

## **Resolution 1-F20. Advocating for Visitation and Support of Hospitalized Individuals for Persons with Cognitive or Intellectual and Developmental Disabilities during a Pandemic**

(Sponsor: Texas Chapter; Co-Sponsors: Governor Classes 2020, 2021, 2022, 2023)

WHEREAS, the American College of Physicians is committed to advocating for access to quality health care for all, regardless of race, ethnicity, socioeconomic status or other factors<sup>(1)</sup> and WHEREAS, intellectual and developmental disabilities affect up to 3% of people in the United States<sup>(2)</sup>; and

WHEREAS, persons with intellectual and developmental disabilities are less likely to receive adequate medical care than the general population despite their increased burden of chronic health problems and shortened life expectancy<sup>(3)</sup>; and

WHEREAS, individuals with intellectual and developmental disabilities may have certain limitations or behaviors that may impact clinical care for both the patient and provider, such as limited verbal communication skills, difficulties with understanding consent, care plans, and treatment, situational trauma with unfamiliar settings, low stress thresholds, and ongoing anxiety due to separation from support figures; and

WHEREAS, these limitations to care are exacerbated with separation from designated support figures; and

WHEREAS, designated support figures may provide vital bio-psycho-social information not otherwise available to medical staff that can impact clinical decisions and outcomes, and;

WHEREAS, when legally eligible designated support figures may act as the patient's medical proxy, or provide communication support between the patient and hospital staff, and;

WHEREAS, few physicians have had formal training regarding the specific needs of this population or may not possess the comfort level required to treat people with intellectual and developmental disabilities and few medical schools include content regarding people with such disabilities in their curricula<sup>(6)</sup>; and

WHEREAS, training and increased familiarity with individuals with disabilities leads to favorable outcomes of greater confidence and willingness to provide care; therefore be it

**RESOLVED, that the Board of Regents advocates for hospitals/health care systems to revise their “No Visitors” policy to allow persons with cognitive or intellectual deficits and/or developmental disabilities a designated support figure while in their institution during pandemics.**

### **REFERENCES:**

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<sup>2</sup>The ARC: Intellectual Disability. Retrieved

<sup>3</sup>U.S. Surveillance of Health of People with Intellectual Disabilities: A White Paper; Centers for Disease Control and Prevention/National Center on Birth Defects and Developmental Disabilities Health Surveillance Work Group. September, 2009.

<sup>4</sup>Autistic Self Advocacy Network Policy Brief: The case for designation of people with intellectual and developmental disabilities as a medically underserved population. April 2014.

<sup>5</sup>Section 330 of the Public Health Service Act. 42 USC § 254b(b)(3)(A)2010.

<sup>6</sup>Woodward L et al. An innovative clerkship module focused on patients with disabilities. Academic Medicine, Vol. 87, No. 4. April 2012.

Additional references:

### **Intellectual Disability (Intellectual Developmental Disorder)**

Intellectual disability involves impairment of general mental abilities that impact adaptive function in three domains. These domains determine how well an individual copes with everyday tasks.

Conceptual domain includes skills in language, reading, writing, math, reasoning, knowledge and memory

Social domain refers to empathy, social judgement, interpersonal communication, ability to make and retain friendships

Practical domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, organizing school and work tasks.

Symptoms begin during the developmental period and are diagnosed based on severity of deficits in adaptive function.

*Source: American Psychiatric Association*

### **Developmental Disability**

The current definition under the DD Act defines “developmental disability” as a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:

II) Receptive and expressive language.

III) Learning.

IV) Mobility.

V) Self-direction.

VI) Capacity for independent living.

[VII) Economic self-sufficiency; and

(v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

*Source: Title 42 U.S. Code § 15001 Section 102 (8).*

American Medical Association House of Delegates Policy H-90.968 Medical care of persons with developmental disabilities.

American Medical Association CMS Report 3-I-11. Designation of the intellectually disabled as a medically underserved population.

**Resolution 2-F20. Studying the Impact of the SARS-CoV-2 Pandemic and Developing Policy to Insure Safe Operation of Long-term Care Facilities during Healthcare Emergencies**

(Sponsor: Oregon Chapter)

WHEREAS, maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care; and

WHEREAS, many of the most fragile and elderly members of our society spend transitional time or reside permanently in the long-term care (LTC) environment which includes skilled nursing facilities, post-acute care facilities, intermediate care facilities, residential care facilities, memory care units, adult care homes, assisted living facilities, et al.; and

WHEREAS, the COVID-19 pandemic has exposed gaps in our ability to safely staff LTC facilities due to rapid escalation in numbers of affected residents combined with reduced numbers of staff available for their care; and

WHEREAS, death rates for the elderly and LTC residents have been disproportionately high during the COVID-19 pandemic with >79% of deaths occurring in those over the age of 64, and COVID-19 deaths in LTC facilities accounting for approximately 27% of deaths in states reporting these statistics; and

WHEREAS, many complex factors contribute to reduced HCP availability in a pandemic situation or other times of crisis including but not limited to: illness among healthcare personnel; social factors such as transportation, housing, childcare and care of other family members; widespread demand for HCP, which creates a local deficit in staff availability and competition for workers' scheduled time especially when HCP work at multiple facilities; quarantine requirements for HCP who have had a suspected or known exposure; and

WHEREAS, the existing LTC workforce is disproportionately composed of racial and ethnic minorities who are at risk for worse outcomes should they develop COVID-19 and they may also be in high risk categories for other reasons or have family members in high risk categories, reducing their willingness to assume the increased risk of caring for patients with highly contagious illnesses; and

WHEREAS, the majority of workers in the LTC environment are lower-wage workers and this work may not be considered highly desirable, resulting in difficulty maintaining an experienced and knowledgeable staff of HCP under normal circumstances; and

WHEREAS, the narrow revenue margin for companies managing LTC facilities dictates lean staffing ratios in order to keep the business viable; and

WHEREAS, prior natural disasters such as flooding and hurricanes have exposed similar care challenges for LTC facilities; and

WHEREAS, all these factors result in few options for mitigation of staffing challenges in LTC facilities in a crisis, worsening the safety of HCP in the work environment and placing residents/patients at risk of unsafe care environments when staff availability is reduced; and

WHEREAS, although much attention has been paid to shortages of PPE to protect front-line healthcare workers in inpatient settings, LTC workers' access to PPE has been even more limited and had little attention despite widespread COVID-19 outbreaks in LTC facilities; and

WHEREAS, state health departments and public health departments have been ill-equipped to provide additional resources when a LTC staffing crisis occurs; and

WHEREAS, a safe and adequately resourced work environment is an issue of justice, equity, and respect for both LTC workers and the vulnerable elderly population in our country; therefore be it

**RESOLVED, that the Board of Regents, in collaboration with other stakeholders, studies the impact of SARS-CoV-2 pandemic on post-acute care and long-term care facilities to better understand the emergency needs of LTC facilities (including managing gaps in staffing and resources) when responding to natural disasters and health emergencies; and be it further**

**RESOLVED, that the Board of Regents collaborates with other stakeholders in using this evidence to develop policy and guidance for federal, state and local public health authorities to insure safe operation of long-term care facilities during public health emergencies and natural disasters, with policy recommendations to include but not be limited to:**

- a) Planning for adequate funding and access to resources
- b) Planning for emergency staffing of health care and maintenance personnel
- c) Planning for insuring safe working conditions of LTC staff

**REFERENCES:**

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2. <https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm> (as of April 30, 2020)
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10. <https://paLTC.org/amda-white-papers-and-resolution-position-statements/checklist-pro-active-care-vulnerable-patients>
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12. <https://www.nytimes.com/interactive/2020/05/09/us/coronavirus-cases-nursing-homes-us.html>

### **Resolution 3-F20. Readdressing the Issue of Hospital Patient Status**

(Sponsor: Tennessee Chapter)

WHEREAS, it has become increasingly difficult for patients to qualify for inpatient status as insurers designate higher levels of acuity to meet inpatient requirements. Patients requiring IV diuretics for acute heart failure, IV steroids for COPD exacerbations, of continuous vasoactive drips for cardiac dysrhythmias, for instance, no longer meet requirements for inpatient hospitalization; and

WHEREAS, financial penalties create pressure for hospitals to designate more patients, even some with critical illness, as observation status; and

WHEREAS, hospitals are forced to employ teams of utilization reviewers to navigate an increasingly complicated status process, further increasing health care costs; and

WHEREAS, observation status forces patients to pay significantly more for hospital based services and medications; and

WHEREAS, this overly complex system, driven by insurers, negatively impacts patients, physicians, hospitals, and health care systems; therefore be it

**RESOLVED, that the Board of Regents advocates for support of decreased complexity of inpatient and observation status, and recommends a transparent, consistent reimbursement of appropriate care; and be it further**

**RESOLVED, that the Board of Regents promotes development of clinical diagnostic standards for inpatient and observation status.**

## **Resolution 4-F20. Advocating for Coverage of Mental Health Counselor and Marriage and Family Therapist Services under Medicare**

(Sponsor: Montana Chapter)

WHEREAS, the population of older adults in the United States is expected to nearly double over the next 20 years, such that those 65 and older will increase from 13 percent to 20 percent of the population; and

WHEREAS, if the prevalence of mental health disorders among older adults remains unchanged, over the next 20 years the number of older adults with mental health and/or substance disorders will nearly double from about 8 million to about 15 million people; and

WHEREAS, Medicare presently recognizes psychologists, clinical social workers, and psychiatric nurses to provide covered mental health services; and

WHEREAS, mental health counselors and marriage and family therapists have equivalent education and training to clinical social workers, but are not eligible to serve Medicare beneficiaries; and

WHEREAS, recognition of mental health counselors and marriage and family therapists would increase the pool of eligible mental health professionals in the Medicare program by over 120,000 licensed practitioners; and

WHEREAS, legislation has been introduced previously toward this end in the 113<sup>th</sup> and 114<sup>th</sup> Congress, and currently in the 116<sup>th</sup> Congress as the “Mental Health Access Improvement Act of 2019” (HR.945/S.286); therefore be it

**RESOLVED, that the Board of Regents advocates for the passage of federal regulation and/or legislation to mandate Medicare coverage of mental health counselor and marriage and family therapist services.**

### **Sources:**

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American Mental Health Counselors Association. Advocacy: Medicare. Retrieved from <https://www.amhca.org/advocacy/medicare>

S.286 – Mental Health Access Improvement Act of 2019. Retrieved from <https://www.congress.gov/bill/116th-congress/senate-bill/286?q=%7B%22search%22%3A%5B%22s.286%22%5D%7D&s=1&r=1>

**Resolution 5-F20. Defining Physician Practice Styles in ACP Policy**

*[SPONSOR ACCEPTED AS REAFFIRMATION -- NO DEBATE]*

(Sponsor: Florida Chapter)

WHEREAS, the umbrella of internal medicine is comprised of many different clinical disciplines; and

WHEREAS, the practice of medicine allows for internists to focus on various practice styles; and

WHEREAS, several societies have arisen to address the needs of various branches of internal medicine; and

WHEREAS, many corporate systems do not properly define inpatient vs outpatient care in an attempt to control the flow of patients; and

WHEREAS, corporate systems are trying to steal patients by conflating primary care with inpatient care; and

WHEREAS, hospitalists are focused on inpatient care; and

WHEREAS, primary care physicians focus on outpatient and inpatient care; and

WHEREAS, primary care physicians have many roles and provide longitudinal care in a comprehensive fashion; and

WHEREAS, no specific policy or definition has been codified to elucidate the responsibilities of various physician types; and

WHEREAS, this issue will become increasingly important as more physicians become employed and lose their identity with their professional home; and

WHEREAS, the ACP is the premier organization for internal medicine; and

WHEREAS, properly defining responsibilities and practice styles can help to reinvigorate the identity of physician types; and

WHEREAS, it is important for ACP to take the lead on defining primary care; therefore be it

**RESOLVED, that the Board of Regents will officially define as policy the various types of physician practice styles that include but are not limited to primary care physician and hospitalist.**

## **Resolution 6-F20. Creating a Congressionally-Mandated COVID-19 Commission to Inform Future Public Health Pandemic Efforts**

(Sponsor: Oregon Chapter)

WHEREAS, ACP policy supports a coordinated federal, state, tribal, and local effort to strengthen public infrastructure in order to ensure the US healthcare system is capable of responding to public health needs<sup>1</sup>; and

WHEREAS, ACP policy that predates the global COVID-19 pandemic<sup>2</sup> warned of the need for a comprehensive health care response to a global pandemic in order to save lives, decrease illness, and avoid disruption to the economy; and

WHEREAS, the United States has been the apparent epicenter of the global COVID-19 pandemic and subsequent concerns arising about the United States' capabilities to mount a strategically formulated and concerted response with regards to: effective testing strategies, timely directives on appropriate utilization of social distancing directives, evidence-supported efforts to maintain strategic stockpiles of Personal Protective Equipment (PPE) and ventilators; and

WHEREAS, the College is committed to evidence-based and responsible policy development for the benefit of the public<sup>3</sup>, in order to develop innovative strategies that improve the delivery and quality of healthcare<sup>4</sup>; and

WHEREAS, due to the complex interplay of local, state, and national agencies in pandemic response, traditional academic institutions may not have the authority or resources to acquire all information needed to effectively study and evaluate the United States' preparedness and immediate response to the COVID-19 pandemic; and

WHEREAS, in recent historic national crisis - namely the September 11, 2001 terrorist attacks - congressional leaders established the 9-11 commission<sup>5</sup> which was an independent bi-partisan effort to prepare a full and complete account of the circumstances surrounding the September 11, 2001 terrorist attacks, including preparedness for and the immediate response to the attacks; and

WHEREAS, commissioning a similar broad-reaching task force under the direction of The United States Congress to complete a comprehensive review and report on the United States' preparedness and immediate response to the COVID-19 pandemic will inform preparation and response to future pandemics; therefore be it

**RESOLVED, that the Board of Regents advocates for passage of federal legislation to create a congressionally-mandated commission, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform future public policy and health systems preparedness; and be it further**

**RESOLVED, that the Board of Regents bring forth a resolution requesting that our AMA advocate for passage of federal legislation to create a congressionally- mandated commission, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform future public policy and health systems preparedness.**

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<sup>2</sup>[https://www.acponline.org/system/files/documents/advocacy/current\\_policy\\_papers/assets/pandemic\\_flu.pdf](https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/pandemic_flu.pdf)

<sup>3</sup>[https://www.acponline.org/advocacy/current-public-policy-papers/acps-public-policy-development-process?\\_ga=2.211018716.858997394.1586448659-1183262080.1583363361](https://www.acponline.org/advocacy/current-public-policy-papers/acps-public-policy-development-process?_ga=2.211018716.858997394.1586448659-1183262080.1583363361)

<sup>4</sup>[https://www.acponline.org/system/files/documents/about\\_acp/who\\_we\\_are/strategic\\_priorities/acp-strategy18-20.pdf](https://www.acponline.org/system/files/documents/about_acp/who_we_are/strategic_priorities/acp-strategy18-20.pdf)

<sup>5</sup> <https://www.9-11commission.gov/>

## **Resolution 7-F20. Promoting Policy Standards for Workplace Violence Prevention and Management**

(Sponsor: Council of Early Career Physicians; Co-sponsors: Council of Resident/Fellow Members, Council of Student Members, Colorado, Connecticut, Georgia, and Mississippi Chapters)

WHEREAS, workplace violence, a form of workplace trauma, includes “adversity in the work environment through harassment, bullying, threats, and assault in the workplace” [1,2], including but not limited to systemic racism [3], sexual harassment and other forms of discrimination, as well as physical violence, such as homicide [4,5]; and

WHEREAS, the American College of Physicians’ position paper on the hidden curriculum addresses workplace violence in the clinical learning environment [6], but does not address workplace violence involving the patient or their caregivers as perpetrators, with the physician or healthcare professional as the victim; and

WHEREAS, the ACP Ethics Manual does not cover workplace violence perpetrated by patients and caregivers against physicians and healthcare professionals [7], which constitutes 9% of workplace injury incidents in healthcare, and furthermore, one-third of these are perpetrated by patients [8,9]; and

WHEREAS, in a 2014 survey of hospitals, violence perpetrated by patients in the workplace accounted for 75% of aggravated assaults and 93% of all assaults against employees [10,11]; and

WHEREAS, workplace violence in healthcare settings is likely underreported [10]; and

WHEREAS, a Charter of Professionalism for Health Care Organizations [12] states that, “Organizations should monitor the well-being of their employees and provide resources both to improve their general health and to relieve those who suffer disproportionately...and provide resources for those who struggle” [13]; and

WHEREAS, ACP identifies among its 2018-2020 strategic goals “supporting healthy lives for physicians” and inclusivity as a priority theme of the College [14]; and

WHEREAS, standards for workplace violence prevention and management in health care have been published by the Occupational Safety and Health Administration (OSHA) [15] and the Joint Commission [16], however, their adoption and implementation in hospitals and healthcare systems is not standard due to a lack of familiarity with and/or voluntary nature of such guidelines [10] (only 14 hospitals participate in OSHA’s Voluntary Protection Program [8,17]); and

WHEREAS, the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 7141) introduced to Congress in November 2018 stipulates that hospitals would be required to implement plans to prevent violence, and that hospitals could face fines for not reporting incidents to OSHA [18]; and

WHEREAS, healthy lives of physicians are threatened by workplace violence perpetrated by patients and caregivers, including a fourfold higher risk of healthcare workers requiring time away from work as a result of violence compared to other types of injury [9,19]; therefore be it

**RESOLVED, that the Board of Regents creates policy to support physicians by promoting the development of clear institutional procedures that prevent and address workplace violence, in alignment with OSHA and Joint Commission standards, for example mandatory reporting of injury cases to OSHA and root cause analyses of reported workplace violence, including physical and verbal violence, sexual harassment, racism, and other forms of discrimination; and be it further**

**RESOLVED, that such a policy also includes addressing a need for interdisciplinary collaboration (e.g. with nursing and other health professional organizations, along with relevant non-medical disciplines with expertise in workplace violence prevention) to support reduction of workplace violence for everyone to have a safe and supportive workplace environment; and be it further**

**RESOLVED, that the Board of Regents include in such a policy statement: (1) support for legislation that addresses workplace violence perpetrated against physicians; (2) strongly recommend that hospitals and healthcare systems implement clearly written and transparent institutional policy regarding workplace violence; and (3) identify high-quality, competency-based education for healthcare worker and bystander training (e.g. skills in de-escalation), either through third-party organizations or as a service developed by the ACP, with the aim of promoting rapid identification and response to impending workplace violence and systematic management of instances of workplace violence when they occur [20].**

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**Resolution 8-F20. Studying the Impact of and Advocating for Assistance with the Public Service Loan Forgiveness Program**

(Sponsor: Council of Resident/Fellow Members; Co-sponsor: Council of Early Career Physicians and Council of Student Members)

WHEREAS, more than 70% of those graduating medical school report education related debt, with a median debt of \$200,000 [1]; and

WHEREAS, more than 40% of those students in debt plan, at graduation, to enter loan repayment programs, the most popular of which is the Department of Education Public Service Loan Forgiveness (PSLF) [1]; and

WHEREAS, educational debt is associated with increased life stress and may be a factor in the choice of practice type and specialty choice [2]; and

WHEREAS, as of 2019, less than 1% of submitted loan forgiveness applications were approved [3], likely related in part to lack of guidance from the Department of Education (DOE) [4,5]; and

WHEREAS, refinancing loans with a private lender will disqualify borrowers for PSLF and consolidating loans with government lenders resets the PSLF payment schedule, increasing the number of payments needed to qualify; and

WHEREAS, current borrowers of medical school debt are in a precarious position, forced to hold on to higher interest loans with the government despite growing uncertainty surrounding their ability to have their loans forgiven even while working in a not-for-profit setting [6]; therefore be it

**RESOLVED, that the Board of Regents study the impact of the DOE Public Service Loan Forgiveness Program on all physicians and physicians-in-training with a current or rejected application in this program; and be it further**

**RESOLVED, that the Board of Regents partner with other relevant stakeholders to advocate on behalf of physician trainees and early career physicians who have active applications in the DOE Public Service Loan Forgiveness Program by directly interfacing with the DOE to ensure improvements in the transparency and simplification of the approval process, and development of a fair appeals process for rejected applications; and be it further**

**RESOLVED, that the Board of Regents work to create resources for students, trainees, and early career physicians that educate them in the important details and pitfalls of the application process for the DOE Public Service Loan Forgiveness program.**

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## **Resolution 9-F20. Studying New Issues Emerging from the COVID-19 Pandemic that Impact Health Disparities in Marginalized and At-Risk Communities and Recommending Public Policy Solutions**

(Sponsor: New York and Massachusetts Chapters)

WHEREAS, outcomes from the COVID-19 pandemic in the United States demonstrate that a disproportionate impact of this disease is borne by minority and marginalized communities; and

WHEREAS, the American College of Physicians is a champion of health disparities research as demonstrated in recent policy guidance including “Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper”<sup>1</sup> and “Envisioning a Better US Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health”<sup>2</sup>; and

WHEREAS, health disparities research focused on education, environmental health, public health, transportation, labor, and other policies is not broad enough to encompass all of the factors that impact health outcomes for at-risk populations in the current pandemic including vulnerabilities that arise from classifications as essential workers, the necessity of using public transportation, lack of access to personal protective gear, employment conditions that prevent social distancing, and others; and

WHEREAS, the COVID-19 pandemic demonstrates that at-risk communities are found in all regions of the country including rural, urban, and suburban areas and that, although there is a great deal of overlap in the difficulties encountered among populations in different regions, these communities also face unique challenges as well; and

WHEREAS, in rural areas, farm workers are essential workers for public food supply and guidelines for safe practices at work must be implemented to ensure the health of the farm worker community<sup>3</sup>; and

WHEREAS, in urban areas, patient transportation aides, home healthcare workers, public transportation operators, and numerous others, provide the workforce infrastructure necessary for the effective operation of critical services and guidelines for safe practices are needed to prevent the spread of disease while at work, home, interacting with community residents, and others; and

WHEREAS, the ACP recognizes a lack of adequate public health infrastructure for vulnerable populations and the importance of supporting programs which reduce health disparities for marginalized groups<sup>4</sup>;

WHEREAS, ACP members provided care to patients suffering from COVID-19 from the moment the disease first emerged through the present and, with the spread of disease anticipated until a cure or

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<sup>1</sup> Daniel, Hilary; Sue Bornstein; and Gregory Kane. “Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper.” *Annals of Internal Medicine*. 168:577-578. 2018.

<sup>2</sup> Butkus, Renee; Katherine Rapp; Thomas Cooney and Lee Engel. “Envisioning a Better US Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health. *Annals of Internal Medicine*. 172:550-559. 2020

<sup>3</sup> 2018 ACP Policy Statement Addressing Social Determinants to Improve Patient Care and Promote Health Equity

<sup>4</sup> 2012 ACP Policy Position Strengthening the Health Care Infrastructure p 10

vaccine is developed, are in a position to promote the adoption of recommendations developed pursuant to this resolution for the benefit of vulnerable populations; therefore be it

**RESOLVED, that the Board of Regents study the factors that influence health outcomes for at-risk communities during this virus pandemic; and be it further**

**RESOLVED, that the Board of Regents develop public policies to protect all essential workers, with a focus on marginalized populations, during pandemics and mitigate adverse outcomes; and be it further**

**RESOLVED, that the Board of Regents issue a policy supporting the creation of enforced federal mandates for workplace protections for all essential workers during the Covid-19 pandemic, to ensure adequate protective equipment and enforce physical distancing in every aspect affecting occupational health including communal housing and close quarters in the workplace; and be it further**

**RESOLVED, that the Board of Regents develop public policies to promote equitable healthcare for all and to mitigate the impact of COVID-19 for vulnerable populations.**

## **Resolution 10-F20. Seeking Federal Protection for Doctors that Administer Vaccines**

(Sponsor: Florida Chapter; Co-sponsors: District of Columbia and Southern California I)

WHEREAS, vaccines have been proven to save lives and are an effective means of infection prevention; and

WHEREAS, data has proven multiple times that vaccines are not linked with autism or other serious illness; and

WHEREAS, many groups persist in unfounded anti-vaccine rhetoric; and

WHEREAS, these groups are becoming increasingly more widespread and hostile; and

WHEREAS, these groups are harassing medical professionals in the course of their duties; and

WHEREAS, physicians have been assaulted by anti-vaccine groups, such as the attack on Dr. Richard Pan in California; and

WHEREAS, these groups have organized and coordinated their efforts to disrupt modern science; and

WHEREAS, one of these groups has a Facebook page "Inundate the ACIP" to systematically protest and disrupt the CDC held meeting of the Advisory Committee of Immunization Practices (1); and

WHEREAS, the repeated activities required increased security at these meetings; and

WHEREAS, these groups are using scare tactics and threats to interfere with physicians who give vaccines including posting defamatory statements on social media; and

WHEREAS, the FACE or Freedom of Access to Clinic Entrances Act protects physicians who provide reproductive services from being blockaded, attacked or disrupted and created a national task force to handle these issues (2); and

WHEREAS, no such specific regulation exists to protect vaccine providers; and

WHEREAS, the possibility of more disruptive and possibly fatal attacks may occur; therefore be it

**RESOLVED, that the Board of Regents seeks federal protection for doctors who give vaccines which includes but is not limited to seeking similar legislation to the Freedom of Access to Clinic Entrances Act for vaccine providers.**

### **REFERENCES:**

1. <https://www.facebook.com/pg/InundateCDCACIP/posts/>
2. [S.636 - 103rd Congress \(1993-1994\): Freedom of Access to Clinic Entrances Act of 1994](#)

## **Resolution 11-F20. Formalizing the Residency Program Closure Process and Preventing Hardships for Trainees**

(Sponsor: Council of Resident/Fellow Members; Co-sponsor: Council of Early Career Physicians and Council of Student Members)

WHEREAS, the closing of Hahnemann University Hospital disrupted the training of 571 residents and fellows, including those who had signed contracts after The Match of 2019, with minimal notice given to these trainees;<sup>1</sup> and

WHEREAS, Hahnemann sent letters to incoming residents stating their jobs were not in jeopardy in April 2019, but by June 26th, announced that the hospital was shutting down;<sup>2</sup> and

WHEREAS, CMS requires residents to be at the closing institution on the day of closing in order for federal funding to transfer to a receiving hospital, which prevents residents who have found a new program to transfer immediately and creates a barrier to their integration into a new program;<sup>3,4</sup> and

WHEREAS, fifty-five residents on J-1 visas faced potential deportation as a result of the sudden hospital closure due to their visa status requiring minimal gaps in their employment;<sup>5</sup> and

WHEREAS, closures similar to that of Hahnemann have nearly occurred and may occur in the future necessitating a re-evaluation of how the Accreditation Council for Graduate Medical Education (ACGME) and the Centers for Medicare and Medicaid Services handles such closures as to not jeopardize the health of our patients or the training of our future physicians;<sup>6</sup> and

WHEREAS, The National Resident Matching Program has a government protected monopoly over the entire residency labor market forcing vulnerable residents into a multiyear agreement with a single hospital with several roadblocks, as seen in this Hahnemann example, to transfer to another program;<sup>7</sup> therefore be it

**RESOLVED, that the Board of Regents work with the ACGME, CMS, and other relevant stakeholders to create a formal and transparent residency program closure process, delineating a hospital's responsibility to prevent hardships for trainees including, but not limited to, a reasonable amount of notice to trainees, attempts to relocate trainees prior to closure, allowing trainees to start work at their accepting institution at a reasonable time before the day of closing, and assistance in filing for visa extensions; and be it further**

**RESOLVED, that the Board of Regents collaborate with ACGME to study the impact of an annual financial health assessment as part of its accreditation process for all hospitals where trainees may rotate as part of their common program requirements.**

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2. Philly's hospital's unexpected closure leaves residents scrambling. <https://www.acepnow.com/article/philly-hospitals-unexpected-closure-leaves-residents-scrambling/>. Updated 8/14/19. Accessed 10/14/19.

3. What residents need to know about the Hahnemann University Hospital closure. <https://www.aamc.org/news-insights/what-residents-need-know-about-hahnemann-university-hospital-closure>. Updated 07/18/19. Accessed 10/14/19.
4. A major hospital announces it is closing: the fallout for neurology residents and patient services. [https://journals.lww.com/neurotodayonline/Fulltext/2019/09050/A\\_Major\\_Hospital\\_Announces\\_It\\_Is\\_Closing\\_The.8.aspx](https://journals.lww.com/neurotodayonline/Fulltext/2019/09050/A_Major_Hospital_Announces_It_Is_Closing_The.8.aspx). Updated 09/05/19. Accessed 10/14/19.
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7. Hammer, P. and W. Sage. Critical issues in hospital antitrust law. *Health Affairs*. 2003;22(6)88-100.

## **Resolution 12-F20. Supporting the Mental Health of Medical Students**

(Sponsor: Council of Student Members; Co-sponsors: Council of Early Career Physicians, Council of Resident/Fellow Members, and District of Columbia Chapter)

WHEREAS, ACP currently has policy on providing mental health services in Graduate Medical Education (Resolution 10-F07) but not Undergraduate Medical Education; and

WHEREAS, one of ACP's goals is to serve the professional needs of the membership, support healthy lives for physicians, and advance internal medicine as a career; and

WHEREAS, burnout and depression are highly prevalent in practicing physicians (1, 2) and arise as early as medical school, with a 2016 meta-analysis reporting depression or depressive symptoms in 27.2% of medical students but only 15.7% of those students seeking psychiatric treatment (3); and

WHEREAS, medical students experience burnout and depression at a much higher rate than those in the same age cohort in the general population (4) despite beginning medical school with a lower rate of burnout and depression symptoms (5); and

WHEREAS, burnout and depression in medical students can associate with negative outcomes such as career choice regret (6), increased rate of medical errors as residents (7-9), and increased risk for a suicide attempt (10); and

WHEREAS, while both the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation standards state that a medical school has in place an effective system of counseling for medical students, the implementation and effectiveness of these programs vary (11, 12); therefore be it

**RESOLVED, that the Board of Regents advocates for medical student access to free, confidential, and easily available stigma-free mental health and substance use disorder services; and be it further**

**RESOLVED, that the Board of Regents advocates for the education of medical students in the recognition of the signs and symptoms of burnout and depression; and be it further**

**RESOLVED, that the Board of Regents study the opportunity to collaborate with other stakeholders including the American Medical Association and Association of American Medical Colleges to study the incidence of and risk and protective factors for depression and suicide among physicians, residents, and medical students.**

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**Resolution 13-F20. Updating ACP Policy to Define Ownership of Patient Medical Records**

*[SPONSOR ACCEPTED AS REAFFIRMATION -- NO DEBATE]*

(Sponsor: Florida Chapter; Co-sponsor: District of Columbia Chapter)

WHEREAS, physicians create a patient's medical record as an interpretation of the patient's symptoms and physical findings; and

WHEREAS, debate continues as to who is entitled to those medical records; and

WHEREAS, the physician becomes the custodian of record to maintain those records; and

WHEREAS, patients, insurance companies, and multiple other entities may require copies of those records; and

WHEREAS, a cost may be incurred to copy those records that can be onerous to many practices; and

WHEREAS, the patients may not fully understand what they are legally entitled to; and

WHEREAS, many state statutes define the physician as the owner of the medical records; and

WHEREAS, employed physicians may be put in a conflicted situation where the employer is trying to control the records created by the physician; and

WHEREAS, the intellectual property of the physician needs to be respected; therefore be it

**RESOLVED, that the Board of Regents update policy to reflect that the patient medical record is created and owned by the physician, but patients are only allowed to have a copy of those records.**