

Spring 2024 BOG Resolutions

Resolution 1-S24. Developing Educational Programs to Train Internal Medicine Physicians in the Care of Sexual and Gender Minority Persons

(Sponsor: Vermont Chapter; Co-sponsors: Japan, Maryland, Massachusetts, Minnesota, New York, Oregon, and South Dakota Chapters)

Resolution 2-S24. Training the Physician Workforce on Battling Misinformation

(Sponsor: Council of Early Career Physicians)

Resolution 3-S24. Updating ACP Policy on ABIM MOC Process

(Sponsor: Kansas Chapter; Co-sponsors: District of Columbia, Nebraska, and New York Chapters)

Resolution 4-S24. Improving the Experience of International Medical Students (IMS) and International Medical Graduates (IMG) Seeking Clinical Observerships and Letters of Recommendation in the United States of America and Canada

(Sponsor: Class of 2027; Co-sponsors: Arizona, Delaware, Iowa, Minnesota, New Jersey, Ohio, South Dakota, Vermont and Western Pennsylvania Chapters; Council of Early Career Physicians)

Resolution 5-S24. Advocating for Continued Coverage and Physician Discretion of Colon Cancer Screening

(Sponsor: California Northern Chapter; Co-sponsors: Class of 2025 and Council of Early Career Physicians)

Resolution 6-S24. Advocating for Vaccination Incentives

(Sponsor: Colorado Chapter; Co-sponsors: Southern California II, District of Columbia, Kansas and Virginia Chapters)

Resolution 7-S24. Requesting that CMS Reimburse for Shingrix Vaccinations Administered in Physicians' Offices

(Sponsor: District of Columbia Chapter)

Resolution 8-S24. Approaching Physician Suicide as a Problem Requiring Healthcare System Change

(Sponsor: Maryland Chapter; Co-sponsor: Council of Early Career Physicians [CECP] and New York Chapter)

Resolution 9-S24. Acknowledging the Individual Right to Decisional Privacy

[SPONSOR ACCEPTED AS REAFFIRMATION—NO DEBATE]

(Sponsor: Minnesota Chapter)

Resolution 10-S24. Updating ACP Policy to Support Physicians Pursuing Collective Bargaining and Unionization

(Sponsor: Oregon Chapter; Co-sponsors: Class of 2025; CECP; Connecticut, Hawaii, Illinois, Minnesota, and New York Chapters)

Resolution 11-S24. Developing Policy to Address the Creation of State-level Prescription Drug Affordability Boards

(Sponsor: Illinois Chapter)

Resolution 12-S24. Streamlining Longitudinal, Uninterrupted Access to Critical Health Services that Support Daily Activities and Safe, Independent Living for Patients with Neurodegenerative Diseases

(Sponsor: Pennsylvania Chapter)

Resolution 13-S24. Unifying Inclusive United States Graduate Medical Education (GME) Stakeholders to Accelerate a More Effective Action Strategy to Address Primary Care Physician Shortages and Misdistribution

(Sponsor: Pennsylvania Chapter)

Resolution 14-S24. Reducing the Risk of Medical Workplace Violence

(Sponsor: District of Columbia Chapter)

Resolution 15-S24. Requesting that ACP Strengthen Associated Policy and Advocate for NASEM-Recommended Processes around the Development of the Dietary Guidelines for Americans

(Sponsor: Alaska Chapter)

Resolution 16-S24. Educating the Public about the Appropriate Identification of Healthcare Professionals in Clinical Settings

(Sponsor: New York Chapter; Co-sponsors: BOG Class of 2025; CECP; Illinois Southern, Montana, Southern California II, and Pennsylvania-Eastern Chapters)

Resolution 17-S24. Promoting and Developing Initiatives Related to Narrative Medicine

(Sponsor: California Southern III Chapter; Co-sponsors: Class of 2025; California Northern, California Southern I, California Southern II, Illinois Southern, Japan, Maine, New York, Tennessee, and Wisconsin Chapters)

Resolution 18-S24. Supporting our Military Membership at the American College of Physicians by Developing a Special Dues Category for Active Members of the U.S. Armed Forces

(Sponsor: Arizona Chapter; Co-sponsors: Class of 2027; Georgia and Ohio Chapters)

Resolution 19-S24. Applying Chapter Dues for Members, FACPs and MACPs Rejoining ACP

(Sponsor: Michigan Chapter; Co-sponsor: Class of 2026 and Wisconsin Chapter)

Resolution 20-S24. Addressing the Environmental Burden Associated with American College of Physicians Publications

(Sponsor: Vermont Chapter; Co-sponsors: Japan, South Dakota, Utah, and Washington Chapters)

Resolution 21-S24. Creating Policy to Guide the Selection of Future ACP Annual Scientific and BOG Meetings

(Sponsor: New York Chapter; Co-sponsor: New Mexico Chapter)

Resolution 1-S24. Developing Educational Programs to Train Internal Medicine Physicians in the Care of Sexual and Gender Minority Persons

(Sponsor: Vermont Chapter; Co-sponsors: Japan, Maryland, Massachusetts, Minnesota, New York, Oregon, and South Dakota Chapters)

WHEREAS, the American College of Physicians has recognized the need for culturally and clinically competent care for sexual and gender minority (SGM) patients, and has called for undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME) programs to incorporate SGM health issues into their curriculum; and

WHEREAS, over 1.6 million adults (ages 18 and older) and youth (ages 13 to 17) identify as transgender in the United States, or 0.6% of those ages 13 and older; and

WHEREAS, a systematic literature review of all peer-reviewed articles published in English between 1991 and June 2017 revealed extensive evidence demonstrating that gender transition improves the overall well-being of transgender people; and

WHEREAS, transgender persons have a higher prevalence of poor general health, more days per month of poor physical and mental health, and a higher prevalence of myocardial infarction; and

WHEREAS, 39% of transgender persons in the U.S. report experiencing serious psychological distress, compared with only 5% of the U.S. population and 40% of transgender persons report having attempted suicide in their lifetime—nearly nine times the attempted suicide rate in the U.S. population (4.6%); and

WHEREAS, one-third (33%) of transgender persons who have seen a health care provider in the past year report having at least one negative healthcare experience, such as verbal harassment, refusal of treatment, or having to educate the health care provider about transgender people to receive appropriate care and 23% of transgender persons report that they did not see a doctor when they needed to because of fear of being mistreated as a transgender person; and

WHEREAS, there are numerous barriers to health care for transgender persons with the largest barrier reported by transgender persons being the paucity of knowledgeable physicians and advance practice providers; and

WHEREAS, trainees report less comfort with providing hormone care for transgender persons than providing the same hormone care to other patients and physicians perceive barriers to the care of transgender patients and report that clinical management of transgender patients is complicated by a lack of knowledge; therefore be it

RESOLVED, that the Board of Regents recognize the importance of education for all internal medicine physicians regarding the topics of sexual and gender minority health and the provision of culturally and clinically competent gender affirming care at all levels of medical training including undergraduate and graduate medical education; and be it further

RESOLVED, that the Board of Regents, along with other stakeholders, develop continuing medical education programs to educate internal medicine physicians about sexual and gender minority health and inclusive of training regarding the provision of culturally and clinically competent gender affirming care.

References:

1. Hilary Daniel, BS and Renee Butkus, BA. Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians. *Ann Intern Med.* 21 July 2015. <https://doi.org/10.7326/M14-2482>
2. Jody L. Herman Andrew R. Flores Kathryn K. O'Neill, How Many Adults and Youth Identify as Transgender in the United States? UCLA School of Law Williams Institute. June 2022
3. What We Know Project, Cornell University, "What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?" (online literature review), 2018.
4. Ilan H Meyer, Taylor N T Brown, Jody L Herman, Sari L Reisner, Walter O Bockting. Demographic Characteristics and Health Status of Transgender Adults in Select U.S. Regions: Behavioral Risk Factor Surveillance System, 2014. *Am J Public Health.* 2017 Apr;107(4):582-589. doi: 10.2105/AJPH.2016.303648. Epub 2017 Feb 16.
5. The Report of the 2015 U.S. Transgender Survey by: Sandy E. James Jody L. Herman Susan Rankin Mara Keisling Lisa Mottet Ma'ayan Anafi December 2016. <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>
6. Joshua D. Safer, Eli Coleman, Jamie Feldman, Robert Garofalo, Wylie Hembree, Asa Radix, and Jae Sevelius. Barriers to Health Care for Transgender Individuals. *Curr Opin Endocrinol Diabetes Obes.* 2016 Apr 1; 23(2): 168–171. doi: 10.1097/MED.0000000000000227
7. John W Snelgrove, Amanda M Jasudavicius, Bradley W Rowe, Evan M Head, and Greta R Bauer. "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Serv Res.* 2012; 12: 110.
Published online 2012 May 4. doi: [10.1186/1472-6963-12-110](https://doi.org/10.1186/1472-6963-12-110) PMCID: PMC3464167 PMID: [22559234](https://pubmed.ncbi.nlm.nih.gov/22559234/)

Resolution 2-S24. Training the Physician Workforce on Battling Misinformation

(Sponsor: Council of Early Career Physicians)

WHEREAS, ACP is committed to stopping and preventing the spread of disinformation and misinformation; and

WHEREAS, ACP's mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine; and

WHEREAS, ACP's vision is to be recognized globally as the leader in promoting quality patient care, advocacy, education and career fulfillment in internal medicine and its subspecialties (1); and

WHEREAS, ACP serves on the advisory committee for the Council of Medical Specialty Societies (CMSS), National Academy of Medicine (NAM) and World Health Organization's (WHO) initiative to Identify Credible Sources of Health Information that could be used by social media companies (2); and

WHEREAS, *Annals of Internal Medicine* publishes original, evidence-based scientific content for internal medicine physicians; and

WHEREAS, ACP has created a section on its website dedicated to Efforts to Fight Medical Misinformation and Disinformation about the spread of both disinformation and misinformation on social media, public news channels and other digital channels (2); and

WHEREAS, the ACP called for action to prioritize and coordinate efforts to address health related dis- and misinformation through a variety of interventions. Further, the ACP called to elevate evidence-based, credible sources (3); therefore be it

RESOLVED, that the Board of Regents build upon the existing resources to train individual physicians or teams on impactful best practices for combating dis- and misinformation at the patient and community levels; and be it further

RESOLVED, that the Board of Regents create a guide to available misinformation resources, including a toolkit for use at the chapter level and for local education and meetings.

References:

1. About ACP: Mission, Vision, Goals & Core Values. <https://www.acponline.org/about-acp/who-we-are>
2. ACP's Efforts to Fight Medical Misinformation and Disinformation. <https://www.acponline.org/about-acp/who-we-are/acps-efforts-to-fight-medical-misinformation-and-disinformation>
3. Crowley R, Mathew S, Hilden D. (2023, July 18) Modernizing the United States' Public Health Infrastructure: A Position Paper From the American College of Physicians. *Ann of Int Med*. <https://www.acpjournals.org/doi/10.7326/M23-0670>

Resolution 3-S24. Updating ACP Policy on ABIM MOC Process

(Sponsor: Kansas Chapter; Co-sponsors: District of Columbia, Nebraska, and New York Chapters)

WHEREAS, the current ACP policy states that maintenance of certification (MOC) should not be the sole determinant for licensure (1); and

WHEREAS, despite current ACP policy, many physicians are still being faced with hospitals, insurance companies, and state medical boards mandating MOC as a condition of licensure; and

WHEREAS, this negatively affects their ability to practice medicine and provide access of care to patients; and

WHEREAS, physicians are faced with multiple administrative burdens that detract from clinical activity and emotional wellbeing; and

WHEREAS, MOC requirements involve additional time and expense which lead to increased burnout at a time when U.S. physician shortages are increasing; and

WHEREAS, many subspecialty physicians must maintain multiple certifications, further exacerbating time constraints; and

WHEREAS, there has been demonstrable and widespread physician dissatisfaction with the MOC process (2, 3, 4, 5, 6); and

WHEREAS, the MOC process is not a validated assessment of physician knowledge; and

WHEREAS, strong evidence does not exist to substantiate that MOC leads to better quality outcomes; and

WHEREAS, nothing in this resolution is to devalue the concept of lifelong learning, initial certification, or maintaining quality and appropriate care; and

WHEREAS, the goal of maintenance of certification should be lifelong learning and not lifelong testing; and

WHEREAS, an alternative certifying board (NBPAS) accepted by many national and international accrediting bodies is based on CME and does not require lifelong testing or arbitrary MOC criteria (7); therefore be it

RESOLVED, that the Board of Regents update ACP policy to advocate for an individualized, learner centered ABIM maintenance of certification process based primarily on CME completion without the need for additional testing, assessments, or other burdensome requirements.

References:

1. Updating Policy on MOC and Licensure Requirements (Spring 2018)
<https://services.acponline.org/resolutions/ACPMModules/PrintSingleResolution.aspx?ResolutionID=1135>
2. <https://blogs.jwatch.org/hiv-id-observations/index.php/eternity-recertification-in-medicine-some-thoughts-about-the-tests-we-take/2023/09/08/> accessed on September 29, 2023
3. <https://www.kevinmd.com/2023/08/we-must-protest-our-moral-outrage.html> accessed on September 29, 2023

4. Uprety D, West HJ. Maintenance of Certification (MOC)—Benefit vs Burden. *JAMA*. Published online September 22, 2023. doi:10.1001/jama.2023.17056
5. <https://www.tctmd.com/news/cardiologists-anger-flares-anew-over-abim-maintenance-certification> accessed on September 29, 2023
6. <https://www.change.org/p/eliminate-abims-moc-requirement> accessed on September 29, 2023
7. <https://nbpas.org/pages/nbpas-acceptance> accessed on September 29, 2023

Resolution 4-S24. Improving the Experience of International Medical Students (IMS) and International Medical Graduates (IMG) Seeking Clinical Observerships and Letters of Recommendation in the United States of America and Canada

(Sponsor: Class of 2027; Co-sponsors: Arizona, Delaware, Iowa, Minnesota, New Jersey, Ohio, South Dakota, Vermont and Western Pennsylvania Chapters; Council of Early Career Physicians)

WHEREAS; the “ACP aims to connect, support, and inspire internal medicine physicians worldwide by meeting their unique needs through educational engagements, and rich and mutually beneficial collaborations with other organizations across the globe on a variety of programs;” and

WHEREAS, ACP strives to support internal medicine physicians practicing in the United States and across the world; and

WHEREAS, 39.8% of practicing Internal Medicine physicians in the United States are international medical graduates (1) ; and

WHEREAS, the current U.S. Physician shortage is projected to worsen over the next several years (2,3) and makes the availability of qualified and trained international medical graduates an issue of major need that has to be addressed; and

WHEREAS, the recent revision in the reporting of USMLE Step 1 results to pass/fail makes it difficult to assess the competency of candidates for residency programs in the absence of valid documentation of clinical and research work in United States; and

WHEREAS, there is increasing anecdotal reports of fraudulent documentation of such clinical experience for eligible candidates by physicians in the U.S.; and

WHEREAS, international medical graduates are being exploited in view of the lack of a fair, transparent and credible system for ascertaining the veracity of documentation of the clinical and research experience of International Medical Graduates (IMG); therefore be it

RESOLVED, that the Board of Regents, with other partners, develops a standard for letters of recommendations and clinical observerships in the United States and Canada; and be it further

RESOLVED, that the Board of Regents condemns the exploitative practice of for-profit letter of recommendations and observerships; and be it further

RESOLVED, that the Board of Regents further studies the problem and works with ACGME, AAIM, APDIM and other partners to develop a transparent, ethical and fair system to enhance IMS and IMG medical training and incorporation into the U.S. healthcare workforce.

References:

1. Physician Specialty Data Report. AAMC.org
2. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. AAMC report 2021. Washington DC.
3. American College of Physicians Senate Committee on the Judiciary, Subcommittee on Immigration, Citizenship and Border Security Hearing on [“Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce”](#) September 14, 2022

Resolution 5-S24. Advocating for Continued Coverage and Physician Discretion of Colon Cancer Screening

(Sponsor: California Northern Chapter; Co-sponsors: Class of 2025 and Council of Early Career Physicians)

WHEREAS, the age of colon cancer in average risk patients is beginning to affect younger and younger patients (1); and

WHEREAS, in the past the ACG has recommended screening beginning at age 45 for those of African-American descent (2); and

WHEREAS, recent changes were made such that the USPSTF, ACG, American Cancer Society, and American Society of Colon and Rectal Surgeons all recommend initial screening for colon cancer at age 45 (3-6); and

WHEREAS, the ACP has recently recommended no change in colon cancer screening, whether by colonoscopy or FIT, for average risk patients (remaining at age 50); and

WHEREAS, the public may be unclear as to when to begin screening; and

WHEREAS, insurance companies may be inclined to deny coverage of colonoscopy screenings at earlier ages, especially affecting vulnerable populations who may be underinsured; therefore be it

RESOLVED, that the Board of Regents advocates for continued insurance coverage of colon cancer screening at whatever age a physician considers appropriate based on individual patient risk.

References:

- 1) National Cancer Institute. Why is colon cancer rising among young adults. [cancer.gov](https://www.cancer.gov) 5 November 2020
- 2) Rex DK, et al ACG Clinical Guideline: Colorectal Cancer Screening. *Am J Gastroenterol* 2009;104:739–750
- 3) Davidson KW, et al. (US Preventive Services Task Force,)Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2021;325(19):1965.
- 4) Shaukat A, et al. ACG Clinical Guidelines: Colorectal Cancer Screening 2021.*Am J Gastroenterol*. 2021;116(3):458.
- 5) Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society <https://onlinelibrary.wiley.com/doi/abs/10.3322/caac.21457>
- 6) [fasces.org](https://www.fasces.org)

Resolution 6-S24. Advocating for Vaccination Incentives

(Sponsor: Colorado Chapter; Co-sponsors: Southern California II, District of Columbia, Kansas and Virginia Chapters)

WHEREAS, the American College of Physicians supports vaccinations as an effective preventive medicine strategy; and

WHEREAS, evidence-based vaccines are a critical tool in preventing the spread of infectious diseases including COVID-19 (1); and

WHEREAS, widespread vaccination is necessary to achieve community immunity; and

WHEREAS, insurance companies have a vested interest in promoting the health and well-being of their members and reducing the associated costs; and

WHEREAS, offering incentives for vaccination can encourage individuals to get vaccinated and help to increase vaccination rates; and

WHEREAS, vaccinations have been shown to significantly reduce healthcare costs by preventing and controlling the spread of infectious diseases (2,3,4); and

WHEREAS, unvaccinated patients are more likely to be admitted to the hospital and thus increasing costs and also strain medical staffs (5,6); therefore be it

RESOLVED, that the Board of Regents will partner with other medical specialty organizations to advocate for insurance companies including Medicare and Medicaid, to reduce their premiums or offer some other financial incentive to those members who are vaccinated according to Advisory Committee on Immunization Practices (ACIP) recommendations.

References:

1. ACP policy: "What Is the Antibody Response and Role in Conferring Natural Immunity After SARS-CoV-2 Infection? Rapid, Living Practice Points From the American College of Physicians (Version 2)" <https://www.acpjournals.org/doi/10.7326/M21-3272> which states "Currently, vaccination is the best clinical recommendation for preventing infection, reinfection, and serious illness from SARS-CoV-2 and its variants."
2. Zhou F, Shefer A, Wenger J, Messonnier M, Wang LY, Lopez A, et al. Economic Evaluation of the Routine Childhood Immunization Program in the United States, 2009. *Pediatrics*. 2014;133(4):577-585. doi:10.1542/peds.2013-0698.
3. Molinari N-AM, Ortega-Sanchez IR, Messonnier ML, Thompson WW, Wortley PM, Weintraub E, et al. The Annual Impact of Seasonal Influenza in the US: Measuring Disease Burden and Costs. *Vaccine*. 2007;25(27):5086-5096. doi:10.1016/j.vaccine.2007.03.046.
4. Cynthia G. Whitney, MD,¹ Fangjun Zhou, PhD,² James Singleton, PhD,² and Anne Schuchat, MD¹ *MMWR Morb Mortal Wkly Rep*. 2014 Apr 25; 63(16): 352–355. Published online 2014 Apr 25. PMID: PMC4584777 PMID: 24759657. Benefits from Immunization During the Vaccines for Children Program Era — United States, 1994–2013
5. Tenforde MW, Olson SM, Self WH, et al. Effectiveness of Pfizer-BioNTech and Moderna Vaccines Against COVID-19 Among Hospitalized Adults Aged ≥65 Years - United States, January-March 2021. *MMWR Morb Mortal Wkly Rep*. 2021;70(18):674-679. doi:10.15585/mmwr.mm7018e1
6. Havers FP, Chung JR, Belongia EA, et al. Influenza Vaccine Effectiveness and Outcomes among US Patients Aged 2 to 49 Years During the 2018-2019 Season. *J Pediatric Infect Dis Soc*. 2020;9(3):207-216. doi:10.1093/jpids/piz010.

Resolution 7-S24. Requesting that CMS Reimburse for Shingrix Vaccinations Administered in Physicians' Offices

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians regularly publishes policy statements on matters which affect optimal medical care of its physicians' patients; and

WHEREAS, the missions and goals of the ACP include advocating and promoting responsible positions on public policy relating to health care for the benefit of our patients; and

WHEREAS, Shingrix vaccinations appear to be reimbursed by the federal government only if patients receive them at pharmacies (i.e., not at their own physicians' offices); and

WHEREAS, being able to provide patients with Shingrix vaccinations covered by the federal government when patients are at their physicians' offices increases the likelihood that a maximum number of American citizens can be protected against Shingles; therefore be it

RESOLVED, that the Board of Regents requests that the federal government cover Shingrix vaccinations provided at physicians' offices so patients have the option to receive optimal care and coverage against shingles – with their primary care providers; and be it further

RESOLVED, that the Board of Regents requests that the federal government cover Shingrix vaccinations provided at physicians' offices so physicians have the maximum ability to provide patients with this protection against what can be a painful and debilitating disease.

Resolution 8-S24. Approaching Physician Suicide as a Problem Requiring Healthcare System Change

(Sponsor: Maryland Chapter; Co-sponsor: Council of Early Career Physicians [CECP] and New York Chapter)

WHEREAS, the ACP holds physician well-being as a core value and has previously identified physician and medical student suicide as a pressing matter of concern (1, 2); and

WHEREAS, an amended resolution 3-F18 was approved by the BOR on November 3-4, 2018, as follows:

“RESOLVED, that the Board of Regents develops a policy statement, in addition to and in alignment with the existing ACP Physician Well-being and Professional Satisfaction initiative, that calls on institutions to embrace transparency, accountability, and collaboration as core features of a comprehensive response to an individual physician suicide (including medical students, resident and fellow physicians, and practicing, non-practicing or retired physicians). These three core features should also guide partnerships with the public (e.g. media), the medical community, and other organizations to better understand and intervene upon the alarming nature and socio-organizational context of physician suicides; and be it further

RESOLVED, that the Board of Regents in such a policy statement calls for healthcare and medical education institutions to monitor and improve meaningful physician health outcomes, implement standardized postvention activities and investigative activities, including but not limited to:

- 1) Investigative procedures (e.g. root cause analyses with attention to organizational/environmental contributors or related policies, psychological autopsy, and other activities, such as Morbidity & Mortality conferences, Schwartz Rounds;
- 2) Systematic reporting of investigative findings, while maintaining respect of family members’ wishes and abiding by ethical principles of communication about suicide; and
- 3) Provision of compassionate resources, in keeping with ‘creating an environment of psychological safety’, to support appropriate grieving for peers, colleagues and members of the community of a physician who has completed suicide.”; and

WHEREAS, the adoption of resolution 3-F18 resulted in the Ethics, Professionalism, and Human Rights Committee’s (EPHRC) creation of a policy statement that was published in the *Journal of General Internal Medicine* in 2021 (2) that describes the dire nature of the problem of physician suicide, identifying factors that could be unique to physician suicide such as a higher rate or recent work-related stressors than in suicides of non-physicians, and advocates for evidence and interventions while acknowledging the challenging ethical issues making collection of such information difficult; and

WHEREAS, it is estimated 300-400 physicians died each year by suicide in the pre-pandemic era, the pandemic, increased corporatization of medicine, and other changes in health care have likely contributed to even higher levels of stress at work and higher rates of depression and burnout subsequent to the EPHRC’s publication; and

WHEREAS, little progress has been made despite the publication of the EPHRC’s policy statement in 2021 in elucidating the contributors, mitigators, and best practices to determine the relative benefits of structural and educational interventions to reduce physician suicide, nor is any format for public reporting and confidential data collection available to better understand systems contributions to this problem; and

WHEREAS, the relatively sparse interventions instituted since publication of that policy statement focused on identification and treatment of physician depression but largely ignores systems factors that contribute to depression and burnout; therefore be it

RESOLVED, that the Board of Regents approach physician suicide as a problem requiring healthcare system change and, with other partners as appropriate, create a task force, or work with others to form an intergroup task force, to study the problem of physician suicide to address the scope and root causes of physician suicide, evaluate evidence about this topic that has emerged after the publication of the EPHRC's paper addressing this, and recommend structural changes to healthcare work and training settings, as well as educational and other interventions aimed to reduce the incidence of physician suicide.

References:

1. American College of Physicians. Resolution 3-F18, "Developing ACP Policy Calling for Transparency and Community Learning Towards Physician Suicide Prevention"
2. DeCamp M, Levine M; ACP Ethics, Professionalism and Human Rights Committee. Physician Suicide Prevention and the Ethics and Role of a Healing Community: an American College of Physicians Policy Paper. *J Gen Intern Med.* 2021 Sep;36(9):2829-2835. doi: 10.1007/s11606-021-06852-z. Epub 2021 Jun 2. PMID: 34076842; PMCID: PMC8170626.

Resolution 9-S24. Acknowledging the Individual Right to Decisional Privacy

[SPONSOR ACCEPTED AS REAFFIRMATION—NO DEBATE]

(Sponsor: Minnesota Chapter)

WHEREAS, respect for patient autonomy, defined as the duty to protect and foster a patient's free, uncoerced choices, is one of the guiding principles of modern medical ethics (1); and

WHEREAS, the right to decisional privacy is the constitutional right of an individual to make and implement important personal decisions without governmental interference (2); and

WHEREAS, in the clinical context, the right to decisional privacy, based on the common-law right of self-determination and patient's liberty interest under the Due Process Clause of the XIV Amendment to the U.S. Constitution, corresponds to the ethical concept of respect for patient autonomy (1, 3) and forms the legal basis of decision-making in medicine; and

WHEREAS, focusing on the patient-clinician relationship as a necessary component of decisional privacy in the clinical context devalues the individual's legal rights and questions the patient's autonomy; and

WHEREAS, new developments in law, policy, and technology may, in some instances, remove the need for a clinician to be involved in such care altogether, and therefore, continued emphasis on the patient-clinician relationship may hinder further development in this area; therefore be it

RESOLVED, that the Board of Regents acknowledges that *patients' right to autonomy includes the right to make their own independent medical decisions, with or without reliance on a patient-clinician relationship* and, as such, will adopt and advocate for positions in furtherance of this acknowledgment.

References:

1. Sulmasy, L. S., Bledsoe, T. A., & ACP Ethics, Professionalism and Human Rights Committee(2019). American College of Physicians Ethics Manual: Seventh Edition. *Annals of internal medicine*, 170(2_Suppl), S1–S32.
2. *Whalen v. Roe*, 429 U.S. 589 (1977).
3. Snyder L. Life, death, and the American College of Physicians: the Cruzan case [Editorial]. *Ann InternMed*. 1990;112:802-4.

Resolution 10-S24. Updating ACP Policy to Support Physicians Pursuing Collective Bargaining and Unionization

(Sponsor: Oregon Chapter; Co-sponsors: Class of 2025; CECF; Connecticut, Hawaii, Illinois, Minnesota, and New York Chapters)

WHEREAS, the American Medical Association (AMA) supports the right of physicians to engage in collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians eligible for that right under federal law (1); and

WHEREAS, the AMA points out that bargaining units composed entirely of physicians are presumed appropriate (1), a recommendation that makes sense in recognition of physicians' unique skills and ethical and professional obligations; and

WHEREAS, in 1999 the AMA provided financial support for the establishment of a national labor organization - Physicians for Responsible Negotiation (PRN) - under the National Labor Relations Board (NLRB) to support the development and operation of local physician negotiating units as an option for employed physicians and physicians in-training, but ultimately withdrew support in 2004 as few physicians signed up (1); and

WHEREAS, the numbers of physicians who are union members is estimated to have grown significantly since then with a 26% increase from 2014 to 2019 when 67,673 physicians were members of a union (1); and

WHEREAS, the percentage of physicians now employed by hospitals, health systems, or corporate entities has increased significantly, most recently reported up to 73.9% as of January, 2022 (up from 47.4% in 2018), and the number of physician practices acquired by hospitals and corporate entities between 2019-2022 also accelerated during the pandemic (2, 3); and

WHEREAS, dominant hospitals, healthcare systems, and other corporate entities employing physicians may present limited alternatives to physicians working in a market largely controlled by their employer or where covenants-not-to-compete may further contribute to the employer's bargaining advantage (1); and

WHEREAS, the transition from independent professional physician workforce to employed physician workforce fundamentally alters the dynamics between hospitals, health systems, corporate entities and physicians, with a risk of negatively affecting the conditions of care delivery and quality of care provided (4), and fundamentally changes the physician-patient relationship; and

WHEREAS, the corporatization of medicine, including involvement of private equity in healthcare, raises questions about incentive alignment, costs, and downstream effects on patients (5, 6); and

WHEREAS, recent years have seen an increase in physician burnout, which accelerated during the COVID-19 pandemic, directly related to time spent on electronic health record documentation, bureaucratic administrative tasks, and moral injury related to an incongruence between what physicians care about and what they are incentivized to do by the healthcare system (7, 8, 9, 10, 11); and

WHEREAS, standardization of work schedules, time of appointments, and other work conditions is increasing as physicians become employed. Research shows that burnout is directly impacted by loss of control of work conditions and that allowing such control reduces stress, burnout, and even cardiovascular risk (12); and

WHEREAS, physicians face a dominant power when negotiating with hospital employers and may not have countervailing influence without collective bargaining (1); and

WHEREAS, collective bargaining is an effective tool for protecting patient care safety standards, improving work conditions, ensuring pay and job security, and providing a process for grievances; and

WHEREAS, being unionized is associated with improved pay and benefits and reduced compensation differences for minority groups (13); and

WHEREAS, the National Labor Relations Board determined in 2022 that employed physicians are not in a supervisory role and are therefore eligible to unionize (14); and

WHEREAS, interest in exploring collective bargaining for residents and practicing physician groups has increased in some parts of the country, likely driven by dynamics seen in the profession's shift to "employed status" for the majority of physicians and concerns by resident physicians about the conditions in which they worked during the COVID-19 pandemic (15, 16, 17, 18, 19, 20); and

WHEREAS, the American College of Physicians' detailed policy on collective bargaining for physicians was published in 2001 and the key points were reaffirmed with edits by the Board of Regents in 2022. ACP's position significantly restricts methods physicians can use to influence employers and business interests without offering alternative solutions (21, 22); and

WHEREAS, collective bargaining and unionizing does not mandate using strikes; for example, first responder unions use binding arbitration as a tactic instead of strikes. Other methods that could be considered include (but may not be limited to) work slow-downs, picketing, resignation en masse, whistleblowing to regulators and accrediting bodies, boycotts including administrative tasks, and halting billing activities; therefore be it

RESOLVED, that the Board of Regents update policy to:

- a) **Support of the right of physicians to engage in collective bargaining, including physician unionization;**
- b) **Advocate for the expansion of the numbers of physicians eligible for this right under state and federal law; and**
- c) **Provide comprehensive guidance on physicians' regulatory and ethical obligations in balancing direct patient care and advocacy within health systems during the collective bargaining process; and be it further**

RESOLVED, that the Board of Regents bring a resolution to the American Medical Association (AMA) seeking study of opportunities for the AMA and other physician associations to support physicians initiating collective bargaining, including but not limited to unionization.

References:

1. <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>
2. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZflmFdXlvGg%3d%3d
3. <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>
4. https://jamanetwork.com/journals/jama/fullarticle/2799930?guestaccesskey=4b40dae9-69a2-4ec1-b2db-b5f235c67122&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=etoc&utm_term=122722

5. <https://acpinternist.org/archives/2022/03/3-cs-corporatization-consolidation-commodification.htm>
6. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01535>
7. [https://www.mayoclinicproceedings.org/article/S0025-6196\(22\)00515-8/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext)
8. <https://academic.oup.com/jamia/article/26/2/106/5230918>
9. https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login_success_email_match_norm#1; <https://www.acpjournals.org/doi/10.7326/M16-0961>
10. <https://www.acpjournals.org/doi/10.7326/M16-0961>
11. <https://nap.nationalacademies.org/catalog/25521/taking-action-against-clinician-burnout-a-systems-approach-to-professional>
12. <https://link.springer.com/article/10.1007/s11606-013-2597-8>
13. <https://jamanetwork.com/journals/jama/fullarticle/2799909>
14. <https://www.jdsupra.com/legalnews/following-the-doctor-s-orders-nlr-7925443/>
15. <https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html>
16. <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html?smid=nytcore-ios-share&referringSource=articleShare>
17. <https://www.medpagetoday.com/special-reports/features/104210>
18. <https://www.opb.org/article/2022/06/03/st-charles-hospital-union-bend-health-care-workers-oregon/>
19. <https://www.oregonlive.com/business/2023/07/labor-unrest-spreads-in-oregon-health-care-industry-some-physicians-seek-to-form-union.html>
20. <https://minnesotareformer.com/2023/08/16/allina-primary-care-doctors-launch-historic-effort-to-unionize-more-than-550-clinicians/>
21. https://www.acpjournals.org/doi/10.7326/0003-4819-134-9_Part_1-200105010-00018?articleid=714461
22. https://www.acponline.org/sites/default/files/documents/advocacy/where_we_stand/assets/acp_policy_compendium_6_6_2023.pdf (accessed 10/2/2023, page 16, section on “Collective Bargaining”)

Resolution 11-S24. Developing Policy to Address the Creation of State-level Prescription Drug Affordability Boards

(Sponsor: Illinois Chapter)

WHEREAS, the escalating cost of prescription drugs creates an undue financial burden on consumers and state governments and decreases access and adherence to medication treatment; and

WHEREAS, drug manufacturers may change the list prices of their drugs at any time after launch, and over the period from January 2022 to January 2023, more than 4,200 drug products had price increases, of which 46 percent were larger than the rate of inflation (1); and

WHEREAS, a survey from the Kaiser Family Foundation in 2023, found that about three in ten adults report not taking their medicines as prescribed at some point in the past year because of the cost (2); and

WHEREAS, Federal legislation (Inflation Reduction Act) controls prices for some medications covered by Medicare but not those covered by other insurance plans nor for patients without pharmacy benefits; and

WHEREAS, ACP supports multiple policies to stem the escalating cost of prescription drugs, including price transparency, allowing publicly funded health programs to negotiate volume discounts, and the reimportation of certain drugs, among others (3), (4); and

WHEREAS, ACP policy does not address the creation of state-level mechanisms and legislation to stem the escalating costs of medication, and there are multiple approaches that states have used (5); and

WHEREAS, amongst the various states several approaches to controlling pharmaceutical costs that are being explored include Prescription Drug Accountability Boards (PDABs), price gouging bills, PBM regulations and Medicaid payment limits. While these laws address important aspects of drug pricing, recently enacted PDAB legislation that includes the ability to set upper payment limits offers the greatest opportunity yet for direct action by states working to bend the cost curve; and

WHEREAS, Prescription Drug Affordability Boards (PDABs) are state-level independent bodies with the authority to evaluate high-cost drugs and set Upper Payment Limits (UPLs) on what consumers will pay in order to reduce prescription drug costs to consumers. PDABs address all payors within a state and across all steps of the pharmaceutical supply chain; and

WHEREAS, ACP State Chapters may be involved as members of such boards or certainly important clinical stakeholders in advising which medications should be evaluated; and

WHEREAS, in 2019, [Maryland became the first state](#) to establish a PDAB. Currently, eight other states (Colorado, Maine, New Hampshire, Ohio, Oregon, Washington, Michigan and Minnesota) have followed Maryland and enacted laws establishing PDABs. According to the National Academy for State Health Policy, a [number of other states](#) (Arizona, Connecticut, Massachusetts, New Jersey, New Mexico, Pennsylvania, Rhode Island, and Virginia) have [introduced legislation that is currently pending](#). Illinois legislators plan to introduce PDAB legislation in the spring 2024 legislative session; and

WHEREAS, ACP policy does not address the creation of state-level Prescription Drug Affordability Boards (PDAB) as a means to stem the escalating cost of prescription drugs; therefore be it

RESOLVED, that the Board of Regents develop policy to address creating state-level Prescription Drug Affordability Boards to bolster federal efforts to control medication costs.

References:

1. [Bosworth, A, Sheingold, S, Finegold, K, Sayed, B.A., De Lew, N, Sommers, B.D. \(Issue Brief No. HP-2023-25\). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. October 2023.](#)
2. <https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/>
3. [Stemming the cost of Prescription Drugs ACP Position Paper 2016](#)
4. ACP Letter regarding H.R. 4895, the Lowering Drug Costs for American Families Act (2023)
5. [State Strategies to Lower Drug Costs NASHP 2021](#)

Resolution 12-S24. Streamlining Longitudinal, Uninterrupted Access to Critical Health Services that Support Daily Activities and Safe, Independent Living for Patients with Neurodegenerative Diseases

(Sponsor: Pennsylvania Chapter)

WHEREAS, the number of Americans aged 65 and older is projected to nearly double from 52 million in 2018 to 95 million in 2060, and the number of Americans with Alzheimer’s Disease and Related Dementias (ADRD) is estimated to double by 2060;¹ and

WHEREAS, there are currently no available treatments to cure neurodegenerative diseases, rendering focused prioritization on support of daily activities and safe, independent living;^{1,2} and

WHEREAS, primary care physicians play a vital role in the early detection, diagnosis, ongoing medical and care management, and caregiver support for patients with neurodegenerative diseases;³ and

WHEREAS, mandatory recertifications for patients with neurodegenerative diseases cause nonsensical and unacceptable disruptions in access to critical health and support services, while consuming resources and disempowering and frustrating patients, caregivers, and clinicians;^{4,5} and

WHEREAS, streamlining care for patients with neurodegenerative diseases aligns with the call of Centers for Medicare and Medicaid Services’ (CMS’s) 2024 Physician Fee Schedule for enhanced principal illness navigation (PIN) services for patients facing debilitating illnesses;⁶ and

WHEREAS, the uninterrupted promotion of the autonomy of longview clinical decision-making can reduce unnecessary paperwork and decrease clinician burnout, while improving health outcomes and physician, patient, and caregiver satisfaction;⁷ therefore be it

RESOLVED, that the Board of Regents advocates for streamlined, longitudinal, uninterrupted access to critical health services that support daily activities and safe, independent living for patients with neurodegenerative diseases by taking the following actions:

- 1. Partner with federal agencies and other stakeholders to disseminate best practices, new research findings, and clinical guidelines related to the care of patients with neurodegenerative diseases; and**
- 2. Advocate to CMS and other payers to remove the mandatory recertification requirements that support daily activities and safe, independent living, generating the opportunity to redirect the administrative cost savings into impactful critical health services.**

References:

¹ <https://pubmed.ncbi.nlm.nih.gov/32564745/>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9495472/>

³

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2809953#:~:text=One%20recent%20study1%20found,ages%20and%20new%20treatments%20emerge.>

⁴ <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c04.pdf>

⁵ <https://www.fightchronicdisease.org/sites/default/files/FINAL%202021-05-26%20PFCD%20Infographic%20Neurodegenerative.pdf>

⁶ <https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>

⁷ <https://link.springer.com/article/10.1007/s11606-019-05381-0>

Resolution 13-S24. Unifying Inclusive United States Graduate Medical Education (GME) Stakeholders to Accelerate a More Effective Action Strategy to Address Primary Care Physician Shortages and Misdistribution

(Sponsor: Pennsylvania Chapter)

WHEREAS, there is a repeatedly predicted, notable, national shortage of primary care physicians compounded by undeniable geographic distribution disparities;^{1,2} and

WHEREAS, primary care physicians are uniquely positioned and proven to positively impact longevity, quality of life, and the cost of health care;^{2,3} and

WHEREAS, an adequate primary care physician workforce is a cornerstone of effective pandemic prevention, preparedness, response, and recovery;⁴ and

WHEREAS, physicians tend to practice in the communities where they complete their GME training;⁵ and

WHEREAS, there are historical differences in academic capacity across states and communities, compounded by the systemic federal and state funding disparities across GME programs;⁶ and

WHEREAS, the recommendations of the 2016 Position Paper of the Alliance for Academic Internal Medicine and the ACP concerning GME reform remain relevant and crucial to inform a national GME reform action strategy, inclusive of all stakeholders;⁷ and

WHEREAS, public and private payers that benefit from physician GME should, like all stakeholders, share the responsibility of contributing to providing stable financial support for GME;⁸⁻⁹ and

WHEREAS, there is an opportunity to improve intentional, high-impact collaboration across federal agencies that fund GME, including the Centers for Medicare and Medicaid Services (CMS's) Inpatient Prospective Payment System and Inpatient Rehabilitation Facilities Hospitals programs, Health Resources and Services Administration (HRSA's) Teaching Health Center and Children's Hospital GME Programs, Department of Veterans Affairs (VA), and the Department of Defense (DOD); and

WHEREAS, there is an opportunity to improve intentional, high-impact collaboration between federal agencies that fund GME and GME accreditation, certification, and licensing bodies, including but not limited to the Accreditation Council of Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS); therefore be it

RESOLVED, that the Board of Regents advocates for inclusive stakeholders of GME to organize, ignite, and accelerate a more effective, collective impact action strategy to address primary care physician shortages and misdistribution by engaging in the following measures:

- 1. Promote increased, intentional collaboration across CMS, HRSA, VA, and DOD-funded GME programs to simplify and implement a more functional GME payment program with defined shared metrics of success;**
- 2. Advocate for strategic federal GME finance reforms promoting primary care, including reasonable per resident amounts (PRAs), funding stability, and equitable investments designed to meet the needs of patients and populations;**
- 3. Advocate for inclusive Medicaid funding for community-based primary care GME programs in every state;**
- 4. Advocate for commercial payer engagement in funding primary care GME; and**

5. **Advocate for the Accreditation Council for Graduate Medical Education to accelerate innovation, collaboration, and coordination across GME sponsoring institutions and programs to improve the shared metrics of success that meet the nation's primary care physician workforce needs.**

References:

- ¹ <https://www.aamc.org/media/54681/download>
- ² <https://www.brookings.edu/articles/we-need-more-primary-care-physicians-heres-why-and-how/>
- ³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6435370/>
- ⁴ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(23\)00963-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00963-7/fulltext)
- ⁵ <https://www.acpjournals.org/doi/10.7326/M15-2917>
- ⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6008034/>
- ⁷ <https://pubmed.ncbi.nlm.nih.gov/27135592/>
- ⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7308777/>
- ⁹ <https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1109-the-financing-of-graduate-medical-education.pdf>

Resolution 14-S24. Reducing the Risk of Medical Workplace Violence

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians regularly publishes policy statements on matters which affect the health and well-being of physicians; and

WHEREAS, the Mission and Goals of the American College of Physicians includes serving the professional needs of the membership, supporting healthy lives for physicians and advancing Internal Medicine as a career; and

WHEREAS, there have been increasing reports over the past few years of workplace violence in medical settings, including a report of at least one physician being killed by such an incidence; therefore be it

RESOLVED, that the Board of Regents discuss what actions might be taken to reduce the risk to physicians from workplace violence. Actions might include, but are not limited to, having ACP develop teaching packages which provide instruction on how to deal with such incidents in a manner that reduces the risk of serious injuries occurring, as well as encouraging medical settings to place in service protective measures such as screening for individuals entering medical settings with handguns or other potentially lethal instruments.

Resolution 15-S24. Requesting that ACP Strengthen Associated Policy and Advocate for NASEM-Recommended Processes around the Development of the Dietary Guidelines for Americans

(Sponsor: Alaska Chapter)

WHEREAS, ACP seeks to reduce health disparities and to use scientifically sound, evidence-based findings to optimize health for all; and

WHEREAS, the epidemic of obesity and other diet-related conditions has been rapidly increasing (1); and

WHEREAS, this epidemic impacts some groups more than others, thus contributing to health disparities (2); and

WHEREAS, the ACP initiative around advancing equitable obesity care is specifically committed to addressing equity and anti-bias in obesity prevention and management (3); and

WHEREAS, the Dietary Guidelines for Americans (DGA) significantly impact food consumption, especially by those who rely on federal food programs such as SNAP, WIC, the National School Lunch Program, military meals, meals for the elderly, meals for the incarcerated, and others, thus impacting these groups more than others; and

WHEREAS, as was mandated and funded by Congress, the National Academies of Sciences, Engineering and Medicine (NASEM) has formulated a set of recommendations for improving the processes for developing the DGA to provide more rigorous, evidence based DGA (4,5); and

WHEREAS, the NASEM recommendations have not been fully implemented (6,7); therefore be it

RESOLVED, that ACP policy be strengthened to support advocacy for implementation of the National Academies of Sciences, Engineering and Medicine (NASEM) recommendations for processes around Dietary Guidelines for Americans (DGA) development; and be it further

RESOLVED, that the Board of Regents shall advocate for implementation of the NASEM and Guidelines International Network's recommendations for processes around DGA development to the greatest extent possible prior to release of each set of DGA.

References:

- 1) <https://www.cdc.gov/obesity/data/adult.html>
- 2) <https://stacks.cdc.gov/view/cdc/106273>
- 3) <https://www.acponline.org/about-acp/who-we-are/advancing-equitable-obesity-care>
- 4) <https://nap.nationalacademies.org/catalog/24883/redesigning-the-process-for-establishing-the-dietary-guidelines-for-americans>
- 5) <https://nap.nationalacademies.org/catalog/24637/optimizing-the-process-for-establishing-the-dietary-guidelines-for-americans>
- 6) <https://nap.nationalacademies.org/catalog/26406/evaluating-the-process-to-develop-the-dietary-guidelines-for-americans-2020-2025>
- 7) <https://nap.nationalacademies.org/catalog/26653/evaluating-the-process-to-develop-the-dietary-guidelines-for-americans-2020-2025>

Resolution 16-S24. Educating the Public about the Appropriate Identification of Healthcare Professionals in Clinical Settings

(Sponsor: New York Chapter; Co-sponsors: BOG Class of 2025; CECF; Illinois Southern, Montana, Southern California II, and Pennsylvania-Eastern Chapters)

WHEREAS, ACP Policy since 2009 has eliminated the use of the term “provider” and “prescriber” in lieu of “physicians” in all publications and communications, and the President’s message in 2019 by Dr. McLean declared that the word “provider” should not be used as an identity for physicians (1); and

WHEREAS, the training of an Allopathic and Osteopathic Physician vs. Advanced Practice Practitioner or other non-physician healthcare professionals is more comprehensive and thus the title of Doctor should be reserved for physicians in the clinical setting; and

WHEREAS, it can be misleading when some non-physician individuals use the title of Doctor and improper use of the title ignores the substantial education, training and qualifications of physicians; and

WHEREAS, the use of the title Doctor by non-physician clinicians may be confusing to the public and patients; and

WHEREAS, patients have the right to know and deserve clarity and transparency about who is providing their health care; and

WHEREAS, in the state of the California, Truth in Advertising laws that protect the public from deception have regulated who can use the title Doctor and it is concerning that this law is currently being challenged by Nurse Practitioners (2); therefore be it

RESOLVED, that the Board of Regents as part of its Internal Medicine Physician Identity Campaign (3) specifically clarify the definition of the title Doctor as used by physicians and emphasize the appropriate use of the title in clinical settings; and be it further

RESOLVED, that the Board of Regents provide guidance for development of a multi-pronged public education campaign by ACP to promote the accurate identification of the members of a healthcare team based on their license of training; and be it further

RESOLVED, that the public education campaign be delivered in a manner that patients understand the differences of training between an advanced practice practitioner, non-physician clinician and physician, and thus avoid being deceived by individuals or healthcare entities who are promoting non-physicians as Doctors.

References:

1. PRESIDENT'S MESSAGE | SEPTEMBER 2019
<https://acpinternist.org/archives/2019/09/defining-our-identity-does-not-include-the-p-word.htm>
2. <https://www.washingtonpost.com/nation/2023/07/18/doctor-nurse-title-lawsuit-california/>
3. ACP Internist Weekly | PROFESSIONAL IDENTITY | AUGUST 23, 2022
ACP launches identity campaign
<https://www.acponline.org/about-acp/acp-global-engagement/acp-global-newsletter/global-newsletter-archive/november-2022/acp-launches-a-new-identity-campaign-celebrating-the-depth-and-diversity-of-internal-medicine>

Resolution 17-S24. Promoting and Developing Initiatives Related to Narrative Medicine

(Sponsor: California Southern III Chapter: Co-sponsors: Class of 2025; California Northern, California Southern I, California Southern II, Illinois Southern, Japan, Maine, New York, Tennessee, and Wisconsin Chapters)

WHEREAS, ACP has a commitment to diversity, equity, and inclusion, and recognizes the importance of cultural humility in the delivery of health care to patients, and seeks ways to promote these values and skills to members; and

WHEREAS, ACP's priority areas include membership growth and engagement; valued professional identity; and diversity, equity, and inclusion; and

WHEREAS, ACP recognizes the importance of humanism and storytelling in medicine through educational sessions, publications, Story Slams, workshops, skill-building activities, and awards; and

WHEREAS, a number of ACP Chapters sponsor and support narrative medicine and storytelling activities; and

WHEREAS, narrative medicine harnesses knowledge from the humanities and the arts in the service of health care, ensuring patients are not alone in their illness journey by supplying clinicians with skills to connect with patients and understand their points of view; and

WHEREAS, narrative medicine increases relational skills, empathy, reflection, improves health outcomes, decreases burnout, enhances well-being, community, inclusion, belonging, and strengthens professional identity; therefore be it

RESOLVED, that the Board of Regents perform a needs assessment related to narrative medicine activities and consider the promotion and amplification of existing resources as needed; and be it further

RESOLVED, that the Board of Regents explore the possibility of additional opportunities including but not limited to invited sessions, a national narrative medicine competition, networking and community-building, and increasing avenues for publication and presentation.

References:

1. ACP DEI Policy: <https://www.acponline.org/about-acp/who-we-are/diversity-equity-and-inclusion-dei>
2. ACP Priority Themes and Goals: https://www.acponline.org/sites/default/files/documents/about_acp/who_we_are/strategic_priorities/acp-strategy21-24.pdf
3. Examples of ACP National Narrative Medicine activities: Annals Story Slams, On Being a Doctor, ACP Awards, IM Skills-Building Sessions, CME Activities : <https://www.acpjournals.org/doi/10.7326/W23-0005>, <https://www.acpjournals.org/journal/aim/authors2>; <https://www.acponline.org/about-acp/awards-masterships-and-competitions/nicholas-e-davies-memorial-scholar-award-for-scholarly-activities-in-the-humanities-and-history-of>; <https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment/mini-but-mighty-skills-for-well-being/using-stories-to-explore-identity-and-enhance-well-being-narrative-medicine>; Internal Medicine 2023 sessions: *Clinical Skills Center: Stories that Heal and Reveal: A Radical Listening and Reflective Writing Workshop* and *Mini but Mighty Skills: Using Stories to Explore Identity and Enhance Well-being*
4. Examples of ACP Chapter Narrative Medicine activities: https://www.acponline.org/sites/default/files/documents/about_acp/chapters/wi/23mtg/2023_ACP-

- [WI Narrative Medicine Booklet.pdf](#); <https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment/acp-well-being-champions/im-thriving/archive/november-19-2021/from-the-trenches>; https://www.acponline.org/sites/default/files/documents/about_acp/chapters/ca/2023NarrativeMedCompetition.pdf; <https://washingtonacp.org/storyslam/>;
https://www.txacp.org/amsimis/TXACP/Meetings_Events/On_Being_a_Doctor/TXACP/About/Being_a_Doctor/On_Being_A_Doctor_Collection.aspx?hkey=ef956c66-7c3f-4a41-8d9f-080e91e471e0
5. <https://acpinternist.org/archives/2020/10/narrative-medicine-seeks-the-story-behind-the-illness.htm>
 6. Charon R. At the membranes of care: stories in narrative medicine. *Acad Med.* 2012 Mar;87(3):342-7. doi: 10.1097/ACM.0b013e3182446fbb. PMID: 22373630; PMCID: PMC3292868.
 7. Milota MM, van Thiel GJM, van Delden JJM. Narrative medicine as a medical education tool: A systematic review. *Med Teach.* 2019 Jul;41(7):802-810. doi: 10.1080/0142159X.2019.1584274. Epub 2019 Apr 14. PMID: 30983460.
 8. Weiss T, Swede MJ. Transforming Preprofessional Health Education Through Relationship-Centered Care and Narrative Medicine. *Teach Learn Med.* 2019 Apr-May;31(2):222-233. doi: 10.1080/10401334.2016.1159566. Epub 2016 May 4. PMID: 27141931.
 9. National Academy of Medicine National Plan for Health Workforce Well-Being: <https://nam.edu/initiatives/clinician-resilience-and-well-being/national-plan-for-health-workforce-well-being/>
 10. Liao HC, Wang YH. Narrative medicine and humanities for health professions education: an experimental study. *Med Educ Online.* 2023 Dec;28(1):2235749. doi: 10.1080/10872981.2023.2235749. PMID: 37434389; PMCID: PMC10339765.

Resolution 18-S24. Supporting our Military Membership at the American College of Physicians by Developing a Special Dues Category for Active Members of the U.S. Armed Forces

(Sponsor: Arizona Chapter; Co-sponsors: Class of 2027; Georgia and Ohio Chapters)

WHEREAS, there are currently 2,405 ACP members who are active members of the U.S. Armed Forces in three military chapters¹; and

WHEREAS, these military members and their colleagues provide medical care to the over 1.3 million members of the military², 1.6 million family members of the military, 1.1 million National Guard and Reserve members and their families; and

WHEREAS, members of the Armed Forces are not permitted to use their educational funds for society memberships; and

WHEREAS, other medical societies including the American Medical Association provide discounted memberships and special benefits for members of the Armed Forces; therefore be it

RESOLVED, that the Board of Regents develop a special dues category and pricing for active members of the U.S. Armed Forces.

References:

¹ Facts for active members from Military chapters comes from ACP Governors Chapter Portal

² Military numbers come from Governors of Military Chapters and USAFacts.org ([2023 Current State of the Union: US Military & Defense \(usafacts.org\)](https://usafacts.org/))

Resolution 19-S24. Applying Chapter Dues for Members, FACP's and MACP's Rejoining ACP

(Sponsor: Michigan Chapter; Co-sponsor: Class of 2026 and Wisconsin Chapter)

WHEREAS, Chapters are encouraged to charge local dues in order to maintain the chapter's financial self-sufficiency and to fund programming for members; and

WHEREAS, Chapter Dues make up 36-65% of Chapter income to individual domestic chapter budgets; and

WHEREAS, Chapters are asked annually to determine their dues rate for the following fiscal year and provide that information to the national ACP office; and

WHEREAS, any individual who is delinquent in dues payment by 20 months is considered a "former member" by ACP and therefore considered a "new member" by ACP when they reinstate; and

WHEREAS, domestic new and reinstating Members pay the New Chapter Member Fee (\$25 for new and reinstating Members 8 years or less out of medical school and auto-elected Members; and \$35 for new and reinstating Members 9 or more years out of medical school) and the New Chapter Member Fee is prorated based on the time of year; and

WHEREAS, these individuals do not pay full chapter dues until they renew in July of the following year; and

WHEREAS, this New Chapter Member Fee of \$35 is ~55% lower than the average Chapter dues for domestic chapters (\$75) creating a significant financial benefit to those who lapse and rejoin at the expense of chapter dues; and

WHEREAS, Chapters are encouraged to use these funds to support chapter programming at the time the new member joins ACP, similar to the use of Chapter dues; and

WHEREAS, the use of the New Chapter Member Fee by ACP instead of Chapter dues for those rejoining leads to decreased funding for Chapters and a reduction of programming and resources at the Chapter level; therefore be it

RESOLVED, that the Board of Regents should eliminate the use of the New Chapter Member Fee and instead apply Chapter Dues for Members, Fellows and Masters of the College.

Resolution 20-S24. Addressing the Environmental Burden Associated with American College of Physicians Publications

(Sponsor: Vermont Chapter; Co-sponsors: Japan, South Dakota, Utah, and Washington Chapters)

WHEREAS, climate change, air and water pollution and other environmental impacts of human activity are widely considered by public health authorities and professional medical societies to be the leading threat to human health; and

WHEREAS, the American College of Physicians has recently acknowledged the central importance of comprehensively addressing Environmental Health in its second of two position papers on the subject, calling for “immediate action” to limit global temperature rise to 1.5 degrees Celsius; and

WHEREAS, the present default provision of *Annals* and other publications to American College of Physicians members in the United States and around the world comes at a significant environmental cost, via the procurement of raw materials and the expenditure of energy and resources for the production and transportation of materials; and

WHEREAS, the readership of the *Annals of Internal Medicine* and other American College of Physicians publications is comprised of healthcare professionals invested in the health of the individuals and communities they serve, including the broader global community; therefore be it

RESOLVED, that the Board of Regents address the environmental burden of printed *Annals of Internal Medicine* and other ACP publications presently being delivered in print by shifting to electronic delivery by default, allowing members to “opt in” to printed materials according to preference.

References:

[1] Crowley R, Mathew S, Hilden D. Environmental Health: A Position Paper From the American College of Physicians. *Ann Intern Med.* 2022 Nov;175(11):1591-1593. doi: 10.7326/M22-1864. Epub 2022 Oct 25. PMID: 36279541.

[2] Crowley RA; Health and Public Policy Committee of the American College of Physicians. Climate Change and Health: A Position Paper of the American College of Physicians. *Ann Intern Med.* 2016 May 3;164(9):608-10. doi: 10.7326/M15-2766. Epub 2016 Apr 19. PMID: 27089232.

[3] Atwoli L et al. Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity, and Protect Health. *N Engl J Med.* 2021 Sep 16;385(12):1134-1137. doi: 10.1056/NEJMe2113200. Epub 2021 Sep 5. PMID: 34491006.

[4] <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>

Resolution 21-S24. Creating Policy to Guide the Selection of Future ACP Annual Scientific and BOG Meetings

(Sponsor: New York Chapter; Co-sponsor: New Mexico Chapter)

WHEREAS, ACP has a diverse membership that embraces marginalized groups including those who identify as women, LGBTQ+, BIPOC and immigrants; and

WHEREAS, ACP is committed to being an anti-racist, diverse, equitable and inclusive organization dedicated to policy, advocacy and action to confront and eliminate, racism, racial disparities, discrimination, bias and inequities in health and health care within our own organization; and

WHEREAS, ACP policy recognizes that racial and ethnic minority populations in the U.S. experience disparities in their health and health care that arise from factors including structural racism, discrimination, social determinants of health and quality of care (1,2); and

WHEREAS, ACP policy advocates for access to comprehensive health and that abortion services are an important component of comprehensive health care; and

WHEREAS, ACP policy believes in the principle of patient autonomy to ensure access for all patients to the full range of reproductive health care, including abortion, contraception methods and whether or not to continue a pregnancy and that such reproductive health care decisions are foundational to the patient-physician relationship (3); and

WHEREAS, ACP opposes government restrictions that erode equitable access to reproductive health care services, including family planning, sexual health information, the full range of medically accepted forms of contraception, and abortion, that are evidence-based, clinically indicated, and guided by biomedical ethics (3); and

WHEREAS, ACP strongly condemned the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* and issued a statement on this decision (4); and

WHEREAS, ACP has supported LGBTQ+ and transgender rights in health care, including opposing governmental interference in the patient-physician relationship that prevents physicians from providing their patients with evidence-based medical services; and

WHEREAS, the United States healthcare policy is dictated by individual states and in certain states policies are strikingly less able to support patients and ACP members (5); and

WHEREAS, national and state organizations such as the NAACP, LULAC, the Human Rights Campaign, and Equality Florida have issued U.S. location specific advisories regarding the safety of travel for African Americans, Latinos, persons of color, immigrants, and LGBTQ persons (6-9); and

WHEREAS, many states are failing to provide adequate and even life saving treatment to pregnant people and several states have passed legislation that allows an individual or institution to refuse to provide healthcare for LGBTQ persons; and

WHEREAS, several states have passed legislation that define "sex" in ways that may impact transgender people's access to bathrooms or facilities according to their gender identity interfering with their ability to participate in normal civic affairs; and

WHEREAS, several states have taken administrative or legislative actions allowing or directing state agencies to take emergency jurisdiction over children who are receiving gender affirming care, causing those living in, or traveling to those states to do so with fear of potential family separation; and

WHEREAS, national ACP programs including the Annual Scientific Meeting, Board of Governors meeting, and other educational programs aim to foster excellence and professionalism in the practice of medicine by bringing members and leaders together for networking, education and scientific collaboration; and

WHEREAS, ACP's mission to advance diversity in membership and leadership should consider the importance of the safety of its members and staff and not expose marginalized groups to undue hazards and stressors in the course of their work and participation in ACP; therefore be it

RESOLVED, that the Board of Regents create policy, guided by ACP values, regarding locations for future meetings that:

- 1. Focuses on the personal safety in meeting locations for members, staff, and family members who may be accompanying members and staff, taking into consideration racial/ethnic background, national origin, gender identity, sexual orientation, religion or disability;**
- 2. Considers ready access to healthcare in a meeting locality including the full range of emergency pregnancy healthcare needs and equal and compassionate access to healthcare without regard to race, ethnicity, gender, and sexual identification; and**
- 3. Considers mitigation strategies such as, but not limited to, offering a virtual option for attending the meeting and offering traveler insurance that covers emergency medical evacuation, when the meeting location ends up at a location that may compromise safety.**

References:

1. Josh Serchen, Robert Doherty, Omar Atiq, et al; , for the Health and Public Policy Committee of the American College of Physicians. [A Comprehensive Policy Framework to Understand and Address Disparities and Discrimination in Health and Health Care: A Policy Paper From the American College of Physicians](#). Ann Intern Med.2021;174:529-532. [Epub 12 January 2021]. doi:10.7326/M20-7219
2. Renee Butkus, Katherine Rapp, Thomas G. Cooney, et al; for the Health and Public Policy Committee of the American College of Physicians . [Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health](#). Ann Intern Med.2020;172:S50-S59. [Epub 21 January 2020]. doi:10.7326/M19-2410
3. Josh Serchen, Shari Erickson, David Hilden, et al. [Reproductive Health Policy in the United States: An American College of Physicians Policy Brief](#). Ann Intern Med.2023;176:364-366. [Epub 28 February 2023]. doi:10.7326/M22-3316
4. <https://www.groupof6.org/dam/AAFP/documents/advocacy/prevention/women/ST-G5-SCOTUS-DobbsVJackson-062422.pdf>
5. <https://www.acponline.org/advocacy/acp-advocate/archive/may-19-2023/acp-advocates-against-restrictions-on-gender-affirming-care>
6. <https://floridatraeladvisory.com/> ; <https://www.npr.org/2023/05/22/1177455149/civil-rights-groups-warn-tourists-about-traveling-to-florida#:~:text=In%20its%20warning%20for%20Hispanic,held%20by%20undocumented%20immigrants%2C%20among>
7. <https://eqfl.org/updated-travel-advisory-HRC>
8. <https://naacp.org/resources/naacp-travel-advisory-state-florida>
9. [LULAC'S HISTORIC WARNING AGAINST LATINOS TRAVELING TO FLORIDA IS A REMINDER OF ARIZONA FOLLOWING SB1070](#)