services, abided by 11 hospitals in Ohio, has discouraged some providers from providing prompt care for nonviable pregnancy when fetal heart tones are present[18-21]; and

WHEREAS, hospital directives which prohibit abortion, or termination of an otherwise viable pregnancy, have a history of being misconstrued to apply to nonviable pregnancy, resulting in the delay of medically-indicated treatment[20,22-26]; and

WHEREAS, the risk of miscarriage is 46% higher in Black women than White women, and in the years 2015-2016, Black women in Ohio had twice the likelihood of nonviable pregnancy as White women[26,27]; and

WHEREAS, patients from low socioeconomic backgrounds, minority populations, or rural areas, may be less likely to recognize symptoms and consequences of ectopic pregnancy and therefore disproportionately experience adverse clinical outcomes[,28,29]; and

WHEREAS, patients in rural areas who are not deemed to require emergent intervention may not have another hospital to which they can be transferred to receive appropriate non-emergent care[30,31]; and

WHEREAS, black and Hispanic patients are less likely to receive pharmacologic intervention or tubal-conserving surgery in the setting of ectopic pregnancy, resulting significant disparity in overall morbidity and a 6.8% higher death rate[32,33,35-37]; and

WHEREAS, patients with a median income <$60,000 annually disproportionately receive open abdominopelvic surgery for treatment of ectopic pregnancy instead of minimally invasive laparoscopic surgery, resulting in higher rates of complications, infertility, and mortality in this lower income patient demographic[38]; and

WHEREAS, the American Medical Association's Medical Student Section supports access to the standard of care in cases of nonviable pregnancy and opposes policy that restricts timely access to this care[39]; **therefore be it**

RESOLVED, the Ohio State Medical Association (OSMA) supports patients' timely access to standard treatment of nonviable pregnancy, including but not limited to miscarriage, molar pregnancy, and ectopic pregnancy, in both emergent and non-emergent circumstances; and, **be it further**

RESOLVED, the OSMA opposes any hospital directive, policy, or legislation that may hinder patients' timely access to the accepted standard of care in both emergent and non-emergent cases of nonviable pregnancy.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

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RELEVANT OSMA POLICY

OSMA Policy 9 - 1986 - Quality Assurance: 1. Members of quality assurance mechanisms assure that patient care is consistent with accepted standards of medical practice.

RELEVANT AMA AND AMA-MSS POLICY

420.020MSS Access to Standard Care for Nonviable Pregnancy: AMA-MSS opposes any hospital directive, policy, or legislation that may hinder patients' timely access to the accepted standard of care in both emergent and non-emergent cases of non-viable pregnancy [MSS Res. 059, A-21]

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 10 – 2022

Introduced by: OSMA Medical Student Section

Subject: Supporting Expectant Mothers on Medicaid Seeking Tubal Ligations During Cesarean Sections with Informed Prenatal Care and Administrative Support

Referred to: Resolutions Committee No. # 1

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WHEREAS, women seeking Medicaid-funded tubal ligation must complete the "Consent to Sterilization" section of the Medicaid Title XIX form within a window of at least 30 days before the procedure and no more than 180 days before the procedure; and the only exception to these time constraints involves emergency abdominal surgery or premature delivery, wherein expedited approval of the form takes 72 hours to complete[1]; and

WHEREAS, the mean length of labor and delivery time is around eight hours, which is much less than the required 72 hour approval time[2]; and

WHEREAS, the structure and content of the current "Consent to Sterilization" form, as provided by Medicaid, displays low readability and is not fully comprehensible for all patients as demonstrated by a review that found 34% of patients incorrectly responded regarding the permanence of the tubal ligation procedure for sterilization[1]; and

WHEREAS, assessments of this form indicate that its literacy level does not match that of the average American woman, and that it has been found that this form does not match universal guidelines for patient education relating to informed consent, thus demonstrating a need for further patient counseling[3]; and

WHEREAS, patients with private insurance are not subject to the same regulations and are not required to complete equivalent paperwork, resulting in differential access to tubal ligations for high-income women who can afford private insurance versus low-income women whose income is within 133% of the federal poverty level and who are eligible for Medicaid, thus resulting in inequality in reproductive health and bodily autonomy[1]; and

WHEREAS, it has been shown that 47% of women who requested the tubal ligation procedure and did not receive it due to administrative constraints and obstacles presented by Medicaid requirements became pregnant within the year following their previous delivery, which is a pregnancy rate higher than that of women who had not requested the procedure[1]; and

WHEREAS, it is estimated that these barriers to tubal ligation procedures result in 62,000 unfulfilled requests for sterilization each year, leading to 10,000 abortions and 19,000 unintended births leading to an estimated annual national Medicaid cost of 215 million dollars, and 40% of state Medicaid costs are covered by the state of Ohio[1,4]; and

WHEREAS, eligibility for Medicaid coverage of the tubal ligation procedure may not be approved after the delivery period as the procedure is no longer "pregnancy-related"[1]; and

WHEREAS, the American College of Obstetrics and Gynecology Committee on Health Care for Underserved Women has previously recommended revision of the Medicaid policy indicating provider and health professional acknowledgment of the current issue[1]; and

WHEREAS, it has been shown 37% of contraceptive-using reproductive aged women use a permanent method, including tubal ligation[5]; and

WHEREAS, racial minorities and low-income women are more likely to choose this method and present barriers disproportionately affect these groups[5]; and

WHEREAS, some states cover tubal ligation for Medicaid-qualified patients under their family planning programs or through State Plan Amendments (SPA) to Medicaid, which may serve as a funding alternative to Medicaid coverage for these patients, however tubal ligations are not covered under these programs in the State of Ohio[6]; and

WHEREAS, American Medical Association (AMA) policy D-75.994 regarding Tubal Ligation and Vasectomy Consents (2013) and AMA policy H-290.977 Medicaid Sterilization Services Without Time Constraints (2011) support the reduction of time constraints for the consent for permanent sterilization procedures through Medicaid; and

WHEREAS, the above AMA policies address current barriers for underprivileged patients to access permanent contraception, but do not address the need for complete consent, knowledge, and autonomy; and

WHEREAS, the Ohio State Medical Association (OSMA) does not currently have any policies addressing family planning or prenatal care for non-teenage mothers or any policies addressing tubal ligation and currently only addresses informed consent in the context of abortion procedures in Policy 13 “Abortion as a Medical Procedure” under the “Statement of Abortion of OSMA Committee on Maternal Health”; and

WHEREAS, the OSMA currently addresses arbitrary paperwork and signature deadlines in Medicaid policies only in the context of hospital and rehabilitation unit admission under Policy 15 “Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission”; **therefore be it**

RESOLVED, our OSMA supports the sufficient education of physicians involved in prenatal care, obstetrics, and family planning on current Medicaid policy; and, **be it further**

RESOLVED, our OSMA encourages physicians to spend sufficient time educating and counseling patients on the Consent to Sterilization form, necessary steps for its completion, and the implications of tubal ligations; and, **be it further**

RESOLVED, our OSMA adopts the AMA policies “Tubal Ligation and Vasectomy Consents D-75.994” and “Medicaid Sterilization Services Without Time Constraints H-290.977” that supports changes to Medicaid policy relating to time constraints for tubal ligation consent forms.

Fiscal Note: $ (Sponsor)
$500 (Staff)

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RELEVANT AMA AND AMA-MSS POLICY

Medicaid Sterilization Services Without Time Constraints

Our AMA will pursue an action to amend federal Medicaid law and regulations to remove the time restrictions on informed consent, and thereby allow all patients, over the age of 21 and legally competent, to choose sterilization services.

Res. 226, A-01 Reaffirmed: BOT Rep. 22, A-11 Reaffirmed: BOT Rep. 7, A-21

Tubal Ligation and Vasectomy Consents D-75.994

1. Our AMA will work closely with the American College of Obstetricians and Gynecologists, the American Urological Association, and any other interested organizations, to advocate to Congress for the legislative or regulatory elimination of the required 30 day interval between informed consent and a permanent sterilization procedure.
2. Our AMA will work with the Centers for Medicare & Medicaid Services to eliminate the time restrictions on informed consent for permanent sterilization procedures.

Res. 1, I-13 Modified: Speakers Rep., I-15

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 11 – 2022

Introduced by: OSMA Medical Student Section

Subject: Addressing Weight Stigma Among Healthcare Workers

Referred to: Resolutions Committee No. # 1

WHEREAS, according to the most recent data from the Centers for Disease Control and Prevention (CDC), the prevalence of obesity among Ohioans has reached an all-time high of 35.5%, making it one of 16 states with an obesity rate over 35%[1]; and

WHEREAS, the obesity rate among children in Ohio is now above the national average[2]; and

WHEREAS, approximately two-thirds of people who have obesity (as defined by a Body Mass Index (BMI) of ≥30 kg/m^2) report feeling stigmatized by healthcare providers, even when seen for physical complaints unrelated to their weight[3,4]; and

WHEREAS, perceived weight stigma is associated with negative consequences such as avoidance of healthcare encounters, lower physical activity, and greater disordered eating, rather than acting as motivation to engage in healthy lifestyle behaviors that may lead to weight loss[5–11]; and

WHEREAS, obesity is associated with more advanced stage at presentation of various cancers, suggesting that people with obesity suffer from delays in diagnosis of serious medical conditions[12–14]; and

WHEREAS, weight discrimination is associated with increased risk for chronic medical conditions such as diabetes, negative emotions, and physical symptoms even after controlling these associations for BMI and other variables such as physical activity and depressive symptoms[7,15–17]; and

WHEREAS, a study of nearly five thousand medical students in the United States found that a majority of students demonstrate implicit (74%) and explicit (67%) weight bias as measured by an Implicit Association Task (IAT), and that implicit weight bias was comparable to reported bias against minoritized racial groups[18]; and

WHEREAS, in a study of bariatric patients who had experienced weight stigma, the reported instances stemmed from encounters with providers from a wide variety of specialties, often for treatment unrelated to their bariatric surgery[4]; and

WHEREAS, clinical encounters that promote healthy behaviors (such as physical activity) for people of all weights and take into account a person's lived environment strengthen physician-patient rapport, encourage progress towards health goals, and increase self-esteem[19–22]; and

WHEREAS, a number of weight-inclusive health interventions have been studied, including but not limited to Health at Every Size[23,24], Health in Every Respect[25], Physical Activity at Every Size[26], and Well Now[27]; and

WHEREAS, health promotion techniques that are weight-inclusive compared to "weight-normative" (emphasizing weight and weight loss when defining health and well-being) can be advantageous for patients because health behaviors such as eating 5+ servings of fruits and vegetables daily, exercising regularly, consuming alcohol in moderation, and avoiding smoking decrease mortality regardless of BMI[20,28]; and

WHEREAS, an Agency for Heathcare Research and Quality (AHRQ) review of 88 trials found that behavioral counseling in areas such as diet and physical activity without an emphasis on weight loss demonstrated a significant improvement in health outcomes such as blood pressure and cholesterol, as well as in various behavioral outcomes[29]; and

WHEREAS, health at Every Size interventions, which focus on body acceptance and intuitive eating (eating nutritious food when hungry and stopping when full) have demonstrated benefits in improved diet quality, eating behaviors, lipid profiles, and psychological factors despite no reduction in weight or BMI[23,30–32]; and

WHEREAS, the Well Now non-diet course teaches participants the importance of body signals like energy levels, hunger, and emotions to improve health demonstrated significant improvements in diet quality, physical activity, and mental well-being despite participants' BMI remaining stable[27]; and

WHEREAS, body weight is recognized as the result of complex genetic and environmental factors rather than a number easily within an individual's control[33,34]; and

WHEREAS, negative attitudes towards those of higher body weight are reduced when individuals receive education focused on the multifactorial, rather than behavioral, nature of obesity[35,36]; and

WHEREAS, strategies for reducing implicit bias must include first recognizing that a bias exists and can be measured through publicly available Implicit Association Task tests[37–39]; and

WHEREAS, educational approaches for healthcare providers and students that address weight stigma improve attitude, knowledge and comfort around discussing weight, as well as challenge beliefs about the "controllability" of weight[40,41]; **therefore be it**

RESOLVED, our Ohio State Medical Association (OSMA) supports health promotion techniques that center around healthy behavior and lifestyle modifications rather than weight reduction alone; and, **be it further**

RESOLVED, Our OSMA supports educational training to further educate healthcare providers and trainees about the multifactorial nature of body weight, the impact of weight stigma, and strategies to reduce weight stigma's detrimental health effects on Ohioans.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 12 – 2022

Introduced by: OSMA Medical Student Section

Subject: Divestment from Fossil Fuels

Referred to: Resolutions Committee No. # 1

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WHEREAS, there is significant agreement that humans have contributed to global warming and significant evidence that this warming is a driver of climate change[1,2]; and

WHEREAS, over 200 medical journals recognize climate change as the single greatest threat to human health this century and encourage action to limit global temperature increases[3,4]; and

WHEREAS, climate change currently causes deleterious health effects in Ohio and regionally, including: worsened lung disease, exposure to infectious disease, lower birth weights, exposure to toxic pollution in water, increased risk of heat-related morbidity, and worsened mental health[5-9]; and

WHEREAS, climate change is primarily caused by the combustion of fossil fuels into the global atmosphere[10]; and

WHEREAS, Ohio is within the top 10 coal-consuming states, and is the largest oil-producing state east of the Mississippi River[11]; and

WHEREAS, in 2010 Ohio was 2nd in the United States in health burden attributed to the combustion of fossil fuels[12]; and

WHEREAS, limiting the dangers of climate change requires a rapid shift from fossil fuel energy to low carbon systems[13]; and

WHEREAS, in the United States, fossil fuel corporations helps shape US energy policy and influence energy transition options, effectively preventing a meaningful shift toward clean energy[14]; and

WHEREAS, fossil fuel corporations have specifically dissuaded financial and regulatory support of renewable energy in Ohio as seen in Ohio House Bill 6, which removed renewable energy standards beyond 2027 and bailed out coal and nuclear power plants in response to illegal donations from Ohio FirstEnergy[15]; and

WHEREAS, divesting financial resources away from fossil fuel companies and toward sources of clean, renewable energy successfully reduces financial support of oil and gas companies, and divestment portfolios have significantly lower carbon emissions than benchmark portfolios[16-17]; and

WHEREAS, divestment from fossil fuels is a fiscally responsible investment strategy, with studies showing that divestment portfolios perform similarly to or better than benchmark portfolios[16-17]; and

WHEREAS, as of mid-2018, almost 900 institutions across the world with over $8 trillion worth of assets-under-management have made some kind of commitment to fossil fuel divestment[18]; and

WHEREAS, physicians have a commitment to "First, do no harm", and therefore should work to minimize the indirect harm caused through the production of greenhouse gases[19]; and

WHEREAS, the American Medical Association (AMA) declared its commitment in 2018 to divest from fossil fuel corporations and to support similar efforts by other medical organizations (D-135.969)[20]; and

WHEREAS, our Ohio State Medical Association (OSMA) has expressed support for the expansion of renewable energy at the state level (Policy 09-2019), and divestment away from fossil fuels will further the OSMA's commitment to Ohio's environmental health[21]; and

WHEREAS, our OSMA's current investment policy does not include environmental sustainability as an investment objective or consideration[22]; **therefore be it**

RESOLVED, that our OSMA adopts the following, partially adapted from AMA policy (D-135.969, AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies): The OSMA and "any affiliated corporations or subsidiaries should work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels"; and, **be it further**

RESOLVED, that our OSMA includes environmental sustainability as an objective within its investment policy; and, **be it further**

RESOLVED, that our OSMA should choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and, **be it further**

RESOLVED, that our OSMA will encourage efforts of physicians and other health professional associations to proceed with divestment; and, **be it further**

RESOLVED, that our OSMA shall report every five years to the Council and the House of Delegates, for a period of ten years, on progress toward divestment of fossil fuel investments.

Fiscal Note: $ (Sponsor)
$ 1,000 (Staff)

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RELEVANT OSMA POLICY

Policy 09 – 2019 – Impact of Climate Change on Human Health

1. That the Ohio State Medical Association supports efforts at the state level for expansion of renewable sources of energy.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 13 – 2022

Introduced by: OSMA Medical Student Section

Subject: Curbing Opioid-Related Deaths in Ohio Through Medication-Assisted Treatment and Harm Reduction Services

Referred to: Resolutions Committee No. # 1

WHEREAS, unintentional drug poisoning has been the leading cause of injury-related mortality in Ohio since 2007[1]; and

WHEREAS, emerging data is highlighting the exacerbation of opioid-related deaths in the COVID-19 pandemic, especially through decreased access to services, treatment, and support systems via distancing and quarantine; staff and resource reductions in existing services and treatment; transportation dynamics that encourage the production of a toxic, contaminated supply of drugs; and the increase of potential relapse and death from unemployment and early, unsupervised prison release[2]; and

WHEREAS, the death rate for drug overdose for Black non-Hispanics has been steadily increasing, constituting the demographic of highest mortality at a rate of 42.9 deaths per 100,000 among the 4,028 deaths in 2019[3]; and

WHEREAS, the contribution of fentanyl in overdose-related deaths has been increasing from 58% in 2016 to 76% in 2019, and factored in 82% of heroin-related, 77% of cocaine-related, and 72% of methamphetamine-related overdose deaths[3–6]; and

WHEREAS, Project Deaths Avoided With Naloxone (DAWN) was founded in 2012 in Ohio to distribute naloxone intervention devices and provide training on its indications and appropriate usage, which has expanded to include 140 programs, 280 naloxone distribution sites, and 82% of Ohio counties[7]; and

WHEREAS, and accessible and sensitive method developed for urinalysis, fentanyl test strips dipped in water mixed with a small amount of drug sample can detect as little as 0.125 µg/mL of fentanyl content[8]; and

WHEREAS, the use of evidence-based services, such as medication-assisted treatment, and harm reduction methods, such as fentanyl test strips, are shown to be highly effective, yet are implemented in segregated ways, resulting in lack of access to substance abuse programs among black and indigenous persons of color[9]; and

WHEREAS, black Ohioans accounted for 27% of drug arrests in 2020, yet comprised only 17% participating in drug treatment courts[10]; and

WHEREAS, black and Hispanic/Latinx people are more likely to utilize methadone for medication-assisted treatment in the setting of more regulated systems, compared to the usage

of buprenorphine by white demographics available in office-based settings – compounded as 62 out of 88 Ohio counties lack methadone access[9,11]; and

WHEREAS, while the use of fentanyl strips to mitigate overdose fatalities is being increasingly recognized, such as distributing through Hamilton County's initiative, The Exchange Project, and the distribution network supported by the Alcohol, Drug Addiction & Mental Health Services (ADAMHS) Board of Cuyahoga County, funding is segregated and subject to budgetary decisions[12,13]; and

WHEREAS, promoting the use of fentanyl test strips among the illicit drug user population will mitigate the need for more costly interventions, such as naloxone, and reduce mortality within this demographic[14]; and

WHEREAS, in Policy 20 – 2017, our OSMA has previously recognized that physicians have contributed to the overuse of opioids and impress a need to actively work against opioid and illegal drug overdoses through harm-reduction and medication-assisted treatment[15]; and

WHEREAS, fentanyl test strips can allow providers to engage with drug users and seekers with higher engagement, allowing for the dissemination of safe practices, overdose prevention, and support programs[16]; **therefore be it**

RESOLVED, that our Ohio State Medical Association (OSMA) advocates for the use of medication-assisted treatment, including but not limited to methadone or buprenorphine, and harm reduction methods without penalty when clinically appropriate; and, **be it further**

RESOLVED, that our OSMA support public awareness campaigns to increase education of evidence-based services for opioid addiction, including but not limited to medication-assisted treatment, harm reduction, and recovery services; and, **be it further**

RESOLVED, that our OSMA support existing and pilot programs for the distribution of fentanyl test strips in at-risk communities in Ohio.

Fiscal Note: $ (Sponsor)
$ 1000 (Staff)

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Relevant OSMA Policy
Policy 20 – 2017 – Ohio Physicians and the Opioid Problem

1. That it is the Official Policy of the OSMA that all physicians should have the ability to prescribe all medications, including controlled substances, using the highest standards of care and professionalism, providing the best possible care to each patient. All physicians should work diligently to help find solutions to the problems of abuse of prescription medications, use and overdose of illegal substances, and opioid overdose. Physicians acknowledge that substance abuse has many factors and that physicians have contributed to overuse of opioids. However, other causes of misuse of controlled substances should be the significant focus of remedial action.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 14 – 2022

Introduced by: OSMA Young Physician Section, OSMA District 2 and OSMA District 5

Subject: Eliminating Parking Costs for Patients

Referred to: Resolutions Committee No. # 1

- -

WHEREAS, in the United States, an estimated four million individuals fail to receive annual medical care due to transportation barriers[1]; and

WHEREAS, many patients with common illnesses attend multiple outpatient appointments a year, such as one study which showed 47% of patients with hypertension had four or more visits in 2014[2]; and

WHEREAS, parking prices at some of the country's largest medical centers can be as high as $10 to $20 per day; and

WHEREAS, the public transportation system across Ohio varies greatly in terms of usage, location, and infrastructure, with most of the public transport concentrated in the cities; and

WHEREAS, approximately one-half of Ohio's population lives in communities with fixed route services, but a much smaller portion lives within walking distance[3]; and

WHEREAS, public transport is not readily available in all locations, such as rural areas where the scarcity of local physicians can still require patients to drive to urban areas for care[4]; and

WHEREAS, programs such as non-emergency patient/medical transportation (NEMT) are often limited to approved patients within Medicaid and can have many disadvantages, including restrictions on the type and number of rides, the necessity of a social worker to coordinate transportation, having to schedule days in advance, and carpooling with other patients leading to longer travel and wait times[5]; and

WHEREAS, the average cost of an NEMT in 2014 was $28, and this price rises in rural and suburban areas that are farther from medical centers[5,6]; and

WHEREAS, when surveying older Americans, the group that utilizes the most inpatient and outpatient healthcare, rideshare services were not seen as a practical option, with 74% of patients reporting no knowledge of these services and only 1.7% making use of them[7]; and

WHEREAS, in a study of patients with heart disease, individuals reported the high cost of parking at healthcare facilities as a financial barrier to attending multiple specialist appointments[8]; and

WHEREAS, in a study of factors influencing family burden in pediatric hematology/oncology, parking was cited as one of the most disproportionately distressing factors[9]; and

WHEREAS, nonmedical costs, such as transportation, meals, and child care, have been reported to range from $50 to $165 a day, further contributing to a family's financial stress[10]; and

WHEREAS, the lower the financial burden a patient has, the less likely they are to miss appointments and adhere to treatment, preventing high cost emergent situations that would lead to hospitals losing money on patients who cannot pay[11]; and

WHEREAS, reduced parking fees have been cited as an incentive for patients to travel to hospitals that can offer better treatment than local counterparts[12]; and

WHEREAS, a minority of hospitals rely on non-patient care income to offset revenue losses, such that providing parking vouchers would only represent a minor loss in revenue while providing a major benefit to patients[13]; and

WHEREAS, many hospitals have already implemented programs for patient parking such as reduced monthly rates and free validated parking[14-16]; and

WHEREAS, several associations of healthcare facilities focus on developing solutions for and advocating improvements in social and economic aspects of healthcare, including the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association[17-24]; **therefore be it**

RESOLVED, that Ohio State Medical Association work with relevant stakeholders to recognize parking fees as a burden of care for patients and to implement mechanisms for eliminating parking costs.

Fiscal Note: $ (Sponsor)
$ 25,000 (Staff)

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 15 – 2022

Introduced by: OSMA Medical Student Section

Subject: Opposing the Criminalization of Self-Managed Medication Abortion

Referred to: Resolutions Committee No. # 1

- -

WHEREAS, self-managed medication abortion is defined as sourcing and consuming World Health Organization (WHO)-recommended medications to end a pregnancy outside of a medical setting[1]; and

WHEREAS, the demand for self-managed abortion in the United States is increasing, and in 2018 there were greater than 200,000 searches per month for information on medication abortion[2]; and

WHEREAS, of those who searched information on medication abortion, 70% were in the Midwest or South, indicating that people in Ohio may be searching for the skills to manage their own abortion[2]; and

WHEREAS, medication abortion can be achieved by a combined regimen of mifepristone 200mg followed by misoprostol 800mcg for pregnancies up to 11 weeks, and a regimen of misoprostol 800mcg alone is effective for pregnancies up to 12 weeks[1]; and

WHEREAS, the WHO states that "The medical abortion process can be self-managed for pregnancies up to 12 weeks of gestation, including the ability to take the medications at home, without direct supervision of a health-care provider"[12]; and

WHEREAS, the Ohio Revised Code does not explicitly criminalize a person for self-managed medication abortion[18]; and

WHEREAS, there have multiple U.S. cases where women have been arrested and charged after attempting to self-induce an abortion using abortifacients without clinical supervision[13,19-22]; and

WHEREAS, women who experience miscarriages have been reported by medical professionals who suspect they may have self-induced an abortion[13,19-22]; and

WHEREAS, enforcement of fetal homicide laws relies on medical professionals' reporting to authorities; and

WHEREAS, these laws make women wary of seeking care for miscarriage and self-managed abortion, and can create situations in which women are forced to weigh the costs of forgoing care against the possibility of being reported to the authorities[13]; and

WHEREAS, future Ohio legislation may prompt physicians to investigate women seeking medical care for abortion of an unknown cause, which could result in a patient with a spontaneous abortion being wrongly criminalized for a self-induced medication abortion; and

WHEREAS, in Indiana, a woman was sentenced to 20 years in prison for feticide after informing a physician that she miscarried, yet this was overturned by existing state laws protecting patients from such prosecution[13,14]. Having such protections for pregnant women would directly protect women from injustices such as these[14]; and

WHEREAS, although it is currently legal to have an abortion and obtain abortifacients outside of a medical setting, criminalization of those self-managing abortions still occurs[17]; and

WHEREAS, medical providers have no obligation to report patients to the police for having possibly self-managed an abortion, and in doing so may even violate state and federal medical privacy laws[15]; and

WHEREAS, medical providers are obligated to treat patients who have managed their own abortions, and therefore should not be criminalized for providing necessary medical care; and

WHEREAS, on December 16 2021, the Food and Drug Administration (FDA) removed the requirement that mifepristone be dispensed only in healthcare settings, such as clinics, hospitals, and doctors' offices[18]; and

WHEREAS, Ohio State Medical Association (OSMA) Policy 13 - 1973 defines abortion as a medical procedure, failing to address medication abortion, which is distinct from procedural abortion; and

WHEREAS, our American Medical Association opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services[16]; **therefore be it**

RESOLVED, that the OSMA amend Policy 07-2020, Legislative or Regulatory Interference in the Practice of Medicine in the State of Ohio, by addition as follows:

Legislative or Regulatory Interference in the Practice of Medicine in the State of Ohio, OSMA Policy 07 - 2020

1. The OSMA actively works to ensure that the sanctity of the physician-patient relationship is protected in all legislative and regulatory matters.
2. Current OSMA Policy 18 - 2012 (Criminalization of Medical Care) be amended to read as follows:

The OSMA opposes any portion of proposed legislation OR RULE that criminalizes clinical practice that is the standard of care.

1. That current OSMA Policy 10 – 1990 (Policy on Abortion) be amended as follows:

1. It is the position of the OSMA that the issue of support of or opposition to abortion is a matter for members of the OSMA to decide individually, based on personal values or beliefs.

2. The OSMA shall take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

3. Items 1 and 2 notwithstanding, the OSMA shall take a position of opposition to any proposed Ohio legislation or rule that would:

• Require or compel Ohio physicians to perform treatment actions which are not consistent with the standard of care; or,

•Require or compel Ohio physicians to perform investigative tests or questioning of a patient who has had an abortion of unknown cause; or,

• Require or compel Ohio physicians to discuss treatment options that are not within the standard of care and/or omit discussion of treatment options that are within the standard of care

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

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RELEVANT OSMA POLICY

Policy 13 – 1973 – Abortion as a Medical Procedure

1. The House of Delegates of the OSMA adopts as its policy the statement of abortion issued by the OSMA's Committee on Maternal Health, with the exception that abortion upon request, like any other medical procedure, should be performed only in the maternal patient's best interests, and the standards of sound clinical judgment, which together with informed maternal patient consent, should be determinative according to the merits of each individual case.

RELEVANT AMA AND AMA-MSS POLICY

Oppose the Criminalization of Self-Induced Abortion H-5.980

1. Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion. *Res. 007, A-18* 0453-6

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

2022 OSMA Policy Sunset Report

Introduced by: OSMA Council

Subject: 2022 OSMA Policy Sunset Report

Referred to: Resolutions Committee # 1

WHEREAS, Chapter 5, Section 14 of the Ohio State Medical Association Constitution and Bylaws provides that: any resolution/policy adopted by the House of Delegates four (4) or more years prior to each Annual Meeting will be reviewed by the Council for purposes of recommending whether to retain each policy. The House of Delegates will be notified of those policies subject to review prior to the Annual Meeting at which they will be considered. Any policy not retained by House action on the report submitted by the Council becomes null, void and of no effect; **therefore be it**

RESOLVED, That the recommendations of OSMA Council published prior to the Annual Meeting as the 2022 OSMA Policy Sunset Report be adopted by the OSMA House of Delegates.

Ohio State Medical Association Policy Compendium Review –

2022 OSMA Policy Sunset Report

OSMA policy from years 1932 through 2018 and 2021 Sunset Report

(This is a list of Policy numbers and titles. The full text of policies recommended "RETAIN" as edited and "NOT RETAIN" is contained in this report. All other OSMA policies will be retained as they are shown in the OSMA Policy Compendium available on www.osma.org.)

Policies to be Retained as Edited:

Policy 01 – 2016 – Membership List Exchange
Policy 07 – 2016 – Cannabinoids
Policy 14 – 2017 – Maintain Rights of County Medical Societies

Policies to be Not Retained:

Policy 01 – 2018 – Constitution and Bylaws Amendments
Policy 02 – 2018 – Young Physicians
Policy 12 – 2018 – Dietary Supplements
Policy 00 - 2021 OSMA Policy Sunset Report

Full text of policies recommended "RETAIN" as Edited and "NOT RETAIN"

Recommendation	Policy	Comment
RETAIN as Edited	**Policy 01 – 2016 – Membership List Exchange** 1. ~~The OSMA replaces Policy 09 - 2015 and 10 - 2015 (DELETED FROM POLICY COMPENDIUM) with the following:~~ The OSMA and County Medical Societies shall exchange membership lists twice per year on or around March 31 and September 30.	Stricken portion accomplished
RETAIN as Edited	**Policy 07 – 2016 – Cannabinoids** 1. The OSMA opposes recreational use of cannabis. 2. The OSMA supports Institutional Review Board (IRB) approved clinical research to explore the potential risks versus benefits of using cannabinoids to treat specific medical conditions. 3. The OSMA supports focused and controlled medical use of pharmaceutical grade cannabinoids for treatment of those conditions which have been evaluated through Institutional Review Board (IRB) approved clinical research studies and have been shown to be efficacious. 4. The OSMA recommends that marijuana's status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines and alternate delivery methods. 5. The OSMA supports limiting cannabinoids prescribing rights, if permitted, to physicians (MDs and DOs).	Stricken portion accomplished

Recommendation	Policy	Comment
	6. The OSMA opposes legalization of any presently illegal drugs of substance abuse including, but not limited to, cannabis and cocaine, except in the instance of appropriate evidence-based use approved by the FDA. 7. The OSMA encourages physician participation in future legislative and regulatory discussions regarding the legal use of cannabinoids. ~~8. This policy replaces OSMA Policy 65-1991 (DELETED FROM POLICY COMPENDIUM).~~	
RETAIN as edited	**Policy 14 – 2017 – Maintain Rights of County Medical Societies** 1. The OSMA will recognize and respect the independent structure, organization and domain of the actively functioning county medical societies in the state of Ohio. ~~2. The rights of the county medical societies to appoint their representatives to serve in the OSMA House of Delegates shall be preserved.~~	Regional delegates are now selected by district, not county except that each county with active OSMA members has at least one delegate and alternate delegate (per current Constitution and Bylaws)
NOT RETAIN	**Policy 01 – 2018 – Constitution and Bylaws Amendments** 1. The OSMA Constitution and Bylaws were updated to incorporate the changes adopted by the 2018 OSMA House of Delegates. The current OSMA Constitution and Bylaws are available on www.osma.org.	Accomplished
NOT RETAIN	**Policy 02 – 2018 – Young Physicians**	Accomplished

Recommendation	Policy	Comment
	1. Policy 02 – 2018 created a Young Physicians Section. The OSMA Constitution and Bylaws were updated to incorporate the changes adopted by the 2018 OSMA House of Delegates. The current OSMA Constitution and Bylaws are available on www.osma.org.	
NOT RETAIN	**Policy 12 – 2018 – Dietary Supplements (rescinded and replaced by Policy 31–2021)**	Accomplished
NOT RETAIN	**Policy 00 – 2021 - OSMA Policy Sunset Report Click here to view report**	Recommendations adopted by the 2021 OSMA HOD

Fiscal Note: $0 (Sponsor)

$0 (Staff)