**Resolution 1-F19. Creating a Toolkit to Optimize Physician-Led Care Teams with Advanced Practice Providers**

(Sponsor: Colorado Chapter)

WHEREAS, the ACP has supported efforts to drive physician-led team-based care with nurse practitioners and physician assistants with policy including the *Principles Supporting Dynamic Clinical Care Teams* paper in 2013; and

WHEREAS, there is little literature to guide physician-advanced practice provider best practices in the clinical setting and little time is devoted to this topic in residency training, and

WHEREAS, the ACP seeks to serve the professional needs of our membership; and

WHEREAS, internal medicine specialist and subspecialist ACP members and physician assistant and nurse practitioner ACP affiliate members continue to learn about and strive to optimize high functioning team-based workflows and communication about patient care in clinical settings; therefore be it

**RESOLVED, that the Board of Regents create a toolkit to share best practices and specific real-life examples of successful team-based clinical care models that include internal medicine physicians working with advanced practice practitioners.**

**Resolution 2-F19. Establishing a Work Group to Improve Care Coordination between Hospital and Ambulatory Care**

(Sponsor: Council of Subspecialty Societies; Co-sponsor: Colorado Chapter)

WHEREAS, there is often a breakdown in care coordination when patients are hospitalized from outpatient care and discharged to outpatient care; and

WHEREAS, the ACP has worked with the Society of Hospital Medicine to formulate a collaborative care template; and

WHEREAS, ACP has an existing policy paper developed through CSS: *The Patient-Centered Medical Home Neighbor: the Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices*, and a High Value Care Coordination tool kit to define and operationalize expectations for optimizing the referral process between primary care and specialty care as the Medical Neighborhood; and

WHEREAS, the CSS is currently working on the principles and expectations for how to better share care between ambulatory care teams across the continuum of roles and processes needed for care coordination beyond the referral process; therefore be it

**RESOLVED, that the Board of Regents establish a collaborative work group for ACP to work with other societies to establish principles and expectations to help improve the coordination of care between hospital care teams and ambulatory care clinicians/care teams to improve the care of patients and the experience of clinicians.**

**Resolution 3-F19. Recommending the Initial Referral Appointment with an Internal Medicine Subspecialist Be Conducted by a Physician**

(Sponsor: Mississippi Chapter)

WHEREAS, as recognized by the American College of Physicians (ACP) Policy Monograph on Nurse Practitioners in Primary Care (1), the number of training programs for advanced practice providers (APPs) and the number of APPs continues to grow, with these APPs finding increasing roles in internal medicine subspecialty practices; and

WHEREAS, as noted in the American College of Gastroenterology (ACG) Practice Toolbox: Adding Advanced Practice Providers to your Practice, it is becoming increasingly common for referral appointments to be conducted by APPs, who "perform history and physical examinations, formulate differential diagnosis and treatment plans" with no involvement of an internal medicine subspecialty physician; and

WHEREAS, the Accreditation Council for Graduate Medical Education requires that an internal medicine residency educational program must include "exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties (2)," making it likely that internal medicine physicians requesting referrals to an internal medicine subspecialist have sufficient clinical experience of the given subspecialty to manage some issues effectively but have reached the limit of their experience; and

WHEREAS, the American Board of Internal Medicine certification examination includes content from all of the internal medicine subspecialties, making it likely that internal medicine physicians requesting referrals to an internal medicine subspecialist have sufficient medical knowledge to manage some issues effectively but have reached the limit of their knowledge; therefore be it

**RESOLVED, that the Board of Regents advocate through existing collaborative relationships that initial referral appointments with internal medicine subspecialty consultants be conducted by a physician, rather than by an advanced practice provider, in order to give the patient an actual higher level of care.**

References:


1. Nurse Practitioners in Primary Care. American College of Physicians Policy Monograph. 2009.
2. Accreditation Council for Graduate Medical Education Program Requirements for Graduate Medical Education in Internal Medicine, effective July 1, 2017.

**Resolution 4-F19. Insuring that ACP Guidelines Consider the Potential Adverse Effects of Polypharmacy**

(Sponsor: BOG Class of 2021)

WHEREAS, polypharmacy is often considered to be five or more medications per patient; and

WHEREAS, polypharmacy may include prescription medications, over-the-counter drugs and supplements that were either never necessary, indicated but not beneficial, or no longer necessary; and

WHEREAS, polypharmacy is a public health problem that may affect as many as two-thirds of adults over the age of 65 years; and

WHEREAS, polypharmacy increases the risk of drug-drug interactions, adverse drug events, preventable hospitalizations, and mortality; and

WHEREAS, polypharmacy increases the risk of non-adherence to medications that are necessary and high-value; and

WHEREAS, polypharmacy is associated with high costs to patients and health care delivery systems; and

WHEREAS, many current clinical guidelines emphasize "step therapy" and escalation of dosage to achieve therapeutic goals, insufficient attention is paid to "step down" therapy to taper or deprescribe medications that were not beneficial or no longer provide benefit; and

WHEREAS, current American College of Physician policies and guidelines recognize polypharmacy as a harm that might be mitigated by implementation of shared decision-making and patient-centered medical homes, current ACP policy does not treat polypharmacy as an outcome for intervention by itself; and

WHEREAS, some ACP guidelines suggest consideration of "deintensifying pharmacologic therapy," there are others that do not address the potential risks associated with polypharmacy; therefore be it

**RESOLVED, that the Board of Regents advocates for and works with stakeholders and guideline developers to insure that ACP guidelines incorporate evidence-based, patient-centered recommendations to consider the potential adverse effects of polypharmacy and reduce the burden of medication overload.**

References:

https://lowninstitute.org/wp-content/uploads/2019/04/medication-overload-lown-web.pdf

Medication Overload: America's Other Drug Problem
lowninstitute.org

Qaseem A, Wilt TJ, Kansagara D, Horwitch C, Barry MJ, Forciea MA; Clinical Guidelines Committee of the American College of Physicians. Hemoglobin A1c Targets for Glycemic Control With Pharmacologic Therapy for Non pregnant Adults With Type 2 Diabetes Mellitus: A Guidance Statement Update From the American College of Physicians. Ann Intern Med. 2018 Apr 17;168(8):569-576. doi: 10.7326/M17-0939. Epub 2018 Mar 6. PMID: 29507945

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medicare_reform_patient_centered_medical_home_2007 (https://www.acponline.org/cgi-bin/policy-library)

acp_response_to_sfc_chronic_care_policies_2015 (https://www.acponline.org/cgi-bin/policy-library)
ACP Policies and Recommendations | Advocacy | ACP
www.acponline.org

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Linsky A, Meterko M, Bokhour BG, Stolzmann K, Simon SR. Deprescribing in the context of multiple providers: understanding patient preferences. Am J Manag Care. 2019 Apr;25(4):192-198. PMID: 30986016

**Resolution 5-F19. Researching and Recognizing Gender Expectations for Female Physicians**

(Sponsor: Colorado Chapter)

WHEREAS, the ACP published policy supporting gender equity in physician compensation in 2018; and

WHEREAS, the ACP works to serve the professional needs of the membership and support healthy lives for physicians; and

WHEREAS, there is anecdotal and published evidence that patients have differing expectations of female versus male physicians, and female patients tend to seek more empathic listening, longer visits, and more communication, especially with female physicians; and

WHEREAS, it has then been proposed that because female physicians are not allotted additional time for patient care, this added burden may increase physician burnout (1); therefore be it

**RESOLVED, that the Board of Regents research gendered expectations of female physicians and its contribution to their work burden and wellness; and be it further**

**RESOLVED, that the Board of Regents propose and advocate for mechanisms to recognize and address the differential clinical burden placed on female physicians by patient expectations.**

1. Linzer, M. & Harwood, E. J GEN INTERN MED (2018) 33: 963. https://doi.org/10.1007/s11606-018-4330-0

**Resolution 6-F19. Developing Guidelines on Treatment of Obesity to Improve Access to Obesity Treatment**

(Sponsor: Council of Resident/Fellow Physicians)

WHEREAS, obesity has been formally recognized as a chronic disease since 2008, and increases risk of developing many chronic diseases [1] including diabetes, hypertension, coronary artery disease, OSA, GERD, and depression [2]. Obesity significantly contributes to increased healthcare expenditures [3], with 50% additional healthcare expenditures required for each patient with BMI >30 [4] compared to lower BMI patients. Currently 40% of the United States population is overweight and 30% obese, with further increase anticipated in the next decade [5]; and

WHEREAS, the American Academy of Family Medicine, American College of Endocrinology, American Heart Association, American College of Cardiology, American College of Surgeons, American Medical Association, and National Institute of Health all support this recognition as a distinct chronic disease [6]; and

WHEREAS, current billing requirements and regulation do not allow physicians to be reimbursed for obesity treatment unless in the context of treating another medical issue [7]. Additionally, at this time Medicare currently only covers limited lifestyle interventions for medical weight loss; and

WHEREAS, obesity is a disease that often affects at risk populations, including rural and urban populations and demonstrates significant racial and ethnic disparities [8]. This increased prevalence, combined with a lack of current payment by CMS and private insurers for obesity treatment, creates significant inequalities in obesity management [9]; and

WHEREAS, obesity treatment through weight management has been shown to provide long lasting weight loss [10], improve outcomes in diabetes [11], and lower the frequency of healthcare utilization [12] and decrease healthcare costs [13]; therefore be it

**RESOLVED, that the Board of Regents develop guidelines on treatment of obesity as a chronic disease and its management; and be it further**

**RESOLVED, that the Board of Regents should advocate for all insurers to cover evidence based treatments for Obesity.**

**References:**


1. Tsai AG, Bessesen DH. Obesity. Ann Intern Med. 2019;170:ITC33–ITC48. doi: 10.7326/AITC201903050
2. Luppino FS, de Wit LM, Bouvy PF, et al. Overweight, Obesity, and Depression: A Systematic Review and Meta-analysis of Longitudinal Studies. Arch Gen Psychiatry. 2010;67(3):220–229. doi:10.1001/archgenpsychiatry.2010.2
3. Maria Lucia Specchia, Maria Assunta Veneziano, Chiara Cadeddu, Anna Maria Ferriero, Agostino Mancuso, Carolina Ianuale, Paolo Parente, Stefano Capri, Walter Ricciardi, Economic impact of adult obesity on health systems: a systematic review, European Journal of Public Health, Volume 25, Issue 2, April 2015, Pages 255–262, https://doi.org/10.1093/eurpub/cku170
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**5.** Obesity and Severe Obesity Forecasts Through 2030 Finkelstein, Eric A. et al. American Journal of Preventive Medicine , Volume 42 , Issue 6 , 563 - 570
6. Jastreboff, A.M.; Kotz, C.M.; Kahan, S.; Kelly, A.S.; Heymsfield, S.B. Obesity as a disease: The Obesity Society 2018 position statement. Obesity 2019, 27, 7–9
7. "Obesity Coding." *AACE Obesity Resource Center*, American Academy of Clinical Endocrinologists, obesity.aace.com/files/obesity/toolkit/billing_codes.pdf.
8. Krishnaswami A, Sidney S, Sorel M, Smith W, Ashok R. Temporal Changes in Health Care Utilization among Participants of a Medically Supervised Weight Management Program. Perm J. 2019;23:18-134. doi:10.7812/TPP/18-134
9. Trust for America's Health. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. Washington, D.C.: Trust for America's Health, 2008. (accessed May 2019)
10. Apolzan JW, Venditti EM, Edelstein SL, Knowler WC, Dabelea D, Boyko EJ, et al. Long-Term Weight Loss With Metformin or Lifestyle Intervention in the Diabetes Prevention Program Outcomes Study. Ann Intern Med. [Epub ahead of print 23 April 2019] doi: 10.7326/M18-1605
11. Goel A. Intensive weight management in primary care improved weight loss and remission of type 2 diabetes. Ann Intern Med. 2018;168:JC30. doi: 10.7326/ACPJC-2018-168-6-030
12. Petersen R, Pan L, Blanck HM. Racial and Ethnic Disparities in Adult Obesity in the United States: CDC's Tracking to Inform State and Local Action. *Prev Chronic Dis*. 2019;16:E46. Published 2019 Apr 11. doi:10.5888/pcd16.180579
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**Resolution 7-F19. Engaging Stakeholders to Reduce Violence and Teach Conflict Resolution in U.S. Schools**

(Sponsor: New York Chapter)

WHEREAS, one of ACP's stated goals includes, "To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members"; and

WHEREAS**,** violent themes and actions are increasingly a part of everyday life in the U.S.; and

WHEREAS**,** physicians are called to address the physical and emotional results of violence with individual patients; and

WHEREAS**,** violent themes and actions are negative components associated with social determinants of health; therefore be it

**RESOLVED, that the Board of Regents engage appropriate stakeholders to deescalate violence and teach conflict resolution in all middle and high schools in the U.S.; and be it further**

**RESOLVED, that the Board of Regents work with appropriate stakeholders to reduce the number of violent messages and acts in all forms of media, video games, movies, etc. and instead increase the message of peaceful conflict resolution and mutual respect.**

**Resolution 8-F19. Formulating Policy on Worker Excessive Heat Protection**

(Sponsor: Virginia Chapter; Co-sponsors: California II, California III, Florida, and New Mexico Chapters)

WHEREAS, ACP policy on Strengthening the Public Health Infrastructure supports "reducing illnesses relating to environmental pollution, global climate change, and other environmental risks" (1); and

WHEREAS, the Fourth National Climate Assessment identifies outdoor workers, who often labor in extreme heat without protections, as a population that "experience(s) increased climate risks due to a combination of exposure and sensitivity" (2); and

WHEREAS, according to the Bureau of Labor Statistics (BLS) annual Survey of Occupational Injuries and Illnesses, "exposure to excessive environmental heat stress killed 783 U.S. workers and seriously injured 69,374 workers from 1992 through 2016" (3); and

WHEREAS, according to Yale Environment 360, "Global warming is resulting in more frequent days of extreme heat, and record-breaking summers are now becoming the norm. 2017 was the second-hottest year on record, surpassed only by 2016 (4); and

WHEREAS, an ACP position paper on *Climate Change and Health* points out that "many European countries …launch(ed) public health interventions to minimize heat-related health problems in a region or population" (5); and

WHEREAS, Public Citizen and other organizations are petitioning the Occupational Safety and Health Administration (OSHA) to establish a standard for occupational heat exposure, which includes protections such as mandatory rest breaks, and access to shade and to hydration (3); and

WHEREAS, ACP has no existing policy on excessive heat protections; therefore be it

**RESOLVED, that the Board of Regents studies data on illnesses caused by excessive heat exposure and formulate a policy on worker excessive heat protection.**


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3. https://www.citizen.org/sites/default/files/180717_petition_to_osha_on_heat_stress-signed_final_0.pdf
4. https://e360.yale.edu/digest/its-official-2017-was-the-second-hottest-year-on-record
5. https://annals.org/aim/fullarticle/2513976/climate-change-health-position-paper-american-college-physicians?resultClick=3

**Resolution 9-F19. Endorsing the Federation of State Medical Boards April 2018 Report on Stem Cell Therapies**

(Sponsor: New York Chapter)

WHEREAS, one of ACP's stated goals includes, "To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members"; and

WHEREAS**,** stem cell and regenerative therapies offer opportunities for advancement in the practice of medicine; and

WHEREAS**,** there may be evidence for improved patient outcomes through health innovation and technology; and

WHEREAS, the FSMB April 2018 report states "concern about a growing number of providers and clinics in the United States that are undermining the field. Such providers and clinics have been known to apply, prescribe or recommend therapies inappropriately, over-promise without sufficient data to support claims, and exploit patients who are often in desperate circumstances and willing to try any proposed therapy as a last resort, even if there is an excessive cost or scant evidence of efficacy"; therefore be it

**RESOLVED, that the Board of Regents endorses the Federation of State Medical Boards Report (April 2018) (1) evaluating the prevalence, promotional practices and incidence of patient harm related to regenerative and stem cell therapies in the U.S.; and be it further**

**RESOLVED, that the Board of Regents refer to the Federation of State Medical Boards Report (April 2018) to educate physicians and the public concerning unregulated clinics and Stem Cell Tourism.**

**Reference:**

(1) Federation of State Medical Boards Regenerative and Stem Cell Therapy Practices
Report and Recommendation of the Workgroup to Study Regenerative and Stem Cell Therapy Practices - Adopted as policy by the FSMB April 2018
https://www.fsmb.org/siteassets/advocacy/policies/fsmb-stem-cell-workgroup-report.pdf

**Resolution 10-F19. Optimizing Data Coming from Pharmacy Benefit Manager Systems to Improve Patient Prescription Adherence**

(Sponsor: Michigan Chapter)

WHEREAS, patient adherence with prescription drug access and usage is important to all physicians; especially primary care internists (PCPs) who prescribe multiple medications and track patients over time as they move within the health care system; and

WHEREAS, pharmacy benefit manager systems (PBMs) record all types of patient information, for example: patient demographics, payor name and benefit package as well as formularies, prices, dates of prescriptions and prescribers names; and

WHEREAS, most PCPs now participate in E-prescribing systems such that prescribed medications interface with electronic medical records and pharmacy software systems that include patient demographics and other patient/provider pharmacy utilization history; and

WHEREAS, PBMs and pharmacies regularly use marketing tools to prompt PCPs regarding when medications are due for refill and other information regarding safety concerns such as drug interactions or allergies; therefore be it

**RESOLVED, that the Board of Regents work with PBMs such that the information shared between physicians and PBMs be clinically meaningful and prioritized to include: Pricing information to include current formulary pricing per drug such that physicians become familiar with costs for improved utilization and patient education and to enhance patient adherence and affordability; and be it further**

**RESOLVED, that the Board of Regents work with PBMs such that data is shared between the PBM or the pharmacy and the prescribing physician regarding patient access: date of pick up or delivery of a prescription to the patient or patient's representative.**

**Resolution 11-F19. Addressing Generic Medication Recalls**

(Sponsor: New York Chapter)

WHEREAS, one of ACP's stated goals includes, "To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members"; and

WHEREAS**,** there have been many generic medication recalls in the United States because of poor manufacturing processes and lack of oversight by the Federal Drug Administration; and

WHEREAS**,** these recalls have resulted in medication shortages and higher costs to patients; therefore be it

**RESOLVED, that the Board of Regents petition CMS for reimbursement of brand medications at the lowest copayment tier so that patients can be effectively treated until the generic drug recall and shortage is resolved.**

**Resolution 12-F19. Opposing MedPac's Potential Plan to Limit the Ability of Medicare Patients to Select a Traditional Fee for Service (FSS) Option**

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians has a long history of advising our national advisory committees and Congress on aspects of medical policy which affect medical care to patients and the provision of this care by physicians; and

WHEREAS, it is a primary goal of the American College of Physicians to advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members; and

WHEREAS, MedPac in its April 4, 2019 meeting reiterated its "long standing intent in moving Medicare away from the traditional FFS model"; and

WHEREAS, not only did MedPac reiterate this intention to work towards eliminating the ability for Medicare patients to choose FFS care, but it specifically presented four possible scenarios for how this might be accomplished to variable degrees; and

WHEREAS, all of these scenarios are centered around the concept that Medicare Advantage (MA) and Accountable Care Organization (ACO) models should be the replacement for FFS care options for Medicare patients; and

WHEREAS, MA and ACO models have not (as even admitted by MedPac in their presentation) been more than "modestly" successful in their goals of reducing costs; and

WHEREAS, MedPac in its presentation only barely discussed the issue of quality of medical care and the way in which older patients who are used to FFS care might find difficultly adjusting to completely new models of medical care; therefore be it

**RESOLVED, that the Board of Regents oppose MedPac's determined intent to do away with the current FFS option for Medicare patients; and be it further**

**RESOLVED, that the Board of Regents call upon MedPac to provide strong evidence that eliminating the usual option for FFS care will both significantly save money while also maintain the current level of medical care provided to Medicare recipients (including factoring in the difficulty Medicare patients may have in suddenly adjusting to a completely new medical care model).**

**Resolution 13-F19. Advocating for CMS to Ease the Burdens of Risk Adjusted Factor Scoring on Physicians Practicing in Accountable Care Organizations**

(Sponsor: North Carolina Chapter)

WHEREAS, novel payment models such as accountable care organizations are shifting financial risk to clinicians; and

WHEREAS, Hierarchical Condition Categories (HCC) are a risk-adjustment tool derived from ICD codes within retrospective claims data originally intended for use by Medicare Advantage Plans; and

WHEREAS, Risk Adjusted Factor scores are the sum of a patient's reported HCCs and are used to predict expected annual expenditure; and

WHEREAS, it is important that the medical record accurately capture severity of illness and risk; and

WHEREAS, current HCC and RAF scores are flawed and only predict 12% of cost variation between individual beneficiaries[1]; and

WHEREAS, an unintended consequence has occurred where the highest possible RAF score is now desired in order to maximize the Medicare shared savings a practice will receive; and

WHEREAS, physicians are now expected by administrators to spend time during each clinic visit hunting for the highest HCC code; and

WHEREAS, this system can encourage implicit fraud by charging codes that are not medically necessary (e.g., thoracic aortic atherosclerosis), hijack the visit agenda from the patient, and contribute to physician burnout; and

WHEREAS, these changes to the practice of medicine are made with little evidence behind how they affect patient outcomes, patient experience, or provider experience; therefore be it

**RESOLVED, that the Board of Regents lobby CMS to develop policies that minimize the burdens that RAF scoring has placed on clinicians and maximize the accuracy of risk adjustment scoring by leveraging automated data collection technologies in the EHR that capture and store clinical data to accurately account for severity, comorbidities, sociodemographic and other risk factors contributing to patient health outcomes without relying on clinicians and clinic staff to re-enter this data at each clinical encounter; and be it further**

**RESOLVED, that the Board of Regents should call for more research on how value-based medicine is affecting patient outcomes, cost, the patient experience, and the provider experience.**

**Reference**:

1. Pope GC, Kautter J, Ingber MJ, Freeman S, Sekar R, Newhart C. *Evaluation of the CMS-HCC Risk Adjustment Model: Final Report*. RTI International for the Centers for Medicare & Medicaid Services; March 2011. https://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf

**Resolution 14-F19. Reviewing Literature on the Impact of Informal Caregiving on Healthcare Outcomes**

(Sponsor: BOG Class of 2021; Co-sponsor: BOG Class of 2022)

WHEREAS, caregiving is a major component of a social support network and is, therefore, a social determinant of care and affects health inequalities and outcomes[1]; and

WHEREAS, the shift of care burden to home-based settings falls disproportionately to women and minorities[2] and thus contributes to disparities in care; and

WHEREAS, shifts in healthcare towards outpatient and home-based settings increases the demand for caregiving from informal care providers including a patient's family and friends; and

WHEREAS, there is no consistent and accessible caregiving guidance available for informal caregivers; and

WHEREAS, access to skilled, knowledgeable, and competent caregivers at home impacts patient safety, including adherence to medical recommendations and treatments, recognition of worsening health status, and risk factors for medically complex, frail and functionally impaired individuals; and

WHEREAS, informal caregivers often experience periods of social isolation and loneliness, leading to a deterioration in a caregivers emotional and physical well-being[3] [4] [5]; and

WHEREAS, caregivers living with individuals with cognitive or physical disorders are at particularly high-risk of experiencing negative outcomes as a consequence of caregiving responsibilities; and

WHEREAS, an estimated 16.1 million caregivers in the United States provide unpaid caregiving to someone with dementia; and

WHEREAS, internists oversee and manage individuals with multiple medical problems, cognitive and physical function decline, and create comprehensive treatment plans overseen and implemented by informal caregivers; therefore be it

**RESOLVED, that the Board of Regents review the literature regarding family and informal home-based caregiving as it impacts health outcomes, and summarize the evidence regarding caregiver education and training, well-being, and the impact of findings on patient outcomes; and be it further**

**RESOLVED, that the Board of Regents develop a strategy to inform and educate internists on the importance of and best ways to support family and informal caregivers, including certification programs and education; and be it further**

**RESOLVED, that the Board of Regents develop guidance, best practices and tools for physicians to use in consultation with patients and their caregivers that aligns with patient and caregiver needs.**

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[1] Daniel H, Bornstein SS, Kane GC. *Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper*; Ann Intern Med 2018; 168: 577-578.

[2] Reinhard, SC, Levine C, and Samis S. *Home Alone: Family Caregivers Providing Complex Chronic Care.* AARP Public Policy Institute and United Hospital Fund, 2012.

[3] Adelman R et al. *Caregiver Burden: A Clinical Review*. JAMA 2014, Mar 12; 311:1052-60.

[4] *Caregiving in the US*. AARP 2015 Research Report.

[5] http://central.capc.org/eco_player.php?id=509&cid=335&pid=335&token=1ee5b19ca25f4c0916fac7a11c4aea1b

**Resolution 15-F19. Developing Ethical Guidance on Medical Professional Online Endorsements as Social Media Influencers**

(Sponsor: Council of Resident/Fellow Physicians)

WHEREAS, the advent of social media has allowed physicians and medical students to reach a wide audience that spans well beyond those encountered for direct patient interaction; and

WHEREAS, many professional organizations such as the ACP and AMA have offered guidance on professionalism in the world of social media; [1,2,3] and

WHEREAS, pharmaceutical and health product companies had dramatically expanded marketing in recent years including using social media as a way to target consumers; [4] and

WHEREAS, a recent trend in some social media platforms is to use popular users as advertisers for various products (sometimes called "Influencers"); and

WHEREAS, social media has blurred the lines between personal story and advertisement; and

WHEREAS, physicians, health professionals, and now medical students have actively engaged in advertising for products – both health and non-health related – knowingly or unknowingly using their credentials as support; [5,6,7] and

WHEREAS, there is increasing concern about the deceptive nature of advertisements for health products online which confound a patient's ability to discern advertisement from endorsements; and

WHEREAS, the Federal Trade Commission supports truth in advertising and suggests that bloggers and social media users should be disclosing when they are being paid or otherwise compensated for supporting products however currently does not enforce these guidelines; [8] and

WHEREAS, although ACP has policy on social media and online professionalism, the College does not provide guidance on the topic of social media influencers/advertisers nor does it address engagement in deceptive advertising on these platforms; therefore be it

**RESOLVED, that the Board of Regents develop ethical guidance on medical students and physicians advertising/endorsing products online without clearly stating they are paid/compensated for their posts/endorsements; and be it further**

**RESOLVED, that the Board of Regents advocate that physicians and medical students using blogging and social media for financial gains have clearly stated conflicts of interests to help patients/consumers discern claims that are financially motivated from statements that are evidenced based; and be it further**

**RESOLVED, that the Board of Regents consider inclusion of these recommendations in future updates to its *Ethics Manual*.**

**References**:

1. Farnan JM, Snyder sulmasy L, Worster BK, et al. Online medical professionalism: patient and public relationships: policy statement from the American College of Physicians and the Federation of State Medical Boards. Ann Intern Med. 2013;158(8):620-7.

2. Professionalism in the Use of Social Media - Code of Medical Ethics Opinion 2.3.2. American Medical Association. https://www.ama-assn.org/delivering-care/ethics/professionalism-use-social-media. Accessed April 22, 2019.
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**Resolution 16-F19. Opposing 'Conscience Clauses' as Discriminatory**

(Sponsor: Council of Resident/Fellow Physicians)

WHEREAS, the Department of Health & Human Services of the United States Government has created a new division named the "Conscience and Religious Freedom Division" which recognizes conscience protections for healthcare providers who refuse to perform, accommodate, or assist with certain health care services on religious or moral grounds (1); and

WHEREAS, specific states have also enacted laws allowing for physicians to refuse to treat patients based on a sincerely held religious belief, protecting them from state licensing board disciplinary actions (1,2); and

WHEREAS, it is known that religious refusal laws disproportionately affect women, women of color, and members of the LGBTQ+ community (1); and

WHEREAS, the American College of Physicians (ACP) has policy stating that "All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high-quality health care."[3]; and

WHEREAS, ACP has recognized the role of governments in regulating the physician-patient relationship but also recognized governments should not interfere with the practice of evidenced-based medicine (4); and

WHEREAS, ACP notes that state medical boards regulate the practice of medicine and grant privileges to practice, and "ensure patients that licensed physicians meet professional standards of care, ethics, and professionalism that, if not met, could compromise patient safety"(4); and

WHEREAS, the American Medical Association (AMA) has stated that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination" (5); and

WHEREAS, the current ACP *Ethics Manual* states, "Although the physician must address the patient's concerns, he or she is not required to violate fundamental personal values, standards of medical care or ethical practice, or the law. If the physician cannot carry out the patient's wishes after seriously attempting to resolve differences, the physician should discuss with the patient his or her option to seek care from another physician" (6); therefore be it

**RESOLVED, that the Board of Regents oppose any legislation or directive by a state or federal government which excuses clinicians from the duty to provide basic medical care including (but not limited to): emergency services, primary care services, education on all potential evaluation and treatment options for their suspected disease, and appropriate referral to another provider based on "conscience clauses", a form of discrimination which allows clinicians to refuse services to a patient based on their race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion; and be it further**

**RESOLVED, that the Board of Regents work with other professional organizations such as the American Medical Association, American Academy of Family Physicians, and American College of**

**Obstetricians and Gynecologists to combat the growing effort by state and federal governments to allow for damaging conscience refusals.**

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