

Resolution 1-S22. Advocating for Transparency of Medical Honor Society Selection Processes to Eliminate Racial Disparities in Membership Induction and Decreased Use of Selection in Residency Application Consideration

(Sponsor: Council of Student Members; Co-Sponsor: New Mexico Chapter)

WHEREAS, the American College of Physicians (ACP) believes that a diverse, equitable, and inclusive physician workforce is crucial to promote equity and understanding among clinicians and patients and to facilitate quality care, and it supports actions to achieve such diversity, equity, and inclusion; and

WHEREAS, the ACP recommends implementation of policies and practices to eliminate racism and discrimination experienced by health care professionals, especially medical students, residents, and faculty; and

WHEREAS, the ACP recommends that policymakers strengthen U.S. education at all levels to improve health, health literacy (inclusive of digital health), and diversity in medical education; and

WHEREAS, the ACP recognizes that there are implicit biases in Alpha Omega Alpha medical honor society induction and further recommends that faculty and students should be trained to recognize biases¹⁸; and

WHEREAS, the ACP endorses that addressing sources of institutional racism through transparency and accountability measures is the first of many steps required to begin correcting historical racial injustices²⁰; and

WHEREAS, the national Coalition for Physician Accountability (COPA) has published guidance on the challenges associated with the transition from undergraduate medical education to graduate medical education and offers recommendations to address inequities, increase transparency, and enhance wellness¹⁹; and

WHEREAS, Alpha Omega Alpha (AOA) chapters must adhere to the guidelines that only students ranking in the highest quartile by academic performance be eligible and only 16% of medical students may be inducted as determined by a selection committee¹⁷; and

WHEREAS, students underrepresented in medicine consistently receive lower scores on standardized exams both before and during medical school and studies have shown that Black students receive consistently lower grades than nonblack students in clerkships²⁻⁴; and

WHEREAS, one study found that most students receiving “Outstanding” clerkship marks were white (71%), with non-underrepresented in medicine minoritized students receiving 13%, and underrepresented in medicine minoritized students only earned 3%⁵ and

WHEREAS, nonacademic factors, such as race/ethnicity, gender, and personality traits (introvert/extrovert), may influence perceived clinical performance, which in turn influences induction into medical honor societies^{5,10}; and

WHEREAS, statistically significant associations exist between race/ethnicity and USMLE Step 1 scores⁴; and

WHEREAS, differences in exam scores could be due to other characteristics associated with higher exam scores, like socioeconomic status and educational advantage, rather than medical knowledge alone¹⁶; and

WHEREAS, an amplification cascade may exist, in which even small differences in assessed performance can lead to larger differences in grades and selection for awards or induction into AOA⁷; and

WHEREAS, associations between AOA membership and high USMLE Step 1 scores exist, yet no associations between reported hours dedicated to leadership activities or community service exist, suggesting these are not strongly weighted during election into AOA^{1,13}; and

WHEREAS, even after controlling for USMLE Step 1 scores, research productivity, community service, leadership activity, and Gold Humanism membership, Black and Asian medical students are less likely to be inducted AOA members than their white counterparts¹; and

WHEREAS, white students were nearly six times more likely than Black students and nearly two times more likely than Asian students to be AOA members¹³; and

WHEREAS, there are already challenges for minoritized students in being accepted into medical school and succeeding once admitted, including social barriers, systemic racism, and biases, for which current AOA induction guidelines may be perpetuating or compounding^{8,11}; and

WHEREAS, residency program directors report utilizing a number of honor grades during medical school clerkships and AOA membership to select future residents⁹; and

WHEREAS, induction into medical honor societies, such as AOA, is associated with competitiveness for highly selective residency programs and specialties, career advancement, having careers at academic medical centers, and attaining rank of full professor, dean, or departmental chair¹; and

WHEREAS, 11 of the past 19 U.S. Surgeons General and more than 50 Nobel laureates have been AOA members¹²; and

WHEREAS, the membership imbalance favoring white students could represent a form of structural racism¹; and

WHEREAS, some institutions, including University of California San Francisco School of Medicine, have suspended their affiliation with AOA, partially due to bias in assessment²¹; and

WHEREAS, AOA has been called upon to implement strategies that would increase transparency and accountability, including encouraging release of membership demographics by year¹⁴; and

WHEREAS, AOA has expressed a commitment to diversity, inclusion, and equity¹⁵; therefore be it

RESOLVED, that the Board of Regents advocate for the release of demographic data of Alpha Omega Alpha inductees to ensure the selection process is transparent across institutions and to mitigate racial/ethnic disparities in selection of Alpha Omega Alpha members; and be it further

RESOLVED, that the Board of Regents request that the national Coalition for Physician Accountability provide recommendations to address the impacts of racial/ethnic disparities (along with other disparities that may exist, such as gender and socioeconomic status) in Alpha Omega Alpha as it pertains to program evaluation of student applications when making the transition from medical student to resident; and be it further

RESOLVED, that the Board of Regents advocate for reduced weighting of medical honor society status in resident selections until racial disparities in the selection process have been adequately identified and addressed.

References

- ¹Boatright, D., O'Connor, P. G., & E Miller, J. (2020). Racial Privilege and Medical Student Awards: Addressing Racial Disparities in Alpha Omega Alpha Honor Society Membership. *Journal of general internal medicine*, 35(11), 3348–3351. <https://doi.org/10.1007/s11606-020-06161-x>
- ²Miller, C., Stassun, K. A test that fails. *Nature* 510, 303–304 (2014). <https://doi.org/10.1038/nj7504-303a>
- ³Davis, D., Dorsey, J. K., Franks, R. D., Sackett, P. R., Searcy, C. A., & Zhao, X. (2013). Do racial and ethnic group differences in performance on the MCAT exam reflect test bias?. *Academic medicine : journal of the Association of American Medical Colleges*, 88(5), 593–602. <https://doi.org/10.1097/ACM.0b013e318286803a>
- ⁴Kleshinski, J., Khuder, S. A., Shapiro, J. I., & Gold, J. P. (2009). Impact of preadmission variables on USMLE step 1 and step 2 performance. *Advances in health sciences education : theory and practice*, 14(1), 69–78. <https://doi.org/10.1007/s10459-007-9087-x>
- ⁵Low, D., Pollack, S. W., Liao, Z. C., Maestas, R., Kirven, L. E., Eacker, A. M., & Morales, L. S. (2019). Racial/Ethnic Disparities in Clinical Grading in Medical School. *Teaching and learning in medicine*, 31(5), 487–496. <https://doi.org/10.1080/10401334.2019.1597724>
- ⁶Wijesekera, T. P., Kim, M., Moore, E. Z., Sorenson, O., & Ross, D. A. (2019). All Other Things Being Equal: Exploring Racial and Gender Disparities in Medical School Honor Society Induction. *Academic medicine : journal of the Association of American Medical Colleges*, 94(4), 562–569. <https://doi.org/10.1097/ACM.0000000000002463>
- ⁷Teherani, A., Hauer, K. E., Fernandez, A., King, T. E., Jr, & Lucey, C. (2018). How Small Differences in Assessed Clinical Performance Amplify to Large Differences in Grades and Awards: A Cascade With Serious Consequences for Students Underrepresented in Medicine. *Academic medicine : journal of the Association of American Medical Colleges*, 93(9), 1286–1292. <https://doi.org/10.1097/ACM.0000000000002323>
- ⁸van Balen, B., van Arensbergen, P., van der Weijden, I. *et al.* Determinants of Success in Academic Careers. *High Educ Policy* 25, 313–334 (2012). <https://doi.org/10.1057/hep.2012.14>
- ⁹Green, M., Jones, P., & Thomas, J. X., Jr (2009). Selection criteria for residency: results of a national program directors survey. *Academic medicine : journal of the Association of American Medical Colleges*, 84(3), 362–367. <https://doi.org/10.1097/ACM.0b013e3181970c6b>
- ¹⁰Riese, A., Rappaport, L., Alverson, B., Park, S., & Rockney, R. M. (2017). Clinical Performance Evaluations of Third-Year Medical Students and Association With Student and Evaluator Gender. *Academic medicine : journal of the Association of American Medical Colleges*, 92(6), 835–840. <https://doi.org/10.1097/ACM.0000000000001565>
- ¹¹Hill, K. A., Samuels, E. A., Gross, C. P., Desai, M. M., Sitkin Zelin, N., Latimore, D., Huot, S. J., Cramer, L. D., Wong, A. H., & Boatright, D. (2020). Assessment of the Prevalence of Medical Student Mistreatment by Sex, Race/Ethnicity, and Sexual Orientation. *JAMA internal medicine*, 180(5), 653–665. <https://doi.org/10.1001/jamainternmed.2020.0030>
- ¹²Alpha Omega Honor Society [website]. 2016. <https://alphaomegalpha.org>. Accessed January 19, 2016.
- ¹³Boatright, D., Ross, D., O'Connor, P., Moore, E., & Nunez-Smith, M. (2017). Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society. *JAMA internal medicine*, 177(5), 659–665. <https://doi.org/10.1001/jamainternmed.2016.9623>

- ¹⁴Kurtz, Joshua B. MD; Ibrahim, Nadine MD; Fausone, Maureen MD Diversity in Alpha Omega Alpha Honor Medical Society, *Academic Medicine*: December 2020 - Volume 95 - Issue 12 - p 1789 doi: 10.1097/ACM.0000000000003753
- ¹⁵Byyny RL, Martinez D, Cleary L, et al. Alpha Omega Alpha Honor Medical Society: a commitment to inclusion, diversity, equity, and service in the profession of medicine. *Acad Med*. 2019.
- ¹⁶Woolf K, McManus IC, Potts HW, Dacre J. The mediators of minority ethnic underperformance in final medical school examinations. *Br J Educ Psychol*. 2013;83(pt 1):135–159.
- ¹⁷How members are chosen. Alpha Omega Alpha Honor Society. [https:// www.alphaomegaalpha.org/how.html](https://www.alphaomegaalpha.org/how.html). Accessed September 5th, 2021.
- ¹⁸Serchen, J., Doherty, R., Atiq, O., Hilden, D., & Health and Public Policy Committee of the American College of Physicians (2021). 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*, 174(4), 529–532. <https://doi.org/10.7326/M20-7219>
- ¹⁹Chaudhry, H. J., Kirch, D. G., Nasca, T. J., Katsufakis, P. J., McMahan, G. T., Shannon, S. C., & Ciccone, A. L. (2019). Navigating Tumultuous Change in the Medical Profession: The Coalition for Physician Accountability. *Academic medicine : journal of the Association of American Medical Colleges*, 94(8), 1103–1107. <https://doi.org/10.1097/ACM.0000000000002801>
- ²⁰Serchen, J., Doherty, R., Atiq, O., Hilden, D., & Health and Public Policy Committee of the American College of Physicians (2020). Racism and Health in the United States: A Policy Statement From the American College of Physicians. *Annals of internal medicine*, 173(7), 556–557. <https://doi.org/10.7326/M20-4195>
- ²¹UCSF School of Medicine suspends affiliation with Alpha Omega Alpha (AOA) Honor Society (2020). Medical Student News, Faculty News, General UCSF Medical Education News. <https://meded.ucsf.edu/news/ucsf-school-medicine-suspends-affiliation-alpha-omega-alpha-aoa-honor-society>

Resolution 2-S22. Minimizing the Risk of Involuntary Childlessness among Physicians

(Sponsor: Council of Student Members; Co-Sponsor: New Mexico Chapter)

WHEREAS, 85% of female physicians desire children^{1,2}; and

WHEREAS, only 2% of physicians have children before completing medical school³; and

WHEREAS, women who obtain advanced degrees have an increased risk of involuntary childlessness^{2,4-6}; and

WHEREAS, female physicians are more likely to undergo childbirth after the age of 37, when risks of infertility and adverse maternal and fetal outcomes are more common³; and

WHEREAS, 1 in 4 female physicians will face infertility, compared to approximately 9-18% of the US general population^{2,6-9}; and

WHEREAS, even when comparing similar aged women, impaired fecundity is higher among female physicians (for example, among 34-39 year old female physicians impaired fecundity is 28.1% as compared to 34-39 year old general population females at 15.2%)⁶; and

WHEREAS, infertility has physical and financial consequences, including the cost of consulting fertility or reproductive specialists and the high cost of *in vitro* fertilization (IVF)⁸; and

WHEREAS, as of April 2021, only 19 states have passed fertility insurance coverage laws, 13 including IVF coverage, and 11 including fertility preservation¹⁰; and

WHEREAS, the cost of a single cycle IVF can be up to \$20,000, is often not covered by insurance, and future parents often undergo multiple rounds of IVF⁸; and

WHEREAS, physicians assume a considerable amount of debt during medical school (and undergraduate education) and are provided low salaries during training, before reaching their full earning potential; and

WHEREAS, medical students, trainees, and physicians may not have the resources to preserve fertility by other means (like egg, embryo, or sperm cryopreservation) and/or access other fertility treatments; and

WHEREAS, infertility has emotional consequences that can manifest as anxiety, guilt, loss of hope, bereavement, and stigmatization^{8,11,12}; and

WHEREAS, infertility, high-risk pregnancy, and miscarriage are associated with higher rates of burnout in female physicians^{8,13}; and

WHEREAS, the American College of Physicians is committed to strengthening physician well-being; and

WHEREAS, together the physical, financial, and emotional consequences of infertility can have a negative impact on physician well-being⁸; and

WHEREAS, medical training (medical school, residency, fellowship) continues well into prime reproductive years and many female physicians delay childbearing for this reason; and

WHEREAS, one study found that of the 56% of female residents who were married or partnered, 61% were delaying childbearing, often citing their career as an influencer on childbearing decisions⁹; and

WHEREAS, many cited reasons such as a busy work schedules (93%), a desire to not extend their residency training (53%), lack of access to childcare (46%), financial concerns (42%), fears of burdening colleagues (35%), and concerned about pregnancy complications (27%)⁹; and

WHEREAS, fertility should not be a factor that limits women's engagement and advancement within the medical field⁸; and

WHEREAS, the American College of Physicians believe that it is essential for women to have access to affordable and comprehensive health care coverage¹⁴; and

WHEREAS, the American College of Physicians, American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Medical Association, among others, have advocated for mechanisms to maintain board eligibility for residents who take more than 6 weeks of leave, released statements regarding parental leave during residency training, and other statements to encourage flexibility among training programs to minimize extended training through home study or reading electives^{9,15-18}; therefore be it

RESOLVED, that the Board of Regents, with other appropriate stakeholders, advocate for improved insurance coverage provided by schools and programs for trainees (including medical students, residents, fellows) that would allow for access to fertility assessment and management (including, but not limited to, fertility checkups that could include assessment of ovarian reserve, sperm quality, egg/embryo/sperm cryopreservation, IVF treatment, and surrogacy options); and be it further

RESOLVED, that the Board of Regents, with other appropriate stakeholders, advocate for systems level changes within medical training that would address causes of involuntary childlessness among physicians (including, but not limited to, addressing inflexible training hours, inadequate leave, and unavailable childcare options); and be it further

RESOLVED, that the Board of Regents, with other appropriate stakeholders, advocate for increased education and awareness about fertility for trainees and support for trainees and physicians undergoing fertility treatments that may support their well-being (including, but not limited to, free or low-cost psychological support, paid parental leave, flexibility within residency/fellowship programs to minimize extended training and maintain board eligibility, and childcare options).

References

1. Diamond P. The private lives of women doctors. In: Vol 2. *Medica*; 1984:40-45.
2. Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and Childbearing Among American Female Physicians. *J Womens Health*. 2016;25(10):1059-1065. doi:10.1089/jwh.2015.5638
3. Cusimano MC, Baxter NN, Sutradhar R, et al. Delay of Pregnancy Among Physicians vs Nonphysicians. *JAMA Intern Med*. Published online May 3, 2021.

4. Sobotka T. In pursuit of higher education, do we postpone parenthood too long? *Gend Med*. 2006;3(3):183-186. doi:10.1016/S1550-8579(06)80206-8
5. Hamilton AR, Tyson MD, Braga JA, Lerner LB. Childbearing and Pregnancy Characteristics of Female Orthopaedic Surgeons. *JBS*. 2012;94(11):e77. doi:10.2106/JBS.K.00707
6. Parsons M, Kalynych C, Johns TL, Scicchitano MJ, Lott M, Fernandez R. IMPACT survey: IMPaired fecundity in Physicians and Association with Clinical Time. *J Am Coll Emerg Physicians Open*. 2020;1(5):1023-1029. doi:10.1002/emp2.12170
7. Aghajanova L, Hoffman J, Mok-Lin E, Herndon CN. Obstetrics and Gynecology Residency and Fertility Needs: National Survey Results. *Reprod Sci*. 2017;24(3):428-434. doi:10.1177/1933719116657193
8. Marshall AL, Arora VM, Salles A. Physician Fertility: A Call to Action. *Acad Med*. 2020;95(5):679-681. doi:10.1097/ACM.0000000000003079
9. Stack SW, Jagsi R, Biermann JS, et al. Childbearing Decisions in Residency: A Multicenter Survey of Female Residents. *Acad Med*. 2020;95(10):1550-1557. doi:10.1097/ACM.0000000000003549
10. The National Infertility Association. Discover Infertility Treatment Coverage by U.S. State. RESOLVE. Accessed October 15, 2021. <https://resolve.org/what-are-my-options/insurance-coverage/infertility-coverage-state/>
11. Patel A, Sharma PSVN, Kumar P. "In Cycles of Dreams, Despair, and Desperation:" Research Perspectives on Infertility Specific Distress in Patients Undergoing Fertility Treatments. *J Hum Reprod Sci*. 2018;11(4):320-328. doi:10.4103/jhrs.JHRS_42_18
12. Cousineau TM, Domar AD. Psychological impact of infertility. *Best Pract Res Clin Obstet Gynaecol*. 2007;21(2):293-308. doi:10.1016/j.bpobgyn.2006.12.003
13. Györfy Z, Dweik D, Girasek E. Reproductive health and burn-out among female physicians: nationwide, representative study from Hungary. *BMC Womens Health*. 2014;14(1):121. doi:10.1186/1472-6874-14-121
14. Daniel H, Erickson SM, Bornstein SS. Women's Health Policy in the United States: An American College of Physicians Position Paper. *Ann Intern Med*. 2018;168(12):874-875. doi:10.7326/M17-3344
15. ACOG Statement of Policy: Paid Parental Leave. Accessed May 23, 2021. <https://www.acog.org/en/clinical-information/policy-and-position-statements/statements-of-policy/2020/paid-parental-leave>
16. Reed BR, Callen JP, Freedberg IM, et al. Position paper on family or personal leave, including pregnancy, during residency. *J Am Acad Dermatol*. 2001;45(1):118-119. doi:10.1067/mjd.2001.114563
17. Parental Leave During Residency Training. Accessed May 23, 2021. <https://www.aafp.org/about/policies/all/parental-leave.html>
18. Butkus R, Serchen J, Moyer DV, Bornstein SS, Hingle ST. Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians. *Ann Intern Med*. 2018;168(10):721-723. doi:10.7326/M17-3438

Resolution 3-S22. Encouraging Development of Evidence-Based Guidelines for Healthcare Facility Visitation during the Ongoing COVID-19 Pandemic and Future Viral Epidemics

(Sponsor: District of Columbia Chapter; Co-Sponsor: Nebraska Chapter)

WHEREAS, ACP policy supports the principle that patients and their families be treated with dignity and respect; and

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

WHEREAS, family members often can provide important clinical information to physicians that such patients (especially but not limited to impaired and elderly patients) are unable to provide themselves; and

WHEREAS, family members help optimize medical care to such patients by reducing their anxiety and aiding physicians in communicating information regarding their conditions to such patients; and

WHEREAS, some policies in place during the COVID-19 pandemic have prevented the above actions from being implemented as family members (including spouses) have been prevented from having any significant/regular contact with their family members or the physicians caring for their family members due to concerns regarding infection risk; and

WHEREAS, the ACP strongly encourages the use of science-based evidence in the fight against COVID-19 and other viral epidemics in developing emergency room and inpatient policies that allow maximum family involvement in the care of family members while providing a safe environment for health care staff; therefore be it

RESOLVED, that the Board of Regents work actively on encouraging development of evidence-based guidelines for healthcare facility visitation policies which may be enacted during the ongoing COVID-19 pandemic and during future viral epidemics; and be it further

RESOLVED, that the Board of Regents petition local, state, and federal authorities to require that healthcare facilities facilitate and encourage in person visitation to the extent safety precautions allow employing policies regarding in person visitation that are evidence based and reached after consultation with community and physician stakeholders.

References:

Subject: Providing hospitalized patients with Intellectual and Developmental Disabilities (IDD) with Designated Support Staff During the COVID 19 Pandemic: Rationale for Revised Visitor Policy. Hospitalized Patients & Designated Support Staff Policy Statement of the Committee on Public Policy and Advocacy. April 2020. American Academy of Developmental Medicine & Dentistry

Resolution 4-S22. Advocating for Ethical Business Models That Promote Safety in the Care of Vulnerable Elders

(Sponsor: Oregon Chapter; Co-Sponsors: California Northern, Connecticut, Hawaii, Illinois, New York and Utah Chapters)

WHEREAS, the ACP supports the efforts by other organizations to improve the regulatory oversight of boarding care facilities in the United States and to disseminate information on recommendations (1), and a recent policy paper from the College points out that “physicians, regardless of practice setting, should challenge business concerns that are placed above the best interests of patients” (2); and

WHEREAS, the U.S. population is aging and more than half of adults 65 and older will need long-term services and supports (LTSS) including hired in-home caregiving or residential care, and the population receiving these services usually have limited affordable choices available to meet their needs (3); and

WHEREAS, the long-term and post-acute care industry serves this vulnerable population, and currently approximately 70% of all long-term care (LTC) facilities in the U.S. market are for-profit(4). Although research is needed, for-profit facilities have a business incentive which may promote the use of selective admissions preferring Medicare and private-pay over Medicaid residents to optimize revenue(5). For-profit facilities have been shown to reduce staffing levels to cut costs and perform better financially (6, 7, 8), thus demonstrating that the responsibility of for-profit companies to maximize profits can be in direct conflict with providing safe and accessible care to vulnerable populations; and

WHEREAS, for-profit and private equity companies managing LTC facilities in addition to maintaining lower staff-to-resident ratios have been found to have higher rates of deficiencies (violations of federal quality standards) and serious deficiencies (where harm or jeopardy to a resident occurred) (9, 10), to have reduced employee well-being while performing better financially (11), may increase both resident death rates and costs for government payers (12), may also have business disincentives to invest in facility safety updates (e.g. related to earthquake and flooding risk, communicable disease transmission, extreme weather events, structural maintenance, etc.), placing residents at increased risk especially in the setting of increasingly frequent climate-change-related events(13, 14, 15) and for-profit ownership conversion has been associated with deterioration in performance (16) ; and

WHEREAS , not-for-profit and government LTC facilities generally have higher staff-to-resident and RN-to-resident ratios, which are associated with positive outcomes including “fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates” as well as reduced ED visits and hospital readmissions (17, 18, 19); and

WHEREAS, LTC facilities with lower Medicare five-star ratings demonstrated a higher probability of having COVID-19 cases early in the pandemic (20, 21), LTC facilities with lower registered nurse staffing had greater numbers of COVID-19 cases and deaths (22), for-profit LTC facilities were noted to have 60% more cases and deaths than not-for-profit facilities (21), and deaths tied to long-term care facilities account for more than a third of American deaths from COVID-19 in 2019 and 2020 (23, 24, 25, 26); and

WHEREAS, the College, as an organization, represents internal medicine specialists and their physician-led teams who provide the bulk of geriatric care and also advocates for the interests of their patients; therefore be it

RESOLVED, that the Board of Regents develop policy on ethical implications of long-term care business practices, specifically calling for research into and advocating for business models in long-term care for the elderly which incentivize and promote the ethical use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit.

References:

1. American College of Physicians Division of Government Affairs and Public Policy. Policy Compendium: Winter 2019, page 121.
https://www.acponline.org/system/files/documents/advocacy/where_we_stand/assets/acp_policy_compendium_winter_2019.pdf?_ga=2.60824044.1550429684.1620490192-1937147286.1586190870
2. DeCamp M, Sulmasy LS. Ethical and Professionalism Implications of Physician Employment and Health Care Business Practices: A Policy Paper From the American College of Physicians. *Annals Int Med* 2021;174(6):844-851. <https://www.acpjournals.org/doi/10.7326/M20-7093>
3. Nguyen V. Long-term support and services. AARP Public Policy Institute. March 2017.
<https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf>
4. Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-term care providers and services users in the United States: data from the national study of long-term care providers, 2013-2014. *Vital Health Stat* 2016;38:1-118. <https://pubmed.ncbi.nlm.nih.gov/27023287/>
5. Gandhi, Ashvin. Picking Your Patients: Selective Admissions in the Nursing Home Industry. SSRN Sep 2019. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3613950
6. Weech-Maldonado R, Laberge A, Pradhan R, Johnson CE, Yang Z, Hyer K. Nursing home financial performance: the role of ownership and chain affiliation. *Health Care Management Review* 2012;37(3):235-245. DOI: 10.1097/HMR.0b013e31823dfe13
<https://pubmed.ncbi.nlm.nih.gov/22261667/>
7. McGregor MJ, Cohen M, McGrail K, Broemeling AM, Adler RN, Schulzer M, Ronald L, Cvitkovich Y, Beck M. Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *CMAJ* 2005 Mar 1; 172(5):645-549. DOI: 10.1503/cmaj.1040131
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC550634/>
8. Goldstein M, Silver-Greenberg J and Gebeloff R, "Push for Profits Left Nursing Homes Struggling to Provide Care" *New York Times*, May 7, 2020.
9. Harrington C, Olney B, Carrillo H, Kang T. Nursing staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies. *Health Serv Res.* 2012;47(1 pt 1): 106-128. DOI: 10.1111/j.1475-6773.2011.01311.x. <https://pubmed.ncbi.nlm.nih.gov/22091627/>
10. O'Neill C, Harrington C, Kitchener M, Saliba D. Quality of care in nursing homes: an analysis of relationships among profit, quality, and ownership. *Med Care.* 2003 Dec;41(12):1318-30. doi: 10.1097/01.MLR.0000100586.33970.58. PMID: 14668664.
11. Bos A, Boselie P, Trappenburg M. Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review. *Health Care Manage Rev.* Oct/Dec 2017;42(4):352-368. <https://pubmed.ncbi.nlm.nih.gov/28885990/>
12. Gupta A, Howell S, Yannelis C and Gupta, A. Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes (November 12, 2020). NYU Stern School of Business, Available at SSRN: <https://ssrn.com/abstract=3537612> or <http://dx.doi.org/10.2139/ssrn.3537612>
13. Dosa DM, Skarha J, Peterson LJ, et al. Association Between Exposure to Hurricane Irma and Mortality and Hospitalization in Florida Nursing Home Residents. *JAMA Netw Open.* 2020;3(10):e2019460.

- https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771392?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=100620
14. Zavala D. Expecting More Heat Waves, Seattle's Long Term Care Facilities Weigh Need for Air Conditioning. July 6, 2021. <https://www.seattletimes.com/seattle-news/health/with-more-heat-waves-expected-in-the-future-seattles-long-term-care-facilities-weigh-the-need-for-air-conditioning/>
 15. Dangerfield K. 'It's a Death Trap': Families Horrified by Lack of Air Conditioning in Long-Term Care Homes. July 14, 2020. <https://globalnews.ca/news/7161608/long-term-care-homes-heat-wave-air-conditioner/>
 16. Grabowski DC, Stevenson DG. Ownership Conversions and Nursing Home Performance. *Health Serv Res* 2008; 43(4):1184-1203. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517264/>
 17. Comondore VR, Devereaux PJ, Zhou Q et al. Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *BMJ*. 2009 Aug 4;339:b2732. doi: 10.1136/bmj.b2732. PMID: 19654184; PMCID: PMC2721035.
 18. Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. *Health Services Insights*. January 2020. doi:10.1177/1178632920934785
 19. Grabowski DC, Feng Z, Hirth R, Rahman M, Mor V. Effect of nursing home ownership on the quality of post-acute care: an instrumental variables approach. *J Health Econ*. 2013;32(1):12-21. <https://pubmed.ncbi.nlm.nih.gov/23202253/>
 20. Harrington C, Ross L, Chapman S, Halifax E, Spurlock B, bakerjian D. Nursing staffing and coronavirus infections in California nursing homes. *2020 Policy, Politics, & Nursing Practice* 0(0):1-13. DOI: 10.1177/1527154420938707 https://theconsumervoice.org/uploads/files/issues/Harrington_Ross_et_al._Nurse_Staffing_and_Coronavirus_Infections_in_NHs_July_2020.pdf
 21. Rowan P, Lester R, Levere M, Libersky J, Lipson D, Robison J. A Study of the COVID-10 Outbreak and Response in Connecticut Long-Term Care Facilities: Interim Report. August 14, 2020. <https://www.mathematica.org/our-publications-and-findings/publications/a-study-of-the-covid-19-outbreak-and-response-in-connecticut-long-term-care-facilities>
 22. Figueroa JF, Wadhwa RK, Papanicolaos I, et al. Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing With COVID-19 Cases. *JAMA*. 2020;324(11):1103-1105. doi:10.1001/jama.2020.14709. https://jamanetwork.com/journals/jama/fullarticle/2769437?guestAccessKey=258f9d19-b7c2-43e2-9218-55c23d3914bc&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=081020
 23. <https://covidtracking.com/analysis-updates/federal-covid-data-101-working-with-cms-nursing-home-data>. COVID-19 Tracking Project website; accessed on July 12, 2021
 24. Fulmer TT, Koller CF, and Rowe JW. Reimagining Nursing Homes in the Wake of COVID-19. 2020. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202009a> https://nam.edu/reimagining-nursing-homes-in-the-wake-of-covid-19/?gclid=Cj0KCQjwrsGCBhD1ARIsALILBYpGE7HRZUU2y3UHn6M2rANWJeID9QF2XvhyVFJc8ESwwaV1isLM8ScaAgaAEALw_wcB
 25. Jaffe I. For-Profit Nursing Homes' Pleas for Government Money Brings Scrutiny. October 22, 2020. *Heard on Morning Edition*. <https://www.npr.org/2020/10/22/918432908/for-profit-nursing-homes-pleas-for-government-money-brings-scrutiny>
 26. Amirkhanyan A, McCrea A, Meier KJ. Why Some Nursing Homes Are Better Than Others at Protecting Residents and Staff from COVID-19. June 10, 2020. *The Conversation*. <https://theconversation.com/why-some-nursing-homes-are-better-than-others-at-protecting-residents-and-staff-from-covid-19-138703>

Resolution 5-S22. Investigating Problems with and Recommending Modifications in EHRs to Lessen Clinical Interruptions and Improve Clinical Efficacy so as to Reduce Physician Errors, Improve Patient Safety, and Increase Physician Satisfaction with their Profession

(Sponsor: District of Columbia Chapter)

WHEREAS, ACP has frequently over the years commented on issues related to electronic health records (EHRs) and their use by internists, including through white papers and letters to federal government entities; and

WHEREAS, a goal of the ACP is to establish and promote the highest clinical standards and to facilitate the ability of its members to provide optimal medical care to their patients; and

WHEREAS, research has demonstrated that primary care physicians make frequent attention switches during workdays while processing electronic inbox messages; and

WHEREAS, research has demonstrated that interruptions and multitasking by physicians increase physician errors and decrease physician satisfaction with their work; and

WHEREAS, research has demonstrated that physicians can be presented with an unacceptably high volume of unimportant in-basket messages generated by EHR systems. From *MEDPAGE TODAY* September 22, 2021: *Are Doctors Drowning in Inbox Overload?*:

- “Healthcare workers acknowledge that electronic communication has its advantages, but the alerts, notifications, requests, lab results, and direct messages from patients—all contained within their electronic health records (EHR) inbox, often the ‘In Basket’ on EPIC are contributing to burnout.”
- “Others have looked into time spent on inbox messaging. One study that tracked the inbox use of 1,275 primary care physicians found that, on average, they were spending almost an hour in their inbox messages.”
- “One study of the Palo Alto Medical Foundation that included 932 physicians found that messages generated by EPIC far outnumbered those from their patients or coworkers. Of an average of 243 weekly In Basket messages, 114 were automated, 53 were from colleagues, and only 30 were from patients.”; and

WHEREAS, the volume of such unimportant in-basket messages generated by EHR systems contributes to the frequent attention switches physicians make while processing electronic inbox messages; and

WHEREAS, such impediments to patient safety and physician satisfaction represent problems of the highest level of concern to the ACP; therefore be it

RESOLVED, that the Board of Regents initiate an investigation into the manner in which current EHRs unduly burden physicians (thereby compromising patient safety and reducing physicians’ satisfaction with their profession) and develop recommendations for ameliorating this problem. It is requested that in light of the importance that ACP places on providing the highest level of patient care that the Board of Regents initiates this investigation as promptly as possible and not delay action while it pursues its important and commendable goal of developing comprehensive policy on EHRs in conjunction with other stakeholders; and be it further

RESOLVED, that the Board of Regents also engage relevant stakeholders in working to promote decreased burden from EHRs on physicians.

References

Lieu TA, et. al. Evaluation of Attention Switching and Duration of Electronic Inbox Work Among Primary Care Physicians. *JAMA Network Open* 202;4(1):e2031856

Westbrook JI, et. al. Task errors by Emergency Physicians are associated with Interruptions, Multitasking, Fatigue and Working Memory Capacity: A Prospective Direct Observation Study. *BMJ Quality Safety*. 2018;27(8):665-663

Tai-Seale M, et. Al. Physicians' Well-Being Linked to In-Basket Messages Generated by Algorithms in Electronic Health Records. *Health Aff (Millwood)*. 2019;38(7):1073-1078

Hilliard RW, et. al. Are Specific Elements of Electronic Health Record Use Associated with Clinician Burnout More than Others? *Journal of the American Medical Informatics Association*, Volume 27(9): 1401-1410

MEDPAGE TODAY September 22, 2021: Are Doctors Drowning in Inbox Overload?

Resolution 6-S22. Aligning Medicare Contract Risk with Internist Feasibility to Control Risk

(Sponsor: Michigan Chapter)

WHEREAS, Primary Care First (PCF) Medicare Contracts are now underway and the PCF program begins January 1, 2022, to allow primary care physicians to care for non-managed Medicare patients under a risk contract in order that CMS steps closer to value based care and control cost and utilization while optimizing patient care; and

WHEREAS, ACP accepts the need for investment in primary care system (1) and advanced alternative payment models (APP) though ACP has urged CMS to 'freeze mandatory glidepath to higher risk tracks through 2021' due to covid pandemic (2); and

WHEREAS, Internal Medicine Primary Care Physicians see patients with multiple medical problems and many of them use Medicare insurance and cannot maintain practice without seeing Medicare patients who require internal medicine inpatient and outpatient expertise; and

WHEREAS, Internists do not and cannot influence the cost or utilization of services rendered by other physicians or hospitals; and

WHEREAS, Patients have the right to self-select their physicians and self-refer to emergency rooms and hospitals as often as they feel necessary despite some copay costs and coinsurance costs; and

WHEREAS, Internists will be at risk for hospital costs and services under the PCF Medicare contract and Internists have no agency over actuarial risk afforded by the PCF contract; therefore be it

RESOLVED, that the Board of Regents work with CMS and other payors to support Medicare risk contracts for internists and educate the membership on the risk that is aligned with a service that the internist can control and offer a graduated risk threshold adjusted to the internist's patient panel.

References

1. August 24, 2021 Letter to secretary Dept of HHS re "Primary care for America"
2. February 1, 2021 Letter to Dept of HHS re Advanced Alternative Payment Models (APP)

Resolution 7-S22. Containing Incidentalomas for Optimal Utilization of Radiology Services

(Sponsor: Michigan Chapter)

WHEREAS, Internists participate in Medicare risk contracts that require attention to utilization of patient services; and

WHEREAS, Internists balance risk/benefit decisions regarding patient demands, medical liability, diagnostic testing and disease management; and

WHEREAS, Internists require imaging to confirm diagnoses and treatment and do not always have cost efficient choices for imaging; and

WHEREAS, Radiologists interpret imaging without utilization risk and have freedom to interpret and share clinical recommendations; and

WHEREAS, Incidentalomas defined as 'a radiological neologism to denote a lesion found incidentally and of dubious clinical significance'; and

WHEREAS, Incidentalomas have been increasing geometrically such that 70% of patients are affected by incidental imaging findings (1); and

WHEREAS, the American Medical Association has set a code of ethics 'the patient has the right to know' the details of their personal medical history which requires a patient shared decision led by the patient's internist who can best weigh pros and cons customized designed to each patient; and

WHEREAS, Radiologists who recommend clinical correlation allows the internist choice to interpret imaging findings while radiologists who suggest more imaging may lead to overinterpretation and increased liability to the internist and more risk to the patient; therefore be it

RESOLVED, that the Board of Regents work with the American College of Radiology and other physician radiology groups to limit language that suggests or interprets a radiology report such that it invites more testing that may not be clinically corelative, essentially containing incidentalomas for optimal utilization of radiology services; and be it further

RESOLVED, that the Board of Regents work with Radiology Specialists within the current value-based patient care framework so that radiologists work alongside internists and share utilization responsibility and collaborate on the best approach for patient safety, cost and quality care.

Reference

1. How do you solve a problem like incidentalomas? Leonard Berlin MDFACR Applied Radiology

Resolution 8-S22. Establishing a Well-being Submission Category for Medical Students, Resident/Fellows, and Early Career Physicians in ACP National Abstract Competitions

(Sponsor: New York Chapter)

WHEREAS, promoting and supporting physician well-being is central to the mission of the American College of Physicians; and

WHEREAS, ACP's well-being goals include "foster[ing] local communities of well-being by supporting chapter members, practices, and organizations in addressing burnout and the conditions that create it[i];[ii]" and

WHEREAS, ACP hosts a National Abstract Competition each year in conjunction with the ACP Annual Meeting; and

WHEREAS, categories for abstract poster submissions include basic research, clinical research, quality improvement and patient safety, high value care, and clinical vignettes; and

WHEREAS, although the quality improvement and patient safety submission category can accommodate well-being submissions, the underlying value of well-being as a priority area of research will be elevated if identified as a separate research area; therefore be it

RESOLVED, that the Board of Regents, along with other appropriate stakeholders, establish well-being as a new category of research solicited for the ACP National Abstract Competition.

[i] *Physician Well-Being and Professional Fulfillment*. ACP. Accessed Nov 12, 2021.

[ii] "ACP Well-being Champions."

Resolution 9-S22. Formalizing Academic Remediation Processes within Residency and Fellowship

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, identification of under-performing residents and remediation is a common problem that requires organized and goal-directed efforts to address in order to ensure proper training and high standard of patient care; and

WHEREAS, training programs are currently employing varying approaches to address and evaluate poor resident performance with lack of consistency across training programs; and

WHEREAS, programs have an obligation to the community to train competent physicians and a training program that certifies an incompetent physician has fundamentally betrayed its mission; therefore be it

RESOLVED, that the Board of Regents ask the ACGME to audit programs that terminate residents to ensure that structured and formalized processes are being followed to protect patient care while also ensuring fair opportunity for remediation; and be it further

RESOLVED, that the Board of Regents advocate for training programs to provide adequate mental health treatment, including leave of absence, for residents experiencing mental health issues that are interfering with their ability to work and only terminate residents if this process fails to improve performance; and be it further

RESOLVED, that the Board of Regents along with support of local DEI representatives study the impact on residents within minority groups and develop a plan to address bias and structural racism if that is found to be driving unequal termination.

References:

1. <https://www.nejm.org/doi/full/10.1056/NEJMp210527>
2. <https://www.cordem.org/globalassets/files/remediation/guiding-principles-for-remediation.pdf>
3. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2930314/>
4. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5226740/>
5. https://journals.lww.com/academicmedicine/Fulltext/2009/12000/Remediation_of_the_Deficiencies_of_Physicians.38.aspx

Resolution 10-S22. Modifying the ACGME Common Program Requirement regarding Supervision of Residents and Fellows by Physician Attendings

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, 84% of patients state they want physicians to lead their medical care teams¹; 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 states²; and

WHEREAS, the ACGME Common Program Requirements currently state: "VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care."; and

WHEREAS, the American College of Physicians position paper called for a formal evaluation of supervisory competence, explicit attention to the spirit of resident-supervisor relationships, respect for the principle of meaningful patient responsibility, and formal resident credentialing all be taken into account in improving resident supervision⁵; and

WHEREAS, while the Accreditation Council for Graduate Medical Education (ACGME) guidelines state credentials of individuals who may play supervisory roles, there are no statements which specify who and in what setting certain individuals may not serve faculty roles, leaving the ultimate decision upon program directors³; and

WHEREAS, non-physician faculty, such as nurse practitioners and physician assistants are integral part of the teaching teams and may be essential in resident education of procedures; therefore be it

RESOLVED, that the Board of Regents advocate that ACGME Common Program Requirements be modified to remove the allowance for non-physician supervision with the exception of procedure and ultrasound training in the following way: "VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician who is responsible and accountable for the patient's care. Primary supervision of physician trainees, with the exception of procedure and ultrasonography education, should be performed by a Board-eligible or -certified physician."

References:

¹American 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

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

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

⁴Health Resources and Services Administration. https://telehealth.hhs.gov/providers/billing-and-reimbursement/?gclid=CjwKCAjwkN6EBhBNEiwADVfyajSfmPmXeLIQq5t3h1cI3cTPpIRxEqHDCNXiDihyJoIplwJk-zSeRoCbmoQAvD_BwE

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

⁶https://www.researchgate.net/publication/26286949_Beyond_see_one_do_one_teach_one_Toward_a_different_training_paradigm

Resolution 11-S22. Acknowledging Individual ACP Members for Their Commitment to the ACP

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians (ACP) is a membership-based organization; and

WHEREAS, the ACP works very hard to recruit and retain membership; and

WHEREAS, “membership growth and engagement” is a priority theme for FY 2021-24 with a goal of increasing the value and pride of ACP membership for an individual member; therefore be it

RESOLVED, that the Board of Regents create and distribute to individual members visible evidence of ACP’s appreciation to acknowledge members’ commitment to the ACP by way of the following:

(1) Having Certificates of Appreciation sent to members upon reaching 10 years and 20 years of membership in the ACP

(2) Having small Plaques of Appreciation sent to members upon reaching 25 years of membership (“gold level”), 35 years of membership (“platinum level”), and 45 years of membership in the ACP

(3) Having a more elaborate Plaque of Appreciation sent to members upon reaching 50 years of membership (“diamond level”) in the ACP; and be it further

RESOLVED, that the Board of Regents distribute such Certificates of Appreciation and Plaques of Appreciation to current and future ACP members in good standing with their total years of membership counted retroactively as well as prospectively. Consecutive and nonconsecutive years of membership shall count towards the total years of membership.

Resolution 12-S22. Forming a National ACP International Medical Graduate Council

(Sponsor: Maryland Chapter: Co-Sponsor: Massachusetts Chapter)

WHEREAS, as of 2020 there are 233,177 active licensed physicians from International Medical Graduate backgrounds practicing in the United States. International Medical Graduates as a cohort have increased by 24 % in the decade between 2010 and 2020^[1]; and

WHEREAS, Internal Medicine as a specialty is comprised of 40% International Medical Graduate physicians, which equates to 47,840 active licensed physicians.^[2] ACP membership is comprised of 34% International Medical Graduate physicians; and

WHEREAS, 2021 NRMP Match data reports that of 9,024 categorical internal medicine residency seats available, 38% were matched by International Medical Graduates^[3]. This portends that International Medical Graduates will continue contributing substantially to the tradition of internal medicine training programs and professional societies, including the American College of Physicians (ACP), in the future; and

WHEREAS, the 2021 NRMP Match data reports that 25% of all categorical internal medicine residency positions were filled by non-U.S. citizen International Graduates, these trainees face significant challenges such as visa management, acculturation to the training program, and assimilation to their new living environment. Recognizing and assisting this vulnerable group during their training and beyond can yield long benefits for these physicians as well as for the ACP; and

WHEREAS, the ACP is an organization whose vision statement is to be recognized globally as a leader in promoting quality care, advocacy, education, and career fulfillment in internal medicine and its subspecialties. The ACP embraces the value of all manner of Diversity, Equity, and Inclusion, including those physicians from traditionally less represented backgrounds including Women in Medicine. Recognizing our collective diversity as an organization is a marker of strength, not separation. International Medical Graduates practicing in the U.S. have trained collectively from 169 countries around the globe, and they bring a broad range of perspectives and experiences that inform their professional activities as physicians; and ²

WHEREAS, opportunity exists to grow ACP membership both nationally and internationally by increasing engagement with physicians from an International Medical Graduate background; therefore be it

RESOLVED, that the Board of Regents of the American College of Physicians shall form a National ACP International Medical Graduate Council, towards the goal of furthering the Excellence, Professionalism, Leadership, Compassion, Inclusion, Equity and Justice, and Well-being of ACP membership; and be it further

RESOLVED, that this National ACP International Medical Graduate Council serve as an educational and advocacy council for this large body of our members to address their unique challenges, promote equity in representation and compensation in all practice settings, as well as foster career advancement.

^[1] Aaron Young, Humayun J. Chaudhry, Xiaomei Pei, Katie Arnhart, Michael Dugan, Kenneth B. Simons; FSMB Census of Licensed Physicians in the United States, 2020. *Journal of Medical Regulation* 1 July 2021; 107 (2): 57–64. doi: <https://doi.org/10.30770/2572-1852-107.2.57>

^[2] AAMC 2020 Physician Specialty Report. <https://www.aamc.org/data-reports/workforce/report/physician-specialty-data-report>

^[3] National Resident Matching Program, Results and Data: 2021 Main Residency Match®. National Resident Matching Program, Washington, DC. 2021.