OSMA 2025 Annual Meeting – Resolution Committee Two
Online Testimony – Preliminary Report

Res. #	Comment By:	Representing	Position	Comment
29	Melissa M.	Self	Oppose	The term "embryonic cardiac activity" over "fetal heartbeat" before 10 weeks gestation is recommended and preferred by the American College of Obstetricians and Gynecologists and the Society of Radiologists in Ultrasound. https://www.acog.org/contact/media-center/abortion-language-guide https://pubs.rsna.org/doi/full/10.1148/radiol.240122
29	Elizabeth M.	Co-Author	Support	**As one of the authors, I only just realized that the resolution as posted was not the final version that we submitted. I will re-submit the final version in advance of the annual meeting, but without reposting the whole thing, please note that we had an additional references for your consideration: Whereas, all standard medical and embryology texts acknowledge that the fetal heartbeat begins within the first month of development. For example, in 2020, researchers from the University of Oxford's Division of Cardiovascular Medicine noted in their basic introduction to cardiovascular embryology that 'The initiation of the first heartbeat via the primitive heart tube begins at gestational day 22, followed by active fetal blood circulation by the end of week 4' [2]. Other papers and scholarly works agree that the onset of the heartbeat is somewhere between 22-30 days postfertilization [3, 4]. [2] https://pubmed.ncbi.nlm.nih.gov/31533099/ [3] https://www.ehd.org/virtual-human-embryo/ages.php?stage=17 [4] https://pmc.ncbi.nlm.nih.gov/articles/PMC2000955/pdf/1294.pdf ** OSMA staff corrected the error when it was brought to our attention on 3.17.24.
29	Adam B.	Self	Support	Speaking on behalf of myself, I support this resolution. The opposition to the use of the term "fetal heartbeat," though minimal, seems rather strange. The term doesn't assert that the child's heart is fully formed at six weeks in utero. It merely approachably describes a heart that is functioning properly for the child's age, and if allowed to continue developing will soon function the way our own adult hearts do. So why have some fringe groups, in the past few years, pushed for the use of the less approachable and unclear but synonymous term "physiologic electrical activity" instead? Likely, the intent was to prevent people without medical training from consciously acknowledging that we are talking about a living human. "Fetal heartbeat" is a clearly understandable term that helps the medical field be easily comprehensible to ordinary citizens at a time when it is crucial to not be elitist and exclusionary in our field.

				For further analysis, I recommend the following article from the Ethics and Public Policy Center: https://eppc.org/publication/the-real-science-of-fetal-heartbeats/
29	Joe H.	Self	Support	Agree with Adam B - well said.
29	Amy B.	ACOG	Oppose	We should encourage the correct use of medical terminology unless of course the aim is to confuse the public which we often see if the case around abortion policy and legislation. ACOG agrees with the terminology as written in the current policy and opposes any change that does not align with the radiologic references ie. "embryonic cardiac activity" over "fetal heartbeat" before 10 weeks gestation. We are scientists and physicians. The use of zygote, embryo, and fetus can and should be used and taught. We should be able to discuss when structures are and are not fully formed when talking with patients and legislators if we are going to have a discussion on abortion. https://www.acog.org/contact/media-center/abortion-language-guide https://pubs.rsna.org/doi/full/10.1148/radiol.240122
29	Philip R.	Self	Support	Speaking for myself. Why do people want to eliminate the phrase "fetal heartbeat?" The only possible reason is to get rid of the humanization of the fetus, so that abortions can be performed without compunction and eliminate any emotional association with abortion. I believe the ACOG prefer the "embryonic cardiac activity" for the same reason, not because it is academically more accurate. The authors of this resolution have given succinct reasoning as to keeping the "heartbeat" phrase: medical tradition, convention, physiology and unambiguous patient and public communication all support striking the #5 Resolution.
29	Brandon F.	RFS	Oppose	I would reiterate what our representatives from ACOG have referenced below: that the term "fetal heartbeat" is not the medically accepted term and that legislation should use medically accurate language so as not to confuse the general public.
29	Susie P.	Self/Co-author	Support	The fetal heart is fully formed by week 10, therefore 'fetal heartbeat' from gestational week 10 through the end of pregnancy is the correct medical terminology. As the co-author of this resolution, I am open to adding 'embryonic cardiac activity' to refer to gestations younger than 10 weeks, as has been offered here in the comments - thank you for the heads up!
29	Maria P.	YPS	Oppose	"Fetal heartbeat" is an inaccurate term to utilize in discussions of ultrasound assessment of cardiac activity. As representatives of the medical profession we should seek to align our language with the recommended language that is most scientifically accurate which is what the existing policy requires. ACOG specifically recommends use of embryonic cardiac activity before 10 weeks and fetal cardiac activity afterwards. https://www.acog.org/contact/media-center/abortion-language-guide

				Some commenters allege that by insisting on medically inaccurate language that we are somehow being political however changing medically accurate language to medically inaccurate language is actually political and specifically leads to politicians and legislators with no medical background to grossly misinterpret information which has historically led to inappropriate limitations on the practice of evidence based medical care including but not limited to abortion. The OSMA should oppose any attempts to politicize language away from the most scientifically accurate information to avoid interference in the physician-patient relationship and avoid inappropriate restrictions on abortion care both of which our OSMA supports.
29	Jen Wayland	MSS	Oppose	In addition to the points previously stated that existing language is preferred by multiple specialty societies, it is important that we advocate for accurate medical terminology, especially to avoid misinterpretation and confusion when laws are applied. This is important in this case in particular because the term "fetal heartbeat" is often used inaccurately in legislation, for example, at 6 weeks' gestation the accurate scientific/medical term is "embryo" and not "fetus," and the valves that create "heartbeat" sounds are not yet formed.
29	Charles S.	Stark County Med. Soc.	Support w/suggested amendment	The Stark County Medical Society supports the resolution but would like to amend by ending resolve #4 after health care services, omitting "including fertility treatments, contraception, and abortion" because ... The OSMA recognizes and supports each individual physician's right to maintain their own personal views. It is neither our duty nor our intent to alter personal views." Yet, including the last word in this resolve means that the OSMA, and by corollary, the OSMA members support abortion, not respecting the individual member's views.
29	Glen M.	Self	Oppose	Speaking on behalf of myself in opposition for many of the reasons others have commented. I would direct the resolution committee to a recent case in South Carolina in which the South Carolina Supreme Court is currently debating the statutory meaning of "fetal heartbeat" precisely because it is ambiguous, ill-defined, and contrary to widely accepted medical guidelines and knowledge. Let's listen to our OB-GYN subject matter experts on this topic and put this to bed rather than look ridiculous debating semantics of a topic on which we already have clear policy.
29	Adam B.	Self	Response to Glen's Comment	Hopefully your concerns will be sufficiently addressed by Susie P's amendment. Speaking more broadly on the topic: The fact that a fringe fragment of abortion activists are so adamantly against the use of "fetal heartbeat" can't be explained alone by a dogmatic insistence to be medically precise language. Everyone from a simple farmer to the most prestigious physician knows that a child in the womb is developing, growing, and doesn't fully resemble their final form. We all use common vernacular to

				describe medical conditions and in policies and medical settings all the time. In fact, our medical schools specifically instruct us to use language that is as approachable to patients as possible. So why does “fetal heartbeat” really upset them so much? It is because they desperately want to avoid the use of language that treats these children as living humans. The Ethics and Public Policy Institute lays out the history of this tactic (https://eppc.org/publication/the-real-science-of-fetal-heartbeats/). This can also be seen in the slogan “my body, my choice” which makes it seem as if only one person is involved in an abortion. This slogan takes into account the mother's perspective as it should, yet it fails to consider the innocent child's perspective. If these children are thought of as living human beings, then the activists will have to grapple with the bioethics of killing a healthy child. A position they are too afraid to address directly. If they are not afraid to address it, then let them support this resolution and prove it.
29	Susie P.	Self/Co-author	Support w/suggested amendment	We do not rely solely on ACOG's position on 'fetal heartbeat' terminology for the following reasons: ACOG's position in 2023 was 'that the heart chambers are not yet developed and cannot be detected by ultrasound until gestational weeks 17-20.' https://web.archive.org/web/20230921023047/https://www.acog.org/contact/media-center/abortion-language-guide The SC case mentioned on this thread (about the 'Heartbeat Bill'): https://perma.cc/5KKH-AQ2Y In this filing are multiple statements, offered by the plaintiffs (Planned Parenthood), admitting that 'medical consensus' states that the heart has fully formed by 9-10 weeks, and that 'fetal heartbeat' refers to the point in pregnancy when the heart has fully formed. On page 6 there is a footnote on the SC filing, written by the attorneys for Planned Parenthood, that reads: '6 In their petition for rehearing in Planned Parenthood II, Petitioners cited an amicus brief submitted by the American College of Obstetricians and Gynecologists, the American Medical Association, and the Society for Maternal-Fetal Medicine for the proposition that “a true fetal heartbeat exists only after the chambers of the heart have been developed and can be detected via ultrasound, which typically occurs around 17–20 weeks’ gestation [(LMP)].” Br. of Amici Curiae

				Am. Coll. of Obstetricians and Gynecologists et al. in Supp. of Planned Parenthood S. Atl. et al. at 10, Planned Parenthood II (emphasis added). After consulting with experts, Petitioners understand that a heart forms earlier than that, but that an ultrasound will not be able to detect the essential features of a heart until later. Crockett Decl. ¶ 30. Some highly sophisticated technology will be able to detect the four chambers of the heart as early as twelve weeks (typically performed for patients with high-risk pregnancies), and an echocardiogram (also for patients with high-risk pregnancies) performed at 18–20 weeks LMP allows for an even more detailed visualization of the heart. Id. ¶¶ 34–35' Since that filing, ACOG has amended its statement on terminology in its 'Guide to Language and Abortion' (linked by an opposing commenter below on this thread), removing its 2023 criteria that the structures of the heart must also be detectable by ultrasound, to state 'Until the chambers of the heart have been developed, it is not accurate to characterize the embryo or fetus's cardiac development as a heartbeat'. Yet, this is ACOG's recommended language: 'Embryonic cardiac activity" before ten completed weeks of gestation and "fetal cardiac activity" after ten completed weeks of gestation.' ACOG does not recommend EVER using the word 'heartbeat'...at any point in development. https://www.acog.org/contact/media-center/abortion-language-guide Therefore, it seems that ACOG's position on this topic is based on its desire to defeat Heartbeat Bills in the courts, not on objectively true scientific data. The other link posted on this thread in opposition to Resolution #29 is here: https://pubs.rsna.org/doi/full/10.1148/radiol.240122 In it, the Society of Radiologists in Ultrasound make statements that their purpose in creating a lexicon is in reaction to the Dobbs decision and how it affects access to abortion, and the possibility that criminal charges for practitioners may result from Dobbs without a (protective) lexicon. Specific to the term 'heartbeat', the Society states 'However, the term 'heart' implies a fully formed organ, and cardiac development is gradual and incomplete during the GAs discussed in this document (17,38).' The Society's citation #17 https://perinatology.com/Reference/Fetal%20development.htm states 'the heart is beating at'...(lists a rate), beginning at 7 weeks gestation; and the Society's citation #38 https://pubmed.ncbi.nlm.nih.gov/23633400/ doesn't seem to mention the timeline of cardiac development or what to call cardiac activity at all - but I could not access the full article. https://pmc.ncbi.nlm.nih.gov/articles/PMC7265763/figure/F2/

				Medical knowledge to date seems to tell us that the heart fully forms by 10 weeks gestation, and at that point cardiac activity is termed 'fetal heartbeat'; prior to 10 weeks gestation, it is termed 'embryonic cardiac activity'. I can accept that, and I am willing to amend the Resolution to reflect this.
29	Adam B.	Self	Response to Susie's Comment	On Behalf of myself, I second an amendment along the lines of Susie P's comment. This will quell some commenters' concerns regarding "medical accuracy" and allow us to unify behind this resolution.
29	Tracy G.	Self	Oppose	I will cite the same reference from ACOG as Amy B and Maria P. This resolution attempts to use the term fetal heartbeat to incite emotion. The term fetal heartbeat and embryonic cardiac activity are not interchangeable. Furthermore, the term "viable" pregnancy should be used only to refer to the age of fetal viability, which is approximately 22-23 weeks and based on the gestational age the NICU is comfortable resuscitating. I also find issue with the resolution stating that the language should be changed so lobbyists don't get confused. Issues surrounding pregnancy and abortion can be confusing and quite nuanced, so are best left to women and their doctors, not politicians. Changing the language to serve a political purpose would be highly unethical for a medical organization. https://www.acog.org/contact/media-center/abortion-language-guide
30	Melissa M.		Oppose	Evidence based medicine and extensive research are pretty clear that vaccines, including the COVID-19 vaccine, are safe and effective and have saved millions of lives.
30	John C.	Self	Oppose	
30	Engy H.	Self	Oppose	
30	Shannon T.	District 2	Oppose	
30	Christopher W.	YPS	Oppose	
30	Suzanne S.	Self	Oppose	
30	Philip R.	Self/Author	Support	It was originally submitted with a request for title change to "Rational Approach to Immunizations." I am sorely disappointed in the lack of knowledge in my colleagues concerning adverse effects of immunizations, and especially the mRNA, covid-19 vaccinations. I would have expected opposition a year ago, and indeed received criticism for these views in 2021. But I don't understand why physicians would oppose making pharmaceutical companies take liability for the products they sell, unless they have ulterior motives or relationships with these companies. Physicians are not trained, nor do they report, vaccine-associated adverse events(1,2). It is now well known that there is an increase in morbidity and mortality post-Covid 19 vaccine – not due to "long Covid(3,4,5);" doctors need to pay attention to trends of patient disease in their clinics, to get vaccination histories, and consider the correlation of a post-immunization myocarditis, neurological event such as Guillan-Barre, stroke, or cancer acceleration. Physicians need to do their research objectively and get past the

				cognitive dissonance because they took the shots, due to medical school teachings, hospital mandates, government and other invested parties' coercion. Even our own Cleveland Clinic reported the ineffectiveness of the vaccine in preventing infection(6). Post-C-19 immunization myocarditis, for example, is now thoroughly documented(5-7) and the possibility of this was previously discredited as were other adverse events. All-cause mortality post-VAX introduction has been documented in the US(3,4,9,10,11,12) and other countries that are keeping data, including UK and Czechoslavakia(13), among others(14). This Resolution is straightforward, and simply asks physicians and healthcare workers to give informed consent (required in administration of all medications), and for pharmaceutical companies to be liable for the products they sell. Why would physicians oppose this? 1. https://academic.oup.com/cid/article/61/6/864/451758?login=false 2. https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf 3. https://ijvtpr.com/index.php/IJVTPR/article/view/101/341 4. https://ijvtpr.com/index.php/IJVTPR/article/view/104/371 5. https://publichealthpolicyjournal.com/breakthrough-infection-signal-in-vaers-corroborates-igg4-mediated-increased-susceptibility-to-sars-cov-2/ 6. https://pmc.ncbi.nlm.nih.gov/articles/PMC10234376/ 7. https://news.yale.edu/2023/05/05/yale-study-reveals-insights-post-vaccine-heart-inflammation-cases 8. https://www.cdc.gov/vaccine-safety/vaccines/covid-19.html#cdc_generic_section_6-a-closer-look-at-the-safety-data 9. https://www.nejm.org/doi/full/10.1056/NEJMoa2110737 10. https://jamanetwork.com/journals/jama/fullarticle/184421 11. https://insurancenewsnet.com/innarticle/excess-mortality-continuing-surge-causes-concerns 12. https://www.sciencealert.com/unexpected-deaths-in-the-us-are-rising-at-an-alarming-rate 13. https://substack.com/home/post/p-157570287?source=queue 14. https://www.sciencedirect.com/science/article/pii/S0264410X24001270?via%3Dihub
30	Adam B.	Self	Support	I think there may be some people misreading this resolution, as it doesn't attack the use of vaccine. It merely offers a more nuanced approach to the issue so that we can regain public trust. While the evidence clearly shows that, in general, vaccines have saved countless lives and improved our society, there have certainly been examples of harmful side effects as well. We should not forget a basic tenet of medicine: patient autonomy. We should not be forcing people to get a vaccine against their will or without their fully informed consent. Too often, patients skeptical of vaccines are met with animosity instead of reasonable conversation, and their concerns are dismissed (I have witnessed this firsthand in clinical settings). Covid vaccine

				mandates have unfortunately damaged public trust in physicians, and done more harm than good, as many studies have shown (sources 1-4). Let us evaluate our mistakes and take active steps, like passing this resolution, to restore trust in our profession. Bardosh, Kevin, et al. "The unintended consequences of COVID-19 vaccine policy: why mandates, passports and restrictions may cause more harm than good." BMJ global health 7.5 (2022): e008684. Olick, Robert S., Jana Shaw, and Y. Tony Yang. "Ethical issues in mandating COVID-19 vaccination for health care personnel." Mayo Clinic Proceedings. Vol. 96. No. 12. 2021. Nahum, Ari, Dimitri M. Drekonja, and Jonathan D. Alpern. "The erosion of public trust and SARS-CoV-2 vaccines—more action is needed." Open forum infectious diseases. Vol. 8. No. 2. US: Oxford University Press, 2021. https://sciencebasedmedicine.org/trust-in-science-and-vaccines-continues-to-decline-why/
30	Joe H.	Self	Support	Big Pharma should be held accountable if appropriate and as they receive all the profits they should be the entity funding the vaccine adverse event reporting system (VAERS) but not the entity managing it. Educating physicians regarding VAERS & vaccine side effects and encouraging the use of VAERS are positive things that can help us better care for our patients. Simplifying the data input to improve the burden of utilization is a positive step in this rarely discussed problem. None of us should deny that vaccines, although safe and effective in most cases, do have adverse events which do cause harm and it up to us to manage those situations. As physicians we function daily in the practice of medicine explaining risk:benefit of treatments then respecting a patient's autonomy (if of age & sound mind). No mandates - this assumes it is best for all in all circumstances and devalues the individual. I have seen many patients lose their confidence and trust in traditional medicine during the Covid mandates and that loss of trust is driving some of them away from traditional medicine (see Dr Norman Moser's resolution on alternative treatment harms) into potentially dangerous poorly studied alternatives and is a contributor to an escalating refusal of some people to have true vaccines like the MMR. We need to study this better and improving and using the VAERS is a good start.
30	Brian B.		Oppose	Simplifying VEARs; sure.

				Undermining vaccines; one of the greatest achievements of mankind for saving years of life? NO!
30	Brandon F.	RFS	Oppose	
30	Charles S.	Stark County Med. Soc.	Support w/suggested amendment	Confusing resolution. Stark county medical society would like to make a substitute resolution: RESOLVE. - That the OSMA SUPPORT THE use OF DOUBLE-BLIND, PLACEBO CONTROLLED STUDIES BEFORE APPROVAL OF NEW VACCINES TO PROPERLY DOCUMENT THEIR THE EFFICACY AND SAFTY. THAT THE OSMA ENCOURAGE THE AMA TO LOBY THE CDC TO SIMPLIFY THE VAERS ENABLING PHYSICIANS TO MORE EASILY REPORT ADVERSE EVENTS FROM VACCINES. THAT THE OSMA ENCOURAGE THE USE OF IMMUNIZATION REPORTING SYSTEMS FOR PATIENTS OF ALL AGES. THAT THE OSMA ENCOURAGES THE PROTECTION OF PATIENTS AUTONOMY AND INFORMED CONSENT WITH RESPECT TO IMMUNIZATIONS. AND THAT THE OSMA RESPECTS AN INDIVIDUAL'S RIGHT TO SELF DETERMINATION REGARDING HEALTH CARE TREATMENTS INCLUDING VACCINATIONS AND THAT NO PERSON SHOULD BE FORCED TO UNDERTAKE ANY TREATMENT AGAINST THEIR WILL.
30	Glen M.	Self	Strongly Oppose	I'd like to point out that the resolution uses citations inappropriately. For instance, whereas 1 cites to source 1 to claim "vaccinations are the only medical treatments in which pharmaceutical companies and healthcare providers are released from liability". However, this is not true. The PREP Act releases providers from liability for administering countermeasures during a pandemic. Treatments authorized under Emergency Use Authorization release providers from liability. And there is considerable state law variability in terms of liability for the production and sale of vaccines. Further, source 3 is a blog post written by an individual who spent 11 years in jail for cheating investors out of $700 million and source 4 is authored by a vaccine claimant lawyer who clearly has professional biases. The resolution asks for randomized, double-blind, placebo-controlled vaccine trials, but does not cite any scholarly work. Additionally, regarding Resolved 3, there is already considerable statutory and common law product liability (which would include pharmaceuticals) in Ohio. See O.R.C. Title 23 Chapter 2307 Civil Actions.
30	Ellena P.	Self	Strongly Oppose	The final whereas states that childhood diseases such as diabetes, allergies, and autism are linked to vaccine schedules. Studies regarding links to vaccines and autism have been debunked numerous times. The HRSA data cited does not support a link between vaccine schedules and the diseases as mentioned in the WHEREAS.

30	Saaleha Shamsi	MSS	Oppose	On behalf of the MSS, in Strong Opposition.
30	Philip R.	Self/Author	Support	GlenM wrongly claims that cited references supporting Resolution 30 are inappropriate. The cited reference 1 is accurate, since it refers to the National Vaccine Childhood Injury Act (NVCIA) of 1986. This act was promoted by pharmaceutical companies, claiming they could not afford to develop vaccines for the greater good if hampered by lawsuits. The NVCIA site states "The law preserved the right for vaccine injured persons to bring a lawsuit in the court system if federal compensation is denied or is not sufficient or when there was evidence a drug company could have made a vaccine safe." Well, please read the Act, and the requirements, and you find out who pays compensation to victims, if they can prove injury (difficult): the taxpayer. Another problem with the NVCIA is that to file a claim a Special Master is appointed in the court, and the time limits for injury determination are laughable, usually 24 to 15 days(1). Often parents or patients won't realize they have been injured till later, and now it's too late to apply, and the manufacturer is "off the hook" There is considerable misunderstanding of PREP and general liability protections. PREP applies to pandemics, giving protection to various parties under the EUA. But should a manufacturer be absolved from liability under EUA if data presented for approval was fraudulent or withheld (as Pfizer approval studies were). And should EUA be granted if there are treatments, even if off-label use of FDA approved medications, as there were with Covid-19? The comment about Reference 3 is ingenuous; although it is a blog post, the blog is from an HHS report(2), and the critic only needed to make one click to go to the original source, an excerpt of which follows: "Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported." Instead the critic attacks the blogger, who had posted accurately. This is akin to attacking the messenger because there is disagreement with the message. Regarding Reference 4, does the commenter GlenM have evidence that the attorney cited has insufficient credibility? When the entire Resolution 30 refers to pharmaceutical liability, it's natural to cite an attorney, and the attorney is referring to original sources.

				Would the commentor Glen M. please cite a scholarly, randomized, controlled trial of a vaccine which uses saline as a placebo, not a control which is a previously approved vaccine? 1. https://www.govinfo.gov/content/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap6A-subchapXIX-part2-subparta-sec300aa-13.pdf 2. https://openvaers.com/images/r18hs017045-lazarus-final-report-20116.pdf Please read the references provided in my previous comment, thank you.
30	Glen M.	Self		Speaking as an individual. Again, the author misuses citations. Citing fraudulent data regarding the Pfizer vaccine, Phillip M provides no scholarly evidence. Indeed, this is commonly used, fringe conspiracy theory put forth by Republican attorney generals and influencers that has been repeatedly debunked. See https://www.kff.org/the-monitor/volume-04/. As a former regulatory policy intern for a Fortune 500 corporation who worked on PREP Act policy for providers, I reject the idea that my knowledge of PREP Act and EUA liability is misunderstood. The author claims that vaccines are the only type of health service that waive liability for providers, but, as I stated, both the PREP Act and EUA waive liability for other services, such as the provision of ventilation during a pandemic. See https://www.congress.gov/crs-product/LSB10443#:~:text=To%20be%20covered%20by%20the,during%20a%20public%20health%20emergency. The cited sources are biased, many are opinions or commentaries rather than scholarly work, and several are written by individuals with clear monetary conflict of interests, such as the vaccine plaintiff's attorney, who would stem to earn more should the author's proposed policy become law.
30	Gary K.	Self	Oppose	I write in opposition to this resolution because it is built on flawed premises, particularly its misrepresentation of vaccine safety data and its unrealistic demands for placebo-controlled trials. One of the resolution's core arguments places undue faith in VAERS data. While adverse event reporting is important, VAERS is an open system, allowing anyone—including the general public—to submit reports without medical verification. It does not establish causation, yet the resolution treats its raw data as definitive proof of harm. The resolution also suggests that VAERS is difficult to use, yet I was able to navigate the system to file a report in under seven minutes and nearly submit a report on my own mild Right Deltoid soreness after an anthrax vaccine. It is similarly simple to download and sort VAERS data. A few clicks and you can download an easy to operate .XLS spreadsheet. My quick analysis of Ohio's 2025 VAERS reports reveals cases where individuals claimed to both have "no

				symptoms" and not require further medical care yet were still counted. These examples illustrate how raw VAERS data is being substantively overvalued. Another resolved statement proposes that OSMA should only support vaccines that have undergone placebo-controlled trials. This would mean opposing the Rabies vaccine—an indisputably life-saving intervention—since no placebo-controlled study exists. Should we then conduct such a study, knowing that those in the placebo arm would almost certainly die? This resolution ignores the ethical and practical realities of vaccine development. For these reasons and others, I urge opposition to this resolution.
30	Susan H.	District 3	Oppose	Oppose as written.
31	John C.		Support	In support of this important resolution.
31	Engy H.	Self	Support	
31	Shannon T.	District 2	Support	
31	Joe H.	Self	Support	
31	Brian B.	Self	Support w/suggested amendment	Since resolves must stand on their own, change IDR from an abbreviation to words.
31	Susie P.	Self	Support	
31	Charles S.	Stark County Med. Soc.	Support w/suggested amendment	What is IDR. Should define it somewhere. I guess it means independent dispute resolution. The Stark County Medical Society feels it could be reworded
32	Susan H.	District 3/Author	Support	Health insurance companies are increasingly paying physicians using electronic funds transfer and are charging the physician for this transfer of funds. This is not appropriate as it decreases the amount of reimbursement that the physician receives. Any fees for transfer of funds should be paid by the insurance company, not the physician.
32	John C.	Self	Support	
32	Engy H.	Self	Support	
32	Joe H.	Self	Support	
32	Carl W.		Support	Costs of physician payment should be the responsibility of the insurer.
32	Charles S.	Stark County Med. Soc.	Support	The SCMS feels the fiscal cost is a lot, but may be worth it.
33	John C.	Self	Support	
33	Engy H.	Self	Support	
33	Shannon T.	District 2	Oppose	Reaffirmation of current policy. Not sure how this is different from Policy 25-2020.
33	Joe H.		Support	Similar to policy 25-2020. It seems the insurance companies have attempted a work around by adjusting copay costs. If this is true the copay is made higher effectively allowing the vouchers but still punishing the customer.

33	Charles S.	Stark County Med. Soc.	Support w/suggested amendment	The SCMS would REPLACE the resolution by stating :The OSMA endorses the AMA policy # 25-2020 (Co-Pay Accumuatators)
33	Adam B.	Self	Support	I concur with Joe H's assessment.
33	Amber Prater	MSS	Support	Our OSMA currently supports including payments towards manufacturer assistance programs into patient copayments and deductibles. This addresses "co-pay accumulator programs", which do not allow for these payments to count toward patient deductibles. As a result of legislation on behalf of patients against co-pay accumulator programs, co-pay maximizer programs were started. Within these programs, insurance companies adjust the maximum copayment a patient has based on their participation in a manufacturer assistance program. It is typically set at the maximum payment of the assistance program. With previous support of legislation against co-pay accumulators, it makes sense that our OSMA support legislation against these maximizer programs which can be financially harmful to our patients.
33	Susan H.	District 3	Oppose	Speaking for District 3, we oppose the resolution as written. We support reaffirmation of OSMA policy 25-2020.
34	Engy H.	Self	Support	
34	Shannon T.	District 2	Oppose w/suggested amendment	Oppose as written. On behalf of District 2. Consider striking R4, R5. Amend R1 to read as follows: RESOLVED, that our OSMA supports a decrease in prior authorizations in Medicare Advantage plans and Traditional Medicare
34	Charles S.		Support w/suggested amendment	Again. no need to reinvent the wheel. REPLACE the resolution with "The OSMA endorses AMA policy # H-330.867 and D-285.959."
34	Norman M.	District 3	Support w/suggested amendment	District 3 supports resolution number 34 with amendment approving resolve number 12 and three and striking resolve number four and five
35	Engy H.	Self	Oppose	
35	Shannon T.	District 2	Oppose w/suggested amendment	Oppose as written. Support R2. Strike R1, R3.
35	Joe H.	Self	Oppose	Illegal is illegal. Providing benefits to illegals encourages further law breaking as no consequences result from the illegal action. We must be a country of laws and enforcement of those laws. Reform the immigration system rather than encourage illegal activity. Emergent need care is the proper balance in this issue. Personally, I prefer to do the volunteer mission trips to the illegals country of origin and work there to improve their knowledge and help develop their resources so they are better equipped to care for the people in their own communities which also serves to help decrease illegal migration. I love the people but must not encourage lawlessness.
35	Adam B.	Self	Oppose	I second Joe H's points. Additionally, current subsidized coverage (such as guaranteed emergency care) is sufficient and fairly allocated.
35	Philip R.	Self	Oppose	Vehemently oppose. Ohio cannot afford this resolution, and I agree with the other commentors. This resolution should be rejected outright. It is not fair to make Ohio taxpayers pay for

				and encourage illegal entry into the country. As Dr. H said, if efforts were made by those who support this resolution to help resolve conditions in other countries, the circumstances of illegal immigration into this country could be remediated. South American and other countries around the world have potential and resources to take care of their citizens, but corruption and socialist ideas like this resolution stifle progress in all aspects of their societies.
35	Charles S.	Stark County Med. Soc.	Oppose / Refer	The SCMS feels at best this should be REFERRED to Council. We question the data in the whereas.
35	Glen M.	MSS	Support	Regarding concerns about cost, these are sufficiently addressed in the resolution. The cost of providing undocumented immigrants insurance through Medicaid expansion is less than half that of U.S.-born adults. Further state expansion of health insurance subsidies to undocumented immigrants would drastically reduce total poverty, stimulating economic growth and ultimately leading to a more resilient economy. Finally, tax-paying undocumented immigrants have kept the Medicare Trust Fund solvent - they stabilize government programs and should at the very least be permitted to access subsidies. Regarding concerns about the data in the whereas, I would welcome the commenters to point to specific sources that seem questionable. This resolution was extensively written and reviewed by a team of authors. Without concrete examples of "bad data", this concern feels rather moot. Further, as evidence-based practitioners, we should be reviewing and assessing the data ourselves, rather than referring it to the Council. Referral to Council exists for questions of internal policy or when decisions cannot be made by the House. Circumventing the democratic process out of a nebulous concern for "bad data" seems misguided. Regarding District 2's amendment, we oppose striking R1 and R3. Regarding R1, the OSMA has a long history of taking stances on issues of federal policy. Most recently, the OSMA has worked extensively to fight Medicare reimbursement reductions. There is no objective reasons we cannot do the same for the extension of insurance subsidies. Regarding R3, I do not see how we can adopt R2 and continue to have policy that excludes non-citizens such as undocumented immigrants. Resident is the preferred legal and demographic term. Lastly as an individual, I am saddened by the use of the term "illegals" in this comment thread to refer to undocumented immigrants. It's violent and unnecessary language. When we talk about fellow human beings, let's encourage the use of respectful language. If you wouldn't call your patient "illegal", don't put that in writing in this thread.
35	Amber P.	Self	Support	In SUPPORT of this resolution and Glen's comments above. Further, OSMA policy 13-2024 states that our OSMA recognizes health and healthcare access as a human right, thus we can not support giving healthcare to select individuals simply based on their documentation status. As a human right, EVERY human

				being should be able to access healthcare that they need in Ohio. Concurrent with Glen's comment, it is disheartening to see such rhetoric against members of our communities. Many of the immigrants in our communities are contributing to them in ways in which others may not be able to. In terms of paying for this care and coverage, undocumented immigrants DO pay taxes, and are unfortunately withheld the social benefits that those taxes are funded. This article (https://taxpolicycenter.org/fiscal-facts/yes-undocumented-immigrants-pay-taxes-and-receive-few-tax-benefits#:~:text=Some%20estimates%20suggest%20undocumented%20immigrants,and%20local%20taxes%20in%202022.&text=Immigrants%20of%20any%20legal%20status,taxes%20deducted%20from%20their%20wages.) from the tax policy center highlights that in 2022, over $100 billion in taxes were paid by our undocumented friends, neighbors, and colleagues. I personally have colleagues who were DACA students - brought to the US by their parents as children for their own SAFETY. Violence in their home countries necessitated they leave their homes, and the United States holds promises of a better life, unfortunately with a long and laborious process to be "documented". These colleagues are some of the most brilliant physicians, scientists, and teachers that I know. Emergency care is NOT sufficient for our communities. It is expensive, delayed, and not a long term solution for these populations
35	Maria P.	YPS	Support	We know that our immigrant and undocumented community face significant health disparities stemming from the socioeconomic factors that affect their ability to access care. If they have no affordable ability to access care their contact with the healthcare system is only at the time of life threatening emergencies and while we are morally and legally mandated to provide this care the cost to the system is significant and felt by the physicians clinicians and hospitals - by providing the proposed subsidized care these costs are passed to the state and if individuals are better able to access care may avoid the much higher significant costs to the system of their uninsured status. Ohio hospitals and physicians cannot afford to not support this resolution. Pillai, D., Artiga, S., Hamel, L., Shumacher, S. Kirzinger, A., Presiado, M., Kearney, A. Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants, KFF: September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/ (accessed march 19, 2025) This resource lays out in detail the struggle of our immigrant community in seeking care and their limited resources in accessing it as well as the discrimination they must navigate in navigating the system demonstrated by the data collected here

				and so well by some of the commentary surrounding this resolution.
35	Norman M.	District 3	Oppose	
35	Amy B.	ACOG	Support	On behalf of Ohio ACOG based on committee statement 4 "Healthcare for Immigrants" https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2023/01/health-care-for-immigrants
36	Melissa M.	Self	Support	
36	John C.	Self	Support	
36	Engy H.	Self	Support	
36	Shannon T.	District 2	Support w/suggested amendment	Support but would recommend striking R2.
36	Joe H.	Self	Oppose	This will lead to disproportionate use for lesbian, gay, trans since their lifestyle choice greatly hinders reproduction by natural design. This is a consequence of their choice so the financial burden should not be carried by the general community. This also promotes further unnatural highly costly situations such as a man having a uterine transplant and attempting IVF. Adoption is the best societal option when all factors are considered - risk, cost, societal need.
36	Delia Sosa	Self		Being LGBTQ+ is not a lifestyle choice. It is who we are.
	Adam B.	Self		Joe H is correct to point out that proposals such as this lead to inordinate costs and leads to traditional couples having difficult access to such care. We do not need to think of this as a hypothetical as these policies have been tried in the UK and proved Joe's assertion. There are many articles on this, here is the first one that popped up: https://www.gbnews.com/news/nhs-fury-grossly-discriminatory-plan-favours-trans-men-lesbians-ivf-over-heterosexual-couples
36	Carson H.	MSS	Support	Current Ohio law and insurance practices fail to adequately cover essential fertility services for many individuals, including LGBTQ+ people and those who are single, by narrowly defining infertility and excluding fertility preservation from coverage. The American Society for Reproductive Medicine's updated definition of infertility acknowledges the unique needs of LGBTQ+ individuals, yet Ohio law continues to lag behind, perpetuating financial barriers to necessary care. This resolution aligns with the OSMA's commitment to supporting access to evidence-based health services as well as existing AMA policy.
36	Adam B.	Self	Oppose	I oppose this resolution as currently written. Resolved clause 1 is far too broad and has potential to be misused to support positions opposed by the OSMA body. The current policies should be maintained. The purpose of our profession is to return patients' bodies to a healthy status where they can perform the duties they are designed to do.
36	Philip R.		Oppose	Policy 37-1988 is adequate, and should be maintained. As written: Res 1 could result in insurers paying for unusual surgeries for individuals to attempt pregnancy. It should be the right of private insurers to provide or not provide fertility services; couples who intend to have children can pay increased

				premiums, whereas other individuals not intending to procreate could pay lower premiums. The hypocrisy of the progressive policies is blatant, when on one hand, AMA policy supports promoting future fertility through gamete preservation prior to undergoing "gender affirming" medical or surgical therapies, while on the other hand supports and even encourages abortion policies!
36	Charles S.	Stark County Med. Soc.	Oppose	The SCMS has real questions as to the thinking behind this resolution. Why rescind OSMA Policy 37-1988?? Treatment for fertility is based on whether a patient is male or female.
36	Maria P.	YPS	Support	Access to IVF and other methods of assisted reproductive services is essential to the concept of reproductive justice which is the freedom to have children, not have children, and to parent in safe and healthy environments. By leaving the interpretation of the availability of these services to the insurance companies it increases administrative burden on physicians to jump through hoops for approvals for services that would otherwise be covered, it also increases barriers to access this care for individuals who need it. We know that Black and Hispanic individuals are more likely to require reproductive assistance but less likely to be offered it, and these limitations may worsen those disparities. Additionally protection of family creation for LGBTQ individuals should be protected as well. The recently passed reproductive rights amendment in 2023 by Ohioans also protects access to IVF for all so by encouraging adoption of broader standards we are in line with the broad consensus of our state citizens. Additionally young physicians are interested in practicing where their rights to create a family are protected and this will encourage more recruitment to our state.
36	Norman M.	District 3	Support w/suggested amendment	Retain resolved number one delete resolve number two.
37	John C.	Self	Oppose	To what extent does OSMA already participate in this referral education? This is a very large fiscal note for an important service that we may already be partaking in.
37	Shannon T.	District 2	Support w/suggested amendment	Recommend following amendments for R1 and R2 read as follows: RESOLVED, that our OSMA supports physician awareness of the U.S. Drug Enforcement Agency's Office of Diversion Control's prescription drug take back program; and be it further RESOLVED, that our OSMA encourage the Ohio Department of Health and Human Services to educate the public about the availability of prescription drug take back programs approved by the U.S. Drug Enforcement Agency's Office of Diversion Control
37	Joe H.	Self	Support w/comment on fiscal note	Agree with Shannon T and John C therefore decrease fiscal note to $500 as further amendment. Current Ohio law for acute pain has helped decrease the excess but physicians still need to do the hard work of dialing in the amount to fit the need for each individual rather than simply establish generalized protocols.
37	Charles S.	Self	Support/REFERRAL	The SCMS feels that most physicians are aware of this and the cost is too much. Might change the last resolve to state that the

				OSMA recommend that the Ohio Department of Health and Human Services educate the public.....
37	Sara Z.	MSS	Support	We agree with the proposed amendment focused on patient awareness from Shannon T and D2. We are also doubtful of whether the current fiscal note is necessary for the given action and hope the amendment resolves the need for the large fiscal note.
37	Norman M.	District 3	Oppose	We do not believe that OSMA should expand its resources on this topic.
38	Engy H.	Self	Support	
38	Kevin M.	Self	Oppose	While this sounds like a do good type thing, unfunded mandates drive schools crazy. Here the free EpiPen give aways to schools and camps ended a few years ago. So the 130,930 schools in the US would have to spend ~$26,000,000 for one set(pair) of EpiPens. But if it is a large school, then where is it kept and how fast can it get to the child. So some may develop mandates that one for every floor or number of students. These EpiPens expire about every year, not from the epinephrine but from the auto injector mechanism, so this becomes a yearly expense with 99.1% of them thrown away. If the school tries to keep them longer than the "expiration" date then they may be liable to some attorney suing if a student should happen to die. While there is a benefit, the real costs have not been explored in this resolution and thus I have to say I oppose it.
38	Shannon T.	District 2	Support w/suggested amendment	Recommend amendment R2 to delete mandatory. Concern over mandating training especially if not funded.
38	Joe H.	Self	Oppose	No mandates. Local teachers and school administrators are currently responsible to know the students they serve enabling customization of each individual's needs. This is best not blanket mandates or protocols which devalue a person's individual needs. Articles are not Ohio specific and data across states can vary greatly just like from city to town to village.
38	Madeline E.	Self	Support	Speaking on behalf of myself in support of this resolution and of District 2's amendment to remove the word "mandatory" from both resolved clauses.
38	Glen M.	MSS		Speaking on behalf of the MSS in support of Madeline's comments and suggestions.
38	Charles S.	Stark County Med. Soc.	Refer/Suggested amendment	The Stark County Medical Society has some real concerns about the inappropriate use of Epi-Pens and would suggest we support AMA policy instead. At least remove the word mandatory in resolve #1.
38	Adam B.	Self	Oppose	While I love the idea of this resolution and hope to see something like it implemented in the future, Kevin M made some great points. With the prices and expiration being what they are, this is simply not feasible. Perhaps after prices of epi-pens are brought down some day, this resolution will make sense to pass.
38	Norman M.	District 3	Oppose	District 3, opposes this resolution to the expense and rapid expiration date of these drugs.
39	Brian B.	Self	Oppose	I'm not aware that OSMA opposes these ideas. Resolution is too vague and doesn't call for specific actions.

39	Ellena P.	MSS	Support	The OSMA does not currently have policy related to overdose prevention education, most policies center around access to medication-assisted treatment. This and other resolutions proposed to HOD expand the breadth of actions our OSMA can take to address our state's substance use crises.
39	Philip R.	Self	Oppose	There are already numerous OSMA policies on opioids and overdosing: Policies 13-2022, 27-2021, 29-2024, 30-2024, 8-2023. The current administration will now help improve our overdosing epidemic by controlling illegal immigration and drug trafficking, which former administrations corruptly encouraged.
39	Adam B.	Self	Oppose	I second Philip R's points. Very well put. Passing this resolution would expend OSMA time and resources without significant benefits.
39	Charles S.	Stark County Med. Soc.	Refer	The SCMS supports the idea, but needs referral.
39	Norman M.	District 3	Oppose	Reaffirm the existing policies on this matter.
40	John C.	Self	Support	
40	Engy H.	Self	Support	
40	Brian B.	Self	Support w/suggested amendment	Wording on 7 seems awkward. Maybe “implementation of widespread education about” would be better.
40	Philip R.	Self	Support w/suggested amendment	Revise: Policy 13-2022 Resolution #5: Should be struck since research, policy and education should be for all citizens regardless of race. I am personally aware of 2 neighborhood families who lost sons due to overdose, both white middleclass.
40	Adam B.		Responding to Philip R. comment above	I second this amendment. This is an issue affecting people of all backgrounds. We should leave divisive political language out of it, so we can all support this resolution fully united.
40	Charles S.		Support w/suggested amendment	Would support limiting the resolution to the amended resolves # 3 and # 7. The rest has nothing to do with the resolution before us. We do not know how available the test strips for Xylazine are. Apparently they are available in New York City.
40	Daniel Leonard	MSS/Author	Support	Speaking on behalf of the authorship team, in support of this resolution that expands upon current harm reduction service policies such as Policy 13-2022 - Curbing Opioid-Related Deaths in Ohio Through Medication-Assisted Treatment and Harm Reduction Services. We are in support of our resolution to expand the language to include Xylazine as a threat to harm reduction and include Xylazine-related harm reduction services in the language of new resolutions.
40	Norman M.	District 3	Support	
41	Susan H.	District 3/Author	Support	Our area has recently lost pharmacies in Ada, Delphos, Spencerville, and other small towns, leaving those towns without a pharmacy. The prescriptions from those pharmacies were sent to one pharmacy in Lima which is now overwhelmed with long lines both inside the store and in the drive through. In addition, patients in those small towns must now travel 10 to 20 miles to reach a pharmacy. There is evidence that this type of situation results in less compliance with filling and taking prescribed medications. Mail order pharmacies usually do not fill Schedule II medications which results in patients not able to obtain important medications such as pain medicines and

				stimulants (Ritalin). We need to work with the Ohio Pharmacy Board and the Ohio Department of Insurance to study this problem and develop solutions. OSMA and AMA do not have current policy regarding pharmacy deserts so the issue of pharmacy deserts also needs to be referred to AMA.
41	John N.	Self	Support	I completely agree with Dr. Hubbell. My town, Coldwater, recently lost its pharmacy. This is not a good situation for many patients.
41	John C.	Self	Support	
41	Engy H.	Self	Support	
41	Stephen H.	SPS	Support	SPS considers this serious issue that needs to be addressed.
41	Amber Prater	MSS	Support	
41	Charles S.	Stark County Med. Soc.	Support w/suggested amendment	The SCMS feels this is a national problem, and would suggest limiting the resolution to just the last resolve, to refer to the AMA.
42	John C.	Self	Support	
42	Engy H.	Self	Support	
42	Saaleha Shamsi	MSS	Support	
42	Shannon T.	District 2	Refer	Support sentiment but concern over details and process. May need Council input.
42	Joe H.	Self	Support	Currently I prescribe certain medications for a surgical window and have to stop the pharmacies auto refills which adds another administrative burden. Allowing physicians to opt out of the auto refills reduces unnecessary work. Regarding detail and process - the primary work would be responsibility of the pharmacy to offer opt out to each physician and accordingly have IT engineers to modify their current computer algorithms. This is appropriately a state and National issue that would help decrease unnecessary physician administrative burden.
42	Charles S.	Stark County Med. Soc.	Refer to Council / Also suggested amendment	The SCMS agrees with the idea, but rejects the resolution as written. It is complex. How does one op out of automatic refills to all the pharmacies your patients use. We might suggest a substitute resolution: "Because of safety concerns, the OSMA advises against the use of automatic refill requests by pharmacies." To put this into action would require a much larger fiscal note.
43	Melissa M.	Self	Support	
43	John C.	Self	Support	Why is this fiscal note so high? It only says "support" these efforts. **OSMA Staff Note: We don't always know the intent of the words used in the Resolved clauses. Staff put this under the "public education campaign" ($100,000+) as it details specific things that OSMA should be "encouraging" healthcare organizations to alter work spaces, breast milk refrigeration options and altering work schedules.
43	Engy H.	Self	Support	
43	Joe H.	Self	Oppose w/comment on fiscal note.	Myself as an independent physician collectively employing over 200 employees having many currently breastfeeding have found open communication works better than the rigidity of policies:

				1) no work stations builds are needed nor justified as expense is high while wearable breast pumps have worked well for most allowing use of mobile laptops etc. and results in better productivity. 2) We use patient rooms in each of our buildings for privacy having a laminated movable sign indicating breastfeeding room allowing managers to coordinate specific needs of individuals as works best within their work zones. 3) Storage has been simple as refrigerators are already present and labeling within the refrigerator prevents accidents. Mini fridge is another option. Fiscal note recommended to be amended to $500.
43	Brandon F.	RFS	Support	
43	Saaleha Shamsi	MSS	Support	
43	Charles S.	Stark County Med. Soc.	Oppose	The SCMS actually opposed this because it is already AMA Policy as well as federal law (the Pump Act and FLSA protection of breast pumping at work)
43	Maria P.	YPS	Support	Support of breastfeeding is a good public health investment as the benefits of breastfeeding (reduction in breast cancer risk, infant immunity to diseases, etc) should not be with held from the very individuals who provide care to others. Additionally many individuals who are in training or immediately out of training are busy building their families and looking for supportive policies and states to do so. Especially given the uncertainty of federal protections continuing the continuation of breastfeeding protection is crucial to recruitment and retention of female physicians. Finally as someone who breastfed, assuming that people do not need these protections because some people do well with some pumps, is not backed up by the fact that every individual responds differently to different pumping scenarios and providing appropriate breaks and opportunities to pump at baseline is critical to ensuring all are protected effectively no matter their particular situation
43	Norman M.	District 3	Support w/suggested amendment	Support resolution number 43 with amendment that would say resolved the OSMA supports healthcare organizations to allow lactating healthcare, workers and trainees sufficient time to breast-feed and or pump breast, milk, and appropriate resources for them to maintain their work and study responsibilities
44	Engy H.	Self	Strongly Support	
44	Engy H.	OMSS	Support w/suggested amendment	On behalf of OMSS. We suggest the following: that our OSMA encourages training for health care professionals for elder injustice, including neglect, abuse and exploitation. OMSS believes that addressing policy for mitigation of elder inequities, while necessary, would require: -Separate legislation -Adjustments to current state policies

				-Increased support for Adult Protective Services, Office on Aging, and other support services These broader policy changes would be better served as a separate resolution rather than diluting the training focus of Resolution 44.
44	Madeline E.	Self	Support	Speaking on behalf of myself in support of this resolution and of District 2's amendment to change the resolved clause to "that our OSMA encourages training for health care professionals for elder injustice, including neglect, abuse and exploitation."
44	Stephen H.	SPS	Support	SPS is in favor is in favor this resolution for increase training
44	Joe H.	Self	Support	Encourage training perhaps through CME for current physicians to screen for neglect, abuse, exploitation. The improved recognition will result in mitigating actions by recognizing physicians and help identify specific policy needs. A good start.
44	Brian B.	Self	Oppose	From the AAFP article referenced: The U.S. Preventive Services Task Force found that current evidence is insufficient to assess the balance of harms and benefits of screening all older or vulnerable adults for abuse and neglect. At this time, there does not appear to be supportive evidence that screening and early detection of elder abuse and neglect reduce exposure to abuse, or physical or mental harm from abuse.
44	Brian B.	Self	Oppose	To fully follow all recommended screening guidelines, a primary care provider would need an estimated 26.7 hours per day. This includes 14.1 hours for preventive care, 7.2 for chronic disease care, 2.2 for acute care, and 3.2 for documentation and inbox management. Need to address issues of time and payment…
44	Glen M.	MSS	Support OMSS suggested amendment with additional suggested amendment	We support the OMSS amendment to narrow the focus of this resolution to training, however, we would change "healthcare professionals" to "medical students, residents, and physicians". We want to emphasize that this resolution does not require students or physicians to follow or implement relevant screening guidelines, rather, it supports the provision of training. Thus, there should be no need to address time and payment.
44	Madeline E.	Self	Support	Speaking on behalf of myself in support of this resolution and of District 2's amendment to change "healthcare professionals" to "medical students, residents, and physicians" to support a more broad focus.
44	Norman M.	District 3	Support	
45	Shannon T.	District 2	Support w/suggested amendment	Support with amendments. On behalf of District 2. R2, R3 strike advocates and replace with supports.
45	Joe H.	Self	Oppose	Ohio citizens within our borders are our primary responsibility. As this resolution addresses global issues it is outside the purview of the OSMA.
45	Brian B.	Self	Oppose	International is outside the purview of the OSMA, but OSMA AMA delegates might take this to our national organization as a resolution…
45	Philip R.	Self	Oppose	Although protection in conflict zones is admirable and may be the purview of advocacy by AMA, my objection is using the statement that "healthcare is a fundamental human right..." Although previous OSMA policy 13-2024 was instituted thusly,

				this philosophy confuses positive from negative rights. There are no "fundamental human rights" that require one individual, or group of individuals, to be compelled to give their work effort or property to others. Although compassion may compel, government or authoritarian policy should not. Even if a majority believes free healthcare for all is right, there should be no force for a minority of physicians or other persons to provide these services involuntarily. Doing so fosters mediocracy, overutilization, increase of public debt, and physician burnout. I admire the compassionate physicians who put themselves in harms way to help victims of war, but I agree with Dr. BB that this is an international issue. Europe, Canada, Japan, India and the US, including American constitutional law do not list healthcare as a "fundamental right*" https://en.wikipedia.org/wiki/Fundamental_rights
45	Saaleha S.	Self	Response to Philip R. comment above	Speaking on behalf of myself in response to Dr. R: The policy you are discussing, 13-2024, currently is supported by the OSMA Policy Compendium and thus was included in support of our resolution. Issues with this OSMA policy and the nature of what constitutes a right is not the subject of these resolved clauses. Revisions (as proposed by Adam B) of this policy would be better served as their own resolution or proposed resolved clauses.
45	Adam B.	Self	Oppose	Similar to Philip R. I take issue with the assertion that "healthcare is a fundamental human right..." One cannot have a right to the labor of another. OSMA policy 13-2024 should be revised to correct this. If we were to consider it a human right, why are we hypocritically charging money for it? The proponents of healthcare as a human right should either offer their services to anyone free of charge or refrain from making this claim.
45	Charles S.		Consent/Reject	This is not the job of the OSMA. Except for maybe Cleveland, we are not in a combat zone. $50,000?
45	Saaleha S.	MSS	Support	In SUPPORT of the resolution as written. It is incredible that our state has so many physicians committed to serving patients that are in crises. We all know doctors at our medical schools involved in the global health arena and with changes in safety abroad, we want to support their work and safe return. Within our organization and the AMA, there are opportunities for us to back these physicians. Ohio physicians deserve our support of safe and effective global health practices. While directly dealing with international conflicts may be out of the scope of the OSMA, we strongly believe that Ohio physicians who choose to take the time to serve in conflict zones should not be abandoned by their state-side peers. Advocating for the safety and protections of medical professionals who come back to work in our Ohio hospitals should be paramount. Having our own internal policy regarding the protection of physicians ensures that our AMA Delegation is able to act in the best

				interest of Ohio physicians regardless of where they are currently practicing medicine. Medical personnel should not be targeted when they are providing healthcare to the most vulnerable abroad. They should not be treated as collateral damage in conflict zones. As training physicians, our priority first and foremost are our patients. Nobody should have to worry about their safety when they are treating any individual. Having the OSMA advocate for the safety of healthcare workers is crucial to protecting Ohio physicians who are only upholding their oath as healthcare providers–keeping patients from harm.
45	Amber Prater	Self	Support	I want to echo what Saaleha and the MSS have mentioned regarding the value of physician lives here in Ohio. As we are facing physician shortages now and even more so in the near future, each physician's life is critical. I would add also that many medical schools in the state have Global Health programs - including Wright State, OSU, UToledo, UCincinnati, and NEOMED - where not only faculty but students are going abroad. These programs strive to ensure students are safe and the regions in which they travel to are safe, but situations are fluid with most international global health regions being listed at least “Level 2: Exercise with caution” from US Dept of State for crime and civil unrest. An OSMA policy would ensure that the voice of Ohio physicians and students is heard at the AMA, and medical professionals can be reassured about their protections overseas.
45	Norman M.	District 3	Oppose	Oppose this resolution because it's beyond SMA's scope.
46	Joe H.	Self	Oppose	No mandates. Paid sick leave being forced on employers risks high abuse by employees who will be tempted to take off work for their marginally ill child or for any child related issue. This will ultimately increase child absenteeism as parents will now have an incentive to keep them home. Better method is to invest in family unit formation including across generations. Invest in the family instead so that generations will return to working together in raising the kids/grandkids.
46	Adam B.	Self	Oppose	The resolved clause is far too broad. “Paid sick leave” is a righteous cause to a certain extent, but we all know that excessive allowance of sick leave can lead to abuses. Furthermore, the discrepancy in access to sick leave for families below the poverty level is brought up to insinuate an injustice, but this can be explained by the types of jobs these people hold. Common jobs at this income level such as part time jobs and basic manual labor contracting usually do not provide any benefits. The lack of benefits is due to a surplus of people willing to do these jobs over the need. As these individuals move on to higher level employment and professions, they will inevitably get access to such benefits. This is the purposeful design of our economic system: to encourage upward mobility, as any functional economy must. If entry level employees had all of their wants, needs, and desires fulfilled in their positions, they would have no reason to raise themselves to higher levels.
46	Philip R.	Self	Oppose	Agree with Drs. JH and AB. Most businesses and healthcare employers provide a certain number of days off paid, which include sick days. Indiscriminate use of paid sick leave leads to

				abuses. OSMA has no need to interfere with the conduct of these businesses.
46	Farzana Qurban Ali	Self	Support	Seeing patients in healthcare settings, interacting with coworkers who are parents, and reflecting on my school experiences made me aware that we need a better system to support employees and parents in maintaining their health. During my Master of Public Health education, I participated in a virtual, simulated, case-based learning experience where we made decisions for a patient balancing her health and the well-being of her children. Time and time again, we were forced to deprioritize her medical needs because she couldn't afford to miss work, highlighting the heartbreaking reality that many individuals face—sacrificing their health to maintain financial stability. This reality became even clearer through my experiences volunteering at free health clinics, where I encountered countless patients who struggled to schedule appointments because they couldn't afford to take time off work. Many of these clinics operated in the evening to accommodate patients working first-shift jobs, but even with this flexibility, some individuals still found it difficult to prioritize their health. Beyond the clinic, while working in retail and as a hospital technician, I had difficult conversations with coworkers—many of them parents—who faced similar challenges. They wanted to take care of themselves and their children but were forced to delay or forgo medical care because missing work meant risking their income, which their families depended on for survival. These experiences opened my eyes to the harsh choices people are forced to make between their health and their livelihood. It is disheartening that individuals must compromise one essential human need—healthcare—for another—financial security. This ongoing struggle inspired my commitment to advocating for a policy that removes these barriers, ensuring that no one has to choose between caring for their health and providing for their family.
46	Charles S.	Stark County Med. Soc.	Refer	The SCMS would not support mandatory paid sick leave because of the burden placed on small employers. Consider endorsing AMA Policy H-440.823.
46	Norman M.	District 3	Oppose	District 3 opposes resolution number 46 because of private practice cannot afford to offer this benefit
47	Carson Hartlage	MSS	Support	Medical debt is a crisis that impacts millions of Americans, disproportionately harming the most vulnerable members of our communities. It forces patients to choose between basic necessities and necessary medical care, exacerbating health disparities and worsening social determinants of health. Despite its devastating impact on patients, medical debt represents a negligible portion of hospital revenue, and it fuels a debt collection industry that profits off of financial hardship. The policies outlined in this resolution—including limits on interest, wage garnishment, and home liens—are essential to protecting patients from financial ruin due to medical expenses. In

				addition, hospitals ensuring clear patient instructions on payment plans and financial assistance would enable patients to navigate their medical bills without unnecessary distress. This resolution provides the OSMA with an opportunity to stand firmly with patients, advocating for a healthcare system that prioritizes well-being over profit, as well as align with existing AMA policy on this topic.
47	Charles S.	Stark County Med. Soc.	Support	Again, the SCMS believes that AMA Policy H-373.990 covers all of this resolution. What about H-CAP, It used to cover hospital costs for people at or below 100% poverty level.
47	Norman M.	District 3	Oppose	
48	Engy H.	Self	Support	
48	Shannon T.	District 2	Support w/amendment suggestion	Support with amendment. On behalf of District 2. Recommend R1 first line to read as follows: RESOLVED, that our OSMA encourage the formation of a strategic stockpiling board for all disasters, ...
48	Joe H.	Self	Support	Agree with amend to streamline language to reflect 'all disasters'.
48	Glen M.	MSS	Support	In support of this resolution and of District 2's proposed amendment to Resolved 2. I want to clarify that I believe District 2 is attempting to amend Resolved 2 and not Resolved 1 based on the text they included.
48	Charles S.	Stark County Med. Soc.	Support	The SCMS would support this.
48	Norman M.	District 3	Support w/suggested amendment	Support resolution number 48 and we agree that with the first resolved that to change the word pandemic to disaster, but we believe the second resolved should be deleted.
49	Engy H.	Self	Strongly Support	
49	Engy H.	OMSS	Support	Increasing funding for GME programs in Ohio is important to addressing access to care in the future and addressing the physician shortage that is being used as reason to expand scope of practice for non-physicians.
49	Shannon T.	District 2	Support w/suggested amendment	Support with amendment. Amendment to R2 first line to read as follows RESOLVED, that our OSMA CONTINUE TO advocate for increased state and federal funding for...
49	Joe H.	Self	Support	This is a critical issue that needs addressed to best serve the people of our state and support future generations of medicine. Also establishing medical coverage that meets each regions needs will help to diminish the growth and scope of practice creep by non physician providers who are able to argue they have no physician around to supervise or guide them.
49	Charles S.	Stark County Med. Soc.	Support w/suggested amendment	The SCMS suggests combining #49 and 50.
49	Maria P.	YPS	Support	We are wasting the talents, time and energy of hundreds of medical students every year who fail to match to residency slots. Increasing GME funding will help address the physician shortage and allow more roles to be properly filled with

				physicians instead of compromising with less well trained alternatives
49	Norman M.	District 3	Support w/suggested amendment	District 3 supports resolution number 49 in its concepts and we believe resolutions number 49 and 50 should be combined.
50	Susan H.	District 3/Author	Support	We need funding for more GME positions in Ohio. This can come through partnerships with local companies who need physicians in Ohio to take care of their employees. This can also come from insurance companies who insure patients in Ohio and who report large profits each year. Physicians who do their residency training in Ohio tend to stay and practice in Ohio. There are still graduating medical students who cannot match into a residency program due to no slots being available. We need to establish more training slots in Ohio through creative thinking about new opportunities for funding.
50	Engy H.		Support w/suggested amendment	Can combine with previous resolution. Physician shortage is the first talking point NPPs organizations use for advocating for independent practice of medicine for non-physicians. We must work on effort to recruit and train more physicians to solve the shortage instead of lowering the entry bar to the practice of medicine.
50	Ryan S.	District 3	Support	Increasing state funding for Graduate Medical Education (GME) is critical, especially given Ohio's growing healthcare needs and physician shortages. It's important to emphasize that physicians often remain in the areas where they complete their residency training, making strategic investment in residency programs, particularly in rural and underserved communities, essential. By prioritizing funding toward these areas and specialties experiencing the greatest shortages, Ohio will strengthen local healthcare infrastructure, improve access, and foster long-term community health and economic vitality. This investment is essential for a healthier Ohio now and in the future.
50	Engy H.	OMSS	Support	Increasing funding for GME programs in Ohio is important to addressing access to care in the future and addressing the physician shortage that is being used as reason to expand scope of practice for non-physicians
50	Shannon T.	District 2	Support	
50	Suzanne S.	Self (Ohio Psychiatric Phys. Assn.)	Support	OSMA Staff note: Dr. Sampang is an active OSMA member. While the OPPA is a closely aligned organization to OSMA, we could accept her comment on behalf of her as an individual. She is an OPPA member.
50	Joe H.	Self	Support w/suggested amendment	Consider combining res 49 & 50. My comments on 49 apply here also.
50	Brandon Francis	RFS	Support	As a soon-to-be fellow who completed residency in Ohio and plans to stay in Ohio for practice, expanding GME spots is an excellent way to continue to grow our physician workforce in the state. We do have some hesitations regarding public-private partnerships listed in R3 with the concern that this could include the involvement of private equity in GME funding, but are overall in support of this resolution.
50	Maria P.	YPS	Support	We have been advocating for increased GME spots for decades and we need action now to avoid a physician shortage, take

				charge of the healthcare teams and exploring alternatives to payment models for this training is overdue.
51	Shannon T.	District 2	Oppose as written/suggested amendment	This is national issue not a state issue. Consider amending R1 to read that the OSMA supports exploring healthcare reform elements to achieve universal healthcare and striking R2.
51	Elizabeth M.	Self	Oppose/agrees with Dr. Trotter's comments.	On behalf of myself, agree with above reasons for opposition.
51	Susan H.	Self	Oppose as written	I suggest reaffirmation of current OSMA policies 11-2010 and 05-2011 and others in lieu of this resolution.
51	Joe H.	Self	Oppose	Agree with Susan H.
51	Adam B.	Self	Oppose	Speaking on behalf of myself, I strongly oppose this resolution for its opposition to current OSMA policy and the historical record of universal healthcare models. Universal healthcare has been tried many times and has always failed. While the US healthcare system is by no means perfect, we should not embrace systems that have repeatedly failed. The only example provided by the authors of a nation with this supposedly great system is Germany, which benefits from having a comparatively miniscule military budget due to the reliance on US protection and thus can implement their system without a complete economic collapse. Even so, its healthcare system is on the brink of collapse and has necessitated revision as more recent articles demonstrate: https://www.euronews.com/health/2024/02/05/germanys-health-crisis-why-europes-biggest-economy-is-fending-off-a-chronic-doctor-shortag https://www.dw.com/en/germany-begins-major-reform-of-its-hospital-sector/a-69236520
51	Brandon Francis	RFS	Support	We thank the authors for their well-researched resolution and thoughtful proposal regarding paths forward for healthcare reform in our state. We especially share the authors' concerns regarding administrative costs in our current healthcare delivery infrastructure and share their awareness of local governments in Ohio passing resolutions which call for healthcare reform at the state level. Our RFS is supportive of the thrust of this resolution and strongly requests that our reference committee draft feedback reflective of the strengths of this resolution and the opportunity to explore other healthcare financing strategies at the state level.
51	Michael M.	Self	Support	In strong support of this resolution and in agreement with the RFS comments. I would encourage all OSMA members interested in the resolved clauses to read through the well-sourced arguments in the full resolution. I did want to respond to some of the points raised in the comments here. Addressing the suggestion to instead have this resolution reaffirm policies 11-2010 and 05-2011. I do oppose this suggestion, but more importantly, there may be some clerical need to address this on the PDF policy compendium and the OSMA Website. Policy 11-2010 was already rescinded by OSMA Policy 6-2023, and Policy 5-2011 was amended by Policy 16-2021. **You can see the updated language under Policy 16-2021, but it was not updated correctly under Policy 5-2021 (at least on the PDF here:

				https://osma.org/aws/OSMA/asset_manager/get_file/366536?ver=2042). **Staff note: The OSMA policy compendium will be updated to reflect this change. Additionally, in regard to the discussion surrounding Germany and its struggle with its health care system. This 2024 KFF (link: https://www.kff.org/health-policy-101-international-comparison-of-health-systems/?entry=table-of-contents-how-does-health-spending-in-the-u-s-compare-to-other-countries) report comparing countries health care systems on many different metrics, including Coverage, Spending, Outcomes, Quality of Care, Access to Care, the US does way worse than other countries is some metrics or among the worst in others. The articles shared regarding Germany's health system do not lay the blame of their struggles on the universality of the payment model of the health systems itself, and instead state they are aiming to embrace AI and digital solutions, reform payment to hospitals that will actually improve patient care and more appropriately lengths in hospital stays, and state a need to increase physician pay and number of primary care physicians. However, the KFF study I linked shows that Germany still has a much higher physician per patient capita than the US, especially among General practitioners. Additionally, the article that was linked about Germany's health crisis states that medical students in Germany are opting to practice in Denmark, Sweden, and Switzerland because of their better working conditions and higher pay. These countries have universal health systems that are most closely aligned with single payer health care, so these countries are not "failing". Medical students and doctors in Germany are either moving to or inclined to move to those countries and not the US. Something to keep in mind.
51	Philip R.	Self	Oppose	This contradicts Ohio Policies 9-1989, 37-1980, 43-1993, 63-1994 (Reaffirmed in 2019), and 08-2016, in which the value of free-market, private practice had been regarded as the foundation of US medical excellence. Universal, single-payer reform does not maximize healthcare equity and cost-effectiveness. The countries which provide this have bureaucratic inefficiency, and lag behind the US in technological advancement. The German situation is interesting. Docs leave there also due to their huge migration problem, so the system is inundated with illegal residents. The fact that the physicians leave Germany for other countries is not an argument for universal HC: All these countries have more homogeneous populations (especially Sweden - but this is changing due to mass illegal migrations encouraged by global forces) and Denmark and Switzerland have mixed private and public options. Now the Swedish HC has serious problems, such as staffing, bureaucracy, long waiting times, and high levels of poor quality treatment.*

				The metrics concerning poor US HC do not impress me. When was the last time you or friend wanted to go overseas for treatment? Personal examples: 1.My cousin's diabetic wife was pursuing a degree in Oxford in the Uk. She developed macular retinopathy and received laser through England's Health Service, she thought she was getting state-of-art. Examination later showed laser macular scarring, and routine therapy then and now in US was ocular injection which would have avoided this. 2. Do you travel to Canada often as I do? Talk to the citizens who have to come to US to get timely treatment for serious conditions. On a recent visit, a Canadian oral surgeon had to wait 2 months for MRI for knee injury. I told him to come over to Seattle for a high quality MRI, he could schedule it in a week for a reasonable out-of-pocket cost. * https://www.statista.com/statistics/1272133/problems-with-national-health-care-system-in-sweden/
51	Akshaykumar Ganesh	Self	Support	I would like to respond to some concerns raised regarding the resolution. There is no question that the current system is failing our patients: one in three Ohioans is struggling with a medical bill, and two out of every five have delayed or forgone necessary medical care because they couldn't afford it (https://www.healthcarevaluehub.org/advocate-resources/publications/ohio-residents-struggle-afford-high-healthcare-costs-support-range-government-solutions-across-party-lines). It is this inability for this large group of people to access medical care in the first place that is driving the worse performance of the US in the healthcare metrics cited in the resolution. The inaccessibilty of care due to this cost in the US is so debilitating that - yes, Americans are traveling abroad to receive quality medical care at rates affordable to them! In 2017, 1.4 million Americans did so! (https://www.amjmed.com/article/S0002-9343%2818%2930620-X/fulltext) It is therefore imperative that the OSMA adopt this resolution not just to acknowledge the shortcomings of our own system, but to strive towards a better future for our patients.
51	Amber P.	Self	Strong Support	I think that everyone can agree that healthcare reform is needed both national and at the state level. The United States while spending the most on healthcare consistently performs the worst on key healthcare metrics. This is can be seen through the OECD's Data Explorer. Further, Ohio performs very poorly when compared to other states by the HPIO (https://www.healthpolicyohio.org/files/publications/2024healthvaluedashboardfinal2.pdf) despite healthcare spending near the average of all states. It is clear that on both a state level and a national level, we are not getting the health outcomes we are spending on. Contrary to what many may believe, healthcare reform does not have to occur on a national level, and in fact, it may be best started at the level of the state! Other countries, such as Canada, had to reform and build their health systems

				territory by territory. In the US, this has occurred with other social policies such as women's suffrage, the regulation of working hours, and social safety net programs, all which were started at the state level. I have personally sat and cried with patients who were so frustrated about their inability to access their physicians in a timely manner. They had sat months and months, bouncing doctor to doctor with severe pain. I have talked with numerous physicians who are frustrated with the growing administrative burdens that we are seeing in our current healthcare system, and I have personally experienced the healthcare disparities that occur when you can not afford healthcare. This resolution calls for reform that would provide improved accessibility and choice for all patients, be more efficient in terms of cost and administrative oversight, and help to reduce disparities by reducing cost. This is in alignment with OSMA policy 6 – 2023 and 13-2024 as it would increase access to comprehensive, affordable, high-quality health care and support efforts to achieve this for everyone.
51	Charles S.	Self	Refer	Must refer this to Council. In the first place, we have a system in this country that is much like the German system. We also have the largest single payer system in the world, the "Affordable care Act", and welfare. Direct primary care is popular out west, and is the most affordable system allowing patients to contract directly with physicians. The OSMA and AMA have always supported and advocated for a multi-payer system. In England, if you want good care, you go private. In Canada you get blue cross and come to the US. IN Austria, which has the German System, the biggest trend is for doctors to op out of the system and see patients on a fee for service cash basis. I think the best system is a Health Savings Account.
51	Norman M.	District 3	Oppose	District 3 opposes resolution number 51 in favor of supporting and reaffirming current policy.
52	Shannon Trotter, DO	District 2	Oppose w/suggested amendment	Concern this is too specific and into the weeds of treatment, which OSMA tends to refrain from making comments on. Would consider supporting R2 and deleting R1, R3.
52	Susan H.	Self	Oppose	I agree that it is a great idea to monitor fluctuations in blood pressure, but this is NOT the best use of resources of our OSMA. This is a clinical issue, not an issue for our OSMA.
52	Zarah S.	MSS/Authors	Support	Speaking on behalf of the authorship team, we strongly urge support for this resolution, which seeks to advance the clinical application of blood pressure variability (BPV) by integrating it into electronic medical records (EMRs). Extensive medical literature demonstrates that BPV is a powerful and independent predictor of cardiovascular outcomes, comparable to cholesterol levels in assessing cardiovascular risk. Despite this, BPV remains largely absent from clinical guidelines and EMR systems, limiting its use in risk stratification and decision-making. Without systematic incorporation into EMRs, healthcare providers lack the tools to utilize BPV in clinical practice, missing a critical opportunity to improve patient outcomes.

				The American Medical Association (AMA) has long supported the integration of risk-related health data into EMRs to enhance clinical decision-making and risk assessment. AMA policies such as H-478.990 (tobacco use) and H-95.904 (substance use history) establish a precedent for incorporating risk markers into EMRs to improve patient care. Similarly, BPV is a well-documented cardiovascular risk marker, and its inclusion in EMRs aligns with these AMA-supported strategies for enhancing preventive care and risk assessment. By integrating BPV into EMRs, providers would have another valuable tool to identify at-risk patients and intervene earlier, ultimately improving cardiovascular outcomes. Some concerns have been raised in opposition to this resolution. First, while some argue that this is a clinical issue rather than an OSMA issue, OSMA has consistently supported the use of EMR-integrated quality tracking tools to improve patient care across all specialties. OSMA has urged the Office of the National Coordinator for Health Information Technology to require EMR vendors to incorporate automatic tracking systems for quality monitoring, recognizing the importance of leveraging EMRs to improve health outcomes. Supporting BPV integration aligns with these efforts, as it enhances risk stratification and enables clinicians to make more informed decisions about cardiovascular care. Others worry that this issue is too specific and outside OSMA's scope. However, this resolution does not dictate treatment protocols; rather, it advocates for the integration of an evidence-based risk factor into EMRs, similar to other quality metrics OSMA has supported, where it can be used alongside well-established cardiovascular risk markers. BPV is not a niche clinical tool, it is a broadly relevant predictor of cardiovascular events that warrants systematic tracking.
52	Joe H.	Self	Support	I see this similar to last years weight/BMI resolution. Just like using other methods to monitor and instruct patients on their weight problems this resolution encourages physicians in Ohio to use BPV as a tool to help manage their medical conditions. That said, having IT engineers at EHR build the algorithm to calculate BPV posting it adjacent to the BP readings serves as a quick utilization tool. This and the research aspects of this resolution are more national level perhaps through our OSMA AMA delegation.
52	Brian B.	Self	Oppose	Two problems: 1. " The lack of established thresholds to differentiate normal from pathologic BPV and limited clinical data have delayed its inclusion and standardized management guidelines…" 2. " Although an effective medical treatment for BPV has not yet been established, patients can reduce the risk of BPV related complications by making lifestyle modifications…" which we already recommend. This needs further standards developed before we should invest resources, including OSMA political capital.

52	Norman M.	District 3	Oppose	After reading the resolution through a number of times I realize how much time was spent on preparing a resolution. On the surface it sounds like a great idea and I don't disagree with the primary thoughts proposed. However, the practicality of following is data, makes it difficult to impose this resolution. At this point in time, we don't have good data as to what is the definition of BPV and guidelines as to what is a good BPV versus a bad BPV. And some people require higher blood pressures just to meet cerebral perfusion pressure. And there are so much very beauty in between patients that makes interpretation of this data very difficult. I do agree that at sometime in the future when we have more data that proposal of his nature would probably be entirely beneficial. At this point in time, although the idea is good the practicality is just not there.
53	Melissa M.	Self	Support	
53	John C.	Self	Support	
53	Engy H.	Self	Support	
53	Susan H.	Self	Support	I support this resolution. In vitro fertilization has been a very important part of our family.
53	Shannon T.	District 2	Oppose	Only oppose because of the specificity. Maintain broad OSMA policy already in place protects physicians from criminality and we should not address individual procedures.
53	Joe H.	Self	Oppose	This is a broad sweep. IVF may not always be applied appropriately as high dollars are at stake in this emotional issue and the love of money has been clearly shown to influence decision making. Many ethical issues are embedded within this issues as well for which legal accountability options should remain open. Closing off legal accountability in developing technologies only reveals that there is something to hide.
53	Jen Wayland	MSS	Support	In support of this important resolution that will help protect physicians and patients from criminalization/liability for standard IVF practices.
53	Adam B.	Self	Oppose	I second Shannon T's concerns.
53	Maria P.	YPS	Support	IVF is a crucial aspect of family creation for many, especially physicians who face higher rates of infertility and delayed childbearing. To protect against the criminalizing of evidence based health care related to IVF is common sense and will allow this care to be provided unabated by providers in our state and allow physicians who wish to practice here to be allowed access appropriate to family creation.
53	Norman M.	District 3	Support w/suggested amendment	The third district supports resolution number 53 by amendment and the amendment should read the Ohio State medical Association opposes the criminalization of in vitro fertilization
54	John C.	District 2	Support	
54	Engy H.	Self	Support w/ Suggested Amendment	Support/Amend -That third party payor is responsible for the cost associated for the transfer of records. Some payors make it burdensome for physicians to send documents by requiring fax/mail documents only. The cost of any non-digital transfer should be covered by the payor.
54	Susan H.	Self	Support	Insurance companies are downcoding office visits without any evidence that downcoding is appropriate as they have not

				reviewed the medical records. The act of downcoding then requires the physician and staff to appeal which takes time and effort to do.
54	Joe H.	Self	Support	AI is increasingly used by insurance carriers and embedded within that are algorithms that interpret the CPT codes in their favor. Automatic down coding is burdensome to us in human time, dollars, and stress effects as appeals are needed. All of this are signs that the insurance industry is in need of reform as they are increasingly practicing medicine through their own internal policy making. Accountability is needed.
54	Akshaykumar Ganesh	MSS	Support	Denial and downcoding of claims by third party payers, especially without consulting the medical record, not only places a cost burden on physicians and patients, it also represents an injustice to the patient in the form of delayed, denied, or insufficient care. There should be a substantive and clearly articulated reason for any form of denial of care. Arizona HB2130 - which obligates health insurance companies to provide detailed information and substantive answers to questions for each denied claim or prior authorization - stands as an example that we can aspire to. The OSMA should adopt this resolution to work towards clearer communication between third party payers, physicians, and patients to avoid an unnecessary loss of time and money.
54	Norman M.	District 3	Support w/suggested amendment	OK district 3 supports resolution number 54 in amends. By addition the additional resolve should read resolved that our own OSMA advocate for a clear and concise appeals process for downed claims and that the payer be required to such claim adjudication within 30 days of filing an appeal.
55	John C.	District 2	Support	
55	Engy H.	Self	Support	
55	Harsimran M.	MSS	Support	
55	Susan H.	Self	Support w/title change	I support the Resolved clause as I agree that a standard application for Medicaid providers is essential. However, I think that the title of the Resolution needs to be changed, including removing the word "compact" which is a different concept.
55	Joe H.	Self	Support	Streamline. Reduce redundancies.
55	Norman M.	District 3	Support w/title change	Support with previously mentioned change in resolution title.
56	Joe H.	Self	Oppose	Resolution is broad and needs to acknowledge the many other forms of care already active. Each region is unique so blanketing government funds for mobile units when the region would do better with improved integration of currently available resources risks resource mismatching. Studies need to be Ohio and region specific and should leverage hospital system support. Mobile units are a high cost option and won't be able to have the continuity that medical clinics operating in homeless shelter/meal & grocery center/free clothing store can achieve/job & housing assistance sites can achieve (Refuge of Hope, Canton OH).
56	Adam B.	Self	Oppose	While I applaud the authors' good intentions with this resolution, it lacks sufficient evidence to justify its claims of benefits and the policy's implementation would incur massive costs on the state not justified by the proof provided.

				Joe H is correct in pointing out that there are far better approaches.
56	Philip R.	Self	Oppose	Mobile health units are not necessary in the US, which benefits from being a highly mobile society, with multiple health locations, and numerous transportation options (public bus, friends and family, Uber). The expense of this would be unsustainable and increase costs of healthcare provision for all.
56	Amy B.	Self	In response to Philip R.'s comment	I disagree and point to this report as transportation is widely regarded as a driver of infant mortality. Rural areas are maternal care deserts and not everyone has family or friends willing to transport them 30-60 minutes to the closest maternity care center. Mobile units can potentially improve outcomes. https://www.healthpolicyohio.org/our-work/publications/transportation-action-guide
56	Sara Z.	MSS	Support	I would like to clarify our purpose and support of this resolution. In the state of Ohio, pop-up clinics and mobile units, alongside brick and mortar clinics, are already established and providing communities with increased access to healthcare. Our call to action is to support the work of the health systems who've chosen such avenues for patient outreach. If there were to be relevant legislation regarding street medicine and mobile units, I would be remiss if the OSMA was not in support of them. Additionally, while some may not these to be the "best" way to support patients, in many communities, like Columbus and Toledo, mobile care units are already operating and providing patient care.
56	Norman B.	District 3	Oppose	
57	Engy H.	OMSS	Support w/suggested amendment	On behalf of OMSS. OMSS suggests an amendment to the resolve as follows: supporting legislation to mandate that insurers cover 100% of the agreed upon fee for primary care visits and preventative services and that no copays can be placed upon the patient.
57	Shannon T.	District 2	Oppose	
57	Adam B.	Self	Oppose	While I applaud the authors' good intentions with this resolution, it lacks sufficient evidence to justify its claims of benefits and the policy's implementation would incur financial losses on physician practices and may lead to the over-utilization of medical resources.
57	Brian B.	Self	Oppose	I read through the articles where website addresses were provided by the author. None of them suggested eliminating co-pays as a solution to decreasing barriers in accessing Primary Care. In fact, one was a study on VA patients where some do not have a copay.
57	Ellena P.	Self	Supports OMSS suggested amendment w/alternate language	Speaking on behalf of myself. I support the OMSS recommendation. An alternative could read: RESOLVED, our OSMA supports the elimination of copayments for primary care visits and preventive services
57	Philip R.	Self	Oppose	It is stated that "there is a growing shortage of primary care physicians in Ohio…partly related to the underpayment of cognitive services." The elimination of copays certainly would

				reduce the cash flow in a primary care practice and aggravate the problem of underpayment. Copays are absolutely necessary to avoid overutilization of health services, and reduce unnecessary physician visits.
57	Amber Prater	Self	Support	I do feel that the amendment provided by Engy is very strong and emphasizes the purpose of the resolution. This health forum article provided by the resolution author highlights that patients who have higher levels of cost sharing (ie. copayments) have increased difficult accessing and refilling their medications, and further highlights that decreases in cost sharing increase persistent medication use and adherence, and increase overall use of substitute health care services. This is particularly highlighted for patients with chronic conditions. No where is the battle for medication access and compliance more important that in primary care services, where our primary care physicians are the first line of care into the healthcare system and often the point of contact for new and chronic issues. Further, it is well known that the high cost of care in medicine is a significant barrier for many patients. Year after year, the Kaiser Family Foundation reports the percentage of persons who avoid care due to cost. Most recently, 1 in 4 Americans avoided seeking any type of care because it was too expensive overall. (https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/). This includes things such as a prescription, not going to the dentist, AND seeking care from a healthcare provider. When you look at just the burden to pay for care after receiving it, this number jumps up to nearly 50% - 50% of the population who struggle to pay for healthcare, something that our OSMA has in policy is a human right. This resolution aims to help alleviate some of that financial barrier for the initial point of contact with the healthcare system. States such as California that have invested in primary care have seen improved health outcomes such as reductions in all-cause mortality, heart disease mortality, infant mortality, low birth weight, and life expectancy to name a few. A reduction in cost to for patients to see a primary care or family physician would remove a barrier for our patients, improving access, and ultimately improving healthcare outcomes.
57	Charles S.	Self	Oppose	I am opposed to this resolution as written. Patients should have options. In most cases, the less the co=pay, the higher the cost of insurance. Co-pays are a universal mechanism used in most countries to control costs and over utilization. It is true, if you cut out a few organ transplants, heart surgeries, and cancer treatments, you can pay for a lot of primary care visits.
57	Amy B.	Self	In response to Charles S. comment	Please site your source for "most countries" as most developed countries have nationalized health care systems. Almost 50% of American births are covered by Medicaid where no copay is

				necessary. It seems only the PRIVATE AMERICAN healthcare system requires copays and I do not see anyone getting lower premiums these days. I have cited a source with countries that provide FREE healthcare to their citizens. https://www.playroll.com/blog/countries-with-free-healthcare
57	Joe H.	Self	Oppose	
57	Norman M.	District 3	Oppose	