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

*[SPONSOR ACCEPTED AS REAFFIRMATION]*

(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.**

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**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.**

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

*[SPONSOR ACCEPTED AS REAFFIRMATION]*

(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 states[2]; 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 condition[8]; 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**

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**organizations (such as medical staff credentialing entities) to use non-stigmatizing language in 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, Southern California III, 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.**

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**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 inequities[1]; 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 health[2]; and

WHEREAS, gerrymandering has the potential to influence PDOHs and perpetuates health inequities in resource-poor and minoritized communities[3]; 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 officials[4]; 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 outcomes[3]; 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 gerrymandering[3]; 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 Act[3–5]; 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 others[4]; 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" approach[7]; 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 health[7]; 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.**

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**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, Illinois, New York , Minnesota , 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 illness[1]; 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 Organization[9]; and

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[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 roups 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 pregnancy[18]; and

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[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 2015–2019BMJ 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-abortions-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/texass-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 relationship[19], 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 2019Volume 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 statements[1] and advocacy for the FAMILY act (HR804/S248) via letter of support[2], 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 laws[3]; 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 workers[4]; and

WHEREAS, the FFRCA 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.**

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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
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**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 health[1]; 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 work[2]; and

WHEREAS, up to 75% of transgender women have engaged in sex work during their lifetimes[3]; 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 worldwide[4]; 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 year[6]; 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 care[5]; 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 services[12]; 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 STIs[12]; and

WHEREAS, previous arrest or recent incarceration is associated with major depression and poor mental health among sex workers[13]; 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 experience[21]; 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 agency[21]; 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 care[21–24]; 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 behavior[25–27]; 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 needs[22]; 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 period[1]; 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 tendencies[30]; 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 workers[12]; 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 workers[30]; 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 organization[33]; and

WHEREAS, ACP has a goal of achieving equity for LGBT individuals in the health care system[34]; 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 health[35]; and

WHEREAS, ACP supports the availability of resources for those affected by intimate partner and sexual violence[36]; and

WHEREAS, ACP opposes legislation or regulations that limit access to comprehensive reproductive health care for women[37]; and

WHEREAS, ACP believes that it is essential for women to have access to affordable, comprehensive, and nondiscriminatory public or private health care coverage[37]; 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.**

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**Resolution 10-F22. Reducing ACP Plastic Waste**

(Sponsor: Oregon Chapter; Co-sponsors: BOG Class of 2025; New York, Illinois-Southern, Hawaii, Southern California III, 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.**

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**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 ACCEPTED AS REAFFIRMATION]*

(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
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