**OSMA 2025 Annual Meeting – Resolution Committee One: Online Testimony – Preliminary Report**

| Res. # | Comment By: | Representing | Position |
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| 1 | Susan H. | Self | Support |
| My conflict is that I am a member of both the WPS and the SPS. I totally agree with this resolution which adds representation from all of the Sections to the OSMA Council. Since the HOD only meets once per year, better representation is needed for the Sections. I also agree with decreasing the number of At Large Councilors. As a previous member of the Nominating Committee, I know that we have had difficulty getting enough candidates for the At Large positions. Also decreasing the number will help to keep the Council a manageable size. | | | |
| 1 | Engy H. | Self | Support |
| WPS, SPS, and IMGs should be represented on the OSMA council. | | | |
| 1 | Ellena P. | Medical Student Section | Support |
| The Medical Student Section supports this resolution. | | | |
| 1 | Engy H. | OMSS | Support |
| On behalf of OMSS section. We support. Representation on the Council should be consistent for every section. | | | |
| 1 | Stephen H. | SPS | Support |
| On behalf of the SPS section we support including SPS on council. | | | |
| 1 | Shannon T. | District 2 | Support |
| Support. | | | |
| 1 | Brandon F. | RFS | Support |
| Support. | | | |
| 1 | Susan H. | District 3 | Support |
| District 3 supports this as written. | | | |
| 2 | Susan H. | Self | Support |
| Support this resolution as written. | | | |
| 2 | Elizabeth M. | Self | Support |
| Agree with this resolution as it protects our members and allows more open and honest discussions. Especially if OSMA already has official recordings of the proceedings, no one else needs to be recording it. | | | |
| 2 | Engy H. | Self | Support |
| This resolution will encourage more open and honest dialogue. | | | |
| 2 | Shannon T. | District 2 | Support |
| Support | | | |
| 2 | Joe H. | Self | Support |
| Appropriate personal and organizational protections. | | | |
| 2 | Adam B. | Self | Support |
| Support | | | |
| 2 | Susan H. | District 3 | Support |
| We support this. | | | |
| 3 | Engy H. | Self | Support |
| I support this noble resolution, but I am afraid with the changing political climate, these important initiatives will meet resistance in the state and federal government levels. | | | |
| 3 | Amy B. | Self | Support |
| Current political climate may not allow for policy change but when the opportunity presents itself OSMA should come out in full support. | | | |
| 3 | Johnathon R. | Self | Support |
| Although others see this as a difficult time to support an environmental justice resolution, I feel that this is exactly the time for physicians to speak truth to power. We know that the social determinants of health are at least as important or even more important for our healthcare services for determining health outcomes. There is no controversy on that fact. We should support this resolution and encourage our state legislators to buffer some of the extremist attacks on the EPA that are happening out of Washington. We all need clean air, clean water, homes safe from lead paint, safe and healthy food and should encourage our state EPA to maintain reasonable standards. | | | |
| 3 | Shannon T. | District 2 | Support |
| Support | | | |
| 3 | Elizabeth M. | Self | Oppose |

On behalf of myself - I just don't think this is a good use of OSMA's time. It's a stretch to say that we have any expertise in this area of what policies promote good environmental changes. I agree that we should have regulations to promote clean air, clean water, safe and healthy food, etc. But do I know anything about what fertilizers are better for the environment or our food, weighed against how well they work for growing crops? Or what regulations will result in less pollution from power plants? I think it's fair for us to recognize how these things affect patient's health but not something we need to be taking the lead on. Don't we have bigger things to worry about that more directly affect patients? Like making sure our patients can afford their insurance and their medications, and get transportation to appointments, and that hospitals and facilities are meeting safety standards but without being over-regulated?

| 3 | Suzanne S. | OPPA | Support |
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On behalf of the Ohio Psychiatric Physicians Association. The environmental effects of rising temperatures, extreme weather, poor air quality, and changes in precipitation that lead to vector-borne diseases are directly related to negative health effects (cardiovascular, respiratory, infectious disease, neurobehavioral). The Institute of Medicine calls Pollution prevention the new patient safety movement. OSMA should take every opportunity to mitigate these negative effects.

| 3 | Philip R. | Self | Oppose |
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This Resolution, while well-meaning, is the scope of law-makers and environmental agencies. Other commenters have made political comments; indeed the term "environmental justice" is a talking point of the left that underneath is racist because it treats citizens and taxpayers based on color. Laws have been passed already sufficient to address these issues. Thus my reply is that the first Trump administration created Opportunity Zones, and other policies which resulted in higher minority employment and income than ever, with the logical result that minority opportunity and healthcare would naturally improve. This Resolution also refers to "…historic redlining and other racist housing policies" which are now illegal. OSMA needs to stay away from environmental justice and stick to medical issues.

| 3 | Adam B. | Self | Oppose |
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While I applaud the authors' good intentions with this resolution, it lacks actionable detail and risks unintended harm. The resolution's call for "state action to address and remediate environmental injustice" lacks specificity on implementation, funding, or measurable outcomes. Remediation efforts (e.g., reparations) could discriminate against innocent people in the name of addressing an injustice from before any of those people were born, forcing them to bear the cost of an offense they had no part in. Additionally, the cost of implementing this resolution would deprive the OSMA of funds and energy that could be spent on more clear and achievable resolutions and potentially deprive the state and healthcare industry of funds that could otherwise benefit our patients. The resolution doesn't address these trade-offs, focusing only on benefits without risk assessment. Due to this lack of specifics and un-addressed potential for harm, the resolution should be rejected.

| 3 | Ellena P. | Self/Medical Student Section | Support |
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This resolution is written as broad support on purpose. It would not be within the scope of the OSMA to define and initiate environmental justice initiatives at the state level, and, as you put, would take a lot of resources to do so. Instead, this resolution uses the word "supports", so that, if something were to come up at the statehouse or in a government agency, the OSMA could have the impetus to offer its support for that initiative. Environmental injustice is clearly defined in R1 so that staff know which types of policies or programs would fit within the focus of this resolution, while R2's breadth allows staff and members to dictate how would be most efficient for the OSMA to support. If the resolve was dictating exactly what the OSMA should be doing, then it might be overly-pedantic.

| 3 | Joe H. | Self | Oppose |
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Environmental agencies exist to identify, address, and remediate environmental conditions that impact the public health. OSMA resources are better used on issues of unity such as insurance companies practicing medicine through their policy making, scope of practice issues as other fields increasingly attempt to gain the authority to treat problems outside their expertise, physician burnout, loss of physician autonomy by insurance, hospital, and employer policies, unfair physician reimbursement. Physician involvement should remain a generalized support for all people in any community in Ohio who are experiencing environmentally caused adverse health conditions.

| 3 | Susie P. | Self | Oppose |
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This should have been condensed to simply state that OSMA supports efforts to improve water, soil, air quality as they affect the health of Ohioans. That is a resolution that I would support.

| 3 | Ellena P. | Medical Student Section | Support |
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Last year, this resolution was very popular in HOD, however the definition of "environmental justice" was a point of confusion in the House. In order to ensure that the proposed policy was clear in its directions, it was referred to Council. We agree with Council's recommendations to use the US HSS 2024 definition of environmental injustice in this resolution. Council deliberated over various definitions and we agree that this is the most appropriate one. The RESOLVED clauses as written by Council would allow the OSMA to take action to support state-level actions to promote healthy environments for all Ohioans, without dictating the OSMA to define or initiate it in the state. This is reasonable for the scope of the OSMA - we should adopt this policy so that our OSMA can leverage its support for environmental health and equity where it is appropriate.

| 3 | Tracy G. | Self | Support |
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| As an OBGYN, there is ongoing concern about the environmental impact on pregnancy outcomes. https://www.acog.org/advocacy/policy-priorities/environmental-health | | | |
| 3 | Susan H. | District 3 | Oppose |
| We oppose this resolution as written. The subject is outside of OSMA's advocacy efforts and our dollars should be spent on more pressing needs. | | | |
| 5 | Susan H. | District 3 (Authors/Sponsor) | Support |
| I am writing for District 3 which is the sponsor of the resolution. We feel that the number of resolutions submitted has increased to the point of being too cumbersome for adequate discussion of each one. Resolutions need to add important OSMA policy to help with our legislative and political agendas. Each group submitting resolutions needs to carefully discuss them and determine that the resolutions do not duplicate or only minimally change current policy. This resolution also asks that an individual member get support of a district, section or specialty society to submit a resolution. This will help the individual member gain initial support of their idea and also get suggestions for wording that might be more acceptable to the HOD. | | | |
| 5 | John N. | District 3 (Authors/Sponsor) | Support |
| Speaking also for District 3. I completely agree with Dr. Hubbell. This change is long overdue. Once again, this year, one section has authored 26 the 56 proposed resolutions. None of us can give careful review to all these resolutions and make thoughtful comments. It is extremely time consuming for the members of the resolutions committee to go through resolution after resolution and assess whether this is covered under existing policy. I strongly urge the HOD to make the resolution process more focused and efficient. | | | |
| 5 | Elizabeth M. | Self | Support |
| Agree that it is overwhelming to see so many resolutions, and difficult to give full attention to each one. I'd much prefer to see fewer and higher quality resolutions! It would allow our leadership to better focus on priority areas also. | | | |
| 5 | John C. | Self | Oppose, with amendment suggestion |
| Speaking on behalf of myself in opposition to this resolution as written, and with a proposed amendment. My proposed amendment would be to:<br><br>1.) Strike R1 in its entirety<br>2.) Keep R2, while striking any reference to the limits proposed in R1<br><br>Placing arbitrary numerical limits on the number of resolutions submitted by a single entity stands in opposition to our House's unique and longstanding tradition of service to the ideas of our physician members. The needs of our patients and the House of Medicine fluctuate and evolve from year to year, and our HOD's policies and procedures should be dynamic to match. I would hate for my own district to be limited to 5 resolutions in a year where six critical needs are identified as requiring urgent attention with unique additions to our policy compendium.<br><br>That said, I see wisdom in requiring individuals to seek co-sponsorship from a district, section or specialty society. This would organically improve both the quality and quantity of resolutions prior to our HOD deliberations, without any arbitrary numerical limits that might stifle the dynamic vitality of our association. | | | |
| 5 | Susan H. | Self (Authors/Sponsor) | Support |
| In response to Dr. Corker, District 3 would not have been able to submit all of the resolutions we submitted this year under this new rule. We are not tied to the number 5 but felt that was a reasonable starting point for discussion. | | | |
| 5 | Kevin M. | Self | Oppose |
| All I can say is that limits First Amendment issues. I realize that as a private organization OSMA had the ability to limit discussion and other limits, but an arbitrary number has nothing to do with the number of important issues that may come up. If you don't like an issue, call the question to get it moved on. I agree that many resolutions are not worth the paper they are written on, but this just impedes any corrections so a bureaucratic organization (think of the board of medicine) may continue to harm physician practices. | | | |
| 5 | Philip R. | Self | Support |
| Attending first OSMA meeting 2 years ago, I was appalled at the number of resolutions submitted by a particular section, a section that may not even be practicing in Ohio within a few years, and not representative of the majority of practicing clinicians. I support this resolution in its entirety; eliminating R1 defeats the purpose of this resolution. | | | |
| 5 | Stephen Terry H. | Self | Amendment Suggestion |
| Recommend amendment to replace 1 & 2 resolve<br>Districts or sections that submit more than 5 resolutions will need to have a specifically named member to co-sponsor submission of their resolutions (co-sponsors can only submit a maximum of 5 co-sponsored resolutions). | | | |
| 5 | Glen M. | Self | Oppose |

Speaking as an individual and not on behalf of the MSS. As a seven-year member of the OSMA, I empathize with members concerned about the volume of resolutions. But nonetheless I strongly oppose this resolution. If we as an organization are willing to censor our members by capping the number of resolutions, we should avoid arbitrary numbers with no basis in evidence or reasoning.

As a former member of the AMA MSS Governing Council, I'm no stranger to these arguments. We received similar sentiments from other organizational units within the AMA quite often. But when we shared our thorough, peer-reviewed, months-long vetting process for resolutions, much of this sentiment vanished. As an OSMA-MSS, we have adopted a similarly arduous process for resolution submission. As an organization, we should be encouraging ALL sections and districts to be as thorough in their resolution submission process. We all benefit when resolutions are thoughtful, timely, and well-researched, rather than haphazardly submitted. As leaders in evidenced-based medicine, let's continue to encourage evidence-based internal procedures and resist subjective resolution caps that could diminish our ability to act judiciously on Ohio policy issues.

| 5 | Stephen H. | SPS | Support, in part |
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We support limiting the number of resolutions that can be submitted at each meeting however it can be done without impacting any specific section and will rely on the resolution committee to determine the best way to do this.

| 5 | Susan H. | Self | Support |
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Speaking for myself. For example, if a section such as Senior Physicians Section has more than 5 resolutions, the authors would need to submit their 6th resolution with another section, geographic district, or specialty society as cosponsor. This would be beneficial to the SPS as the section only has one vote in the HOD. If they get support from a district, specialty society, or section for their idea, the resolution will most likely be better written and have more votes to start with. This should raise the quality of resolutions as it requires more support before additional resolutions can be submitted.

| 5 | Adam B. | Self | Support |
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On behalf of myself as a student, I support this resolution. Quality beats quantity any day and by limiting the number of resolutions, members will have more time to review resolutions and ensure that they are of the highest quality. With over 50 resolutions to go through this year, it is difficult for any of us busy medical students or physicians to make the time to do our due diligence with all of these nuanced topics.

Encouraging members from different sections to collaborate will also limit the number of redundant resolutions so that we can combine proposals about a single issue such as marijuana policy or scope creep. Moreover, it will give us more time at the convention to discuss more controversial issues in detail so we can come to better conclusions. These limitations would not infringe on first amendment rights as they do not place a limit on the number of resolved clauses, or the types of topics that can be discussed. This resolution merely will help us focus our efforts and help us be more efficient as an organization.

| 5 | Shannon T. | District 2 | Oppose |
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Oppose.

| 5 | Joe H. | Self | Support |
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I like the idea which should stimulate more inter physician and inter group discussions throughout the year resulting in refinement of resolutions as well as integration of similar issues into a single resolution. As a sports med doc I see this as positive competition. In diving, for example, the state is divided into zones and each zone competes in their region and the top 8 move on to the state championships. For OSMA PAC the resources are limited which requires a choice as to what to pursue. As districts/sections this concept may help unite our focus to critical Ohio physician issues.

| 5 | Alisha R. | YPS | Oppose |
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Speaking on behalf of the Young Physicians Section, in opposition to this resolution. Our mission statement (“The Ohio State Medical Association (OSMA) is dedicated to empowering physicians, residents and medical students to advocate on behalf of their patients, communities and profession.") specifically highlights that our purpose is to EMPOWER our members to advocate for patients and our profession. One of the main ways we do this is through our democratic process of bringing forth resolutions, debating their merits, and adopting policy to guide our staff and determine our priorities. All around us, we see diminishing participation in organizations. We continue to participate in meetings and committees that focus on our dwindling memberships/dues/participation. The volume of resolutions being submitted truly gives me hope for the future of organized medicine. We need to encourage every voice that wants to speak up. This is what it means to empower people and increase participation. As young physicians, we understand the concerns about the volume of business when we are in the midst of building careers, raising families, and engaging in professional development. We, especially, desire an efficient process. However, stifling the resolution submission process is not how we achieve efficiency or our mission. We can and we have done this through our online testimony and resolution committee reports. If we want to continue to be the voice for physicians in Ohio, then we need to continue to encourage and empower participation in this great organization.

| 5 | Gary K. | Self | Oppose |
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I encourage opposition because it places unnecessary and arbitrary limits on member participation in OSMA policymaking. While I appreciate the intent to streamline the process, this resolution undermines the democratic and representative nature of our House

of Delegates. The strength of OSMA lies in its ability to address a broad range of issues affecting physicians and patients. Arbitrarily capping resolutions stifles critical discussions, particularly for larger district who would be disproportionately affected by having to represent more voices in a constrained subset of resolutions.

Yes, some are frustrated when a few individuals or groups submit a high number of resolutions, and have declared that volume doesn't equal quality. Let me share an opinion, lowering volume doesn't create quality either. The number of resolutions submitted and the value they bring to OSMA policy are separate issues. If we were running out of time at HOD, there might be a case for limiting submissions, but that simply hasn't happened in recent HOD sessions. In fact, we often finish early such that lunch is barely even ready. So what problem is this trying to solve?

More importantly, we have proven systems in place to manage the resolution process efficiently:

- Asynchronous testimony allows members to weigh in online before the HOD meeting, ensuring all voices are heard and gives ample time for people to thoughtfully consider the weight of goodness in each resolution.
- The reference committee process can further consolidate similar resolutions or refine language to avoid redundancy.
- Finally, the consent calendar allows uncontested resolutions to pass quickly without unnecessary debate, allowing our HOD to focus on those items that are most important.

Efficiency is important, but it shouldn't come at the expense of engagement. Physicians who take the time to draft resolutions do so because they see an issue affecting their colleagues, their practices, and their patients. Our role is to thoughtfully consider these ideas, not to shut down participation before the discussion even starts. Instead of limiting resolutions, we should continue improving our processes to ensure meaningful debate and strong policy decisions.

| 5 | Susie P. | Self | Support |
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With so many resolutions to look through, things get missed. Not a good practice.

| 5 | Brandon F. | RFS | Oppose |
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Speaking on behalf of the RFS, in opposition to this resolution. While we understand the intent to streamline our processes, we believe this measure will ultimately stifle the democratic process within our organization.

Limiting the number of resolutions that can be submitted risks preventing unique, timely, and important ideas from being presented and debated on the house floor. Our organization thrives on the diversity of thought and the ability of individual members to bring forth issues of concern. By imposing arbitrary limits, we silence voices and potentially miss out on critical discussions.

Additionally, this resolution could have unintended consequences for individual members who wish to raise issues of concern that may not align with the priorities of their District, Section, or Specialty Society, but may be widely supported in the remainder of the house. The requirement for a co-sponsor from these entities would create a barrier to entry, effectively silencing individual voices.

| 5 | Adam B. | Self | Support |
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Speaking on behalf of myself, I think a great example of the quality issues and errors that can slip through the cracks with this current setup is the strange case of resolution 4 this cycle. That resolution has as of now been officially withdrawn.

7/11 citations were nonexistent or linking to unrelated pages as detailed in Elizabeth M's comment on that thread. I sincerely hope that was due to poor preparation and an insufficient review process by the MSS and not a willful attempt to mislead the OSMA. Were it not for the diligence of our colleague and the luck of this resolution being one of the first on the docket, this glaring error would have gone unnoticed.

To accomplish our mission, the OSMA must be held in high esteem by the public and our policy makers. Beside the compelling points made by others, approving resolution 5 will help us maintain that status by limiting ill-prepared resolutions like 4 from making it this far.

| 5 | Carson H. | Self | Oppose |
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Limiting the number of resolutions risks curtailing the OSMA's ability to advocate for a wide range of pressing issues. As Ohio continues to grow, the OSMA should remain at the forefront of medical policy to ensure physicians can practice effectively and that patients receive the best possible care. A robust and dynamic policy-making process is essential to fostering physician well-being, advancing public health, and maintaining the OSMA's influence in state-level advocacy. Narrowing the scope of discussion would diminish the OSMA's ability to adapt to evolving healthcare challenges and limit our impact in a time when strong, localized medical advocacy is more critical than ever.

| 5 | Ellena P. | Medical Student Section | Oppose, recommend Refer |
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On behalf of the MSS in OPPOSITION of R1 and for REFERRAL of this R2 to Council for an informational report.

We agree with Dr. Kevin M. and Dr. Corker's concerns. We would be supportive of Dr. Corker's amendment, however as a Section we are opposed to any policy which might limit members' speech. An arbitrary limit on the number of resolutions or adding requirements for submission will make it more difficult for people to get involved with the OSMA.The large number of resolutions is a sign that a lot of people feel excited to engage with our OSMA. This resolution points to a need to further streamline conversation, ensure quality, and promote collaborative contributions. Any limit on speech could discourage people from joining or staying involved.

We are glad that this resolution is bringing forward discussion about how to promote quality in resolutions and to make organizational changes that facilitate meaningful participation. Currently, the online commenting period, refcom, and HOD are ways our OSMA ensures quality resolutions and facilitates discussion.

Our MSS has a rigorous review process because of our numbers and timeline. In November we begin our online drafting period, followed by a resolution review committee that cross-checks the policy compendium, citations, and suggests edits. Our GC serves as a refcom ahead of an internal debate during our section meeting where resolutions are deliberated and voted upon. This year, we received over 80 ideas, reviewed 52 drafts, and adopted 27 for referral to the OSMA HOD. The sheer number of resolutions we manage is a certain challenge, but a welcome one. Referral will allow us to share and refine our processes in Council, we can continue to improve, while helping other sections do the same.

This year we paired student authors with volunteer physician partners to receive feedback on MSS resolutions (thanks to OSMA staff member Sean McCullough for helping with this!), and we worked with District leaders to get feedback on resolutions during their District meetings ahead of submission to HOD. In another example, Council requested advocacy priorities from our OSMA lobbyists, and many of these inspired the resolutions submitted this year. Through referral, Council members can share strategies for managing resolutions and create resources for resolution authors that clarify quality standards (e.g. an updated resolution writing guide, building upon recent initiatives started to promote cross section collaboration, etc.).

That being said, there is a lot of things we can do to collaborate to make this process more efficient for everyone, and we hope that we can achieve this through referral and continued conversation - not through limiting Members' speech.

| 5 | Saaleha S. | Self | Oppose |
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Speaking on behalf of myself, in OPPOSITION to the resolution as written with preference to refer the overarching issue of quantity of resolutions to Council.

Many prior commenters have cited time as the largest deterrent to their review process. Rather than imposing arbitrary limits for each district,section, or individual, perhaps Council could consider a more informed process. Expanding the commenting period, or having resolutions due to the OSMA at an earlier time could alleviate the burden that some may feel in reviewing resolutions solely in March. As written, having cosponsorship between sections included in this 5 resolution limit deliberately hinders collaboration. Perhaps refining our process all together could instead promote collaboration between sections, so as to prevent repeat ideas (like this year's GME or Physician-Led Team resolutions). This could look like an open forum, much like our commenting forum, to submit ideas and garner coauthors and sponsorships. The MSS does something similar and has great success in decreasing the number of ideas (80+) to submitted final drafts (27) (more here: https://drive.google.com/file/d/1GmXixMtdOTSZVkjOYh1kU08KXA-nn4iT/view?usp=drive_link ).

Alternatively, perhaps the OSMA could choose to match the pace of other states, like those in our Greater Lakes States Coalition. Wisconsin (https://www.wismed.org) hosts 3 policy cycles a year to deal with the breadth of issues their members bring forth. Other states like Massachusetts (https://www.massmed.org) and Delaware (https://www.medicalsocietyofdelaware.org/delaware/) host annual and interim policy cycles. The Council could also benefit from seeking insight from the AMA delegation, who collectively reviewed 161 resolutions in the month(s) leading up to AMA Interim. Delegation members individually reviewed up to 74 resolutions, often asynchronously, and were able to form well developed opinions to represent Ohio and the Greater Lakes States. The Delegation's methodology could benefit Council in determining a process regarding streamlining, though I agree with Dr. Gary K and request Council to determine whether this is even necessary if we are routinely concluding business much earlier than anticipated.

Finally, I ask Council to consider studying what is considered "unmanageable" (Whereas 4) as this can be incredibly subjective when comparing districts and sections who have more members to provide input, or individuals who may feel encumbered by many reviews, and authorship provided no support for this claim.

| 5 | Glen M. | Self | Oppose |
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This year, the MSS worked with advocacy staff to identify physician reviewers for student-written resolutions prior to our MSS annual meeting. These relationships strengthened the quality of the resolutions that were reviewed and fostered inter-district,

inter-section collaboration, much of what the authors seek in Resolution 5. However, most if not all of the individuals that have commented in support of this resolution did not participate as physician reviewers/mentors. Because this process is infantile (2024 was its first year), it should only continue to grow and improve. We should be strengthening current resolution review procedures and encouraging physician participation rather than imposing subjective limits and using censorship as pretext to discriminate against the MSS.

| 5 | Savanna K. | Self | Oppose |
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Speaking on behalf of myself as a medical student and NOT on behalf of MSS, I strongly oppose this resolution. MSS already has a rigorous review process before MSS policies are brought to OSMA at large. Our policies go through 2 reviews before being voted on an posted here. Therefore, MSS attempts to bring strong policies and the weaker policies either get amended to become stronger, are reworked to attempt again next year, or they get abandoned all together. Originally, MSS started with over 50 policy ideas and now MSS have brought forth about 20ish from this original pool. Additionally, this year we were matched with physician mentors. As most of these mentors were great, practicing physicians are very busy. A very important policy might be brought forward by a medical student, but might not go anywhere due to no physician connections. Being able to bring a concern forward and make the medical community aware is the beauty of OSMA; with this policy, that is lost. I was a policy writer this year, as I wrote policy 21-marijuana guidelines due to Ohio legalization. I loved being able to think about and work with my team of medical students to see what could be great guidelines to benefit public health. This policy did not receive a physician mentor, and if I would have needed a co-sponsor, this policy would not be here. I am all for combining my policy with the other marijuana policy brought forward, but since that policy was not made aware to MSS, this is why we did not collaborate earlier. Overall, MSS works extremely hard to bring forth strong policies and silencing medical student policies simply because they do not have a physician sponsor would harm the MSS ability to bring policies forward.

| 5 | Jennifer W. | Self | Oppose |
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I oppose this resolution and would support referral for reasons outlined by previous commenters. I am extremely concerned about the consequences of this resolution on the ability of our members to advocate for issues of concern. This could ultimately result in fewer voices being heard. I understand and appreciate the need for thorough review and discussion of each resolution. However, in my years of attendance at OSMA meetings, there has never been insufficient time to complete all business on the floor of the house. If the resolution committee is not able to work with the current number of resolutions, this would suggest that their structure or timeline should be revised.

| 5 | Jon B. | Self | Oppose, recommend Refer |
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Speaking on behalf of myself in opposition to R1 of this resolution, and for referral of R2 to Council. Restricting the number of resolutions allowed per section would severely hinder the advocacy of the OSMA. While it does take time to review the resolutions, many present novel and pressing issues that not only improve the practice of medicine from the physician's perspective, but also improve the lives of the patients that seek care. The number of resolutions reflects the ability for voices across different perspectives in medicine to be heard, and the power the OSMA has to impact change in our communities.

As someone who was assigned a physician reviewer for a resolution this cycle, I did find the physician review to be very helpful and appreciated the feedback. However, I do not agree that co-sponsoring a resolution should count against the total number of allowed resolutions for a section (although I am still against any limit at all). To me, this would discourage physicians from offering their feedback and cosponsoring, knowing that it could count against them, and negatively impact those new to the policy process that want assistance. Because I do see the value in some aspect of physician review and co-sponsorship, I would support referral of R2 to Council to compile an informational report, and also support referral of Dr. Corker's amendment mentioned below to assess its potential impact on physicians.

| 5 | Zarah S. | Self | Oppose |
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Speaking on behalf of myself in strong opposition. This proposal undermines the fundamental principles of representation, open discourse, and grassroots advocacy within our organization. Imposing an arbitrary cap on the number of resolutions restricts the ability of our diverse membership to address pressing issues in medicine and patient care. The OSMA HOD serves as the primary forum for physicians to bring forth concerns, propose solutions, and shape organizational policy. By limiting the number of resolutions, the association risks silencing important voices and preventing timely discussion on emerging medical, ethical, and professional matters.

| 5 | Adam B. | Self | Support | |
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On behalf of myself as a student. Although most physician commenters thus far seem to be supportive of this resolution, I see several medical students have expressed similar concerns on this thread (such as Jon B, Jennifer W, Savanna K, Glen M, Saaleha S, Carson H, Glen M, and Ellena P (representing MSS)) regarding this resolution limiting the ability to address important issues.
This concern is unfounded as everyone has the ability to coordinate and communicate concerns to ensure the most pressing matters are addressed each year. This resolution's implementation will also encourage more discourse and negotiation even before the online comments open, allowing for more representative and higher-quality resolutions with a higher degree of consensus to advance.

A valid point brought up for future discussion was about potentially adding another policy cycle into the calendar for OSMA. This would allow more time to discuss even more issues in detail as well and I advocate this be looked into in next year's cycle.

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| 5 | Andrew N. | Self | Oppose |

While this resolution seems like a reasonable solution for addressing the volume concerns, it inherently limits the democratic processes that go into resolution introduction and adoption. Forcing each section to hand select a limited number of resolutions will introduce bias into which topics are pursued. We should not limit speech (in the form of resolutions) as an advocacy body.

Moreover, this will discourage participation from physicians, residents, and medical students across the state. The fact that we are seeing more resolutions means there is more participation and more advocacy on behalf of our profession. Why should we discourage participation within an organization whose power comes from its numbers? If the burden of resolutions is too high, we the organization should expand its workforce, not limit its member participation! I see this as a myopic solution to a larger problem, which will only hurt the future of the organization. Thank you!

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| 5 | Charles S. | Self | Support |

Strongly support. This would need a bylaw change. If we require a practicing physician to obtain co-sponsorship for resolutions we should also ask the medical students to have a geographic sponsor for their resolutions.

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| 6 | Elizabeth M. | Self | Support |

On behalf of myself, agree with formally aligning with the AMA's code of ethics on this issue.

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| 6 | John C. | Self | Support |

Support.

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| 6 | Engy H. | Self | Support |

Support.

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|---|---|---|---|
| 6 | Philip R. | Self | Support |

Support.

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| 6 | Adam B. | Self | Support |

Support.

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| 6 | Amber P. | Medical Student Section | Support |

Speaking on behalf of the MSS, in SUPPORT of this resolution as written.

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| 6 | Shannon T. | District 2 | Support |

Support.

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| 6 | Tani M. | Self | Oppose |

Speaking as an individual in opposition to this resolution. I am not opposed to the content of this resolution however Ohio Revised code stipulates following the AMA code of ethics: "Subject to section 4731.226 of the Revised Code, violation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule. The state medical board shall obtain and keep on file current copies of the codes of ethics of the various national professional organizations. The individual whose license or certificate is being suspended or revoked shall not be found to have violated any provision of a code of ethics of an organization not appropriate to the individual's profession." (https://codes.ohio.gov/ohio-revised-code/section-4731.22)

Thus this resolution asks that OSMA supports following the law, which sounds like we don't follow the law unless we have a policy to follow the law. My other concern with the language itself is that the AMA may update their code of ethics and change the text which would then put our policy in conflict with the revised code.

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| 6 | Glen M. | Self | Oppose |

Speaking as an individual with experience working in physician credentialing and discipline within the legal department of a large health system in opposition to this resolution. Dr. Malhotra has eloquently stated my concerns. Should the AMA Code of Ethics be updated, which happens quite regularly per the review of the AMA Council on Ethical and Judicial Affairs, this would put our policy compendium in opposition to state law, the optics and effects of which would be quite embarrassing for our organization.

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| 6 | Joe H. | Self (Author) | Support | |

Speaking for myself as author, this resolution is designed to unite OSMA in this matter with the AMA policy which strengthens the importance of the physician conscience through unity. Every physician has rights of conscience. Any weakening of those rights would increase individual stress, suicide risk, burnout etc. and compromise the uniqueness that each of us bring to the profession of medicine. Institutional policies and procedures in places of employment/education often put individual physicians in situations that are uncomfortable, and at times untenable, as we are the working decision makers who risk being coerced into doing actions against our deepest held belief systems. Supporting this reinforces the law and unites OSMA with AMA. A cord of 3 is hard to be broken...

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| 6 | Susie P. | Self | Support |

Support.

| 6 | Susan H. | District 3 | Support |
|---|---|---|---|
| We support this resolution. If AMA changes this section of the code of ethics, we would just need to update our policy. | | | |
| 7 | Engy H. | Self | Support |
| Support. | | | |
| 7 | Susan H. | Self | Oppose |
| Our OSMA cannot pass policy for the American Medical Association. We can pass policy for OSMA only. We can ask our OSMA delegation to take a policy to the AMA HOD for discussion. This resolution needs to be amended to fix that issue. Also there could be a physician who is running for office who does not identify with the policies of our OSMA. All candidates, including physicians, need to be vetted before they are supported by our OSMA. | | | |
| 7 | Elizabeth M. | Self | Oppose |
| Oppose as written. Agree with the general sentiment that having more physicians in elected office would be great. But as noted, the AMA already works with AMPAC and their Candidate Workshop and Campaign School, and I'm not getting any indication from the whereas clauses of what we would add or what we think that AMPAC is not doing well. More background on what AMPAC currently does to support candidates would be helpful to know, too.<br><br>I would also want more discussion with actual physician legislators first to see if they think these measures would have helped their campaigns? For example, Dr Anita Somani is a recently elected State Representative for Ohio's 11th House District and I believe an AMA member, but she wasn't on the list anywhere - I don't know if she worked with AMPAC or OSMA's PAC during her campaign. Dr Terry Johnson is a State Senator for Ohio's 14th Senate District and a retired physician, but I don't know if he's an AMA member. Also as the resolution acknowledges, physician resources are sometimes scarce for both donations (especially from newer physicians) and time (nobody has enough of that!), so I'm not sure that just publicizing to physician groups would be that helpful or a good use of resources. I would be fine with some sort of amended language looking more to study the issue and see what we could add, after understanding more of what AMPAC and the OSMA PAC currently do already to support candidates. | | | |
| 7 | Shannon T. | District 2 | Oppose |
| Agree with Susan H. comments and need for candidates to align with OSMA policy. | | | |
| 7 | Johnathon R. | Self | Oppose |
| Needs revision. I agree that we should vet the candidates we support. I am not sure what OSMAPAC does now to align our support with policy ideas or problems that need solving in a way that is good for patients and physicians. | | | |
| 7 | Joe H. | Self | Oppose |
| An individual's campaign should do the work. Not every physician aligns with every OSMA policy. It is difficult to get unity amongst physicians even when the issue would clearly benefit physicians. | | | |
| 7 | Philip R. | Self | Oppose |
| Because of the deep political divisions even within OSMA. Candidates or candidate spouses of OSMA members should get support only from those physicians with whom they are politically aligned. | | | |
| 7 | Adam B. | Self | Oppose |
| I oppose this resolution. Promoting specific physicians or spouses as candidates risks alienating OSMA members with differing political views, especially if AMPAC or AMA leaders "vet" candidates based on subjective criteria. This could fracture unity at a time when physicians need a cohesive voice against external threats like insurance overreach or scope creep. | | | |
| 7 | Amy B. | Self | Oppose |
| Physicians do not always align on political views. OSMAPAC and AMPAC are not transparent with candidate selection. Forced support should not be written into policy. | | | |
| 7 | Ellena P. | Self | Oppose |
| I oppose this resolution. I am very supportive of having physicians run for office and would be excited to see the OSMA/OSMAPAC support them. However, I don't think it's appropriate to make a policy that forces support for physicians, or spouses for that matter. It is also confusing because our OSMAPAC/AMAPAC operate somewhat independently from HOD. I think it is more appropriate for our OSMA to connect its members with opportunities to learn about candidacy, should that be their interest. | | | |
| 7 | Glen M. | Self | Oppose |
| Speaking as an individual. As a former OSMAPAC member, OSMAPAC operates independently from the OSMA. While we certainly use OSMA policy to guide some of our discussions and contributions, we were not bound by it. Thus, this resolution likely would not accomplish its goals. If there is a sentiment to support physicians and their spouses, it should be brought to the OSMAPAC Chair and board members rather than via resolution through the House. | | | |
| 7 | Susan H. | District 3 | Oppose |
| District 3 opposes this resolution as written. We agree with comments by Dr. Hubbell. | | | |
| 8 | Susan H. | District 3 (Authors/Sponsor) | Support |
| I am writing for District 3 which is the sponsor of the resolution. We feel that all physicians who supervise APP's should be licensed in Ohio and should practice medicine in Ohio. OSMA does not have current policy on this issue. We did not make a requirement that | | | |

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| the physician live in Ohio as we have many physicians who live just across the state line in Indiana and Kentucky and Michigan who are licensed in Ohio and practice medicine in Ohio. | | | |
| **8** | **John C.** | **Self** | **Support, with amendment suggestion** |
| On behalf of myself, I would just like to clarify the intent of the resolution with the following amendment by addition:<br><br>RESOLVED, that our OSMA advocate that state regulators and legislators establish policies that ensure physician collaborators or supervisors of advanced practice providers PROVIDING PATIENT CARE IN OHIO be licensed in Ohio and practice medicine in Ohio.<br><br>Adding "providing patient care in Ohio" would clarify that the scope of this resolution is intended only for APP's providing care in Ohio. If this is the case, then the rest of the resolution follows, and appropriately addresses the need for direct supervision (proximity) by physicians licensed in the state of Ohio. | | | |
| **8** | **Susan H.** | **District 3 (Authors/Sponsor)** | **Support** |
| We agree with Dr. Corker's amendment. | | | |
| **8** | **Engy H.** | **Self** | **Support** |
| Support | | | |
| **8** | **Engy H.** | **OMSS** | **Support** |
| On behalf of OMSS section. We support. Pushing back against scope creep is important and ensuring the healthcare is physician-led is essential. | | | |
| **8** | **Shannon T.** | **District 2** | **Oppose, in part** |
| Oppose as written. Would support with John C. amendment offered. Also consider combining resolutions 8, 9, 10 into one comprehensive resolution. | | | |
| **8** | **Joe H.** | **Self** | **Support, with amendment suggestion** |
| Amend to clarify the work/supervision is performed in Ohio. | | | |
| **8** | **Glen M.** | **Medical Student Section** | **Support, with amendment** |
| Speaking on behalf of the MSS in support of Dr. Corker's amendment and of combining resolutions 8, 9, and 10. | | | |
| **9** | **Susan H.** | **District 3 (Authors/Sponsor)** | **Support** |
| I am writing for District 3 which is the sponsor of the resolution. We feel that a physician should be the head of the health care team and the teams should be physician led. There have been research studies done which show that the physician led team is more cost effective and thus saves money. We oppose independent practice by APPs. | | | |
| **9** | **Melissa M.** | **Self** | **Support** |
| Writing for myself, I agree with and support this resolution. I oppose independent practice by non-physician providers. | | | |
| **9** | **John C.** | **Self** | **Support** |
| Support. | | | |
| **9** | **Engy H.** | **Self** | **Support** |
| I believe that non-physician practitioners (NPPs) should not practice medicine independently in primary care (as this lead to increase testing, costs, and unnecessary consults, delay access to specialty care to those who actually need it), or within medical specialties, as they don't have the standardized training that is completed by all physicians and verified by national board exams and regulating bodies. Additionally NPPs are not held to the same medical-legal standards of care as physicians do, so any malpractice consequences can't be enforced equally across all practitioners. | | | |
| **9** | **Varun Y.** | **Self** | **Support** |
| Support. | | | |
| **9** | **Engy H.** | **OMSS** | **Support** |
| On behalf of OMSS section. We support. Pushing back against scope creep is important and ensuring the healthcare is physician-led is essential. | | | |
| **9** | **Shannon T.** | **District 2** | **Support** |
| Support. Consider combining resolutions 8, 9, 10 into one comprehensive resolution. | | | |
| **9** | **Joe H.** | **Self** | **Support** |
| The next level in this will be how many NPPs can be supervised by a single physician. Guidance will need developed in that regard as these issues evolve. | | | |
| **9** | **Susie P.** | **Self** | **Support** |
| Support. | | | |
| **9** | **Glen M.** | **Medical Student Section** | **Support** |
| Speaking on behalf of the MSS in support of this resolution and of combining 8, 9, and 10. | | | |
| **10** | **Susan H.** | **District 3 (Authors/Sponsor)** | **Support** |
| I am writing for District 3 which is the sponsor of Resolution 9. We support this for the same reasons we support Resolution 9 and expect that the Resolutions Committee will combine the resolutions along with our other resolution about licensed physicians. | | | |

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| 10 | John C. | Self | Support |
| Support on behalf of myself, and combine with similar resolutions from District 3 | | | |
| 10 | Engy H. | Self | Support |
| Strongly support. Similar to resolutions 8 and 9 | | | |
| 10 | Engy H. | OMSS | Support |
| On behalf of OMSS section. We support. Pushing back against scope creep is important and ensuring the healthcare is physician-led is essential. | | | |
| 10 | Shannon T. | District 2 | Support |
| Support. Consider combining resolutions 8, 9, 10 into one comprehensive resolution. | | | |
| 10 | Johnathon R. | Self | Support |
| I certainly agree that the best use of APPs is in close collaboration with physicians who are on site and available for discussion of complex cases. There should also be a limit on the number of APPs a single physician can supervise. I would suggest no more than two or three. When I was training MD IM residents in the clinic we never assigned more than 3-4 to a supervising physician at a time. I believe that ACGME also limits family medicine with similar limits on the number of trainees that can be supervised by an attending? This makes sense to me for APPs as well. | | | |
| 10 | Joe H. | Self | Support |
| Resolution committee one will do well to merge resolutions 8,9,10 and consider adding a language reflecting the need for a limitation in number of APPs/NPPs that a physician will be able to supervise while maintaining highest quality care. | | | |
| 10 | Susie P. | Self | Support |
| Support. Well-worded. | | | |
| 10 | Brandon F. | RFS | Support |
| We share the author's concerns regarding the scope of practice expansion legislation introduced in our Ohio State Legislature. Patients in Ohio deserve the highest standard of care under the supervision of a licensed physician. Improving access to care is not accomplished by lowering our standard of care or posing increased costs of healthcare to payors. Evidence supports the increased cost burden of non-physician practitioners due to increased ordering of diagnostic tests and non-therapeutic interventions. Anecdotally, members of our RFS have shared with our section their experiences of increased healthcare utilization and delayed therapeutic/curative care to patients managed by non-physician providers. Advanced practice providers have a vital role in our healthcare system and need to be utilized to the extent of their training; however, our RFS supports the continued practice of physician-led teams. | | | |
| 10 | Glen M. | Medical Student Section | Support |
| Speaking on behalf of the MSS in support of this resolution and of combining 8, 9, and 10. | | | |
| 10 | Maria P. | YPS/Author | Support |
| On behalf of YPS we authored and thus support this resolution. Physician led teams are crucial to ensuring high quality care and confusing patients about the roles of care team members is inherently deceptive to patients to their harm. | | | |
| 11 | Joseph L. | Self | Support |
| Everything said is valid & important; We should not as an occupation re-define assistant. | | | |
| 11 | Engy H. | Self | Support |
| There are many ongoing efforts to blur the lines and decreased credentials transparency. AMA data shows that majority of patients prefer to receive care from physician. This efforts by PA associations is aimed as blurring the lines between the two professions. | | | |
| 11 | Engy H. | OMSS | Support |
| On behalf of OMSS section. We support. Pushing back against scope creep is important and ensuring the healthcare is physician-led is essential. | | | |
| 11 | Shannon T. | District 2 | Support |
| Support. | | | |
| 11 | Joe H. | Self | Support |
| Consider adding language in the form of an additional resolved that requires all non physician providers to have “(not a physician)” after their name & credentials. | | | |
| 11 | Amy B. | ACOG | Support |
| Patients should be clear who are on their care team. This change is confusing to patients. | | | |
| 11 | Brandon F. | RFS | Support |
| As early career physicians we appreciate the educational differences between physicians and physician assistants and have collectively experienced such nuance in the clinical setting, even prior to completing our specialty and subspecialty training. We agree that the term "physician associate" is a misrepresentation of licensure status as well as level of medical education and specialized graduate medical education. We encourage the reference committee to recommend adoption of resolution 11 as written and thank the authors for this contribution. | | | |
| 11 | Susie P. | Self | Support |

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| Support. | | | |
| **11** | **Glen M.** | **Medical Student Section** | **Support** |
| Speaking on behalf of the MSS in support of this resolution. | | | |
| **12** | **Norman M.** | **Self/Authors** | **Support** |
| I am Dr. Moser. Myself and three Internal Medicine residence created this resolution. While practicing as a nephrologist, I was asked to see a patient for a first time consult for elevation of serum creatinine. I had studied his chart. He had not seen a healthcare provider for quite some time. But one year prior his creatinine was 2.8 and now 3.2. He came with his spouse. I apologized for having to give him a bad prognosis on our first appointment, but told him he was close to needing dialysis. His spouse announced that he wasn't going to need dialysis. Surprised, I asked her why. She told me that she was an herbalist and had an office just like mine. She wears a white lab coat and a stethoscope. Puzzled, I asked her how she learned how to use a stethoscope. Her answer was "YouTube". She told me that she was treating her husband with her herbal products. I asked her for a list of her herbal products, and for some reason, my eyes focused on "black cohash". I looked up black cohash in Epocrates. I found under the side effects section that black cohash can cause kidney failure. I asked her if she was aware of this, showing her the data on my cell phone. She was surprised. She did not know this was a side effect of black cohash because she had not looked it up. I made a follow up visit for the patient and ordered a kidney ultrasound and other tests. Unfortunately, a week later, he wound up in the emergency room with kidney failure, and was flown to Toledo for hospitalization and treatment.<br><br>In other case, I saw a consult in the intensive care unit for acute kidney failure. As I pulled back the blanket to examine this 32 year old female patient, I saw a fungating looking mass down her right leg. I asked her what it was. She said "that's my malignant melanoma". She said it so well that I assumed that she had an oncologist. When I asked for her oncologist's name, she responded by telling me that she's being treated by a naturalist. Her husband was standing on the other side of the bed during the interview and I could feel him tensing up. I immediately ordered a total body CAT scan and sat at the desk to prepare my consult. Then noticed a lady with a white lab coat standing to the right to the patient who appeared to be rubbing the patient's liver. I walked into the room and introduced myself and asked her who she was. She told me that she was the patient's naturalist I asked her what she was doing. She told me she was giving the patient a liver poultice. She explained that by rubbing the liver, she could massage all of the toxins out of the patient's body (where is the evidence-based medicine in that). I didn't know how to wiggle out of this problem so I asked her if she had hospital privileges at our hospital. I received a blank stare. I explained to her that she needed to have hospital privileges in order to perform that procedure in this or any hospital. Of course she did not have hospital privileges. I also asked her if she had malpractice insurance coverage at our hospital. Another blank stare. I told her that she needed malpractice insurance coverage and privileges at this hospital in order to care for a patient. She quickly left the room. I sat down at the desk to review the CT scans and her husband approached me. He asked me what I thought. I reviewed the CT scans with her husband watching, and I identified all of the metastatic disease. I also telephoned an oncologist who looked at the scans from his computer. The oncologist told us that the patient's tumor burden was so high that there was nothing we could do. The husband was livid. He wanted to seek conventional healthcare but was led to believe by the church that conventional healthcare was wrong and that a naturalist could get rid of the cancer. The patient died six weeks later.<br><br>There are many people on social media that make medical recommendations without appropriate training, education, regulation, or licensing. These people mislead the public. In addition to our resolution, I feel that a future resolution needs to be created making it illegal for people to make healthcare recommendations without appropriate credentials. Please support our resolution. | | | |
| **12** | **Johnathon R.** | **Self** | **Support** |
| Some states (California) require Naturopaths and Homeopaths to inform in writing that they are not licensed. | | | |
| **12** | **Susan H.** | **Self** | **Support** |
| Agree that there needs to be some type of regulation over anyone who recommends any type of pill, liquid, or other substance that patients ingest. | | | |
| **12** | **B.R.** | **Self** | **Support** |
| Reading Dr Moser's comment- I am saddened by Ohioans being misled. It reminds me of "snake oil" of the past. Alternative treatment providers should have to follow some type of education & Licensing scheme. | | | |
| **12** | **Shannon T.** | **District 2** | **Oppose** |
| Oppose as written but agree with sentiment. Concern over broad language of oversight and ask. Should we address licensure issues in Ohio, metrics for education or ask for the State Medical Board to provide oversight? What about naturopaths, other nonphysician occupations? | | | |
| **12** | **Tracy G.** | **Self** | **Oppose/Question** |
| I had the same question (as Shannon T.). Is this resolution requesting the state of Ohio license these individuals? | | | |
| **12** | **Stephen H.** | **SPS** | **Support** |
| On behalf of the SPS we support the intent of this resolution. | | | |
| **12** | **Joe H.** | **Self** | **Support** |

A pervasive problem for which this too might be partly addressed like my statements for resolutions 8,9,10,11 by requiring all non doctors doing any form of intervention to any person to clearly have statements indicating they are
1) not a physician and
2) their treatment is not intended to replace the role of the medical doctor with whom this treatment should be disclosed.

We will never be able to coordinate educational criteria and testing for every subcategory of provider so this kind of 'warning label' requirement would help bring caution and direction to patients who have little understanding of the many forms of providers.

| 12 | Philip R. | Self | Oppose |
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The issue of alternative care practitioners is not a simple one. Aside from the unregulated group of naturopaths, herbalists, etc. there are others such as Chiropractors, Optometrists, etc; regulated groups from which we have all seen substandard care (this can include our own MD's and DO's – of course who are trained and required to achieve a Standard of Care, monitored by our medical board). There are also many caring, effective non-medical practitioners that the public seeks because of problems with our current big pharma-influenced, insurance-driven, top-down, production-line medical model. Despite the compelling examples Dr. Moser gives, we need to examine the risk/benefit of regulating alternative health practitioners. I agree that the non-licensed practitioners need to inform patients of their status any time the practitioner is charging for a service, as is done in California.

| 12 | Norman M. | Self | Support, in reply to Philip R. |
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Please be aware that chiropractors and optometrists are educated, regulated and take board exams. Big Pharma, as ominous as they seem, is also very regulated to make sure that what they produce first does no harm. The people that we are addressing in this resolution have not obtained accredited education and have not proven themselves as safe and effective. They tend to lead the patient away from accredited health care. This action decreases the quality of care that the patient receives. I am aware that there are caring people out there that try to help. But, if there mislead the patient, are they really helping?

| 12 | Amy B. | Self | Support with amendments |
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I support the idea of this resolution but these practitioners do not need education. The PUBLIC needs to have a clear understanding of their training and education and how it comes to MD/DO training.

| 12 | Susie P. | Self | Support |
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Support.

| 12 | Norman M. | Self/Author | Support |
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After reading many of your responses, it became clear to me that I did not get across my intent of this resolution very clearly. For that reason, I apologize and I would like to take a moment of your time to clarify my thoughts. I am sure that many of you have been involved in patient care with patients who have seen naturalist or herbalist. And you may have found it somewhat difficult to care for these people. My initial thought in creating this resolution was simply to raise your awareness that this goes on in our Public. The second is the fact that many of these nontraditional helper providers make medical recommendations to patients that the patients will follow. It is my thought that if anybody makes a healthcare recommendation that they should be appropriately credentialed and licensed. If a physician makes an error or then they are quite at risk for lawsuit. However, if an herbalist makes an error or I doubt that they will get sued. I doubt that they even have malpractice insurance. And my resolution was not a tool to try to license these practitioners. The resolution also is not a tool to provide endorsement of their treatment modalities. The intent of my resolution was to raise the awareness of helper providers in Ohio to do practice evidence based medicine. Resolution was also designed to try to create an environment to discuss mechanisms to ensure that these nontraditional health care providers, eat become educated and certified or not allowed to practice. Conventional physicians, practice evidence-based medicine. We have science to prove the what we do works. Herbalist and naturalist and homeopaths do not have the size to prove that their therapies are safe and effective. I apologize for any confusion and I hope this raised your awareness.

For an additional and somewhat entertaining story, Google, the Internet for Belle Gibson. Netflix did a documentary on this young lady entitled "The search for instagrams greatest con artist" and Apple Cider Vinegar. Many people fell for her lies and many people died by following her advice and not seeking conventional health care.

| 13 | Joe H. | Self | Oppose |
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Police have a difficult and risky job which is vitally important to protect law abiding citizens. This resolution will tend to pit Ohio physicians against our state's police force. Police go to work every day not knowing if they will come home. Criminals, law breakers, have been increasingly disrespecting and devaluing the role of our police who need out support to protect our people from law breakers who frequently choose to perform acts of violence to our law abiding citizens and to each other. The social determinant of health classification should not involve the good work of our police forces. Our focus is best directed to the sources that lead people to commit criminal acts which might be things like mental health, lack of work options, finance management education, geographical issues which make it difficult to escape damaging lifestyles, etc.

| 13 | Philip R. | Self | Oppose |
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Police monitoring such as bodycam requirements, and public iPhone recordings have become commonplace, leading in many cases to justified police arrests and indictments. However, functioning in the current criminal environment with overzealous scrutiny of police actions is leading to low morale and poor police retention(1,2).

In reality, the proportion of arrests according to race is about 2% of the respective populations, white vs Black/Af-American(3). The number of officers killed or assaulted in the line of duty from 2021 through 2023 was higher than any 3 year period in the previous 20 years(4).

It is not right to burden ER and other physicians in the determination of police brutality, when there is enough other legal and social oversight now.

1. Police retention and morale is low: https://academic.oup.com/policing/article/doi/10.1093/police/paae036/7629915
2. https://www.npr.org/2021/06/24/1009578809/cops-say-low-morale-and-department-scrutiny-are-driving-them-away-from-the-job
3. https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/tables/table-43
4. www.fbi.gov/news/press-releases/fbi-releases-officers-killed-and-assaulted-in-the-line-of-duty-2023-special-report-and-law-enforcement-employee-counts

| 13 | Adam B. | Self | Oppose |
|---|---|---|---|

On behalf of myself, I oppose this resolution due to its questionable claims and infeasible implementation.

While advocating for patients in any situation is praiseworthy, this resolution is misguided in its approach. The authors support their resolution with the statistics of more non-White individuals being killed in police interactions than White interactions. Based on this they suggest there is some injustice at play. But they conveniently ignore the fact that the use of force in nearly all of these incidents are ruled justified. In fact one of the largest studies ever published on the topic by Harvard University's Prof. Roland Fryer showed that nationwide, there was no racial difference in officer-involved shootings (source 1). The author of the study admitted publicly to having an anti-police bias and was initially unhappy with the results, so he hired a new set of assistants to repeat the entire study and they found the same conclusion. His study was suppressed and his career suffered due to his findings not matching the desired narrative, as he explains in this interview (source 2). Another large study came to similar conclusions in 2021 (source 3).

Over the past decade, the media has used isolated cases to instill a false belief in the population that unjust uses of force by police are more widespread than they are, as shown by the Manhattan Institute's study (source 4). Any human institution is prone to have some bad actors, medicine and law enforcement included. However, just as it is wrong for a police officer to racially profile someone, it is wrong for us to condemn police use of force in general based on misleading data.

This resolution also unreasonably places an extra burden on physicians to determine if excessive force was used on patients. While physicians can determine if a child is abused based on patterns of injuries or skeletal surveys showing a history of unexplainable injuries, these are not comparable to police use of force incidents. The amount of force an officer must use to subdue a suspect can range from none at all to deadly force. Anything on that scale can be justified if the situation necessitates it.

If a criminal is in a shootout with an officer and is brought into the ED with a GSW, do the authors expect the physician to determine whether the shooting was justified all while treating the patient? That is unrealistic. Physicians are not district attorneys or police internal affairs investigators. Let us leave the job of determining whether use of force is justified to the legal professionals and focus on our job as physicians: treating our patients.

Sources:
1: An Empirical Analysis of Racial Differences in Police Use of Force by Roland Fryer, 2017
2: Harvard Professor: The Facts About Police Brutality - Roland Fryer (https://www.youtube.com/watch?v=ruYXzlzoU_A )
3: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2870189
4: https://manhattan.institute/article/perceptions-are-not-reality-what-americans-get-wrong-about-police-violence

| 13 | Elizabeth M. | Self | Oppose |
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The resolution forgets that correlations does not entail causation. For police violence to be considered a social determinant of health, causation must be established. No evidence is presented to this end. For example, the correlation between use of force incidents and poorer health outcomes can be easily explained. More use of force incidents occur in high crime areas due to increased interaction with the police, and these high crime areas tend to be in poorer communities. Poverty, low education, and lower access to healthcare are all present in these communities and have a far greater impact on public health than police incidents.

| 13 | Susie P. | Self | Oppose |
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Aren't we already required to report suspected abuse, including by law enforcement? Disagree with claiming this as a social determinant of health. Concerned with comment that police presence negatively affects the health of the community. Plenty of data in the post defund the police era seem to suggest the opposite is true.

| 13 | Nikita D. | Self/Author | Support |
|---|---|---|---|

As a primary author on this resolution that was resubmitted this year after being rejected by the medical student section of the OSMA last year, I write to provide my perspective in response to the previous comments.

I acknowledge the wisdom in the previous comments and recognize the importance of not pitting physicians or medical professionals against the police. That is not the intention of this resolution and is not the stance that the writing reflects. In no way shape or form is this resolution intended to disrespect any police officers who serve their community honorably. However, I recognize this is an inflammatory topic and people from various backgrounds are going to feel sensitive to the topic and how this resolution is written no matter which perspective they have.

This point of this resolution is for the medical community in Ohio to acknowledge that there is a there is a problem with police violence in our communities, particularly against black and brown people. This is a point that has been clearly acknowledged by the AMA and APHA in previous policies. Why is it so crazy to think that the OSMA might support a policy that aligns with those existing in national medical organizations?

Nowhere in this resolution is it insinuated that police men and women are not good people that join the force for the right reasons, nor does the writing in this resolution suggest that police force are not also affected by criminal violence. That violence from one community to another (criminals to police) exists does not negate that violence occurs vice versa (police to citizens). As the primary author of this resolution, writing on behalf of myself, who holds much respect for the position of military and police officers as public servants, I write this comment only to underscore that the purpose of this resolution is to ask the OSMA to acknowledge that police brutality exists in this era and is a problem worth recognizing within the medical community.

The first draft of this resolution asked only for acknowledgment of this issue under the guidance of the medical student section. At the recommendation of the OSMA MSS leadership, we amended the resolution to have a more active stance involving “mobilizing” and empowering physicians to report these issues when they see them. I would feel just as strongly about this resolution without that language. The question this resolution asks the OSMA is: can we as a medical community recognize that police brutality exists and is an issue in the nation and in Ohio? I wish that this wasn’t such a difficult truth to recognize.

| 13 | Jessy S. | Self | Support |
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On behalf of myself, I want to thank the authorship team for researching and writing a resolution on this timely advocacy topic! The authors have cited strong references published within the last 10 years to support their whereas clauses, including current AMA policies that recognize police brutality as a social determinant of health and a manifestation of structural racism that disproportionately impacts minority communities.

The resolution also includes several whereas clauses with facts mentioning that Ohioans from minority groups are more likely to be subject to excessive force and be killed during police encounters than their white counterparts. I believe that receiving injuries (and dying) due to excessive force will diminish one's health and the health of their family. Given that police brutality is a manifestation of structural racism, I agree that police brutality is a social determinant of health. Again, thank you for bringing this resolution to the OSMA!

| 13 | Taseen A. | Self | Support |
|---|---|---|---|

The authors have cited a number of references within recent years indicating the sheer impact of police brutality on healthcare. It is evident and well-cited that systemic racism runs rampant within law enforcement, leading to severe health outcome consequences. Not only is this an issue of national importance, but the authors have cited many clauses and facts indicating the effect of police brutality on health outcomes within Ohio. Given the arguments posed by the authors and the breadth of evidence they cite, it is evident that police brutality is a social determinant of health and must be officially noted as such.

Moreover, one of the greatest concerns in the fight against police brutality is the lack of enforcement. Many officers in public cases end up walking free due to the sheer degree of protection law enforcement officials receive. Unquestionably demonstrating the effects of this issue in healthcare would be a necessary step in ensuring that survivors and victims of police brutality receive the justice they deserve. I thank the authors for their hard work in bringing this topic to light and hope to see it pass!

| 13 | Charles S. | Self | Recommend Refer |
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Resolve #1 cannot be supported. Correlation does not mean cause. More "police violence" occurs in areas with more crime and poorer health to begin with.

| 13 | Susan H. | District 3 | Oppose |
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District 3 opposes this resolution as written.

| 14 | Engy H. | Self | Support |
|---|---|---|---|

Support.

| 14 | Kevin D.M. | Self | Support |
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|---|---|---|---|
| Given the past history of the SMBO squashing physicians' rights the only logical action is to support this resolution that the OSMA supports the First Amendment rights of physician. | | | |
| **14** | **Philip R.** | **Self** | **Support** |
| Support. | | | |
| **14** | **Stephen H.** | **SPS** | **Support** |
| SPS supports this resolution which protects free expression without fear of suppression of one's opinion. | | | |
| **14** | **Shannon T.** | **District 2** | **Support** |
| Support. | | | |
| **14** | **Johnathon R.** | **Self** | **Support** |
| I would certainly agree that an arrest for nonviolent civil disobedience should not be a cause for loss of licensure or privileges. | | | |
| **14** | **Adam B.** | **Self** | **Support** |
| Support. | | | |
| **14** | **Joe H.** | **Self** | **Support, with amendment suggestion** |
| Agree wholeheartedly however I would not limit resolved 1 thus would amend by removing the words "related to medical practice." As it is written it suggests that the limit should be within medical practice but this is a character issue regardless of in or out of medical practice. | | | |
| **14** | **Adam B.** | **Self** | **Support amendment, in reply to Joe H.** |
| This is a very good point. On behalf of myself, I support this amendment to strike "related to medical practice" | | | |
| **14** | **Gary K.** | **Self** | **Oppose amendment, reply to Joe H.** |
| I appreciate the request for amendment. However, I oppose the proposal which would leave the sentence ending in "misconduct." The intent of the resolution is to affirm protections for physicians engaged in peaceful, nonviolent protest. If we remove this language "related to medical practice," we broaden the exceptions so much that even civil disobedience—one of the key issues this resolution seeks to address—would fall outside the scope of protection. We must ensure that we strike the right balance between reasonable professional standards and safeguarding physicians' First Amendment rights. Removing this key phrase actually undermines the resolution. We should be supporting it without removing the language. | | | |
| **14** | **Philip R.** | **Self** | **Support with amendment** |
| Support with amendment: "That OSMA support the physicians' rights of free speech in transmitting medical information to patients, if this information can be supported by medical literature, and/or qualified alternative opinion, and if the advice is unlikely to result in harm to the patient. OSMA support should exist even if this information goes against the general or prevailing opinion."<br><br>This resolution is important due to the animosity and medical board actions, including threats of loss of licensure, in Ohio and elsewhere against the physicians (who were clearly in the minority of health providers) who stood against the prevailing narrative of benefits of COVID mRNA vaccines, and mandates; including those who spoke out about the effectiveness of other available therapies. These minority physicians have now been exonerated both by errant medical boards and the public as knowledge of adverse effects and increased morbidity and mortality among mRNA, C-19 vaccinated individuals is being reported. | | | |
| **14** | **Saaleha S.** | **Medical Student Section** | **Support with amendments** |
| In support of the resolution with the following proposed amendments to have these protections apply to medical students/trainees as well:<br><br>RESOLVED, that the OSMA affirms its support for physicians *AND MEDICAL TRAINEES* 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<br><br>RESOLVED, that OSMA advocate to relevant credentialing organizations, the State Medical Board of Ohio, hospital systems, *MEDICAL SCHOOLS* and insurers that nonviolent protest related arrests of physicians *AND MEDICAL TRAINEES* should not be considered relative to their fitness to practice medicine; and be it further<br><br>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. | | | |
| **14** | **Brandon F.** | **RFS** | **Support** |
| Writing on behalf of the RFS, in support of this resolution, including the suggested amended language to include medical students/trainees. | | | |
| **14** | **Susie P.** | **Self** | **Support** |
| Agree with proposed amendments in the comments, to also include protection for medical students. | | | |
| **14** | **Tracy G.** | **Self** | **Support** |

| | | | |
|---|---|---|---|
| Support. | | | |
| **14** | **Maria P.** | **YPS** | **Support** |
| We support this resolution. The increasing politicization of health care has forced physicians to use our voices to advocate on behalf of our patients and ourselves. To punish physicians for fighting for our very survival and that of our patients is unjust and will lead to loss of exceptional clinicians when we are already facing a shortage of physicians. | | | |
| **14** | **Susan H.** | **District 3** | **Support** |
| We support this resolution. | | | |
| **15** | **John N.** | **Self** | **Support** |
| Speaking for myself, in favor of the resolution. Why does a 70 year old mostly retired white male physician support DEI preservation? Perhaps seeing how small town and rural America is discriminated against over the years. Perhaps seeing how vital my African American physician colleagues were in residency in Dayton years ago to serve the Black community. Perhaps it is just simply the right thing to do. I am sure it will be argued that some initiatives may have gone too far. But it would be a terrible thing to scrap all DEI initiatives and go back now. | | | |
| **15** | **John C.** | **Self** | **Support** |
| Support, on behalf of myself (a white male early career physician), for all of the salient reasons elucidated by Dr. John N. Diversity, Equity and Inclusion are values that are vital to creating a competent, compassionate, adequate and representative physician workforce for our patients and our communities. | | | |
| **15** | **Johnathon R.** | **Self** | **Support** |
| Agree that we need to support not abolish the diversity, equity and inclusion efforts made over the past the past 160 years in our country. We fought a civil war over it. We are not going back. | | | |
| **15** | **Melissa M.** | **Self** | **Support** |
| I am speaking for myself, in favor. | | | |
| **15** | **Engy H.** | **Self** | **Support** |
| DEI does not equal lack of merit, it means including a diverse group of equally qualified individuals. Medicine is one of the most regulated professions in the country and we are not credentialed based on our color, race, religion, or gender, we are credentials based on national licensing and board exams. | | | |
| **15** | **Gabe L.** | **Self** | **Support** |
| DEI is an integral part of medical practice and education. If DEI is cut out of education, it will come at the cost of patient lives. We already currently see disparities amongst different marginalized communities when it comes to health, which can improve over time through education and diversifying our workforce. Cutting out DEI will lead to the downfall of our healthcare system. | | | |
| **15** | **Maya D.** | **Medical Student Section** | **Support** |
| Speaking on behalf of the Medical Student Section in SUPPORT of resolution 15, in agreement with Dr. Corker. Diversity, equity, and inclusion (DEI) within medical school has immense importance for the advancement of education of current medical students and future physicians. It is crucial in the development of culturally competent physicians who know how to properly treat and care for diverse populations. The AAMC emphasizes the importance of diversity in medical education and the physician workforce, noting that it is critical to better patient understanding and improving care. Studies have also shown that patient outcomes are improved when diverse teams provide care, as it enhances team communication, fosters innovation, and further advances the medical field. This evidence underscores the necessity of protecting and supporting DEI initiatives, particularly in light of local and national political policies that threaten these efforts at higher education institutions. The repercussions of lacking DEI extend to the patient, training, and learning environments, ultimately diminishing the quality of care provided in Ohio and beyond and hurting the reputation of our institutions. Having the support from OSMA would be beneficial and impactful, because it shows that physicians understand the importance of diversity, equity, and inclusion within medical education and beyond. It also shows that physicians within Ohio recognize the impact of having cultural competent physicians, leading to improved treatment and outcomes for all populations when in practice. | | | |
| **15** | **Adam B.** | **Medical Student Section** | **Oppose** |
| Speaking on behalf of myself as a medical student, the above statement is unfortunately misleading. While we have all heard the claims repeated over the past few years that the race of the provider has an impact on patient care, a large scale review of the studies presented have shown them to have used significantly flawed methodology and design, invalidating their findings. This is evidenced in the attached guide from DONOHARMMEDICINE.org https://donoharmmedicine.org/wp-content/uploads/2024/09/DEI-Study-Flaws-full-report-Sept-2024.pdf<br><br>But even if we conclude that the evidence is just inconclusive, we must still contend with the implication of the claim. Simply augmenting the number of providers with certain physical attributes does not ensure that those physicians will be assigned to patients that match them. Are the authors of this resolution suggesting segregating care (Only White doctors for White patients, only Black doctors for Black patients, etc.)? We have advanced so far as a country to overcome past racism and view one another on | | | |

the basis of the content of our character, not the color of our skin. We should not go back to the dark days of segregation as DEI advocates.

As evidence in my previous comment and multiple physicians' comments demonstrates, these DEI programs do not have the effects that they claim to aim for, in fact they are often counterintuitive and lead to division.

| 15 | Philip R. | Self | Oppose |
|---|---|---|---|

Medical school admissions, appointment and employment should be based on merit and performance, and the racist ideology of judging by skin color should now be ended. Engy H said it all: "Medicine is one of the most regulated professions in the country and we are not credentialed based on our color, race, religion, or gender, we are credentials based on national licensing and board exams."

Six-hundred thousand Americans died over this issue, MLK spoke out against judging by race, laws prohibiting racism have been passed, and devoted activists have made it clear that racism can't be tolerated. People of color can be proud that they can compete at any level, including medicine, and OSMA should support merit-based ideology.

| 15 | Joe H. | Self | Oppose |
|---|---|---|---|

My view of DEI is that is causes division by categorizing people. What is better is what medical has always known - every person is unique in every way so treat them with the uniqueness they deserve.

Having students intermingle across cultures can be achieved in different ways. Perhaps a lesser emphasis on doing endless research and more emphasis on community service in the prisons, homeless shelters, anti-human trafficking entities, drug recovery homes, disability recreation centers, international healthcare teams. In these places every student, resident, and physician will quickly learn that all people are more alike than they ever knew as their underlying biases gradually dissolve through serving peoples unlike themselves.

| 15 | Amy B. | ACOG | Support |
|---|---|---|---|

Medicine has a racism problem. It is causing disparities in maternal outcomes. Patients should see physicians who look like them. It was not until 2017 that women exceeded the number of men entering medical school and yet we still are not in the c-suite or leading departments at equal rates. If merit alone mattered all these should be equal but they are not.
https://www.acog.org/about/diversity-equity-and-inclusive-excellence
https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/
https://www.aamc.org/news/brief-timeline-women-medicine

| 15 | Brandon F. | RFS | Support |
|---|---|---|---|

I am lucky to work in an institution with representation in our residency program from across the world, and I firmly believe our program is better because of it. Every day, I speak with colleagues who teach me new things and connect with patients in ways that I simply cannot due to their shared experiences. Diversity in medicine is something that should be promoted, not punished.

| 15 | Elizabeth M. | Self | Oppose |
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I am tired of us putting race over competency, Diversity, equity, and inclusion all sound like innocent enough words, but there is a reason there is so much backlash against their usage right now, and it is because so-called DEI policies actually tend to do the opposite of what they purport - they increase division and fear. See more discussion of this at:
https://aristotlefoundation.org/reality-check/what-dei-research-concludes-about-diversity-training-it-is-divisive-counter-productive-and-unnecessary/

DEI proponents argue that their policies do not decrease the importance of merit, but by applying any other metric than merit in admissions, merit will by definition be less important. DEI policies condition people to accept lower standards from people of "disadvantaged" backgrounds, leading to what Thomas Sowell calls the "soft bigotry of low expectations." As if some races are not able to get the same test scores as others, so we should lower our expectations of what they can achieve. You can label it DEI, but in practice the policies actually exacerbate racism!

No one is denying that there are discrepancies between the percent of medical students of certain ethnicities vs the percent of the US population, but a basic understanding of statistical analysis lets us know that this is not proof of racism. Just as the disproportionately high representation of African Americans in the NBA and NFL are not proof of racism. The inherent factors that led to our current reality are not the race of the applicant. Black students do not have some inherent characteristic that makes them incapable of achieving academic or career success, it is quite offensive and absurd to suggest such a thing.

And finally, while race concordance with one's doctor might be nice if all else is equal, any reasonable patient will tell you that they'd rather have a doctor who is competent vs one who has the same skin tone as them. Does it make a difference to my

argument if I tell you that I am 100% Taiwanese Chinese? It shouldn't, but DEI makes it so that people feel like they have to declare these things.

| 15 | Ellena P. | Self | Support |
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Diversity, equity and inclusion initiatives in my medical school have greatly helped my education. For example, while learning about certain pathologies and nomenclature, we discuss the history behind the discoveries (like the history of Henrietta Lacks, Nazi experimentation). Before my family medicine rotation, I had the opportunity to do an OSCE with patients with disabilities so that I could understand their experience and be better-prepared to take care of them in clinic. During our sessions on implicit bias, I learned how black peoples' pain often goes unheard, leading to higher risk of sickle cell crises and maternal morbidity/mortality. These discussions have been critical to my understanding of medicine, scientific research/ethics, and how I will be a good caregiver for all of my patients in the future.

Often there is a dichotomy presented between diversity/equity/inclusion and "competency". Often, this is under the assumption that students of color, 1st gen students, veterans and others who are disadvantaged are somehow unworthy of their seats in my classes or that they were given an opportunity that they don't deserve. This assumption is not only harmful, but it is incorrect. I have classmates who are from programs at OSU such as the MEDPATH program, which helps disadvantaged students enter medical school by pursuing a post-bacc at OSU and then matriculating into classes. The MEDPATH students shine in medical school, often serving as tutors, earning AOA membership, present research at conferences and more. DEI is not giving handouts. It's giving people who have potential, but face barriers to success, a chance to shine. And in the process, it makes all of us better.

| 15 | Adam B. | Self | Oppose |
|---|---|---|---|

On behalf of myself as a student. While I appreciate the authors' likely intent of fostering a compassionate and collaborative atmosphere, DEI policies have been completely counterproductive to their objectives. The authors of this resolution claim DEI training sessions will make people more tolerant and inclusive, but the data shows that they have done just the opposite. A recent large study from the Network Contagion Research Institute and Rutgers University showed that instead of reducing bias, the DEI and so called "anti-racist" trainings significantly increased hostile attribution bias (source 1).

Since the massive increase in DEI departments and sessions across the country in 2020, we have seen numerous examples of the fear, hatred, and division they foster (source 2). There have been countless situations of questionable claims being presented at diversity workshops to malign the character of the majority population (source 3). Anyone that showed skepticism or dared question the claims were met with hostility (source 4). In some cases, students who challenge claims have been punished or expelled (source 5); employees have been suspended (source 6); physicians silenced (source 7). One whistleblower who leaked DEI training session material maligning the majority population lost his employment (source 8). In a tragic case in July of 2023 public school principle Richard Bilkszto was even driven to suicide after unending harassment and public humiliation for the crime of questioning a claim made by a diversity trainer (sources 9 &10). These are just some examples of the hostile environment that DEI programs create. Everyone understands that our country has had its faults in the past, but punishing people today for mistakes made by people they never met and died before they were even born is unjust and immoral.

Furthermore, these DEI policies harm the minority students and physicians they purport to support. So many talented minority students have worked hard and earned their position in the medical field, but because of DEI policies they are left with a label always over them that they did not actually earn their place and were only given it to meet a quota. World renowned neurosurgeon and one of the most famous Black physicians, Dr. Ben Carson, recently made this case in an interview: As chief of Pediatric Neurosurgery at Johns Hopkins, I would come across racist people before DEI, but when they would see that I was in that position, they would say wow for a young Black man to make it to that level he must be really good. However with DEI, people look at someone like me in that position, they can just say that he got that position to meet a diversity quota and doubt his abilities. (Paraphrased, full statement can be found here: https://www.youtube.com/watch?v=ceiYCsZlIIk ).

Thus, if the goal of these interventions is to create a more compassionate and collaborative atmosphere, DEI should not be used, and we should focus our efforts elsewhere. Let's not give bad actors ammunition to belittle the hard work and achievements of our colleagues and instead go back to an environment of merit that only considers the real differences between candidates, not the way someone looks.

1. Network Contagion Research Institute (https://networkcontagion.us/wp-content/uploads/Instructing-Animosity_11.13.24.pdf )
2. Haskell, 2024; "What DEI research concludes about diversity training: it is divisive, counter-productive, and unnecessary" Aristotle Public Policy Institute
3. For example, KawarthaNOW (2018, March 6). "Racial injustice event planned at Trent University creates controversy"KawarthaNow. https://bit.ly/3ShnxNh ; Calder, R. (2023, March 25). "NYC teachers' union hosting seminar on'harmful effects of whiteness.'" New York Post. https://bit.ly/3NYOjZ6 ; Eustachewich, L. (2021, February 23). "Coca-Cola slammed for diversity training that urged workers to be 'less white.'" New York Post. https://bit.ly/3NWfYtF;VdubBoogie (2017, October 9).

Ashleigh Shackelford gives a presentation on Racism [Video]. YouTube. https://bit.ly/4aTz6lY ; Watts, M. (2020, July 17). "In Smithsonian race guidelines, rational thinking and hard work are white values." Newsweek. https://bit.ly/3O3dPfT
4. For example, Follert, J. (2018, March 7). "Are you privileged because you're white, male, heterosexual? UOIT posters spark controversy." Oshawa This Week. https://bit.ly/47ExoSB ; Hummel, T. (2021, April 30). "EXCLUSIVE LOOK: Here's a deep dive into one university's anti-white diversity training." The College Fix. https://bit.ly/3HimJlW
5. For example, Dawson, T. (2021, August 11). "Manitoba medical students expelled over 'pro gun and pro-life' Facebook posts wins court ruling." National Post. https://bit.ly/3TXDE4Y ; see also, Dawson, T. (2021, February 4). "Ryersonstudent journalist claims he was fired from campus newspaper over his Catholic views." National Post. https://bit.ly/48wlBHw .
6. For example, Huber, D. (2021, May 9). "Canadian professor suspended for 'unkind' blog post denying systemic racism." The College Fix. https://bit.ly/4aTzmBs .
7. Richard Bosshardt MD, 2023; "A Physician Turns Activist" Sensible Medicine
8. Robertson, K. (2023, January 17). "College upholds firing of whistleblower who shared 'antiracism' training with media." The College Fix. https://bit.ly/48TqTN8
9. Bildy, L. (@LDBildy). (2023, July 20). "With his family's permission, I am very saddened to release this statement about the passing of my client, Richard Bilkszto" [followed by Tweet]. [X Post (formerly Twitter)]. https://bit.ly/47DVzke
10. Subramanya, R. and A. Blaff (2023, August 3). "A racist smear. A tarnished career. And the suicide of Richard Bilkszto."The Free Press. https://bit.ly/3O1WiEK

| 15 | Susie P. | Self | Support, in part |
|---|---|---|---|
| I agree with some of the Resolution, but I am not sure about the solution that it proposed. I am in favor of fairness to all people. I also know that there is unfairness in the system. I have experienced discrimination in the healthcare field myself, and pay disparity also (hourly rate based pay, not direct billing to third parties). I also think ignorance or other things can negatively impact the care some of our patients receive. I just don't know what the best solution to this problem is. I would have liked to have seen some specific actions proposed in the Resolution, rather than just 'DEI training', since that could mean anything. | | | |
| **15** | **Maria P.** | **YPS** | **Support** |
| We SUPPORT this resolution. DEI is about ensuring that the best and brightest are able to achieve. Systemic racism, discrimination and injustice has been an affirmative action program for those who are less qualified, DEI initiatives seek to level the playing field as a response to injustices and obstacles that individuals have had to overcome because of the racism and discrimination they have faced. To abandon these principles is to worsen health disparities and to limit opportunities for those who are the most deserving. DEI ensures excellence because it ensures we are obtaining recruitment from the best of everyone not just a privileged few.<br><br>In addition, the abandoning of DEI initiatives is harmful to our state as it discourages highly qualified individuals from desiring to live in a place where their state institutions are beholden to one privileged group rather than all citizens of the state on equal footing. It will further erode the ability to retain young physicians and their families in our state. | | | |
| **15** | **Tracy G.** | **Self** | **Support** |
| I strongly support this resolution. I echo Dr. Phyllis' sentiments that DEI in medical education is essential, not only for curriculum and learning about a variety of human experiences, but for the economy of our state. Patients need doctors who look like them. DEI is not about hiring unqualified individuals. It ensures that qualified individuals are not overlooked because they are diverse. We, as physicians, cannot possibly provide compassionate, empathetic care to patients without learning about reasons behind certain behaviors. A perfect example is the history of gynecology. When this history is taught in medical schools, it is easy to see why black women would be mistrusting of the healthcare system. This helps bridge cultural gaps in patient care and ultimately will improve outcomes.<br>https://www.acog.org/about/diversity-equity-and-inclusive-excellence/betsey-lucy-and-anarcha-days-of-recognition#:~:text=Every%20year%20on%20February%2028,and%20Anarcha%20Days%20of%20Recognition | | | |
| **15** | **Charles S.** | **Self** | **Oppose** |
| We have moved beyond this. | | | |
| **15** | **Susan H.** | **District 3** | **Oppose** |
| Speaking for District 3 in opposition to this resolution. OSMA has adequate policy already to cover this topic. | | | |
| **16** | **Melissa M.** | **Self** | **Support** |
| Speaking for myself, in favor of this resolution to support non-binary, intersex, and transgender people. | | | |
| **16** | **John C.** | **Self** | **Support** |
| Support. | | | |
| **16** | **Carson H.** | **Medical Student Section** | **Support** |
| Gender-concordant identity documentation is essential for the health, safety, and access to services of transgender and gender-diverse (TGD) individuals. However, structural barriers, such as medical documentation requirements, continue to obstruct access to appropriate legal identification. Additionally, TGD individuals are increasingly targeted at both state and federal levels, including through bans on gender marker changes on legal documents. | | | |

In Ohio, individuals seeking to update the gender marker on their state ID must provide a signed affidavit from a healthcare provider. Birth certificate changes, however, are governed at the county level, resulting in inconsistent policies across the state. A majority of counties do not allow changes at all, creating further inequities.

In 2015, the United Nations High Commissioner for Human Rights recommended that the process for legal gender recognition should be based on self-determination, without requirements of sterilization, medical treatment, or divorce. These recommendations have since been adopted by the World Professional Association for Transgender Health (WPATH), globally across numerous countries, and by many U.S. states.

This resolution supports modernizing Ohio policy to promote health equity for TGD individuals. Eliminating medical documentation requirements and ensuring uniform access to gender marker changes across all counties are critical steps toward aligning Ohio with internationally established human rights standards. Furthermore, introducing an “X” gender marker, already implemented in many states, would provide necessary recognition and protections for nonbinary individuals, ensuring all Ohioans can navigate society with dignity, safety, and freedom from discrimination.

| 16 | Amber P. | Self | Support |
|---|---|---|---|

Speaking on behalf of myself, in SUPPORT of this resolution. Ensuring that transgender and gender-diverse (TGD) individuals feel safe in the state is critically important to us as medical professionals. In my clinical experience, I have interacted with numerous TGD individuals across clinical sites who do not feel safe at home or in our communities. They do not feel supported and are facing homelessness, have had multiple suicide attempts, or have mental health concerns that are seriously impacting their ability to function in day-to-day life. While for some changing a gender marker on an ID and birth certificate may seem small, it is a big step towards supporting, acknowledging, and affirming TGD individuals that the OSMA should support.

| 16 | Adam B. | Self | Oppose |
|---|---|---|---|

I oppose this resolution as it will increase discrimination. Let us consider the case of gender-fluid individuals, whose gender identity can change between male, female, the 72 other gender identities commonly quoted (per MedicineNet), or multiple at the same time, regularly. As the authors have affirmed the distinction between sex and gender and suggest that having an ID that has a sex that does not match a person’s current gender identity can cause them psychological harm, it is logical to conclude that if the ID had a gender identity that did not match their current gender identity, that would cause them even greater harm. Gender fluid individuals deserve the same respect and accommodation as other members of the TGD community and it would be unreasonable and discriminatory to make them have to get a new ID every time their identity changes. Perhaps a more equitable and inclusive approach to these individuals would be to provide counseling on the difference between sex and gender (as the authors affirm is the case in whereas clause 1). This way, these valuable members of our diverse community can learn that the indication of sex doesn’t threaten their gender identity and their anxiety over the issue can be alleviated.

| 16 | Delia S. | Self | Support, in reply to Adam B. |
|---|---|---|---|

Speaking on behalf of myself. I am a genderfluid person, and I would argue that many if not most of us understand the difference between sex and gender. If anything, the indication of sex on government is more frustrating to us than anything else because it is a marker of our genitals, not our gender, which is not something we may not want to share with anyone who requests to see our ID. We should be able to choose the most affirming gender/sex marker on our IDs just like everyone else. And I would sincerely appreciate our identities as genderfluid people not being used as a "case" to argue that no one else should be allowed to self-identify on government issued IDs.

| 16 | Adam B. | Self | Oppose |
|---|---|---|---|

On behalf of myself, as a member of the LGBTCQQIP2SHAA+ community as well, I can understand your concern on this matter. However, your comment proves my point that there is confusion in the community about sex vs gender, by you reducing “sex” to merely mean genitals. It is the only objective biological definition of who we are in regard to this topic. Sex can be determined not just based on our reproductive organs, but our bone structures, chromosomes, and other objective metrics. If archeologists find our remains in 1000 years, they will be able to easily tell whether we were men or women (sex), they will have no way of telling our gender identity because as you would agree, that is subjective. The LGBTCQQIP2SHAA+ community has widely accepted that one can change genders but not sex, hence the switch to using “transgender” vs “transsexual” in recent years. The purpose of ID’s is to be an objective and unchanging proof of our identity, which can only be provided by sex not gender. While it is noble of you to suggest that you would rather have a more difficult time with ID’s so that others may feel better, you do not speak for all gender-fluid people. We cannot pass discriminatory policies like this that will inevitably lead to harm for these invaluable members of our society.

| 16 | Delia S. | Self | Support |
|---|---|---|---|

What about the people that these policies will help? What about the significant number of transgender people who aren't genderfluid? What about intersex people, like myself, who do not fall neatly into the boxes of "male" and "female"? In your original argument, you stated that a genderfluid person's identity on any given day may not match what is on their ID and would be

distressing. If that is the case, it refutes your argument that the sex/gender marker on IDs is "objective and unchanging proof of our identity" as sex and gender are not the same.

| 16 | Adam B. | Self | Oppose |
|---|---|---|---|

It doesn't refute my argument as I stated a gender-fluid person's GENDER identity may change but their sex never well. Therefore the statement that sex is an objective and unchanging proof of our identity is correct, and there is no contradiction.

| 16 | Joe H. | Self | Oppose |
|---|---|---|---|

Agree with Adam B. Additionally, to best treat the person in front of me it is critical for me to know their biological base. The truth of the biology cannot be undone and our attempts to modify it complicate the care of the person by increasing the probability of miscommunication and error. We need a record of the base biology to act quickly and decisively in urgent matters.

| 16 | Tracy G. | Self | in reply to Joe H. |
|---|---|---|---|

This seems to be an argument against transgender persons in general, not the resolution.

| 16 | Philip R. | Self | Oppose |
|---|---|---|---|

Difficulties with state officials and documents, when the gender can change periodically, agree with Adam B.

| 16 | Elizabeth M. | Self | Oppose |
|---|---|---|---|

This may be a case of unintended consequences - if the federal Real ID requirements now allow only 2 genders, then Ohioans who list themselves as “x” gender may actually experience more difficulty with trying to use their ID in other states, for example for airplane travel, if the ID is not accepted by the federal government.

| 16 | Susie P. | Self | Oppose |
|---|---|---|---|

This resolution seems to imply that people are having a hard time finding physicians to help them change their gender on government documents, or that having to access a physician is harmful. Also, the resolution states that 21 other states do not require physician involvement in changing one's gender on government documents - I would like to see data that could indicate if this helped, harmed, or if there were any unintended consequences before supporting this.

| 16 | Adam B. | Self | Oppose |
|---|---|---|---|

Another major reason to oppose this resolution is that it pushes to change OH ID's in a manner that would make them fail the US federal "Real ID" criteria, which go into effect this year. This would harm individuals with an "X" marking as Elizabeth M pointed out, but it would also harm all Ohioans as the Feds would invalidate all OH ID's for not meeting these standards. The issues from this could make travel more difficult, including for medical care. For the sake of all Ohioans, this resolution should be rejected.

| 16 | Alisha R. | YPS/Co-Author | Support |
|---|---|---|---|

Speaking on behalf of the YPS as one of the co-authors in support of this resolution. This issue was brought to our attention by a fellow young physician who was trying to help a patient in a rural county obtain a driver's license that was congruent with their identity. The physician had previously worked in another Ohio county where he had been able to help patients obtain changes to their state IDs. Upon moving to a new job, he discovered that while the ID is issued by the state, there is not consistency among the BMVs at the county level. We recognize that there are a lot of changes happening at both the state and federal level right now that impact this situation; however this should not prevent our organization from passing policy that helps our patients. I would agree that we has physicians should not have to "sign off" or "attest" to the gender identity for our patients so they can obtain a state ID that is congruent, but as it stands currently we are being asked to validate our patients in some counties. We would love a consistent process across the state that allows our patients to obtain IDs that are consistent with their identity.

| 16 | Carson H. | Medical Student Section | Support |
|---|---|---|---|

REAL ID compliant IDs are governed by a federal act and issued at the state level. Currently, the REAL ID Act simply requires compliant IDs to contain a gender marker, allowing many states to offer “X” markers when they issue REAL IDs. Further, while gender markers on passports have been restricted by the federal government, the State Department has stated that existing passports with “X” markers are valid until renewal, negating the argument that such a policy would invalidate “all” Ohioans’ IDs if the federal government chooses to attempt to limit gender markers on REAL ID compliant documents.

Further, driver’s licenses and birth certificates are not medical records; they are legal identification documents. Choosing to change one’s gender marker is a personal decision and is not an easy process. Many transgender individuals choose to do so simply out of fear of discrimination and harassment due to having to show an ID that does not align with their presentation.

Finally, streamlined processes to obtaining accurate identification benefit many vulnerable patient populations, as outlined in this report from the Movement Advancement Project: https://www.mapresearch.org/file/MAP-Identity-Documents-report-2022.pdf "

| 16 | Adam B. | Self | Oppose, in reply to Carson H. |
|---|---|---|---|

Regarding Real ID: Per Executive Order 14168, titled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government" signed January 20, 2025: This order mandates that all federal agencies recognize only two immutable biological sexes—male and female—defined at conception. It further requires the replacement of the term "gender" with "sex" in official materials. This order will apply to Real ID recognition. As the determination is made based on the manner in which IDs are created and distributed, the changes proposed in this resolution would be in opposition to these new federal policies.

| 16 | Glen M. | Self | in reply to Adam B. |
|---|---|---|---|
| Speaking as an individual with a clarifying point to Adam B. Executive Orders are not law and the executive order would not affect the issuance of state, tribal, or territorial documentation. State police powers derived from the Tenth Amendment allow for issuance of state IDs. See https://www.gardenstateequality.org/clarifying-the-impact-of-trumps-anti-trans-executive-order/ | | | |
| 16 | Adam B. | Self | in reply to Glen M. |
| Speaking as an individual with a clarifying point to Glen M. I am not suggesting that the executive order controls state ID. I am accurately stating that it will impact Federal guidelines pertaining to what state ID's are considered "REAL ID." OH will of course move to qualify our ID's to REAL ID standards for the benefit of all Ohioans, particularly since the current Governor and Legislature are in agreement with the Federal government on this matter. | | | |
| 16 | Tracy G. | Self | Support |
| All persons deserve the right to self-identify their gender without the additional administrative burden. Cis gender individuals do not need a physician affidavit for their identification, therefore requiring transgender, intersex and nonbinary individuals to do so is stigmatizing. | | | |
| 16 | Charles S. | Self | Oppose |
| Don’t waste our time. | | | |
| 16 | Susan H. | District 3 | Oppose |
| We oppose this resolution. | | | |
| 17 | Michael M. | Self | Support |
| Gender Dysphoria falls under the diagnosis of body dysphoric syndrome. This syndrome’s most well-known diagnosis is anorexia nervosa. These patient receive counseling and not surgery, as should patient with gender dysphoria. | | | |
| 17 | Melissa M. | Self | Oppose |
| Speaking for myself, I oppose this resolution. We should not be supporting non-evidence based and discriminatory laws passed by the Ohio house and senate. "Gender affirmation" is the term used by national and international experts and the medical community so why would we use a different term? | | | |
| 17 | John C. | Self | Oppose |
| Oppose. | | | |
| 17 | Joshua D. | Self | Oppose |
| This resolution is extremely problematic. It frequently misframes its 60 citations, is punitive to our physician members practicing evidence based care now and in the past, and is a thinly veiled strike at the general trans community through the guise of being about minors, as many of the resolved statements are easily extrapolated to the adult trans community. It also comes down to a fact that the premises of the argument are based in misleading information with biased and aggressive language, and I'm not even sure we can have a fair and democratic debate on an argument that has a base of sand. I strongly advocate for the rest of the House of Delegates to also oppose this motion. | | | |
| 17 | Adam B. | Self | in reply to Joshua D. |
| This resolution has to do with a harmful procedure that the evidence now shows to be unjustified. While this is certainly a contentious issue, it is our job as physicians to have difficult conversations (with patients and colleagues). It is not possible to address your concern over citations due to your lack of specific examples. I would be happy to address any specific concern regarding the evidence presented, and look forward to discussing this further on the convention floor. | | | |
| 17 | Engy H. | Self | Support, with amendment suggestion |
| On behalf of myself. I don't believe that gender "affirming" language needs to be changed, however, I do believe given the permanence of the impact of hormonal/surgical interventions, such interventions should await until the individual is able to give their own informed consent (18 years of age), and that long term studies/surveys are needed of individuals who underwent hormonal/surgical transgender care as minors versus those who did not. | | | |
| 17 | Gabe L. | Self | Oppose |
| I strongly oppose this piece of legislation. Terminology of the use Alteration makes transitioning seem more definitionally like a choice. This is a gross misrepresentation of what it means to transition and could potentially put more patients, specifically trans and non-binary patients, at risk for self-harm and/or suicide. This bill itself is supported by literature that is incredibly biased and ignores the countless studies that show gender affirmation is beneficial. No other surgery requires countless studies to prove that it benefits patients and their well-being. Cosmetic surgeries like breast augmentation has higher regret rates than gender affirmation surgery. This bill is not about protecting children or about correcting improper terminology. It is intentionally perpetuating transphobia, just utilizing different words. Why are we focusing our time and energy on restricting a community that already faces incredible amounts of bias and hatred, from obtaining the healthcare they need? It is ridiculous that this bill is even being proposed and it will place OSMA on the wrong side of history should it pass. | | | |
| 17 | Jonathan T. | Self | Support |
| On behalf of myself, I oppose any medical procedures/treatment that leads to permanent body alterations and sterilization of minors. | | | |

| 17 | Ellen F. | Self | Oppose |
|---|---|---|---|
| Speaking as an individual I strongly oppose this resolution. The trans community is a very vulnerable community because of how they are treated by society. It is our duty as medical professionals to support our patients and leave personal beliefs at the door while providing medical care, which includes gender affirming care. Our patients deserve better than discrimination. This community has gone through enough and this is thinly veiled transphobia. Trans people are still going to exist as they always have. All this does is make it more difficult to access the care they deserve. That is not congruent with the oath I took as a physician. | | | |
| 17 | Adam B. | Self | in reply to Ellen F. |
| While I can appreciate that this is an uncomfortable issue for some people to discuss, it is our duty as physicians to have these difficult conversations. It is also our duty to protect our patients from harmful irreversible procedures pushed with impunity, even in the face of evidence contradicting their efficacy. I would respectfully request that we focus on the facts and forgo Ad hominem attacks like "transphobia" which will get us nowhere. | | | |
| 17 | Ellen F. | Self | in reply to Adam B. |
| I am more than willing to have these conversations with my patients and am not uncomfortable doing so because I took an oath to be there for patients no matter my personal beliefs. All physicians should do the same. I will also call transphobia out for what it is when I see it. | | | |
| 17 | Kimberly S. | Self | Oppose |
| Strongly oppose – I speak on behalf of myself. Gender-affirming care, especially surgery, typically involves a multi-stage process with significant time dedicated to assessment, hormone therapy, real-life experience, medical and psychological care with multiple specialists, often taking years before surgery is considered.<br><br>Genital mutilation is not applicable in this scenario. Genital mutilation is the removal or altering of external organs - typically the clitoris, can also involve cautery, infibulation, and others - for nonmedical reasons but with the goal of sexual control of the individual (e.g., sex does not feel good or is now painful). More information available on the WHO website.<br><br>What is more, I don't think I have any idea what is best for children's genitals but that it should be between the child, their parents, and their doctor(s). Therefore, I do not feel I should support a resolution that seeks to take away medical treatment options for said child.<br><br>Finally, and most obviously, this goes against current national guidelines and recommendations, including but not limited to American Medical Association (AMA), ACEP (American College of Emergency Physicians), APA (American Psychiatry Association), and AAFP (American Academy of Family Physicians). | | | |
| 17 | Adam B. | Self | in reply to Kimberly S. |
| Thank you for your comment. The definition of genital mutilation is not dependent on the reason for the act: “The cutting or excision of all or some of the genital organs, especially clitoridectomy.” The principle behind our opposition to the practice of genital mutilation in some Muslim countries and genital mutilation in the name of “gender affirmation” here in America is the same: healthy body parts should not be chopped off of people. When someone presents with gender dysphoria, we should follow the real evidence (and common sense) and treat them with counseling to reconcile their misguided self-perception with physical reality. | | | |
| 17 | Irene M. | Self | Oppose |
| As an Emergency Medicine physician I strongly oppose this resolution. This will lead to harm for many children. I believe in bodily autonomy and think decisions related to healthcare should be between the person affected and their physician. In the case of minors this should also involve their parents. It is none of my business as a private citizen. Gender affirming care is life affirming care. Undergoing gender affirming care is not something taken lightly for those who want it and need it. This resolution will harm Ohio residents and I am 100% against it as a physician and as a private citizen. | | | |
| 17 | Adam B. | Self | in reply to Irene M. |
| Thank you for your comment, we agreed that we should avoid harming patients. I’m sure we can also agree that bodily autonomy has certain limits: We place suicidal patients on 72 hr psych holds, if we find a patient cutting themselves on purpose we stop them, etc. When a permanent procedure like this is being considered, for a child no less, we should not be taking it lightly. As the studies cited and many others have shown, these procedures have unproven long term efficacy and likely lead to more harm than good. Additionally we are acting on this issue as physicians not merely random citizens. The citizens of this nation count on us to stand up regarding harmful practices like this. | | | |
| 17 | Jack A. | Self | Oppose |
| Speaking as an individual, this resolution should be opposed. The OSMA should align itself with all other major expert medical organizations on this matter including but not limited to the American Medical Association (AMA), American Psychiatric Association (APA), American Psychological Association (APA), American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Association of American Medical Colleges (AAMC). The proper terminology remains “gender-affirming care” and “gender affirmation” according to all major expert medical organizations. The OSMA should not independently deviate from widely established care strategies and norms. | | | |

Many statements and citations made within the resolution are problematic with some statements being false.

Examples:
Line 47 “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 [sic] youth.” appears to be inaccurate with a reasonable interpretation of “long-term” as well as “safety and efficacy”.

Cited:
de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014;134(4):696-704. doi:10.1542/peds.2013-2958

This study followed 55 individuals from approximately age 13.6 to approximately age 20.7 and involved management using puberty suppression, gender-affirming hormones, and gender-affirming surgery. These interventions were shown to alleviate gender dysphoria and improve well-being to levels comparable to those of the general adult population.

Multiple cited studies were methodologically weak, including those conducted by Lisa Littman, a well-known and controversial figure. Littman’s results were published based on anonymous surveys sent out to individuals using “trans-critical” website forums and blogs. These studies exhibit significant bias and are of questionable utility. Numerous critiques of these studies have been previously published.

There are other problematic citations such as “The Gender Trap: the trans agenda’s war against children” by Gays Against Grooming Publishing which appears to support complete denial of transgender identity.

This resolution is particularly challenging with its many claims which are difficult to parse through its many citations. A complete refutation would likely total tens of thousands of words.

In summary, this resolution should be opposed because it would cause the OSMA to deviate from all major expert medical organizations in its care strategies and norms, it contains factual errors, and it relies on numerous problematic citations. This serves as a brief introduction as to why this resolution should be opposed.

| 17 | Adam B. | Self | in reply to Jack A. |
|---|---|---|---|

Thank you for sharing your concerns. I’ll address your concerns in order:

Medical bodies have agreed on many things in the past and have changed their mind. Lobotomies and sterilization for certain demographics were widely accepted for a long time and we now recognize them as gross miscarriages of justice and medical ethics. In fact your point is counterintuitive to your side as there was a consensus in the medical community against this very issue of performing sex changes on minors until just a few years ago. Surely you are not suggesting that new information shouldn’t lead to us reevaluating our stances. If that were the case, your current stance would not have made it into the policies of these medical organizations. Furthermore, we would not be the first organization to take this stance; the American Society of Plastic Surgeons, Endocrine Society, American College of Pediatricians and others have found there to be insufficient evidence to support these genital surgeries on minors. As stated in the resolution, new evidence has even led to several countries’ health services, such as the UK’s NHS, restricting these procedures.

As with most studies supporting your claims, your cited study from de Vries has major issues with internal and external validity as detailed from the analysis of multiple such studies linked below:

"Patients received traditional psychotherapy alongside puberty blockers. It is entirely unclear which treatments led to changes in mental health. There is no comparison group. The researchers simply survey minors about their mental health before and after starting puberty blockers. But mental health naturally fluctuates, so without a comparison group it’s impossible to infer whether these changes are related to the initiation of puberty blockers. Participants were all from the Netherlands, where receipt of puberty blockers requires early-onset gender dysphoria that persists into adolescence. In many American clinics, puberty blockers are prescribed to kids with a more recent onset of gender distress. Participants received puberty blockers between 2000 and 2008, more than a decade before the exponential growth in the diagnosis and treatment of gender dysphoria among American adolescents. In other words, the minors who participated in this study were likely not as steered by social contagion, the dynamic in which minors become more likely to identify as transgender due to positive affirmation among peers, both in person and online."

As such studies are invalidated, this resolution's claim is true that there isn't sufficient long term evidence to support these procedures.
https://donoharmmedicine.org/wp-content/uploads/2024/09/Pediatric-Gender-Study-Flaws-report-Sept2024-2.pdf

The fact that political groups are involved in this topic did not make this a political issue. The issue being of great concern to the general public is why political groups have picked up on it. Your argument is a double edged sword, as many of the sources of studies quoted by your side to support these procedures are equally political in nature.

In summary, medical associations are not infallible and positions change all the time, the study you cite struggles with validity, and while this issue has certainly become a part of political discussion that is not a reason to discount certain data.

| 17 | Michael C. | Self | Support |
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Speaking as a primary care physician who has seen so many patient's children's lives damaged by the effects of social media trying to influence their kids towards questioning their sexuality and frequently are disappointed when they try to assume another "identity". It is insanity and I'm glad that the OSMA is taking a stand for the sake of common sense.

| 17 | Suzanne S. | OPPA | Oppose |
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On behalf of the Ohio Psychiatric Physicians Association. The OSMA supports evidence-based treatment and should align itself with the other expert medical organizations on this matter. The individual authors of this resolution cite problematic references that do not meet usual scientific standards.

| 17 | Maria P. | YPS | Oppose |
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We strongly oppose this resolution. This resolution contains many falsehood as noted by other commenters, and flies directly in opposition to decades of research and data on the subject.

"Gender affirming care" is the appropriate terminology based on recommendations from all other expert medical organizations including our AMA and OSMA should not go rogue from all established reputable medical organizations to fulfill political grievances.

Puberty blockers were approved by the FDA over 30 years ago and have been found to be safe and effective. They are used regularly to treat precocious puberty in cisgender children as well as to pause puberty in transgender children. Hormone replacement therapy is also safe for both youth and adults with provider supervision and appropriate management. Depending on how long a person has been taking hormone replacement therapy medications, the effects may be fully or partially reversible as well.

Additionally gender affirming care is literally lifesaving care that should continue to be provided and not withheld due to ideology.

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423 Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Netw Open. 2022;5(2):e220978. doi:10.1001/jamanetworkopen.2022.0978

Quote: "receipt of gender-affirming care, including puberty blockers and gender-affirming hormones, was associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality"

https://publications.aap.org/pediatrics/article-abstract/145/2/e20191725/68259/Pubertal-Suppression-for-Transgender-Youth-and?redirectedFrom=fulltext

Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. Pediatrics. 2020 Feb;145(2):e20191725. doi: 10.1542/peds.2019-1725. Erratum in: Pediatrics. 2021 Apr;147(4):e2020049767. doi: 10.1542/peds.2020-049767. Erratum in: Pediatrics. 2024 Jul 1;154(1):e2024067026. doi: 10.1542/peds.2024-067026. PMID: 31974216; PMCID: PMC7073269.

Quote: "those who received treatment with pubertal suppression, when compared with those who wanted pubertal suppression but did not receive it, had lower odds of lifetime suicidal ideation"

These two studies are but a fraction of the evidence based literature out that that clearly supports gender affirming care.

Finally, we note that young physicians, frequently look to live and practice in states in which they have access to appropriate healthcare for their families and themselves. By adopting this resolution, we would be setting policy that seeks to remove access to that care, stigmatize that care and deter young physicians from moving her to practice or remain to practice in Ohio which is to the detriment of our society.

| 17 | Adam B. | Self | Support |
|---|---|---|---|
| There is clearly a divide in the evidence and insufficient proof for long term efficacy for these procedures on minors. More and more medical associations in the US and abroad are reversing course on this issue based on the newest data and we should follow their lead. Considering the permanence of surgeries and puberty blockers, we should not be endorsing their use based on the data available to us. | | | |
| 17 | Philip R. | Self/Co-Author | Support |
| Hormonal therapy for minors should be restricted to growth hormone/pituitary abnormalities. Whereas one of the commenters suggests weak literature support for this Resolution, the body of research supporting benefits of gender-changing hormone therapy for children is not compelling at all. The study citing the "long-term" treatment (ages 13-20) is not conclusive; suicide rates in transgender adults are very high. Is this because they didn't get hormonal therapy in their teens? The fact that other countries, and our Ohio State Legislature, prohibit gender-altering treatments for minors should not be ignored. | | | |
| 17 | Amy B. | Self | Oppose |
| Speaking on behalf of myself oppose due to<br>1. Fiscal note is off given recommending studies so would need to be funded<br>2. Recommending change of medical language is not within the purview of OSMA<br>3. OSMA has no duty to report support to the government and the law is still under judicial review and in fact was blocked March 18, 2025 https://www.acluohio.org/en/press-releases/state-district-court-appeals-blocks-ohios-ban-gender-affirming-care-trans-minors<br>4. ACOG support gender affirming care https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals<br>5. adolescent Surgery is rare | | | |
| 17 | Joe H. | Self | Support |
| It is obvious that this topic is very contentious with many stories & research on both sides of the argument. Current law and popular opinion are in support. The goal of medicine is human flourishing and historically this has been a battle against microorganisms, viruses, parasites, fungus, cancers, organ failure, trauma, aging, autoimmune diseases… All of these have a natural history to them that medicine recognized as detrimental to the human condition. It appears humanity has reached a place in history where the beautifully made unique biological design of the body is considered the disease because the mind has made it so. What do we do with the children who feel they were led, coerced, or otherwise manipulated into transitioning? Do they have a right to justice by suing the doctors and institutions they believe manipulated them? Nobody wants to be on the wrong side of history. | | | |
| 17 | Joe H. | Self | Support |
| Agree with Adam B - well said. The Cass report out of England published in April of 2024 is very insightful as it summarizes all data to date. Here is a small clip from the findings of the Cass report::<br><br>“While a considerable amount of research has been published in this field, systematic evidence reviews demonstrated the poor quality of the published studies, meaning there is not a reliable evidence base upon which to make clinical decisions, or for children and their families to make informed choices.<br><br>The strengths and weaknesses of the evidence base on the care of children and young people are often misrepresented and overstated, both in scientific publications and social debate.”<br><br>The Cass report is a big (380+ pages) red flag warning to all of America and the world. We would do well to slow down and reevaluate & redesign so we don’t accidentally harm any child. It is clear now that evidence base is not what many think it is rather it has become a word of justification.<br><br>Caution is better path. | | | |
| 17 | Brandon F. | RFS | Oppose |
| Writing on behalf of the RFS, in opposition to this resolution. We believe this resolution is detrimental to the health and well-being of transgender individuals, particularly youth, and contradicts established medical knowledge. We are particularly concerned that this resolution contradicts the OSMA's past stance on this issue and would be a harmful reversal of the organization's position. To backtrack on this commitment would be a disservice to the membership and the patients we serve. The assertion that gender-affirming care is experimental and harmful is simply not supported by the weight of scientific evidence. | | | |
| 17 | Susie P. | Self | Support |
| This resolution addresses only minors; it is consistent with multiple European nations. 60 citations - the most I have seen yet for other resolutions. | | | |
| 17 | Philip B. | Self | Support |
| There is data to support some gender affirming care but the pendulum appears to have swung to the extreme where young girls with complex life issues(physical and psychological trauma for one) are turning to gender dysphoria treatment as their answer. | | | |

Adolescence is an independent risk factor for a host of psychological diagnoses which we know ameliorates with time. Being a adolescent female today is frightening because our society is not a protective of the female sex.

So many broken homes, children are left alone to raise themselves, women are preyed upon by men in their homes who are not their fathers, children are exposed to explicit sexual content and experiences before they are emotionally ready to understand issues of autonomy and agency. This is the breeding that is at the core of this wave of young girl's desire to be something other than the sex they were born. So what do we do with this…give them what they think they need? It is easier to put a surgeon to work on this than a good psychoanalyst. We also believed electrical shock treatment was the only way to treat psychosis in the 1930's and 40's. How many people did we maim in the process? Over time the supposed "data" that we use to support our present course and I am sure that we will realize we went too far on this pendulum. Doctors who took the Hippocratic oath "to do no harm" will look back knowing they should have moved more slowly and carefully- looking at data from other countries and digging more closely at their own data.

I saw a pretty 17 year old female in my office today with every psychological diagnosis you could imagine including gender dysphoria who was on a hormone blocker. My heart went out to her. She doesn't need a surgical knife and the removal of her female parts to find herself. She needs the love of parents, a supportive environment around her and good psychological care from us in the medical community.

| 17 | Tracy G. | Self | in reply to Philip B. |
|---|---|---|---|

This is an oversimplification of the issue and not based on any scientific fact. Plenty of transgender individuals come from stable, loving homes. It is concerning that an adult male is referring to a young teenage patient as "pretty". Every adolescent needs a supportive household and loving parents. Gender dysphoria and lack of societal acceptance are much more likely to cause psychological distress than gender affirming care.

| 17 | Elizabeth M. | Self | Support |
|---|---|---|---|

On behalf of myself, the most important part of this resolution I believe is R2 and R3. It is primarily asking that we slow down gender altering treatments (specifically in minors), and that treatments that do occur should be in controlled studies, and that more studies should be done to look carefully at the effects of gender altering treatments on minors. I don't think anyone can deny the fact that gender altering treatments for minors have increased exponentially, and that these treatments are all relatively new, and especially have never been done on such large scales. Everything we know is extrapolated from small studies, so the long-term effects of these treatments are largely unknown. The Cass report and Great Britain's closing of their Tavistock Center should give everyone pause.

I think we will look back on gender alteration surgery in minors the same way we now look back on the opioid epidemic - everyone went along with writing prescriptions to some extent, because everyone else was doing it, so it was accepted as medical "standard of care" to treat the patient's pain and escalate dosing as often as necessary. We felt like we were helping the patients treat their pain, and the patients thought that was what they wanted, too. Everyone thought it was fine until suddenly it wasn't, and now we have OARSS and all the accompanying regulations in place. Let's be more cautious and let the OSMA be a leader in this area by recognizing that things may have gone too far, instead of just going along with the crowd.

| 17 | Delia S. | Medical Student Section | Oppose |
|---|---|---|---|

Speaking on behalf of the Medical Student Section in strong opposition to this resolution. As of March 18, 2025, the 10th Circuit Court of Appeals overturned bans on puberty blockers and hormone therapy for trans minors in Ohio. The language of this resolution cites outdated and inaccurate sources and does not mention the strong evidence for the effectiveness of gender-affirming care. No medical intervention comes without risks, and thus far we do not have evidence for any significantly negative or life-threatening risks from gender-affirming care. In addition, this resolution mentions "genital mutilation" being conducted on transgender youth, but a 2024 study from the Harvard T.H. Chan School of Public Health found that gender-affirming surgery is rarely performed on transgender people under age 18 (Dai 2024, doi:10.1001/jamanetworkopen.2024.18814). There are, however, non-consensual surgeries performed on intersex youth and infants, which our OSMA worked towards preventing at the last HOD with the passage of Resolution 27-2024: "Care for Infants and Youth with Variations in Sex Characteristics/Intersex". Finally, the language of many of the Whereas clauses and the final Resolved clause suggest that transgender people are subjected to gender-affirming care without their informed consent or assent and are pressured into receiving gender-affirming care without adequate support, but this is untrue. All physicians, including those who provide gender-affirming care, are held to the same practice standards, which includes informed consent. As someone who has personally benefitted from the life-saving gender-affirming care I received, I can tell you from personal experience, as well as the existing standards of care across medical associations, that those of us who receive gender-affirming surgery are required to have a letter both from a primary care physician and a therapist or psychiatrist supporting our choice to proceed with surgery. This is not a decision any of us takes lightly, and we often have to prove that we have received adequate support in order to access this care. The Medical Student Section cannot support a resolution which would further inhibit transgender people's ability to access the care we need, and as the Medical Student Section, we strongly oppose this resolution.

| 17 | Carson H. | Self | Oppose |
|---|---|---|---|

Several evidence-based rebuttals of the Cass Review have been published by medical and legal experts:
https://www.nejm.org/doi/full/10.1056/NEJMp2413747
"Our concern here is that the Review transgresses medical law, policy, and practice, which puts it at odds with all mainstream U.S. expert guidelines. The report deviates from pharmaceutical regulatory standards in the United Kingdom. And if it had been published in the United States, where it has been invoked frequently, it would have violated federal law because the authors failed to adhere to legal requirements protecting the integrity of the scientific process."
https://law-yale-edu.uc.idm.oclc.org/sites/default/files/documents/integrity-project_cass-response.pdf
"It is not an authoritative guideline or standard of care, nor is it an accurate restatement of the available medical evidence on the treatment of gender dysphoria. It is not an effective framework for enhancing clinical services for a marginalized group of people. "

| 17 | Nicholas A. | RFS | Oppose |
|---|---|---|---|

This resolution states that "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 their culturally determined gender roles" and then immediately resolves to place undue attention and pressure related to their culturally determined gender roles on these children and adolescents by rescinding OSMA policy that protects these patient's ability to pursue being themselves. The claims regarding gender affirming care endorsed by this resolution are based on a body of work incredibly reliant on the Cass Review, which has been heavily critiqued by a multitude of experts in the fields of pediatrics and endocrinology for its conclusions (summarized excellently by McNamara et al in "An Evidence Based Critique Of "The Cass Review" On Gender Affirming Care For Adolescent Gender Dysphoria") and critically never actually called for a ban on gender affirming care for minors. This resolution also strongly misrepresents current gender-affirming care practices; most egregiously through its perpetuation of the false premise that mental health support and counseling are placed by the wayside in favor of immediate surgical referral, when in fact holistic, longitudinal mental health evaluation and support is a core tenet of WPATH guidelines. Gender Affirmation is based on a strong body of evidence that demonstrates the efficacy and necessity of transitioning to improve the health of these patients and to save lives, and thus the RFS strongly recommends the OSMA HOD does not adopt resolution 17.

| 17 | Adam B. | Self | in reply to Nicholas A. |
|---|---|---|---|

Dr. Arnold indicates that mental health support and counseling are a part of current evaluation. The issue is that this "mental health support and counseling" consists of affirming whatever the child says, or in some cases the parent claims the child says. Real therapy, examining why the child's view of his/her gender is not in line with the physical reality of his/her sex, is what the proponents of this resolution are advocating, instead of the current plan of just saying yes to anything.

| 17 | Jon B. | Self | Oppose |
|---|---|---|---|

Speaking on behalf of myself as an individual in strong opposition to this resolution. Other commenters have outlined the flaws in the Cass Review and why this cannot simply be applied to the United States, and why it does not provide support for a ban on gender-affirming care for minors. The OSMA should not support a resolution that goes against the evidence-based recommendations of our country's most reputable medical societies, even if our legislature passed a bill banning this care (which has now been thrown out by the court). The false narrative that these are unsafe treatments given without substantial consideration and evaluation only serves to further marginalize a community already at a higher risk for worse health outcomes, especially mental health outcomes.

| 17 | John O. | Self | Support |
|---|---|---|---|

Speaking for myself I support the resolution. Honoring our Hippocratic Oath to do no harm should be our OSMA's policy north star. In echoing the sentiment of the chief editor of the BMJ (British Medical Journal) *The Cass Review: an opportunity to unite behind evidence informed care in gender medicine," this is an opportunity for OSMA to have a second bite of the apple in protecting minors.

The Cass Review, the most comprehensive literature review coupled with follow-up of the available of the National Health Service's 9,000 patients. determined that there was little to support gender affirming care in minors. (The GDS (Gender Identity Development Services) to which many were referred refused to release data)

There are definite risks and harms associated with gender affirming care and as a result of the Cass Review, England is joining with Norway Sweden Finland and other European Nations in restricting access to gender affirming care except in tightly controlled circumstances. These and others conclude the proper care is based on love, respect, and emotional and mental support.

| 17 | Amber P. | Medical Student Section | Oppose |
|---|---|---|---|

Speaking on behalf of the MSS, in STRONG OPPOSITION of this resolution. We agree whole-heartedly with the sentiments of Gabe, Joshua, and Melissa already commented here. In addition, this resolution makes an attempt to rescind policy passed through the HOD as recently as 2023 which undermines the credibility of the OSMA as a legislative partner in Ohio. Most recently, the OSMA worked with numerous organizations across the state - AAP Ohio, OOA, OPPA, OCA, OSPA, ACS Ohio, Ohio AFP among others - to oppose HB 68 which banned gender affirming care. This coalition of organizations ALL OPPOSE a ban on gender affirming care, as does and should continue to the OSMA. Rescinding this policy could impact the OSMA's credibility if we flip our policies on this

matter multiple times within a year. Further, there has been no new evidence indicating gender affirming care is harmful. The current OSMA policy on this topic aligns with the AMA.

| 17 | Adam B. | Self | in reply to Amber P. |
|---|---|---|---|

Numerous MSS sponsored resolutions seek to rescind or revise existing OSMA policies, this year included. Why does it undermine our credibility to revise a stance here based on evidence, but not in other MSS resolutions based on far less evidence? This seems rather duplicitous.

| 17 | Joe H. | Self | in reply to Amber P. |
|---|---|---|---|

The Cass study debunks arguments being made in opposition. It was published 4/2024. Polls show the majority of our society does not support gender affirming care in minors and pushing it onto the people will further erode their trust in traditional medicine.

| 17 | Tracy G. | Self | Oppose |
|---|---|---|---|

Strongly oppose. The resolution's language is purposefully designed to incite strong emotions by use of terms such as mutilation. We need to trust that transgender, nonbinary and intersex individuals can make decisions regarding their health with their caregivers and physicians. NIH data strongly shows that gender affirming care reduces the risk of suicide in transgender youth, contrary to the data in the resolution. The Trevor Project suggests that there is an increase in suicidality in trans youth when such bans are put in place.
https://pmc.ncbi.nlm.nih.gov/articles/PMC9793415/
https://www.npr.org/sections/shots-health-news/2024/09/25/nx-s1-5127347/more-trans-teens-attempted-suicide-after-states-passed-anti-trans-laws-a-study-shows
https://www.hcplive.com/view/suicide-risk-reduces-73-transgender-nonbinary-youths-gender-affirming-care
https://pmc.ncbi.nlm.nih.gov/articles/PMC8099405/#:~:text=A%20total%20of%2027%20studies,Kuiper%20and%20Cohen%2DKettenis%20classification

| 17 | Joe H. | Self | in reply to Tracy G. |
|---|---|---|---|

This topic is gender dysphoria which is not the physical condition of intersex. Intersex has physical sexual characteristics of both sexes from birth and is distinctly different from gender dysphoria.

| 17 | Tracy G. | Self | Oppose |
|---|---|---|---|

For those using the Cass Report, this is an evidence based critique:
https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf

| 17 | Joe H. | Self | in reply to Tracy G. |
|---|---|---|---|

The quote I provided earlier from the Cass report 4/2024 reveals major flaws in the science up to that date which removes the evidence based argument.

| 18 | John C. | Self | Oppose |
|---|---|---|---|

While well-intentioned, this resolution would have unintended negative consequences for many physicians in the state of Ohio, especially those struggling to maintain independent practice. Total health care costs are best controlled by the organic innovation of practicing physicians, not our government. Our government should be making targeted, strategic investments in those areas of medicine proven to save money in the long-run, not placing arbitrary caps on any one area of care.

| 18 | Susan H. | Self | Oppose |
|---|---|---|---|

I oppose this resolution. Caps on health care expenditures are not the answer for the rising cost of health care. Statewide tracking of health care expenses is not good use of resources. Instead we need to look at the profits of health insurance companies, including Medicare Advantage, and the amount of money spent there on administration and executive salaries and staff working on such burdensome tasks as prior authorization.

| 18 | Jonathon R. | Self | Oppose |
|---|---|---|---|

Oppose as written. I once worked with a wonderful country doc when I was in the National Health Service Corp who had a saying. "You don't cut a dog's tail off one inch at a time. You will get bit." The health insurance industry is the dog. It is their administrative complexity and profit seeking that is in need of control. They have no interest in cost control. They will get to keep a percentage of whatever we spend. Why would they want to keep spending down by improving primary care and investing in public health to improve the social determinants of health?

All of the world's medical literature supports primary care because it will save lives and money. If we paid PCPs an annual income of the sort we pay orthopedists or urologists there would be no shortage. In order to get to a system where the cost savings and lifesaving that well trained primary care doctors can bring to our care, we need to deal with the current system. Deming, who taught the Japanese who to make great cares once said, "Every system is perfectly designed to give the results that it gives." Our system controlled by health insurers is perfectly designed to be a jobs program for health care profiteers and bureaucrats.

We need Universal coverage, a single system can make it Simple, one set of rules and payments no matter who is in your care. Rich or poor you will get paid the same for your skills not for locating your office in the suburbs. If it is universal and simple, the savings will make it affordable. USA- universal makes it simple which makes it affordable.

The CBO looked at improved expanded Medicare for all in December 2020. They say we can cover everyone with comprehensive benefits, no copays or deductibles, allow any patient to see any doctor or use any hospital. It means we can actually negotiate for drug and equipment prices like the Europeans do. The savings would be substantial for both doctors and hospitals given what they will save by the insurance related billing and administrative simplicity. It will boost our incomes and give us control over our work lives again. This universal simple affordable system would save at a minimum (per the CBO) $40 Billion annually vs. the current sickness care non-system.

| 18 | Joe H. | Self | Oppose |
|---|---|---|---|

Many great points already expressed by others.

| 18 | Adam B. | Self | Oppose |
|---|---|---|---|

The price controls suggested in this resolution will harm many physicians' practices if implemented. The problems with price controls have been well known for years as we have seen their failure whenever they have been implemented (usually in socialist countries like Venezuela). Below is an article from the Hoover institute thoroughly laying out the short and long term failures of these policies. Doing the same thing over again and expecting a different result is the definition of insanity.
https://www.hoover.org/research/price-controls-still-bad-idea

| 18 | Philip R. | Self | Oppose |
|---|---|---|---|

Medicare and Insurers have already provided for increased financial incentives for primary care, and will continue to do so. Also the idea of "inflation caps" is very poor; with rising physician employer business costs including computer and office expense, insurance, employee payroll, etc. these restrictions on charges will drive physicians away.

| 18 | Michael Massey | Medical Student Section | Support |
|---|---|---|---|

Speaking on behalf of the MSS in support of this resolution. Since I was also part of the authorship team, I wanted to address the concerns raised in the comments of this resolution. We are in support of this resolution for a few reasons.

1) Health care costs are out of control and health care cost have outpaced the inflation of all other goods and services, quote "Inflation in medical care prices and overall health spending typically outpaces inflation in the rest of the economy. However, since 2021, medical prices have grown at a similar rate as in past years while prices in some other parts of the economy grew much more rapidly than in the past.

While medical care prices increased by 2.2% between March 2023 and March 2024, the prices of all goods and services increased by 3.5%, according to an updated analysis. Prices for hospital services and related services (7.7%) – both inpatient (6.9%) and outpatient (8.3%) – as well as for nursing homes (3.9%) rose faster than for prescription drugs and physicians' services (0.4% and 0.7%, respectively)." (Source: https://www.kff.org/health-costs/issue-brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/ ). The overall aim of only one of the pillars of our resolution, which is the growth cost controls or inflation caps, is just to keep the health care inflation equal to the inflation of the rest of the economy.

2) With little oversight or accountability between hospitals and insurance companies, hospitals and health systems can charge hyperinflated prices and insurance companies can shift more and more of the costs onto the patient ( https://time.com/198/bitter-pill-why-medical-bills-are-killing-us/ ), and laws enacted to reign in health care costs and provide transparency, like The Transparency Rule have been very poorly enforced (https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/64b9898df7a22a6151fe7d07/1689880974977/July+2023+PRA+Hospital+Price+Transparency+Compliance+Report.pdf ).

3) The US invests very little into primary and preventative health care, and the literature demonstrates that higher investments into primary care lowers health care spending and improves outcomes (Sources 10-15 of the resolution and https://www.aafp.org/dam/AAFP/documents/advocacy/state/toolkits/primary-care-investment/primary-care-policy-and-investment-toolkit.pdf )

4) Finally, the policies this resolution has proposed have been enacted and studied in several states now, and have shown to lower health care costs substantially, while having no effect or improving health care outcomes (https://pubmed.ncbi.nlm.nih.gov/30715981/ ).

In writing and now even in responding to the concerns outlined in the comments, we have not been able to find any literature or articles that actually demonstrates that these inflation caps or control mechanisms have hurt independent private practices in these states.

However, we do not want to hand wave away the concerns raised by OSMA members here and are happy to defer to the reference committee regarding the inflation cap policy promoted in our resolution.

| | | | |
|---|---|---|---|
| We would also point out that our resolution also calls for the OSMA to advocate for state targets for commercial insurers to increase their total health expenses percentage in primary care and care coordination, which is another proven method to reducing total health care costs, and none of the commenters raised an issue with that resolved clause. | | | |
| **18** | **Charles S.** | **Self** | **Oppose** |
| Primary care physicians are already being squeezed out of existence by inflation and increasing overhead. | | | |
| **18** | **Susan H.** | **District 3** | **Oppose** |
| We oppose as written. | | | |
| **19** | **John C.** | **Self** | **Support** |
| This would be a huge help to our student applicants, providing support for them in an area of great need. | | | |
| **19** | **Engy H.** | **Self** | **Support** |
| Support. | | | |
| **19** | **Shannon T.** | **District 2** | **Support** |
| Support. | | | |
| **19** | **Joe H.** | **Self** | **Support** |
| Mental health management is vital and issues associated with it are at the heart of many modern problems. Institutional processes are increasingly complicated and can unintentionally harm. | | | |
| **19** | **Suzanne S.** | **OPPA** | **Support** |
| Support, on behalf of the Ohio Psychiatric Physicians Association. | | | |
| **19** | **Susie P.** | **Self** | **Support** |
| Support. | | | |
| **19** | **Saaleha S.** | **Medical Student Section** | **Support** |
| Support. | | | |
| **20** | **John C.** | **Self** | **Support, with amendment suggestion** |
| I support R1, but would oppose R2 as outside the purview of our OSMA. | | | |
| **20** | **Elizabeth M.** | **Self** | **Support** |
| I support child proof packaging as a harm-reduction tactic for THC products, and also some sort of mandatory reporting of positive marijuana tests in pediatric patients (I don't know that it has to be a database, but at least having some statistics for tracking exposure and adverse events would be helpful for public health efforts). | | | |
| **20** | **Stephen Terry H.** | **SPS** | **Support** |
| SPS supports this resolution as a patient safety issue. | | | |
| **20** | **Shannon T.** | **District 2** | **Support** |
| Support. Consider combining resolution 20 and 21. | | | |
| **20** | **Joe H.** | **Self** | **Support** |
| Support. | | | |
| **20** | **Suzanne S.** | **OPPA** | **Support, in part** |
| On behalf of the Ohio Psychiatric Physicians Association. Mostly support. I do not believe a database is justified, would be too costly. Agree with combining Resolutions 20 and 21. | | | |
| **20** | **Susie P.** | **Self** | **Support, in part** |
| This is common sense. Database - yes. I disagree that it would be too costly. | | | |
| **20** | **Susan H.** | **District 3** | **Support R1, Oppose R2** |
| We support Resolved 1. We oppose Resolved 2. | | | |
| **21** | **Douglas W.** | **Self** | **Oppose** |
| The wording of the resolution is problematic as it states that 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 approved clinical research studies" but also "opposes legalization of any presently illegal drugs of substance abuse including cannabis, except an instance for improved evidence-based use by the FDA". In order for cannabis to be clinically researched, it must be removed from federal Schedule 1 status and essentially legalized. | | | |
| **21** | **Savanna K.** | **Medical Student Section** | **Support** |
| Speaking on behalf of the MSS, with a clarifying point to Douglas W: our policy proposes amendments via addition to an already approved policy, Policy 07 - 2016- Cannabinoids. We want to add points 8-11. Points 2 and 6, which this comment is directed at, are already approved in our OSMA policy compendium. | | | |
| **21** | **Engy H.** | **Self** | **Support** |
| Support. | | | |
| **21** | **Shannon T.** | **District 2** | **Support** |
| Support. Consider combining resolution 20 and 21. | | | |

| 21 | Susie P. | Self | Support |
|---|---|---|---|
| Support. | | | |
| 21 | Susan H. | District 3 | Support |
| We support this resolution. | | | |
| 22 | John C. | Self | Support |
| Support. | | | |
| 22 | Engy H. | Self | Support |
| Support. | | | |
| 22 | Shannon T. | District 2 | Oppose, with amendment suggestion |
| Oppose as written. Would support with the following amendment:<br>RESOLVED, that our OSMA supports that comprehensive training on intimate partner violence screening be available to medical students, residents, and physicians in Ohio. | | | |
| 22 | Joe H. | Self | Oppose, with amendment suggestion |
| Oppose. Agree with Shannon T./District 2 | | | |
| 22 | Suzanne S. | OPPA | Support |
| Support. | | | |
| 22 | Brandon F. | RFS | Support |
| Support. | | | |
| 22 | Susie P. | Self | Support |
| As a survivor of IPV, I fully support this resolution as written. Thank you, Medical Student Section, for presenting this resolution. | | | |
| 22 | Glen M. | Medical Student Section | Support, with amendment |
| In support of this resolution and of District 2's amendment. Intimate partner violence is a growing national and state public health concern. Medical students and physicians are uniquely positioned to learn about sexual violence and screen for it during clinical visits and hospital admissions. | | | |
| 22 | Nicholas A. | RFS | Support |
| As outlined in the preamble of this resolution, IPV affects a significant percentage of our patient population and is at the moment under screened, resulting in patients not being referred to resources and professionals with the potential to radically improve their health and safety. By formally acknowledging the importance of training medical students, residents, and physicians regarding recognizing, screening, and referring for IPV with formal policy, OSMA will encourage physician training programs at all levels to improve their approach to IPV, and thus the RFS recommends the OSMA HOD adopts resolution 22. | | | |
| 22 | Susan H. | District 3 | Oppose, support with amendments |
| We oppose the Resolved as written and support District 2's amended language. | | | |
| 23 | Engy H. | Self | Support |
| Support. | | | |
| 23 | Susan H. | Self | Oppose |
| Speaking for myself, I am opposed to this resolution as written.<br>1. Our OSMA cannot pass policy for AMA.<br>2. The FDA already encourages reporting of side effects of medications and the capability of doing a data base. I do not think that creating a new data base for these specific drugs is necessary. | | | |
| 23 | Shannon T. | District 2 | Oppose |
| Oppose. | | | |
| 23 | Joe H. | Self | Oppose |
| Oppose, agree with Susan H. | | | |
| 23 | Susie P. | Self | Support, with amendment suggestion |
| Amend to "RESOLVED, that our OSMA 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)." | | | |
| 23 | Susan H. | District 3 | Oppose |
| We are opposed to this resolution as written.<br>1. Our OSMA cannot pass policy for AMA.<br>2. The FDA already encourages reporting of side effects of medications and has the capability of doing a data base. We do not think that creating a new data base for these specific drugs is necessary. | | | |
| 24 | Engy H. | Self | Support |
| Support. | | | |
| 24 | Chris B. | Self | Support |

| | | | |
|---|---|---|---|
| I think that considering compensation for physicians for time spent on annual compliance would assist in preventing unfunded compliance mandates and provide pressure to ensure that the compliance topics and education activities are provided in an efficient manner. | | | |
| **24** | **Ellena P.** | **Medical Student Section** | **Support** |
| The Medical Student Section supports this resolution. | | | |
| **24** | **Engy H.** | **OMSS (Authors/Sponsor)** | **Support** |
| OMSS brought this resolution as physicians are already overburdened with compliance training in healthcare facilities and this would help streamline and/or help cover the cost associated with the time spent doing the training. | | | |
| **24** | **Joe H.** | **Self** | **Support** |
| Streamline, reduce redundancies. | | | |
| **24** | **Maria P.** | **YPS** | **Support** |
| We support this resolution. Eliminating redundancies will help limit the burden of duties on physicians and reduce burn out and increase retention of physicians. | | | |
| **24** | **Susan H.** | **District 3** | **Support** |
| We support this resolution. | | | |
| **25** | **John C.** | **Self** | **Support** |
| Support. | | | |
| **25** | **Engy H.** | **Self** | **Support** |
| Support. | | | |
| **25** | **Engy H.** | **OMSS** | **Support** |
| Support. On behalf of OMSS. Having the option of creating physician-owned hospitals is important for competition in the healthcare marketplace. Physicians are also directly responsible and liable for treatment outcomes, as opposed to be business corporations. | | | |
| **25** | **Susan H.** | **Self** | **Support** |
| I support this resolution. This is no reason why physicians should not be able to own a hospital. The rules against physician ownership are arbitrary and unfair. | | | |
| **25** | **Shannon T.** | **District 2** | **Oppose, with amendment suggestion** |
| Oppose as written. Support R1 with deletion of advocate and replace with work with interested parties. Delete R2, R3, R4. | | | |
| **25** | **Joe H.** | **Self** | **in reply to Shannon T.** |
| Physicians are the interested party. There is no one else. What is your rationale to opposition and/or cutting out the resolved clauses? | | | |
| **25** | **Johnathon R.** | **Self** | **Oppose** |
| I agree if anyone can "own" a hospital then I have no problem with it being physicians. My problem is that we all pay for all of it and there is no evidence that competition has improved quality or lowered costs in health care. We need hospitals that are targeted to the needs of the population. If we had a certificate of need for large capital expenses and it was docs putting a hospital in an area of need, I am fine with it. If it is duplicating services, it will just increase costs for all of us. | | | |
| **25** | **Joe H.** | **Self** | **in reply to Johnathon R.** |
| If docs can again OWN hospitals then our future discussions at OSMA can be to address how to meet the need even better. If docs stay restricted in this way then we have even less hope of making a difference. | | | |
| **25** | **Joseph H.** | **Self (Authors, District 6)** | **Support** |
| As the author of the resolution and having the support of district 6 this resolution works to empower physicians to reclaim some control over healthcare in our communities bringing a unique facet of competition to a market dominated by businessmen. At the heart of the physician is the patient and this equips us to make the hard financial decisions in a unique way. Physician owned facilities employ businessmen to do what they do best but we have the power of override. As a historical reminder, physician owned hospitals tripled in number the decade prior to the ACA. The ACA and the lobby behind it have effectively deterred the competition, us. Let us unite with the AMA, and others, to restore this option for the communities we serve. Physicians are the interested party here so it is up to us. The American Hospital Association has and will oppose physician ownership. Why would physicians oppose it? | | | |
| **25** | **Adam B.** | **Self** | **Support** |
| Support. | | | |
| **25** | **Joe H.** | **Self** | **Support** |
| Currently every worker in a hospital has legal freedom to own a hospital except for physicians. Since 15 years have passed with significant restriction on physician ownership the ability to properly study and compare POH vs non POH is limited. CMS has studied and reported showing no issue in referral patterns by owning physicians as compared to non owning physicians. Consolidation is a driving force in cost escalation while competition of at least 4 hospitals in a designated region decrease costs. This law is discriminatory against one group only - physicians. | | | |
| **25** | **Glen M.** | **Medical Student Section** | **Support** |
| Speaking on behalf of the MSS in support of this resolution and of District 2's amendment. | | | |

| | | | |
|---|---|---|---|
| 25 | Neil S. | Self | Support |
| I support the resolution. No one can lead an organization to provide high quality, patient-centered care better than physicians. | | | |
| 25 | Susan H. | District 3 | Support, with amendment |
| We suggest amendment to Resolved 1 to say: Our OSMA supports policies to restore physicians ability to own, expand, or construct any form of hospital. We oppose the other resolved clauses. | | | |
| 26 | John C. | Self | Support |
| Support. | | | |
| 26 | Engy H. | Self | Support |
| Support. | | | |
| 26 | Susan H. | Self | Support |
| Totally support requiring seat belt use in moving vehicles. When I was in California for the Rose Bowl, the buses were equipped with seat belts and the drivers were required to do a safety message stating that California law requires seat belts. They did not go through the bus checking on whether the seat belts were actually being used but I had mine on. My dad installed seat belts in our family car before they were standard in cars. The data is clear that seat belts should be worn. | | | |
| 26 | Harsimran M. | Medical Student Section | Support |
| Speaking on behalf of the Medical Student Section, we support this resolution. | | | |
| 26 | Shannon T. | District 2 | Oppose, with amendment suggestion |
| Oppose as written. Would support with amendments. Recommend following amendments to R1 and R2:<br>RESOLVED, that the Ohio State Medical Association supports efforts to increase seat belt utilization; and be it further<br>RESOLVED, that the Ohio State Medical Association supports efforts to increase compliance with seat belt utilization laws. | | | |
| 26 | Susie P. | Self | Support |
| It is well known that seat belt use reduces MVC related injury and death. | | | |
| 26 | Gary K. | Self | Support |
| I am in support of this resolution with the minor changes suggested by District 2. This policy is thematically consistent with the stance the OSMA took in 1991 on protective helmets: 62-1991. | | | |
| 26 | Susan H. | District 3 | Support, with amendment |
| We support Resolved 1. We would amend Resolved 2 to say: Our OSMA supports requiring seat belt use in back seats of cars and on school buses and other forms of public transportation. | | | |
| 27 | Susan H. | Self | Oppose |
| I am opposed to this resolution as I do not feel that this is the purview of our OSMA. Water quality in Ohio is already highly regulated by the EPA and reports are published regularly regarding water quality. Also Ohio already has a plan to address this issue and it continues to be implemented. | | | |
| 27 | Johnathon R. | Self | Support |
| There are already water quality improvement efforts going on in Ohio but with the Federal EPA under full attack I feel it is appropriate that we as physician speak out for environmental protection and even more important that OSMA support the Ohio EPA and protect them from similar attacks. | | | |
| 27 | Adam B. | Self | Support |
| Support. | | | |
| 27 | Susie P. | Self | Support |
| Support. | | | |
| 27 | Susan H. | District 3 | Support, with amendments |
| We support Resolve 1 as written. We suggest substituting "support" for amplify in R2. We support deleting resolved clauses 3 and 4. | | | |
| 28 | John C. | Self | Support |
| Support. | | | |
| 28 | Engy H. | Self | Support |
| Support. | | | |