

## **Resolution 1-F21. Calling on ACP to Advocate to ACGME to Require a Longitudinal Advocacy Curriculum to Meet Internal Medicine Residency Milestones**

(Sponsor: Massachusetts Chapter)

WHEREAS, ACP's vision includes recognition globally as a leader in promoting advocacy for responsible positions on public policy related to healthcare for the benefit of the public, patients, and physicians; and

WHEREAS, ACP's core values include leadership that upholds the highest standards of professionalism, education, and advocacy; and

WHEREAS, advocacy is critical to expanding access to healthcare for patients and health equity for all patients; a core aim of ACP policy initiatives; and <sup>[1][2]</sup>

WHEREAS, the American Board of Internal Medicine Foundation and the American Medical Association include public advocacy among professional competencies and responsibilities of physicians; and <sup>[3],[4]</sup>

WHEREAS, the Internal Medicine ACGME Milestones 2.0 effective July 1, 2021 includes a competency for residents to be "Actively engaged in influencing health policy through advocacy activities at the local, regional, or national level."; and <sup>[5]</sup>

WHEREAS, formal advocacy curriculum in graduate medical education is an evidence-based strategy to improve trainees' knowledge, attitudes, and reported self-efficacy around advocacy, and <sup>[6],[7]</sup>

WHEREAS, the precedent for requiring structured educational experiences to prepare trainees in their role as advocate in Accreditation Council for Graduate Medical Education (ACGME) Program Requirements has existed in Pediatrics since 1997, and<sup>[8]</sup>

WHEREAS, ACP is the leader in advocacy for Internal Medicine and in providing educational training in advocacy; therefore be it

**RESOLVED, that the Board of Regents advocates to ACGME to require a longitudinal advocacy curriculum in ACGME Internal Medicine Residency Program Requirements and that ACP uses its expertise to develop this advocacy curriculum.**

### References:

<sup>[1]</sup> Ayotomiwa Ojo Raquel Sofia Sandoval Derek Soled Amanda Stewart. "No Longer An Elective Pursuit: The Importance Of Physician Advocacy In Everyday Medicine: Health Affairs Blog." Health Affairs, 19 Aug. 2020.

<sup>[2]</sup> Butkus, Renee, et al. "Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health." Annals of Internal Medicine, vol. 172, no. 2\_Supplement, 2020, doi:10.7326/m19-2410.

<sup>[3]</sup> ABIM Foundation, et al. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136(3):243–6.

<sup>[4]</sup> AMA Declaration of Professional Responsibility. American Medical Association. Accessed May 11, 2021. <https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility>.

- <sup>[5]</sup> Milestones by Specialty. Accreditation Council for Graduate Medical Education. Access May 19, 2021. <https://www.acgme.org/What-We-Do/Accreditation/Milestones/Milestones-by-Specialty/>.
- <sup>[6]</sup> Howell BA, Kristal RB, Whitmire LR, Gentry M, Rabin TL, Rosenbaum J. A systematic review of advocacy curricula in graduate medical education. *J Gen Intern Med*. 2019. <https://doi.org/10.1007/11606>. 1525-1497
- <sup>[7]</sup> McDonald M, Lavelle C, Wen M, Sherbino J, Hulme J. The state of health advocacy training in postgraduate medical education: a scoping review. *Med Educ*. 2019;53(12):1209–1220. doi:10.1111/medu.13929
- <sup>[8]</sup> Lichtenstein C, Hoffman BD, Moon RY. How Do US Pediatric Residency Programs Teach and Evaluate Community Pediatrics and Advocacy Training? *Acad Pediatr*. 2017 Jul;17(5):544-549. doi: 10.1016/j.acap.2017.02.011. Epub 2017 Feb 28. PMID: 28254496.

## **Resolution 2-F21 . Advocating for Inclusion of Antimicrobial Resistance and Stewardship Education in Medical School Curriculum and Internal Medicine Residency**

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, antimicrobial resistance is a serious and complicated public health problem recognized by the World Health Organization as one of the top 10 global health threats<sup>1</sup>; and

WHEREAS, the Centers for Disease Control and Prevention notes that at least 2.8 million antibiotic-resistant infections occur, and as a result, more than 35000 people die every year<sup>2</sup>; and

WHEREAS, the ACP has published several guidelines to promote appropriate use of antibiotics in certain settings<sup>3,4</sup>; and

WHEREAS, the emphasis that is currently placed on antimicrobial resistance and stewardship varies widely between different undergraduate medical education and internal medicine residency training programs, despite increasing use of empiric broad-coverage antibiotics amid the COVID-19 pandemic<sup>5</sup>; therefore be it

**RESOLVED, that the Board of Regents collaborate with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Infectious Diseases Society of America, and other pertinent stakeholders, to make education on antimicrobial resistance and stewardship a required component of the curriculum for medical students and internal medicine residents.**

### References:

1. World Health Organization. Antimicrobial resistance. <https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance> (Accessed May 10, 2021)
2. U.S. Department of Health and Human Services, CDC. Antibiotic Resistance Threats in the United States, 2019. <https://www.cdc.gov/drugresistance/pdf/threats-report/2019-ar-threats-report-508.pdf> (Accessed on May 10, 2021)
3. Rachael A. Lee, Robert M. Centor, Linda L. Humphrey, et al. Appropriate Use of Short-Course Antibiotics in Common Infections: Best Practice Advice From the American College of Physicians. *Ann Intern Med.* [Epub ahead of print 6 April 2021]. doi:10.7326/M20-7355
4. Aaron M. Harris, Lauri A. Hicks, Amir Qaseem. Appropriate Antibiotic Use for Acute Respiratory Tract Infection in Adults: Advice for High-Value Care From the American College of Physicians and the Centers for Disease Control and Prevention. *Ann Intern Med.* 2016;164:425-434. [Epub ahead of print 19 January 2016]. doi:10.7326/M15-1840
5. Hsu, J. How covid-19 is accelerating the threat of antimicrobial resistance. *BMJ* 2020;369: m1983. doi: 10.1136/bmj.m1983

### **Resolution 3-F21. Removing Criteria that Disqualifies Applicants for Invited Fellowship for Lapsed Payment of Dues**

(Sponsor: New York Chapter; Co-Sponsors: BOG Class of 2025, Massachusetts, Oregon, and South Dakota Chapters)

WHEREAS, the American College of Physicians and affiliated state and international Chapters are membership-based organizations; and

WHEREAS, ACP and Chapters collectively work to recruit and retain members; and

WHEREAS, according to ACP membership materials, ideal candidates for membership are Internists who “go above and beyond in their care of patients; [are] leaders who make a difference in the lives of others professionally or in their local communities; [and are] dedicated to fostering excellence and professionalism in the practice of medicine;<sup>[11](#)</sup>” and

WHEREAS, ACP recruitment materials further state “[a]s a peer-reviewed, peer-supported credential, the FACP designation has significant value. It recognizes ongoing individual service, contributions to the practice of medicine, and enables members to become more involved with ACP, nationally and locally. ACP Fellows embody what it means to be part of the ACP community. They inspire those around them – from patients, to students, to colleagues;” and

WHEREAS, in the vast majority of instances, Internists are welcomed to Fellowship by being a dues-paying member for the 3 years immediately prior to submitting for Fellow status, having an active medical license, practicing or holding an academic position for at least three years, focusing clinical activity in internal medicine, a subspecialty, or neurology; participating in continuing medical education; and volunteering time in community service or community activities; and

WHEREAS, an alternative pathway for Fellowship is available through Invited Fellowship, which occurs when ACP leaders (current and past Regents, Governors, Governors-elect or ACP staff who are Masters or Fellows) invite a colleague to Fellowship. This applies to any highly qualified candidate who meets the requirements for advancement to Fellowship; and

WHEREAS, applicants for Invited Fellowship are declined if the applicant was a member of ACP in the past, but let his or her membership lapse at any point in the preceding three years; and

WHEREAS, applicants for Invited Fellowship would be eligible except for their lapsed dues payment status and this rule, which was instituted in summer 2019, has created a barrier to Invited Fellowship; and

WHEREAS, Invited Fellowship is sometimes used to target worthy women and other underrepresented physicians who often fly “under the radar” and are less likely to seek fellowship through the traditional or guided pathway; therefore be it

**RESOLVED, that the Board of Regents redact the lapsed dues payment exclusion criteria from the Invited Fellowship application process and consider payment of dues at the time of advancement to fellowship to be instituted as new policy.**

References:

[11](#) “Leaders, Mentors, Educators, Researchers, Influencers, Fellows in Internal Medicine: Take Your Career to the Next Level.” ACP Fellowship. Accessed on Web May 11, 2021.

## **Resolution 4-F21. Supporting a Policy to Avoid Conflicts of Interest for Physician Solicitation of Financial Contributions from Patients**

(Sponsor: Pennsylvania Chapter; Co-Sponsors: New York, Maine, New Hampshire, Florida, Wisconsin, Puerto Rico, Massachusetts, and BOG Class of 2022)

WHEREAS, many grateful patients wish to make contributions to physicians, practices or health systems in order to express their gratitude; and

WHEREAS, philanthropy is generally considered to be a “voluntary action for the public good” and is associated with an increased well-being and a sense of empowerment for the donor; and

WHEREAS, grateful patient fund raising (GPFR) provides substantial philanthropic funding for health care institutions; and

WHEREAS, some institutions offer physicians direct financial incentives for soliciting philanthropic donations from patients; and

WHEREAS, if institutions offer incentives to physicians to encourage their participation in GPFR, a potential ethical conflict is created between the physician’s interest in the patient’s medical care and outcomes and the physician’s interest in securing a philanthropic gift from the patient in order to realize an incentive; and

WHEREAS, GPFR discussions must be avoided when patients are clinically vulnerable; and

WHEREAS, the current ACP Ethics Manual (7<sup>th</sup> edition) includes only a brief mention of this subject: “Physician involvement in patient or family gifts to an institution can raise ethical issues for the patient–physician relationship and confidentiality. Donations should be explored with the institution’s administration.”; and

WHEREAS, the AMA (in their Code of Medical Ethics) and the Association for Healthcare Philanthropy (in a white paper on the subject) both include more robust guidance on this issue and advise against direct solicitation or physician incentives, as a means of sustaining public trust and maintaining the integrity of the doctor-patient relationship; therefore be it

**RESOLVED, that the Board of Regents support the creation of a policy, and more detailed guidance in the ACP Ethics Manual, regarding physician involvement in fundraising from patients, which limits any real or perceived conflict of interest with patient care including, but not limited, to a) prohibiting physician financial incentives and b) ensuring that physician participation is voluntary and without repercussions.**

References:

ACP Ethics Manual (7<sup>th</sup> ed). Available at <https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-seventh-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-seventh-edition>

AMA Code of Medical Ethics Opinion 2.3.5: Soliciting Charitable Contributions from Patients. Available at <https://www.ama-assn.org/delivering-care/ethics/soliciting-charitable-contributions-patients>

Ethical Issues and Recommendations in Grateful Patient Fundraising and Philanthropy. *Academic Medicine*:  
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[file:///C:/Users/maryg/Downloads/Ethical\\_Issues\\_and\\_Recommendations\\_in\\_Grateful.18.pdf](file:///C:/Users/maryg/Downloads/Ethical_Issues_and_Recommendations_in_Grateful.18.pdf)

## **Resolution 5-F21. Addressing Concerns about Private Equity Firms and Their Effect on Medical Care**

(Sponsor: District of Columbia Chapter)

WHEREAS, a recent policy paper published in the *Annals of Internal Medicine* and various news reports have raised questions as to whether purchases of medical entities by private equity groups (ones whose primary mission is profit making rather than supporting medical practices in remaining viable and effective) may be resulting in adverse effects upon quality of patient care in general and, in particular, upon quality of care provided to diverse populations; and

WHEREAS, a mission of the American College of Physicians is to establish and promote the highest clinical standards and ethical ideals; and

WHEREAS, the ACP has recently reemphasized the importance of addressing inequalities in care to divergent populations; and

WHEREAS, the recent ACP policy paper recommended that “systematic studies of this trend on patients, medicine, and society are needed” to understand the scope of this problem; therefore be it

**RESOLVED, that the Board of Regents work actively on developing specific policies for encouraging the collection of data on the scope of private equity group purchases of medical entities, including potentially:**

- 1. Contacting other relevant medical organizations such as the American Medical Association and the American Academy of Family Practice regarding ways to work together to encourage collection of relevant data.**
- 2. Contacting organizations like the Robert Wood Johnson Foundation to encourage efforts to study whether there is a significant problem and, if so, how to ameliorate it**
- 3. Asking ACP chapters to contact their membership to gather a better understanding as to how our membership is being affected by the purchase of medical practices and organizations by private equity groups.**

References:

[https://www.acponline.org/acp\\_policy/policies/ethical\\_and\\_professional\\_implications\\_of\\_physician\\_employment\\_health\\_care\\_business\\_practices\\_2021.pdf](https://www.acponline.org/acp_policy/policies/ethical_and_professional_implications_of_physician_employment_health_care_business_practices_2021.pdf)

## **Resolution 6-F21. Facilitating Research and Treatment of Covid “Long Haulers”**

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has devoted considerable efforts towards educating its membership about the Covid 19 Virus epidemic; and

WHEREAS, the ACP is an organization whose mission and goals include promoting the highest clinical standards and in advocating responsible positions on individual health and on public policy related to health care for the benefit of the public and our patients; and

WHEREAS, there is increasing concern that there are many individuals who after developing acute Covid-19 infection may continue to have symptoms related to the infection even after the acute effects of the virus resolve; and

WHEREAS, some of these “Long Haul” patients demonstrate symptoms of severe fatigue made worse by activity, unrefreshing sleep, autonomic dysfunction, and/or “brain fog which are symptoms seen with the Chronic Fatigue/Myalgic Encephalomyelitis (CFS/ME) Syndrome and in POTS.”; and

WHEREAS, Covid is a viral disease as CFS/EM and POTS are theorized to be; and

WHEREAS, techniques useful in treating symptoms of one set of presumed post viral illnesses might be useful in treating similar symptoms when experienced by “Long Haul” Covid patients; and

WHEREAS, much has been learned about the management of CFS/ME and POTS over the past three decades (including the fact that “typical” approaches used in medicine to rehabilitate individuals debilitated from traditional medical illnesses can sometimes be counterproductive in treating patients with CFS/EM and POTS) ; and

WHEREAS, the National Institutes of Health has announced that Congress has provided \$1.15 billion in funding over four years for NIH to support research into the prolonged health consequences of SARS-CoV-2 infection; therefore be it

**RESOLVED, that the Board of Regents take the following actions to facilitate research and treatment of individuals with “Long Haul” Covid:**

- 1. Commend the NIH on its plan to fund comprehensive and coordinated basic research into the prolonged health consequences of SARS-Cov-2 infection, while also strongly encouraging the NIH to proceed as fast as is considered scientifically appropriate with the funding of well-designed treatment trials in light of the anticipated widespread amount of human suffering expected from this condition.**
- 2. Request that as the NIH funds “Long Haul Covid” treatment programs, it facilitate the development of clinical trials which assess the effectiveness of treatment approaches proven useful for CFS/ME and POTS disease when offered to Covid “Long Haulers” with symptoms similar to CFS/ME and/or POTS disease.**
- 3. Encourage “Long-Haul Covid” clinics such as ones being developed at some teaching centers to apply for NIH funding to explore best practices for treating individuals with “Long-Haul Covid” including ones which utilize techniques related to those used in treating CFS/ME and POTS.**



- 4. Encourage or/and aid in the development of professional education programs which provide opportunities for clinicians to learn about the principles of management of CFS/ME, POTS, and similar syndromes so they can utilize such knowledge when treating Covid “Long Haul” patients when traditional medical approaches do not appear appropriate or are not proving effective.**

References:

NIH: Trying to Make Sense of Long COVID Syndrome. Posted on January 19<sup>th</sup>, 2021 by Dr. Francis Collins

NIH: Turning Discovery into Health. Statement from the NIH Director. February 23, 2021: NIH launches new initiative to study “Long Covid”

NIH: Turning Discovery into Health. Research Opportunity Announcement TA-21-015A Post-Acute Sequelae of SARS-CoV-2 Infection Initiative: Clinical Science Core, Data Resource Core, and PASC Biorepository Core

## **Resolution 7-F21. Advocating for Pan Asian/Asian American Racial/Ethnicity Data Inclusion and Representation to Promote Health Equity**

(Sponsor: Massachusetts Chapter; Co-Sponsors: Michigan, California Southern Region 2, California Southern Region 3, California Northern, Florida, Indiana, Minnesota, South Dakota, Louisiana, New Jersey Northern, and New Jersey Southern Chapters; Council of Early Career Physicians, Council of Student Members, and BOG Class of 2025)

WHEREAS, “ACP recommends that U.S. policymakers commit to understanding and addressing disparities in health and health care related to a person's race, ethnicity, religion, and cultural identity [their personal characteristics], as aligned with ACP's mission “to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.” [1]; and

WHEREAS, ACP believes that a commitment to diversity, inclusion and equity strengthens the organization's capacity to respond to the needs of its members, patients, the profession and the public, as one of its core values; and

WHEREAS, accurate, inclusive, and comprehensive health data promotes health equity for all patients; and

WHEREAS, data for the Pan Asian/Asian American communities are frequently omitted or not included, or are classified as “other”, in health surveys and public health or medical studies [2] [3]; and

WHEREAS, this omission and/or lack of representation impedes the evaluation of health disparities affecting, and impairs the achievement of health equity for, the Pan Asian/Asian American communities; and

WHEREAS, the Pan Asian/Asian American communities conventionally include all peoples of birth or descent from the countries of the East Asian Subcontinent, Southeast Asian Subcontinent, South Asian Subcontinent, and may also include Indigenous Native Hawaiian peoples and non-Hawaiian Pacific Islanders; and

WHEREAS, the Pan Asian/Asian American categorization represents a very heterogeneous and diverse group of peoples whose cultural, immigrant, and health experiences in the U.S. often differ significantly; therefore be it

**RESOLVED, that the Board of Regents advocates, in collaboration with other stakeholders (including but not limited to the National Academies of Science, Engineering, and Medicine [NASEM], and other organized medicine societies), for the collection and inclusion of the Pan Asian/Asian American communities’ disaggregated racial/ethnic data in health systems, health surveys, public health and medical studies, whenever such surveys and studies provide data on other communities of color. This advocacy can also include requests for major funders of scientific studies to set standards for data collection ensuring inclusion of Pan Asian/Asian American communities’ disaggregated racial/ethnic data.**

References:

[1] Josh Serchen, BA; Robert Doherty, BA; Omar Atiq, MD, David Hilden, MD, MPH. "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." *Annals of Internal Medicine*, April 2021.

[2] Christopher W. Tessum, Joshua S. Apte, Andrew L. Goodkind, Nicholas Z. Muller, Kimberley A. Mullins, David A. Paoella, Stephen Polasky, Nathaniel P. Springer, Sumil K. Thakrar, Julian D. Marshall, and Jason D. Hill "Inequity in consumption of goods and services adds to racial–ethnic disparities in air pollution exposure" *PNAS* March 26, 2019 116 (13) 6001-6006

[3] American Cancer Society. *Colorectal Cancer Facts & Figures 2017-2019*. Atlanta: American Cancer Society; 2017.

**Resolution 8-F21. Facilitating Physicians in Providing Medical Care to Their Out-of-State Patients Without Imposing Undue Burdens or Compromising Doctor-Patient Relationships**

(Sponsor: District of Columbia Chapter)

WHEREAS, missions of the ACP include advocating responsible public policy relating to health care, as well as to serve the professional needs of the membership; and

WHEREAS, ACP regularly promotes or suggests policy that affects the manner in which its membership is best able to care for their patients; and

WHEREAS, the recent Covid epidemic has highlighted the difficulties physicians encounter when trying to provide medical care to their patients when their patients are out of state; and

WHEREAS, attempts are underway or being contemplated to partially ameliorate this problem through structures such as the “Interstate Medical Licensure Compact” program or through broad national licensing initiatives supported by companies such as Amazon; and

WHEREAS, broadening the ability of physicians to care for their patients when they are elsewhere in the country is desirable, it is also possible that efforts to extend licensure may result in local primary care physicians finding themselves in a position of competing with large national commercial organizations (for which financial rewards are their primary goal); and

WHEREAS, these type of actions by large commercial organizations may result in the weakening of local doctor-patient relationships; and

WHEREAS, the ACP has commented on many occasions that there is value in strong doctor-patient relationships; and

WHEREAS, it is important also to consider whether an overall national system of physician licensure should be pursued rather than depend upon rather cumbersome complicated methods such as the “Interstate Medical Licensure Compact” or temporary waivers such as provided by CMS during the Covid pandemic; therefore be it

**RESOLVED, that the Board of Regents investigate current initiatives being pursued, such as the “Interstate Medical Licensure Compact” program, and provide recommendations that address how initiatives can be developed that allow physicians to provide medical care to their patients when they are out of state through a system which is not excessively onerous but still protective of the doctor-patient relationship.**

References:

Page 7 of ACP statement to US Senate Committee: “Examining Our COVID-19 Response: An Update from the Frontlines” March 9, 2021

**Resolution 9-F21. Providing Educational Material to Physicians on the Changes to the “Stark Law” as Announced by CMS in November 2020**

(Sponsor: District of Columbia Chapter)

WHEREAS, mission of the ACP include establishing and promoting the highest clinical standards and ethical ideals and to serve the professional needs of the membership; and

WHEREAS, the ACP regularly provides information to members through the ACP Internist, Web email, and through the Practice Education section of the ACP website; and

WHEREAS, CMS announced what they described as “historic changes” to the Physician Self-Referral Regulations (“Stark Law”) in November 2020, which they stated would “open avenues for healthcare providers to ensure patients receive highest quality of care.”; and

WHEREAS, many physicians are unaware of these changes and their implications for practicing high quality and comprehensive care; therefore be it

**RESOLVED, that the Board of Regents prepare educational material for ACP members which explain the changes in the Stark Law, as well as to provide examples of how these changes may enable ACP members to increase quality and comprehensiveness of care. Potentially this could be done in part by developing a learning module on the ACP website.**

References:

CMS Fact Sheet: Modernizing and Clarifying the Physician Self-Referral Regulations Final Rule (CMS-1720-F) November 20, 2020 (for physicians)

## **Resolution 10-F21. Promoting Policy Standards for Reporting Diagnostic Errors of Hospitalized and Ambulatory Patients**

(Sponsor: Ohio Chapter)

WHEREAS, the 2015 United States National Academy of Medicine (NAM)'s report, *Improving Diagnosis in Health Care*, concluded that diagnostic errors - defined as "the failure to establish an accurate and timely explanation of the patient's health problem(s) or communicate that explanation to the patient"- represents a major public health problem likely to affect every one of us at least once in our lifetime, sometimes with devastating consequences<sup>1</sup>; and,

WHEREAS, more than 12 million Americans are affected each year by diagnostic errors<sup>2</sup>, with perhaps one-third of those suffering serious harms<sup>3</sup>; and

WHEREAS, diagnostic errors are not only the most common and catastrophic of medical errors, but also the most costly, with aggregate costs to the healthcare system likely in excess of \$100 billion<sup>4</sup>; and

WHEREAS, the 2015 NAM report declared that "improving the diagnostic process is not only possible, but it also represents a moral, professional, and public health imperative." It also noted that diagnostic errors are "the bottom of the iceberg" of patient safety<sup>4</sup> and improving diagnosis is "the next frontier for patient safety"<sup>5</sup>; and

WHEREAS, despite the toll of diagnostic error on lives and resources, reporting of diagnostic error in healthcare organizations to tackle this problem remains minimal, which limits the progress in maturing the science of improving diagnostic quality and safety in every care settings<sup>1,6</sup>; and

WHEREAS, diagnostic error is commonly multifactorial in origin, typically involving both system-related and cognitive factors<sup>7</sup>; and

WHEREAS, to routinely assess the quality of diagnostic care, we need methods to better identify and define diagnostic errors; and

WHEREAS, finding and reporting diagnosis errors in hospitalized and ambulatory patients remains a challenge due to lack of reporting systems that are specifically designed to capture these errors, which is different than medical errors and near misses that are mostly related to treatment but not to the diagnosis<sup>1</sup>; and

WHEREAS, lack of specialized health information technology (HIT) systems specifically designed to capture diagnostic errors is a barrier for accurate and relevant data collection<sup>8</sup>; and

WHEREAS, the current national quality measurements endorsed by national organizations do not take diagnostic accuracy into account. Thus, organizations may be rewarded for achieving high ratings on quality measures even if patient has received the correct treatment for an incorrect diagnosis<sup>8</sup>; and

WHEREAS, the current measures of quality of care in primary care are not focused on diagnostic error<sup>9</sup>; and

WHEREAS, reporting of diagnostic errors among the hospitalized and ambulatory patients is urgently needed in order for health care organizations to be able to analyze it and to come up with appropriate solutions to reduce it and subsequently prevent it<sup>9,10</sup>; and

WHEREAS, the American College of Physicians is a member of the Coalition to Improve Diagnosis, convened and led by the Society to Improve Diagnosis in Medicine (SIDM), which has a single goal of improving the diagnostic process through increasing awareness and engagement, identifying and driving the adoption of effective quality improvement interventions and catalyzing actions by member organizations<sup>11</sup>; and

WHEREAS, the American College of Physicians has a published position paper titled “ Patient Safety in The Office- Based Practice Setting”<sup>12</sup>,that addresses reporting medical errors, including diagnostic errors, in the ambulatory office setting; and

WHEREAS, the American College of Physicians in the same position paper recommended that health information technology (HIT) systems should be tailored to emphasize patient safety improvement<sup>12</sup>, but didn’t’ provide specific recommendations on development of diagnostic errors reporting mechanisms or protocols outside the physician office setting; and

WHEREAS, the American College of Physicians goals include: to advocate responsible position on public policy related to health care for the benefit of the public, patients, and the medical profession and to establish and promote the highest clinical standards and ethical ideals; and

WHEREAS, the College strategic priorities for 2020-21 include “to drive systematic change in healthcare to support physicians in providing the best possible care”; and

WHEREAS, the significance of reporting diagnostic errors for organizational learning, patient safety, healthcare safety culture and physician’s engagement, is substantial. The creation of systems that can capture these errors is fundamental to enhance overall quality and safety of diagnosis and healthcare; therefore be it

**RESOLVED, that the Board of Regents:**

- **Advocate for automated use of health information technology (HIT) to securely report diagnostic errors in healthcare organizations (HCO).**
- **Promote engagement and support of the organizations’ leadership and stakeholders at all levels.**
- **Promote continuous analysis of the reported diagnostic errors, understand how diagnostic errors occur and subsequently create system fixes that can prevent them from happening again; and be it further**

**RESOLVED, that the Board of Regents:**

- **Promote a safety culture around patient safety events related to diagnostic errors.**
- **Promote proper education and training on diagnostic errors reporting systems as part of organizations’ safety culture.**
- **Promote medical education around diagnostic errors as part of medical schools and internal medicine residency programs curriculum.**

## References:

1. Improving Diagnosis in Health Care. Institute of Medicine; 2015. Available from: <http://www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx>. Accessibility verified January 15, 2018.
2. Singh H, Meyer AN, Thomas EJ. The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. *BMJ Qual Saf*. 2014.
3. Singh H, Giardina TD, Meyer AN, Forjuoh SN, Reis MD, Thomas EJ. Types and origins of diagnostic errors in primary care settings. *JAMA Intern Med*. 2013;173(6):418-25.
4. Newman-Toker DE. Diagnostic value: the economics of high-quality diagnosis and a value-based perspective on diagnostic innovation. Modern Healthcare Annual Patient Safety & Quality Virtual Conference; June 17, 2015.
5. Newman-Toker DE, Pronovost PJ. Diagnostic errors--the next frontier for patient safety. *JAMA*. 2009;301(10):1060-2.
6. Saltzman AB, Keita M, Saber Tehrani AS, Hassoon A, Hough DE, Newman-Toker DE. US federal research funding on diagnostic error substantially lags its public health burden. Diagnostic Error in Medicine 10th International Conference, October 8-10, 2017; Newton, MA.
7. [Mark L. Graber, MD](#); [Nancy Franklin, PhD](#); [Ruthanna Gordon, PhD](#), Diagnostic Error in Internal Medicine. *Arch Intern Med*. 2005;165(13):1493-1499. doi:10.1001/archinte.165.13.1493
8. Patient safety primer (PSP). 2018. Reporting patient's safety events (<https://psnet.ahrq.gov/primers/primer/13/reporting-patient-safety-events>).
9. Lorincz CY, Drazen E, Sokol PE, et al. *Research in Ambulatory Patient Safety 2000–2010: A 10-Year Review*. American Medical Association, 2011.
10. Wynia MK, Classen DC. Improving ambulatory patient safety: learning from the last decade, moving ahead in the next. *JAMA*. 2011 Dec 14; 306(22): 2504-5. doi: 10.1001/jama.2011.1820. PMID: 22166611.
11. <https://www.improvediagnosis.org/coalition-members/>
12. [https://www.acponline.org/acp\\_policy/policies/patient\\_safety\\_in\\_the\\_office\\_based\\_practice\\_setting\\_2017.pdf](https://www.acponline.org/acp_policy/policies/patient_safety_in_the_office_based_practice_setting_2017.pdf)



## **Resolution 11-F21. Advocating for Legislation that Supports Modernization of Supervision of Non-Physician Practitioners**

(Sponsor: Council of Resident/Fellow Members; Co-Sponsor: Georgia Chapter)

WHEREAS, 84% of patients state they want physicians to lead their medical care teams<sup>1</sup>; and

WHEREAS, nurse practitioners (NPs) have been licensed to prescribe medications in all 50 states, practice independently immediately upon graduation in twenty-three states including Washington D.C., and practice independently after varying amounts of time in several other states; and physician assistants (PAs) are seeking independent practice in some states<sup>2</sup>;

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) has stated that patients can have a “licensed independent practitioner” as the sole practitioner responsible for patient care in a residency training program<sup>3</sup>; and

WHEREAS, the COVID pandemic has elucidated the potential uses for telemedicine medicine<sup>4</sup>; and

WHEREAS, the American College of Physicians (ACP) has previously supported the use of a “virtual” clinical care team to allow for supervision of non-physicians<sup>5</sup>; therefore it be

**RESOLVED, that the Board of Regents advocate for legislation that supports the modernization of supervision of PAs and nurse practitioners (NPs) to include supervision requirements for telemedicine encounters, and to address limitations on the number of PAs and NPs supervised by a single physician; and be it further**

**RESOLVED, that the Board of Regents advocate for ACGME requirements to specify that supervision of physician trainees should be performed by physicians; and be it further**

**RESOLVED, that the Board of Regents study and update their position statement on best practices for supervising non-physician practitioners to ensure physician-led care, to address telemedicine, number of non-physician practitioners supervised by a single physician, and physician trainee supervision.**

### References:

<sup>1</sup>American Medical Association. Truth in Advertising Survey Results. [https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey\\_0.pdf](https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/tia-survey_0.pdf)

<sup>2</sup>American Association of Nurse Practitioners. <https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief>

<sup>3</sup>Accreditation Council for Graduate Medical Education. Core Program Requirements. <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf>

<sup>4</sup>Health Resources and Services Administration. [https://telehealth.hhs.gov/providers/billing-and-reimbursement/?gclid=CjwKCAjwkN6EBhBNEiwADVfyayjSfmPmXeLIQq5t3h1cl3cTPpIRxEqHDCNXiDiHyJoclpwJk-zSeRoCbmoQAvD\\_BwE](https://telehealth.hhs.gov/providers/billing-and-reimbursement/?gclid=CjwKCAjwkN6EBhBNEiwADVfyayjSfmPmXeLIQq5t3h1cl3cTPpIRxEqHDCNXiDiHyJoclpwJk-zSeRoCbmoQAvD_BwE)

<sup>5</sup><https://www.acpjournals.org/doi/10.7326/0003-4819-159-9-201311050-00710>

## **Resolution 12-F21. Providing Support for Lactating Physician Mothers**

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, the percentage of female physicians is currently 36%<sup>1</sup>, and the percentage of medical students identifying as female has most recently approached 55% and is expected to grow<sup>2</sup>; and

WHEREAS, there is a persistent pay gap between women and men in medicine<sup>3</sup>; and

WHEREAS, multiple organizations including the American College of Obstetricians and Gynecologists<sup>4</sup> and the American Association of Pediatrics<sup>5</sup> support the importance of providing breastmilk to infants; and

WHEREAS, many physician mothers set a goal of breastfeeding of one year, however most do not achieve this goal, with just under half reporting work demands as their reason for premature breastfeeding cessation<sup>6</sup>; and

WHEREAS, only 32 states have laws that specifically address exempt employees such as physicians, and even those who do often do not include protections for pumping location and time<sup>7</sup>; and

WHEREAS, the American College of Physicians (ACP) has supported steps to achieving gender equality in the recent past, including opposition to discrimination on the basis of reproductive status<sup>8</sup>; and

WHEREAS, at least one institution has provided one year of support for ambulatory clinicians in the form of lactation credits, allowing one 30-minute lactation hold in each half-day clinic session<sup>9</sup>; therefore it be

**RESOLVED, that the Board of Regents develop a position statement that highlights the importance of supporting physician mothers in achieving their breastfeeding goals, including encouraging hospitals and clinics to develop policies that provide private lactation spaces in close proximity of workspaces and equipped with a phone and computer to address productivity goals, and to offer physicians protected time for lactation without affecting income, for the first 12 months of their child's life.**

References:

<sup>1</sup><https://www.kff.org/other/state-indicator/physicians-by-gender>

<sup>2</sup>Association of American Medical Colleges. Matriculating Student Questionnaire: 2020 All Schools Summary Report. December 2020.

<sup>3</sup><https://hbr.org/2019/11/how-to-close-the-gender-pay-gap-in-u-s-medicine>

<sup>4</sup>Committee on Obstetric Practice: Breastfeeding Expert Work Group. Optimizing Support for Breastfeeding as Part of Obstetric Practice. October 2018.

<sup>5</sup>Breastfeeding and the use of human milk. Pediatrics. 2012, 129(3):e827-e841.

<sup>6</sup>Sattari M, Levine D, Neal D, Serwint Janet. Personal breastfeeding behavior of physician mothers is associated with their clinical breastfeeding advocacy. Breastfed Med. 2013 Feb; 8(1): 31-37

<sup>7</sup><https://www.ncsl.org/research/health/breastfeeding-state-laws.aspx>

<sup>8</sup><https://www.acpjournals.org/doi/full/10.7326/M17-3438>

<sup>9</sup>[https://campuslifeservices.ucsf.edu/familyservices/35/lactation\\_credits\\_for\\_ucsf\\_health\\_ambulatory\\_clinicians](https://campuslifeservices.ucsf.edu/familyservices/35/lactation_credits_for_ucsf_health_ambulatory_clinicians)