# OSMA and AMA Policies Relevant to 2025 Proposed Resolutions
# Resolution Committee One: Resolutions 1-28

## *Resolution 1-2025: IMG, WPS, SPS Seats on Council*

**OSMA Policy**
**N/A**

**AMA Policy**
**N/A**

## *Resolution 2-2025: Procedure for Approval for Recording of OSMA Meetings*

**OSMA Policy**
**N/A**

**AMA Policy**
**N/A**

## *Resolution 3-2025: Support for Environmental Justice Initiatives*

**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.

**AMA Policy**
**Policy D-135.997: Environmental Contributors to Disease and Advocating for Environmental Justice**
1. Our American Medical Association will advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease.
2. Our AMA asks the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues.
3. Our AMA encourages federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities.
4. Our AMA will lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

**Policy H-135.905: Furthering Environmental Justice and Equity**
1. Our American Medical Association supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practices with full participation by the community residents in these decisions.
2. Our AMA supports measures to protect frontline communities from the health harms of proximity to fossil fuel extraction, refining and combustion, such as the best available technology to reduce local pollution exposure from oil refineries, or health safety buffers from oil extraction operations.
3. Our AMA supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practice, thereby protecting residents of these communities from displacement.

**Policy D-135.966: Declaring Climate Change a Public Health Crisis**
1. Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that:
    - Limit global warming to no more than 1.5 degrees Celsius.

- Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.
- Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
6. Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes.

## *Resolution 4-2025: WITHDRAWN BY SPONSORS*

## *Resolution 5-2025: Limits on Numbers of Resolutions*

**OSMA Policy**
**N/A**

**AMA Policy**
**N/A**

## *Resolution 6-2025: Physician Exercise of Conscience and Sound Medical Ethics*

**OSMA Policy**
**N/A**

**AMA Policy**
**AMA Principles of Medical Ethics: I,II,IV,VI,VIII,IX**

## *Resolution 7-2025: Supporting and Promoting AMA Member Physicians and Physician Spouses as Candidates for Local, State and Federal Office*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy G-640.025: Encourage Physicians as Legislative Candidates**

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.

## *Resolution 8-2025: Ohio License and Medical Practice in Ohio Required for Physician Collaborators/Supervisors of Advanced Practice Providers*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy H-35.988: Independent Practice of Medicine by Advanced Practice Registered Nurses**
Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight

## *Resolution 9-2025: Physician Led Health Care Teams (Dist. 3 submission)*

**OSMA Policy**

**Policy 19 – 2007 – State Medical Board Oversight**

1. The OSMA reaffirms the principle 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.

**AMA Policy**

**Policy H-35.988: Independent Practice of Medicine by Advanced Practice Registered Nurses**

Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

**Policy H-35.964: Regulation of Advanced Practice Nurses**

1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.
2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.

**Policy H-160.950: Guidelines for Integrated Practice of Physician and Nurse Practitioner**

Our American Medical Association endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

**Policy H-160.947: Physician Assistants and Nurse Practitioners**

Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

## *Resolution 10-2025: Physician Led Health Care Teams (YPS submission)*

**OSMA Policy**

**Policy 19 – 2007 – State Medical Board Oversight**

1. The OSMA reaffirms the principle 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.

**AMA Policy**

**Policy H-35.988: Independent Practice of Medicine by Advanced Practice Registered Nurses**

Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

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10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

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8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

## *Resolution 11-2025: Opposing the Use of Physician Associate*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy D-405.977: Non-Physician Title Misappropriation**
Our AMA will: (1) actively oppose the American Academy of Physician Assistants' (AAPA's) recent move to change the official title of the profession from "Physician Assistant" to "Physician Associate"; and (2) actively advocate that the stand-alone title "Physician" be used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic medicine (DOs), and not be used in ways that have the potential to mislead patients about the level of training and credentials of non-physician health care workers.

## *Resolution 12-2025: Regulating Practitioners that Practice Non-Conventional Medicine (Herbalists, Naturalists, Homeopaths, Ayurveda, Asian Herbal Medicine)*

**OSMA Policy**
**Policy 14 – 2012 – Addressing Safety and Regulation in Medical Spas**
1. The OSMA supports regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight.
2. The OSMA advocates that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine.
3. The OSMA continues to evaluate the evolving issues related to medical spas in conjunction with the interested medical specialty societies.

**Policy 31 – 2021 – Dietary Supplements and Herbal Remedies**
1. The OSMA rescinds policy 12-2018 Dietary Supplements.
2. The OSMA adopt new policy regarding dietary supplements and herbal remedies to read as follows:
   (1) The OSMA supports AMA efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
   (2) The OSMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
   (3) The OSMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
   (4) The OSMA encourages the AMA to work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
   (5) The OSMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
   (6) The OSMA encourages that the AMA continue to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
      (a) Dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
      (b) Dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
      (c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
      (d) Regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers; and

(7) The OSMA encourages the AMA to support FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement
(8) The OSMA encourages the AMA to work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
(9) The OSMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
(10) The OSMA encourages the AMA to strongly urge dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for supports that the product labeling of dietary supplements and herbal remedies to:

(a) Not include structure/function claims that are not supported by evidence from robust human studies;
(b) Not contain prohibited disease claims.
(c) Eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
(d) Require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
(e) Include accurate and useful disclosure of ingredient measurement.

(11) The OSMA encourages the AMA to support the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
(12) The OSMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
(13) The OSMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

**Policy H-480.973: Unconventional Medical Care in the United States**
Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the classification system of alternative medicine set forth by the NCCIH at the NIH, "Major Domains of Complementary and Alternative Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine.

**Policy H-295.902: Alternative Medicine**
(1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities.
(2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions.

**Policy H-480.964: Alternative Medicine**
Policy of our American Medical Association on alternative medicine is:

1. Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies.
2. Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated.
3. Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment.

**<u>AMA Policy</u>**

**Policy H-150.954: Dietary Supplements and Herbal Remedies**

(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:

> (a) Dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
> (b) Dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
> (c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
> (d) Regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.

(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.
(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:

> (a) Not include structure/function claims that are not supported by evidence from robust human studies;
> (b) Not contain prohibited disease claims;
> (c) Eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
> (d) Require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
> (e) Include accurate and useful disclosure of ingredient measurement.

(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

## ***Resolution 13-2025: Mobilizing Healthcare Professionals to Address Police Violence as a Public Health Crisis***

**OSMA Policy**
**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.

**AMA Policy**
**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.

## *Resolution 14-2025: Physicians Engaged in Non-Violent Civil Protest*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy D-65.973: Physicians Arrested for Non-Violent Crimes While Engaging in Public Protests**
Our American Medical Association advocates to appropriate credentialing organizations and payers – including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of healthcare goods and services – that arrests of physicians for nonviolent civil disobedience occurring while exercising their First Amendment rights of protest should not be deemed germane to the ability to safely and effectively practice medicine.

## *Resolution 15-2025: Support for Diversity, Equity, and Inclusion in Ohio Medical Schools*

**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 173 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.

**AMA Policy**

**Policy D-295.963: Continued Support for Diversity in Medical Education**

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-208 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 231 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.

**Policy D-295.301: Model Legislation to Protect the Future of Medicine**

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.

**Policy H-350.974: Racial and Ethnic Disparities in Health Care**

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 is an issue of highest priority for the American Medical Association.

2. Our AMA emphasizes three approaches that it believes should be given high priority:
   a. 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.
   b. 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.
   c. 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
   a. Actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs.
   b. 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.
   c. Supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

## *Resolution 16-2025: Gender-Identification on State Government IDs*

**OSMA Policy**

**Policy 22-2016: Lesbian Gay Bisexual Transgender Queer (LGBTQ) Protection Laws**

1. The OSMA supports the protection of Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals from discriminating practices and harassment.
2. The OSMA advocates for equal rights protections to all patient populations.

**AMA Policy**

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

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.

## *Resolution 17-2025: Gender Dysphoria*

**OSMA Policy**

**Policy 5 – 2023 -- Protection for Physician Administration of Gender Affirming Care**

1. The OSMA opposes any efforts to ban the administration of evidence-based care to patients when determined to be clinically indicated by their physician.
2. The OSMA opposes legislative or regulatory actions that would penalize physicians, Allied Health professionals, or healthcare entities who administer evidence-based gender-affirming care to patients.
3. The OSMA reaffirms Policy 15-2020 – supporting gender-affirming care for transgender and gender minority patients.

**Policy 15 – 2020 – Supporting Gender-Affirming Care for Transgender and Gender Minority Patients**

1. The OSMA reaffirms existing Policy 23-2016 - Expanding Gender Identity Options on Physician Intake Forms.
2. The OSMA supports individualized, gender-affirming, evidence-based treatment and clinical practices in caring for transgender and gender minority patients.
3. The OSMA supports educational training to further educate healthcare providers on how to provide competent, respectful, evidence-based care to transgender and gender minority patients.

**AMA Policy**

**Policy H-185.927: Clarification of Evidence-Based Gender-Affirming Care**

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
   a. Advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
   b. Oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
   c. Support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
   d. Communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

## *Resolution 18-2025: Support for Statewide Tracking of and Control Mechanisms for Health Care Expenditure Growth that Promote Primary Care*

**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 224 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 230 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.

**<u>AMA Policy</u>**

**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.

## *Resolution 19-2025: Mental Health Disclosures Policy for Medical Applicants*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy H-98 295.858: Access to Confidential Health Services for Medical Students and Physicians**

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 139 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.

**Policy H-345:970: Improving Mental Health Services for Undergraduate and Graduate Students**
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.

**Policy H-345.981: Access to Mental Health Services:**
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.

## *Resolution 20-2025: Mandating Child-Proof Packaging on Marijuana Products Sold Legally in the State of Ohio*

**OSMA Policy**
**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.

**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.

**AMA Policy**

**Policy H-95.924: Cannabis Legalization for Adult Use (commonly referred to as recreational use)**

1. Our American Medical Association believes that cannabis is a dangerous drug and as such is a serious public health concern.
2. Our AMA believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older.
3. Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant people, and people who are breastfeeding.
4. Our AMA believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product 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.
5. Our AMA believes laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness.
6. Our AMA encourages local, state, and federal 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.
7. Our AMA supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.
8. Our AMA encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety.
9. Our AMA encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis.
10. Our AMA will advocate for 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.
11. Our AMA supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities.
12. Our AMA will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

## *Resolution 21-2025: Marijuana Guidelines Following Ohio Legalization*

**OSMA Policy**

**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.

**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.

**AMA Policy**

**Policy H-95.952: Cannabis and Cannabinoid Research**

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

**Policy H-95.924: Cannabis Legalization for Adult Use (commonly referred to as recreational use)**

1. Our American Medical Association believes that cannabis is a dangerous drug and as such is a serious public health concern.
2. Our AMA believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older.

3. Our AMA discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant people, and people who are breastfeeding.
4. Our AMA believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product 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.
5. Our AMA believes laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness.
6. Our AMA encourages local, state, and federal 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.
7. Our AMA supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.
8. Our AMA encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety.
9. Our AMA encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis.
10. Our AMA will advocate for 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.
11. Our AMA supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities.
12. Our AMA will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

## *Resolution 22-2025: Support for Education on Intimate Partner Violence Screening with Medical Students, Residents, and Physicians*

**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.

**AMA Policy**

**Policy H-515.965: Family and Intimate Partner Violence**

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 support 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.

**Policy D-515.982: Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse**
(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.)

**Policy H-295.912: Education of Medical Students and Residents about Domestic Violence Screening**
(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.)

## ***Resolution 23-2025: Registry for Potential Side Effects of GIP & GLP-1 Medications***

**OSMA Policy**
**N/A**

**AMA Policy**
**N/A**

## ***Resolution 24-2025: Streamlining Annual Compliance Training for Physicians***

**OSMA Policy**
**N/A**

**AMA Policy**
**N/A**

## *Resolution 25-2025: Physician-Owned Hospitals*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy D-215.983: Physician-Owned Hospitals**

1. Our American Medical Association will advocate for policies that remove restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type.
2. Our AMA will study and research the impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, and the impact on competition in highly concentrated hospital markets.
3. Our AMA will continue to support physician leadership in healthcare and advocate for policies that enable physicians to provide the highest quality care to their patients, including policies that remove unnecessary barriers to physician ownership of hospitals.
4. Our AMA will work to educate its members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership.
5. Our AMA will collaborate with other stakeholders to develop and promote policies that support physician ownership of hospitals.

## *Resolution 26-2025: Seat Belts Laws*

**OSMA Policy**
**N/A**

**AMA Policy**
**Policy H-15.982: Mandatory Seat Belt Utilization Laws**
Our AMA:

1. Supports mandatory seat belt utilization laws which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints;
2. Favors informing state medical societies about the status of mandatory seat belt utilization laws which simultaneously relieve automobile manufacturers of their responsibility to install passive restraints;
3. Urges reconsideration of the administrative regulation of the U.S. Department of Transportation that would release automobile manufacturers from the responsibility of providing passive restraints when mandatory seat belt utilization for two-thirds of the U.S. population is attained; and
4. Supports the amendment of state seat belt laws which contain exemptions for emergency medical services personnel, such that these laws would provide exemptions only when personnel are actively involved in patient care.

## *Resolution 27-2025: Advancing Public Health Protections Against Per- and Polyfluoroalkyl Substances (PFAS)*

**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.

**AMA Policy**

**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.

**Policy 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.

## *Resolution 28-2025: POLICY SUNSET REPORT*

**OSMA Policy**

**N/A**

**AMA Policy**

**N/A**