**OSMA and AMA Policies relevant to 2023 Proposed Resolutions**
**Resolution Committee Two**
**Resolutions 16-31**

**Resolution 16-2023** **Strengthening the OSMA Stance on Abortion Policy in Ohio**

**AMA POLICY**

**Preserving Access to Reproductive Health Services D-5.999**
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or 1 other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

**AMA Policy on Abortion H-5.990**
The issue of personal support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which... may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

**OSMA POLICY**

**Policy 10 – 1990 – Policy on Abortion**

1. It is the position of the OSMA that the issue of support of or opposition to abortion is a matter for members of the OSMA to decide individually, based on personal values or beliefs.

2. The OSMA shall take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

3. Items 1 and 2 notwithstanding, the OSMA shall take a position of opposition to any proposed OSMA legislation or rule that would:

    • Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning of a patient which are not consistent with the medical standard of care; or,

• Require or compel Ohio physicians to discuss treatment options that are not within the standard of care and/or omit discussion of treatment options that are within the standard of care.

**Policy 09-2022 – Access to Standard Care for Nonviable Pregnancy**

1. The Ohio State Medical Association (OSMA) supports patients' timely access to standard treatment of nonviable pregnancy, including but not limited to miscarriage, molar pregnancy, and ectopic pregnancy, in both emergent and non-emergent circumstances.
2. The OSMA opposes any hospital directive, policy, or legislation that may hinder patients' timely access to the accepted standard of care in both emergent and non-emergent cases of nonviable pregnancy.

**Resolution 17-2023 Opposition to Criminalization of Pregnancy Loss**

**AMA POLICY**

**Opposition to Criminalization of and Civil Liability for Pregnancy Loss as the Result of Medically Necessary Care D-160.911**
Our AMA will advocate: (1) that pregnancy loss shall not be criminalized for physicians or patients; and (2) that physicians and patients should not be held civilly and/or criminally liable for pregnancy loss as a result of medically necessary care.

**OSMA POLICY**

**Policy 18 – 2012 – Criminalization of Medical Care**
The OSMA opposes any portion of proposed legislation or rule that criminalizes clinical practice that is the standard of care.

**Resolution 18-2023 Rescind Abortion Policy 13-1973**

**AMA POLICY**

No relevant AMA Policy.

**OSMA POLICY**

**Policy 13 – 1973 – Abortion as a Medical Procedure**

1. The House of Delegates of the OSMA adopts as its policy the statement of abortion issued by the OSMA's Committee on Maternal Health, with the exception that abortion upon request, like any other medical procedure, should be performed only in the maternal patient's best interests, and the standards of sound clinical judgment, which together with informed maternal patient consent, should be determinative according to the merits of each individual case.

Statement on Abortion of OSMA Committee on Maternal Health

*In view of the recent decision of the United States Supreme Court on abortion the following statement is issued by the OSMA's Committee on Maternal Health.*

*Abortion shall mean an operation to intentionally terminate a pregnancy with a live or stillborn fetus weighing 500 grams or less, or under 20 completed weeks of gestation. For its performance, adequate facilities, equipment and personnel are required to assure the highest standards of patient care.*

*First trimester abortions (up to 12 weeks since conception) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by the State of Ohio.*

*Abortions beyond the first trimester should be performed in a hospital.*

*Facilities for the performance of first trimester abortions should include appropriate surgical, anesthetic and resuscitation equipment. In addition, the following should be provided:*

*1. Verification of the diagnosis and duration of pregnancy.*

*2. Pre-operative instructions and counseling.*

*3. Recorded pre-operative history and physical examination, particularly directed to identification of pre-existing or concurrent illnesses or drug sensitivities that may have a bearing on the operative procedures or the anesthesia.*

*4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.*

*5. Prevention of Rh sensitization.*

*6. A receiving facility where the patient may be prepared and receive necessary pre-operative medication and observation prior to the procedure.*

*7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia and can be safely discharged by the physician.*

*8. Post-operative instructions and arrangements for follow-up including family planning advice.*

*9. Adequate permanent records.*

*It is recognized that abortion may be performed at a patient's request or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept, an abortion.*

*The usual informed consent, including operative permit, should be obtained. The same indications for consultation should apply to abortions as to other medical-surgical procedures.*

*Abortions should be performed only by licensed physicians who are qualified to identify and manage those complications that may arise from the procedure.*

**Policy 18 – 2012 – Criminalization of Medical Care**

1. The OSMA opposes any portion of proposed legislation or rule that criminalizes clinical practice that is the standard of care.

**Resolution 19-2023 Support for Access to Emergency Contraception**

**AMA POLICY**

**Access to Emergency Contraception D-75.997**

1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA).

2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel.

**OSMA POLICY**

**Policy 22 – 2001 – Neutrality Regarding Emergency Contraceptive Pill**

1. The OSMA is neutral in regard to emergency contraception pills.

**Policy 12 – 2002 – Emergency Contraception**

1. The OSMA encourages hospitals to assure that sexual assault victims are informed about the availability and effectiveness of emergency contraception.

| **Resolution 20-2023** | **Moratorium on Utility Discontinuation in Pregnancy and 12 Months Postpartum** |
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**AMA POLICY**

No relevant AMA Policy

**OSMA POLICY**

No relevant OSMA Policy

| **Resolution 21-2023** | **Utilizing Principles of Collective Impact to Address Pregnancy-Related Morbidity and Mortality in Ohio** |
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**AMA POLICY**

No relevant AMA Policy

**OSMA POLICY**

No relevant OSMA Policy

| **Resolution 22-2023** | **Comprehensive Reproductive Healthcare Training in Medical Schools** |
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**AMA POLICY**

**Medical Training and Termination of Pregnancy H-295.923**

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.
4. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.

5. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees.

**OSMA POLICY**

**Policy 38 – 2021 – Advocating for the Adoption of Statewide Sexual Education Standards**

1. The OSMA supports age-appropriate, evidence based, comprehensive health education in schools beginning in early childhood.
2. The OSMA defines comprehensive sexual education as including, but not limited to, the following subjects: normal reproductive development, human sexuality (including intimate relationships), healthy sexual and nonsexual relationships, gender identity and sexual orientation, abstinence, contraception, prevention of sexually transmitted infections, communication, consent, decision making, recognizing and preventing sexual violence, and reproductive rights and responsibilities.
3. The OSMA will advocate for the adoption of required, state-wide sexual health education standards for K-12 schools that are in accordance with this resolution and the policies of the OSMA.

**Policy 29 – 2000 – Education to Prevent Teenage Pregnancy and Sexually Transmissible Diseases**

1. The OSMA adopts as policy, AMA policy H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence and Distribution of Condoms in Schools, which states that the AMA supports responsible sex education which includes: information on reproductive biology, accurate and understandable information on sexual abstinence, sexual responsibility, availability and reliability of contraceptives including condoms, alternatives in birth control, and other information aimed at prevention of pregnancy and sexual transmission of diseases.

**Policy 57 – 1990 – Health Promotion and Disease Prevention Education**

1. The OSMA supports the implementation of effective health promotion/disease prevention curricula in medical schools, residency programs and CME programs.

| **Resolution 23-2023** | **Allow Unmatched Medical School Graduates to Practice as Dependent Physicians Under Physician Supervision** |
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**AMA POLICY**

No relevant AMA Policy

**OSMA POLICY**

No relevant OSMA Policy

| **Resolution 24-2023** | **Support for Expanding Graduate Medical Education Funding** |
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**AMA POLICY**

**The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967**

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to

advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly

advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

**OSMA POLICY**

**Policy 06-2013 – Crafting Innovative Ways of Funding Graduate Medical Education**

1. The OSMA supports legislation to convene a state based task force of key stakeholders to include representatives from private business enterprises such as health insurance companies, private practice physicians, members of the general public, and academic medical center employees to study current graduate medical education (GME) financing in Ohio and investigate creative alternatives for GME funding that rely less on federal resources.

| **Resolution 25-2023** | **Coverage of Restorative Care for Survivors of Domestic Abuse or Intimate Partner Violence** |
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**AMA POLICY**

No relevant AMA policy

**OSMA POLICY**

**Policy 28 – 1996 – Breast Reconstruction Availability**

1. The OSMA supports access to breast reconstruction surgery for all women, if they desire it, and that access should be available regardless of timing in relationship to the onset of the deformity or absence of their breast, and that insurance carriers' coverage should not discriminate against the female breast for reconstructive coverage including symmetry operations on the opposite breast.

| **Resolution 26-2023** | **Codifying Efforts for Legislative Action on Prior Authorization** |
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**AMA POLICY**

No relevant AMA Policy

**OSMA POLICY**

Policy 23 – 2022 – Prohibit Reversal of Prior Authorization

1. The Ohio State Medical Association (OSMA) supports legislation to prohibit retroactive denial of a previously approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service.

2. The OSMA delegation to the AMA will take this topic regarding reversal of prior authorization to the AMA House of Delegates to advocate for this change as a part of their greater effort to eliminate prior authorization all together.

Policy 14 – 2019 – Compensation for Prior Authorization Services

1. The OSMA opposes pre-authorization as a requirement for patient care. 2. The OSMA shall seek legislation that provides for appropriate compensation to physician offices for expenses incurred in obtaining prior authorizations for patient care.

**Current & Proposed Legislation**

Congress: H.R.7995 - GOLD CARD Act of 2022
Introduced in House (06/09/2022)

Getting Over Lengthy Delays in Care As Required by Doctors Act of 2022 or the GOLD CARD Act of 2022

This bill exempts physicians from prior authorization requirements under Medicare Advantage plans with respect to specific items and services if at least 90% of the physician's requests for such items and services were approved during the previous plan year.

Ohio: New Prior Authorization Legislation to Be Introduced

For more than a year, your OSMA advocacy team has been preparing to embark on a major legislative initiative dealing with continued hassles that Ohio physicians and their practices are facing due to prior authorization. The goal of this legislation, which will be sponsored by Rep. Kevin Miller (R-Newark), is to create a “gold card” system for prior authorization, giving physicians a way to “earn” their way out of prior authorization requirements by demonstrating a high prior authorization success rate. Similar legislation was recently passed and enacted in the state of Texas.

**Resolution 27-2023 Reimbursement for Medical Interpreter Services**

**AMA POLICY**

**Certified Translation and Interpreter Services D-385.957**
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

**OSMA POLICY**

**Policy 23 – 2020 – Government Pay for Government Mandates**

1. The OSMA advocates for policies that allow for physician judgment and documented medical decision-making to supersede government regulation – including the utilization of Augmented Intelligence – in instances of disputes in patient care.

2. The OSMA advocates for policies that require “proof of concept,” in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third party mandate or regulation on patient care and the physician-patient relationship.

3. The OSMA advocates for policies requiring government, insurance company or other third party entities to fully fund any mandates or regulations imposed on patient care and the physician-patient relationship. 4. The OSMA delegation to our AMA will write a resolution for A-20 asking our AMA to advocate for similar policies.

**Resolution 28-2023 Decrease Costs for Ohio Patients with Diabetes with Commercial Insurance**

**AMA POLICY**

**Insulin Affordability H-110.984**
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.

**OSMA POLICY**

**Policy 23 – 2020 – Government Pay for Government Mandates**

1. The OSMA advocates for policies that allow for physician judgment and documented medical decision-making to supersede government regulation – including the utilization of Augmented Intelligence – in instances of disputes in patient care.

2. The OSMA advocates for policies that require “proof of concept,” in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third party mandate or regulation on patient care and the physician-patient relationship.

3. The OSMA advocates for policies requiring government, insurance company or other third party entities to fully fund any mandates or regulations imposed on patient care and the physician-patient relationship. 4. The OSMA delegation to our AMA will write a resolution for A-20 asking our AMA to advocate for similar policies.

**Resolution 29-2023 Law Enforcement Escorting Incapacitated Patients to the Emergency Department**

**AMA POLICY**

No relevant AMA Policy

**OSMA POLICY**

**Policy 20 – 2016 – Improving Outcomes of Law Enforcement Responses to Mental Health Crisis through the Crisis Intervention Team Model**

1. The OSMA supports continued research into the public health benefits of CIT law enforcement training. 46

2. The OSMA encourages physicians, physician practices, allied healthcare professionals, and medical communities to collaborate with law enforcement training programs in order to improve the outcomes of police interventions in mental health crises.

3. The OSMA supports the use of public funds to facilitate CIT training for all interested members of police departments

**Resolution 30-2023** **Support for 988 Response System**

**AMA POLICY**

No relevant policy

**OSMA POLICY**

No relevant policy

**Resolution 31-2023** **Clarification of Prescription Abbreviations (QD, BID, TID, QID)**

**AMA POLICY**

**Medication (Drug) Errors in Hospitals H-120.968**

(1) Our AMA encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications:

(a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.
(b) Physicians should evaluate the patient's total status and review all existing drug therapy before prescribing new or additional medications (e.g., to ascertain possible antagonistic drug interactions).
(c) Physicians should evaluate and optimize patient response to drug therapy by appropriately monitoring clinical signs and symptoms and relevant laboratory data; follow-up and periodically reevaluate the need for continued drug therapy.
(d) Physicians should be familiar with the hospital's medication-ordering system, including the formulary system; the drug use review (DUR) program; allowable delegation of authority; procedures to alert nurses and others to new drug orders that need to be processed; standard medication administration times; and approved abbreviations.
(e) Written drug or prescription orders (including signatures) should be legible. Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.
(f) Medication orders should be complete and should include patient name; drug name (generic drug name or trademarked name if a specific product is required); route and site of administration; dosage form (if applicable); dose; strength; quantity; frequency of administration; and prescriber's name. In some cases, a dilution, rate, and time of administration should be specified. Physicians should review all drug orders for accuracy and legibility immediately after they have prescribed them.
(g) Medication orders should be clear and unambiguous. Physicians should: (i) write out instructions rather than use nonstandard or ambiguous abbreviations (e.g., write "daily" rather than "qd" which could be misinterpreted as "qid" or "od"); (ii) not use vague instructions, such as "take as directed"; (iii) specify exact dosage strengths (such as milligrams) rather than dosage form units (such as one vial) (an exception would be combination products, for which the number of dosage form units should be specified); (iv) prescribe by standard nomenclature, using the United States Adopted Names (USAN)-approved generic drug name, official name, or trademarked name (if a specific product is required) and avoid locally coined names, chemical names, unestablished abbreviated drug names (e.g., AZT), acronyms, and apothecary or chemical symbols; (v) always use a leading "0" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a terminal "0" (e.g., 5.0 ml); (vi) avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5 g); (vii) spell out the word "units" rather than writing "u"; (viii) and use the metric system. Instructions with respect to "hold" orders for medications should be clear.
(h) Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies.

(2) Our AMA encourages the hospital medical staff to take a leadership role in their hospital, and in collaboration with pharmacy, nursing, administration, and others, to develop and improve organizational systems for monitoring, reviewing, and reporting medication errors and, after identification, to eliminate their cause and prevent their recurrence.

**OSMA POLICY**

No relevant policy