

Resolution 1-F22. Improving Knowledge and Skills Surrounding the Care of Young Adults with Special Healthcare Needs in Internal Medicine Residency

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, children with special healthcare needs are defined as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (1); and

WHEREAS, there are an estimated 13.9 million children with special healthcare needs, translating to about 19% of all children in the U.S., who will graduate from the pediatric to adult healthcare system (2); and

WHEREAS, this patient population has unique medical pathologies that were, at one point, only seen in pediatric practice; and

WHEREAS, this patient population and their families often have unique social structures, require long term services and supports, and rely on multiple financial payors (1, 4, 5); and

WHEREAS, studies show that a majority of surveyed internal medicine residents reported being inadequately trained to care for youth with special health care needs (6,7); and

WHEREAS, the ACP, in collaboration with the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), has committed to raise awareness of pediatric to adult healthcare adoptions in Resolution 10-S15; therefore be it

RESOLVED, that the Board of Regents will create toolkits for internal medicine trainees to supplement their knowledge and skills in congenital diseases, family centered patient care, and how best to navigate the social, legal and financial circumstances unique to young adult patients with special healthcare needs; and be it further

RESOLVED, that the Board of Regents will commit to collaborating with the AAP and AAFP to study ways in which experience with and comfort in caring for this patient population can be incorporated in medical training.

References:

1. National Survey of Children's Health, Children with Special Healthcare Needs Data Brief. 2017-2018. <https://mchb.hrsa.gov/data-research/national-survey-childrens-health>.
2. U.S. Department of Health & Human Services, Health Resources & Services Administration, Maternal & Child Health, Children with Special Health Care Needs (Date Last Reviewed: March 2019), <https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs#ref1>.
3. National Research Council, Institute of Medicine. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington, DC: The National Academies Press; 2009.
4. Colver A, McConachie H, Le Couteur A, et al.; Transition Collaborative Group. A longitudinal, observational study of the features of transitional healthcare associated with better outcomes for young people with long-term conditions. *BMC Med* 2018;16:111.
5. Williams E. and Musumeci, MB, "Children with Special Healthcare Needs: Coverage, Affordability and HCBS Access." Kaiser Family Foundation. October 4, 2021. <https://www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/>.
6. Mennito S. . Resident preferences for a curriculum in healthcare transitions for young adults. *South Med J*. 2012; 105 9: 462– 466.
7. Wilson L, Wild D. What happens when special needs children grow up?. *Yale J Biol Med*. 2009;82(2):83-85.

Resolution 2-F22. Studying How to Accommodate Adequate Paid Parental Leave in American Residency and Fellowship Programs

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, childbirth requires a minimum period of disability leave to facilitate recovery, and the birthing parent's first postpartum appointment is not until 6 weeks after delivery, at which time their degree of recovery is first evaluated[1]; and

WHEREAS, Cesarean sections account for 31.8% of all births and are categorized as a major abdominal surgery[2]; and

WHEREAS, maternity leave is associated with higher quality mother-child interactions and improved attachment security[3]; and

WHEREAS, paternity leave is associated with increased long-term bonding between fathers and children, decreased divorce risk between parents, and lower rates of illness among mothers[4]; and

WHEREAS, lack of maternity leave is associated with significantly increased risk of both infant and maternal hospitalization at 21 months postpartum[5]; and

WHEREAS, the American Academy of Pediatrics (AAP) supports 12 weeks of paid parental leave[6, 7]; and

WHEREAS, breastfeeding is recommended for at least 1 year by the AAP and at least 2 years by the WHO, yet fewer than 36% of parents in the United States are breastfeeding their infants at 1 year[8]; and

WHEREAS, infants must be fed every 2-3 hours, around-the-clock, for the first several months of their lives, and nursing/pumping at this frequency during the first few months of the infant's life is essential for establishing an adequate milk supply; and

WHEREAS, workplace lactation accommodations are frequently inadequate[9], and trainees frequently experience significant practical and hierarchical limitations on being able to pump at work every 2-3 hours even if a lactation room is available[10]; and

WHEREAS, early return to work as well as occupations (like residency) requiring long mother-baby separations have both been shown to decrease breastfeeding frequency[11], especially among resident physicians[12]; and

WHEREAS, 15% of women experience postpartum depression[13] and 20% of women experience postpartum anxiety[14]; and

WHEREAS, the prevalence of depression among resident physicians is already unacceptably high, with a 2015 systematic review and meta-analysis published in JAMA finding a 29% prevalence of depression among resident physicians and a 4-fold increase in depressive symptoms during residency, robustly correlating exposure to residency training to higher depressive symptoms[15, 16]; and

WHEREAS, longer periods of maternity leave are associated with a reduced risk of maternal postpartum depression[17]; and

WHEREAS, specifically for physicians, the average medical school graduate owes over \$240,000 in student loan debt[18]; and

WHEREAS, taking unpaid parental leave is often not a viable financial option for trainees, particularly those from lower socioeconomic backgrounds; and

WHEREAS, quality daycare is expensive and in short supply[19]; and

WHEREAS, the Match system of determining resident and fellow training locations often uproots trainees from their family and support system, which when combined with no guaranteed paid parental leave and the expense and limited availability of accredited daycare options makes adequate childcare difficult; and

WHEREAS, the current lack of adequate paid parental leave for trainee physicians in the United States places excessive financial burden on trainees and exacerbates existing inequality and lack of diversity in the physician workforce; and

WHEREAS, the duration of undergraduate and medical school education, lasting a minimum of 8 years, followed by residency and potentially fellowship training occurs during peak reproductive years; and

WHEREAS, female physicians have been shown to delay childbearing, and this effect is more pronounced among specialists, who experience generally longer training durations[20]; and

WHEREAS, the average cost of in-vitro fertilization is close to \$20,000[21]; and

WHEREAS, female physicians report needing more paid maternity leave than is presently offered and having negative experiences upon return to work after childbirth, including lack of access to lactation supplies and protected time, difficulty obtaining childcare, and discrimination[22-24]; and

WHEREAS, programs with paid leave lasting up to approximately six months have positive effects on maternal and child health and wellbeing without significant career costs[25]; and

WHEREAS, twenty-nine months of paid parental leave is the global average[26, 27], with the United States representing a notable exception, and is successfully implemented in residency and fellowship programs in these countries without compromising training or patient care; and

WHEREAS, resident physicians in Canada, for example, are offered 1 year of paid parental leave[28]; and

WHEREAS, although the ACGME recently mandated that residency and fellowship programs offer trainees 6 weeks of paid parental leave starting in July 2022[29], which is consistent with what the ACP currently supports[30, 31] and covers the minimum disability/recovery requirement after childbirth, this is not sufficient to address the above mental health, child-parent bonding, breastfeeding, financial, or equity arguments for longer parental leave; and

WHEREAS, the proposed 6 weeks of paid parental leave is half of what the AAP recommends and is not consistent with the length of paid parental leave that is routinely and successfully provided to people, including physician trainees, in most other countries; therefore be it

RESOLVED, that the Board of Regents, in conjunction with the AAP and other physician organizations including representation from resident organizations, form a task force to study how residency and

fellowship training programs in the United States could successfully accommodate a 12-week paid parental leave.

References:

1. *Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice*. 2015, Geneva.
2. *Method of Delivery*. Centers for Disease Control and Prevention 2022 May 23, 2022]; Available from: <https://www.cdc.gov/nchs/fastats/delivery.htm>.
3. Plotka, R., Busch-Rossnagel, N.A., *The role of length of maternity leave in supporting mother-child interactions and attachment security among American mothers and their infants*. International Journal of Child Care and Education Policy, 2018. **12**(2).
4. Popper, N., *Paternity Leave Has Long-Lasting Benefits. So Why Don't More American Men Take It?* The New York Times, 2019.
5. Jou, J., et al., *Paid Maternity Leave in the United States: Associations with Maternal and Infant Health*. Matern Child Health J, 2018. **22**(2): p. 216-225.
6. Nancy A. Dodson, H.J.T., *Paid parental leave for mothers and fathers can improve physician wellness*. American Academy of Pediatrics News, 2020.
7. Takagishi, J., et al., *Parental Leave for Residents and Pediatric Training Programs*. Pediatrics, 2022. **149**(3).
8. Resources, U.S.D.o.H.a.H., *CDC Releases 2018 Breastfeeding Report Card*. The Centers for Disease Control and Prevention, 2018.
9. Kozhimannil, K.B., et al., *Access to Workplace Accommodations to Support Breastfeeding after Passage of the Affordable Care Act*. Women's Health Issues, 2016. **26**(1): p. 6-13.
10. Peters, G.W., et al., *Lactation challenges of resident physicians- results of a national survey*. BMC Pregnancy and Childbirth, 2020. **20**(1): p. 762.
11. Johnston, M.L. and N. Esposito, *Barriers and Facilitators for Breastfeeding Among Working Women in the United States*. Journal of Obstetric, Gynecologic & Neonatal Nursing, 2007. **36**(1): p. 9-20.
12. Miller, N.H., D.J. Miller, and M. Chism, *Breastfeeding practices among resident physicians*. Pediatrics, 1996. **98**(3 Pt 1): p. 434-7.
13. *The American College of Obstetricians and Gynecologists Committee Opinion no. 630. Screening for perinatal depression*. Obstet Gynecol, 2015. **125**(5): p. 1268-1271.
14. Nonacs, R., *Perinatal Anxiety: Common But Not Frequently Recognized or Treated*. 2019.
15. Mata, D.A., et al., *Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Systematic Review and Meta-analysis*. JAMA, 2015. **314**(22): p. 2373-83.
16. Durkin, M., *Facing depression in medical residency*. ACP Internist, 2016.
17. Kornfeind, K.R. and H.L. Sipsma, *Exploring the Link between Maternity Leave and Postpartum Depression*. Womens Health Issues, 2018. **28**(4): p. 321-326.
18. Hanson, M., *Average Medical School Debt*. 2021.
19. Brigid Schulte, A.D., *The First Pillar of Care: Cost*. The New America Care Report, 2016.
20. Cusimano, M.C., et al., *Delay of Pregnancy Among Physicians vs Nonphysicians*. JAMA Intern Med, 2021. **181**(7): p. 905-912.
21. Gurevich, R., *How Much Does IVF Really Cost?* VeryWell Family, 2021.
22. Juengst, S.B., et al., *Family Leave and Return-to-Work Experiences of Physician Mothers*. JAMA Network Open, 2019. **2**(10): p. e1913054-e1913054.
23. Willett, L.L., et al., *Do Women Residents Delay Childbearing Due to Perceived Career Threats?* Academic Medicine, 2010. **85**(4): p. 640-646.
24. Henry, T.A., *The impact of parenthood on residency*. 2016.
25. Maya Rossin-Slater, J.S., *Time On with Baby and Time Off from Work*. The Future of Children, 2020. **30**(2): p. 35-51.
26. Miller, C.C., *The World 'Has Found a Way to Do This': The U.S. Lags on Paid Leave*. The New York Times, 2021.
27. *Parental Leave Systems*. OECD Family Database, 2021.
28. Canada, R.D.o., *Having a family during residency*. 2022.
29. *2022 ACGME Institutional Requirements*. The Accreditation Council for Graduate Medical Education, 2021.
30. *Women's Health Policy in the United States: An American College of Physicians Position Paper*. Annals of Internal Medicine, 2018. **168**(12): p. 874-875.
31. *Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians*. Annals of Internal Medicine, 2018. **168**(10): p. 721-723.

Resolution 3-F22. Improving Behavioral Health Access for Physicians Through Intentional Stigma Reduction

(Sponsor: Arizona Chapter: Co-sponsors: Council of Early Career Physicians, New York, Ohio, and Council of Student Members)

WHEREAS, COVID-19 has posed significant challenges to the overall well-being and mental wellness of physicians and trainees.¹ And, the ACP Well-being and Professional Fulfillment staff and committee members have partnered with advocacy colleagues to create a state-based advocacy toolkit to empower grassroots members to take this on in their states²; and

WHEREAS, state medical licensing and institutional credentialing applications routinely ask questions about mental health and are cited as possible deterrents to physicians from seeking mental health care^{3,4,5} and do not have an impact on the safe practice of medicine; and

WHEREAS, national recommendations from FSMB and NAM offer guidance on crafting non-stigmatizing questions about mental health and provide supportive language to physicians on taking care of their mental health^{6,7} while ensuring the competent practice of medicine; and

WHEREAS, guidance exists on alternative questions about the ability of physicians to be able to provide care in a safe, competent, ethical, and professional manner that does not stigmatize having a mental health diagnosis or seeking mental health care for any medical condition⁸; and

WHEREAS, several states such as North Carolina, Virginia, Arizona, New Mexico and others have recently recognized the need to encourage treatment of mental health amongst licensees, similar provisions do not exist across all states thus creating regional variation, particularly prone to concerns of physician well-being; therefore be it

RESOLVED, that the Board of Regents promote and support state chapter efforts by providing resources for state chapters such as the existing knowledge/advocacy toolkit (e.g., letter templates, evidence/background information) to encourage state licensing boards and credentialing organizations (such as medical staff credentialing entities) to use non-stigmatizing language in

¹ Lai J, Ma S, Wang Y, et al. Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Netw Open*. 2020;3(3):e203976.

² ACP: Advocacy Toolkit: Revising License and Credentialing Applications to Not Ask About Mental Health <https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment/advocacy-toolkit-revising-license-and-credentialing-applications-to-not-ask-about-mental-health>

³ Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical licensure questions and physician reluctance to seek care for mental health conditions. *Mayo Clin Proc*. 2017;92(10):1486-1493.

⁴ Arnhart K, Privitera MR, Fish E, et al. Physician burnout and barriers to care on professional applications. *J Leg Med*. 2019;39(3):235-246.

⁵ Story J, Solberg D. Barriers to Mental Illness and Substance Abuse Treatment Among Physicians and the Impact on Patient Care. *Mo Med*. 2017;114(2):91-93.

⁶ Federation of State Medical Boards. Physician Wellness and Burnout. Published April 2018. Accessed March 16, 2021. <https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>

⁷ Saddawi-Konefka D, Brown A, Eisenhart I, Hicks K, Barrett E, Gold JA. Consistency Between State Medical License Applications and Recommendations Regarding Physician Mental Health. *JAMA*. 2021;325(19):2017–2018. doi:10.1001/jama.2021.2275

⁸ Barrett, E, Lawrence, E, Waldman, D, Brislen, H. Improving How State Medical Boards Ask Physicians About Mental Health Diagnoses: A Case Study from New Mexico. *Ann Intern Med* 172:617–618, 2020.

credentialing processes across health care organizations when inquiring about a history of behavioral health conditions and physician's competence to practice; and be it further

RESOLVED, that the Board of Regents collaborates with other professional organizations (such as ACGME, AAMC, and National Association Medical Staff Services) and relevant stakeholders to advocate for the use of non-stigmatizing language to support physicians seeking mental health care.

Resolution 4-F22. Advocating for the Evaluation and Mitigation of Racial Bias Risk on Clinical Care Decisions

(Sponsor: Oregon Chapter; Co-sponsors: BOG Class of 2025; New York, Illinois-Southern, Hawaii, Washington, and Utah Chapters; Council of Student Members)

WHEREAS, ACP has committed to being an actively anti-racist organization, seeking to unravel the influences of racism in the healthcare system when they are found (1); and

WHEREAS, race is a social and political construct not a biological one, yet race has been used in medical research as a surrogate for genetic or population differences; and

WHEREAS, ascertaining what is meant by “race” in the scientific literature can be difficult (Is it self-determined? Assigned by the investigator? What label is used for those of mixed heritage?) and not standardized, making it nearly impossible to use with any clarity when delivering care; and

WHEREAS, race as a determinant of health has negatively influenced health outcomes for many reasons. 2) Policies and practices of healthcare systems and the legal and regulatory climate in which they operate; racial bias, discrimination, and stereotyping at the point of care; the historical and current policies reflecting structural and individual racism which all act to reduce access to opportunity in many ways; and the lived experience of race in the United States which includes internalized racism (also intersecting with other factors such as gender, socioeconomic status, and geography) all have been shown to contribute to adverse health consequences (3); and

WHEREAS, the medical community is in the process of scrutinizing the ways historical use of race in clinical research and decision-making may contribute to disparities in health outcomes for different racial groups in the United States (4, 5, 6) and developing new approaches to account for the harmful effects of racism on health when making care recommendations (7); and

WHEREAS, a joint task force of the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN) recently announced recommendations for immediate adoption of a new 2021 CKD-EPI creatinine eGFR equation which has been refit to estimate kidney function without a race variable and expanded use of cystatin C in hopes of promoting health equity and taking an approach that does not generate disparate care (8, 9); and

WHEREAS, race may introduce bias when used in algorithms that influence clinical decisions, and there is an urgent need to address latent bias in artificial intelligence (AI) algorithms as they become more mainstreamed and prevalent over time (10, 11, 12, 13, 14, 15, 16, 17); and

WHEREAS, greater diversity is needed among the people designing algorithms to try and mitigate the likelihood of biased systems as systems can be biased based on who builds them, how they’re developed and how they’re ultimately used (18); and

WHEREAS, close examination and recognition of the inequities of race-based medicine, determining the best solutions, and preventing the inadvertent influences of bias is beyond the scope of what an actively practicing clinician can take on; therefore be it

RESOLVED, that the Board of Regents, in collaboration with key stakeholders, advocates that all clinical tools, algorithms, or processes have their risks of racial bias evaluated and mitigated; and be it further

RESOLVED, that the Board of Regents develop, integrate, and iteratively refine a health equity framework into their methods for developing clinical guidelines recommendations.

References:

- 1) ACP Issues Organizational Commitment to be Anti-Racist, Diverse, Equitable, and Inclusive, Oct 21, 2020. <https://www.acponline.org/acp-newsroom/acp-issues-organizational-commitment-to-be-anti-racist-diverse-equitable-and-inclusive>
- 2) Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance. The Commonwealth Fund, Nov 18, 2021. <https://www.commonwealthfund.org/publications/scorecard/2021/nov/achieving-racial-ethnic-equity-us-health-care-state-performance>
- 3) Smedley BD. The Lived Experience of Race and Its Health Consequences. AJPB 2012; <https://ajph.aphapublications.org/doi/full/10.2105/AJPB.2011.300643>
- 4) Ioannidis JPA, Powe NR, Yancy C. Recalibrating the Use of Race in Medical Research. JAMA 2021;325(7):623-624. <https://jamanetwork.com/journals/jama/fullarticle/2775794>
- 5) Vyqas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight-- Reconsidering the Use of Race Correction in Clinical Algorithms. NEJM 2020;383:874-882. <https://www.nejm.org/doi/full/10.1056/NEJMms2004740>
- 6) AMA letter to The Honorable Richard E. Neal, Chairman, Committee on Ways and Means, Sept 25, 2020. <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-9-25-Letter-to-Neal-re-Response-to-Race-Clinical-Algorithms.pdf>
- 7) US Preventive Services Task Force. Actions to Transform US Preventive Services Task Force Methods to Mitigate Systemic Racism in Clinical Preventive Services. JAMA. 2021;326(23):2405-2411. <https://jamanetwork.com/journals/jama/fullarticle/2786145>
- 8) Delgado C, Baweja M, Burrows NR, Crews DC, Eneanya ND, Gadegbeku CA, Inker LA, Mendu ML, Miller WG, Moxey-Mims MM, Roberts GV, St. Peter WL, Warfield C, Powe NR. Reassessing the Inclusion of Race in Diagnosing Kidney Diseases: An Interim Report From the NKF-ASN Task Force. 2021;78(1):103-115. <https://www.sciencedirect.com/science/article/pii/S0272638621005060>
- 9) Delgado C, Baweja M, Crews DC, St. Peter WL, Warfield C, Powe NR. A Unifying Approach for GFR Estimation: Recommendations of the NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease. American Journal of Kidney Diseases Sept 23, 2021; [https://www.ajkd.org/article/S0272-6386\(21\)00828-3/fulltext](https://www.ajkd.org/article/S0272-6386(21)00828-3/fulltext)
- 10) Panch T, Mattie H, Atun R. Artificial intelligence and algorithmic bias: implications for health systems. J Glob Health. 2019;9(2):020318. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6875681/>
- 11) Decamp M, Lindvall C. Latent bias and the implementation of artificial intelligence in medicine. Journal of the American Medical Informatics Association. 2020;27(12):2020-2023. <https://academic.oup.com/jamia/article/27/12/2020/5859726>
- 12) Christensen DM, Manley J, Resendez J. Medical Algorithms Are Failing Communities of Color. Health Affairs Blog. 2021. <https://www.healthaffairs.org/doi/10.1377/hblog20210903.976632/full/>
- 13) Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Algorithmic Bias in Health Care: A Path Forward. Health Affairs Blog. 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20191031.373615/full/>
- 14) Rössli E, Rice B, Hernandez-Boussard T. Bias at warp speed: how AI may contribute to the disparities gap in the time of COVID-19. JAMIA 2021;28(1):190-192. <https://academic.oup.com/jamia/article/28/1/190/5893483?login=true>
- 15) McCradden MD, Joshi S, Anderson JA, Mazwi M, Goldenberg A, Shaul RZ. Patient safety and quality improvement: Ethical principles for a regulatory approach to bias in healthcare machine learning. Journal of the American Medical Informatics Association. 2020;27(12):2024-2027. <https://academic.oup.com/jamia/article-abstract/27/12/2024/5862600?redirectedFrom=fulltext>
- 16) Gianfrancesco MA, Tamang S, Yazdany J, Schmajuk G. Potential Biases in Machine Learning Algorithms Using Electronic Health Record Data. JAMA Intern Med. 2018;178(11):1544-1547. <https://pubmed.ncbi.nlm.nih.gov/30128552/>
- 17) Parikh RB, Teeple S, Navathe AS. Addressing Bias in Artificial Intelligence in Health Care. JAMA 2019;322(4):2377-2378. <https://jamanetwork.com/journals/jama/article-abstract/2756196#>

- 18) Heilweil R. Why Algorithms Can Be Racist and Sexist: A computer can make a decision faster. That doesn't make it fair. Recode. Feb 18, 2020. <https://www.vox.com/recode/2020/2/18/21121286/algorithms-bias-discrimination-facial-recognition-transparency>

Additional literature that is pertinent:

- 1) Panch T, Mattie H, Celi LA. The "inconvenient truth" about AI in healthcare. Npj Digital Medicine 2, Article number:77 (2019). <https://www.nature.com/articles/s41746-019-0155-4>
- 2) Rajkomar A, Hardt M, Howell MD, Corrado G. Ensuring Fairness in Machine Learning to Advance Health Equity. Annals of Internal Medicine. 2018;169:866-872. <https://www.acpjournals.org/doi/pdf/10.7326/M18-1990>
- 3) <https://publichealth.berkeley.edu/news-media/research-highlights/ziad-obermeyer-and-colleagues-at-the-booth-school-of-business-release-health-care-algorithmic-bias-playbook/>
- 4) Liaw ST, Liyanage H, Kuziemy C, Terry AL, Schreiber R, Jonnagaddal J, de Lusignan S. Ethical use of Electronic Health Record Data and Artificial Intelligence: Recommendations of the Primary Care Informatics Working Group of the International Medical Informatics Association. Yearb Med Inform 2020:51-7. <https://www.thieme-connect.com/products/ejournals/html/10.1055/s-0040-1701980>

Resolution 5-F22. Advocating for an End to Political Gerrymandering as an Approach to Addressing Social Drivers of Health

(Sponsor: New York, Co-sponsors: Connecticut and New Mexico Chapters; BOG Class of 2025; CSM, and CECP)

WHEREAS, political determinants of health (PDOH) involve the systemic process of structuring relationships, distributing resources, and administering power (including policy making) in ways that either advance health equity, or exacerbate health inequities¹; and

WHEREAS, PDOH create social drivers of health, like poor environmental conditions, inadequate transportation, unsafe neighborhoods, lack of healthy food options, and others that affect health²; and

WHEREAS, gerrymandering has the potential to influence PDOHs and perpetuates health inequities in resource-poor and minoritized communities³; and

WHEREAS, the term gerrymandering refers to the manipulation of boundaries of an electoral constituency to favor one political party over another; and

WHEREAS, gerrymandering affects all legislation by shifting who becomes elected officials⁴; and

WHEREAS, gerrymandering includes tactics like “packing” and “cracking”, in which political lines are determined in a manner to dilute votes and deny particular voters a sufficiently large voting bloc within any districts; and

WHEREAS, cracking techniques limit groups ability to advocate for the resources they need from those making policy decisions that impact health and health outcomes³; and

WHEREAS, racial/ethnic gerrymandering is illegal, but political gerrymandering is not; and

WHEREAS, in some states, race and political party are highly correlated, resulting in a similar effect to racial gerrymandering³; and

WHEREAS, degree of gerrymandering is correlated with variation in Medicaid expansion, with states that are heavily politically gerrymandered having more opposition to the Affordable Care Act³⁻⁵; and

WHEREAS, Medicaid expansion is associated with improvements in many health outcomes, like chronic disease management among low-income communities, reductions in uninsured individuals, lower mortality rates, reduced opioid overdose deaths, among others⁴; and

WHEREAS, heavily gerrymandered states have demonstrated less effective COVID-19 pandemic response, with poor performance in indexes of health measures^{3,6}; and

WHEREAS, the American College of Physicians recognizes and promotes the “health in all policies” approach⁷; and

WHEREAS, the American College of Physicians supports increased efforts to evaluate and implement public policy interventions with the goal of reducing inequities and addressing social determinants of health⁷; therefore be it

RESOLVED, that the Board of Regents, along with other stakeholders, adopt policy recognizing political gerrymandering as a significant public health problem and advocate for an end to political gerrymandering as part of the ongoing effort of ACP to address healthcare disparities and promote health equity.

References:

1. Dawes D. Health Inequities: A Look at the Political Determinants of Health During the COVID-19 Pandemic. *American Journal of Health Studies*. 2020;35(2). doi:10.47779/ajhs.2020.191
2. Political Determinants of Health. Satcher Health Leadership Institute. Accessed May 3, 2022. <https://satcherinstitute.org/priorities/political-determinants-of-health/>
3. Syed Q, Schmidt S, Powell RE, et al. Gerrymandering and Political Determinants of Health. *Population Health Management*. Published online April 14, 2022:pop.2021.0362. doi:10.1089/pop.2021.0362
4. How Partisan Gerrymandering Limits Access to Health Care. Center for American Progress. Accessed May 3, 2022. <https://www.americanprogress.org/article/partisan-gerrymandering-limits-access-health-care/>
5. Keena A, McGann AJM, Smith CA, Latner M, eds. The Policy and Social Consequences of State Legislative Gerrymandering. In: *Gerrymandering the States: Partisanship, Race, and the Transformation of American Federalism*. Cambridge University Press; 2021:117-134. doi:10.1017/9781108995849.006
6. The Best and Worst States to Work in America – during COVID-19. Accessed May 3, 2022. <https://www.oxfamamerica.org/explore/countries/united-states/poverty-in-the-us/covid-map/>
7. Daniel H, Bornstein SS, Kane GC. Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. *Annals of Internal Medicine*. Accessed June 2, 2020. <https://www.acpjournals.org/doi/10.7326/M17-2441>

Resolution 6-F22. Promoting Equitable Representation from All ACP Chapters at the ACP Annual Leadership Day Events

(Sponsor: Arizona Chapter; Co-sponsor: Nevada Chapter)

WHEREAS, the stated goals of ACP include advocating responsible positions on individual health and on public policy related to health care for the benefit of the public, patients, the medical profession, and our members and to also serving the professional needs of the membership including residents and students; and

WHEREAS, ACP has a long tradition of sponsoring and promoting a Leadership Day in Washington, D.C., to support members including residents and students to meet with their elected officials, promote ACP national and chapter legislative issues to their elected officials, and learn about advocacy efforts of the College; and

WHEREAS, ACP members, especially resident and student members from smaller ACP chapters and those ACP chapters at farther distances from Washington, D.C., have a much higher financial burden to attend this important educational and advocacy program and thus run the risk of under-representation; therefore be it

RESOLVED, that the Board of Regents promote equitable representation from all ACP Chapters at the ACP Annual Leadership Day Events by providing chapter scholarship guidance and allocating equitable scholarship travel funds to support attendance for members including resident and students demonstrating financial need from smaller and more distant ACP Chapters.

Resolution 7-F22. Protecting Access to Reproductive Health Care Services

[WITHDRAWN BY SPONSOR—ACP position statement issued after submission fulfilled intent]

(Sponsor: New Mexico Chapter; Co-Sponsors: Council of Student Members, Council of Resident and Fellow Members, Il Northern, New York , Minnesota , Il Southern, Oregon, Connecticut, Indiana, Washington, BOG Class of 2025)

WHEREAS, internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness¹; and

WHEREAS, the current policy of the ACP, “Women's Health Policy in the United States: An American College of Physicians Position Paper” of 2018 states, “ACP supports the current legal framework that allows women to obtain abortions before fetal viability or in later stages of pregnancy to protect the health of the mother and opposes efforts that would further restrict a woman's constitutional right to privacy in medical decision making, as upheld by the Supreme Court,” and also, “ACP believes in respect for the principle of patient autonomy on matters affecting patients' individual health and reproductive decision-making rights, including about types of contraceptive methods they use and whether or not to continue a pregnancy as defined by existing constitutional law,”²; and

WHEREAS, legislative efforts to restrict access to abortion are commonplace, increasingly restrictive, take many forms, and directly impact access to essential health care; and

WHEREAS, since 2018, the ACP has relied on current policy to strongly defend reproductive rights through amicus briefs, viewpoints, and statements on several recent challenges to reproductive rights and related medical practice^{3, 4, 5, 6} including United States v. Texas^{7, 8} and Dobbs v. Jackson Women’s Health Organization⁹; and

¹ <https://www.acponline.org/about-acp/about-internal-medicine>. Accessed 2022 May 27

² Ann Intern Med. 2018 Jun 19;168(12):874-875. doi: 10.7326/M17-3344. Epub 2018 May 29.

³ Amicus brief submitted to U.S. Court of Appeals for the Ninth Circuit in the case of Isaacson v. Brnovich <https://www.psychiatry.org/getattachment/aaddb35a-e89d-4604-a3ae-89c923059c6c/amicus-2021-Isaacson-et-al-v-Brnovich-No-21-16645.pdf>

⁴ Amicus brief submitted to Montana Supreme Court in the case of Planned Parenthood of Montana v. Montana <https://apps.montanafreepress.org/montana-legislature-lawsuit-tracker/filings/DA-21-0521/2022-03-28-amicus-brief-acog-et-al.pdf>

⁵ Internal Medicine Physicians Say Oklahoma Abortion Legislation Will Criminalize Health Care <https://www.acponline.org/acp-newsroom/internal-medicine-physicians-say-oklahoma-abortion-legislation-will-criminalize-health-care>

⁶ Internal Medicine Physicians Say Idaho Abortion Legislation Will Harm Patient-Physician Relationship <https://www.acponline.org/acp-newsroom/internal-medicine-physicians-say-idaho-abortion-legislation-will-harm-patient-physician-relationship>

⁷ Leading Physician Groups Oppose Texas Legislation That Threatens Access to Reproductive Patient Care; 2021. <https://www.acponline.org/acp-newsroom/leading-physician-groups-oppose-texas-legislation-that-threatens-access-to-reproductive-patient-care>

⁸ Internists Say Texas Law Violates Patient Autonomy and Egregiously Harms the Patient-Physician Relationship; 2021. <https://www.acponline.org/acp-newsroom/internists-say-texas-law-violates-patient-autonomy-and-egregiously-harms-the-patient-physician>

⁹ Amicus brief submitted to SCOTUS in Dobbs v. Jackson Women's Health Organization; 2021. <https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/amicus-briefs/2021/20210920-dobbs-v-jwho-amicus-brief.pdf?la=en&hash=717DFDD07A03B93A04490E66835BB8C5>

WHEREAS, on May 2, 2022, a leaked draft opinion from the U.S. Supreme Court revealed a plan to broadly reverse the constitutional right to abortion originally defined by *Roe v. Wade* and *Planned Parenthood v. Casey*¹⁰, thereby triggering a cascade of abortion bans across the country and at the same time severely weakening ACP policy; and

WHEREAS, in the many states that have passed or are contemplating criminal laws that restrict abortion, pregnant people and health care workers are increasingly at risk of civil penalties, criminal investigation, arrest, incarceration, and the attendant mental and physical health consequences of the criminal justice system; and

WHEREAS, one in four U.S. women will seek and obtain an abortion before the age of 44^{11,12}; and

WHEREAS, if *Roe v. Wade* is overturned, forty-one percent of patients of reproductive age would see the nearest abortion clinic close and the average distance they would be required to travel to obtain an abortion would increase from 35 miles to 279 miles;¹³ and

WHEREAS, currently, 49% of patients that get an abortion are under the poverty line and another quarter are very close to the poverty line;¹⁴ and

WHEREAS, people in underserved populations (such as racialized minorities, sexual and gender minorities, and those with low socioeconomic status) already face disparities in regard to accessing reproductive health services, including lower insurance rates, higher pregnancy mortality rates, limited geographic access to care, and lower exposure to comprehensive sexual education, and will be disproportionately affected by restrictive abortion and reproductive health laws;^{15, 16, 17} and

WHEREAS, laws that criminalize or otherwise penalize or restrict abortion negatively impact access to the availability of medical care for a range of other common pregnancy outcomes, including miscarriage and ectopic pregnancy¹⁸; and

¹⁰ Statement on Alleged Draft Supreme Court Opinion Re: *Roe v. Wade* from Health and Human Services Secretary Xavier Becerra: <https://www.hhs.gov/about/news/2022/05/03/statement-alleged-draft-supreme-court-opinion-re-roe-v-wade-health-and-human-services-secretary-xavier-becerra.html>

¹¹ <https://www.guttmacher.org/united-states/abortion/state-policies-abortion>

¹² Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015–2019 *BMJ Global Health* 2022;7:e007151.

¹³ Myers C, Jones R, Upadhyay U. Predicted changes in abortion access and incidence in a post-*Roe* world. *Contraception*. 2019 Nov;100(5):367-373. doi: 10.1016/j.contraception.2019.07.139. Epub 2019 Jul 31.

¹⁴ Sanger-Katz M, Miller CC, Bui Qand. Who Gets Abortions in America? New York: The New York Times, 2021, <https://www.nytimes.com/interactive/2021/12/14/upshot/who-gets-abortion-in-america.html>.

¹⁵ Dehlendorf C, Weitz T. Access to Abortion Services: A Neglected Health Disparity. *J Health Care Poor Underserved*. 2011 May;22(2):415-21. doi: 10.1353/hpu.2011.0064

¹⁶ The Disproportionate Harm of Abortion Bans: Spotlight on *Dobbs v. Jackson Women’s Health*. New York: Center for Reproductive Rights, 2021, <https://reproductiverights.org/supreme-court-case-mississippi-abortion-ban-disproportionate-harm/>.

¹⁷ Blumenthal D, Zephyrin L. Texas’s New Abortion Law Will Harm People of Color, Further Entrench Racist Policies. New York: The Commonwealth Fund, 2021, <https://www.commonwealthfund.org/blog/2021/texas-new-abortion-law-will-harm-people-color-further-entrench-racist-policies>.

¹⁸ Kellogg S. Missouri House passes anti-abortion bill further tightening restrictions on providers. St. Louis: St. Louis Public Radio, 2022, <https://www.kcur.org/politics-elections-and-government/2022-04-06/missouri-house-passes-anti-abortion-bill-further-tightening-restrictions-on-providers>.

WHEREAS, the passage of laws imposing criminal and civil penalties for abortion create a climate of fear that leads pregnant people to delay necessary care and diminishes trust in the healthcare system; and

WHEREAS, the ACP has strong existing policy against government interference in the physician-patient relationship¹⁹, and decisions related to appropriate, safe and ethical health care delivery should be decided by physicians and experts in health care, rather than by politically motivated non-experts; and

WHEREAS, internal medicine physicians hold a range of personal opinions on abortion, and yet we stand together in working for what will best support the health of our patients, and against both patients and colleagues being threatened with legal penalties for procedures that are within the established standards of health care; and

WHEREAS, there are other federal and state statutes in place currently that protect physicians' conscience-based objections, that allow individuals to opt out of participating in medical procedures which will result in the termination of pregnancy^{20, 21, 22, 23}; therefore be it

RESOLVED, that the Board of Regents protect access to reproductive health care services by updating its existing policy to be independent of constitutional or other legal frameworks and reaffirming policy that legislation restricting access to reproductive health services (including abortion) without valid medical justification jeopardizes health; and be it further

RESOLVED, that the Board of Regents adopt policy to specifically oppose certain legislative barriers to comprehensive reproductive health care, including but not limited to:

- **bans on telemedicine to provide medication abortions,**
- **unjustified medication abortion restrictions,**
- **mandatory counseling and delays including required parental or partner involvement,**
- **arbitrary bans on abortions after a certain point in pregnancy,**
- **laws that single out abortion for criminal or civil penalties, and**
- **laws that attempt to restrict travel for abortion care, or penalize the provision of practical, financial, or logistical support to patients seeking abortion care**
- **Targeted Regulations of Abortion Provider (TRAP) laws.**²⁴

¹⁹ ACP Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship, 2012. https://www.acponline.org/acp_policy/policies/patient_physician_relationship_rev_2012.pdf

²⁰ 42 U.S.C. § 300a-7 et seq.

²¹ <https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience>

²² <https://www.hhs.gov/conscience/conscience-protections/index.html>

²³ American College of Physicians Ethics Manual, Seventh Edition. Ann Int Med. 15 January 2019 Volume 170, Issue 2_Supplement Page: S1-S32

Resolution 8-F22. Supporting Paid Sick Leave for Workers in the United States

(Sponsor: Washington Chapter)

WHEREAS, in the United States there is no national law mandating paid leave for either of the main types of leave: Paid Family and Medical Leave (typically used for birth or adoption, longer-term illnesses or chronic conditions) and Paid Sick Leave (typically used for routine short-term illnesses such as respiratory infections or other conditions); and

WHEREAS, ACP has supported the need for Paid Family and Medical Leave through its policy statements¹ and advocacy for the FAMILY act (HR804/S248) via letter of support², but ACP has not yet supported Paid Sick Leave; and

WHEREAS, only 11 states have statewide Paid Sick Leave laws, 4 states have local laws determining Paid Sick Leave, and 4 states have a mix of state and local Paid Sick Leave laws³; and

WHEREAS, the COVID-19 pandemic underscores the need for workers to stay home when sick; and

WHEREAS, the federal government recognized the inadequacy of Paid Sick Leave COVID-19 pandemic by passing the Families First Coronavirus Response Act (FFCRA) which expanded coverage to eligible workers⁴; and

WHEREAS, the FFCRA law expired December 31, 2020, leaving workers with the same lack of guaranteed access to Paid Sick Leave; and

WHEREAS, healthcare organizations have a special responsibility to advocate for the health of workers through policies and laws; and

WHEREAS, access to Paid Sick Leave is lowest in the most disadvantaged residents, further worsening healthcare inequities; therefore be it

RESOLVED, that the Board of Regents support the creation of an ACP policy statement that strongly endorses paid sick leave for workers in the United States.

References:

1. ACP Policy Compendium, Spring 2021 (Updated 9/17/2021), p 46, 143-144, 304
2. Statement for the Record, American College of Physicians To the United States Senate Committee on Health, Education, Labor and Pensions On "Paid Leave for Working Families: Examining Access, Options, and Impacts" May 18, 2021.
https://www.acponline.org/acp_policy/testimony/acp_statement_for_the_record_to_the_senate_health_education_labor_and_pensions_committee_hearing_paid_leave_for_working_families_examining_access_options_and_imp_2021.pdf
3. Nagele-Piazza L, SHRM-SCP. Many Employers Must Offer Paid Sick Leave Beyond the Pandemic. April 13, 2021. Accessed 2/14/2022 at: <https://www.shrm.org/ResourcesAndTools/legal-and-compliance/state-and-local-updates/Pages/Many-Employers-Must-Offer-Paid-Sick-Leave-Beyond-the-Pandemic.aspx>
4. Families First Coronavirus Response Act: Questions and Answers. Accessed <https://www.dol.gov/agencies/whd/pandemic/ffcra-questions#12> 3/21/2022.

Resolution 9-F22. Calling for Improved Health Care for Sex Workers and the Decriminalization of Sex Work that Involves Participation of Consenting Adults

(Sponsor: Council of Student Members)

WHEREAS, consenting sex workers and victims of sex-trafficking are priority populations for public health¹; and

WHEREAS, in the later part of the 20th century, it is estimated that 46 million women (1.5% of the world's female population) had engaged in part- or full-time sex work²; and

WHEREAS, up to 75% of transgender women have engaged in sex work during their lifetimes³; and

WHEREAS, transgender women are 49 times more likely to have HIV than their adult counterparts and WHO/UNAIDS identified transgender women sex workers as having the highest prevalence of HIV worldwide⁴; and

WHEREAS, sex workers and sex-trafficking victims are at a disproportionate risk of violence and homicide, poor sexual health, worse perceived mental health, and poorer social determinants of health (such as not having completed high school or a sense of belonging or community)⁴⁻¹²; and

WHEREAS, up to 55% of cisgender women employed by sex work report workplace violence in the past year⁶; and

WHEREAS, sex workers are at increased risk for bloodborne pathogens and infections like HIV, chlamydia, and gonorrhea compared to their counterparts^{1,9,10}; and

WHEREAS, sex workers have been noted to have nearly triple the prevalence of unmet health care needs, and trafficking victims are noted to rarely receive preventative care⁵; and

WHEREAS, there may be intersectional aspects to consider and other vulnerabilities of sex workers, including human trafficking, poverty, substance use disorder, disability, immigration, sexism, racism, transphobia, and homophobia; and

WHEREAS, criminalization of sex work disrupts their work environments, support networks, risk reduction strategies, and access to health or justice services¹²; and

WHEREAS, decriminalization of sex work that involves the participation of consenting adults is necessary to decrease sex trafficking and exploitation of labor; and

WHEREAS, decriminalization of sex work that involves the participation of consenting adults involves protecting the workers but does NOT involve removing penalties for sex traffickers or for abuse of any kind towards sex workers; and

WHEREAS, repressive policing practices of sex work is associated with increased risk of sexual and physical violence from clients or partners and engaging in condom-less sex, and twice the odds of infections including HIV and STIs¹²; and

WHEREAS, previous arrest or recent incarceration is associated with major depression and poor mental health among sex workers¹³; and

WHEREAS, there is a positive association with drug and alcohol use (including drug use, non-prescription opioid use, and excessive alcohol use) and repressive policies^{12,14-18}; and

WHEREAS, repressive police policies, interaction with police, and police harassment are associated with avoiding healthcare services among sex workers^{12,19,20}; and

WHEREAS, typically sex workers report the experience of seeking mental health support as a negative experience²¹; and

WHEREAS, sex workers have reported poor treatment from mental health practitioners due to the practitioner imposing beliefs that sex work is a pathological root cause of mental health issues, approached their health with fascination and voyeurism, and seeing sex workers as victims lacking agency²¹; and

WHEREAS, sex workers have identified the stigma surrounding their profession having a significant impact on their mental health and fear of stigma can lead to non-disclosure to their physicians, which may lead to less comprehensive health care²¹⁻²⁴; and

WHEREAS, sex workers demonstrated greater health outcomes in countries where sex work is legalized and/or decriminalized^{12,25-27}; and

WHEREAS, decriminalization of sex work in New Zealand has resulted in improved workplace safety, emotional/mental health, and access to health and social care services^{22,28,29}; and

WHEREAS, decriminalization of sex work led to sex workers being more likely to engage in health service seeking behavior²⁵⁻²⁷; and

WHEREAS, in New Zealand, where sex work has been decriminalized, 91.8% of surveyed sex workers had accessed a general practitioner for sexual health needs²²; and

WHEREAS, mathematical modeling demonstrated that decriminalization of sex work could reduce incidence of HIV by half among sex workers and their clients over a 10-year period¹; and

WHEREAS, the FIGO Committee for Ethical Aspects of Human Reproduction and Women's Health states that women sex workers are entitled to medically-indicated preventive and therapeutic care in a non-judgmental, professional setting, without prejudicial stereotyping or stigma and that practitioners must be vigilant to recognize and redress their own tendencies³⁰; and

WHEREAS, there is growing support for occupational health and safety to better support sex worker health and growing public preference to decriminalize sex work^{31,32}; and

WHEREAS, there is a need to reform sex-work related laws and practices to help improve health outcomes of sex workers¹²; and

WHEREAS, the FIGO Committee for Ethical Aspects of Human Reproduction and Women's Health states that providers and medical associations have a responsibility to support their governments and societies to identify and relieve abuse of sex workers³⁰; 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 and within our own organization³³; and

WHEREAS, ACP has a goal of achieving equity for LGBT individuals in the health care system³⁴; and

WHEREAS, ACP supports increased efforts to evaluate and implement public policy interventions with the goal of reducing socioeconomic inequalities that have a negative impact on health³⁵; and

WHEREAS, ACP supports the availability of resources for those affected by intimate partner and sexual violence³⁶; and

WHEREAS, ACP opposes legislation or regulations that limit access to comprehensive reproductive health care for women³⁷; and

WHEREAS, ACP believes that it is essential for women to have access to affordable, comprehensive, and nondiscriminatory public or private health care coverage³⁷; therefore be it

RESOLVED, that the Board of Regents, along with other relevant stakeholders, develop curriculum to educate physicians on personal bias, stigmatization, and comprehensive health care for sex workers to provide better care for sex workers; and be it further

RESOLVED, that the Board of Regents, along with other relevant stakeholders, create policy and advocate for the decriminalization of sex work that involves participation of consenting adults and expungement of records for sex workers to better support sex worker health.

References:

1. Shannon K, Strathdee S, Goldenberg S, et al. GLOBAL EPIDEMIOLOGY OF HIV AMONG FEMALE SEX WORKERS: INFLUENCE OF STRUCTURAL DETERMINANTS. *Lancet*. 2015;385(9962):55-71. doi:10.1016/S0140-6736(14)60931-4
2. Benoit C, Jansson SM, Smith M, Flagg J. Prostitution Stigma and Its Effect on the Working Conditions, Personal Lives, and Health of Sex Workers. *The Journal of Sex Research*. 2018;55(4-5):457-471. doi:10.1080/00224499.2017.1393652
3. Herbst JH, Jacobs ED, Finlayson TJ, et al. Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review. *AIDS Behav*. 2008;12(1):1-17. doi:10.1007/s10461-007-9299-3
4. Baral SD, Poteat T, Strömdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *The Lancet Infectious Diseases*. 2013;13(3):214-222. doi:10.1016/S1473-3099(12)70315-8
5. Benoit C, Ouellet N, Jansson M. Unmet health care needs among sex workers in five census metropolitan areas of Canada. *Can J Public Health*. 2016;107(3):e266-e271. doi:10.17269/CJPH.107.5178
6. Deering KN, Amin A, Shoveller J, et al. A Systematic Review of the Correlates of Violence Against Sex Workers. *Am J Public Health*. 2014;104(5):e42-e54. doi:10.2105/AJPH.2014.301909
7. Ward H, Day S, Weber J. Risky business: health and safety in the sex industry over a 9 year period. *Sex Transm Infect*. 1999;75(5):340-343.
8. Potterat JJ, Brewer DD, Muth SQ, et al. Mortality in a Long-term Open Cohort of Prostitute Women. *American Journal of Epidemiology*. 2004;159(8):778-785. doi:10.1093/aje/kwh110
9. Baral S, Beyrer C, Muessig K, et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *The Lancet Infectious Diseases*. 2012;12(7):538-549. doi:10.1016/S1473-3099(12)70066-X
10. Grath-Lone LM, Marsh K, Hughes G, Ward H. The sexual health of female sex workers compared with other women in England: analysis of cross-sectional data from genitourinary medicine clinics. *Sex Transm Infect*. 2014;90(4):344-350. doi:10.1136/sextrans-2013-051381

11. Roxburgh A, Degenhardt L, Copeland J. Posttraumatic stress disorder among female street-based sex workers in the greater Sydney area, Australia. *BMC Psychiatry*. Published online 2006:12.
12. Platt L, Grenfell P, Meiksin R, et al. Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies. *PLoS Med*. 2018;15(12):e1002680. doi:10.1371/journal.pmed.1002680
13. Patel SK, Saggurti N, Pachauri S, Prabhakar P. Correlates of Mental Depression Among Female Sex Workers in Southern India. *Asia Pac J Public Health*. 2015;27(8):809-819. doi:10.1177/1010539515601480
14. Argento E, Chettiar J, Nguyen P, Montaner J, Shannon K. Prevalence and correlates of nonmedical prescription opioid use among a cohort of sex workers in Vancouver, Canada. *International Journal of Drug Policy*. 2015;26(1):59-66. doi:10.1016/j.drugpo.2014.07.010
15. Wirtz AL, Peryshkina A, Mogilniy V, Beyrer C, Decker MR. Current and recent drug use intensifies sexual and structural HIV risk outcomes among female sex workers in the Russian Federation. *International Journal of Drug Policy*. 2015;26(8):755-763. doi:10.1016/j.drugpo.2015.04.017
16. Shokoohi M, Karamouzian M, Sharifi H, et al. Crystal methamphetamine use and its correlates in women engaged in sex work in a developing country setting. *Drug and Alcohol Dependence*. 2018;185:260-265. doi:10.1016/j.drugalcdep.2017.12.025
17. Odinokova V, Rusakova M, Urada LA, Silverman JG, Raj A. Police sexual coercion and its association with risky sex work and substance use behaviors among female sex workers in St. Petersburg and Orenburg, Russia. *International Journal of Drug Policy*. 2014;25(1):96-104. doi:10.1016/j.drugpo.2013.06.008
18. Socías ME, Deering K, Horton M, Nguyen P, Montaner JS, Shannon K. Social and Structural Factors Shaping High Rates of Incarceration among Sex Workers in a Canadian Setting. *J Urban Health*. 2015;92(5):966-979. doi:10.1007/s11524-015-9977-9
19. Shannon K, Rusch M, Shoveller J, Alexson D, Gibson K, Tyndall MW. Mapping violence and policing as an environmental-structural barrier to health service and syringe availability among substance-using women in street-level sex work. *International Journal of Drug Policy*. 2008;19(2):140-147. doi:10.1016/j.drugpo.2007.11.024
20. Sou J, Goldenberg SM, Duff P, Nguyen P, Shoveller J, Shannon K. Recent im/migration to Canada linked to unmet health needs among sex workers in Vancouver, Canada: Findings of a longitudinal study. *Health Care for Women International*. 2017;38(5):492-506. doi:10.1080/07399332.2017.1296842
21. Treloar C, Stardust Z, Cama E, Kim J. Rethinking the relationship between sex work, mental health and stigma: a qualitative study of sex workers in Australia. *Social Science & Medicine*. 2021;268:113468. doi:10.1016/j.socscimed.2020.113468
22. Abel G. Sex workers' utilisation of health services in a decriminalized environment. *N Z Med J*. 2014;127(1390):30-37.
23. Sawicki DA, Meffert BN, Read K, Heinz AJ. Culturally competent health care for sex workers: an examination of myths that stigmatize sex work and hinder access to care. *Sexual and Relationship Therapy*. 2019;34(3):355-371. doi:10.1080/14681994.2019.1574970
24. Stigma, sex work, and substance use: a comparative analysis - Benoit - 2015 -Sociology of Health & Illness - Wiley Online Library. Accessed March 24, 2022. <https://onlinelibrary.wiley.com/doi/10.1111/1467-9566.12201>
25. O'Connor CC, Berry G, Rohrsheim R, Donovan B. Sexual health and use of condoms among local and international sex workers in Sydney. *Sexually Transmitted Infections*. 1996;72(1):47-51. doi:10.1136/sti.72.1.47
26. Pell C, Dabbhadatta J, Harcourt C, Tribe K, O'Connor C. Demographic, migration status, and work-related changes in Asian female sex workers surveyed in Sydney, 1993 and 2003. *Australian and New Zealand Journal of Public Health*. 2006;30(2):157-162. doi:10.1111/j.1467-842X.2006.tb00110.x
27. A decade of decriminalization: Sex work 'down under' but not underground - Gillian M Abel, 2014. Accessed March 24, 2022. <https://journals.sagepub.com/doi/abs/10.1177/1748895814523024>
28. Seib C, Fischer J, Najman JM. The health of female sex workers from three industry sectors in Queensland, Australia. *Social Science & Medicine*. 2009;68(3):473-478. doi:10.1016/j.socscimed.2008.10.024
29. Abel GM. Different stage, different performance: The protective strategy of role play on emotional health in sex work. *Social Science & Medicine*. 2011;72(7):1177-1184. doi:10.1016/j.socscimed.2011.01.021
30. Ethical health care of sex workers. *International Journal of Gynecology & Obstetrics*. 2016;133(2):245-246. doi:10.1016/j.ijgo.2016.02.001
31. Beyrer C, Crago AL, Bekker LG, et al. An action agenda for HIV and sex workers. *The Lancet*. 2015;385(9964):287-301. doi:10.1016/S0140-6736(14)60933-8
32. Ross MW, Crisp BR, Månsson SA, Hawkes S. Occupational health and safety among commercial sex workers. *Scandinavian Journal of Work, Environment & Health*. 2012;38(2):105-119. doi:10.5271/sjweh.3184

33. ACP. The American College of Physicians' Commitment to Being an Anti-Racist, Diverse, Equitable, and Inclusive Organization. https://www.acponline.org/acp_policy/policies/acp_diversity_equity_inclusion_commitment_2020.pdf
34. Daniel H, Butkus R, for the Health and Public Policy Committee of the American College of Physicians*. Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians. *Ann Intern Med.* 2015;163(2):135-137. doi:10.7326/M14-2482
35. Daniel H, Bornstein SS, Kane GC. Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. *Annals of Internal Medicine.* Accessed June 2, 2020. <https://www.acpjournals.org/doi/10.7326/M17-2441>
36. ACP. ACP Letter of Support for Reauthorization of the Violence Against Women Act. https://www.acponline.org/acp_policy/letters/acp_letter_of_support_for_reauthorization_of_the_violence_against_women_act_march_2021.pdf
37. Daniel H, Erickson SM, Bornstein SS. Women's Health Policy in the United States: An American College of Physicians Position Paper. *Annals of Internal Medicine.* 2018;168(12):874-875. doi:10.7326/M17-3344

Resolution 10-F22. Reducing ACP Plastic Waste

(Sponsor: Oregon Chapter; Co-sponsors: BOG Class of 2025; New York, Illinois-Southern, Hawaii, and Utah Chapters; Council of Student Members)

WHEREAS, ACP's goals include advocating for responsible positions on individual health and on public policy related to health and health care for the benefit of the public, patients, the medical profession, and our members (1); and

WHEREAS, ACP, as a member of the Medical Society Consortium on Climate and Health, endorses support for "addressing climate change through reduction in fossil fuel use" and taking other measures that "contribute to sustainability" and "reduce the carbon footprint of the health delivery system" (2); and

WHEREAS, ACP previously published and committed to recommendations for physicians and the broader healthcare community to engage in sustainable practices that reduce carbon emissions, including the prevention of waste (3); and

WHEREAS, plastics contribute substantially to carbon emissions and climate change throughout their lifecycle from extraction and transportation of the fossil fuels used to make plastics, to plastics refining and manufacturing, waste management, and unmanaged plastic waste in the environment, (4, 5); and

WHEREAS, the healthcare sector is one of the largest contributors to environmental degradation, producing approximately 4.4% of the world's total greenhouse gas emissions, and contributing significantly to plastic waste production, which accounts for approximately 25% of healthcare waste, including non-hazardous and non-medical plastic waste (6, 7, 8); and

WHEREAS, plastic waste is ubiquitous in the United States as well as other developed countries, and is especially notable and problematic in places with limited waste management. While some countries, organizations and individuals attempt to recycle plastic waste, over 90% isn't recycled and is either incinerated, which further generates CO₂ and toxic gas emissions, or ends up in landfills and/or the ocean (9); and

WHEREAS, each year approximately 8 million tons of plastic waste spreads into the ocean and millions of animals are killed yearly by plastic waste via entrapment or ingestion (10); and

WHEREAS, microplastics have been found in many aquatic species, terrestrial animals, and in human tissue through not only ingestion, but more recently inhalation as well (11, 12, 13); and

WHEREAS, given limits in plastic recycling and the millions of tons of plastic used annually, an important way to reduce plastic waste is by using less plastic; and

WHEREAS, ACP currently does not have any policy specifically regarding the use of plastic, plastic waste production, or goals for reduction by the organization; therefore be it

RESOLVED, that the Board of Regents reduce its organizational use of plastic. This includes reducing or eliminating the use of plastic at all in-house, regional and annual ACP meetings, as well as at ACP-sponsored CME events, limiting use of plastic wrap with publications, and making deliberate decisions about choosing sustainable, non-plastic materials for all ACP events and products; and be it further

RESOLVED, that the Board of Regents publicize their goals of reducing and/or eliminating plastic waste (e.g. plastic wrap with publications, etc.) and making deliberate decisions about choosing sustainable, non-plastic materials for all ACP events and products; and be it further

RESOLVED, that the Board of Regents bring forth a resolution to the AMA HOD that our AMA reduce its organizational use of plastic and encourage all medical organizations to do the same. This includes reducing or eliminating the use of plastics in AMA related materials, limiting use of plastic wrap with publications, and making deliberate decisions about choosing sustainable, non-plastic materials for all AMA meetings and products.

References:

1. <https://www.acponline.org/about-acp/who-we-are/mission-vision-goals-core-values>
2. <https://medsocietiesforclimatehealth.org/about/mission-and-consensus-statement/>
3. <https://www.acpjournals.org/doi/10.7326/M15-2766>
4. <https://yaleclimateconnections.org/2019/08/how-plastics-contribute-to-climate-change/>
5. <https://www.ciel.org/reports/plastic-health-the-hidden-costs-of-a-plastic-planet-may-2019/>
6. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01103#:~:text=Health%20care%20generates%20%E2%80%93, and%20use%20of%20scarce%20water>
7. <https://www.who.int/news-room/fact-sheets/detail/health-care-waste>) (https://noharm-europe.org/sites/default/files/documents-files/6886/2021-09-23_Measuring-and-reducing-plastics-in-the-healthcare-sector.pdf
8. <https://www.nationalgeographic.com/science/article/can-medical-care-exist-without-plastic#:~:text=Practice%20Greenhealth%2C%20a%20non%2Dprofit,most%20of%20which%20is%20plastic.>
9. <https://www.npr.org/2020/09/11/897692090/how-big-oil-misled-the-public-into-believing-plastic-would-be-recycled>
10. <https://www.nationalgeographic.com/environment/article/plastic-pollution>
11. <https://www.scientificamerican.com/article/from-fish-to-humans-a-microplastic-invasion-may-be-taking-a-toll/>
12. <https://www.sciencedirect.com/science/article/pii/S0160412022001258>
13. <https://www.sciencedirect.com/science/article/pii/S0048969722020009?via%3Dihub>

Resolution 11-F22. Recognizing Physicians Outside of Internal Medicine for Honorary ACP Fellowship

(Sponsor: Texas Chapter)

WHEREAS, recognizing physician colleagues outside of internal medicine for their contribution to the practice of medicine can help unify physicians collectively to one mission; and

WHEREAS, it meets the College's mission for diversity and equity – recognizing diverse population of physicians for remarkable accomplishments regardless of training; and

WHEREAS, it helps with recruitment and retention, allowing members to recognize colleagues outside the College for their achievements in promoting the art and science of medicine; and

WHEREAS, the individual would still need to meet rigorous criteria set forth when being considered, criteria could/should be established that would maintain the College's high standards and honor of the designation; and

WHEREAS, the College bylaws allow the Board of Regents (BOR) to bestow Honorary Fellowship, there is no established process for recognizing physicians who are not internal medicine trained, as there is no process via the Awards Committee or Mastership Committee for a routine vetting process for recommendation to the BOR such as exists with national awards and Masterships; therefore be it

RESOLVED, that the Board of Regents recognize physicians outside of the internal medicine discipline whose extensive body of work impacts the daily lives of all physicians within the U.S. and possibly across nations by granting honorary ACP fellowship, e.g. FACP(Hon); and be it further

RESOLVED, that the Board of Regents establish criteria and nominations process for recognizing physicians outside of internal medicine with Honorary Fellowship.

Resolution 12-F22. Asking CMS to Cover Insulin Pumps under Part B for Insulin Dependent Diabetics

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians regularly promotes medical policy for the benefit of patients' well-being; and

WHEREAS, it is a goal of the ACP to advocate responsible positions on public policy for the benefit of the public and our patients; and

WHEREAS, patients with insulin dependent diabetes often take insulin multiple times per day; and

WHEREAS, insulin pumps are available and facilitate this process, and

WHEREAS, Medicare Part B does not pay for insulin pumps despite the fact that other medical equipment is paid for by Medicare Part B; and

WHEREAS, presently insulin pumps are only partially paid for by Medicare Part D with a large copayment; and

WHEREAS, many Medicare patients do not even have Medicare Part D; therefore be it

RESOLVED, that the Board of Regents request CMS to pay for insulin pumps for insulin dependent diabetics under Medicare Part B.

Resolution 13-F22. Addressing the Recent Sharp Increases in Medical Liability Insurance Premiums around the Country

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians is an organization which works on a national level regarding matters like medical liability insurance (1,2) affecting the practice of medicine by its membership and the ability of patients to access medical care from its membership; and

WHEREAS, an important mission of the American College of Physicians is to serve the professional needs of its membership, advance internal medicine as a career and, in general, advocate for responsible positions relating to health care for the benefit of its patients and the public; and

WHEREAS, after nearly a decade of fairly stable rates, the proportion of medical liability insurance premiums that have increased year-to-year over the past three years have reached highs unseen since the turn of the century (3); and

WHEREAS, high insurance premiums potentially affect the ability of physicians to care for patients and the ability of patients to access medical care; and

WHEREAS, the American College of Physicians has not addressed by any new significant public policy statements the issue of medical liability insurance in recent years; and

WHEREAS, the American College of Physicians has, in specific, not publicly in any significant manner addressed this new worrisome spike in medical liability insurance premiums; therefore be it

RESOLVED, that the Board of Regents address the issue of the recent sharp rise in medical liability insurance premiums around the country, as well as consider ways to work effectively with other national medical organizations including the AMA, relevant medical specialty societies, and other appropriate stakeholders in this process.

References:

"Medical Liability Reform: Innovative Solutions for a New Health Care System". April 2014 ACP Policy paper

"Summary of ACP's Positions on Medical Liability Reform." December 2011

AMA Policy Research Perspectives: "Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Third Year in a Row." Jose R. Guardado PhD, 2022 American Medical Association