OSMA and AMA Policies Relevant to 2024 Proposed Resolutions
Resolution Committee One
Resolutions 1-18 and Policy Sunset Report

Resolution 1-2024: Insurance Coverage for Substance Use Disorder

OSMA Policy

OSMA Policy 79 – 1977 – Insurance Coverage for Alcoholism Treatment

1. The OSMA continues to recognize alcoholism as an illness or disease.
2. The OSMA continues to support treatment of alcoholism.
3. The OSMA supports health insurance coverage for treatment alcoholism in whatever setting 55 is most appropriate and cost effective.

AMA Policy

AMA – H-290.962: Medicaid Substance Use Disorder Coverage

1. Our AMA will advocate that the Centers for Medicare and Medicaid Services provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders.
2. Our AMA will advocate for clear billing and coding processes regarding the medical management and treatment of all substance use disorders.
3. Our AMA recognizes the expertise of addiction specialist physicians and the importance of improving access to management and treatment of addiction services with Medicaid payment for all physician specialties.

AMA – H-185.974: Parity for Mental Health and Substance Use Disorders in Health Insurance Programs

1. Our AMA supports parity of coverage for mental, health, and substance use disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders.

AMA - H-185.916: Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care

Our AMA supports requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws.

Resolution 2-2024: OSMA Membership Structure

OSMA Policy

See OSMA Bylaws:

https://osma.org/aws/OSMA/asset_manager/get_file/334466?ver=485

AMA Policy

No relevant policy.

Resolution 3-2024: Update of OSMA Bylaws to Include Representative Members from the Women Physician Section, Senior Physician Section, and International Medical Graduates Section on OSMA Council

OSMA Policy

See OSMA Bylaws:

https://osma.org/aws/OSMA/asset_manager/get_file/334466?ver=485

AMA Policy

No relevant policy.

Resolution 4-2024: Amending OSMA Constitution and Bylaws to Require Council to Solicit Section Feedback/Approval on Public Statements on State Ballot Measures

OSMA Policy

See OSMA Bylaws:

https://osma.org/aws/OSMA/asset_manager/get_file/334466?ver=485

AMA Policy

No relevant policy.

Resolution 5-2024: Improving Institutional Memory/Revising OMSS Bylaws

OSMA Policy

See OMSS Bylaws:

https://associationdatabase.com/aws/OSMA/asset_manager/get_file/891705

AMA Policy

No relevant policy.

Resolution 6-2024: AMA Delegation Attendance

OSMA Policy

No relevant policy.

AMA Policy

No relevant policy.

Resolution 7-2024: Clarity in Advertising and Marketing

OSMA Policy

OSMA Policy 05 – 2012 – AMA's Truth in Advertising Campaign

1. The OSMA shall work to enact state legislation to help provide clarity and transparency 50 for patients when they seek out and go to a health care practitioner and that the 51 legislation includes provisions similar to those included in the AMA's Truth in Advertising 52 campaign.

AMA Policy

AMA - H-270.982: Truth in Advertising Standards for Managed Health Care Plans
It is the policy of the AMA to seek legislation which would provide that managed health care plans meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification and concurrent review practices.

AMA – H-405.967: Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings
The AMA opposes US West Yellow Pages or any other corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory.

AMA – D-405.974: Clarification of Healthcare Physician Identification: Consumer Truth & Transparency
Our AMA will advocate for: (1) legislation that would establish clear legal definitions for use of words or terms "physician," "surgeon," "medical doctor," "doctor of osteopathy," "M.D." , "D.O.," or any other allopathic or osteopathic medical specialist; and (2) "Truth & Transparency" legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and board licensure in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. -ologist) that can mislead the public.

AMA – H-405.951: Definition and Use of the Term Physician
Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
    a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
    b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
    c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.

3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

AMA – H-405.969: Definition of a Physician

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

AMA – H-405.964: Truth in Advertising

1. AMA policy is that any published lists of "Best Physicians" should include a full disclosure of the selection criteria, including direct or indirect financial arrangements.
2. Our AMA opposes any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses.

Resolution 8-2024: Cost of Living Payment Increases

OSMA Policy

No relevant policy.

AMA Policy

No relevant policy.

Resolution 9-2024: Amending OSMA Resolution 15-2023 to Allow for Broader Abortion Advocacy

OSMA Policy

OSMA Policy 15 – 2023 -- Strengthening the OSMA Stance on Abortion Policy in Ohio

1. The OSMA amend OSMA Policy 10-1990- Policy on Abortion by addition and deletion as follows: 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.~~ 1. 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.~~ 2. Item~~s~~ 1 ~~and 2~~ notwithstanding, the OSMA shall take a position of opposition to any proposed ~~OSMA~~Ohio legislation or rule that would:
      - Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning and OR education 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; and be it further
2. The OSMA supports an individual's right to decide whether to have children, the number and spacing of children, as well as the right to have the information, education, and access to evidence-based reproductive health care services to make these decisions.
3. The OSMA opposes non-evidence based limitations on access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion.
4. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing evidence-based reproductive health care services within the medical standard of care.
5. The OSMA collaborates with relevant stakeholders to educate legislators and amend existing state laws so that the term "fetal heartbeat" is not used to inaccurately represent physiological electrical activity.

AMA Policy

AMA – D-5.996: Expanding Support for Access to Abortion Care

1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

AMA – H-5.980: Oppose the Criminalization of Self-Managed Abortion

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

AMA – H-5.990: Policy on Abortion

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.

AMA – D-5.999: Preserving Access to Reproductive Health Services

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 other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges 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 – D-5.997: Access to Methotrexate and Other Medications Based on Clinical Decisions
1. Our AMA opposes restrictions on prescribing, distributing, or dispensing of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination.
2. Our AMA will work with relevant stakeholders to provide educational guidance on laws, regulations, or other policies that impede prescribing, distributing, or dispensing of methotrexate and other medications because of their impact or perceived impact on a pregnancy.

Resolution 10-2024: Protecting Access to Abortion for Patients Using Teratogenic Medications

OSMA Policy

OSMA Policy 15 – 2023 -- Strengthening the OSMA Stance on Abortion Policy in Ohio

1. The OSMA amend OSMA Policy 10-1990- Policy on Abortion by addition and deletion as follows: 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.~~ 1. 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.~~ 2. Item~~s~~ 1 ~~and 2~~ notwithstanding, the OSMA shall take a position of opposition to any proposed ~~OSMA~~Ohio legislation or rule that would:
        - Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning and OR education 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; and be it further
2. The OSMA supports an individual's right to decide whether to have children, the number and spacing of children, as well as the right to have the information, education, and access to evidence-based reproductive health care services to make these decisions.
3. The OSMA opposes non-evidence based limitations on access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion.
4. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing evidence-based reproductive health care services within the medical standard of care.
5. The OSMA collaborates with relevant stakeholders to educate legislators and amend existing state laws so that the term "fetal heartbeat" is not used to inaccurately represent physiological electrical activity.

AMA Policy

AMA – D-5.996: Expanding Support for Access to Abortion Care

1. Our AMA will advocate for: (a) broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs; (b) explicit codification of legal protections to ensure broad, equitable access to abortion services; and (c) equitable participation by physicians who provide abortion care in insurance plans and public programs.

2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

AMA – H-5.980: Oppose the Criminalization of Self-Managed Abortion

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

AMA – H-5.990: Policy on Abortion

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.

AMA – D-5.999: Preserving Access to Reproductive Health Services

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 other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges 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 – D-5.997: Access to Methotrexate and Other Medications Based on Clinical Decisions

1. Our AMA opposes restrictions on prescribing, distributing, or dispensing of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination.
2. Our AMA will work with relevant stakeholders to provide educational guidance on laws, regulations, or other policies that impede prescribing, distributing, or dispensing of methotrexate and other medications because of their impact or perceived impact on a pregnancy.

Resolution 11-2024: Transparency in Pregnancy Counseling

OSMA Policy

OSMA Policy 37-2021 – Patients' Right to Know

1. OSMA affirms that in the state of Ohio, a physician is an individual who is authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery in Ohio as defined in the Ohio Revised Code.
2. OSMA strongly recommends medical facilities to require medical personnel in direct contact with patients to wear or display notification to patients disclosing their specific professional qualifications, and when possible, to encourage verbal disclosure to patients of the same information before delivery of health care services.
3. OSMA will pursue legislation that will require medical facilities that employ personnel, whom are required by law to engage in a collaboration or supervisory agreement with a physician, to publicly

display the name of the collaborating or supervising physician in a common area of the medical facility, such as a waiting room or lobby.

4. OSMA will pursue legislation that will require that, in the event that collaboration or supervision by a physician is no longer required by state law for specific medical personnel, the facility must inform patients that there is not a collaborating physician overseeing or otherwise involved in their care.

OSMA Policy 07-2022- Addressing the Roles of licensed Health Professionals in Preventing Public Health Misinformation

1. The OSMA opposes legislation that mandates licensed healthcare professionals provide non-evidence-based healthcare information to patients.
2. The OSMA: 1.) Will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and 2) will work with public health agencies and professional societies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information and address misinformation that undermines public health initiatives.

OSMA Policy 07-2020 - Legislative or Regulatory Interference in the Practice of Medicine in the State of Ohio

1. The OSMA actively works to ensure that the sanctity of the physician-patient relationship is protected in all legislative and regulatory matters.
2. Current OSMA Policy 18 - 2012 (Criminalization of Medical Care) be amended to read as follows: The OSMA opposes any portion of proposed legislation OR RULE that criminalizes clinical practice that is the standard of care.

   That current OSMA Policy 10 – 1990 (Policy on Abortion) be amended as follows:
   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 which are not consistent with the 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.

OSMA 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.

OSMA Policy 15 – 2023 -- Strengthening the OSMA Stance on Abortion Policy in Ohio

1. The OSMA amend OSMA Policy 10-1990- Policy on Abortion by addition and deletion as follows:
   Policy 10 – 1990 – Policy on Abortion
   - ~~a. 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.~~
   - ~~b.~~ 1. 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.
   - ~~c.~~ 2. Item~~s~~ 1 ~~and 2~~ notwithstanding, the OSMA shall take a position of opposition to any proposed ~~OSMA~~Ohio legislation or rule that would:
      - Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning and OR education 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; and be it further

2. The OSMA supports an individual's right to decide whether to have children, the number and spacing of children, as well as the right to have the information, education, and access to evidence-based reproductive health care services to make these decisions.
3. The OSMA opposes non-evidence based limitations on access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion.
4. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing evidence-based reproductive health care services within the medical standard of care.
5. The OSMA collaborates with relevant stakeholders to educate legislators and amend existing state laws so that the term "fetal heartbeat" is not used to inaccurately represent physiological electrical activity.

AMA Policy

AMA – H-420.954: Truth and Transparency in Pregnancy Counseling Centers

1. It is AMA's position that any entity that represents itself as offering health-related services should uphold the standards of truthfulness, transparency, and confidentiality that govern health care professionals.
2. Our AMA urges the development of effective oversight for entities offering pregnancy-related health services and counseling.
3. Our AMA advocates that any entity offering crisis pregnancy services
    a. Truthfully describe the services they offer or for which they refer—including prenatal care, family planning, termination, or adoption services—in communications on site and in their advertising, and before any services are provided to an individual patient; and
    b. Be transparent with respect to their funding and sponsorship relationships.
4. Our AMA advocates that any entity licensed to provide medical or health services to pregnant women
    a. Ensure that care is provided by appropriately qualified, licensed personnel; and
    b. Abide by federal health information privacy laws.
5. Our AMA urges that public funding only support programs that provide complete, non-directive, medically accurate health information to support patients' informed, voluntary decisions.

Resolution 12-2024: Making Ohio an Abortion Care Safe Haven

OSMA Policy

OSMA 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.

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    ~~d. 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.~~
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AMA Policy

AMA – D-5.996: Expanding Support for Access to Abortion Care

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2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

AMA – H-5.980: Oppose the Criminalization of Self-Managed Abortion

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

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AMA – D-5.999: Preserving Access to Reproductive Health Services

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 other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges 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.

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1. Our AMA opposes restrictions on prescribing, distributing, or dispensing of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination.
2. Our AMA will work with relevant stakeholders to provide educational guidance on laws, regulations, or other policies that impede prescribing, distributing, or dispensing of methotrexate and other medications because of their impact or perceived impact on a pregnancy.

Resolution 13-2024: Improving Transparency of Parental Leave Policy in Graduate Medical Education

OSMA Policy

OSMA Policy 34 – 2021 – Increasing Transparency of the Resident Physician Application Process
1. The OSMA and interested stakeholders shall study options for improving transparency in the resident application process which works towards holistic review of residency applicants.
2. The Ohio Delegation to the AMA shall forward this resolution to the AMA.

OSMA Policy 21 – 2023 – Comprehensive Reproductive Health Care Training
1. The OSMA supports the protection and delivery of evidence-based, comprehensive reproductive health care training including training in abortion and family planning for Ohio medical students, residents, and trainee.
2. The OSMA opposes legislation limiting comprehensive reproductive health care training, which includes abortion and family planning training.

AMA Policy

AMA – H-405.960: Increasing Practice Viability for Physicians Through Increased Employer and Employee Awareness of Protected Leave Policies

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other

physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board

eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.

AMA – H-405.954: Parental Leave

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

AMA – D-295.308: Parental Leave and Planning Resources for Medical Students

1. Our AMA will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

Resolution 14-2024: Ohio Medical School Suicide Prevention

<u>OSMA Policy</u>

OSMA Policy 35 – 1982 – Education Regarding Suicide Recognition, Prevention and Treatment

1. The OSMA encourages physicians to continue their education in the recognition, treatment, and prevention of potential suicides and the management of survivors of suicide attempts.

AMA Policy

AMA – H-295.858: Access to Confidential Health Services for Medical Students and Physicians

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
    a. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
    b. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
    c. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
    d. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages undergraduate and graduate medical education programs to create mental health substance use awareness and suicide prevention screening programs that would:
    a. be available to all medical students, residents, and fellows on an opt-out basis;
    b. ensure anonymity, confidentiality, and protection from administrative action;
    c. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
    d. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA

supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

AMA – H-405.948: Factors Causing Burnout

Our AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

Resolution 15-2024: Support for Parental Leave

OSMA Policy

OSMA 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.

OSMA Policy 15 – 2023 -- Strengthening the OSMA Stance on Abortion Policy in Ohio

1. The OSMA amend OSMA Policy 10-1990- Policy on Abortion by addition and deletion as follows:
   Policy 10 – 1990 – Policy on Abortion
   - ~~g. 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.~~
   - ~~h.~~ 1. 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.
   - ~~i.~~ 2. Item~~s~~ 1 ~~and 2~~ notwithstanding, the OSMA shall take a position of opposition to any proposed ~~OSMA~~Ohio legislation or rule that would:
     - Require or compel Ohio physicians to perform treatment actions, investigative tests, or questioning and OR education 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; and be it further
2. The OSMA supports an individual's right to decide whether to have children, the number and spacing of children, as well as the right to have the information, education, and access to evidence-based reproductive health care services to make these decisions.
3. The OSMA opposes non-evidence based limitations on access to evidence-based reproductive health care services, including fertility treatments, contraception, and abortion.
4. The OSMA opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing evidence-based reproductive health care services within the medical standard of care.
5. The OSMA collaborates with relevant stakeholders to educate legislators and amend existing state laws so that the term "fetal heartbeat" is not used to inaccurately represent physiological electrical activity.

AMA Policy

AMA – H-405.960: Increasing Practice Viability for Physicians Through Increased Employer and Employee Awareness of Protected Leave Policies

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.
15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.

AMA – H-405.954: Parental Leave

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in

legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

AMA – D-295.308: Parental Leave and Planning Resources for Medical Students

1. Our AMA will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

Resolution 16-2024: Declaration of Health and Health Care as Human Rights

OSMA Policy

OSMA Policy 6 – 2023 -- Increased Access to Health Care

1. The OSMA continues to express its support for increased access to comprehensive, affordable, high-quality health care.
2. The OSMA rescinds current Policy 11 – 2010 – Promoting Free Market-Based Solutions to Health Care Reform.

OSMA Policy 16 – 2021 – Amend Policy 05—2011: Universal Health Insurance Access

1. The OSMA amends Policy 05—2011 to read:

   Policy 05 - 2011 – Universal Health Insurance Access
   1. The OSMA reaffirms support for universal health insurance access through market and public based initiatives to create incentives for the purchase of coverage.
   2. OSMA will continue to support legislative and regulatory reform to achieve universal health insurance access.

OSMA Policy 01-2017 – Supporting Changes in Health Care Policy that Increase Coverage and Expand Benefits

1. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts and supports providing all Ohio citizens with high quality health care.
2. The OSMA opposes changes to healthcare policy that would decrease access to health care coverage for the citizens of Ohio.
3. The OSMA supports the inclusion of young adults up to age 26 on their parents'/guardians' health care plans.
4. The OSMA supports health care policies that allow states and institutions the right to explore and develop individualized models for covering the uninsured.

OSMA Policy 05 – 2011 – Universal Health Insurance Coverage

1. The OSMA reaffirms support for universal health insurance access for all Americans through market based initiatives to create incentives for the purchase of coverage.
2. OSMA and AMA will pursue legislative and regulatory reform to achieve universal health insurance access through free market solutions.

OSMA Policy 63-1994 – Health-System Reform

1. The OSMA supports only those proposed changes in our health-care system that are in the best interest of patients and which assure that all Americans continue to receive high quality medical care.

2. The OSMA supports the following principles: (1) All Americans shall have access to health insurance; (2) The right of patients to choose their physician freely; (3) The right of patients and their physicians to make medical decisions.
3. The OSMA supports the elimination of underwriting requirements which interfere with the establishment of small business pools.
4. The OSMA supports the elimination of pre-existing condition exclusions from health insurance contracts.
5. The OSMA supports guaranteed portability of health insurance.
6. The OSMA supports, for the medically indigent, the adoption of health insurance vouchers and/or tax credits as one of the mechanisms of providing them health-care coverage.
7. The OSMA supports both Medical Savings Accounts and Medical IRAs as acceptable methods to fund health care.
8. The OSMA supports legislative health-care plans which include fee-for-service as a method of payment for physician services.
9. The OSMA supports the position that free competition and meaningful medical professional liability reform are the more effective ways to contain health-care costs rather than global budgets and spending caps.

AMA Policy

AMA – H-65.960: Health, In All Its Dimensions, Is a Basic Right
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Resolution 17-2024: Support for Safe and Equitable Access to Voting

OSMA Policy

No relevant policy.

AMA Policy

AMA – H-440.805: Support for Safe and Equitable Access to Voting
1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

Resolution 18-2024: Reducing AI Bias in Healthcare

OSMA Policy

OSMA Policy 06 – 2019 – Increase Awareness of Disparities in Medical Access and Treatment in Ohio

1. The OSMA shall work with appropriate stakeholders to increase awareness of Ohio physicians, residents, and medical students of disparities in medical access and treatment in Ohio based on disability, race, ethnicity, geography, and other social and demographic factors through the utilization of existing resources.

OSMA Policy 05 – 2019 – Advancing Gender Equity in Medicine

1. The OSMA adopts the following, which is adapted from American Medical Association policy/directives:
   1. That the OSMA supports gender and pay equity in medicine consistent with the American Medical Association Principles for Advancing Gender Equity in 166 Medicine (see below AMA Policy H-65.961 as adopted at the 2019 AMA Annual Meeting);
   2. That the OSMA:
      a. Promote institutional, departmental, and practice policies, consistent with federal and Ohio law, that offer transparent criteria for initial and subsequent physician compensation;
      b. Continue to advocate for pay structures based on objective, gender-neutral criteria;
      c. Encourages training to identify and mitigate implicit bias in compensation decision making for those in positions to determine physician salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement;
   3. That the OSMA recommends as immediate actions to reduce gender bias to:
      a. Inform physicians about their rights under the Lilly Ledbetter Fair Pay Act, which restores protection against pay discrimination;
      b. Promote educational programs to help empower physicians of all genders to negotiate equitable compensation; and
      c. Work with relevant stakeholders to advance women in medicine;
   4. That the OSMA collaborate with the American Medical Association initiatives to advance gender and pay equity;
   5. That the OSMA commit to the principles of pay equity across the organization 191 and take steps aligned with this commitment.

AMA Policy

AMA – H-480.939: Augmented Intelligence in Health Care

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions.

Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity (ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations—
    a. Identify areas of medical practice where AI systems would advance the quadruple aim;
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
    c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
    d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

AMA – H-65.961: Principles for Advancing Gender Equity in Medicine

Our AMA:

1. Declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. Affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. Endorses the principle of equal opportunity of employment and practice in the medical field;
4. Affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. Acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. Declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. Recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. Affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. Affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

OSMA Policy Sunset Report

OSMA Policy

No relevant policy.

AMA Policy

No relevant policy.