

## OSMA 2026 Annual Meeting – Resolution Committee One: Online Testimony – Preliminary Report

Res. #	Comment By:	Representing	Position
01	Dr. Jeffrey Studebaker	Self	Support
In line 67, councilors should be singular, i.e. councilor.			
01	Dr. Susan Hubbell	Self	Support
As Vice Chair of the Senior Physician Section, I support these Bylaws changes which were passed at OSMA Annual 2025. I agree with the previous comment about the word councilor in line 67, but consider that an editorial change.			
01	Dr. Norman Moser	Self	Support
I support this resolution.			
01	Dr. Johnathon Ross	Self	Support
Improves the diversity in our governance.			
01	Dr. Elana Sitnik	RFS	Support
The RFS supports representation on council for our newly formed senior, women, and IMG physician sections and is optimistic about the council's leadership potential with the inclusion of the diverse perspectives these groups offer.			
01	Dr. Maria Phillis	YPS, Ohio ACOG	Support
Writing on behalf of YPS and ACOG in support. Representative positions on OSMA council is needed based on previously passed policy and to ensure our sections are adequately represented on council.			
01	Dr. Engy Habashy	OMSS	Support
We support.			
01	Dr. Shannon Trotter	District 2	Support
Support.			
02	Dr. Susan Hubbell	Self	Support
I feel that a standing Bylaws committee is important for ongoing review of the OSMA Constitution and Bylaws and for responding to resolutions passed by the House of Delegates that require Bylaws revisions or additions. Appointing members of the committee experienced in Bylaws is important for the best function of the group.			
02	Dr. Norman Moser	Self	Support
I support the proposed changes.			
02	Dr. Johnathon Ross	Self	Support
The by laws certainly should be reviewed and updated as needed at least yearly.			
02	Dr. Charles Hickey	SPS	Support
We support this resolution to establish the Committee on Constitution and Bylaws as a standing committee of our OSMA. We do support specifying the number of members and staggered multi-year terms on this committee to insure continuity and appropriate expertise. We support development of additional Bylaws language that would accomplish this to be brought to next year's OSMA Annual Meeting for consideration.			
02	Dr. John Corker	District 2	Support
Speaking on behalf of D2 in support of this resolution.			
02	Dr. Maria Phillis	YPS, Ohio ACOG	Support
Speaking on behalf of ACOG and YPS in support. Having a standing bylaws committee is important to ensure continuity and expertise on these issues.			
02	Dr. Engy Habashy	OMSS	Support
We support.			
02	Dr. Shannon Trotter	District 2	Support
Support.			
03	Dr. Susan Hubbell	District 3	Support
Speaking on behalf of District 3 in support of this resolution. We feel that it is time to take a comprehensive look at our OSMA resolution process through a task force that includes representation from all involved groups. We have made major changes to our process since 2020 and 2021 and it is time to review what we are doing and decide how to proceed from here. We are especially concerned about the increased number of resolutions which affects the amount of advocacy work required of our staff after passage. We have also noted that some of the subjects of the resolutions have not been relevant to the current practice of medicine in Ohio.			
03	Dr. Steve Sutton	Self	Support
As a first year attendee of the conference in 2025 I was overwhelmed by the number of resolutions as well as the methods by which they are proposed and reviewed. I support a review and recommendations on changing/updating this process.			

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03	Dr. Norman Moser	Self	Support
Streamlining the resolution process will allow us to become more thorough in evaluating each resolution. After a very long day, many of us become weary and may overlook issues that need resolution.			
03	Dr. Johnathon Ross	Self	Support
I would suggest that OSMA evaluates resolutions with criteria. For example, maybe there should be a balance between what we need as an organization, issues that affect the science and practice of medicine and issues that affect our patients. Resolutions that affect all three would get extra attention. Those that only narrowly affect the practice of medicine or are specific to a limited patient care population or have limited or no support on the pre-meeting comments could have stricter time limits for discussion or the resolution review be rejected by the resolution review committees if there is no support there or in the online comments.			
03	Dr. John Naveau	Self	Support
I completely agree with the comment made by Dr. Hubbell on behalf of District 3. There have been informal discussions for a number of years about reforming the resolution process, and it is time to take a good look at the entire process. It is difficult work for the resolutions committees each year and time consuming for any conscientious OSMA member to go through all the resolutions. We need to focus on resolutions that support the mission of OSMA and build a process that enables us to effectively evaluate and implement those.			
03	Dr. Edward Bope	SPS	Support
I write on behalf of the Senior Physician Section in support of this resolution. Designing, defending, remodeling, negotiating and putting resolutions into action is a core activity that adds much meaning to OSMA membership for many physicians. It is the most important part of our annual meeting. It is time to take an organized look at how it should function in this digital, AI world. This resolution supports a strong look at how we do it and how we should do it.			
03	Dr. Chris Paprzycki	District 1	Support
We support creation of a task force to re-assess our resolution process, making it more efficient and impactful. This will allow us to remain innovative, while still maximizing our impact. However, we must be careful that this task force does not stifle the voice of the membership unintentionally. It must remain open to all submissions. There was also concern raised during our caucus about the impact of AI in writing resolutions, including how we determine accuracy of citations.			
03	Dr. Brandon Francis	RFS	Support w/AMENDMENT
Speaking on behalf of the RFS with a proposed amendment. Overall, we are supportive of the asks of the resolution and agree that it would be worthwhile to assemble a taskforce to review the resolution process. However, our only concern is the final portion of R1 regarding review of the number of submitted resolutions. We strongly believe that the open and democratic nature of the House is one of the strongest aspects of our organization and a fundamental principle of the OSMA. Including review of the number of submitted resolutions in this taskforce would only serve to stifle voices and limit the number of important issues the OSMA can address. We believe that the House is capable of deciding which resolutions merit extensive discussion and which resolutions should take up the time and energy of the OSMA staff, not some arbitrary limit. Therefore, we propose that the final phrase of R1 ("and the number of submitted resolutions") be deleted.			
03	Dr. Engy Habashy	OMSS	Support
We support.			
03	Dr. Susan Hubbell	District 3	Support as written
We support the resolution AS IS. We think that the numbers of resolutions should at least be looked at as a part of the task force. That is a definite part of the resolution process and should be examined. The comments about the number of resolutions in this online testimony should be taken into consideration as both sides of the issue have commented. The task force should solicit input from all districts and sections as a part of the process. The number of resolutions committees is also related to the number of resolutions. Is there a maximum number of resolutions for each committee to review? When do we go to three committees? We feel that the number of resolutions should be reviewed as a part of the process.			
03	Dr. Joseph Hellmann	Self	Support
Recommend adopt as amended. Recall one incident last year where the citations in a resolution did not exist resulting in the resolution being removed. Having served on resolution committees there needs to be a thorough review of the complete process. I have found that there is no structured evaluation of the citations nor any process that rates the quality of the articles submitted which we so commonly speak about as 'evidence based' in support of what we vote on to be policy. Research design, bias, etc. matter very much. Often it seems that ideology and political maneuvering is driving the process more than truth in high quality research. It is possible to generate evidence for nearly anything within a short time frame study given the multitude of statistical analysis that are available to sift data through. It sure would be nice to immediately link to every article submitted.			

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03	Dr. Barbara Rogers	Self	Support
I agree with modernizing the process.			
03	Jon Bernard	MSS	Support w/AMENDMENT
On behalf of the MSS, in support of the amendment offered by RFS to strike "the number of submitted resolutions" from R1. We believe the volume of resolutions submitted reflects the extent to which Ohioans' healthcare and physicians' rights within our state are being threatened. Given that the OSMA is our most powerful tool for healthcare advocacy in our state, we feel that limiting resolutions and the important issues they address would not only be undemocratic, but also restrict our ability to advocate on a broad scope of issues at the statehouse.			
03	Dr. Shannon Trotter	District 2	Support w/AMENDMENT
Recommend amend by deletion by line 35 "number of submitted resolutions."			
04	Dr. Susan Payson	Self	Support
Support.			
04	Dr. Norman Moser	Self	Support
Since this area of Ohio is underserved and has a higher rate of cancer, we should support this resolution.			
04	Dr. Susan Hubbell	District 3	Support w/AMENDMENT
In the third and fifth resolved clause, we recommend changing the word "Appalachian" to "rural" as both of these clauses apply to all of rural Ohio. We have shortages in our area.			
04	Dr. Johnathon Ross	Self	Support
The fact is that there are many diseases and patients who lack access to care due to the fact that we have a sickness care non-system that allocates funding through private insurers that have no obligation to help the underserved. I support the need for better services for rural areas but trying to improve care one set of diseases at a time seems exhausting. We need a unified, simple not for profit system for all of Ohio. The simplicity would bring substantial administrative savings that could be applied to coverage and care. The unified system should have regional funding control so that funding can go to needs that are regionally more important. This cannot be accomplished in a multi-payer for profit insurance environment.			
04	Dr. Chris Paprzycki	Self	Support w/AMENDMENT
Speaking for myself, I support but would broaden this language to all of rural Ohio, not just the Appalachia community. Or say rural Ohio including Appalachia...The second resolve also does not mention a specific community or setting. The last resolve reads as if asking the OSMA to support efforts by doing the following list ourselves. Obviously we don't want the OSMA to be assisting with transportation....			
04	Dr. Tani Malhotra	Self	Support w/AMENDMENT
In enthusiastic support with a few amendments. I applaud the medical students for bringing this important resolution forward. I agree with previous commenters about broadening the language to "rural" rather than Appalachian. My amendments are as follows:			
R1: that OSMA supports policies to sustain rural hospitals AND LABOR AND DELIVERY UNITS			
R3: that OSMA supports expansion of cancer-screening outreach AND MOBILE PRENATAL CARE programs in [Appalachian] RURAL Ohio			
R4: that OSMA supports funding for mobile screening AND PRENATAL ULTRASOUND units and partnerships with local public health departments to address regions with the highest cancer mortality; and be it further			
As an maternal-fetal medicine specialist it behooves me to implore our OSMA and our colleagues to pay attention to the maternity care deserts in Ohio. While prenatal care may be thought of as being on the other spectrum from cancer, I believe that the root of this resolution is to improve accessibility to essential care for rural Ohioans, and what can be more essential than prenatal care. 28 of Ohio's 88 counties are considered maternity care deserts. Labor and delivery units are closing at alarming rates across the state leaving patients with fewer options for care and longer "windshield time" to access essential care.			
As for R4, University Hospitals in Cleveland started the state's and possibly the country's first mobile prenatal ultrasound unit 2 years ago. This is funded through philanthropic funds. Access to high quality prenatal imaging should not rely on the generosity of donors but should be prioritized by our lawmakers. Thus I ask that OSMA support state funding for this as well.			
04	Dr. Maria Phillis	Ohio ACOG	Support
I speak on behalf of ACOG in support of this resolution. We support the original resolution however the proposed commentary detailed here in expanding the coverage to rural and to involve prenatal care is also consistent with ACOG			

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	policy priorities and we would be supportive of these additions as well. We know that there are clear disparities in access to our rural patients in terms of cancer screening and care and that this leads to disparities in outcomes.		
04	Dr. Engy Habashy	OMSS	Support w/AMENDMENT
	We support. We recommend amending "Appalachian" to "rural" Ohio.		
05	Dr. David Mungo	Self	Oppose
	Don't think it is the business of OSMA to tell companies how to conduct their benefits.		
05	Dr. Norman Moser	Self	Support
	I also am not one to want to tell companies how to structure their benefits, However, providing 2 days of paid time off for medical appointments should help drive down the overall costs of health care. Perhaps we should, however, ask the patient for proof that they used the paid time off for health care.		
05	Dr. Susan Hubbell	District 3	Oppose
	We oppose this resolution. We do not feel that OSMA should be commenting on employee benefits. Also our physicians in private practice are barely able to survive currently financially and cannot afford more expenses. In addition if an individual is only working part time, they should have days when they can go to physician visits.		
05	Dr. Johnathon Ross	Self	Support
	We should argue for social policies that will improve the public's health. Family and Medical Leave laws already exist but the leave is unpaid. Businesses have a problem with "presentism" as well as absenteeism- people come to work too sick to be very productive. I would suggest that eliminating copays and deductibles (which have done little to nothing to control healthcare costs) would soften the blow of unpaid family and medical leave. As is noted in the resolution, it is mostly low wage workers who do not have paid medical leave. All OECD countries except the United States and the Republic of Korea provide paid medical leave. This means that 34 out of 36 OECD countries offer some form of paid leave for personal illness, typically funded through a combination of employer liability and public funds. Their healthcare is universal and their costs are about half of ours. We do publicly regulate other business benefits such as retirement plans and overtime pay so this is not a taboo. I would hope that OSMA would not oppose paid medical leave if the legislature decided that all businesses should provide this.		
05	Dr. Elana Sitnik	RFS	Support w/AMENDMENT
	Overall the RFS supports the principle of paid time off for healthcare. However, the specification of 2 days seems somewhat arbitrary and is not supported by evidence cited in the whereas clauses. For this reason, we recommend amending the language to read: "our OSMA supports protected, paid time off for medical appointments for all employees, regardless of full or part-time status."		
05	Dr. Chris Paprzycki	District 1, Self	Support w/AMENDMENT
	District One has concerns that "OSMA will support guaranteeing employees" is ambiguous, and could be interpreted as OSMA-specific employees. Speaking for myself, I would support the RFS amendment.		
05	Dr. Tani Malhotra	Self	Support w/AMENDMENT
	Speaking as an individual in support of the RFS amendment.		
05	Dr. Maria Phillis	YPS, Ohio ACOG	Support
	Speaking on behalf of YPS and ACOG in support of the resolution and the need for paid time off. It is very difficult for anyone to make it to a medical appointment while working full (or even part time when they are working multiple part time jobs) and giving some minimal time to ensure that people can access at least preventative health care benefits the health of our patients and our population and reduces costs from preventable disease.		
05	Cynthia Bukirwa	MSS	Support
	We support this resolution. Considering that people in low-paying jobs often have little to no paid time off, I support this resolution. We view the 2 protected PTO days as appropriate for making a doctor's appointment every 3 months. We are open to amendments on the floor to improve the effectiveness of this resolution based on membership expertise and to address enforcement/HIPAA concerns if necessary.		
05	Dr. Joseph Hellmann	Self	Oppose
	Speaking for myself as an independent physician group business owner with over 250 employees. The heart of this is wonderful but assumes many things about employers and employees. Employers often do care and work with their employees to better their health and I am happy to care for some of those employers themselves who do. If a person's health isn't important enough for them to make and keep appointments, particularly in a world with tele health, then opening the door to have paid time off will become a notable form of abuse of employers and will very likely result in many abusive people making 'emergency visits' to a doctor for questionable reasons so they can avoid certain work duties. This can quickly backfire and result in longer patient wait times. Don't punish employers. Encouraging and supporting physicians		

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	to extend or modify office hours to accommodate patient work schedules is a more appropriate request coming from OSMA. To push this responsibility to employers for our convenience sounds hypocritical.		
06	Dr. Norman Moser	Self	Support
	I support this resolution.		
06	Dr. Johnathon Ross	Self	Support
	In general, I think most physicians need to have a balance of medical expertise and social justice activism. We watch the cruelty of our sickness care non system where care is denied by bureaucrats whose job it is to increase profits for the insurers. We need physicians to be advocates for social justice. It is injustice and inequity that are key harmful effects on the health of our patients. Medical care is only about one fifth of what determines our health. The rest is in the area of the social determinants. Physicians, even those in specialty fields should recognize these facts and pay attention to recruiting students who demonstrate both scientific capability like research and social science capability such as concern and participation in social policy research and action.		
06	Dr. Maria Phillis	Ohio ACOG	Support
	Speaking on behalf of ACOG we support this resolution. The work that OSMA and our professional organizations do in the advocacy space requires engaged and committed physician advocates and valuing these traits in our trainees is one way to ensure that our medical community will continue to have dedicated physician advocates ready to stand up for our profession and our patients.		
06	Dr. Samantha Thomas	RFS	Support w/AMENDMENT
	Speaking on behalf of the RFS in support with amendments to resolution 6. The premise of this resolution is so important as we should be encouraging our colleagues to pursue things that interest them and where they feel they can make the most impact to serve our patients. We would like to offer an amendment in lieu of the language in the underlined section of this resolution as well as recommend a title change to incorporate medical school and fellowship programs in this policy.		
	Amendments to read as follows: Policy 34-2021 – Increasing Transparency of the Medical School, Resident, and Fellowship Physician Application Process		
	<ol style="list-style-type: none"> <li>1. The OSMA and interested stakeholders shall study options for improving transparency in the medical school, resident and fellowship application process, which works towards a holistic review of residency applicants.</li> <li>2. The Ohio Delegation to the AMA shall forward this resolution to the AMA</li> <li>3. The OSMA encourages Ohio medical school, residency, and fellowship programs to improve the holistic and equitable consideration of research, advocacy, service, teaching, mentorship, and other non-research domains in medical school and residency/fellowship selection.</li> </ol>		
	We think this language is more inclusive to all levels of training along with including a more diverse variety of extracurricular activities that can be classified as scholarly activity.		
06	Dr. Joseph Hellmann	District 6	Support
	Of all the holistic review items of a candidate it is the boots on the ground service which most helps to develop a heart of compassion. Service within the community having exposure to people and places like homeless shelters, meal & clothing ministries, pregnancy and parenting centers, addiction recovery, etc. does volumes more to train up a physician than our current model's emphasis.		
06	Dr. Shannon Trotter	District 2	Support w/AMENDMENT
	Amend to delete item 2 as this has already been accomplished.		
07	Dr. Susan Hubbell	District 3	Oppose
	We are opposed to this resolution due to the expense and logistics involved.		
07	Dr. Johnathon Ross	Self	Support
	Federal Regulations Section 1557 of the Affordable Care Act mandates that healthcare providers receiving federal funding must provide language assistance services, including interpreters and translators, to LEP individuals. This rule emphasizes that these services must be free of charge and accessible to patients. The Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS) has clarified that healthcare providers must ensure that interpreters maintain patient confidentiality and meet specific qualifications. State Regulations in Ohio follows federal guidelines and has additional provisions to enhance language access in healthcare settings. The state requires healthcare providers to offer interpreter services to LEP individuals, ensuring that these services are competent and culturally appropriate. Ohio's Department of		

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	Medicaid also emphasizes the importance of language access in its policies, ensuring that Medicaid recipients can access necessary interpreter services.		
07	Dr. Ken Christman	Self	Oppose
	This country has one official language. While every effort is currently made to accommodate those with language difficulties, clinics being held in other languages will be a nightmare for physicians who may not be proficient in those languages.		
07	Dr. Tani Malhotra	Self	Oppose
	As an individual, I oppose this resolution not for its merit but because OSMA does not hold purview over residency education and clinics. As a multilingual person myself, I strongly support the need for high quality translator services that should be broadly available however I cannot support this resolution as written.		
07	Dr. Joseph Hellmann	Self	Oppose
	AI translation tools are quickly advancing and medical training has enough on its plate. On medical missions I use tech and develop relationships with my regional translators. In the USA I use tech to translate other languages medical documents. As tele health AI programs advance I am excited to be able to do tele health to patients in underserved countries with the AI providing translation services real time.		
08	Dr. Norman Moser	Self	Support
	I support this resolution. Health is now very much evidence based. We should keep it that way.		
08	Dr. Susan Hubbell	District 3	Support
	We feel that science should be the basis for our advocacy positions.		
08	Dr. Johnathon Ross	Self	Support
	What are we if we are not advocates for the science of medicine and treatments based on our best evidence as we understand it?		
08	Dr. John Naveau	Self/Author	Support
	As the original author of this resolution, the time seems appropriate for OSMA to again support that we advocate for the science of medicine and treatments based on the best evidence to the best of our understanding. Well said by Dr. Jonathan R. in his comment.		
08	Dr. Philip Roholt	Self	Support
	Support this resolution.		
08	Dr. Chris Paprzycki	District 1	Support, in part (w/AMENDMENT)
	District One agrees with this concept, but felt language was poorly written. Just because it's copy and paste from AMA policy doesn't mean we should keep the poor grammar. The first two are essentially our historical, published mission and values statements and feel performative. Three and four are challenging to read, and we felt this should be focused on the science of medicine, not simply any and all "science." We would ask the reference committee to clean up this language, such as the following: (3) enhancing WITHIN THE OSMA the profile and priority OF SCIENCE AS THE BASIS OF MEDICINE; and (4) bringing science OF MEDICINE to the forefront of OSMA advocacy and legislative initiatives.		
08	Dr. Maria Phillis	YPS, Ohio ACOG	Support
	Speaking on behalf of ACOG and YPS in support of this resolution. All good policy should be scientifically sound and based on evidence based medicine.		
08	Dr. Glen McClain	RFS	Support
	Science is the foundation of everything we do as physicians and trainees. Just as we use empiric data to support clinical decision-making, so too should we use it to support our advocacy. This resolution affirms existing OSMA practice and makes it clear to legislators, regulators, and the public that we are evidence-driven organization.		
09	Dr. Norman Moser	Self	Support
	I support this resolution. After spending over 40 years on call 1 or 2 nights per week, I wish they had this law 30 years ago.		
09	Dr. Susan Payson	Self	Support
	Agree call should be voluntary, post call rest afforded, and hospitals must be required to pay physicians for call related to the uninsured.		
09	Dr. Susan Hubbell	District 3	Support
	We support this resolution as written for the reasons stated in the whereas clauses.		
09	Dr. Johnathon Ross	Self	Support
	If we had a healthcare system with everybody in and nobody out then there would be no uninsured patients and all care would be compensated. Hospitals do give us a "free" workshop with access to other specialties that we need on site 24/7. I believe it is reasonable to accept that there is a quid pro quo for hospital privileges. Call should be limited and recovery time given as we know that our ability to be at our best deteriorates as sleep deprivation increases. Not sure that pay alone will		

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	solve this problem. Regarding burnout- research suggests that moral injury caused by the inability to give the best care to patients is as important as the workload and pay. It's not the work or the pay it's spending all day arguing on the phone with insurance bureaucrats who have never laid eyes or hands on the patient.		
09	Dr. RJ Sontag	Self	Oppose, in part
	I OPPOSE resolveds 1 and 2 and SUPPORT resolved 3. Emergencies happen 24/7/365. Those emergencies require stabilizing care per federal EMTALA regulations. That care often requires a specialist consultation. Those specialists should certainly be compensated for their care, and they deserve wellness considerations. But leaving patients without stabilizing options doesn't serve the population we care about, and it doesn't meet our legal requirements.		
09	Dr. Chris Paprzycki	District 1	Amend?
	District One was unclear the intent of what the authors were asking the OSMA to do to accomplish this, and would request clarification, as the formatting does not match resolution guidelines. (eg, That the OSMA support? advocate?). We also believe that "uninsured" should be removed from the third resolve. We should advocate that any mandatory call should be compensated, no matter the insurance coverage of the patient.		
09	Dr. John Corker	Self	Support w/AMENDMENT
	Speaking on behalf of myself in support of R3 and all amendments proffered by Dr. Chris Paprzycki in his comments. I am in support of Dr. RJ Sontag's comments regarding our legal and ethical EMTALA obligations as it pertains to specialty call for the ER - and thus opposition to R2.		
09	Dr. Engy Habashy	OMSS	Support w/AMENDMENT
	We support the resolution and recommend striking out "uninsured" in the third resolve. All call coverage should be reimbursed appropriately regardless of patient's insurance status.		
09	Dr. Dacia Russell Goman	Self	Oppose
	I am in support of Dr. RJ Sontag's comments regarding our legal and ethical EMTALA obligations as it pertains to specialty call for the ER - and thus opposition to R2.		
09	Dr. Shannon Trotter	District 2	Support w/AMENDMENT
	Support R1.		
10	Dr. Susan Payson	Self	Support
	Lesser trained and fewer staff, with little to no clinical experience, and spotty or nonexistent on-site supervisory support can contribute to the decline of LTC/SNF patients, resulting in human suffering, medical errors and complications, and sometimes premature death.		
10	Dr. Norman Moser	Self	Support
	I agree with the resolution, but am concerned about funding increased staff. Money always seems to be a barrier to quality health care.		
10	Dr. Johnathon Ross	Self	Support
	I agree with Dr. Payson's comment.		
10	Dr. Chris Paprzycki	District 1	Support
	District One supports this well written resolution.		
10	Dr. Jessica Geddes Shea	YPS	Support
	Understaffing in facilities is unsafe and not fair to patients/residents or their families.		
10	Dr. Maria Phillis	Ohio ACOG	Support
	Staffing in facilities that is not safe leads to worse care for the residents, increased hospitalizations and strain on an already taxed hospital workforce.		
10	Dr. Shannon Trotter	District 2	Support
	Support.		
11	Dr. David Mungo	Self	Oppose
	Human behavior tends to stay the same throughout history. When you analyze a behavior, you get less of it when you reward a behavior you get more of it. I don't understand how not penalizing harm caused to a child helps children? When do we criminalize child abuse if not from the beginning? I agree they need help and support the advocacy for treatment programs but that doesn't excuse the crime.		
11	Dr. Norman Moser	Self	Oppose
	I agree with David M. A crime is still a crime.		
11	Dr. Susan Hubbell	District 3	Support w/AMENDMENT
	We recommend amending the new clause to say "EFFECTIVELY PENALIZE PREGNANT PERSONS ONLY FOR BEING DIAGNOSED....." to clarify the issue.		

Res. #	Comment By:	Representing	Position
11	Dr. Jeff Otte	Self	Oppose as written
I see the intent. Perhaps the wording could be simplified to the following: The OSMA opposes efforts to penalize a pregnant person based solely on the diagnosis of substance use disorder.			
11	Dr. Johnathon Ross	Self	Support
I agree with Dr. Hubbell for amendment. Criminalizing drug abuse has been the case for a century or more. It has not stopped addiction and makes no sense. It has not stopped the kingpins from profiting from drug dependency. Is eating junk food and smoking or drinking while pregnant child abuse too? Should we criminalize that behavior as well? I believe the only way to stop the drug trade is to bankrupt the kingpins. We should legally publicly sell the drugs and the clean syringes for much less than whatever the price is on the street and use the funds gained to support rehab facilities located at the same at the same place that the drugs are available. This would bankrupt the dealers and reduce the crime and human trafficking associated with drug abuse. I suspect that there would be no more addicts than there are now and the social costs of policing the drug trade and imprisoning the offenders would be markedly less. You might be able to make a case for mandatory rehab for pregnant addicts but never prison.			
11	Dr. Ken Christman	Self	Oppose
Why not decriminalize drug abuse for everybody? But, if drug abuse constitutes criminal behavior for nonpregnant people, why is it not even more criminal for those who are harming a fetus? Does harming a fetus indicate a propensity to harming an infant? Should physicians not actively condemn those whose practices are promoting deleterious effects on born or unborn children, whether it be nicotine, alcohol, drugs, etc.?			
11	Dr. Tani Malhotra	Ohio ACOG	Support
On behalf of the American College of Obstetricians and Gynecologists in strong support of this resolution. My conflict of interest is that I have previously joined an amicus brief for a case that ultimately acquitted the pregnant person in Ohio. My expertise is in Substance use disorders in pregnancy (happy to provide my bibliography if needed by the resolution committee). Substance use disorder rates in pregnancy increased from 2010 to 2022. 9 out of 10 cases of criminalization of pregnancy has been in cases of drug use, with the majority being in 5 southern states. Coincidentally, these states also lead the US in rates of overdose death. Rates of substance use disorder in pregnancy have increased across the country and have not been impacted by criminalization in states. My point being, criminalization of drug use does not dissuade or stop drug use - it just makes it more dangerous. Criminalization of a MENTAL HEALTH DISORDER dissuades patients from seeking timely care and getting plugged into the resources necessary for their recovery. Patients in recovery get the resources they need to care for their children. Not to mention - the people carrying these pregnancies are people themselves not vessels for fetuses. For my colleagues that believe that drug use should be penalized - for pregnant or non-pregnant individuals, do you believe that diabetes should be criminalized as well? I implore us to try and address the stigma with which we approach patients with substance use disorders as just other chronic illnesses we care for. We are continuing to lose the trust of patients and approaching their care with judgement does not help our case.			
11	Dr. Maria Phillis	YPS	Support
Support on behalf of YPS for the reasons eloquently stated by my ACOG colleague.			
11	Dr. Joseph Hellmann	Self	Oppose
I actively enter prisons monthly and have situation after situation where the person detained is thankful for the situation they are now in. While in these facilities they often get cleaned up, find support, and come to realize how their lives went in a bad direction. They are guided as to how to change persons, places, and things when they get out. Those who take it seriously get a second chance, those who do not return one way or another assuming they survive their next overdose. Prisons serve a public role in more ways than most know. I also am involved with women transitional housing through which woman after woman, and their children, are supported in learning how to live well, or re-learn how to live well over the course of a year or more before they fully transition onto their own. Anyone who is involved in engaging prisoners outside of medical care within prison facilities or in the transitional housing situations post prison please find me at the delegation - I would like to hear about your experiences.			
11	Elena Hausmann	MSS	Support
Criminalizing prenatal drug use through policy does not decrease substance use during pregnancy (1). Criminalization can worsen health outcomes for both pregnant patients and infants as stated in this resolution and comments by ACOG and YPS. We respect the statement of support by ACOG below and echo concerns about stigma and subsequent delay in care or connection to resources. (1. Austin AE, Hergenrother LC, Shanahan ME. Illicit drug use during pregnancy in states with and without punitive prenatal substance use policies. Am J Prev Med. 2025;70(3):108155. doi:10.1016/j.amepre.2025.108155)			

Res. #	Comment By:	Representing	Position
11	Dr. Courtney Holbrook	RFS	Support
Criminalization of SUD in pregnancy pushes pregnant people further into the shadows. Punitive legal actions result in less prenatal care and access to MAT, which are both associated with better neonatal outcomes. If our priority is maternal-infant health, we should focus on reducing the stigma surrounding substance use rather than creating more barriers to care.			
11	Dr. Shannon Trotter	District 2	Oppose as written
Oppose as written (intent may be there to say that diagnosing SUD should not subject pregnant persons to punishment).			
12	Dr. Norman Moser	Self	Oppose
While, on the surface, this resolution seems like the right thing to do, we need to consider the repercussions of the resolution. The purpose of a credit report is to allow the creditor the ability to ascertain the borrower's ability to repay a debt. Medical expenses are still an expense that an individual has to pay.			
12	Dr. Susan Hubbell	District 3	Oppose
We oppose the entire amendment. Transparency is necessary in checking an individual's credit report and medical debt needs to be included in that as it is an obligation of the individual.			
12	Dr. Johnathon Ross	Self	Support
<p>Medical debt for services that Medicare or Medicaid would cover is an unjust burden. Almost all of the medical care that we provide as physicians is indicated I would hope. Going bankrupt due to needed care is unjust. Many oncologists now talk about the "financial toxicity" of chemo. We have the highest copays and deductibles among the rich countries and our costs are double those of countries where care is free at the point of service. Copays and deductibles are NOT saving money or lives. Half of Americans fear bankruptcy due to seeking care. They are skipping tests, visits, meds and other needed care. Rand points out copays and deductible reduce care as much for highly needed care as less needed care.</p> <p>Since the vast majority of care is needed they reduce necessary care more than unnecessary care. Despite these high copays we are twice as expensive as the other OECD countries. They do not effectively reduce costs or improve care. The reason for our high costs is the financial and administrative complexity of our sickness care non-system. Our health system unnecessary administrative expenses and profiteering equals about 10-15% of total spending per the CBO.</p> <p>Here is the Google search- "Studies suggest that implementing an Improved Medicare for All (single-payer) system in the United States could reduce national healthcare expenditure by approximately 13% to 15% annually. Estimates from various studies suggest this translates to savings of roughly \$450 billion to over \$600 billion per year. National Institutes of Health (NIH)   (.gov) A comprehensive 2020 study published in The Lancet calculated that a single-payer system would reduce total healthcare spending by \$458 billion annually (based on 2017 data), despite the costs of expanding coverage to all residents. National Institutes of Health (NIH)   (.gov) Key Drivers of Savings The anticipated savings come primarily from reducing administrative overhead and lowering the cost of medical services and pharmaceuticals: Public Citizen Administrative Efficiency: Consolidating insurance into a single, public system could save over \$200 billion annually by reducing the administrative overhead of private insurers (currently ~12% or more) down to the levels of Medicare (~2%). Pharmaceutical Pricing: Allowing the government to negotiate drug prices (similar to the VA or other developed nations) is projected to save over \$180 billion per year. Hospital and Clinical Fees: Applying Medicare's lower reimbursement rates across all providers could save over \$100 billion annually. Reduced Fraud: A unified system with better monitoring could significantly reduce the \$85+ billion lost to healthcare fraud each year. National Institutes of Health (NIH)   (.gov) Long-Term Impact and Other Projections Over a Decade: Research from the Political Economy Research Institute (PERI) estimated that Medicare for All could save approximately \$5 trillion over a ten-year period. Public Citizen Lives Saved: In addition to financial savings, studies suggest universal, single-payer care could prevent roughly 68,000 to over 211,000 deaths annually (the latter figure specifically in the context of pandemic-era inefficiencies). National Institutes of Health (NIH)   (.gov) Household Costs: While federal taxes would increase to fund the program, most households and employers would see a net reduction in healthcare costs by eliminating premiums, deductibles, and co-pays. Public Citizen Variations in Estimates While a large number of studies agree that Medicare for All would produce net savings, some analyses, such as those from the Mercatus Center or the Urban Institute, have previously projected that while total national spending might decrease (e.g., by \$2 trillion over 10 years), federal government spending would increase substantially, necessitating significant tax changes. RAND" (I might note that these studies assume that doctors, hospitals, medical education and research are held whole financially.)</p>			
12	Dr. Ken Christman	Self	Oppose
I strongly oppose this resolution. There are patients who keep the insurance checks themselves. There are patients who receive huge amounts from insurance policies/litigation who along with their attorneys REFUSE to pay legitimate medical bills. Physicians have traditionally given freely of their time and services to those who truly need them, but there are certain individuals who abuse physicians.			

Res. #	Comment By:	Representing	Position
12	Dr. Joseph Hellmann	Self	Oppose
<p>I see the heart. As physicians we are partly responsible for escalating health care costs. How often are excess tests used to solidify what we already know? How many hospital systems have testing protocols that are simply carried out as if every unique patient's situation fits into an algorithm? Are tests ordered because we have access to them when we already know what needs done? How are we doing with palliative care? How many patients come into our offices asking for certain tests to be done because they have met deductibles? Being involved in out of country medical missions is what it took for me to see how excessive our reliance on testing has become. How about the patient side? Do patients manipulate healthcare providers and institutions to get what they want? Do patients utilize healthcare excessively for a short period then file bankruptcy? One of my single minority mothers shared with me how she made \$144,000 a year - by knowing to 'properly' file assistance forms. We need a return to morality and character virtue.</p>			
12	Elena Hausmann	MSS	Support
<p>As medical debt arises from illness or injury alongside insurance gaps or lack of full coverage, it is structurally different from other debt types in that it does not reflect voluntary financial behavior. Medical debt is a weaker predictor of future default than other debts (1). A CFPB study found that consumers with medical debt performed like borrowers with credit scores ~10 points higher (2). Those who paid off medical collections performed like people 16–22 points higher (2). Additionally, VantageScore does not use medical debt collection data in its latest models because of their recognition that medical debt is a poor predictor (3). Prohibiting medical debt in credit reports is one means to ensure patients continue to seek care and that their access to housing or other resources are not further impacted by a credit score.</p> <p>References: 1. Duarte F, Fonseca J, Kohli P, Reif J. The effects of deleting medical debt from consumer credit reports. National Bureau of Economic Research Working Paper No. 33644. Published 2025. <a href="http://www.nber.org/papers/w33644">http://www.nber.org/papers/w33644</a>  2. Consumer Financial Protection Bureau. CFPB study finds medical debt overly penalizes consumer credit scores. Published May 20, 2014. <a href="https://www.consumerfinance.gov/about-us/newsroom/cfpb-study-finds-medical-debt-overly-penalizes-consumer-credit-scores/">https://www.consumerfinance.gov/about-us/newsroom/cfpb-study-finds-medical-debt-overly-penalizes-consumer-credit-scores/</a>  3. VantageScore. Major credit score news: VantageScore removes medical debt collection records from latest scoring models. Published August 10, 2022. <a href="https://vantagescore.com/consumers/blog/major-credit-score-news-vantagescore-removes-medical-debt-collection-records-from-latest-scoring-models">https://vantagescore.com/consumers/blog/major-credit-score-news-vantagescore-removes-medical-debt-collection-records-from-latest-scoring-models</a></p>			
12	Dr. Shannon Trotter	District 2	Oppose
<p>Like existing policy.</p>			
13	Dr. Susan Hubbell	District 3	Oppose w/RECOMMENDATION TO REAFFIRM EXISTING POLICY
<p>We feel that current OSMA policy covers this issue and recommend reaffirming 25-2017, 05-2019 and 35-2021.</p>			
13	Dr. Johnathon Ross	Self	Support
<p>It seems to me as well that existing policy is quite good. The authors should tell us how they would amend existing policy. I am not clear on the areas the authors want to improve our existing policy.</p>			
13	Dr. Ken Christman	Self	Oppose
<p>I strongly oppose this resolution. There already exists plenty of protection against discrimination of any and all types. The vague wording of this resolution is not conducive to any clarity regarding biases.</p>			
13	Dr. Brandon Francis	RFS	Support
<p>Speaking on behalf of the RFS in support of this resolution. The authors of this resolution do an excellent job of outlining the harms of implicit bias, microaggressions, and systemic discrimination that have negatively impacted our patients and our healthcare colleagues. Adoption of this resolution would strengthen the OSMA's position on this important issue.</p>			
13	Maya Dunson	MSS/Authors	Support
<p>Commenting on behalf of authorship and the OSMA-MSS in support of this resolution. None of current policy addresses evidence-based implicit bias mitigation training and structural competency education within healthcare professionals, which can include all of those who work at medical institutions - not just those in medical school and graduate medical education. We feel that it is extremely important for all health professionals, including physicians who have not received such training, to be trained on implicit bias and cultural competencies because it is integral to their practice and patient care. Also, current policy only discusses implicit bias in terms of gender equity and pay gaps, but there is no policy that recognizes implicit bias, structural inequities, and systemic discrimination as significant contributors to clinical disparities and patient safety, as well as support any practices to prevent and address discrimination, implicit and explicit bias, and microaggression. Due to these clear gaps, we feel that this resolution is timely and necessary.</p>			
13	Dr. Joseph Hellmann	Self	Oppose w/RECOMMENDATION TO REAFFIRM EXISTING POLICY
<p>Agree with Dr. Hubbell and others to reaffirm prior policy. Creating endless programs (when it all simply means that we should do to one another as we would want them to do to us) just frustrates those of us who engage in care in multiple</p>			

Res. #	Comment By:	Representing	Position
	locations for each facility would require of us another checklist item to do every year. This might be fine for a physician who has signed a singular exclusive contract to work as an employee as it is simply more modules to sift through and check off every year.		
13	Dr. Shannon Trotter	District 2	Oppose w/RECOMMENDATION TO REAFFIRM EXISTING POLICY
	Reaffirmation.		
14	Dr. Johnathon Ross	Self	Support
	For over three centuries, we have seen prison reform efforts that have made progress on the treatment of inmates. We should support efforts here in Ohio to reduce imprisonment for nonviolent crimes and for humane treatment of those with substance abuse or mental health issues who are often imprisoned without benefit to them or society. In particular we should strongly support the healthcare improvement recommendations for Ohio prisoners.		
14	Dr. Ken Christman	Self	Oppose
	These are perceived barriers that actually are not the real problem. Additionally, the resolution extends beyond medical care. These issues should be left to the judicial branch.		
14	Dr. Maria Phillis	YPS	Support
	We support this resolution. Our incarcerated populations are at higher risk for certain poor health outcomes due to delayed care, overall lack of access to care and varying standards of that care across facilities. This attempts to address some of these problems and we are in support.		
14	Daniel Leonard	MSS/Authors	Support
	Commenting on behalf of authorship and the OSMA-MSS in support of this resolution. Improving access to timely and equitable health care for incarcerated individuals is essential to improving both individual and public health outcomes. Removing financial barriers and expanding access to mental health, preventative, and gender-affirming care will allow earlier intervention, reduce complications from untreated conditions, and help address the disproportionately high burden of chronic disease, substance use, and mental illness in this population. Strengthening care within correctional settings and during reentry also has the potential to reduce recidivism and improve continuity of care, ultimately benefiting not only incarcerated individuals but the broader community.		
14	Dr. Joseph Hellmann	Self	Oppose
	I will be entering SRCCC facility on Monday and will enter the community portion of the facility where there will be prisoners working out, playing cards, reading books, doing art, playing cornhole and more. Retaining some form of payment actually provides human dignity and a sense of responsibility and accomplishment for these individuals. How to improve decision making in these individuals? How to improve their character? How to develop a smooth on ramp for reintegration into society?		
15	Dr. Jeffrey Studebaker	Self	Support w/AMENDMENT
	In line 19 of resolution #15, I would recommend replacing relegating with delegating.		
15	Dr. Mary LaPlante	Self	Support, w/AMENDMENT
	I would like it to be more descriptive to include that the surgeon personally evaluate the patient prior to surgery and consent the patient. I feel the surgeon should be fully aware of the content provided in the consent and provide the patient to ask them questions during the consent prior to the patient signing it.		
15	Dr. Johnathon Ross	Self	Support
	Agree with edits suggested by others so far.		
15	Dr. John Corker	District 2/Author	Support
	Speaking on behalf of D2 in support of this resolution.		
15	Dr. Glen McClain	Self	Oppose
	Surgical consent is a non-delegable duty. Only the physician performing the procedure can fully understand and relay the risks, benefits, and alternatives. Patients cannot make fully informed medical decisions if the duty is delegated to a provider who is unable to comprehensively answer questions or describe risk. This would also likely increase malpractice claims and decrease patient satisfaction. According to MedPro Group data, over 40% of informed consent claims already involve surgical consent. This resolution represents a drastic change in current ethical and legal requirements for physicians. As an evidenced-based body, significantly more data and discussion on this topic is imperative before we pass policy based on personal anecdotes.		
15	Dr. Shannon Trotter	District 2	Support
	Support.		

Res. #	Comment By:	Representing	Position
16	Dr. Susan Hubbell	District 3	Oppose
We oppose this resolution. We feel this is expensive and not within the purview of OSMA. We also feel that this would be impossible to regulate.			
16	Dr. Johnathon Ross	Self	Support
There is significant concern about HB 134 in the public health community. Here in Lucas County we even inspect food trucks. There are already laws that allow for home made products that have low risk to the public to be sold. The public health experts in our community are very concerned about the risk of home produced foods resulting in serious individual harm or outbreaks of contagious illness from improperly prepared products.			
16	Dr. Ken Christman	Self	Oppose
I oppose this resolution. Do we not have enough regulations in this society already? Adding this regulatory burden will be expensive, unnecessary, and will certainly add to inflation and increased cost of goods.			
16	Dr. Philip Roholt	Self	Oppose
These Microenterprises are truly small scale home businesses, where individuals are able to make a small income using their skills. The foods are usually healthier than what can be found in a grocery store or even restaurants (consider the Chipotle debacle a few years back). Risk to the public is minimal, cost of implementation and regulation is large.			
16	Dr. Chris Paprzycki	District 1	Oppose
We first would recommend removal of reference to a specific bill. However, we have concerns about the practicality of enforcing the standards of retail on home kitchens. The example raised was: does this mean every lemonade stand would be subject to these standards and inspection? This would essentially just throttle all home kitchen entrepreneurship. We would oppose as written.			
16	Dr. Shannon Trotter	District 2	Oppose
Listen/Oppose as written , don't list bill number, not certain our role, and high cost.			
17	Dr. Susan Payson	Self	Support
Support.			
17	Dr. Johnathon Ross	Self	Support
I worked on this resolution with UT medical students and support their work.			
17	Dr. Ken Christman	Self	Support
Medicaid Managed Care is a disaster. It is expensive, unwieldy, and a nearly insurmountable barrier. It must be abolished. The sooner the better.			
17	Akshaykumar Ganesh	MSS	Support
Shifting the management of our Medicaid programs away from the Managed Care Organization model is clearly beneficial in terms of both financial and health outcomes. This is best demonstrated by the example of Connecticut, which has not only saved around \$400 million each year since switching to managed fee-for-service (1), but has demonstrated improved health outcomes in the form of earlier cancer detection (2), and comparatively high primary care and parental health measures (3,4). Especially in light of the 2025 Budget Reconciliation Act which slashes federal Medicaid spending, the MSS believes that the significant administrative savings that will result from moving away from the MCO model will play a crucial role in the survival of Ohio's Medicaid program. We would also like to ask for some clarification on the attached fiscal note. Why is the fiscal note so high for a resolution that calls for passive support of potential legislation?			
References:			
1. Andrews, E. Medicaid switch from MCOs saving taxpayers billions. CT Health Policy. February 19, 2020. <a href="https://cthealthpolicy.org/medicaid-switch-from-mcos-saving-taxpayers-billions/">https://cthealthpolicy.org/medicaid-switch-from-mcos-saving-taxpayers-billions/</a>			
2. Pranit R. Sunkara et al. Association of Medicaid Privatization With Patient Cancer Outcomes. JCO Oncol Pract 20, 708-716. 2024. DOI:10.1200/OP.23.00297			
3. Connecticut Department of Social Services. Report regarding the HUSKY Health program pursuant to Section 17 of Public Act 23-171 (p. 17). February 4, 2025. <a href="https://cthealthpolicy.org/wp-content/uploads/2025/02/DSS-HUSKY-Health-Report-Feb-2025.pdf">https://cthealthpolicy.org/wp-content/uploads/2025/02/DSS-HUSKY-Health-Report-Feb-2025.pdf</a>			
4. Connecticut Department of Social Services. Medicaid landscape analysis: Medical Assistance Program Oversight Council (MAPOC) meeting [Slide 4]. Council on Medicaid Managed Care. December 13, 2024. <a href="https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&amp;%20Presentations/20241213/Landscape%20Analysis%20Report.pdf">https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&amp;%20Presentations/20241213/Landscape%20Analysis%20Report.pdf</a>			
18	Dr. Susan Payson	Self	Support
PEs that purchase healthcare organizations behave like the 'corporate raiders' of the 1980's, as detailed in the resolution. PE healthcare ownership should not be managed; it should be prohibited.			

Res. #	Comment By:	Representing	Position
18	Dr. Susan Hubbell	District 3	Support, in part
We support Resolved clause 2.			
18	Dr. Johnathon Ross	Self	Support
The worst of corporate behavior is trying to buy the healthcare system before we can reform it. We must oppose these unaccountable bandits.			
18	Dr. Ken Christman	Self	Support
I support this resolution. Physician practices should ALWAYS be owned by physicians. It always used to be that way. Sadly, both governmental and nongovernmental payors have discriminated against physician-owned practices with their unfair payment schedules. These unfair and discriminatory payment practices must stop. Small physician practices are especially discriminated against. The resolution does not go far enough, as private equity ownership of physician practices are not the only problem. The public has a right to know who their physician's employer is and what might potentially be a conflict of interest regarding medical care.			
18	Dr. Chris Paprzycki	District 1	Support
District One strongly supports.			
18	Dr. Maria Phillis	YPS	Support
We support this resolution.			
18	Dr. Samantha Thomas	RFS	Support
Speaking on behalf of the RFS in support of resolution 18.			
18	Dr. Joseph Hellmann	Self	Support
Work to restore physician ownership of hospitals by removing subsection 6001 of the ACA 2010 so that physicians themselves can be more involved in the developing of healthcare systems. Currently we are the only group discriminated against in this fashion, reportedly due to conflict of interest, yet ownership by business based systems whose specialty is data driven efficiency & profit is a far greater conflict of interest. Perhaps we should consider putting the teeth back into last year's Physician owned hospital resolution by funding it thereby going on the offensive. Another issue is facility fees. Hospitals are able to set up a primary care office in a Giant Eagle and receive \$125 facility fee per patient visit which drives profit and serves as an incentive to private equity as well as to hospital systems to take over private physician offices as a profit center.			
19	Dr. Susan Payson	Self	Support
Support.			
19	Dr. Susan Hubbell	Self	Support
Speaking for myself in support of this resolution. Especially as patients age, they may no longer require some medications that they have taken for years or they may need a decrease in dosage. Deprescribing should be considered during patient visits to minimize side effects and avoid drug interactions.			
19	Dr. Susan Hubbell	District 3	Support
We support this resolution.			
19	Dr. Johnathon Ross	Self	Support
As a primary care internist, I often found that new symptoms in my patients were caused by meds that had been added or withdrawn too quickly. I remember one time starting an older patient on a new BP med and the patient was having postural near syncope. I told the patient that I knew what was wrong. I told her her doctor (me) was poisoning her. I apologized and that began my effort to always look at the med list as part of my search for an explanation for new symptoms.			
19	Dr. Susan Hubbell	SPS/Authors	Support w/AMENDMENT
We suggest changing Resolved 2 to read "RESOLVED, that our OSMA ENCOURAGE the integration of deprescribing as a standard component of high-quality prescribing practices"; as we have been told that the word "Advocate" makes this resolved clause more expensive. As authors, we support this resolution.			
19	Dr. Elizabeth McIntosh	YPS	Support
We support this resolution. Even taking just 5 daily medicines chronically is usually considered polypharmacy, and greatly increases the risk of medication interactions or adverse reactions. As an outpatient family medicine physician who deals with this all the time, I think we need to encourage more doctors to think about and not be afraid of deprescribing medicines for their patients!			
19	Dr. Chris Paprzycki	District 1	Support
District One strongly supports.			
20	Dr. Susan Hubbell	District 3	Support
We support this resolution.			

Res. #	Comment By:	Representing	Position
20	Dr. Johnathon Ross	Self	Support
Vaccinations are considered one of the most important advances in human history. They are right up there with clean drinking water. They have saved more lives than any other medical advance. They save about 6 million lives around the globe annually. Are they risk free? No, but the alternatives are a million of times worse.			
20	Dr. John Tyznik	SPS	Support
We support this resolution.			
20	Dr. Philip Roholt	District 6	Oppose
There is so much wrong with this Resolution, and with OSMA's past policies based on old, biased studies and self-serving pharmaceutical influences. None of the supporting statements or references show reason to adopt this Resolution, and it should be rejected by OSMA.			
<p>First, concerning #1, Reaffirming past policy 42-2025, the reference quoted refers to CDC's analysis showing that "...The assessment reviewed 20 peer, developed nations and found that the U.S. is a global outlier among developed nations in both the number of diseases addressed in its routine childhood vaccination schedule and the total number of recommended doses..." This is international comparison indicating that the new CDC recommendations, in view of the increased incidence of disease in US minors, should be adopted; the reference the author of Res 20 cited actually speaks against the resolution itself. Also, Resolve #1 resolution itself, concerning 17-2022 and 21-2017 should not be reaffirmed, since both support limitation of personal choice in non-medical exemptions for vaccines. There is too much controversy over this, in addition the people of Ohio and the legislature want freedom of choice. ORC3 313.671 is the Ohio code permitting non-medical exemptions. OSMA should not go against this. This is an issue that should be rejected due to elimination of right to choose treatment of your and your children's bodies. Unfortunately, a resolution last year requesting the striking of 21-2017 and 17-2022 was rejected. Ref #2 is a quote that Democratic Mass governor will not adopt new CDC recommendations. This is a political position, and other more conservative states agree with the new recommendations for vaccine trials based on placebo RCT. "...There is a significant red-blue divide, with almost all states that have moved to maintain vaccine access despite federal changes having Democratic governors. Twenty-three of the twenty-six states that allow pharmacy access for COVID-19 vaccines without a prescription have Democratic governors." <a href="https://www.kff.org/state-health-policy-data/tracking-state-actions-on-vaccine-policy-and-access/">https://www.kff.org/state-health-policy-data/tracking-state-actions-on-vaccine-policy-and-access/</a> So this resolution is parroting a political position, not a scientific one. <a href="https://www.newsweek.com/west-coast-alliance-vaccines-guidance-rfk-cdc-trump-2131550">https://www.newsweek.com/west-coast-alliance-vaccines-guidance-rfk-cdc-trump-2131550</a></p> <p>Ref #4 Refers to the AAP recommendations. The AAP is currently being litigated against for fraudulent recommendations of vaccines. <a href="https://childrenshealthdefense.org/wp-content/uploads/aap-lawsuit-complaint-redacted.pdf">https://childrenshealthdefense.org/wp-content/uploads/aap-lawsuit-complaint-redacted.pdf</a> Ref #5 is the AMA vaccine recommendations. AMA is slow to respond to updated, anti-immunization information; but time will tell as their liberal policies are under attack by scientific research, as is shown by their backtracking on Gender surgery for minors AMA alters position on gender-affirming surgeries for minors It must be noted that only 20-25% of physicians are AMA members, down from 75% in the 50's. <a href="https://americanmedicalassociationreview.com/how-many-members-are-in-the-american-medical-association/">https://americanmedicalassociationreview.com/how-many-members-are-in-the-american-medical-association/</a> Unpopular, progressive AMA and OSMA policies are behind this loss of membership. As more people become aware of the poor policies, OSMA membership will also diminish. Recruitment of physicians is becoming more difficult. OSMA needs to be a leader in policies which benefit patients and the medical profession, not outside interests. This blind following of outdated recommendations will come with continued loss of public trust in the medical profession, which is evidenced over the last 5 years.</p>			
20	Dr. Alexis Hill	Self	Oppose
My sentiments align with Dr. Phil Roholt's, please see his comment.			
20	Dr. Chris Paprzycki	Self	Support
I strongly support this resolution. I would clean up the formatting of the resolve clauses (how does the OSMA accomplish the "ask" of the second resolve), and delete "that are contrary to the CBC but are endorsed by the AMA." The beginning of the second resolve stands well enough on its own.			
20	Dr. John Corker	Self	Support
Speaking on behalf of myself in support of reaffirmation of existing OSMA vaccine policy.			
20	Dr. Lester Hill	Self	Oppose
The present vaccine schedule is arcane and dangerous and needs to be revised.			
20	Dr. Tani Malhotra	Ohio ACOG	Support
On behalf of the American College of Obstetricians and Gynecologists in strong support of this resolution. This is settled science. We are physicians. We follow science, not social media. This is a no-brainer.			

Res. #	Comment By:	Representing	Position
20	Dr. Philip Roholt	District 6	Oppose, in reply to Dr. Malhotra
<p>Opposing this resolution and speaking for District 6. Science is never "settled." <a href="https://www.thefocalpoints.com/p/breaking-peer-reviewed-reanalysis?utm_source=substack&amp;utm_medium=email">https://www.thefocalpoints.com/p/breaking-peer-reviewed-reanalysis?utm_source=substack&amp;utm_medium=email</a> Please review this: <a href="https://ijvtp.com/index.php/IJVTPr/article/view/125/426">https://ijvtp.com/index.php/IJVTPr/article/view/125/426</a></p> <p>And this: <a href="https://zenodo.org/records/17451259?utm_source=substack&amp;utm_medium=email">https://zenodo.org/records/17451259?utm_source=substack&amp;utm_medium=email</a></p>			
20	Dr. Maria Phillis	YPS	Support
<p>The vaccine schedule is based on science that has never been debunked. Abandoning it for political gamesmanship will result in needless suffering and death. As physicians we are asked to do no harm and dismantling the vaccine schedule that has saved countless lives would be the epitome of that.</p>			
20	Dr. Andrew Hill	District 6	Oppose
<p>On behalf of District 6, I strongly oppose the implementation of mandatory childhood vaccination, let alone the significant number of vaccines which are used for various diseases that pose minimal risk to patients at such a young age.</p>			
20	Dr. Elizabeth McIntosh	Self	Support, mostly
<p>Speaking on behalf of myself as a family medicine physician who discusses vaccination schedules with kids and adults every day. I am in favor of most vaccinations and believe that the benefits of vaccination generally outweigh the risks. However, I also acknowledge that some parents and families feel much more strongly against vaccines in general, or against specific ones, and I believe that their conscience should be respected in those cases. For example, if I have a vaccine hesitant family that wants to skip the polio vaccine because their chances of encountering live polio virus are virtually none, I don't think that's a huge deal. Or if I have an adult who has zero risk factors for Hep B exposure who decides that they don't want to redo the entire series, I don't harass them about it. Therefore I think that we should continue to permit non-medical exemptions for required school vaccines, or at least be more neutral about them, and not reaffirm Policy 21-2017. Because the question of non-medical exemptions is not a scientific or medical issue; it's more an issue of how much freedom we as a society allow. As a medical society, we can endorse the effectiveness of certain vaccines while still respecting patients' rights to choose. We do this in other areas and call it shared decision making - like whether someone wants to take a statin for CAD prevention, or whether they are ready to quit smoking. We make recommendations, but don't have to unduly pressure patients into doing things they are uncomfortable with. And non-medical exemptions by definition shouldn't require any sort of medical visit or note, so it's something for the patients, parents, and schools to work out. We should just stay hands off and let that policy expire.</p>			
20	Dr. Brandon Francis	RFS	Support, w/AMENDMENT
<p>Speaking on behalf of the RFS in support of this resolution with proposed amendments. First, thank you to the authors for this important and very timely resolution. We support R1 and reaffirmation of the named policies. While we support the spirit of R2, we feel that the language could be better-worded to broaden its application. We propose deletion of R2 and insertion of the following: "Resolved, that the OSMA oppose the penalization of physicians for adhering to evidence-based immunization guidelines." We would also recommend considering Resolutions 20 and 21 together as they address very similar topics.</p>			
20	Dr. Joseph Hellmann	Self	Oppose w/AMENDMENT
<p>Speaking for myself. I agree with Dr. McIntosh to NOT REAFFIRM policy 21-2017 which she explained well. Removal of freedoms of our patients because we don't agree with their decisions is a form of oppression. If there is a growing rejection by non-medical exemption doesn't that suggest something is wrong either with the way we are approaching the subject (or have approached the subject - Covid) or with what we have defined the science to be? STRIKE R2 - Federal agencies have authority over our associations so we should expect a potential issue if we choose to follow our own way. The conflict simply points out that the science is not settled. We give great attention to interactions between pharmaceuticals. Have we thoroughly studied the interactions of vaccines, immune modulation (such as 2025 flu study by Cleveland Clinic indicating a 27% greater likelihood of getting the flu after the shot which means much more than a simple lack of effectiveness)? Could we also consider the battery of chemicals within our food system and what all that mixed together with a vaccination schedule does to the human body? Perhaps we should make the resolution about pursuing more in depth studies to more deeply evolve the science rather than just increase division.</p>			
21	Dr. Noam Stern	Self/Author	Support
<p>As the author of this resolution, I want to add that at the time of its writing the AAP's child and adolescent vaccine schedule was endorsed by 12 organizations. Since that time, official support for the AAP's vaccine schedule has grown to over 230 organizations including: - The American Medical Association - The American Academy of Allergy, Asthma &amp; Immunology - The American Academy of Emergency Medicine - The American Academy of Family Physicians - The American Association of Immunologists - The American College of Chest Physicians - The American College of Obstetricians and Gynecologists - The American College of Osteopathic Family Physicians - The American College of Physicians - The American College of</p>			

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	Preventive Medicine - The American College of Rheumatology - The American Gastroenterological Association - The American Pediatric Society - The American Pediatric Surgical Association - The American Society of Hematology - The American Society of Pediatric Hematology/Oncology - The American Society of Pediatric Nephrology - The American Thoracic Society - The California Medical Association - The Colorado Medical Society - The Illinois State Medical Society - The Infectious Diseases Society for Obstetrics and Gynecology - The Infectious Diseases Society of America - The National Medical Association - The North American Society for Pediatric Gastroenterology, Hepatology and Nutrition - The Pediatric Heart Transplant Society - The Pediatric Infectious Diseases Society - The Society for Adolescent Health and Medicine - The Society for Maternal-Fetal Medicine - The Society of Critical Care Medicine - The Society of Hospital Medicine. A full list of supporting organizations can be found at: <a href="http://www.aap.org/en/news-room/news-releases/aap/2025/broad-coalition-voices-support-for-aaps-vaccine-recommendations">www.aap.org/en/news-room/news-releases/aap/2025/broad-coalition-voices-support-for-aaps-vaccine-recommendations</a>		
21	Dr. Susan Hubbell	District 3	Support
	We support this resolution.		
21	Dr. Yashu Dhamija	Self	Support
	While I am in support of this resolution, I would like to bring attention to recent news that a judge has struck down RFK Jr's vaccine schedule changes. So we'll have to think about the implications of passing this resolution, how that may conflict with our support of CDC guidance down the road.		
21	Dr. Philip Roholt	Self	Oppose, in reply to Dr. Dhamija
	This will be appealed. The judge who made this decision: "U.S. District Judge Brian E. Murphy, a Biden appointee, granted a motion by the American Academy of Pediatrics for a preliminary injunction against the reduced childhood immunization schedule earlier this year." AAP is being sued by the Childhood Defense Foundation for fraudulent claims concerning vaccine recommendations.		
21	Dr. Johnathon Ross	Self	Support
	The science supports and so should we.		
21	Dr. Ken Christman	Self	Oppose
	I oppose this resolution. It is dangerous to support or oppose the position of any other organization or group, as that position is subject to change. The American Academy of Pediatric schedule is subject to change in the future and OSMA should not offer blanket approval to future changes.		
21	Dr. John Tyznik	SPS	Support
	We support this resolution.		
21	Dr. Leslie Dingeldein	Self	Support
	Speaking for myself as a pediatrician and parent, I support this resolution. The AMA has already endorsed the AAP's vaccine schedule. Vaccines undergo vigorous safety testing and continuous monitoring. Vaccine mandates are an important public health initiative that protect people in our public school systems who are immunocompromised, cannot be vaccinated due to medical conditions, or who are non-responders to vaccines.		
21	Dr. Philip Roholt	District 6	Oppose
	Speaking for District 6. In past OSMA policy, support for ACIP was endorsed. Now because there is a change in ACIP (firing of panel members with obvious conflict of interest, see Res #22), this Resolution wants to change OSMA policy. This Resolution #21 states that vaccines were removed from the old ACIP recommendations "...without undergoing the standard process for scientific review." Please state what this process is, in your opinion, because many of these vaccines were approved WITHOUT "standard review" (long-term, saline placebo RCT). I recommend that, if OSMA wants to change support for ACIP, OSMA appoints a committee to review each of the eliminated vaccines. Many physicians now are advising fewer vaccines, based on expert medical judgement, and on studies such as Paul Thomas' research (a quality study accepted for peer-review publication then forced retraction due to pressure from pharmaceutical and pro-immunization lobbies) and other pertinent vax-unvaxed studies; so this controversial topic and Resolution #21 should not be supported by OSMA; and physicians and patients should be unfettered to use their analysis of research and judgement in vaccine administration, guided by the new ACIP recommendations. While it is acceptable to use opinion articles to support a resolution, there is no reference to any scientific research to uphold this resolution. A prior comment supporting this resolution lists a compendium of organizations, the most important is the AAP; the others follow lock-step with them. AAP has been strongly influenced by pharmaceutical-funded studies and incentives for immunizations, and now is being sued for fraudulent claims concerning vaccines. Refer to Res#22 for references. It is common knowledge that the list of medical errors and misconceptions occurring over the years is long: <a href="https://jamanetwork.com/journals/jama/fullarticle/201218">https://jamanetwork.com/journals/jama/fullarticle/201218</a> <a href="https://www.freethink.com/opinion/consensus">https://www.freethink.com/opinion/consensus</a> <a href="https://www.theepochtimes.com/opinion/the-scientific-consensus-is-">https://www.theepochtimes.com/opinion/the-scientific-consensus-is-</a>		

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	<a href="https://www.scienceunderattack.com/blog/2019/2/18/how-the-scientific-consensus-can-be-wrong-19">often-wrong-3598729 https://www.scienceunderattack.com/blog/2019/2/18/how-the-scientific-consensus-can-be-wrong-19</a>		
	Speaking for myself from personal and medical experience, and although this is anecdotal, I am aware of many healthy unvaccinated children who've never had anything more than minor illnesses, quickly resolved. They seem to be more intelligent than others of similar age.		
21	Dr. Alexis Hill	Self	Oppose
	My sentiments align with Dr. Phil Roholt's/district 6, please see his comment.		
21	Dr. Chris Paprzycki	District 1	Support, in part
	District One supports, but has slight procedural concerns with blind support of any other organization via the resolution process, as outside influences and politics could impact future recommendations. What if roles reverse in the future (politics take over AAP, and ACIP/CDC is once again trustworthy)?		
21	Dr. John Corker	Self	Support, in part
	Speaking on behalf of myself in support of the spirit of this resolution but sharing the concerns of Drs. Paprzycki and Christman regarding the potential pitfalls of OSMA policy that proffers blanket deference and approval of the dynamic policies of another organization. As a result, I offer the following friendly amendment:  Resolved, that our OSMA work with the Ohio Chapter of the American Academy of Pediatrics, I and other interested parties to monitor, evaluate and promote evidence-based best practices as it pertains to child and adolescent vaccine schedules and recommendations, and be it further  Resolved, that our OSMA work with the Ohio Chapter of the American Academy of Pediatrics, the Ohio Department of Public Health and other interested parties to encourage Ohio schools to adhere to evidence-based best practices as it pertains to childhood and adolescent vaccines.		
21	Dr. Elizabeth McIntosh	Self	Support, in reply to Dr. Corker
	I like this amendment. I echo the hesitancy of many other members to just blindly endorse whatever the AAP recommends for vaccines. Just because we agree with it now doesn't mean we will always agree with it. This amendment gets to the heart of the issue without necessarily needing to endorse one specific vaccination schedule, thus offering more flexibility to evaluate recommendations if the evidence changes.		
21	Dr. Tani Malhotra	Ohio ACOG	Support
	While I would normally echo the concerns raised by Drs. Corker and Paprzycki - at this time most of organized medicine is turning to the pediatricians for guidance. Additionally, the experts in childhood vaccines would be the AAP. I would have been more hesitant to follow the AMA because their expertise is not in childhood vaccines and while AAP my guide their policies there may be a lag in updating policies. I feel confident that AAP, much like ACOG updates their recommendations with emerging science.		
21	Dr. Lester Hill	Self	Oppose
	The vaccine schedule for the state of Ohio should reflect that of Health and Human Services. Parents should have the right to vaccinate their children once they are informed of all of the potential dangers and adverse reactions. The schedule should never be associated with financial incentives that reward pediatricians or other primary care providers.		
21	Dr. Maria Phillis	YPS	Support
	We support this resolution. With the dismantling and destruction of bastions of public health we need to support those with the evidence based expertise in childhood vaccinations and that is the AAP. And as an aside, speaking on behalf of myself as a mother, I cannot imagine anything more dangerous for my children than ignoring the science and evidence that has been painstakingly established by the pediatricians - those who I trust to keep my children safe and healthy in all other arenas as well.		
21	Dr. Andrew Hill	Self	Oppose
	I oppose the implementation of mandatory pediatric vaccination and removal of non-medical exemption, given the basic constitutional right of a parent to inform themselves and choose for their own children which pharmaceutical interventions they receive, so long as they are not at risk of immediate harm. And in many cases, the vaccination itself may cause more harm to the child than the theoretical risk of illness.		
21	Dr. Engy Habashy	OMSS	Support
	We support.		
21	Dr. Lester Hill	Self	Oppose
	Please do not blindly put your faith and trust in vaccines without the evidence. Do the research required by your position as a person of great influence. For the sake of the children, question everything. Dig deep in your search for truth. This is a long		

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comment but because of the seriousness of the issue and the fact that children are at the heart of it, it deserves your attention.

As you may know, RCTs are the gold standard in clinical research. To reach the high standard that must be applied to any study of any drug or vaccine, especially ones used for children, it must be a large cohort, randomized and double-blinded, using a TRUE placebo (INACTIVE/INERT substance), in a controlled trial with a true control group and of appropriate duration. These RCTs provide the highest evidence for safety and efficacy, but only if they are randomized, controlled and double blinded to minimize bias and ensure honest, reliable and accurate results. When dealing with human health and life, especially that of a child, all healthcare professionals should and must demand well controlled investigations and statistically significant evidence of safety, including at the minimum, at least two pivotal RCTs demonstrating SAFETY and substantial benefit over placebo. The studies must be independently conducted and reproducible. A LACK of Randomized Controlled Trials (RCTs) for vaccines IS the elephant in the room here that everyone is ignoring.

RCTs to study vaccine safety and efficacy is the gold standard in clinical research and must include the following in order to provide the greatest confidence in evidence for safety and effect. They must include each of the following, for the reasons mentioned: -Large cohort – A large cohort increases statistical power of the study, making it more likely to detect a true effect. Larger samples lead to more precise and reliable treatment effects.

-Controlled – A controlled trial is one in which participants are divided into at least 2 groups: one that receives the experimental treatment and another – the “control” group – that receives the inert placebo. The purpose is to compare outcomes between groups to determine the effectiveness of the intervention, while minimizing the influence of confounding factors such as placebo effect or natural disease progression. The core principal is that random assignment, not selective matching, is what establishes group comparability in a well-designed and well conducted RCT.

-Randomized – Randomized in an RCT means that the participants are assigned to different study groups – such as the experimental group or control group – using a random process, like drawing a number. The random assignment ensures that each participant has an equal chance of being placed in any group, minimizing selection bias and balancing known and unknown confounding factors across groups. This way, any observed differences in outcomes can more confidently be attributed to the intervention being studied rather than preexisting differences between participants.

-Double blinded – Double blinded means that neither the participants nor the researchers (including those administering the treatments and assessing outcomes) know which participants are receiving the experimental treatment or the placebo/control. This prevents bias in treatment administration, outcome assessment, and interpretation of results, ensuring greater objectivity and reliability of the study.

-Placebo – A true placebo is an inactive ingredient such as saline that has no therapeutic effect and lacks active ingredients. It's designed to be indistinguishable from the actual treatment in appearance, taste and administration method to ensure that neither participant nor researchers can tell the difference. This helps isolate the specific effect of the treatment being tested by controlling for psychological and behavioral factors, such a placebo effect.

-Appropriate duration – Appropriate duration refers to the length of time the trial is conducted to reliably detect treatment effect. It must be long enough to observe meaningful changes in the outcome, account for the natural course of the disease, and ensure safety monitoring (side effects or adverse events) but not so long that it exposes participants to unnecessary risks or wastes resources. The duration is determined during the design phase based on clinical knowledge and statistical considerations.

-RCT Reproducibility – Reproducibility in an RCT refers to the ability to replicate study results when the same methods are applied in a new context or population. It ensures that findings are reliable, robust and not due to chance or bias. Reproducibility is threatened by issues like flawed design, selective reporting, small sample size, or lack of transparency in methodology and data. A low reproducibility rate undermines evidence based medicine, as it suggests that some RTC findings may not hold up upon repetition. Measures like pre-registration, transparent reporting and independent replication enhance reproducibility. Tools such as the fragility index assess how robust a trial's conclusions are to minor changes in outcomes. At the minimum, at least two RCTs demonstrating substantial benefit over placebo should be required for vaccines. AMA Board of Trustees Chair David H. Aizuss, MD, said that “parents deserve clear, evidence-based guidance when

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making decisions about their children's health," Vaccine RCTs are the evidence parents need to believe that vaccines are safe and effective for their children.

Let's examine the REFERENCES used to support Resolution 21.

1. The first "reference" on Res. 21 is a June 10, 2025 article by the National Foundation for Infectious Diseases titled, Experts Sound Alarm after ACIP Members Removed. Nothing in this reference addresses the heart of the matter, which is accurate scientific proof of vaccine need, efficacy and most importantly, safety. The data necessary to answer the question of safety simply doesn't exist and instead has been replaced with the blind declaration that each vaccine is "safe and effective." Where is the SCIENCE? During Covid, everyone was told ad nauseum that the vaccines were "safe and effective" and to "trust the science", but where is the science? No accurate scientific data from RCTs, the gold standard in clinical research, exists. As just one example, instead of true placebos, for many vaccine studies, the placebo is other vaccines. PLACEBO, by definition, is an inert substance. People listen to the constant barrage of the oft repeated "safe and effective" narrative, resulting in blind trust. Physicians, who are often incentivized to vaccinate a certain percentage of their patients, do so without providing informed consent or proof of safety.

The references used for Resolution 21 are the equivalent of the "safe and effective" argument in favor of them – without substance or scientific validation. Our attention is once again diverted away from the real issue, which is a lack of accurate safety data on vaccines. By using as a "reference" a simple listing of organizations (rather than honest, independent and accurate clinical trials/studies), we are being told once again to BLINDLY follow opinions and deep-seated beliefs without scientific validation using the Randomized Controlled Trials (RCT), which are the gold standard in clinical research for evaluating the effectiveness and safety of medical interventions, including drugs and vaccines. Leaders & members of the named organizations have been captured and are entrenched in the "safe and effective" narrative that enriches all those who support the status quo. Where are the critical thinkers who ask the right questions and dig deep in an effort to learn the truth? What is needed are accurate RCT studies of appropriate duration following strict guidelines and criteria that can and are repeated for validation and accuracy.

2. The second "reference" link is dead, although I was able to find the story, not from an accurately conducted scientific study, but from the main stream media. The article that appeared June 23, 2025 on NBC News, titled "Kennedy's new vaccine panel lacks experience and shouldn't meet, Sen. Cassidy says" features Sen. Bill Cassidy, who is a medical doctor, not a scientific researcher, criticized Robert F. Kennedy Jr.'s picks for the Advisory Committee on Immunization Practices (ACIP), saying they lacked experience. He was particularly concerned that "some lack experience studying new technologies such as mRNA vaccines, and may even have a preconceived bias against them." First, we have the Covid injections that are promoted as a vaccine (but in reality, by nature and definition, they are gene therapy. The CDC definition of a vaccine prior to changes quietly made in 2021 in order to include mRNA gene therapy shots as vaccines, was: "a product that stimulates a person's immune system to produce immunity to a specific disease." This distinction was used for years and emphasized the goal of generating IMMUNITY. In 2021, in order to classify mRNA gene therapy injections under the vaccine banner, the CDC was forced to change the definition to much broader terms that could include just about any substance, preparation, drug or gene therapy. The new definition of a vaccine is: "a preparation that is used to stimulate the body's immune response against diseases," The disease for which a "vaccine" was developed is now not specific or named, and the word "immunity" was replaced with "immune response". Likewise the definition of "vaccination" was changed. The original definition of "vaccination" had been: the act of introducing a vaccine into the body to produce immunity to a specific disease"; but it was also changed in 2021 to: "the act of introducing a vaccine into the body to produce protection from a specific disease." mRNA technologies are relatively new, so no one really has enough experience with them to form an opinion on how safe they are or how people will respond to them. What we do know from real-world experience with the Covid mRNA shots, which have now been study-proven to cause alarming, horrific and even deadly adverse effects in many who received them, with little to no protection against infection or transmission.
3. The 3rd "reference" is to a January 9, 2026 NPR article titled, "The CDC just sidelined these childhood vaccines. Here's what they prevent." What an embarrassment to the medical profession that an article on NPR should be used as a reference to support the repeated injections of questionable substances and known toxins into the bodies of our children when what is needed is validation of safety. This article itself is pure sensationalism at its best. It

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attempts to estimate how many hospitalizations and deaths were prevented through vaccination, a nearly impossible task due to each individual's uniqueness --- their constitution, health status, response to illness, co-morbidities and many other other factors. Any critical thinker would be asking instead: Where are the RCTs? Where are the studies comparing vaccinated children and unvaccinated children. Where are the long-term follow-up studies? A listing of entrenched organizations is not what is needed; accurate studies done according to the gold standard are. No scientific evidence is used as reference to support the resolution. There aren't even any rational scientific arguments for it. No one has cited even one large cohort, randomized, double-blinded, controlled trial of proper duration using an inert or inactive placebo in a true control group that has been reproduced at least twice by different clinical researchers for any of the vaccines, let alone those on the AAP schedule. These RCTs provide the highest evidence for safety and efficacy, but only if they are randomized, controlled and double blinded to minimize bias and ensure reliable, accurate results. When dealing with human health and life, especially that of a child, all healthcare professionals should and must demand well controlled investigations and statistically significant evidence of safety, including at the minimum, at least two pivotal RCTs demonstrating substantial benefit over placebo.

4. The 4th reference link is for the American Association of Pediatrics (AAP), where you will find an article from July 30, 2025 titled: AAP has been the leading voice on childhood vaccine recommendations since 1930s. Excerpts from the article (in italics) follow with commentary. "Since the 1930s, the AAP has been at the forefront of providing evidence-based guidance to protect children from vaccine-preventable illnesses." According to AAP President Susan J. Kressly, M.D., FAAP. "We start with the science to develop guidance that allows pediatricians to do what's best for children and families." But WHERE is the science to support vaccines? I'm not aware of any vaccine RCTs of sufficient duration that include a true inert placebo control (in fact, for some past vaccine studies, the "placebo" was, shamefully, another vaccine). The RCTs should be reproducible, and at a minimum, there should be at least 2 RCT that confirm results. Because we are talking about children, especially during critical periods of growth and development, vaccine safety for children is paramount and demands no less. From the development of the earliest vaccines, public opposition and anti-vaccine sentiments have been on display. For example, a 1902 smallpox outbreak in Cambridge, Mass., led to a city vaccine mandate. A citizen insisted that mandating all adults to be vaccinated was a rights violation, sparking a Supreme Court case. Those who fail to know history are bound to repeat it. The smallpox vaccine served to increase, rather than decrease, the number of cases and spread of the disease. Hence, one of the largest protests of the day occurred in Leicester (England), resulted in a ban on mandatory vaccines and the implementation of effective health measures earlier rejected by the medical establishment. Contrary to the myth that the vaccine ended the epidemic, it was the adoption of the successful measures used in Leicester, which spread around the globe that ended it. It's no wonder medical professionals today don't know the true history of the smallpox vaccine, as it's been censored and nearly erased from history. One must search the archives of some of the oldest libraries in the world to find the truth. Fortunately, there was one epistemologist with the integrity and quest for truth who did just that. I hope you'll read the book DISSOLVING ILLUSIONS by Dr. Suzanne Humphries, MD, a nephrologist who noticed a trend in her patients for developing kidney damage and even failure following the receipt of the influenza vaccine.

Below are excerpts from an article written by A Midwestern Doctor based on well-researched and accurate information excerpted from Dr. Humphries' book:

...[O]ne physician who tested 3 children with Jenner's vaccine found all 3 subsequently developed smallpox after inoculation, with similar results obtained by other physicians. Nonetheless, the practice gradually caught on, became a larger share of physician income, became more and more popular within the medical field, and over the next hundred years, the number of dissenting physicians gradually diminished. However, what is relatively unknown now is that many did speak out, and published literature with data showing serious issues with the vaccine. A few examples of physicians who spoke out follow: - In 1809, the medical observer reported on over a dozen cases of often fatal smallpox contracted after vaccination (frequently occurring a year after vaccination), while the 1810 medical observer contained 535 cases of smallpox after vaccination (97 that were fatal), and 150 cases of severe vaccine injuries.

-An 1817 London Medical Repository Monthly Journal and Review likewise found that many people who received the smallpox vaccination were still experiencing smallpox. -In 1818, Thomas Brown, a surgeon of 30 years and ardent proponent of vaccination, after vaccinating 1200 people stated: "The accounts from all quarters of the world, wherever vaccination has been introduced... the cases of failures are now increased to an alarming proportion." -In 1829, the Lancet describing a

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	<p>recent outbreak stated “It attacked many who had had small-pox before, and often severely; almost to death; and of those who had been vaccinated, it left some alone, but fell upon great numbers.”</p>		
	<p>-In 1845 George Greogory M.D. reported: “In the 1844 smallpox epidemic, about one-third of the vaccinated contracted a mild form of smallpox, but roughly 8 percent of those vaccinated still died, and nearly two-thirds had severe disease”. Because of the genuine concerns against the immunizations, widespread resistance existed in the public towards the immunization practices. As the press was less censored at this time, there were frequent reports of deaths from smallpox in properly vaccinated citizens, as well as deaths from other conditions after vaccination.</p>		
	<p>-In 1829, William Cobbett, a farmer, journalist, and English pamphleteer, wrote, addressing the failures of vaccination: “Why, that in hundreds of instances, persons cow-poxed by JENNER HIMSELF [emphasis added by Cobbett], have taken the real small-pox afterwards, and have either died from the disorder, or narrowly escaped with their lives!”</p>		
	<p>-A 1850 letter to the “Hampshire Telegraph and Sussex Chronicle,” claimed there were more admissions to the London Small-Pox Hospital in 1844 than during the smallpox epidemic of 1781 before vaccination began, and that one-third of the deaths from smallpox were in people who had previously been vaccinated.</p>		
	<p>-As it became clear that the smallpox vaccine was unable to prevent disease as initially promised, the medical profession moved the goal posts from lifelong “perfect” immunity to “milder disease” to justify vaccination, a tactic that has since repeated with other vaccination campaigns.</p>		
	<p>-Mr. Henry May, writing to the Birmingham Medical Review, in January, 1874 reported that deaths as a result of vaccination were often not reported because of an allegiance to the practice. Often a vaccinated person was recorded as having died from another condition such as chicken pox or erroneously listed as unvaccinated. This corruption of the vital statistics creates many challenges in assessing the efficacy of immunization.</p>		
	<p>Do your own research. Verify the information. Validate facts. Do the right thing to protect the children. The Academy helped inform and promote polio immunization, collaborating with the National Foundation for Infantile Paralysis, which later became the March of Dimes. Large-scale use of the vaccine began by 1955.</p>		
	<p>Following are direct excerpts, quotes and information gleaned from an article examining vaccine safety by A Midwestern Doctor.</p>		
	<p>In 1955, the Polio vaccine was released by the government, and two weeks later, cases began emerging of children across America who had become paralyzed in the limb that was injected with Salk’s polio vaccine. After some investigation, it was discovered that:</p> <ul style="list-style-type: none"> <li>• Only two of the five vaccine manufacturers had produced the same “safe” vaccines used in the clinical trials—which meant many of the vaccines the public got (which at the time were a new experimental technology) had never been tested in humans.</li> <li>• At the urging of Salk, at the time when the vaccine was being mass produced, a different and less safe production process was used so the orders could be met.</li> <li>• Bernice Eddy, an NIH employee, had immediately discovered this mass produced vaccine caused paralysis in monkeys. Note: Eddy had previously upset the NIH after she discovered that adenovirus vaccines caused cancers (which caused the NIH to put up obstacles to her work) but eventually Eddy won and adenovirus vaccines stopped being given to children—at least until COVID-19 (as the J&amp;J vaccine uses a modified adenovirus vector).</li> <li>• All of the paralyzing vaccines came from the same manufacturer (Cutter Laboratories). Note: later paralyzing lots were also identified from Wyeth (better known for making the highly dangerous DPT vaccine), but the general public was never made aware of the other hot polio lots—which the head of the CDC’s polio surveillance unit believed was done to prevent the public from realizing the Polio vaccine in general was unsafe and ineffective.</li> <li>• The (early) FDA delegated testing of the vaccine for safety to the vaccine manufacturers rather than doing so itself.</li> <li>• There were many safety concerns with the testing of the Salk vaccine, but the professional publications chose to censor them and instead continually repeated the message that the vaccine was completely safe and effective. The public was understandably outraged. The government found itself in a public relations crisis, and numerous lawsuits dragged out against Cutter in the courts. In response, the Federal government decided to assume a direct</li> </ul>		

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	<p>involvement in each aspect of the vaccine program, thus switching from being a largely neutral external auditor to being a major stakeholder. As you might guess, this conflict of interest motivated to the government cover up any safety issues with its vaccines (e.g. to protect its investment or to not look bad to the public) and before long business as usual resumed with the Polio vaccine.</p> <ul style="list-style-type: none"> <li>• To quote the book <i>Turtles All The Way Down</i>: “Perhaps the most disturbing element of the entire program has been the disparity between the risks that were known to be involved and the repeated assurances of safety.”</li> <li>• Paul Meier, professor of epidemiology at the Johns Hopkins University School of Public Health The National Foundation, in a memo sent to doctors, also stated emphatically that the [polio] vaccine was completely safe and that the risk of ensuing paralysis was “zero”.</li> <li>• “The best way to push forward a new program is to decide on what you think the best decision is and not question it thereafter, and further, not to raise questions before the public or expose the public to open discussion of the issue.” Paul Meier speaking at an expert panel on the vaccine.</li> <li>• In 1960, five years after the Cutter incident, Bernice Eddy, a NIH employee had determined that the polio vaccines were contaminated with a cancer-causing virus (SV-40) and not fit to give to the public. When she alerted her superiors, she was ordered not to disclose it (to prevent loss of trust in the vaccine program) but eventually decided to publish her findings at a cancer conference—after which she was immediately demoted and lost her lab. Note: in 1959, government officials had become aware their vaccine caused cancer and were frantically trying to find a way to address it (the problem was ultimately a product of cutting costs by producing the vaccines with imported monkey kidneys) while simultaneously doing all they could to promote them to the public. As time went on, more evidence emerged showing there was widespread contamination in the polio vaccines with the SV-40 virus. Finally, in 1963, the federal government forced the vaccine manufacturers to stop growing the vaccine on contaminated SV-40 monkey kidneys—at which point between 40-98 million Americans (and many more globally) were infected. This, in turn led to a massive increase in cancer... Decades later, Canada’s Broadcasting Corporation aired a remarkable program where they highlighted recent findings the SV40 virus was being found in tumors, how it caused cancer and the extensive history of how the polio vaccines became contaminated with the virus: Additionally, many horrible kidney diseases are strongly associated with SV-40 (and likewise have exploded in incidence since the Polio vaccines hit the market). Sadly, since SV-40 was introduced to the population through the vaccine program, there’s been a general reluctance to study its danger—or to acknowledge it was still present in the vaccine supply decades later.</li> <li>• One of the most important takeaways from the polio fiasco was an admission by the FDA in the Federal Register / Vol. 49, No,7 / Friday, June 1, 1984 / Rules and Regulations, page 23007, that any doubts regarding the safety of a vaccine, regardless of their validity, could not be allowed to exist as that would make fewer people get the vaccine. ***** If you were to learn the truth about the Polio vaccine, you may not be so proud to highlight your promotion of it. The AAP also advocated for the National Childhood Vaccine Injury Act of 1986, which created the Vaccine Injury Compensation Program, a no-fault alternative to the tort system with compensation to families in rare cases of vaccine injury. The act was established after lawsuits against vaccine producers led some to say they might stop manufacturing certain vaccines, which would have disrupted the vaccine supply and prices. Because “SOME” vaccine makers threatened that “they MIGHT” stop manufacturing “certain” vaccines, Big Pharma was given immunity from civil liability for vaccine injuries and damage, opening the door for the cutting of corners to reduce cost; diminishing quality control measures in production; new experimental vaccines and a lack of honest independent analysis and investigation using RCTs. What company or corporation is ever given liability exemption from such consequential product? Another ostensible consequence of the 1986 National Childhood Vaccine Injury Act (NCVIA) was a dramatic increase in the number of vaccines added to the childhood schedule. It sounds to me as if Big Pharma was basically saying, “If you don’t protect us from liability for injuries caused by our product, we’ll just stop making them.” The maximum pressure campaign and intimidation by Big Pharma here sounds disconcertingly like a shakedown. And instead of telling them to make a better product, those charged with taking care of the health of our children obliged.</li> <li>• “Another advocacy win came with the creation of the Vaccines for Children program in 1993. The program, which provides immunizations to low-income children at no cost, greatly improved vaccine uptake nationwide.” It would ONLY be a win for children IF vaccines were actually proven to be safe and effective, but this is not the case, because the data to make such a determination doesn’t exist. To my knowledge, the studies/trials needed to make that assertion have not been done. Name one vaccine that has been proven safe and effective through a large cohort RCT of appropriate duration (to cover side effects/events that occur weeks or months after vaccination), using a truly inert placebo control, and the results of which have been produced at least twice. (See also a partial list of questions</li> </ul>		

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	<p>that must be answered in order to determine that vaccines really are safe, effective and do not contribute to future immune failure and chronic disease.)</p> <ul style="list-style-type: none"> <li>• While vaccines on the CDC schedule are not federally mandated, states who follow the CDC recommendations generally require them for school attendance. Many parents do not believe in the need, safety or efficacy of childhood vaccines, and for good reason. Consider just this current resolution to support statewide adoption of the AAP childhood vaccine schedule. There are 5 references used to justify support for it. But the sources are invalid and based on bias, prejudice and self-serving interests. The SCIENCE does not support it. Where are the RCTs proving safety and efficacy? There are no references to science based independent studies or trials; there are only opinions. Beyond that, it seems a form of extortion to force these same parents to vaccinate their children in order to attend school and then demand payment for them. In May, the CDC removed the COVID-19 vaccine from recommended immunization schedules for healthy children. In response, the AAP and other leading medical groups are suing HHS Secretary Robert F. Kennedy Jr. for making unilateral, unscientific changes to federal vaccine policy they called an “assault on science, public health and evidence-based medicine.”</li> <li>• Effectiveness of the Coronavirus Disease 2019 (COVID-19) Bivalent Vaccine. , Nabin K. Shrestha, et al. <a href="https://www.medrxiv.org/content/10.1101/2022.12.17.22283625v1.full.pdf">https://www.medrxiv.org/content/10.1101/2022.12.17.22283625v1.full.pdf</a> This study, from the prestigious Cleveland Clinic, rated the #2 best hospital in the world, showed that people with more shots were more likely to get COVID than people with fewer shots. The vaccines had the opposite effect from what the public was told. Here is a direct quote from the paper which makes this crystal clear: “The risk of COVID-19 also varied by the number of COVID-19 vaccine doses previously received. The higher the number of vaccines previously received, the higher the risk of contracting COVID-19 (Figure 2).” The paper emphasized this point by repeating it again: “The multivariable analyses also found that... the greater the number of vaccine doses previously received the higher the risk of COVID-19.” The study evaluated the effectiveness of the bivalent COVID-19 booster vaccine among 51,011 working-aged employees during a period when Omicron BA.4/BA.5 variants were dominant. The researchers found the bivalent booster provided only 30% effectiveness (95% CI: 20–39%) in preventing infection, analyzed as a time-dependent covariate using Cox regression and adjusted for prior infection history and vaccination status. Key findings: • Protection was modest overall. Risk of infection increased with time since the last prior COVID-19 episode and with the number of prior vaccine doses received.</li> <li>• Post COVID-19 Vaccination Chronic Injuries – Proposed Action            Post_Covid19_Vaccination_Chronic_Injuries_Proposed_Action_Copy.pdf Recently, a confidential report dated February 15, 2026 from the Covid-19 Immunization Workgroup of the Advisory Committee on Immunization Practices (ACIP) and marked was leaked. The document proposes actions to address Post-Acute COVID-19 Vaccination Syndrome (PACVS). Key points related to adverse health effects related to the Covid-19 vaccination follow: The report argues there's a significant gap between public experience and official recognition. According to surveys cited: - Over one-third of vaccinated people reported side effects with 10% reporting major side effects - 24% knew someone who died from vaccine adverse effects - Yet the CDC formally recognizes only a limited set of rare, acute adverse events "Despite growing evidence including extensive patient and clinician testimonials, CDC and other public health agencies in the US do not currently recognize the existence of patients with PACVS." The report defines PACVS as a heterogeneous, multisystem syndrome with symptoms persisting for at least 12 weeks post-vaccination that cannot be explained by other causes. It can involve: - Neurological systems (dysautonomia, neuropathy, cognitive impairment) - Cardiovascular (myocarditis, thrombosis, POTS) - Immune dysfunction - Gastrointestinal issues - Endocrine abnormalities Prevalence estimates range from 0.003% to 0.9% of the population. “Many patients who experienced and reported PACVS-related symptoms after the first vaccine dose were advised - and sometimes even pressured - to continue vaccination with additional doses, causing rechallenge and significant worsening of their symptoms. These experiences undermine public trust.” “Contrary to assertions that PACVS lacks objective findings, reproducible abnormalities have been documented when appropriate diagnostic tools are employed...” These include fibrin microclot imaging, endothelial dysfunction testing, skin biopsy for nerve fiber density, and advanced immune phenotyping. The report references extensive complications potentially associated with COVID-19 vaccination and infection, including: - New-onset type 1 and type 2 diabetes - Neurological disorders (MS, demyelination, seizures) - Autoimmune disease flares - Kidney disease - Blood clots and thrombotic events - Cancer cases - Accelerated vascular aging The authors emphasize this is necessary for "moral and bioethical obligation for solidarity, justice, and equity.”</li> </ul>		

Note the serious adverse effects from the Covid-19 shots. These comments are too long already, but I could have cited here hundreds and hundreds of credible clinical studies proving the serious harms caused by the Covid-19 shots. (And if anyone in

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	<p>a decision making capacity is interested, I'll compile a list.) In addition, even though it is generally known and accepted that less than 1% of adverse effects are reported, VAERS contains more than enough damning information to halt the Covid-19 shots now. For the open-minded, the above leaked memo should at least raise red flags. If you are not already convinced, in the least, apply the PRECAUTIONARY PRINCIPAL, a decision-making approach that advocates taking preventative action in the face of scientific uncertainty when there is a threat of serious or irreversible harm to human health. It emphasizes extreme caution, anticipating harm before it occurs and shifting the burden of proof to the activity proponent to demonstrate safety.</p> <p>Never forget that we are dealing with CHILDREN during sensitive periods of growth and development. Dr. Kressly said the administration's actions are jeopardizing the success of the country's immunization system, a "cornerstone of U.S. public health." If vaccines are the "cornerstone of U.S. public health", no wonder healthcare in the United States is such a mess and the health of the population is steadily declining. Kennedy also fired all 17 voting members of ACIP and appointed new members, some of whom have a history of spreading vaccine misinformation. The new committee said it will conduct a review of the child and adolescent vaccine schedules. This has been addressed in other comments.</p>		
21	Dr. Shannon Trotter	District 2	Support
	Support.		
22	Dr. Susan Payson	Self	Support
	Support.		
22	Dr. John Tyznik	Self	Oppose
	<p>Although anti-vaccination movements have persisted since the introduction of the smallpox vaccine in 1796, the efficacy and safety of current vaccines has been affirmed by innumerable studies. Despite this, vaccine access remains threatened by certain groups. The National Childhood Vaccine Injury Act (NCVIA) of 1986 allowed continued production of life saving vaccines in the face of overwhelming liability threats. The current attack/destruction of the CDC, ACIP, and other health organizations under secretary Robert F Kennedy Jr. dangerously threatens public health nationally and globally. Therefore, the OSMA should support vaccine access in all ways, including maintenance of the 1986 NCVIA.</p>		
22	Dr. Susan Hubbell	District 3	Oppose
	We oppose this resolution as it contradicts current OSMA policy.		
22	Dr. Johnathon Ross	Self	Oppose
	I suspect this is a thinly veiled attack on OSMA vaccination policy.		
22	Dr. Philip Roholt	Self	Support
	Not veiled at all.		
22	Dr. Ken Christman	Self	Support
	<p>Informed consent should always be a necessary ingredient in the delivery of medical care, whether it be for procedures, pharmaceuticals, vaccines, etc. etc. Should patients not have the right to know the potential benefits and risks of ANY proposed therapy? Is this not a hallmark of conscientious medical care? If all patients have a right to know the risks vs. benefits, should they also not have a right to consent or decline? Is this not basic to a free society?</p>		
22	Dr. John Tyznik	SPS	Oppose
	We oppose this resolution.		
22	Dr. Philip Roholt	Self, Author, District 6	Support
	<p>This resolution opposes the current OSMA policies because they are outdated, misguided, and favor outside interests, not patients. Careful analysis into vaccine research clearly shows that past and current consensus is engendered by poor studies with short follow-up, often funded by pharmaceutical companies. The NCVIA allowed unfettered production and promotion of vaccines, and as one commenter stated: "...in the face of overwhelming liability threats." These lawsuits were engendered by real injuries, occurring before and ever since 1986. According to the Health Resources and Services Administration (HRSA) 1 person in 1 million vaccine doses from 2006 to 2022 received compensation from the NVICP (National Vaccine Injury Compensation Program, set up under the NCVIA) (1). If the vaccine adverse event rate is really that low, pharm companies' claim that lawsuits would prevent research development is certainly unfounded. The behavior of Big Pharma, and the deception of many healthcare providers, was clearly revealed in the COVID pandemic, in which Pharm profits exceeded 80 billion in 1 year (2). Please review a sampling of the VAERS reports(3), which as I reported in Resolution #22, is much less than 10% of actual injuries. Pertinent to the COVID-19 vaccines, reports of death due to vaccines increased in 2021 to greater than 20,000 from average of less than 2,000 in prior years. This was not due to Covid or "Long-Covid," (which is currently being blamed for vaccine injuries in the literature) because these reports were specifically related to vaccine administration. As far as Advisory Committee on Immunization Practices (ACIP) is concerned, the new CDC has instituted a</p>		

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	<p>disclosure list for ACIP members, and if you review this list you will note that those fired reported multiple conflicts of interest. The new CDC is more transparent and favors our patients, not pharma. The new CDC is insisting on proper placebo-controlled, long-term vaccine research, with research into multiple vaccine interactions, studies which have been avoided in the past. A concern that "...vaccine access remains threatened by certain groups" is false and unfounded. This resolution does not condone nor imply limitation of vaccine access to those who want them. This resolution emphasizes 3 important, patient-oriented issues: 1) Pharmaceutical liability for their products, 2) Patient informed consent and the freedom to say "No," and 3) Support of proper research into immunizations, as recommended by CDC. It is unconscionable that physicians, who should act in the best interest of their patients, are opposed to these concepts in Resolution 22. 1. HRSA Data and Statistics November 2024 2. <a href="https://blog.zoomrx.com/news/2022-earnings-story-of-pharma-giants/">https://blog.zoomrx.com/news/2022-earnings-story-of-pharma-giants/</a> 3. <a href="https://openvaers.com/covid-data">https://openvaers.com/covid-data</a></p>		
22	Dr. Noam Stern	District 5	Oppose
	<p>We oppose this resolution. Ohio law already requires informed consent for vaccinations. Ohio law also already allows for non-medical exemptions for vaccinations. The National Vaccine Injury Compensation Program is not funded by general taxpayer funds, but a tax on vaccines when they are administered. The process of compensation for adverse events through this program is much easier than the court system, with a significantly lower burden of evidence for claims to be filled. This system was put in place so the public can trust that when rare adverse events happen, they will be able to be compensated. If people are unhappy with this process, they have the option to reject the ruling and sue the pharmaceutical company directly through the standard court system – meaning that pharmaceutical companies do indeed bear liability if they make a vaccine that is not safe. Unfortunately, misinformation about the safety of vaccines has increased in recent years and we are seeing a resurgence of vaccine preventable diseases. The OSMA should not be advocating for policies that harm public health by eroding the public trust in vaccines.</p>		
22	Dr. Philip Roholt	District 6	Support, in reply to Dr. Stern
	<p>We support this resolution. Ohio law does require informed consent. However, for example with the mRNA vaccine no information on adverse events was on the product sheet. Other vaccines that include a sheet don't show AE's from studies longer than 2-3 weeks, or placebo RCT. Yes, Ohio law allows non-medical exemptions. OSMA should stop lobbying against this and we don't agree with prior OSMA policy against non-medical exemptions. NVICP is funded by a "tax on vaccines when they are administered." So this is a tax that is not a tax?? Please read the rules for application for injury compensation: only selected injuries, occurring within 2 weeks of administration. . Please cite the reference that injured patients can sue outside the NVICP. Please cite references concerning the safety of a particular vaccine in a saline, placebo-controlled RTC with study duration longer than 4-8 weeks.</p>		
22	Dr. Leslie Dingeldein	Self	Oppose
	<p>I oppose this resolution. Consent for vaccines is already required.</p>		
22	Dr. Alexis Hill	Self	Support
	<p>My sentiments align with Dr. Phil Roholt's/District 6, please see his comment.</p>		
22	Dr. Chris Paprzycki	District 1	Oppose
	<p>We oppose this resolution as disingenuous, anti-vaccine rhetoric, not to mention that parts of this contradict current OSMA policy.</p>		
22	Dr. Jessica Geddes Shea	YPS, Self	Oppose
	<p>Oppose on behalf of Young Physicians Section and myself. First there are several statements made in whereas clauses that are categorically false, and the references come from predatory anti-vaccine sources rather than reputable medical or scientific publications. Second, it is unnecessary as informed consent is already required (as several other commenters have already pointed out) and it contradicts existing policy.</p>		
22	Dr. Philip Roholt	Self, District 6	Support, in reply to Dr. Geddes Shea
	<p>Please list the false statements. As far as the references, of the 27 total, 13 are from respected scientific journals including JAMA, 5 are from government/HHRS statistics or statments, 7 are opinion articles referencing government policy or lawsuits against AAP or as a result of vaccine injury, and 2 are the actual lawsuit references. In contrast, references from proposed resolutions 20 and 21 are without merit. Res 20 has 3 media announcements/opinion and 2 vaccine schedules. Articles from proposed Res 21, supporting the AAP schedule, have no scientific references proving that the schedule is safe or effective (especially vaccine combinations which are commonly administered) and most of the references are totally opinion from pro-vaccine sources.</p>		
22	Dr. John Corker	District 2	Oppose
	<p>Speaking on behalf of D2 in opposition to this resolution, and in support of existing OSMA vaccine policy.</p>		
22	Dr. Tani Malhotra	Ohio ACOG	Oppose
	<p>On behalf of the American College of Obstetricians and Gynecologists in opposition to this resolution.</p>		

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22	Dr. Lester Hill	Self	Support
<p>The patient should always have the absolute right to receive a vaccination and also refuse vaccination. In the present legalese this interpretation could be hijacked to impose on an individual's God-given rights to control what goes into the body. I am speaking completely for myself.</p> <p>If these vaccines are so safe and effective which there has never been a peer-reviewed double-blind study proving that, then there should be no problems with the pharmaceutical industry assuming any liabilities for their products! If they don't want to assume that liability then they need to get off the playing field!</p>			
22	Dr. Samantha Thomas	RFS	Oppose
<p>Speaking on behalf of the RFS in strong opposition to resolution 22. There is countless evidence that the vaccines are safe and effective and that the previous vaccine schedule before it was changed has been quite effective in protecting children and adults. And now with a recent judge ruling, the new vaccine schedule is thankfully halted with the judge citing procedural failures and lack of scientific basis for these changes. There is no real evidence that vaccines are linked to autism unlike what one of the whereas clauses suggests. Informed consent about vaccines is already common practice, so this resolution is trying to fix a problem that doesn't exist. While we support transparency among the pharmaceutical industry, the asks of this resolution are not rooted in evidence-based medicine and thus the RFS opposes this.</p>			
22	Dr. Philip Roholt	Self, District 6	Support, in reply to Dr. Thomas
<p>We stand behind all of the "Whereas" clauses. I refer all readers to refer to the Peer-review article discussed at the Senate Hearing, a fascinating and enlightening review of the vax vs unvax issue, with comments on autism. To make it easy for you, please see Fig. 2, page 1612; Table 1, p 1618; p 1632, "Toxicants..." and "Conclusions" p 1634. This reference not listed in the Resolution but it should help to educate you on the current controversy. Here is the reference for above reply:  <a href="file:///C:/Users/user/OneDrive/Desktop/OSMA/Resolutions%202026/Res%20%2322/20251212+Oller+on+Zervos+et+al.+2020-2022+NH+DB2+JO-CAS+20251014.pdf">file:///C:/Users/user/OneDrive/Desktop/OSMA/Resolutions%202026/Res%20%2322/20251212+Oller+on+Zervos+et+al.+2020-2022+NH+DB2+JO-CAS+20251014.pdf</a></p>			
22	Dr. Andrew Hill	District 6	Support
<p>There should be no room for compromise when it comes to informed consent. A patient has every right to know exactly what they are receiving, and every right to decline.</p>			
22	Dr. Barbara Rogers	Self	Support
<p>There is already exemptions.</p>			
22	Dr. Joseph Hellmann	Self	Support
<p>I agree with supporting the holding of big Pharm accountable when appropriate as we all should. I agree that non medical exemptions should be maintained since if these are rising it means something is wrong with our messaging or our science and to simply advocate a 'lord it over you' approach is simply not the right thing to do. I agree that mandates are a wrong approach as we should be recognizing by the public's response since the Covid pandemic. Yes, consent is already required so simply remove that portion from the resolution Yes, ohio law permits non medical exemptions so why is OSMA so rigidly against it?</p>			
22	Dr. Shannon Trotter	District 2	Oppose
<p>Oppose.</p>			
22	Dr. Zainulabedin Waqar	Self	Oppose
<p>The VAERS system is self-reported and most likely does under report adverse effects. Much of the under reporting does not effectively capture mild adverse effects such as myalgia, fatigue, erythema at injection site. Rejecting established science and not promoting known vaccinations that have helped protect children has unfortunately led to a measles outbreak in 2026. Adopting this resolution would mean more harm to those who cannot speak for themselves. Parents have the right to autonomy and to make decisions for their children but this puts the immunocompromised vulnerable.</p>			