2025 OSMA Annual Meeting
Resolution Committee One
Resolutions 1-27, OSMA Policy Sunset Report

#1 - IMG, WPS, SPS Seats on Council

#2 - Procedure for Approval for Recording of OSMA Meetings

#3 – Support for Environmental Initiatives

#4 - WITHDRAWN BY SPONSORS

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#6 - Physician Exercise of Conscience and Sound Medical Ethics

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#9 - Physician Led Health Care Teams

#10 - Physician-Led Healthcare Teams

#11 - Opposing the Use of Physician Associate

#12 - Regulating Practitioners that Practice Non-Conventional Medicine (Herbalists, Naturalists, Homeopaths, Ayurveda, Asian Herbal Medicine)

#13 - Mobilizing Healthcare Professionals to Address Police Violence as a Public Health Crisis

#14 - Physicians Engaged in Non-Violent Civil Protest

#15 - Support for Diversity, Equity, and Inclusion in Ohio Medical Schools

#16 - Gender-Identification on State Government IDs

#17 - Gender Dysphoria

#18 - Support for Statewide Tracking of and Control Mechanisms for Health Care Expenditure Growth that Promote Primary Care

#19 - Mental Health Disclosures Policy for Medical Applicants

#20 – Mandating Child-Proof Packaging on Marijuana Products Sold Legally in the State of Ohio

#21 – Marijuana Guidelines Following Ohio Legalization

#22 – Support for Education on Intimate Partner Violence Screening with Medical Students, Residents, and Physicians

#23 – Registry for Potential Side Effects of GIP & GLP-1 Medications

#24 – Streamlining Annual Compliance Training for Physicians

#25 – Physician Owned Hospitals

#26 – Seat Belt Laws

#27 – Advancing Public Health Protections Against Per- and Polyfluoroalkyl Substances (PFAS)

OSMA Policy Sunset Report

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 1 – 2025

Introduced by: OSMA Council

Subject: Update of OSMA Bylaws to Include Representative Members from the Women Physician Section, Senior Physician Section, and International Medical Graduates Section on OSMA Council

Referred to: Resolutions Committee No. 1

WHEREAS, ARTICLE VII of the OSMA Constitution and Bylaws currently states that "The Board of Trustees (referred to herein as "the Council") shall consist of one (1) Councilor from each geographical councilor district, six (6) At-Large Councilors, one (1) member from the Organized Medical Staff Section, one (1) member from the Young Physician Section, one (1) member from the Resident and Fellows Section, one (1) Student Member from the Medical Student Section and the other elected Officers of this Association."[1]; and

WHEREAS, CHAPTER 8 Section 1 of the OSMA Constitution and Bylaws states that the Council shall be the executive body of this Association. Between meetings of the House of Delegates, the Council shall have and exercise all the powers and authority conferred on the House of Delegates by the Constitution and these Bylaws" and "The Council shall consider all questions involving the rights and standing of members" and "The Council shall have full power and authority to employ a Chief Executive Officer, who need not be a physician or member of this Association."[1]; and

WHEREAS, OSMA Constitution and Bylaws 2019 Revised Strategic Priorities states that the "OSMA will increase physician engagement…" and the "OSMA will be the voice for physicians advocating the role of professionals in the changing health care landscape…" and the "OSMA will support the healthy personal and professional development of physicians as well as lead and support physicians as they address population health improvement and public health needs" and the "OSMA will evaluate its governance structure and relationships with other medical societies and organizations to insure we are providing adequate input for all physicians and becoming a more nimble and responsive organization."[1]; and

WHEREAS, OSMA Women Physicians Section Draft Bylaws Chapter 1 states "The purpose of this section is to 1) provide an additional means for section members to participate in OSMA policy making and other activities, 2) enhance OSMA outreach, communication and interchange with members represented in the section, 3) maintain effective communications between the section and the OSMA, 4) promote OSMA membership growth, 5) promote professional development and education of its

members, and 6) to represent the unique interests of women members of the OSMA."[2]; and

WHEREAS, OSMA Senior Physicians Section Bylaws Chapter 1 states "The purpose of this section is to 1) provide an additional means for section members to participate in OSMA policy making and other activities, 2) enhance OSMA outreach, communication and interchange with members represented in the section, 3) maintain effective communications between the section and the OSMA, 4) promote OSMA membership growth, 5) promote professional development and education of its members, and 6) to represent the unique interests of senior members of the OSMA."[3]; and

WHEREAS, OSMA International Medical Graduates Section Bylaws Chapter 1 states "The purpose of this section is to 1) provide an additional means for section members to participate in OSMA policy making and other activities, 2) enhance OSMA outreach, communication and interchange with membership sections represented in OSMA sections, 3) maintain effective communications between the sections and the OSMA, 4) promote OSMA membership growth, 5) promote professional development and education of its members, and 6) to represent the unique interests of international medical graduate members of the OSMA."[4]; and

WHEREAS, OSMA Women (draft), Senior, and International Graduate Physicians Section Bylaws state that amendment of their own section bylaws is "subject to the approval of the Council of the Ohio State Medical Association prior to implementation."[2, 3, 4]; and

WHEREAS, including member seats from the OSMA demographic sections (e.g. Young Physicians Section, Medical Student Section, etc.) on the Council guarantees an opportunity for representation of these sections' unique interests; and this cannot be ensured through representation from the geographical councilor districts; and

WHEREAS, the Women Physician Section, Senior Physician Section, and International Medical Graduates Section do not have a representative on the OSMA Council; and therefore

BE IT RESOLVED, that the OSMA Bylaws shall be updated so that the Council shall additionally include one (1) member of the Women Physician Section, one (1) member of the Senior Physician Section, and one (1) member of the International Medical Graduates Section. The bylaws of each of these sections shall be updated (according to established procedure) to define the process of electing their representative member to the Council; and be it further

RESOLVED, that the OSMA Bylaws shall be updated so that the Council shall include four (4) At-Large Councilors, rather than the current six (6) At-Large Councilors.

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

References

1. Ohio State Medical Association Constitution And Bylaws (Amended April 2024)
2. Bylaws of the OSMA Women Physicians Section
3. Bylaws of the OSMA Senior Physicians Section
4. Bylaws the OSMA International Medical Graduate Physician Section

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 2– 2025

Introduced by: OSMA Council

Subject: Procedure for Approval of Recording of OSMA Meetings

Referred to: Resolutions Committee No. 1

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WHEREAS, the advancement of Artificial Intelligence (AI) technology has given rise to many tools, applications, and programs to assist human worker's productivity and efficiency; and

WHEREAS, some AI tools have been developed to allow individuals to discretely record meeting content and generate notes with minimal effort, especially in virtual meeting settings; and

WHEREAS, governance meetings of organizations have become increasingly held virtually through electronic communication applications such as Zoom and others; and

WHEREAS, our OSMA is not a public entity and represents the interests of its private physician membership; and

WHEREAS, our OSMA currently produces official recordings and minutes of OSMA meetings; and

WHEREAS, our OSMA, for legal and compliance purposes, has an interest to determine the proper methods and means to record all official meetings of the OSMA; and

WHEREAS, OSMA has concerns with the unauthorized use of recordings or other note taking technology such as the creation of unofficial records of meetings that conflict with official records, violation of confidentiality laws, litigation exposure due to potential use of unofficial records against the OSMA, and general potential for malicious use of individuals against the OSMA and its membership; and therefore

BE IT RESOLVED, that Article V of the OSMA Constitution and Bylaws be amended as follows:

. . .

SECTION 7. PROCEDURE FOR APPROVAL OF RECORDING OSMA MEETINGS.

ANY RECORDING OF OSMA MEETINGS OF ITS HOUSE OF DELEGATES, EXECUTIVE COUNCIL, EXECUTIVE COUNCIL SUBCOMMITTEES, SECTIONS, AND OTHER COMMITTEES CREATED BY THIS CONSTITUTION AND BYLAWS IS PROHIBITED UNLESS AS PROVIDED BELOW.

THIS PROHIBITION DOES NOT APPLY TO OSMA STAFF MEMBERS (OR THEIR DESIGNEES) FOR THE PURPOSE OF RECORDING A MEETING TO PRODUCE WRITTEN MINUTES OR TO REPRODUCE THE MEETING ELECTRONICALLY FOR MEETING MEMBERS TO LATER REVIEW.

THIS PROHIBITION DOES NOT APPLY TO OSMA GEOGRAPHICAL DISTRICT MEETINGS. EACH DISTRICT LEADERSHIP SHALL DETERMINE HOW BEST TO ADDRESS RECORDINGS WITHIN ITS VOTING AND GOVERNANCE STRUCTURE.

A BRIEF SUMMARY OF THIS SECTION SHALL APPEAR ON ALL APPLICABLE MEETING AGENDAS.

IF A VIOLATION OF THIS SECTION OCCURS, THE OSMA MAY TAKE SUCH ACTION AS NECESSARY, INCLUDING BUT NOT LIMITED TO:

(1) REQUIRING SUCH PERSON TO IMMEDIATELY CEASE AND DELETE THE RECORDING

(2) REQUIRING SUCH PERSON TO IMMEDIATELY LEAVE THE MEETING

(3) BANNING SUCH PERSON FROM FUTURE OSMA MEETINGS

(4) REMOVING SUCH PERSON FROM ANY OSMA COUNCIL, SECTION, COMMITTEE, OR OTHER OSMA OFFICE, PURSUANT TO CHAPTER 6, SECTION 9 OF THE OSMA BYLAWS

EXCEPTIONS MAY BE MADE ON A CASE-BY-CASE BASIS, AND ONLY UPON APPROVAL BY ALL OF THE FOLLOWING:

(1) THE OSMA PRESIDENT, OR IN THE PRESIDENT'S ABSENCE THE PRESIDENT ELECT;

(2) ALL MEMBERS OF THE MEETING BODY; AND

(3) OSMA LEGAL COUNSEL

Fiscal Note: $ 0 (Sponsor)
$ 500 (Staff)

References:

Section V, OSMA Constitution and Bylaws

ARTICLE V MEETINGS

Section 1. Annual Meeting. This Association shall hold an Annual Meeting at which there shall be a meeting of the House of Delegates.

Section 2. Time and Place of Annual Meeting. The time and place for holding each Annual Meeting shall be fixed by the Council of this Association and Delegates shall be physically present except when the OSMA Council determines that extraordinary circumstances exist that make it impossible or inadvisable for delegates to be physically present.

Section 3. Special Meetings. Special meetings of the House of Delegates shall be called by the President or other officer upon a two-thirds (2/3) vote of the Council or upon filing, with the Chief Executive Officer of this Association, a petition duly authorized and signed by at least fifty active members residing or practicing in at least two OSMA districts. Within ten (10) days after such action of the Council, or the filing of such petition, the Chief Executive Officer shall give written notice to the members of the House of Delegates setting forth the purpose or purposes of such meeting and specifying the time and place thereof, in no event shall the meeting be less than twenty (20) days nor more than sixty (60) days after the mailing of such written notice.

Section 4. At least ten (10) days advance notice of meetings of members shall be published in print or shall be given by use of authorized communications equipment as defined in Section 5.

Section 5. Members and Councilors may attend and participate in all meetings of this Association, including participation by casting any vote that the member or Councilor is qualified to cast, in person or via the use of authorized communication equipment if use of such equipment is approved by the Council. Any member participating in a meeting via authorized communications equipment shall be considered “present” at that meeting for all relevant purposes. Any recorded

transmission by authorized communications equipment shall be considered "written" or a "writing" for all relevant purposes stated in the Constitution and Bylaws. The Council shall establish procedures and guidelines for the use of authorized communications equipment in order to permit the Council to verify that a person is a voting member and to maintain a record of the person's presence and any relevant vote that person casts by use of the authorized communications equipment.

As used in this section and these Constitution and Bylaws, "authorized communications equipment" means any communications equipment that provides a transmission, including, but not limited to, by telephone, telecopy, or any electronic means, from which it can be determined that the transmission was authorized by, and accurately reflects the intention of, the member or Councilor involved and, with respect to meetings, allows all persons participating in the meeting to contemporaneously communicate with each other.

Section 6. Conduct of Meetings. Meetings of the Association may be held in person or by means of authorized communications equipment as defined in this Article if use of such equipment is approved by the Council except as stated in Section 2 of this Article. Voting members who are not physically present at a meeting of voting members may attend the meeting by the use of authorized communications equipment that enables the voting members an opportunity to participate in the meeting and to vote on matters submitted to the voting members, including an opportunity to read or hear the proceedings of the meeting, participate in the proceedings, and contemporaneously communicate with the persons who are physically present at the meeting. Any voting member who uses authorized communications equipment is deemed to be present in person at the meeting whether the meeting is held at a designated place or solely by means of authorized communications equipment. The Council may adopt procedures and guidelines for the use of authorized communications equipment in connection with a meeting of voting members to permit the Association to verify that a person is a voting member and to maintain a record of any vote or other action taken at the meeting.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 3 – 2025

Introduced by: OSMA Council

Subject: Support for Environmental Justice Initiatives

Referred to: Resolutions Committee No. 1

WHEREAS, the OSMA Student Section proposed Resolution 36 – 2024 Support for Environmental Justice Initiatives at the 2024 OSMA Annual Meeting, which was referred to Council for additional consideration; and

WHEREAS, the OSMA Council created smaller workgroups of Council members to review resolutions referred to it from the 2024 annual meeting; and

WHEREAS, one of the Council workgroups reviewed referred Resolution 36 from the 2024 Annual meeting, agreed that the resolution was appropriate, and added a more detailed definition of environmental justice initiatives from the US Environmental Protection Agency and submitted its recommendations to Council; and

WHEREAS, Council reviewed the recommended language by the workgroup, directed staff to include the definition of environmental justice initiatives according to the US Department of Health and Human Services (HHS), and then approved the amended resolution language to be submitted to the House of Delegates at the 2025 OSMA Annual Meeting; and

WHEREAS, environmental justice is defined by the HHS in 2024 as the fair treatment and meaningful involvement of people regardless of race, color, national origin, or income in the development, implementation, and enforcement of environmental laws, regulations, and policies[1]; and

WHEREAS, environmental injustice is the increased exposure to pollution and other environmental health risks, limited access to environmental services, and loss of land and resource rights that are disproportionately experienced by low-income communities and communities of color[2]; and

WHEREAS, due to historic redlining and other racist housing policies, communities of color are often located near heavily polluted areas, with Black people 75 percent more likely to live near facilities that produce hazardous waste[5]; and

WHEREAS, concentrations of known toxic and carcinogenic metals are nearly 10 times higher in racially segregated communities[6]; and

WHEREAS, Black, Hispanic, and Native American people experience higher rates of negative health impacts with extreme heat events and temperature fluctuations than their White counterparts[7]; and

WHEREAS, according to the 2021 Health Value Dashboard, Ohio is ranked 43rd out of 50 states and D.C. on environmental metrics related to air quality, water quality, and toxic substance exposure[3]; and

WHEREAS, in an environmental justice policy scorecard, the Northeast-Midwest Institute ranked Ohio as one of the lowest states in the Midwest due to its lack of legislation on environmental justice[4]; and

WHEREAS, Michigan's Department of Environment, Great Lakes, and Energy has an Office of the Environmental Justice Public Advocate with its own funding and staff that is dedicated to advancing environmental justice in the state[8]; and

WHEREAS, the Biden-Harris Administration granted $2 million in funding for environmental justice projects in Ohio through the U.S. EPA's Environmental Justice Collaborative Problem Solving Cooperative Agreement[9]; and

WHEREAS, Ohio House Bill 429, a bill introduced in the 2022 legislative session by Representatives Casey Weinstein and Stephanie Howse, sought to launch environmental justice programs and build clean energy policy that recognizes equity for historically marginalized communities, but it failed in committee[10]; and

WHEREAS, the U.S. Attorney for the Southern District of Ohio, Kenneth L. Parker, established a new environmental justice initiative for the district in October 2022 to enforce environmental laws and prosecute violations leading to discriminatory environmental and health impacts[11]; and

WHEREAS, the AMA has policies recognizing the harmful impacts to health that environmental pollution and destruction may have and supports the development of environmental committees as well as programs to combat racism (H-65.952; H-135. 931; H-135.932; H 135.973; H-135.969; 135-997); and

WHEREAS, the OSMA "encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans' health" (Policy 27 – 2022); and therefore

BE IT RESOLVED, that the OSMA recognizes environmental justice, as defined by the US Department of Health And Human Services in 2024, as the fair treatment and meaningful involvement of people regardless of race, color, national origin, or income in the development, implementation, and enforcement of environmental laws, regulations, and policies; and be it further

RESOLVED, that the OSMA supports state action to address and remediate environmental injustice and environmental conditions adversely impacting health, particularly in marginalized communities.

Fiscal Note: $ (Sponsor)
$ (Staff)

References:

1. United States Health and Human Services. “Environmental Justice.” *US HHS*, 4 May 2023, https://www.hhs.gov/civil-rights/for-individuals/special-topics/environmental-justice/index.html#:~:text=Environmental%20Justice%20is%20the%20fair,laws%2C%20regulations%2C%20and%20policies.. Accessed 1 Nov. 2024.
2. “Environmental Justice Factsheet.” *Center for Sustainable Systems*, University of Michigan, 2023, css.umich.edu/publications/factsheets/sustainability-indicators/environmental-justice-factsheet. Accessed 30 Nov. 2023.
3. Health Policy Institute of Ohio. “2021 HEALTH VALUE DASHBOARD.” *Health Policy Institute of Ohio*, Apr. 2021.
4. Griffin, Nicholas. Scorecard of Environmental Justice Policies in Northeast-Midwest States. *Northeast-Midwest Institute*, July 2022.
5. Lazaroff, Marissa. *The Crossroads of Environmental Racism and Public Housing*. The Ohio Environmental Council, 2020.
6. Kodros, John K., et al. “Unequal Airborne Exposure to Toxic Metals Associated with Race, Ethnicity, and Segregation in the USA.” Nature Communications, vol. 13, no. 1, 1 Nov. 2022, https://doi.org/10.1038/s41467-022-33372-z.
7. Berberian, Alique G., et al. “Racial Disparities in Climate Change-Related Health Effects in the United States.” *Current Environmental Health Reports*, vol. 9, no. 3, 28 May 2022, pp. 451–464, https://doi.org/10.1007/s40572-022-00360-w. Accessed 30 Nov. 2023.
8. A “Office of the Environmental Justice Public Advocate.” *Department of Environment, Great Lakes, and Energy*, State of Michigan, www.michigan.gov/egle/about/organization/environmental-justice. Accessed 1 Dec. 2023.
9. EPA Press Office. “Biden-Harris Administration Announces $2 Million for Environmental Justice Projects in Communities across Ohio as Part of Investing in America Agenda.” *US EPA*, 24 Oct. 2023, www.epa.gov/newsreleases/biden-harris-administration-announces-2-million-environmental-justice-projects-0. Accessed 1 Dec. 2023.
10. Weinstein, Casey, and Stephanie Howse. Regards Clean Energy and Energy Justice. 21 Sept. 2021, www.legislature.ohio.gov/legislation/134/hb429. Accessed 1 Dec. 2023.

11. U.S. Attorney's Office, Southern District of Ohio. “Southern District of Ohio | U.S. Attorney Parker Launches Environmental Justice Initiative.” *United States Attorney’s Office Southern District of Ohio*, US Department of Justice, 4 Oct. 2022, www.justice.gov/usao-sdoh/pr/us-attorney-parker-launches-environmental-justice-initiative. Accessed 1 Dec. 2023.
12. AMA Policy: Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
13. AMA Policy: Racism as a Public Health Threat H-65.952
14. AMA Policy: 135.024MSS Environmental Health Equity in Federally Subsidized Housing
15. AMA Policy: Stewardship of the Environment H-135.973
16. AMA Policy: Environmental Health Programs H-135.969

OSMA Policy:

Policy 27 – 2022 – Recognition of Climate Change as a Threat to Ohio’s Health

1. The OSMA encourages the development of policy to combat climate change and its health effects in Ohio and to mitigate the undesirable environmental conditions that damage Ohioans’ health.
2. The OSMA encourages education of the broader Ohio medical community to the serious adverse health effects of climate change and local conditions of climate variation.

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. 4 – 2025

WITHDRAWN BY SPONSORS

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 5 – 2025

Introduced by: OSMA District 3

Subject: Limits on Numbers of Resolutions

Referred to: Resolutions Committee No. 1

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WHEREAS, resolutions are submitted for discussion and vote by our OSMA HOD each year so that new OSMA policy can be established to serve as guidance for members and staff during discussion of new legislation, regulations, and rules in the State of Ohio and actions by our OSMA; and

WHEREAS, resolutions that restate current Ohio law or rules or current OSMA policy are not helpful and waste the time and energy of OSMA members, Resolution Committee members, and Delegates during discussion and debate before and during the OSMA Annual Meeting; and

WHEREAS, our members have limited time to review resolutions due to the time requirements of medical practice; and

WHEREAS the number of resolutions has grown to an unmanageable number in the past few years; and therefore be it

RESOLVED, that our OSMA limit the number of resolutions that can be submitted by any District, Section, or Specialty Society to 5 for each Annual Meeting, and be it further

RESOLVED, that any OSMA member who individually wants to submit a resolution for discussion at the OSMA HOD must have a cosponsor which is a District, Section, or Specialty Society and that resolution will count towards the total number allowed for that District, Section, or Specialty Society.

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

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 6 – 2025

Introduced by: Joseph Hellman, MD

Subject: Physician Exercise of Conscience and Sound Medical Ethics

Referred to: Resolutions Committee No. 1

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WHEREAS, patient trust and public confidence in the medical profession recently diminished and a clear united professional ethical standard is a best practice that will serve to restore public trust and confidence while maintaining physician's commitment to medicine's 'do no harm' principle while mitigating the life altering effects of disease, trauma, aging, self destructive choices which includes but is not limited to a lack of education and/or resources; and

WHEREAS, our Ohio State Medical Association has no policy that defines the professional ethical standard; and

WHEREAS, scientific research has similarly suffered having been diluted by a lack of high quality data upon which our medical evidence based practices are constructed which has the potential to alter standards of care in a way that is inconsistent with the scientific method; and

WHEREAS, the physician exercise of conscious has been and is being encouraged to be set aside as medicine evolves deeper into a model which provides services as a patient or authority requests which has resulted in a shift away from our art of medicine and is therefore contributing to physician burnout, suicide, self harm, and increasing moral dilemmas particularly for health system employed physicians and those in training; and

WHEREAS, the American Medical Association has adopted a code of medical ethics opinion 1.1.7 regarding the physician exercise of conscience in order to promote adherence to high ethical standards for the profession and art of medicine; and therefore be it

RESOLVED, that our Ohio State Medical Association adopt and support the AMA Code of Medical Ethics 1.1.7 Physician Exercise of Conscience as set forth below:

AMA Code of Medical Ethics

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely.

Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:
(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal

beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
(d) Be mindful of the burden their actions may place on fellow professionals.
(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

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

References:

1. AMA Principles of Medical Ethics: I,II,IV,VI,VIII,IX

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 7 – 2025

Introduced by: Albert L Hsu

Subject: Supporting and Promoting AMA Member Physicians and Physician Spouses as Candidates for Local, State and Federal Office

Referred to: Resolutions Committee No. 1

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WHEREAS, medicine is under assault from all sides – from insurance companies to trial lawyers to onerous state and federal regulation, and

WHEREAS, the 118th United States Congress (which began on 1/3/23 and ended on 1/3/25) enacted 209 public laws; this contrasts with approximately 16,000 items of state legislation passed annually;[1,2,3] and

WHEREAS, we do not have enough physicians in political office, on the local, state or federal levels; and we should support our physician members who run for office; and

WHEREAS, our medical societies have political action committees (such as AMPAC for AMA) to support candidates running for office; and

WHEREAS, AMPAC holds an annual "Candidate Workshop and Campaign School" to support physicians running for elected offices;[4] and

WHEREAS, there are few mechanisms to enable physician members of our state and national medical societies to network when running for state and federal office; and

WHEREAS, partly due to high educational debt loads, physicians have traditionally had a low level of giving to candidates for local, state, and federal offices; and

WHEREAS, those of us who have more time than money can help candidates for elected office with volunteer time and social media support (retweeting, likes, etc) for those candidates; and

WHEREAS, candidates for political office are interested in meeting potential donors, as well as individuals who may be willing to volunteer to support their campaigns with volunteer time and social media support; and

WHEREAS, there is currently no "central repository" that lists physicians running for state and federal office in the United States; and

WHEREAS, non-member physicians who are running for local, state or federal office should be encouraged to join the AMA and/or their state medical societies; and

WHEREAS, in this age of social media, it should be relatively easy to set up members-only websites with lists of physicians and physician spouses who are running for elected offices, and

WHEREAS, it may be necessary for publicity of candidates for federal office to be a function of AMPAC and not the AMA (due to tax implications, legal concerns, etc); and

WHEREAS, AMPAC and/or our AMA leaders may also determine that certain physicians or physician spouses who are running for elected office, may not merit this recognition; and

WHEREAS, AMPAC and/or our AMA leaders may also determine that certain words or actions of certain physicians or physician spouses who are running for elected office, should merit removal from such lists; and

WHEREAS, given limited resources and bandwidth, it is likely that this proposal should be a collaborative effort between AMPAC and the Political Action Committees (PACs) of our state and specialty societies; and

WHEREAS, such a "vetting process" would likely consume valuable time and resources, such that AMPAC and/or AMA should consider whether the benefit outweighs the cost of doing this**;** and therefore be it

RESOLVED, that our Ohio State Medical Association (OSMA) and AMA study the feasibility and desirability of working together with AMPAC (and state medical society/specialty society PACs, as appropriate) to publicize AMA physician members and physician spouses running for state, federal, and local offices (on AMA and/or OSMA websites), to help enable physicians and trainees to donate money, to contribute volunteer time, and to provide social media support for their campaigns; with a report back at A-26; and be it further

RESOLVED, that our OSMA and American Medical Association (AMA) encourage AMA sections and caucuses to consider establishing a policy or protocol to allow (by invitation) AMA members running for local, state or federal offices to briefly address those groups directly, either virtually or in-person; and be it further

RESOLVED, that our OSMA and American Medical Association (AMA) collaborate with other interested organizations to facilitate opportunities for AMA physician-member and physician-spouse elected officials (at the local, state, and federal levels) to connect, exchange ideas, collaborate, and support each other to protect our patients and our practices; and be it further

RESOLVED, that our OSMA forward this resolution to AMA-HOD at A-25.

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

References:

1. Presentation on "Overview of State Legislatures, Policy, and Politics" at 2025 AMA State Advocacy Summit; Carlsbad, CA. Fri 10 Jan 2025

2. Presentation on "A Conversation with State Legislators" at 2025 AMA State Advocacy Summit; Carlsbad, CA. Fri 10 Jan 2025
3. "Statutes at Large and Public Laws" at congress.gov: https://www.congress.gov/public-laws/118th-congress; accessed 1/11/25
4. AMPAC Candidate Workshop and Campaign School, at https://www.ampaconline.org/political-education/candidate-workshop-and-campaign-school-application; accessed 1/11/25

AMA physician members and spouses in state legislatures (2024-2025, *NOT* a comprehensive list):

Name	State	Position in State Legislature	AMA role
Megan Srinivas, MD	**Iowa (IA)**	**State Representative (District 30)**	**Former AMA Delegate, Former RFS Member of Council on Medical Service**
	Iowa State House website: State Representative https://www.legis.iowa.gov/legislators/legislator?personID=33973&ga=91 **Campaign website: Megan Srinivas for Iowa House District 30 https://www.megan4iowa.com/**		
George Hruza, MD	**Missouri (MO)**	**State Representative (District 089)**	**AMA Alt Delegate (for Missouri, also former MSMA/state medical society president, former AAD/national specialty society president)**
	Missouri State House website: https://house.mo.gov/memberdetails.aspx?district=089&year=2025&code=R **Campaign website: George Hruza for State Representative https://hruzaformissouri.com/**		
Trinidad Tellez, MD	**New Hampshire (NH)**	**State Representative (District 40)**	**Spouse = Travis Harker, MD (AMA Delegate for NH)**
	New Hampshire State House website: The New Hampshire House of Representatives https://gc.nh.gov/house/members/member.aspx?pid=10820 **Facebook page (no website for campaign contributions): https://www.facebook.com/share/156VQXHwpH/?mibextid=wwXIfr**		

Deborah Ferguson	**Arkansas (AS)**	**State Representative (District 63)**	**Spouse = Scott Ferguson, MD (AMA Board of Trustees member)**
	Arkansas State House website: Representative Deborah Ferguson (D) - Arkansas State Legislature **Facebook page (no website for campaign contributions): Deborah Ferguson for Arkansas | Facebook**		

RELEVANT AMA POLICY – G-640.025

Encourage Physicians as Legislative Candidates G-640.025

Topic: Governance	**Policy Subtopic:** Advocacy and Political Action
Meeting Type: Annual	**Year Last Modified:** 2024
Action: Consolidated	**Type:** Governance Policies
Council & Committees: Council on Constitution and Bylaws	**Additional Councils & Committees:** CLRPD

1. Our American Medical Association will continue to identify, encourage, and support physicians to run as state and national legislative **candidates**.
2. Our AMA will not use AMA corporate treasury funds to engage in.

Policy Timeline
Res. 605, A-14Consolidated with G-645.015: CCB/CLRPD Rep. 01, A-24

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 8 – 2025

Introduced by: OSMA District 3

Subject: Ohio License and Medical Practice in Ohio Required for Physician Collaborators/Supervisors of Advanced Practice Providers

Referred to: Resolutions Committee No. 1

- -

WHEREAS, Ohio law requires that Advanced Practice Providers have collaborative or supervisory agreements with physicians; and

WHEREAS, the Ohio State Medical Board should be able to regulate all physicians responsible for care of Ohio citizens; and therefore be it

RESOLVED, that our OSMA advocate that state regulators and legislators establish policies that ensure physician collaborators or supervisors of advanced practice providers be licensed in Ohio and practice medicine in Ohio.

Fiscal Note: $ 500 (Sponsor)
$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 9 – 2025

Introduced by: OSMA District 3

Subject: Physician Led Health Care Teams

Referred to: Resolutions Committee No. 1

- -

WHEREAS, physicians have significantly more training than any other member of the health care team, and should be the leaders of the health care team; and

WHEREAS, studies have shown that independent practice by advanced practice providers in other states results in more testing, more expense, and worse outcomes than is seen for APP's practicing in a team with a physician as leader; and therefore be it

RESOLVED, that our OSMA support physician led team-based approaches to care and oppose advanced practice providers practicing independently without any physician relationship.

Fiscal Note: $ 500 (Sponsor)
$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 10 – 2025

Introduced by: OSMA Young Physician Section

Subject: Physician-Led Health Care Teams

Referred to: Resolutions Committee No. 1

- -

WHEREAS, existing OSMA policy 19-2007 states that “practitioners seeking to expand their scope of practice must have the appropriate experience, training and education to treat patients safely and that the physician should be the leader of the health care team”[1]; and

WHEREAS, current OSMA policy on scope of practice is sparse, though its position can be implied from existing policies topics span across multiple prior policies (including 04-2011 “Evaluation of the Expanding Scope of Pharmacists’ Practice and Interference of Pharmacy Benefit Managers in the Practice of Medicine,” 12-2012 “Pharmacy Scope of Practice,” 12-2014 “Reimbursement Discrimination for Physician Assistants and Nurse Practitioners); and

WHEREAS, legislation addressing inappropriate scope of practice expansion has been introduced, and will likely continue to be introduced in the Statehouse; and

WHEREAS, there is a need for a centralized scope of practice policy that communicates OSMA’s principles on this issue; and therefore be it

RESOLVED, that the Ohio State Medical Association will advocate for, and vigorously defend, healthcare that is physician-led for all patients; and be it further

RESOLVED, that the Ohio State Medical Association opposes advanced practice providers practicing medicine independently without physician supervision; and be it further

RESOLVED, that the Ohio State Medical Association opposes title changes for non-physician practitioners that could be misconstrued by patients as a physician credential; and be it further

RESOLVED, that the Ohio State Medical Association advocates that physician collaborators/supervisors of advanced practice providers be licensed in Ohio and primarily practice in Ohio.

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

References:

1. OSMA Policy 19- 2007 - State Medical Board Oversight

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 11 – 2025

Introduced by: OSMA District 5

Subject: Opposing the Use of Physician Associate

Referred to: Resolutions Committee No. 1

- -

WHEREAS, the educational difference between an physician (MD/DO) and a Physician Assistant is significant; and

WHEREAS, physicians commonly refers to other physicians as associates; and

WHEREAS, patients often have difficulty understanding the difference between physician assistant and physician; and

WHEREAS, physician assistant organizations are taking actions to change their title from physician assistant to physician associate; and

WHEREAS, patients often have difficulty understanding the difference between physician assistant and physician; and

WHEREAS, universities in Ohio are offering Physician Associate degrees as a part of becoming a Physician Assistant; and therefore be it

RESOLVED, that our OSMA work with the State Medical Board to consider Physician Associate a new designation and not recognize any attempts to change physician assistant to physician associate and that the designation of physician associate is misrepresentation of licensure status; and be it further

RESOLVED, that our OSMA work with appropriate organizations to discourage creation of physician associate programs as recognize them as an attempt to change physician assistant to physician associate; and be it further

RESOLVED, that that our OSMA oppose any name change or designation from physician assistant to physician associate; and be it further

RESOLVED, that that our OSMA continue to work to educate the public on the educational difference between physician assistants and physicians (MDs or DOs).

Fiscal Note: $ 50,000 (Sponsor)

$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 12 – 2025

Introduced by: Norman O. Moser, DO

Subject: Regulating Practitioners that Practice Non-Conventional Medicine (Herbalists, Naturalists, Homeopaths, Ayurveda, Asian Herbal Medicine)

Referred to: Resolutions Committee No. 1

WHEREAS, there are many people that practice non-conventional medicine; and

WHEREAS, these practitioners do NOT receive acceptable education; and

WHEREAS, these practitioners tend to lead the patient to believe that they are receiving quality and appropriate health care; and

WHEREAS, these practitioners are NOT required to pass acceptable examinations; and

WHEREAS, these practitioners are NOT regulated by state laws and guidelines

WHEREAS, this may lead to inappropriate treatment of disease, delay in appropriate treatment of disease; both of which could lead to increased disease, morbidity and mortality and therefore increased healthcare costs; and

WHEREAS, this resolution is NOT an attempt to provide legitimacy to practitioners of alternative health care but is an attempt to insure that practitioners of alternative health care “First Do No Harm” and function solely to improve the quality of life and health of patient; and therefore be it

RESOLVED, that the Ohio State Medical Association be part of an effort to create an environment to make sure that herbalists, naturalists, homeopaths, Ayurveda and Asian Herbal medicine receive acceptable education, examination and regulation by the State of Ohio.

Fiscal Note: $ 0 (Sponsor)
$ 500 (Staff)

References:

1. OSMA Policy 14-2012
2. OSMA Policy 31-2021

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 13 – 2025

Introduced by: Medical Student Section

Subject: Mobilizing Healthcare Professionals to Address Police Violence as a Public Health Crisis

Referred to: Resolutions Committee No. 1

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WHEREAS, 1,600,000 American civilians have been treated in hospitals for injuries sustained during contact with law enforcement in the last 20 years[1]; and

WHEREAS, at least 10,276 civilians have been killed by U.S. law enforcement officers in the last 20 years[1-3]; and

WHEREAS, 1,296 people were killed by the U.S. police in 2024, the highest number in the past 10 years[4]; and

WHEREAS, analysis of police killings per 1 million people in Ohio between 2013-2024 reveals that black people are 4.4x more likely to be killed by police than white people in Ohio[5]; and

WHEREAS, analysis of data from 714 police and 88 sheriff's departments in Ohio reveals 285 killings by police from 2013-2021, which is more killings by police per arrest than 55% of states[5]; and

WHEREAS, analysis of data from 714 police and 88 sheriff's departments in Ohio reveals a black person was 4.3x as likely and a LatinX person was 1x as likely to be killed by police as a white person in Ohio from 2013-2021[5]; and

WHEREAS, Ohio has been evidenced to have more unarmed people killed per arrest than 65% of states and more racial disparities in deadly force than 49% of states, per Police Scorecard, an independent 501(c)(3) organization created for nationwide evaluation of policing in the U.S.[5]; and

WHEREAS, in 2023, the Cuyahoga County Prosecutor's Office and Cleveland Division of the FBI indicted more than a third of the East Cleveland, Ohio police department on grounds of public corruption and civil rights violations[6]; and

WHEREAS, in 2021, a study published in *The Lancet* found that the federal National Vital Statistics System for tracking deaths by law enforcement underreports police violence by more than 55% between 1980 – 2018[7]; and

WHEREAS, the *Journal of Urban Health* published an editorial in 2016 titled "Excessive Police Violence as a Public Health Issue" which calls for further data acquisition, analyses, and interventions for mitigation of police violence[8]; and

WHEREAS, the *Journal of Racial and Ethnic Health Disparities* published an article in 2020 titled "Police Brutality and Mistrust in Medical Institutions" reporting that negative encounters with police correlates with increased mistrust in the medical community and worse population health outcomes[9]; and

WHEREAS, in 2017, the *American Journal of Public Health* identified five pathways linking police brutality to poor health outcomes in the African American community – including fatal injuries that increase population-specific mortality rates and adverse physiological responses that increase morbidity[10]; and

WHEREAS, in 2023, the *American Journal of Public Health* reported increased rates of adverse health conditions for people living in heavily policed communities[11]; and

WHEREAS, in 2018, the American Public Health Association passed the policy "Addressing Law Enforcement Violence as a Public Health Issue"[12]; and

WHEREAS, in 2020, the American Medical Association (AMA) president published a statement entitled "Police brutality must stop" that states "AMA policy recognizes that physical or verbal violence between law enforcement officers and the public, particularly among Black and Brown communities where these incidents are more prevalent and pervasive, is a critical determinant of health and supports research into the public health consequences of these violent interactions"[13]; and

WHEREAS, the AMA advocates for "research to be conducted that examines the public health consequences of negative interactions with police, including the impact on civilians and law enforcement professionals" (AMA Policy D-65.987)[14]; and

WHEREAS, the AMA "recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color" (AMA Policy H-65.954)[15]; and

WHEREAS, the OSMA "supports actions that enable accurate reporting and data acquisition to target efforts to address the issue of arrest- and custody-related deaths" (OSMA Policy 24 – 2021 – Acknowledging Death in Custody in the State of Ohio as a Public Health Crisis)[16]; and therefore be it

RESOLVED, that our Ohio State Medical Association recognizes police violence as a determinant of health due to its demonstrated adverse impact on population health and health disparities; and be it further

RESOLVED, that our Ohio State Medical Association supports the development and implementation of protocols for healthcare providers to identify, document, and report suspected cases of police brutality and violence.

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

References:

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https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence.
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16. Acknowledging Death in Custody as a Public Health Crisis. OSMA Policy Compendium. 2021. Accessed January 15, 2024. https://www.osma.org/aws/OSMA/pt/sp/policy-compendium.

Relevant APHA, AMA, and OSMA Policy:

American Public Health Association

Policy Number 201811 - *Addressing Law Enforcement Violence as a Public Health Issue*

"APHA recommends the following actions by federal, state, tribal, and local authorities: (1) eliminate policies and practices that facilitate disproportionate violence against specific populations (including laws criminalizing these populations), (2) institute robust law enforcement accountability measures, (3) increase investment in promoting racial and economic equity to address social determinants of health, (4) implement community-based alternatives to addressing harms and preventing trauma, and (5) work with public health officials to comprehensively document law enforcement contact, violence, and injuries."

American Medical Association

Policy D-65.987 - *Policing Reform*

"Our AMA: (1) will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement; (2) will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death; (3) encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities; and (4) supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. Our AMA advocates for (1) research to be conducted that examines the public health consequences of negative interactions with police, including the impact on civilians and law enforcement professionals; and (2) a change to the U.S. Standard Certificate of Death to include a "check box" that would capture deaths in custody and further

categorize the custodial death using cause and manner of death and information from the "How Injury occurred" section of the death certificate."

Policy H-65.954 - *Policing Reform*

"Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices. Our American Medical Association (1) recognizes the way we police our communities is a social determinant of health; (2) advocates for the reform of qualified immunity and other measures that shield law enforcement officers from consequences of misconduct to further address systemic racism in policing and mitigate use of excessive force; and (3) supports research on the impact upon employed physicians in law enforcement and the potential risk for exacerbating the physician workforce shortage within correctional medicine if qualified immunity was eliminated."

Policy H-15.964 - *Police Chases and Chase-Related Injuries*

"The AMA encourages (1) communities, aided by government officials and medical scientists, to develop and implement guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of **police** pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases."

Ohio State Medical Association

Policy No. 24 – 2021 - *Acknowledging Death in Custody in the State of Ohio as a Public Health Crisis*

"The OSMA supports actions that enable accurate reporting and data acquisition to target efforts to address the issue of arrest- and custody-related deaths."

Emergency Policy No. 01 – 2018 - *Firearms and Public Health*

"1. The OSMA opposes gun violence and supports policy that enforces patient safety. 2. The OSMA lobby for physician immunity from civil and criminal liability, if physicians are required to report potential violent threats by patients. 3. The OSMA encourages firearm safety education. Emergency Policy 01 – 2018 was reaffirmed at the 2019 OSMA House of Delegates."

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 14 – 2025

Introduced by: District 2, Gary Katz, MD, Laurel Barr, MD, Chris Paprzycki, MD, John Corker MD

Subject: Physicians Engaged in Non-Violent Civil Protest

Referred to: Resolutions Committee No. 1

- -

WHEREAS, physicians, as members of society, have historically engaged in peaceful advocacy for public health, justice, and healthcare policy improvements in Ohio and nationally; and

WHEREAS, the First Amendment of the U.S. Constitution guarantees the right to free speech and peaceful assembly, which extends to physicians expressing their concerns on matters affecting patient care, public health, and medical ethics; and

WHEREAS, peaceful protest, including civil disobedience, has been an instrumental method for addressing healthcare-related policies, such as Medicaid expansion, and protecting the physician-patient relationship in Ohio; and

WHEREAS, civil disobedience is defined as a “public, nonviolent, conscientious yet political act contrary to law,” carried out with the aim of bringing about a change in an unjust law (1); and

WHEREAS, law enforcement has used the tactic of “kettling” to corral those engaged in civil disobedience in a manner that does not allow for self-disbursement where threat of escalation exists, and has used other disproportionate forms of state authority against those peaceably assembled (2); and

WHEREAS, law enforcement tactics to these acts have, at times, resulted in arrests of individuals—including physicians—despite their nonviolent conduct; and

WHEREAS, physicians who are arrested for non-violent civil protest may be required to disclose these arrests to state licensure boards, hospital credentialing committees, and insurance payers, which could unfairly impact their professional standing; and

WHEREAS, the Ohio Administrative Code Rule 4731-4-02 outlines the factors considered by the State Medical Board of Ohio when reviewing an applicant’s criminal record, including the nature and seriousness of the offense, the time elapsed, evidence of rehabilitation, and full disclosure of any arrests or convictions. However, this rule does

not explicitly differentiate between arrests related to non-violent civil protest and those involving criminal activity directly relevant to medical competency or ethics; and

WHEREAS, the reporting of non-violent protest-related arrests is typically unrelated to a physician's competency or fitness to practice medicine but may nonetheless result in undue scrutiny or professional repercussions; and

WHEREAS, physicians should not face professional or licensure consequences solely for engaging in nonviolent civil protest that aligns with their professional and ethical obligations to advocate for patient well-being and public health; and therefore be it

RESOLVED, that the OSMA affirms its support for physicians who engage in nonviolent protest and civil disobedience in accordance with their First Amendment rights, provided such actions do not involve violence, fraud, or misconduct related to medical practice; and be it further

RESOLVED, that OSMA advocate to relevant credentialing organizations, the State Medical Board of Ohio, hospital systems, and insurers that nonviolent protest-related arrests of physicians should not be considered relative to their fitness to practice medicine; and be it further

RESOLVED, that OSMA support legislative or regulatory changes to Ohio Administrative Code Rule 4731-4-02 to clarify that nonviolent civil disobedience does not inherently impact a physician's ability to obtain or maintain licensure, provided such actions do not involve violence, fraud, or misconduct related to medical practice.

Fiscal Note: $ 500 (Sponsor)
$ 50,000 (Staff)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 15 – 2025

Introduced by: Medical Student Section

Subject: Support for Diversity, Equity, and Inclusion in Ohio Medical Schools

Referred to: Resolutions Committee No. 1

WHEREAS, according to the Association of American Medical Colleges (AAMC), diversity includes "socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography (including rural and highly rural areas), disability, and age"[1]; and

WHEREAS, equity recognizes the specific circumstances and needs of individuals and groups and provides the resources needed to help them be successful, with the understanding that resources are unevenly distributed at baseline[2]; and

WHEREAS, inclusion provides an environment where everyone has a sense of belonging in medical school and recognizes the various lived experiences of a diversity of patients[2]; and

WHEREAS, although each institution may be unique, initiatives promoting diversity, equity, or inclusion (DEI) collectively represent the efforts of medical schools to help future physicians provide quality care to those from a diversity of backgrounds as well as make medicine and healthcare accessible for all individuals; and[2, 3, 4]; and

WHEREAS, the AAMC affirms that promoting DEI in medical education helps students understand a patient's unique life experiences and provide personalized care[5]; and

WHEREAS, according to the Health Professionals for Diversity Coalition, inclusion of diverse populations in educational and medical training settings improves learning outcomes for medical students by increasing active thinking and intellectual engagement skills in addition to increasing understanding of and empathy for diverse cultures[6]; and

WHEREAS, patient-provider racial/ethnic concordance is associated with increased likelihood of visiting a primary care provider and seeking preventative care, higher patient satisfaction scores, and greater life expectancy, especially for minority patients[7, 8, 9]; and

WHEREAS, initiatives promoting DEI help reduce mental distress and burnout among physicians of all backgrounds[10]; and

WHEREAS, initiatives promoting DEI increase enrollment of students underrepresented in medicine across marginalized communities, which helps create a workforce with more cultural humility that ensures the needs of all patients are met[11]; and

WHEREAS, in March and April 2024, the Embracing anti-Discrimination, Unbiased Curricular, and Advancing Truth in Education (EDUCATE) Act was introduced in Congress, which sought to cut federal funding for U.S. medical schools with DEI programs, prompting opposition from various medical associations such as the AMA, AAMC, ACP, ACOG, AAEM, SAEM, and CHEST, among others[12, 13, 14, 15, 16, 17, 18, 19]; and

WHEREAS, as of December 2024, 15 states have laws focused on restricting or banning DEI efforts in higher education, including medical education[20, 21, 22]; and

WHEREAS, Ohio S.B. 83, known as the Enact Ohio Higher Education Enhancement Act, was originally introduced in 2023 and sought to ban mandatory DEI training unless required to comply with state and federal law, professional licensure requirements, or receiving accreditation or grants before it died in session at the end of 2024[23]; and therefore be it

RESOLVED, that our OSMA recognizes the integral role diversity, equity, and inclusion (DEI) play in developing culturally competent physicians and protecting the health of our patients; and be it further

RESOLVED, that our OSMA oppose any effort to ban diversity, equity, or inclusion (DEI) in Ohio medical schools, especially any efforts to restrict state or federal funding for these schools based upon their promotion of DEI.

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

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RELEVANT OSMA POLICY

Policy 35-2021 – Integrating Anti-Racism Training in Medical School and graduate medical education curricula and admissions

1. The OSMA recognizes the benefit of anti-racism training in medical school and graduate medical education program curricula and admissions processes in increasing diversity of the medical field.
2. The OSMA recommends all Ohio medical schools and graduate medical education programs utilize credible resources to implement recurrent, interactive (in-person or virtual) anti-racism training for medical students and graduate medical trainees and for all admission/selection committee members.

Policy 36-2021 – LGBTQ Health and Medical Education in Ohio

1. The OSMA recognizes the unique health care needs of our LGBTQ patients, and encourages LGBTQ-specific health education in both medical school and graduate medical education curricula.

Policy 05 – 2019 – Advancing Gender Equity in Medicine

1. The OSMA adopts the following, which is adapted from American Medical Association policy/directives:
    a. That the OSMA supports gender and pay equity in medicine consistent with the American Medical Association Principles for Advancing Gender Equity in Medicine (see below AMA Policy H-65.961 as adopted at the 2019 AMA Annual Meeting);
    b. That the OSMA: (a) Promote institutional, departmental, and practice policies, consistent with federal and Ohio law, that offer transparent criteria for initial and subsequent physician compensation; (b) Continue to advocate for pay structures based on objective, gender-neutral criteria; (c) Encourages training to identify and mitigate implicit bias in compensation decision making for those in positions to determine physician salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement;
    c. That the OSMA recommends as immediate actions to reduce gender bias

to: (a) Inform physicians about their rights under the Lilly Ledbetter Fair Pay Act, which restores protection against pay discrimination; (b) Promote educational programs to help empower physicians of all genders to negotiate equitable compensation; and (c) Work with relevant stakeholders to advance women in medicine;

d. That the OSMA collaborate with the American Medical Association initiatives to advance gender and pay equity;
e. That the OSMA commit to the principles of pay equity across the organization and take steps aligned with this commitment.

Policy 06 – 2019 – Increase Awareness of Disparities in Medical Access and Treatment in Ohio

1. The OSMA shall work with appropriate stakeholders to increase awareness of Ohio physicians, residents, and medical students of disparities in medical access and treatment in Ohio based on disability, race, ethnicity, geography, and other social and demographic factors through the utilization of existing resources.

RELEVANT AMA AND AMA-MSS POLICY

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
3. Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.
4. Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
5. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
6. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.
7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
8. Our AMA will recognize the disproportionate efforts by and additional

responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.

9. Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

Model Legislation to Protect the Future of Medicine D-295.301

Our American Medical Association will create model state legislation to protect the ability of medical schools and residency/fellowship training programs to have diversity, equity, and inclusion (DEI) and related initiatives for their students, employees, and faculty to ensure the education and implementation of optimized healthcare.

Racial and Ethnic Disparities in Health Care H-350.974

1. Our American Medical Association recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. Our AMA emphasizes three approaches that it believes should be given high priority:
    1. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
    2. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
    3. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote

the consistency and equity of care for all persons.

4. Our AMA
    1. actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs.
    2. will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers.
    3. supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 16 – 2025

Introduced by: OSMA Young Physician Section, Delia Sosa, Carson Hartlage, Harsimran Makkad, Amber Jean Prater

Subject: Gender-Identification on State Government IDs

Referred to: Resolutions Committee No. 1

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WHEREAS, gender identity and sex assigned at birth are two separate entities and conflating the two erases both transgender and intersex individuals; and

WHEREAS, twenty-two percent of respondents in the 2022 U.S. Transgender Survey reported experiencing verbal harassment, assault, being asked to leave a location, or being denied services after presenting an ID with a name or gender that did not align with their appearance[1]; and

WHEREAS, the ability to obtain aligned identity documents has been associated with improved mental health outcomes such as decreased psychological distress and suicide planning for transgender individuals[2]; and

WHEREAS, driver's licenses are governed statewide by the Bureau of Motor Vehicles, while birth certificates are governed on a county level BMV; and

WHEREAS, in Ohio, changing one's gender identity on a state-issued identification cards requires a signed affidavit from a healthcare provider that "certifies the gender identity of the applicant,"[3]; and

WHEREAS, ambiguity of Ohio law on birth certificate changes and a recent Ohio Supreme Court decision together have left the power to change gender on one's birth certificate to county probate courts, resulting in a majority of counties not processing any gender marker changes[4,5]; and

WHEREAS, some Ohio county probate courts require medical documentation or notarized affidavits from friends and family members for gender marker changes on birth certificates, while others allow self-identification[5]; and

WHEREAS, 21 states do not require health care provider certification for gender marker changes on driver's licenses, and 14 states do not require provider documentation of "appropriate treatment" for gender marker changes on birth certificates[6]; and

WHEREAS, gender identity, transgender people, and intersex people continue to be threatened in the State of Ohio; and

WHEREAS, our OSMA supports the protection of Lesbian, Gay, Transgender, Queer, Intersex, Asexual (LGBTQIA+) individuals from discriminating practices and harassment (Policy 22-2016) in addition to providing individualized, gender-affirming treatment and care (Policy 15-2020); and

WHEREAS, the AMA supports an individual's right to determine their gender identity on government documents and supports policies that allow for a gender change on said documents (H-65.967); and therefore be it

RESOLVED, that the Ohio State Medical Association supports every individual's right to determine their gender identity and sex designation on state-issued government documents including driver's licenses; and be it further

RESOLVED, that the Ohio State Medical Association supports policies that allow for a sex designation or change of designation on all state-issued government documentation to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional; and be it further

RESOLVED, that the Ohio State Medical Association supports policies that include an undesignated or nonbinary gender option for state government records and forms of state government-issued identification.

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

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Relevant AMA Policy

Conforming Sex and Gender Designation on Government IDs and Other Documents H-65.967

1. Our American Medical Association supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.

2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.
5. Our AMA will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 17 – 2025

Introduced by: Johannes Olsen, MD, Joeseph Hellman, MD, Elizabeth McIntosh, MD, Philip Roholt, MD

Subject: Gender Dysphoria

Referred to: Resolutions Committee No. 1

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WHEREAS, Gender Dysphoria is a culturally complex condition in which a person feels incongruent with their biological birth sex causing extreme psychological stress (1); and

WHEREAS, The American Psychological Association writing as recently as July 2024 differentiated the words Sex and Gender as:

> Sex is assigned at birth, refers to one's biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy. Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men and girls and women. These influence the ways that people act, interact, and feel about themselves. While aspects of biological sex are similar across different cultures, aspects of gender may differ. (2); and

WHEREAS, these distinctly different meanings have been with us since antiquity, the word Gender has increasingly appeared in the medical literature employed as a synonym for Sex including in Harrison's Textbook of Internal Medicine (3) (4) (5) (6); and

WHEREAS, conflating the word Sex which is physical, immutable, and anchored in biology with Gender which is culturally and socially determined and mutable, perhaps even fluid, has resulted in conflating the concepts that the words engender, giving rise to the idea that a person uncomfortable with the expectations of culture and society can be in the 'wrong body", a condition known as Gender Dysphoria, and furthermore that the body can be changed to conform to internal feelings that conflict with cultural expectations (7) (8); and

WHEREAS, this has given rise to "Gender Affirming Care" which is promoted as a lifesaving treatment involving medical transition such as taking puberty blocking drugs or cross-sex hormones and sometimes undergoing surgery to alter sex characteristics; and

WHEREAS, there is not a single long-term study to demonstrate the safety and efficacy of puberty blockers, cross-sex hormones, and surgery for restoring wellbeing in transgender believing youth. To paraphrase Hillary Cass, the former president of the Royal College of Pediatric and Child Health Services in England and author of the Cass Review, the scientific foundations for gender affirming care rest on “shaky ground” (9) (10) (11) (12); and

WHEREAS, gender incongruence is neither innate nor immutable and 61-98% of incongruent identities have been documented to align with their biological sex across their lifespan, and usually by late adolescence, including with or without counseling (15) (16) (17) (18) (19); and

WHEREAS, 43-75% of incongruent youth have a significant and untreated mental illness that pre-dated their symptoms of gender incongruence, and many supposed gender non-conforming teens may confuse their anxiety disorders, eating disorders, autism spectrum disorders, mood disorders or childhood trauma with gender dysphoria (20) (21) (22) (23); and

WHEREAS the use of puberty blockers to suppress normally timed puberty is dangerous to youth as evidence points to such interventions being associated with mental illness and other serious health consequences, and over 90% of adolescents on blockers will go on to use cross-sex hormones (24) (25) (26) (27); and

WHEREAS, the package-insert for Lupron, the number one prescribed puberty blocker in America lists “emotional instability” as a side effect and warns prescribers to “monitor for development or worsening of psychiatric symptoms during treatment”; and

WHEREAS, temporary use of Lupron has been associated with and may be the cause of many serious permanent side effects including osteoporosis, mood disorders, seizures, cognitive impairment, voice change, and when combined with cross-sex hormones, sterility. In addition to the Lupron harm, cross-sex hormones bring youth increased risk of heart attacks, stroke, diabetes, blood clots and cancers across their lifespan (27) (28) (29) (30) (31) (32) (33) (51) (57); and

WHEREAS, “gender affirming care” in youth frequently fails to achieve the goal of improving the life of the recipient, and the incidence of suicide is much higher in recipients of “gender affirming care” than in the non-treated transgender population (8) (10) (11) (15) (31) (34) (36); and

WHEREAS, currently, girls as young as age 13 are receiving double mastectomies, and boys as young as 16 years of age are receiving breast implants and are being surgically castrated, undergoing penectomies and having pelvic wounds created to simulate female vaginas. No parent or guardian has any right to allow such mutilation (52) (53) (54) (58) (59) (60); and

WHEREAS, OSMA has already adopted Policy 07-2019 Female Genital Mutilation Ban which condemns the practice of female genital mutilation as defined by the World Health Organization and considers female genital mutilation a form of child abuse; and

WHEREAS, youth transition can be considered experimental, bringing into question the ability of and the right of parents or guardians to provide informed consent, the propriety of providers to request and obtain informed consent, and of minors to assent to such medical or surgical treatments (13) (14) (49); and

WHEREAS, many European nations have called a halt on gender affirming care in minors including Norway, Sweden, Finland, Belgium, the Netherlands, France and the United Kingdom (UK) unless in rigidly controlled circumstances such as in England, where treatment is part of a carefully crafted controlled multicenter study including thorough pre- and long term post-psychological evaluation and follow-up, designed to determine the harms vs benefits of such treatments (10) (37 (38) (39); and

WHEREAS, there is appearing on the horizon some potential legal jeopardy for parents, guardians, providers and institutions from plaintiffs who feel that as transgender individuals their lives were permanently and cruelly altered in the name of "gender affirming care". Organizations espousing such treatments could potentially also become targets of imaginative attorneys (40) (41) (42); and

WHEREAS, the most truthful and compassionate approach toward children and adolescents questioning their gender is to allow them to be themselves without undue attention and pressure related to culturally determined gender roles, while providing adequate psychological care addressing mental and emotional health concerns; and therefore

BE IT RESOLVED, that our OSMA rescind its prior policies 05-2023 & 15-2020 which support gender-altering treatments; and be it further

RESOLVED, that OSMA recommend to the AMA that the United States join with the nations of England, Scotland, Finland, Norway, Sweden, The Netherlands, Belgium, and France in calling a halt to all gender altering treatments in minors unless administered in rigidly controlled circumstances such as part of a tightly controlled long term study; and be it further

RESOLVED, that OSMA recommend to any interested parties that a retrospective study be instituted for long-term follow up evaluation of all minors who have been subject to gender altering interventions; and be it further

RESOVLED, that OSMA report to the Governor and the leaders of the Ohio House and Senate that OSMA supports the recent gender legislation (HB 68) that was passed into law; and be it further

RESOLVED, that the term “gender affirmation” be replaced with “gender alteration” in all discussions regarding the attempt at changing a person’s sex to fit socially constructed roles; be it further

RESOLVED, that our OSMA adopt as a standard policy recommendation that people struggling with gender dysphoria be allowed to develop free of external pressures while having mental, emotional, and spiritual support services that help them through their unique individual process of understanding who they are.

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

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 18 – 2025

Introduced by: Medical Student Section

Subject: Support for Statewide Tracking of and Control Mechanisms for Health Care Expenditure Growth that Promote Primary Care

Referred to: Resolutions Committee No. 1

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WHEREAS, the United States spent at minimum $4,506 per capita more than other developed nations in 2022 on healthcare, yet lags behind in key health outcomes such as life expectancy, infant mortality, and maternal mortality[1]; and

WHEREAS, as a state, Ohio has one of the highest spending rates per capita, ranking 34 of 50 from lowest spending to highest spending, yet remains in the bottom quartile (43 of 50) for population health, which takes into account, health behaviors, chronic disease, life expectancy, and infant mortality[2]; and

WHEREAS, by type of service, most US healthcare dollars (30%) are spent on hospital services, suggesting an emphasis on chronic disease treatment and management with less focus on preventative services; broken down by type of spending, 30% of dollars are spent on administrative costs, suggesting inefficiencies in healthcare spending and delivery[3-4]; and

WHEREAS, the high cost of health care in the US and in Ohio has many implications including but not limited to delays in care, foregoing care, and increased medical debt, all of which disproportionately impact persons of color and low income families and further exacerbate social determinants of health[5-8]; and

WHEREAS, tracking healthcare spending can provide insight to where overinflated health costs are most prominent, as Ohioans have had a dramatic increase in personal Health Expenditures in the past two decades, with an average of spending of $2,669/person/year in 1991 to $10,478/person/year in 2020 with an average increase in personal spending of 4.8% per year[9]; and

WHEREAS, primary care represents over half of patient visits in the U.S. but accounts for less than 6% of healthcare spending and only 0.4% of NIH research funding, despite its critical role in improving outcomes[10-15]; and

WHEREAS, states such as California and Oregon, have used their tracking of healthcare spending to improve primary care and behavioral health spending and adopt alternative payment models that reward quality outcomes[16-17]; and

WHEREAS, Rhode Island's 2010 affordability standards imposed price controls by implementing inflation caps and diagnosis-based payments on contracts between commercial insurers and hospitals and clinics and required commercial insurers to increase their spending on primary care and care coordination services, which decreased quarterly fee-for-service spending by $76 per enrollee, or a decrease of 8.1%, without changing quality measures between 2007-2016[18]; and

WHEREAS, Rhode Island now requires insurers to invest at least 10.7% of their total medical expenses in primary care[19]; and

WHEREAS, Delaware has a similar target of 11.5% of spending into primary care by 2025 while mandating insurers reimburse at least at Medicare rates[20]; and

WHEREAS, Colorado require insurers increase their primary care investment by 2% from 2021-2023 while prohibiting insurers from raising their premiums to offset the cost[21]; and

WHEREAS, OSMA has policies which necessitate knowing healthcare spending dollars, aim to make healthcare more affordable [Policy 18-2016, 18-2019, 18-2021, 20-2022, 27-2023, 6-2023], and promote primary care [Policy 30-1994, 8-2013]; and

WHEREAS, AMA policies advocate for expanding Medicaid eligibility and enhancing premium tax credits to cover uninsured populations, thereby addressing the affordability and accessibility gaps in the current healthcare system [Policy H-165.824]; and therefore be it

RESOLVED, that our OSMA advocates for statewide tracking of healthcare expenses and establish a maximum growth rate for total healthcare costs to curb rising expenses; and be it further

RESOLVED, that our OSMA advocate for inflation caps and diagnosis-based payments in contracts between insurers and providers to manage healthcare costs; and; and be it further

RESOLVED, that our OSMA advocates for state targets for commercial insurers to increase their total health expenses percentage in primary care and care coordination as a strategy to control healthcare spending.

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

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RELEVANT OSMA POLICY

Policy 18 – 2016 – Site of Service Charges

1. The OSMA requests that the American Medical Association continue to address the current inequity of "site of service" charges being used by hospitals and Medicare.

Policy 18 – 2019 – Practice Overhead Expense and the Site-of-Service Differential

1. The OSMA will appeal to the Ohio congressional delegation for legislation to direct CMS to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office.
2. The OSMA will appeal to the Ohio congressional delegation for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that

can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense.

3. The OSMA will appeal to the Ohio congressional delegation for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
4. This policy on practice overhead expense and site-of-service differential be forwarded to our AMA for consideration at the Annual HOD Meeting in June 2019.

Policy 18 – 2021 – Differential Payment

1. The OSMA reaffirms existing policies 18-2016, site of service charges, and 18-2019, practice overhead expense and the site-of-service differential.

Policy 20 – 2022 – Appropriate Physician Reimbursement to Cover Rising Expenses of Office Practice

1. The Ohio State Medical Association (OSMA) advocates that physician reimbursement for all activities be increased to cover the expenses of running an office practice.
2. The OSMA will work with our Ohio State Legislature and Ohio Congressional delegation to improve physician reimbursement.
3. The OSMA Delegation to the American Medical Association (AMA) shall take this resolution regarding improved physician reimbursement to the AMA House of Delegates for action.

Policy 27 – 2023 -- Decrease Costs for Ohio Patients with Diabetes with Commercial Insurance

1. The OSMA will: (1) encourage the Ohio Department of Insurance to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state efforts to limit the ultimate expenses incurred by commercially insured patients for prescribed insulin and diabetic equipment and supplies.

Policy 6 – 2023 -- Increased Access to Health Care

1. The OSMA continues to express its support for increased access to comprehensive, affordable, high-quality health care.
2. The OSMA rescinds current Policy 11 – 2010 – Promoting Free Market-Based Solutions to Health Care Reform.

Policy 30 – 1994 – Increase in Number of Primary Care Physicians

1. The OSMA supports positive incentives such as shifting of more subsidies to primary care medical education programs, increasing reimbursement levels, tax

abatements and loan repayment programs to attract greater numbers of primary care and rural physicians.

2. The OSMA discourages the enactment of restrictive measures such as licensure limitations, quotas in medical education programs, or compulsory measures which are intended to influence the numbers of primary care physicians in Ohio.

Policy 08 – 2013 – Support for More Primary Care Physicians

1. The OSMA shall take steps to increase the number of medical students and residents going into primary care by calling for an increase in the number of residency positions in primary care.

RELEVANT AMA POLICY

Policy H-165.824: Improving Affordability in the Health Insurance Exchanges

1. Our American Medical Association will:
    a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
    b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
    c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
    d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
    a. eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
    b. increasing the generosity of premium tax credits.
    c. expanding eligibility for cost-sharing reductions.
    d. increasing the size of cost-sharing reductions.

Policy H-165.888: Evaluating Health System Reform Proposals

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
    a. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
    b. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
    c. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform

proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

d. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

e. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

f. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

g. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

h. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 19 – 2025

Introduced by: Medical Student Section

Subject: Mental Health Disclosures Policy for Medical Applicants

Referred to: Resolutions Committee No. 1

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WHEREAS, medical students and trainees often face a double standard throughout their education in which discussions of vulnerability are contrasted with the expectation of perfection; they are simultaneously taught to suppress their emotions, both explicitly and implicitly[1]; and

WHEREAS, a 2017 survey from the Mayo Clinic found that approximately 40% of physicians would be reluctant to seek formal medical care for mental health treatment due to concerns of repercussions in terms of their medical license[2]; and

WHEREAS, medical students with pre-existing psychological distress have been shown to have more concerns about stigma and perceived consequences of their mental health conditions being revealed to others[3 4]; and

WHEREAS, a study revealed that about 50.3% of medical students believe that residency program directors may react negatively to their applications if aware of their mental health issues[4]; and

WHEREAS, medical students concerned about possible stigma and/or discrimination are less likely to seek help for their mental health issues[5]; and

WHEREAS, a study of female physicians found that about 50% believed they met the criteria for a psychiatric illness at some point but had chosen to not seek treatment for various reasons, including the belief that they could handle it themselves, feelings of embarrassment or shame, and fear of medical licensing repercussions[4]; and

WHEREAS, self-disclosure may become more challenging over time due to the internalization of negative beliefs about mental health issues[1]; and

WHEREAS, residents' utilization of psychotherapy may significantly increase after switching from an opt-in to an opt-out model of mental health services[6]; and

WHEREAS, a 2020 study on the effects of disclosure of major depressive disorder (MDD) during residency applications on likelihood of interview invites and ranking results found that candidates with disclosed MDD were at a disadvantage to other applicants that

were otherwise equal, namely applicants who disclosed a history of depression had increased odds of being in a lower category of receiving an interview (OR = 3.60, p < .001 for a "perfect" applicant, OR = 2.39, p < .001 for a "good" applicant with leave of absence) and a lower match ranking (OR = 1.94, p = .01 for a perfect applicant, OR = 2.30, p < .001 for a good applicant with leave of absence) compared with the candidate who disclosed a history of diabetes[7]; and

WHEREAS, in alignment with 2023 policy from the AMA, some state medical boards have recently modified their licensure questions to be less intrusive and more focused on *current impairment* due to mental health conditions[7, 8]; and therefore be it

RESOLVED, that the OSMA encourages Ohio medical schools to provide education to medical students on the process of mental health disclosures in residency applications.

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

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8. Access to Confidential Health Services for Medical Students and Physicians H-295.858, Part 2, 2023 AMA.

Relevant AMA and OSMA Policy:

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our American Medical Association will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
    a. provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that:
        i. include appropriate follow-up;
        ii. are outside the trainees' grading and evaluation pathways; and
        iii. are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
    b. ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
    c. encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
    d. remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. *Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.*

3. Our AMA encourages undergraduate and graduate medical education programs to create mental health substance use awareness and suicide prevention screening programs that would:
    a. be available to all medical students, residents, and fellows on an opt-out basis;
    b. ensure anonymity, confidentiality, and protection from administrative action;
    c. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
    d. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA:
    a. encourages state medical boards to consider physical and mental conditions similarly;
    b. encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and
    c. encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA:
    a. encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide;
    b. encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and
    c. will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as:
    a. introduction to the concepts of physician impairment at orientation;
    b. ongoing support groups, consisting of students and house staff in various stages of their education;
    c. journal clubs;
    d. fraternities;
    e. support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or
    f. the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970

Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 20 – 2025

Introduced by: OSMA Resident and Fellows Section

Subject: Mandating Child-Proof Packaging on Marijuana Products Sold Legally in the State of Ohio

Referred to: Resolutions Committee No. 1

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WHEREAS, HB 523 (2016)[1] was approved by legislature, signed by governor 6/8/16 with Issue 2 enacted by voters Nov. 7, 2023, making Ohio the 24th state to legalize adult use of non-medical cannabis [2]; and

WHEREAS, literature shows that marijuana consumption in pediatric patients acutely lead to central nervous system depression, ocular exam abnormalities, ataxia, seizures, vomiting, fever, dehydration, cardiac effects, and changes in respiration and oxygenation with severe cases causing coma, respiratory depression, and requiring intubation with resolution of symptoms ranging from hours to days[3-6]; and

WHEREAS, states with legalized recreational marijuana have seen an increase in regional poison control center reports of pediatric marijuana exposure and pediatric marijuana-related visits to emergency departments, urgent care centers, and hospital inpatient units[7-8]; and

WHEREAS, edible marijuana products are sold as brownies, cookies and candies, which are palatable to children and the prevalence of unintentional edible cannabis exposures are increasing more than non-edible cannabis exposures especially in children under five years old with literature showing adult preference for edible marijuana gummies[9-10] ; and

WHEREAS, the National Poison Data System confirms 7043 pediatric exposures to edible cannabis products in children <6 years old and a 1375% increase in pediatric exposures from 2017 to 2021[10]; and

WHEREAS, the most common site of exposure was a residential setting, 6842 cases (97.1%), with 6391 (90.7%) occurring in the child's own residence[10]; and

WHEREAS, pediatric patients are often unable to confirm marijuana ingestion, and the non-specific effects of THC delay toxicology screening and these patients often endure costly, non-productive testing and interventions such as computerized tomography scans, lumbar punctures, and administration of prophylactic antibiotics and naloxone[6]

RESOLVED, our Ohio State Medical Association advocate for legislation or regulation mandating all cannabinoid products sold legally by licensed marijuana dispensaries in the State of Ohio be sold to consumers in child-resistant packaging; and be it further

RESOLVED, and be it further resolved that our Ohio State Medical Association advocate for a database of cannabinoid positive screenings in children under age 18 be established in the state of Ohio to establish trends in marijuana use and accidental ingestion.

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

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 21 – 2025

Introduced by: Medical Student Section

Subject: Marijuana Guidelines Following Ohio Legalization

Referred to: Resolutions Committee No. 1

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WHEREAS, as of November 2023, Ohioans voted to ratify Issue 2 with a 56.79% majority vote[1]. The law "To Commercialize, Regulate, Legalize, and Tax the Adult Use of Cannabis" went into effect December 7, 2023, legalizing marijuana in the state of Ohio[2]; and

WHEREAS, the State of Ohio has legalized the use of adult-use cannabis, officially defined as marijuana under Chapter 3780 of the Ohio Revised Code, which specifies that "adult use cannabis" or "marijuana" refers to marijuana as defined in section 3719.01 of the Revised Code. The legal framework permits the controlled and regulated sales and consumption of cannabis for individuals aged 21 and older, aiming to reduce illegal sales and promote social equity; and

WHEREAS, black market marijuana sales may continue to flourish even in states that have legalized marijuana, which leads to marijuana consumption still being unregulated and possibly exposing citizens to marijuana laced with other substances[3,4]; and

WHEREAS, cannabis products have been found to have additional allergens and possibly harmful contents. Within the legal market, there have been inconsistencies in labeling. Enforcement of publishing contents of cannabis, such as amounts of CBD, THC, and other additive ingredients such as pesticides, yeast, molds, and heavy metals is important for autonomous consumer health[5,6,7]; and

WHEREAS, the DSM-5 officially recognizes cannabis use disorder as "as a pattern of use that leads to clinically significant impairment or distress" and heavy cannabis use leads to cannabinoid hyperemesis syndrome, which often requires medical intervention[8].

WHEREAS, studies have indicated that cannabis use disorder is correlated to other serious conditions, such as cancer[9] and permanent lung damage[10]; and

WHEREAS, marijuana usage in youth can lead to decreased gray-matter in the brain, which manifests as decreased cognition and anxiety. Additionally, children exposed to marijuana have double the risk of developing schizophrenia and/or psychosis in adulthood[11]; and

WHEREAS, marijuana usage has increased significantly in youth populations, and the development of schizophrenia and psychosis in adolescence is more likely given that the risk also is dependent on the dosage consumed[11]; and

WHEREAS, usage of cannabis by pregnant and breast-feeding women increases the risk of the fetus and newborn developing neuropsychiatric conditions, predominantly those related to the limbic system, later on in life[12]; and

WHEREAS, a recent study found that pharmacy students in Ohio did not feel adequately prepared to counsel their patients on the usage of medical marijuana, especially due to the lack of a solid structured curriculum within current medical education on the subject[13]; and therefore be it

RESOLVED, That our OSMA amend Policy 07 - 2016 by addition and deletion:

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).
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. The OSMA will support urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
9. The OSMA supports state initiatives to regulate recreational and medicinal marijuana effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth.

10. The OSMA encourages local and state public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder.
11. The OSMA will support stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among people who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.

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

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Relevant OSMA Policy:

Policy 07 – 2016 – Cannabinoids

1. The OSMA opposes recreational use of cannabis.
2. The OSMA supports limiting cannabinoids prescribing rights, if permitted, to physicians (MDs and DOs).
3. 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.

Policy 31 – 2024 -- Encourage Cannabis Counseling and Harm Reduction

1. OSMA encourages physicians to be informed regarding risks, benefits, and harm reduction techniques related to cannabis use.

Relevant AMA Policy:

Cannabis and Cannabinoid Research H-95.952

1. Our American Medical Association calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include:

a. disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation;
b. sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes;

c. confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.

4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.

5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.

6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.

Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 22 – 2025

Introduced by: Medical Student Section

Subject: Support for Education on Intimate Partner Violence Screening with Medical Students, Residents, and Physicians

Referred to: Resolutions Committee No. 1

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WHEREAS, the United Nations defines *intimate partner violence (IPV)* as "a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner," including but not limited to physical, sexual, and emotional abuse[1]; and

WHEREAS, the National Intimate Partner and Sexual Violence Survey, conducted by the U.S. Centers for Disease Control and Prevention, revealed in a 2016/2017 report that 47.3% women and 44.2% men in the United States have experienced sexual violence, physical violence, and/or stalking victimization by an intimate partner at least once in their life[2]; and

WHEREAS, intimate partner violence can cause long-term mental health effects, such as post-traumatic stress disorder, in victims and victims' families, and lower self-esteem in children who experience or are present during intimate partner violence[3]; and

WHEREAS, from July 2023 to July 2024, there were 114 deaths from 85 cases of intimate partner violence in Ohio[4]; and,

WHEREAS, the Ohio Bureau of Criminal Identification and Investigation reported over 32,000 domestic violence incidents where charges were filed[5]; and

WHEREAS, in 2013, the U.S. Preventive Services Task Force (USPSTF) began recommending routine IPV screening in women of reproductive and childbearing age to decrease abuse and harm to patients[6,7]; and

WHEREAS, the American College of Obstetrics and Gynecology support screening for IPV and provide educational materials to patients to normalize conversations around IPV and domestic violence[8]; and

WHEREAS, IPV routine screening should be inclusive and extend to men and individuals in the LGBTQ+ community; and

WHEREAS, a systematic literature review of 59 studies found that 11% of screened patients indicated they were experiencing intimate partner violence (IPV), with 32% of patients receiving a referral to follow-up organizations[9]; and

WHEREAS, routine screening for IPV ranges from 3% to 10%, despite the fact that counseling has been shown to reduce stigma around conversations about IPV and IPV victimization[10]; and

WHEREAS, providers often acknowledge the importance of intimate partner violence screening, yet routine screening rates by providers remain low[11]; and

WHEREAS, screening for IPV can connect victims of IPV to resources like housing and child care, empower them and promote self-efficacy, and improve their well-being and safety[12]; and

WHEREAS, current AMA Policy H-515.965 acknowledges family and intimate partner violence to be major public health issues and believes that all physicians should be trained to identify situations of domestic violence and help patients in safety planning[13]; therefore be it

RESOLVED, that our OSMA supports comprehensive training on intimate partner violence screening for medical students, residents, and physicians in Ohio.

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

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13. AMA Policy H-515.965: Family and Intimate Partner Violence. American Medical Association.

Relevant OSMA Policy

Policy 24– 2023 -- Coverage of Restorative Care for Survivors of Domestic Abuse or Intimate Partner Violence 1. The OSMA urges all payers to consider any reconstructive medical and dental treatments for physical injury sustained from or directly related to domestic and intimate partner violence as restorative treatments. 2. The OSMA will work with relevant stakeholders such as the American Medical Association and the Centers for Medicare and Medicaid Service to encourage payers to cover costs associated with reconstructive treatments for physical injury sustained from abuse for survivors of domestic and/or intimate partner violence or abuse. 3. The OSMA supports legislation by the Ohio General Assembly to require all third-party payers, including Medicaid MCOs, to reimburse reconstructive services provided for treatment of physical injury in addition to the medically-necessary restorative care provided to victims of domestic and intimate partner abuse.

Relevant AMA Policy

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under

the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.
(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982 (Our American Medical Association will work with

members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected.)

Education of Medical Students and Residents about Domestic Violence Screening H-295.912 (Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.)

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 23 – 2025

Introduced by: Albert L Hsu, MD

Subject: Registry for Potential Side Effects of GIP & GLP-1 Medications

Referred to: Resolutions Committee No. 1

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WHEREAS, gastric inhibitory polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) medications continue to be heavily advertised and touted as some kind of miracle drug for weight loss—besides their main indication as treatment for diabetes, there are limited studies on the potential side-effects—especially those involving the senior (65 years and older) population, such as muscle loss and bone density loss; and

WHEREAS, the costs of these medications continue to be high and they can potentially cost the healthcare system a lot of money over the long run; and

WHEREAS, there are no clear guidelines of how long patients should be taking these medications, which are meant to be long-term and potentially life-long weight management medications, and whether the weight loss will be maintained if patients ever want to come off them; and

WHEREAS, there are no long-term studies of the potential side effects of these medications while many side effects have been seen; and

WHEREAS, there are no current recommendations to better safeguard patients taking these medications and patients are not required to be monitored by qualified health professionals, such as obesity specialists, endocrinologists, or gastroenterologists, while taking these medications; and

WHEREAS, there is no data to support using GLP-1 receptor agonists during pregnancy; and therefore be it

RESOLVED, that our AMA support and call for a registry of GIP and GLP-1 receptor agonists' side effects, as well as potential impacts on pregnancy (Directive to Take Action).

Fiscal Note: $500+ (Sponsor)
$ $25,000- $500,000 (Staff)

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OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 24 – 2025

Introduced by: OSMA Organized Medical Staff Section

Subject: Streamlining Annual Compliance Training for Physicians

Referred to: Resolutions Committee No. 1

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WHEREAS, the Ohio State Medical Association (OSMA) recognizes the critical importance of compliance training in maintaining high standards of patient care and professional conduct; and

WHEREAS, physicians in Ohio are currently required to complete multiple, often redundant, annual compliance trainings across various healthcare facilities, leading to an undue burden on their time and resources; and

WHEREAS, the current system of annual compliance training often results in physicians spending an average of 8-12 hours annually on repetitive training sessions, time that could be better spent on patient care; and

WHEREAS, the lack of a standardized, centralized system for compliance training contributes to inefficiencies and unnecessary duplication of efforts; and

WHEREAS, the financial burden of these trainings, both in terms of physician time and administrative costs, is significant and often uncompensated; and therefore be it

RESOLVED, that our Ohio State Medical Association collaborate with the Ohio Hospital Association to develop a standardized, centralized system for annual compliance training that reduces redundancy and respects physicians 'time; and be it further

RESOLVED, that our OSMA advocate for the creation of a state-wide reciprocity program that allows physicians to receive credit for compliance training completed at one healthcare entity towards the requirements of others, provided the training meets specific standards; and be it further

RESOLVED, that our OSMA work with relevant stakeholders to explore options for fair compensation or continuing medical education (CME) credits for time spent on mandatory compliance training; and be it further

RESOLVED, that our OSMA Delegation to the American Medical Association (AMA) present this issue to the AMA House of Delegates, seeking national support and action on streamlining compliance training requirements for physicians.

Fiscal Note: $ 10,000 (Sponsor)
$ $25,000- $500,000 (Staff)

References:

1. OSMA Policy Compendium, 2024 Edition
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3. Ohio Hospital Association Annual Report, 2024

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 25 – 2025

Introduced by: OSMA District 6

Subject: Support Physician Owned Hospitals

Referred to: Resolutions Committee No. 1

WHEREAS, the Affordable Care Act Section 6001 severely restricts physician owned hospitals from expanding capacity and limits physician ownership percentage while other health care entities and other health care professionals do not have similar ownership restrictions; and

WHEREAS, physician leadership within their own profession and area of expertise have been suppressed with unknown degrees of effect upon physician fiscal health, physician retirement, physician burnout and suicide, physician turnover within hospitals, patient continuity of care, and physician's empowerment to advocate for the health and well-being of their patients; and

WHEREAS, our market-based healthcare system has high and rising prices, poor pricing practices, and less than ideal quality of care which is in part the result of ever increasing consolidation in hospital markets (1); and

WHEREAS, consolidation has consequences of higher spending while care quality is no better and sometimes lower (2); and

WHEREAS, increased levels of hospital market concentration are shown to increase healthcare costs (3) ; and

WHEREAS, prices at monopoly hospitals are 12% higher than markets with 4 or more rivals (4); and

WHEREAS, same market hospital mergers led to an average 2.6% price increase while hospital spending increased and wages decreased (5); and

WHEREAS, competition, not consolidation, has been proven an effective method to save lives without cost increase (6); and

WHEREAS, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers." (7) and

WHEREAS, the physician owned hospital ban eliminates the benefits of integrated, coordinated care delivery observed in vertically oriented self-referral models (8); and

WHEREAS, benefits of self-referral within integrated delivery models include concepts of one stop shop, improved sharing of clinical information, better care delivery experience by consumers (7,8); and

WHEREAS, reversing the ACA-imposed ban on new construction or expansion of existing POHs will stimulate greater competition and provide patients with another option to receive high quality health care services (7,8); and therefore be it

RESOLVED, our OSMA will advocate for policies that restore physician's options of owning, expanding, and/or constructing any form of hospital; and be it further

RESOLVED, our OSMA will advocate for policies that enable the highest quality of patient care including the removal of barriers to physician's owning hospitals as is found in H.R. 977 and S. 470 known as "Patient Access to Higher Quality Health Care Act of 2023"; and be it further

RESOLVED, our OSMA will work to educate its members and the public on the potential benefits of physician owned hospitals as well as the need for policies that will support and promote physician hospital ownership; and be it further

RESOLVED, our OSMA will collaborate with the AMA and other stakeholders to develop and promote policies that support physician ownership of hospitals.

Fiscal Note $ 5,000 (Sponsor)
$ 25,000- $500,000 (Staff)

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8. Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine, Jesse Ehrenfeld APRIL 12, 2021. Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals. HTTPS://www.aaos.org >globalassets>advocacy

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 26 – 2025

Introduced by: OSMA Young Physician Section

Subject: Seat Belt Laws

Referred to: Resolutions Committee No. 1

WHEREAS, a majority of people killed in motor vehicle accidents in Ohio were not wearing a seat belt[1]; and

WHEREAS, under current state law, all drivers and front seat passengers are required to wear a seat belt, with seat belts optional for back seat passengers 16 years or older[2]; and

WHEREAS, seat belt violations in Ohio are secondary traffic offense, so seat belt non-adherence cannot be the sole reason to pull someone over[3]; and

WHEREAS, although 35 other states have primary seat belt laws for front seat occupants and 18 other states (including neighboring Kentucky and Indiana) have primary seat belt laws for back seat occupants, Ohio does not[4]; and

WHEREAS, Ohio's compliance with seat belt laws (80.8% in 2022) is its lowest since 2005 and well below the national usage rate of 92%[1,5]; and

WHEREAS, Governor Mike DeWine has indicated support for strengthening Ohio's seat belt laws[6]; and therefore be it

RESOLVED, that the Ohio State Medical Association supports laws to increase seat belt utilization; and be it further

RESOLVED, that the Ohio State Medical Association supports efforts to increase compliance with seat belt utilization.

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

References:

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2. https://codes.ohio.gov/ohio-revised-code/section-4513.263
3. https://www.axios.com/local/columbus/2024/04/16/ohio-seat-belt-laws-governor-dewine
4. https://www.ghsa.org/state-laws/issues/Seat%20Belts?state=Ohio
5. https://www.axios.com/local/columbus/2023/10/23/drivers-seat-belt-usage-report-low-down-buckle-up
6. https://fox8.com/news/seat-belt-law-could-soon-change-in-ohio/

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 27 – 2025

Introduced by: Medical Student Section

Subject: Advancing Public Health Protections Against Per- and Polyfluoroalkyl Substances (PFAS)

Referred to: Resolutions Committee No. 1

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WHEREAS, per- and polyfluoroalkyl substances (PFAS), are a group of synthetic chemicals first introduced in the 1940s that are highly resistant to water, heat, grease, and oil[1]; and

WHEREAS, these substances are now commonly found in a variety of products, including drinking water, cleaning products, water-resistant fabrics, stain-resistant carpets, fire-extinguishing foams, nonstick cookware, food packaging, and personal care products like shampoo and dental floss[2]; and

WHEREAS, the extensive use of PFAS, combined with their persistence in the environment, has led to growing contamination of air, water, and soil from both past and ongoing applications of these chemicals[3]; and

WHEREAS, PFAS enters the environment by being disposed of or spilled near surface water, such as lakes and ponds, and can seep into the soil and into groundwater which contaminates drinking water[4]; and

WHEREAS, PFAS have been shown to bind to proteins in the blood, including albumin and fatty acid transporters, allowing them to circulate throughout the bloodstream in the human body[5]; and

WHEREAS, certain PFAS have been found to accumulate in the blood of both humans and animals and have been linked to serious health issues, such as altered immune and thyroid function, liver damage, kidney disease, lipid dysregulation, adverse reproductive and developmental outcomes, and cancer[6]; and

WHEREAS, according to the Agency for Toxic Substances and Disease Registry, PFAS exposure can lead to a range of health issues, including fertility problems, pregnancy-induced hypertension/preeclampsia, increased cholesterol, changes in the immune system, elevated risk of certain cancers (such as testicular and kidney cancer), developmental changes in fetuses and children, liver damage, increased risk of thyroid disease, and a heightened risk of asthma[7]; and

WHEREAS, several research studies have demonstrated that PFAS can penetrate the blood-brain barrier and accumulate in both infant and adult brains[8]; and

WHEREAS, PFAS have been found to pass through the placenta via the mother's bloodstream, and additional research indicates that prolonged exposure to these chemicals can raise the risk of neurodevelopmental delays and future motor function issues[9]; and

WHEREAS, the diversity and complexity of PFAS chemicals present challenges in clinical recognition, intervention, and toxicity assessment, as the biological effects of PFAS may vary by sex, species, and life stage, complicating clinical recognition and intervention[10]; and

WHEREAS, PFAS toxicity is not linked to specific signs or symptoms, so patients with known exposure may be asymptomatic, show signs of other health issues, or be uncertain of their exposure despite living in an affected community[11]; and

WHEREAS, there are no approved medical treatments available to remove PFAS in the body[11]; and

WHEREAS, many factors play into the possible development of symptoms due to PFAS exposure, which includes the duration, frequency, and the amount of PFAS they were exposed to at any given time[12]; and

WHEREAS, in deciding whether to order PFAS blood testing, clinicians can take into account an individual's exposure history, such as the patient's water supply, food, or other pathways, and determine if the results could help guide exposure reduction and health promotion when deciding whether to order testing[13]; and

WHEREAS, patients and clinicians can weigh the risks and benefits of using PFAS blood test results to guide care, considering factors like disease risk, the need for extra screenings, and the potential for false positives leading to unnecessary tests or treatments[13]; and

WHEREAS, individuals may be unknowingly exposed to PFAS, including industrial workers in factories where PFAS are present and people living near PFAS-producing facilities[14]; and

WHEREAS, the likelihood of children being exposed to PFAS increases as they come into contact with common household items, such as carpets and toys[14]; and

WHEREAS, community water systems contaminated with PFAS disproportionately serve higher percentages of Hispanic/Latino and non-Hispanic Black populations and are located in watersheds with a greater number of PFAS sources[15]; and

WHEREAS, Governor DeWine released Ohio's first PFAS Action Plan in 2019, which aimed to sample public drinking water, identify PFAS contaminations in private water systems, establish drinking water action levels, and provide PFAS educational information to the public[16] ; and

WHEREAS, Ohio continued with the PFAS Action Plan 2.0, which revises Action Levels for drinking water and expands Ohio's focus on PFAS through enhanced sampling, investigations, funding, and monitoring[17]; and

WHEREAS, in June 2022, the U.S. Environmental Protection Agency (EPA) issued interim updated drinking water health advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS) at 4 parts per quadrillion due to their potential adverse health effects even at very low exposure levels, and final advisories for GenX Chemicals and perfluorobutane sulfonic acid (PFBS)[18]; and

WHEREAS, in April 2024, the EPA finalized National Primary Drinking Water Regulations for six PFAS compounds, including Maximum Contaminant Levels (MCLs) of 4 parts per trillion for PFOA and PFOS, individual MCLs of 10 ppt for perfluorononanoic acid (PFNA), perfluorohexane sulfonic acid (PFHxS), hexafluoropropylene oxide dimer acid (HFPO-DA), as well as a Hazard Index MCL for mixtures containing PFHxS, PFNA, HFPO-DA, and PFBS[18]; and

WHEREAS, in November 2024, the EPA released its three-year progress report on the PFAS Strategic Roadmap, highlighting advancements in their goals to protect drinking water, address PFAS contamination, improve chemical safety, protect lakes, rivers, and other water bodies, and expand PFAS-related research[19]; and

WHEREAS, the American Medical Association (AMA) supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health[20]; and

WHEREAS, the AMA advocates for states to follow guidelines presented in the EPA's Drinking Water Health Advisories for PFOA and PFOS, with consideration of the appropriate use of Minimal Risk Levels[20]; and

WHEREAS, our OSMA currently supports investigating endocrine-disrupting chemical substances that are in food, agriculture, and household products[21]; and therefore be it

RESOLVED, that our OSMA supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; and be it further

RESOLVED, that our OSMA will amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts; and be it further

RESOLVED, that our OSMA will advocate, at minimum, for guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories; and be it further

RESOLVED, that our OSMA encourages the integration of environmental health advocacy into clinical practice by encouraging physicians to be informed regarding risks of PFAS exposure on patient health.

Fiscal Note: $500+ (Sponsor)
$50,000 (Staff)

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2. Chemicals: Per- and Polyfluoroalkyl (PFAS) Substances. Wisconsin Department of Health Services. 2024 Dec 19. https://www.dhs.wisconsin.gov/chemical/pfas.htm
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8. Xie MY, Lin ZY, Sun XF, Feng JJ, Mai L, Wu CC, Huang GL, Wang P, Liu YW, Liu LY, Zeng EY. Per- and polyfluoroalkyl substances (PFAS) exposure in plasma and their blood-brain barrier transmission efficiency-A pilot study. Environ

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13. PFAS Information for Clinicians - 2024. Agency for Toxic Substances and Disease Registry. 2024 Nov 12. https://www.atsdr.cdc.gov/pfas/hcp/clinical-overview/?CDC_AAref_Val=https://www.atsdr.cdc.gov/pfas/resources/pfas-information-for-clinicians.html
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18. Environmental Protection Agency: PFAS National Primary Drinking Water Regulation. U.S. Government Accountability Office. 2024 May 13. https://www.gao.gov/products/b-336287
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21. Policy 7 – 2023 -- Establishing Support for the Regulation of Endocrine Disrupting Chemicals in Food, Agricultural, and Household Products. OSMA Policy Compendium Policies of the OSMA House of Delegates. 2024 April. https://osma.org/aws/OSMA/asset_manager/get_file/366536?ver=2041

RELEVANT OSMA POLICY

Policy 7 – 2023 – Establishing Support for the Regulation of Endocrine Disrupting Chemicals in Food, Agricultural, and Household Products

OSMA supports the investigation and regulation of the use of endocrine-disrupting chemicals in food, agricultural, and household products.

Policy 03 – 2018 – Pursuit of a Strategic Partnership with the Ohio Public Health Association

1. The OSMA create a formal partnership, establishing an open line of communication, with the Ohio Public Health Association for medical students and physicians. 2. The OSMA support policies and initiatives that may, based on reasonable evidence, produce population health improvements, as well as incentivize healthcare providers, hospitals, clinics, and other healthcare facilities to engage in health promotion

RELEVANT AMA POLICY

H-135.916 – Per- and Polyfluoroalkyl Substances (PFAS) and Human Health

1. Our American Medical Association supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health. 2. Our AMA supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances. 3. Our AMA will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS. 4. Our AMA will amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts.

H-135.939 – Green Initiatives and the Health Care Community

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public

transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES
2025 OSMA Policy Sunset Report

Introduced by: OSMA Council
Subject: 2025 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; and therefore

BE IT RESOLVED, that the recommendations of OSMA Council published prior to the Annual Meeting as the 2025 OSMA Policy Sunset Report be adopted by the OSMA House of Delegates.

Ohio State Medical Association Policy Compendium Review –

2025 OSMA Policy Sunset Report

OSMA policy from years 1932 through the 2024 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:
None

Policies to be Not Retained:
Policy 1 – 2023- Establish a Women Physician Section and Senior Physician Section
Policy 2 – 2023- Establish the OSMA Membership Task Force as an OSMA Standing Committee

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

Recommendation	Policy	Comment
NOT RETAIN	**Policy 1 – 2023- Establish a Women Physician Section and Senior Physician Section**	Accomplished

Recommendation	Policy	Comment
	1. OSMA Constitution and Bylaws are amended to establish a Women and Senior Section.	
NOT RETAIN	**Policy 2 – 2023 -- Establish the OSMA Membership Task Force as an OSMA Standing Committee** 1. OSMA Constitution and Bylaws are amended to establish the Standing Committee on Membership.	Accomplished

Fiscal Note: $0 (Sponsor)
$0 (Staff)