Reference Committee A – Andrew K. Diehl, MD, MSc, FACP, *Chair*

Karen E. Clark, MD, FACP	West Virginia
Bruce A. Leff, MD, FACP, AGSF	Council of Subspecialty Societies
Kenneth E. Olive, MD, FACP	Tennessee
Michael A. Zimmer, MD, FACP	Florida

Spring 2011 BOG Resolutions

*** 1-S11. Recognizing Critical Disaster Preparedness Programs
2-S11. Promoting Personal and Workplace Safety in Healthcare
*** 3-S11. Advocating for Passage of the TRICARE Dependent Coverage Extension Act *(withdrawn)*
4-S11. Investigating the Health Impact of Legislation Targeting Undocumented Immigrant Populations
5-S11. Investigating Possible Work-Related Abuses for Physicians Working Under the Conrad-30 Program
*** 6-S11. Studying "End-of-Pipeline" Issues Related to Early Retirement of Primary Care Internists
7-S11. Increasing Collaboration with SGIM, SHM and Other Internal Medicine Subspecialty Societies
8-S11. Elevating the Concept of Physician Primacy and the Irreplaceable Nature of Physician Leadership at the Head of Medical Decision Making
9-S11. Collaborating with Other Organizations to Study the Impact of Setting Limits on Active Duty Hours for Practicing Physicians
***10-S11. Advocating for the Preservation and Growth of Small, Independent Practices
11-S11. Assessing the Significance of Human Factors in EHR Implementation
12-S11. Providing Internists Regular Input about the Yield of their Office-Based Secondary Prevention Efforts
13-S11. Using Name, Age, and Gender in the Patient Introduction
14-S11. Supporting Federal Legislation and/or Regulations that Require Clearly Labeling Food with Genetically Engineered Ingredients

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*(***Notes: The sponsors of Resolutions 1-S11, 6-S11, and 10-S11 accepted assignment on a consent calendar for reaffirmation at the BOG Business Meeting on Wednesday, April 6. Therefore, these resolutions will not be debated at the Reference Committee Hearing on Tuesday, April 5. Resolution 3-S11 was withdrawn due to legislation passed after submission that fulfills its intent and is listed for historical reference.)*

An Urgent Reminder about Providing Testimony on BOG Resolutions

As a result of conducting Reference Committee Hearings consecutively and considering a larger than usual number of resolutions this cycle, Governors are *urged* to review background in advance and engage in pre-BOG meeting discussion on the GIC newsgroup as the opportunity to provide *testimony at the hearings will be strictly limited*.

Keep in mind that online discussions carry the same weight as live testimony given at the meeting and will be submitted to the Reference Committees for their consideration before the meeting and during their report writing deliberations. To assure your viewpoint is heard on behalf of your chapter, we strongly encourage Governors to use the GIC newsgroup to comment on proposed Spring 2011 BOG Resolutions (see postings dated 12/22/10). Please carefully select the appropriate link to a specific resolution before commenting to assure that BOG members will benefit from your input in a relevant string

As done in the past, you may propose amendments via your BOG Class on Wednesday morning, April 6, at 7:00 a.m. during the *Class Breakfast Caucuses*, when Reference Committee Reports with recommendations will be circulated for review and discussion.

Resolution 1-S11. Recognizing Critical Disaster Preparedness Programs

(Sponsor: Northern California Chapter)

WHEREAS**,** the San Bruno gas leak/fire disaster in September 2010 injured dozens of residents with some resulting fatalities and is but one example of the multiple natural and manmade disasters that occur in the United States each year; and

WHEREAS**,** health practitioners should be educated in "all hazard" disaster preparedness; and

WHEREAS, the National Disaster Life Support Educational Consortium (NDLSEC) has developed courses to prepare responders for mass casualty disasters; therefore be it

RESOLVED, that the Board of Regents recognizes the following programs as critical for disaster preparedness: Core Disaster Life Support (CDLS) Course, Basic Disaster Life Support (BDLS) Course and Advanced Disaster Life Support (ADLS) Course; and be it further

RESOLVED, that the Board of Regents encourages all internists to avail themselves of these courses to prepare themselves for "all hazard" disasters; and be it further

RESOLVED, that the Board of Regents officially communicates its support of these programs to the AMA.

BACKGROUND INFORMATION

Resolution 1-S11. Recognizing Critical Disaster Preparedness Programs

RESOLVED, that the Board of Regents recognizes the following programs as critical for disaster preparedness: Core Disaster Life Support (CDLS) Course, Basic Disaster Life Support (BDLS) Course and Advanced Disaster Life Support (ADLS) Course; and be it further

RESOLVED, that the Board of Regents encourages all internists to avail themselves of these courses to prepare themselves for "all hazard" disasters; and be it further

RESOLVED, that the Board of Regents officially communicates its support of these programs to the AMA.

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1. PREVIOUS RELATED RESOLUTIONS:

25-F05. Exploring Mechanisms to Assist ACP Members in Volunteering during Disaster Conditions, RESOLVED, that the Board of Regents establishes a task force to explore mechanisms to assist ACP members in effectively volunteering during disaster conditions.

At the September 2005 Business Meeting, the Board of Governors (BOG) recommended that Board of Regents (BOR) adopt Resolution 25-F05 as amended. The BOR referred Resolution 25-F05 to the Volunteerism Subcommittee for study and report back through the Membership Committee with input from the Staff Disaster Work Group.

The Staff Disaster Work Group developed policy that describes three types of actions the College would take in the event of a qualifying natural disaster or national emergency. The actions are grouped according to their urgency and timing of when they are expected to be completed. The policy was approved by Senior Staff, the Volunteerism Subcommittee and the Membership Committee. The Board of Regents approved the disaster response policy at its January 2006 meeting.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Membership Division
ACP's Response to Disasters Policy provides guidance on how the College will assist its members in the event of a natural disaster or other national emergency. The policy identifies actions the College will take that are considered pre-disaster preparation, acute disaster response and longer term disaster response. One of the items listed under Pre-Disaster Preparation is:

- Encourage members to become certified by appropriate disaster preparedness agencies, such as the Medical Service Corps, Disaster Management Assistance

Teams, Community Emergency Response Teams (CERT), and other programs, such as the AMA's Basic and Advanced Disaster Life Support (BDLS and ADLS) courses.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
_X_F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.
___I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999)
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 2-S11. Promoting Personal and Workplace Safety in Healthcare

(Sponsor: Kentucky Chapter)

WHEREAS, there have been a number of high profile attacks on physicians recently, including the shooting of Dr. David Cohen at Johns Hopkins Hospital, the invasion of Dr. William Pettit, Jr.'s home which resulted in the deaths of his wife and both daughters, and the murder of Dr. Denny Sandlin in his own outpatient clinic in rural Kentucky, which highlight the diverse range of settings in which violence is occurring against physicians; and

WHEREAS, OSHA estimates that there are 2,600 non-fatal assaults against hospital staff every year, which is a statistic that does not include attacks on outpatient staff, violence perpetrated outside the workplace, nor does it include fatalities; and

WHEREAS, the American Academy of Family Physicians (AAFP) has policy stating that it "encourages all physicians to have a security manual/protocol in place and to go over security issues when training new staff. Physicians and other health professionals should be aware of their surroundings at all times and alert to potentially threatening situations or individuals.";[1] and

WHEREAS, the American College of Emergency Physicians (ACEP) recommends that hospitals "provide a best-practices security system including adequate security personnel, physical barriers, surveillance equipment, and other security components";[2] and

WHEREAS, there are companies, such as The Center for Personal Protection and Safety, that produce teaching aids to educate employees about the importance of situational awareness and rehearse work place safety scenarios and survival strategies which ACP can adapt to healthcare work situations and offer as a product to ACP members; and

WHEREAS, the Joint Commission recently alerted hospitals that the frequency of assaults, rapes and murders of healthcare workers has been growing at an alarming rate and there is the potential that such attacks might be preventable or mitigated; therefore be it

RESOLVED, that the Board of Regents promotes personal and workplace safety in healthcare and encourages physicians to have a security manual/protocol in place and to go over security issues when training new staff; and be it further

RESOLVED, that the Board of Regents recommends that hospitals provide a best-practices security system including adequate security personnel, physical barriers, surveillance equipment, and other security components; and be it further

[1] AAFP: Violence, Illegal Acts Against Physicians and Other Health Professionals
[2] ACEP: Protection from Physical Violence in the Emergency Department Environment

RESOLVED, that the Board of Regents develops educational resources on its own or in collaboration with outside entities which educate its members and their staff on safety issues including personal situational awareness, and outpatient and inpatient personal and workplace safety.

BACKGROUND INFORMATION

Resolution 2-S11. Promoting Personal and Workplace Safety in Healthcare

RESOLVED, that the Board of Regents promotes personal and workplace safety in healthcare and encourages physicians to have a security manual/protocol in place and to go over security issues when training new staff; and be it further

RESOLVED, that the Board of Regents recommends that hospitals provide a best-practices security system including adequate security personnel, physical barriers, surveillance equipment, and other security components; and be it further

RESOLVED, that the Board of Regents develops educational resources on its own or in collaboration with outside entities which educate its members and their staff on safety issues including personal situational awareness, and outpatient and inpatient personal and workplace safety.

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1. PREVIOUS RELATED RESOLUTIONS:

15-F03. Firearms in Health Care Facilities, RESOLVED, that the Board of Regents adopts the position that health care facilities should create a safe environment for medical professionals, visitors, patients and employees; and be it further **RESOLVED**, that the Board of Regents advocates for legislation that makes it illegal to carry firearms into any health care facility, other than security and law enforcement personnel.

At the October 2003 Business Meeting, the BOG recommended that the BOR adopt Resolution 15-F03 as amended. At their October 2003 meeting, the BOR adopted and referred Resolution 15-F03 to the Health and Public Policy Committee for implementation.

The HPPC considered action to implement this resolution at its meeting on February 7, 2004. The HPPC determined that this issue will be added to the agenda for the ACP Washington staff. It also recommended passing the resolution along to the AMA Delegation for a possible AMA resolution, and also possibly to the states. Staff subsequently found that the AMA already had extensive policy seeking to ban guns in hospitals (H-215.977, adopted in 1994, and H-215.978, adopted in 1994 and reaffirmed in 1999). Also, the ACP delegation had recently supported policy (D-145.999), which was approved by the AMA in June 2003 urging Congress "to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at-large may be able to prevent injury, death and the other costs to society resulting from firearms." Staff has continued to monitor the issue of firearm injury prevention and to lobby for appropriate legislation. The College has lobbied for renewal of the ban on assault weapons and for increased funding for the CDC's National Violent Death Reporting System (NVDRS). The College continues to be a participating member of the coalition Doctors Again Handgun Injuries and the HELP (Handgun Epidemic Lowering Plan) Network.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Medical Education and Publishing Division
The Medical Education Division has no background that relates to this resolution.

Policy Analysis and Research
No existing ACP policy.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?

(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.
_X_I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_____ None (0-$999)
___X___ Minimal ($1,000-$14,999) Policy Analysis & Research (PAR)
_____ Moderate ($15,000 - $50,000)
___X___ Significant ($50,000 - $100,000) Med. Educ.& Pub. Div (MEPD).; PAR-If ACP develops educational resources on its own.
_____ Substantial ($100,000 or more)

Resolution 3-S11. Advocating for Passage of the TRICARE Dependent Coverage Extension Act

(Co-Sponsors: Northern California, BOG Class of 2013, and Virginia Chapters)

***(RESOLUTION 3-S11: WITHDRAWN BY SPONSOR:** Legislation passed after submission.)*

WHEREAS, as of June 1, most large civilian insurers and the Federal Employees Health Benefits System implemented the national health reform requirement to allow children to continue under a parent's health coverage until age 26, provided the children have no access to employer coverage. Families who opt for this coverage do not incur any additive premium requirement; and

WHEREAS, the provision extending health insurance coverage to dependent children until age 26 in the Patient Protection and Affordable Care Act (PPACA) does not appear to extend to beneficiaries of TRICARE, a health care program of the U.S. Department of Defense Military Health System serving Uniformed Service members, retirees and their families worldwide; and

WHEREAS, eligibility for TRICARE is lost when either a dependent child turns 23 if enrolled in an accredited school as a full-time student, or 21 if not enrolled; and

WHEREAS, Chapter 55 of Title 10, *United States Code*, governs coverage under the TRICARE program and in §1072(2)(D) the term "dependent" only includes a child who has not attained the age of 21 or has not attained the age of 23 and is enrolled in a full-time course of study at an institution of higher learning; and

WHEREAS, the TRICARE Dependent Coverage Extension Act (H.R. 4923) was introduced on March 24, 2010. A similar bill (S. 3201) was introduced on April 14, 2010. These measures would amend Chapter 55 of Title 10, *United States Code*, to extend TRICARE coverage to dependent children up to age 26; and

WHEREAS, the military provides protection for our citizens at home and abroad; therefore be it

RESOLVED, that the Board of Regents advocates for passage of the TRICARE Dependent Coverage Extension Act (H.R. 4923 and S. 3201) giving the adult children of military members, Active, Reserve, and National Guard the same protection as the children of other U.S. citizens; and be it further

RESOLVED, that the Board of Regents encourages legislators to support bills that would continue coverage for military children under TRICARE until age 26 as provided under the PPACA, retroactive to June 1, 2010.

BACKGROUND INFORMATION

Resolution 3-S11. Advocating for Passage of the TRICARE Dependent Coverage Extension Act (*WITHDRAWN BY SPONSOR)*

RESOLVED, that the Board of Regents advocates for passage of the TRICARE Dependent Coverage Extension Act (H.R. 4923 and S. 3201) giving the adult children of military members, Active, Reserve, and National Guard the same protection as the children of other U.S. citizens; and be it further

RESOLVED, that the Board of Regents encourages legislators to support bills that would continue coverage for military children under TRICARE until age 26 as provided under the PPACA, retroactive to June 1, 2010.

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1. PREVIOUS RELATED RESOLUTIONS:

7-S07. Visibly and Aggressively Advocating to Achieve Universal Access, RESOLVED, that the Board of Regents visibly and aggressively advocates to achieve universal access to medically appropriate, comprehensive, affordable, high-quality health care through exploring a diverse range of payment options; and be it further **RESOLVED**, that the Board of Regents looks at regional and international models, and obtain significant grass roots input.

At its April 2007 Business Meeting, the BOG recommended that the BOR adopt Resolution 7-S07 as amended. At its April 2007 Organizational Meeting, the BOR adopted and referred Resolution 7-S07 to the HPPC for implementation.

At its meeting in May 2007, the HPPC reviewed the resolution and concluded that ACP was already in the process of implementing it. Two new position papers, "Achieving a High Performance Healthcare System: What the U.S. Can Learn from Other Health Care Systems with Universal Access" and "State Experimentation with Reforms to Expand Access to Health Care – a White Paper" were developed in response to the second resolve. Both papers were completed and became the basis for further ACP public policy advocacy. An abridged version of the paper on Achieving a High Performance System was published in the online version of the *Annals* in December 2007 and in the print version in January 2008. Presentations based on the paper were made at the National Congress on the Un- and Under-Insured in December 2007. Extensive media coverage resulted from a press conference, issuance of press releases, satellite radio interviews, placement of Op-Ed letters, meetings with editorial boards, and other publicity through ACP communications. Cover stories appeared in DOCTalk and Modern Health Care. A "Governor's toolkit" and PowerPoint slides were also prepared and posted on the GIC.

HPPC also updated ACP's 7-year plan to achieve universal access, and ACP lobbyists actively supported the Health Care Act that incorporates provisions of ACP's plan. The legislation contains language drafted by ACP. ACP also lobbied for reauthorization of the State Childrens' Health Insurance Program with expanded funding. The legislation passed but was vetoed by President Bush. SCHIP was reauthorized, by subsequent legislation, but not at the expanded level that ACP supported.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Policy Analysis and Research
ACP has supported the provision in the PPACA regarding extending health insurance coverage. Providing the same protections under TRICARE for children up to age 26 would be consistent with ACP policy to achieve universal health insurance coverage and eliminate disparities.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?

(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
_X_B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.
___I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) PAR
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 4-S11. Investigating the Health Impact of Legislation Targeting Undocumented Immigrant Populations

(Sponsor: Arizona Chapter)

WHEREAS, the mission of the College is to "enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine"; and

WHEREAS, the College's advocacy efforts focus on improving the practice of internal medicine and assuring patient access to care; and

WHEREAS, the College takes positions on policy and ethical issues that impair the health of the patients we serve; therefore be it

RESOLVED, that the Board of Regents investigates and assesses the health impact of legislation targeting undocumented immigrant populations on their ability to access clinical care as well as the ability of those who appear to be undocumented; and be it further

RESOLVED, that the Board of Regents investigates and assesses the health impact of legislation targeting undocumented immigrant populations on a provider's ability to provide care; and be it further

RESOLVED, that the Board of Regents investigates and assesses the health care costs of legislation targeting undocumented immigrant populations; and be it further

RESOLVED, that the Board of Regents investigates the ethical factors that underlie the policy implications of targeted legislation on the health of immigrant populations.

BACKGROUND INFORMATION

Resolution 4-S11. Investigating the Health Impact of Legislation Targeting Undocumented Immigrant Populations

RESOLVED, that the Board of Regents investigates and assesses the health impact of legislation targeting undocumented immigrant populations on their ability to access clinical care as well as the ability of those who appear to be undocumented; and be it further

RESOLVED, that the Board of Regents investigates and assesses the health impact of legislation targeting undocumented immigrant populations on a provider's ability to provide care; and be it further

RESOLVED, that the Board of Regents investigates and assesses the health care costs of legislation targeting undocumented immigrant populations; and be it further

RESOLVED, that the Board of Regents investigates the ethical factors that underlie the policy implications of targeted legislation on the health of immigrant populations.

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1. PREVIOUS RELATED RESOLUTIONS:

(See Resolution 3-S11 for related Resolution 7-S07.)

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Center for Ethics and Professionalism
The Ethics, Professionalism and Human Rights Policy Committee (EPHRPC) contributed ethics content to a draft position paper titled "National Immigration Policy and Access to Health Care," for which the Health and Public Policy Committee is the lead committee. This paper is expected to be submitted to the Board of Regents in April 2011.

The ACP *Ethics Manual* and an ethics case study on care of immigrants are cited specifically in positions 6 (Physicians and other health care professionals have an ethical obligation to care for the sick. Immigration policy should not interfere with the ethical obligation to provide care to all) and 7 (Immigration policies should not foster discrimination against a class or category of patients in the provision of health care) of the position paper.

Policy Analysis and Research
The Health and Public Policy Committee has developed a position paper on National Immigration Policy and Health Care Reform. The paper is currently posted for comments and is expected to be submitted for approval at the April 2011 BOR meeting. The paper deals with the public policy issues related to undocumented immigrants.

ACP does not have the capability to independently investigate and assess the health impact of legislation.

In the policy paper, the College addresses concern about the health impact of legislation targeting immigrant populations on their ability to access clinical care.

> Position 2: Patients' access to health care should not be restricted based on immigration status, and people should not be prevented from purchasing health insurance coverage out of their own pockets.
>
> Position 4: National immigration policy should recognize the public health risks associated if undocumented persons do not access health care treatment because of concern about being subjected to criminal or civil prosecution or deportation.
>
> a. Increased access to comprehensive primary care, prenatal care, injury prevention initiatives, and chronic disease management may make better use of the public health dollar by improving the health status of this population and alleviating demand for costly emergency care.
> b. National immigration policy should encourage all residents to obtain clinically effective vaccinations for infectious diseases.

The College also addresses expensive emergency care, unpaid medical bills, and making better use of the public health dollar.

> Position 7: Physicians and other health care professionals have an ethical obligation to care for the sick. Immigration policy should not interfere with the ethical obligation to provide care to all.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
_X_ B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.
___I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

X	None (0-$999) Ethics
	Minimal ($1,000-$14,999)
	Moderate ($15,000 - $50,000)
X	Significant ($50,000 - $100,000) PAR**
	Substantial ($100,000 or more)

**ACP would need to hire a consultant to investigate and assess the impact of legislation as proposed.

Resolution 5-S11. Investigating Possible Work-Related Abuses for Physicians Working Under the Conrad-30 Program

(Sponsor: Arizona Chapter)

WHEREAS, it is a goal of the College to serve the professional needs of the membership; and

WHEREAS, the College's member database indicates that international medical graduates (IMGs) constitute 28% of all non-medical student members; and

WHEREAS, many IMGs participate in the Conrad-30 program and provide needed primary care services in medical underserved areas; and

WHEREAS, the Board of Regents has previously adopted a resolution addressing work issues affecting IMG physicians working under the Conrad-30 program; and

WHEREAS, these IMG physicians, with J-1 visas, continue to suffer work-related abuses including intimidation, loss of benefits, limitations to changes in employment and lack of salary equity; therefore be it

RESOLVED, that the Board of Regents develops a mechanism by which members encountering such abuses (e.g., intimidation, loss of benefits, limitations to changes in employment and lack of salary equity) may report this information directly to the College without fear of retribution for purposes of data collection for advocacy support; and be it further

RESOLVED, that the Board of Regents aggressively works in coalition with other professional societies to investigate possible work-related abuses encountered by IMG physicians with J-1 visas; and be it further

RESOLVED, that the Board of Regents works in collaboration with other professional societies, legislative entities and regulatory bodies to seek change to the program if deemed needed.

BACKGROUND INFORMATION

Resolution 5-S11. Investigating Possible Work-Related Abuses for Physicians Working Under the Conrad-30 Program

RESOLVED, that the Board of Regents develops a mechanism by which members encountering such abuses (e.g., intimidation, loss of benefits, limitations to changes in employment and lack of salary equity) may report this information directly to the College without fear of retribution for purposes of data collection for advocacy support; and be it further

RESOLVED, that the Board of Regents aggressively works in coalition with other professional societies to investigate possible work-related abuses encountered by IMG physicians with J-1 visas; and be it further

RESOLVED, that the Board of Regents works in collaboration with other professional societies, legislative entities and regulatory bodies to seek change to the program if deemed needed.

---

1. PREVIOUS RELATED RESOLUTIONS:

9-F08. Implementing Universal State and Federal J-1 Visa Application Processes
RESOLVED, that the Board of Regents works towards the implementation of universal and simplified state and federal J-1 visa application processes; and be it further
RESOLVED, that the Board of Regents acts for changes to the Conrad 30 program that provide a fair distribution of J-1 visa physicians in the most medically underserved areas based on the total population of the state instead of the current set number of 30 physicians per state regardless of need and population; and be it further
RESOLVED, that the Board of Regents acts on behalf of the Conrad 30 J-1 physicians to allow them to change sponsors among medically underserved areas without restriction within the Conrad 30 system; and be it further
RESOLVED, that the Board of Regents acts to permit Conrad 30 J-1 visa physicians a grace period of 120 days in order to find another Conrad 30 position if relieved of their duties.

At the September 2008 BOG Business Meeting, the BOG recommended that the BOR refer this resolution for study. At its October 2008 meeting, the BOR referred Resolution 9-F08 to the Health and Public Policy Committee for study and report back.

At the February 2009 meeting, the Health and Public Policy Committee (HPPC) reviewed a staff background memo that included information about J-1 visas and waivers, existing ACP policy and ACP support for legislation. Staff recommended that existing policy is sufficient for the College to continue to support the Conrad 30 State program, but that some of the specifics of the resolution may go beyond current ACP policy. HPPC voted to recommend adopting resolved clauses 1 and 3 and not adopting resolved clauses 2 and 4. HPPC recommended that staff seek opportunities to address some of the issues raised in the resolution that are supported by College

policy legislatively. Staff subsequently met with legislative counsel for Senator Kent Conrad, who introduced legislation to reauthorize the Conrad 30 State program. Staff discussed some of the concerns raised in the resolution. Senator Conrad's staff agreed to consider the issues. Staff will continue to monitor legislation related to the Conrad 30 State program. Following further consideration at its meeting on October 17, 2009, HPPC recommended that the BOR adopt Resolution 9-F08 with the modification of changing the word "advocates" to "acts" in the second and third resolve.

On their December 3, 2009 webinar, the BOR approved the recommendation from the HPPC and adopted a modified version of BOG Resolution 9-F08.

12-S07. Advocating for a Streamlined Process to Obtain J-1 and H1B Visas for Non-U.S. Citizen International Medical Graduates, RESOLVED, that the Board of Regents advocate for a streamlined process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire training in a residency program in the U.S.; and be it further **RESOLVED**, that the Board of Regents continue its efforts to increase the number of J-1 visa waiver positions to facilitate the delivery of health care services to medically underserved areas including a further expansion of the Conrad State 30 Program, a popular initiative that draws doctors to regions with a shortage of physicians.

At the April 2007 Business Meeting, the BOG recommended that the BOR refer Resolution 12-S07 for study. At its April 2007 Organizational Meeting, the BOR referred Resolution 12-S07 to the Health and Public Policy Committee (HPPC) for study and report back with input from the Council of Associates (COA).

At its May 2007 meeting, the HPPC reviewed a written report with input from the COA. Sameer Badlani, MD, COA member and member of the IMG Task Force, also attended the HPPC meeting and discussed the BOG resolution and the issue of J-1 and H-1B visas. Staff then researched the issues further and prepared a background report to the HPPC in September 2007. A policy monograph was developed that addressed the visa issue, barriers encountered by IMGs, as well as the issue of "brain drain." The HPPC approved the paper in January 2008 for posting on the GIC. Input on the final draft was obtained from the IMG Task Force as well. At its May 2008 meeting, the BOR approved the policy monograph "The Role of International Medical Graduates in the U.S. Physician Workforce."

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Policy Analysis and Research
The College supports the Conrad 30 Program and the role of IMGs in providing care in underserved areas. The College has lobbied to have the program expanded and made permanent. The College is not aware of existing data on work-related abuses in the program. Program participants may be able to contact the state health departments that facilitated their placement. Gathering evidence of abuse would be helpful in communicating with state/federal health departments.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?

(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.

_X_B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.

___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).

___D. Increase the number of new members and improve retention among current members.

___E. Enhance and assess the effectiveness and vitality of ACP Chapters.

___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.

___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.

___H. Continue to promote the highest professional and ethical standards for our members and organization.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999)

_____ Minimal ($1,000-$14,999)

_____ Moderate ($15,000 - $50,000)

_____ Significant ($50,000 - $100,000)

_____ Substantial ($100,000 or more)

Resolution 6-S11. Studying "End-of-Pipeline" Issues Related to Early Retirement of Primary Care Internists

(Co-sponsors: Texas, Missouri, and Oklahoma Chapters)

WHEREAS, internal medicine workforce issues impact the health care delivery system on all levels; and

WHEREAS, evidence has demonstrated that an adequate primary care workforce enhances quality and efficiency[3]; and

WHEREAS, more physicians are leaving primary care than entering this essential population of physicians; therefore be it

RESOLVED, that the Board of Regents studies "end-of-pipeline" issues related to early retirement of primary care internists in order to diminish the attrition of this seasoned and experienced workforce and considers a partnership with other medical organizations to explore solutions to retain necessary manpower that shall be needed in the near future.

[3] *The Primary Solution: Mending Texas' Fractured Health Care System*. The Primary Care Coalition 2008.

BACKGROUND INFORMATION

Resolution 6-S11. Studying "End-of-Pipeline" Issues Related to Early Retirement of Primary Care Internists

RESOLVED, that the Board of Regents studies "end-of-pipeline" issues related to early retirement of primary care internists in order to diminish the attrition of this seasoned and experienced workforce and considers a partnership with other medical organizations to explore solutions to retain necessary manpower that shall be needed in the near future.

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1. PREVIOUS RELATED RESOLUTIONS:

18-S07. Studying Flexible Work Options to Develop Resources for Internists, RESOLVED, that the Board of Regents study flexible work options for internists with the intention of developing resources such as model work schedules, and make recommendations to balance work and family life while continuing professional advancement/development.

At the April 2007 Business Meeting, the BOG recommended that the BOR adopt Resolution 18-S07 as amended. At their April 21, 2007 Organizational Meeting, the BOR referred Resolution 18-S07 to the Education Committee for implementation with input from the Council of Young Physicians.

There will be two primary ways of approaching implementation of Resolution 18-S07:

1) Surveying members through ACP Internist Weekly and ACP Hospitalist Weekly about individual experiences and models with part-time employment. Information received from the surveys will be used to develop feature articles about part-time employment in the corresponding print publications, *ACP Internist* and *ACP Hospitalist*.

2) Staff in the Medical Education and Publishing Division will work with staff in the Government Affairs and Public Policy Division to update materials about part-time employment that are currently available on ACP Online.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Policy Analysis and Research
In the 2006 position paper, Creating a New National Workforce for Internal Medicine, the College highlighted the fact that general internists are leaving practice sooner than other specialties. That same year, the College's State of the Nation's Healthcare Report included a series of recommendations on reforming Medicare payment policies so that physicians engaging in primary care can receive reimbursement that is commensurate with the value of their contributions. The recommendations included new models for paying physicians for coordination of care of patients with chronic diseases, increased payment for office visits and other evaluation and management services, separate payment for email consultations for non-

urgent health issues that can reduce the need for face-to-face visits, and additional payments to physicians who use electronic health records to improve quality. The College stressed that reducing existing income disparities would make the field more attractive and increase the number of physicians entering and continuing practice in primary care specialties. The College continues to advocate for such changes and much progress has been made in implementing the Patient-Centered Medical Home model. Provisions to support primary care were also included in the Affordable Care Act.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

_X_ A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___ B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___ C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___ D. Increase the number of new members and improve retention among current members.
___ E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___ F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___ G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___ H. Continue to promote the highest professional and ethical standards for our members and organization.
___ I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_____ None (0-$999)
___X___ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 7-S11. Increasing Collaboration with SGIM, SHM and Other Internal Medicine Subspecialty Societies

(Sponsor: Arizona Chapter)

WHEREAS, ACP's members are internists; and

WHEREAS, general internists provide primary care and may see their professional home as the Society for General Internal Medicine (SGIM); and

WHEREAS, primary care and the medical home are increasingly the focus of health policy discussions; and

WHEREAS, many general internists focus on hospital medicine and may see their professional home as the Society of Hospital Medicine (SHM); and

WHEREAS, many internists subspecialize; and

WHEREAS, subspecialists serve as primary care providers for patients for whom they are providing ongoing chronic care; and

WHEREAS, the College strives to serve as the voice for *all* internists; therefore be it

RESOLVED, that the Board of Regents continues to identify areas of synergy with other internal medicine societies, such as, SGIM and SHM, and others that represent general internists and hospitalists; and be it further

RESOLVED, that the Board of Regents works with internal medicine subspecialty societies to explore, identify and affirm examples of primary care practice delivered by internal medicine subspecialists; and be it further

RESOLVED, that the Board of Regents increases collaboration with SGIM, SHM and internal medicine subspecialty societies regarding *shared* interests in the development of the medical home as a new model for health care delivery for the benefit of our patients and develops integrated policy objectives that will promote effective advocacy.

BACKGROUND INFORMATION

Resolution 7-S11. Increasing Collaboration with SGIM, SHM and Other Internal Medicine Subspecialty Societies

RESOLVED, that the Board of Regents continues to identify areas of synergy with other internal medicine societies, such as, SGIM and SHM, and others that represent general internists and hospitalists; and be it further

RESOLVED, that the Board of Regents works with internal medicine subspecialty societies to explore, identify and affirm examples of primary care practice delivered by internal medicine subspecialists; and be it further

RESOLVED, that the Board of Regents increases collaboration with SGIM, SHM and internal medicine subspecialty societies regarding *shared* interests in the development of the medical home as a new model for health care delivery for the benefit of our patients and develops integrated policy objectives that will promote effective advocacy.

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1. PREVIOUS RELATED RESOLUTIONS:

6-S06. Working with SGIM Leadership to Identify Mechanisms that Allow ACP and SGIM to Coordinate Activities and to Achieve a Closer Alliance, RESOLVED, that the Board of Regents work with SGIM leadership to identify mechanisms that allow ACP and SGIM to coordinate activities and to achieve a closer alliance.

At the April 2006 Business Meeting, the BOG recommended that the BOR adopt Resolution 6-S06. At their April 2006 Organizational Meeting, the BOR adopted and referred Resolution 6–S06 to the Executive Committee of the Board of Regents for implementation with input from the Education Committee and the Health and Public Policy Committee.

At the June 2006 Executive Committee Board of Regents Meeting, Dr. Ejnes introduced BOG Resolution 6-S06, Working with SGIM Leadership to Identify Mechanisms that Allow ACP and SGIM to Coordinate Activities and to Achieve a Closer Alliance. He cited existing strategies of ACP and SGIM collaboration under the rubric of the Unification of Internal Medicine (e.g., formally or informally appointing SGIM members to ACP committees and holding joint ACP-SGIM Leadership meetings annually). Dr. Kirk reported on the SGIM Annual Meeting where she and Dr. Michael Barr met with SGIM leadership to dialogue about common goals.

7-S05. Encouraging ACP Interaction with State Medical Societies, **RESOLVED**, that the Board of Regents explicitly authorize the HPPC and ACP Washington office to increase communications through ACP Chapters, to share strategies, to work for common goals, and to share ACP publications dealing with health policy with state medical societies that have common objectives with ACP.

At the April 2005 Business Meeting, the BOG recommended that the BOR adopt Resolution 7-S05 as amended. At their April 2005 meeting, the BOR adopted and referred Resolution 7-S05 to Health and Public Policy staff for implementation.

The Health and Public Policy Committee (HPPC) discussed this resolution and agreed with its intent. Staff will increase efforts to improve communications with state medical societies and HPPC and staff will seek to work more closely with state medical societies on issues where there are common objectives with ACP. During 2006-07, HPPC and staff expect to work more closely with state medical societies on issues related to expanding access to health care, recognizing that progress on this issue is more likely to occur at the state level rather than at the national level.

12-F03. Unified Voice for Internal Medicine and Its Subspecialties, RESOLVED, that the Board of Regents adopt the following as the seventh goal of the College: "To strive to unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members and our profession."

At the October 2003 Business Meeting, the BOG recommended that the BOR adopt Resolution 12-F03. At their October 2003 meeting, the BOR referred Resolution 12-F03 to the Strategic Planning Committee (SPC) for study and report back with recommendations. The SPC recommended the addition of a seventh College goal and the BOR agreed, adopting Resolution 12-F03 at their January 2004 meeting, adding a seventh College goal as follows: “To unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession.”

12-S03. State Medical Association Advocacy, RESOLVED, that the Board of Regents facilitate the cooperation of chapters and their state medical societies to support resolutions to the AMA House of Delegates which advance the College’s agenda.

At its April 2003 Business Meeting, the BOG recommended that the BOR adopt Resolution 12-S03. At its April 2003 Organizational Meeting, the BOR adopted and referred this resolution to HPPC for implementation.

The HPPC considered this resolution at its 2003-04 meetings and agreed that the best way to implement this resolution is on a selective basis. The HPPC noted that building support for the ACP/Bingaman proposal to expand access to health insurance might be a good test. However, at the Annual and Interim meetings of the AMA House of Delegates, the AMA adopted further policy that recommended replacing Medicaid and SCHIP programs for low-income persons with tax credits for the purchase of individually owned health insurance. ACP worked with other medical societies (AAFP, AAP, ACOG, APA, NME, and National Hispanic Medical Association) to substitute alternative language that was more consistent with the ACP/Bingaman proposal, but this was defeated. Staff is drafting another resolution for submission to the AMA to influence AMA policy. This resolution many serve as an example for resolutions that chapters could also bring to their state medical associations in accord with the intent of Resolution 12-S03.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Center for Ethics and Professionalism
The Center for Ethics and Professionalism has been working on a joint paper on ethics and the patient-centered medical home, and is looking for other points of collaboration with SGIM. Ethics staff Lois Snyder is a member of the SGIM Ethics Committee and has previously served on the SHM Ethics Committee and collaborated on joint ethics case studies.

Executive Office
ACP has an established working relationship with SGIM, including working on mutual topics such as practice redesign, Graduate Medical Education (GME) redesign, advocacy, the revitalization of internal medicine, and improving interest in internal medicine among medical students. We recently have been holding joint leadership meetings between ACP and SGIM each year to exchange information, discuss priorities for the coming year, and identify topics of mutual interest and potential collaboration.

Additionally, ACP is collaborating closely with SGIM in planning a summit on the Patient-Centered Medical Home in the academic environment, which will be held in March 2011 at ACP headquarters in Philadelphia. SGIM is the lead organization planning the summit, but a central component of the summit will be ACP's Medical Home Builder and the potential for developing new modules focused on the academic environment.

ACP also has established working relationships with the Society of Hospital Medicine and with a number of the internal medicine subspecialty societies. ACP and these other organizations invite an official representative to each other's annual meeting. ACP's EVP and CEO meets on a regular basis with his counterpart at the Society of Hospital Medicine and with counterparts at several of the internal medicine subspecialty societies. ACP also has particularly close relationships with the American Society of Nephrology, the American Thoracic Society, the American College of Chest Physicians, and the American College of Cardiology to share or collaborate on educational programs, especially at the organizations' annual meetings.

Policy Analysis and Research
SHM and SGIM have seats on the College's Council of Subspecialty Societies along with 24 other subspecialty/internal medicine related organizations. For the past three years, the CSS has worked on refining the role of subspecialists in the patient-centered medical home. The CSS formed a workgroup that has focused on the development of the patient-centered medical home neighbor concept, for those subspecialists that do not qualify or do not wish to become PCMHs. The work of the Council resulted in a position paper on the issue (see http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf). The workgroup continues to work on issues related to implementing the PCMH-N concept. The CSS also receives updates on the status of PCMH demonstration projects, studies, and College activities on the issue at their face-to-face meetings in the fall and spring of each year.

Regulatory and Insurer Affairs
Regulatory and Insurer Affairs (RIA) has been working through the ACP Council of Subspecialty Societies (CSS) to examine and develop the role of subspecialty practices within

the Patient-Centered Medical Home (PCMH) model. A Workgroup has been formed, with representatives from 14 different subspecialty societies (including SGIM and SHM) that has affirmed the appropriateness of a subspecialty practice serving as a PCMH under certain circumstances, and the general importance of involving specialist/subspecialists within the PCMH model to ensure the achievement of improved care coordination and integration. The Workgroup's activities have resulted in the development of the ACP policy paper "The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices" that was approved as ACP policy by the Board of Regents on August 1, 2010. The Workgroup is currently developing model referral/response forms and care coordination agreements between PCMH and specialty/subspecialty practices. It is also examining the feasibility of a PCMH-Neighbor recognition process.

The College through RIA also works very closely with the subspecialty societies on coding and payment issues. There is substantial subspecialty involvement on the College's Coding and Payment Subcommittee and on the Subspecialty Advisory Group on Socioeconomic Affairs (SAGSA). The College also regularly works closely with representatives of the subspecialty societies in preparation for Relative Value Scale Update Committee (RUC) and Current Procedural Terminology (CPT) Coding meetings.

The College, through RIA and DGAPP (Division of Governmental Affairs and Public Policy), also regularly works in collaboration with the subspecialty societies to advocate for issues of mutual interest both at the regulatory and Congressional levels.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
X_D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) Ethics, PAR, and RIA
___X_ Minimal ($1,000-$14,999) Executive Office
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 8-S11. Elevating the Concept of Physician Primacy and the Irreplaceable Nature of Physician Leadership at the Head of Medical Decision Making

(Sponsor: Kentucky Chapter)

WHEREAS, the American College of Physicians is the preeminent organization representing internal medicine in public forums; and

WHEREAS, ACP members feel that at the core of public policy discussions the role of the physician as "the captain of the healthcare ship" must be presented by those who represent them; therefore be it

RESOLVED, that the Board of Regents, in all of its discussions and testimony from the individual through national levels, elevates the concept of physician primacy and the irreplaceable nature of physician leadership at the head of medical decision making, and incorporates this concept within ACP's strategic plan; and be it further

RESOLVED, that the Board of Regents not entertain any resolution which is contrary to the status of physician as the leader of medical decision making.

BACKGROUND INFORMATION

Resolution 8-S11. Elevating the Concept of Physician Primacy and the Irreplaceable Nature of Physician Leadership at the Head of Medical Decision Making

RESOLVED, that the Board of Regents, in all of its discussions and testimony from the individual through national levels, elevates the concept of physician primacy and the irreplaceable nature of physician leadership at the head of medical decision making, and incorporates this concept within ACP's strategic plan; and be it further

RESOLVED, that the Board of Regents not entertain any resolution which is contrary to the status of physician as the leader of medical decision making.

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1. PREVIOUS RELATED RESOLUTIONS:

1-S08. Differentiating between Physicians and Other Health Care Providers, RESOLVED, that the Board of Regents insures that in all ACP publications and public discourse that there be a differentiation between physicians and less intensively trained health care workers, and that when referring to members of a combined health care team that the term "physicians and other health care professionals" be used subject to reasonable editorial discretion.

At the May 2008 Business Meeting, the BOG recommended that the BOR adopt Resolution 1-S08 as amended. At its May 2008 meeting, the BOR referred Resolution 1-S08 to the Marketing and Communications Committee (MCC) for study and report back with input from the Health and Public Policy Committee (HPPC) and Medical Service Committee (MSC).

The MCC sought input from the HPPC and the MSC to see how this resolution might impact the language contained in ACP policies developed by these two committees. The HPPC considered Resolution 1-S08 at its February 7, 2009 meeting. HPPC reviewed the resolution and recommended that it be supported, but with an amendment to the resolve clause adding "subject to reasonable editorial discretion." The MCC agreed with this change and recommended that the BOR adopt Resolution 1-S08 as amended. At its April 2009 meeting, the BOR voted to approve the MCC recommendation.

34-S02. Support of Full and Thorough Treatment, RESOLVED, that the Board of Regents support that the current College policy be amended as follows; ACP-ASIM believes that any effective patient protection legislation must require that physicians, rather than health plans, make determinations regarding the medical necessity appropriateness and number of test procedures and treatments.

At its April 2002 Business Meeting, the BOG recommended that the BOR adopt Resolution 34-S02. This was a substitute resolution submitted by Reference Committee B to replace Resolution 17-S02, which was subsequently not adopted. At its April 2002 Organizational Meeting, the BOR adopted Resolution 34-S02 and referred it to the Medical Service Committee (MSC) for implementation.

The MSC noted that the College continues to pursue federal patient protection legislation where physicians, rather than health insurance plans, make determinations regarding the medical necessity, appropriateness and number of test procedures and treatments. The MSC also engaged the Blue Cross Blue Shield Association (BCBSA) on this specific issue as BCBSA was advocating to Congress that health plan medical directors have the final say regarding medical necessity.

106 (Spring 1997). Medical Decision Making *(see Medical Practice, Professionalism and Quality below).*

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Center for Ethics and Professionalism
It is unclear what is meant by the phrase "physician leadership at the head of medical decision-making." Medical decision making is a term often used to describe the process by which patients or their authorized surrogates make health care decisions. If this refers more to the physician as the head of the patient care team, the ACP *Ethics Manual* provides guidance in its chapter, "The Physician's Relationship to Other Physicians" with sections in particular on consultation and on conflicts between members of a health care team. College policy and advocacy on the patient-centered medical home also addresses the physician's role on the health care team, and a paper under development by the Ethics, Professionalism, and Human Rights Committee (EPHRC) on ethics and the patient centered medical home will consider this further as will the next edition of the *Ethics Manual*.

Executive Office
ACP's vision is "to be the recognized leader in quality patient care, advocacy, education and enhancing career satisfaction for internal medicine and its subspecialties."

ACP's Strategic Plan, approved by the Board of Regents July 31, 2010 and effective through June 2011, includes two specific objectives which emphasize the importance of the patient-physician relationship:

> C-01 Promote the importance of the patient-physician relationship, and of sustaining trust in this relationship, in analyzing the ethical dimensions of health care reform and as a core part of new policy on the ethical aspects of the Patient-Centered Medical Home.
>
> C-03 Promote the attributes of the Patient-Centered Medical Home (PCMH) in practices of varying size and promote the model among the full range of health care stakeholders—including specialists, or "neighbors," advocate expansion consistent with ACP's vision, based on test results, and emphasize importance of the patient-physician relationship.

In April 2010, the Board of Regents approved a new annual strategic planning process to establish and convey the BOR's priorities, expected outcomes, and evaluation criteria for ACP. In order to inform development of ACP's FY 2011-12 Strategic Plan, the Board of Regents'

January 2011 Planning Retreat solicited input from the Board of Regents, Executive Committee Board of Governors, Senior Staff, and ACP Foundation with the goal of developing a focused strategic plan for FY 2011-12. The structure of the new Plan includes several priorities which define broad areas in which ACP will strategically focus resources and initiatives during FY 2011-12, in addition to ongoing operations. Each priority area has specific goals, indicating to staff what should be achieved in each priority area. In February 2011, the BOR approved the FY 2011-12 Strategic Plan, including the following priority area and goals relevant to the proposed resolution:

Priority
To define and communicate the unique value of internal medicine
Goals

- Communicate the distinctive role of internists as providers of patient-centered, complex, high quality and evidence-based care.
- Help internists learn to effectively leverage their position within their practice environments to improve patient care and advance professionalism.
- Improve medical students' and residents' attitudes towards a career in internal medicine and residency training.

Medical Practice, Professionalism and Quality
The intent of these Resolves seems to go beyond just "medical decision making." If just "medical decision making" then a prior resolution, Spring 1997, 106 might be cause for consideration of reaffirmation. The text of that resolution follows:

106. Medical Decision Making
Clauses:WHEREAS, there have been well documented abuses by health care organizations to restrict care (e.g., premature hospital discharge following delivery, denial of payment for emergency room visits, refusal to pay for medically accepted procedures, pre-existing conditions insurance exclusions, gag clauses); and, WHEREAS, the patient-physician relationship and/or medical outcomes have been damaged by these events; and, WHEREAS, there is increasing state and federal legislation to combat these abuses (e.g., mandatory 48-hour stay after delivery, Kennedy-Kassebaum); and, WHEREAS, the micromanagement of medical decision-making in the legislative arena is likely to increase as abuses are identified and addressed by consumers and legislators; and, WHEREAS, physicians must reclaim the responsibility for medical decision-making in the service of their patients; therefore,
BE IT RESOLVED, that the American College of Physicians continue to endorse the principle that individual medical care decisions should remain between physician and patient.

However, another, probably more accurate interpretation of the Resolution 8-S11 is the goal to elevate physician leadership above that of nurse practitioners and other health care professionals in the context of the current health care environment. Relevant work to date on this topic includes the advocacy efforts beginning with the ACP policy paper on Nurse Practitioners in Primary Care (http://www.acponline.org/advocacy/where_we_stand/policy/np_pc.pdf) and more recent efforts in response to the Josiah Macy Foundation report in March 2010 (http://www.acponline.org/advocacy/where_we_stand/other_issues/macy_statement.pdf) and advocacy efforts related to the Institute of Medicine's Future of Nursing report in November

2010 (http://www.acponline.org/pressroom/future_nursing.pdf; and http://www.nejm.org/doi/full/10.1056/NEJMc1013895 - see second Letter to the Editor).

Policy Analysis and Research
The ACP position paper on the Role of Nurse Practitioners in Primary Care includes the following relevant positions:

> Position 1: Physicians and nurse practitioners complete training with different levels of knowledge, skills, and abilities that while not equivalent, are complementary. As trained health care professionals, physicians and nurse practitioners share a commitment to providing high-quality care. However, physicians are often the most appropriate health care professional for many patients.
>
> > A. Whenever possible, the needs and preferences of every patient should be met by the health care professional with the most appropriate skills and training to provide the necessary care.
> >
> > B. Patients with complex problems, multiple diagnoses, or difficult management challenges will typically be best served by physicians working with a team of health care professionals that may include nurse practitioners and other nonphysician clinicians.
> >
> > C. Patients have the right to be informed of the credentials of the person providing their care to allow them to understand the background, orientation, and qualifications of the health care professionals providing their care and to better enable them to distinguish among different health care professionals.
> >
> > D. The College recognizes the important role that nurse practitioners play in meeting the current and growing demand for primary care, especially in underserved areas.
> >
> > E. The College advocates for research to develop effective systems of consultation between physicians and nurse practitioners as clinically indicated.
>
> Position 4: In the patient-centered medical home (PCMH) model, care for patients is best served by a multidisciplinary team where the clinical team is led by a physician. However, given the call for testing different models of the PCMH, ACP believes that PCMH demonstration projects that include evaluation of physician-led PCMHs could also test the effectiveness of nurse practitioner-led PCMH practices in accord with existing state practice acts and consistent with the following:

A. Demonstration projects testing the effectiveness of NP-led PCMH practices should meet the same eligibility requirements as those for physician-led practices.

B. NP-led PCMH practices should be subject to the same recognition standards to participate in the demonstration project as physician-led practices.

C. NP-led PCMH practices should be subject to the same standards of evaluation as physician-led PCMH practices.

D. Patients who are selecting a PCMH as their source of regular care should be informed in advance if it is a physician-led or nurse practitioner-led practice and the credentials of the persons providing care within each practice.

E. All clinicians within the PCMH are operating within existing state practice acts.

F. Payments and evaluation metrics for both physician-led and nurse practitioner-led PCMH practices must take into account differences in the case mix of patients seen in the practice.

A Joint letter commenting on the Institute of Medicine report on the Future of Nursing: Leading Change, Advancing Health (19-Jan-2011) noted:

We feel strongly that physicians and nurses are not interchangeable, and that optimal care for patients is provided by physicians, nurses, and other health professionals working together in a team-based model of care delivery. This is well-illustrated in the delivery of primary care services. “Primary care” includes a wide variety of clinical responsibilities – preventive (“wellness”) care; diagnosis and management of straightforward, acute illnesses; diagnosis of undifferentiated presentations that are not straightforward; ongoing management of a single, chronic problem; ongoing management of a patient with complex and interacting medical problems, etc. We believe that some aspects of primary care – such as the diagnosis of undifferentiated presentations that are not straightforward, and the ongoing management of patients with complex and interacting medical problems – require more extensive clinical training, exposure, and experience, and are most appropriately handled by a physician with in-depth training throughout medical school and residency.

Both the effectiveness and the efficiency of patient care are best served when the scope of practice for all health professionals includes those components of primary care that correspond to, but do not exceed, the full level of their training and experience. Non-physician clinicians should be able to provide those aspects of care for which they are well-trained and that do not require the higher level of scientific background and training of a physician. Adhering to this framework means that each health care professional can focus on those aspects of care that are most appropriate for his or her level of training, background, and experience. **This model is best**

applied in a team-based system of care, such as that provided by the patient-centered medical home, in which physicians, nurses, and other members of the team work collaboratively and distribute different aspects of care to the professionals best suited to handle them.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?

(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.

___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.

_X_C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).

___D. Increase the number of new members and improve retention among current members.

___E. Enhance and assess the effectiveness and vitality of ACP Chapters.

___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.

___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.

_X_ H. Continue to promote the highest professional and ethical standards for our members and organization.

___I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) Ethics, Executive Office, MPPQ & PAR
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 9-S11. Collaborating with Other Organizations to Study the Impact of Setting Limits on Active Duty Hours for Practicing Physicians

(Sponsor: BOG Class of 2014)

WHEREAS, the "College Goals" within the *ACP Strategic Plan* as Board of Regents approved on July 31, 2010, state:

III. To advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members;

IV. To serve the professional needs of the membership, support healthy lives for physicians, and advance internal medicine as a career; and

WHEREAS, the ACP has firmly supported resident duty hour reforms to enhance the educational environment for its Associate Members (Resolution 17-S07, Working with SGIM and APDIM to Study the Impact of Resident Duty Hours on the Clinical and Teaching Responsibilities of Faculty); and

WHEREAS, there is evidence that fatigue occurs in the setting of excessive work hours (Ulmer C., Wolman D., Johns M., eds. *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*. Washington, D.C.: National Academies Press, 2008.); and

WHEREAS, fatigue in practicing physicians has been associated with increased rate of errors (Iglehart JK, N Engl J Med 2008; 359:2633-2635); and

WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) has set and enforced limits on residents' work hours in the interest of patient safety; and

WHEREAS, the Institute of Medicine (IOM) has recommended limits on residents' work hours in the interest of patient safety (*Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*, a December 2008 report from the IOM, asserts that revisions to medical residents' workloads and duty hours are necessary to better protect patients against fatigue-related errors and to enhance the learning environment for doctors in training); therefore be it

RESOLVED, that the Board of Regents, in the interest of patient and physician safety, initiates collaboration with other professional physician organizations to study the impact of setting limits on active duty hours for practicing physicians.

BACKGROUND INFORMATION

Resolution 9-S11. Collaborating with Other Organizations to Study the Impact of Setting Limits on Active Duty Hours for Practicing Physicians

RESOLVED, that the Board of Regents, in the interest of patient and physician safety, initiates collaboration with other professional physician organizations to study the impact of setting limits on active duty hours for practicing physicians.

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1. PREVIOUS RELATED RESOLUTIONS:

13-S04. A Proposed National Center for Patient Safety, RESOLVED, that the Board of Regents work with CMS, AHRQ, and other stakeholders, to develop a National Center for Patient Safety, similar to the FAA, that can 1) develop systems to collect confidential patient safety information; 2) receive confidential data about medical errors and near-misses; and 3) encourage the non-discoverable voluntary disclosure of adverse incidents to affected parties; and 4) create and advocate systems to reduce preventable adverse incidents and improve medical care.

At the April 2004 Business Meeting, the BOG recommended that the BOR adopt Resolution 13-S04 as amended. At their April 2004 meeting, the BOR adopted and referred Resolution 13-S04 to the Health and Public Policy Committee (HPPC) for implementation.

At its May 2004 meeting, the HPPC decided that ACP should continue to support legislation to establish a National Patient Safety Database and a voluntary physician reporting system. HPPC also was going to consider preparing an AMA resolution. On July 22, 2004, the Senate passed the "Patient Safety and Quality Improvement Act of 2003" (S.720), which ACP had been supporting. The House had already passed a similar bill. Consequently, the intent of the resolution has been accomplished. HPPC approved this final report on February 10, 2005.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Medical Education and Publishing
The Medical Education Division has no background that relates to this resolution.

Policy Analysis and Research
The College does not have policy on physician work hours. A 2009 study revealed that physician practice patterns resemble ACGME duty hours guidelines. 57% of physicians reported working less than 80 hours per week. Respondents reported working an average of 59.6 hours per week, 5.9 days off per month, and 12.5 hours between work days. An AMA report in 2001 reported the mean work week for physicians as 57.8 hours, similar to the mean of 59.6 hours found in this study.

The study can be found
http://www.im.org/publications/apmperspectives/documents/june09perspectives.pdf

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

_X_ A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___ B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___ C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___ D. Increase the number of new members and improve retention among current members.
___ E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___ F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___ G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___ H. Continue to promote the highest professional and ethical standards for our members and organization.
___ I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) PAR
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
___X_ Significant ($50,000 - $100,000) Medical Education and Publishing
_____ Substantial ($100,000 or more)

Resolution 10-S11. Advocating for the Preservation and Growth of Small, Independent Practices

(Sponsor: Massachusetts Chapter)

WHEREAS, much of the thoroughness and efficiency in high quality patient care is due to individual physician diligence and continuing care; and

WHEREAS, small independent practices (5 or fewer physicians) help accomplish such outcomes and are the bulwark of our health care system and the mainstay of ACP membership; and

WHEREAS, federal and/or state regulations, policies, or laws have disadvantageously promoted MD's and DO's working in large groups rather than small practices; therefore be it

RESOLVED, that the Board of Regents will strongly advocate specifically for the preservation and growth of small independent practices by working to improve regulations, policies and laws where applicable; and be it further

RESOLVED, that whenever the Board of Regents establishes or promotes policies, regulations, or laws, it shall explicitly evaluate the impact on small independent practices and work to modify such policies and regulations to mitigate any negative effects on such small practices.

BACKGROUND INFORMATION

Resolution 10-S11. Advocating for the Preservation and Growth of Small, Independent Practices

RESOLVED, that the Board of Regents will strongly advocate specifically for the preservation and growth of small independent practices by working to improve regulations, policies and laws where applicable; and be it further

RESOLVED, that whenever the Board of Regents establishes or promotes policies, regulations, or laws, it shall explicitly evaluate the impact on small independent practices and work to modify such policies and regulations to mitigate any negative effects on such small practices.

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1. PREVIOUS RELATED RESOLUTIONS:

10-F10. Developing Methods and Resources for Small Practices to Fairly Negotiate with Accountable Care Organizations, RESOLVED, that the Board of Regents, in support of its existing policy statement (Policy Statement Pertaining to the Development of the Accountable Care Organization Model approved by the BOR April 2010), further develops specific methods and resources through which small practices can fairly negotiate with Accountable Care Organizations and advocates for the implementation of these methods with the Centers for Medicare and Medicaid Services and other insurers.

At the September 2010 Business Meeting, the BOG recommended that the BOR adopt this resolution. At their November 2010 meeting, the BOR referred Resolution 10-F10 to the Medical Service Committee (MSC) for implementation.

4-F06. Supporting Modified Versions of the Advanced Medical Home for Small Medical Groups, RESOLVED, that the Board of Regents continues its efforts to ensure that the Patient Centered Medical Home can be implemented and maintained by solo practices and smaller medical groups, including ensuring necessary up-front payment to capitalize the start-up/transition costs and appropriate payment to maintain needed practice capabilities.

At the October 2006 Business Meeting, the BOG recommended that the BOR adopt this resolution as amended. At their October 2006 meeting, the BOR referred Resolution 4–F06 to the Medical Service Committee (MSC) for study and report back with input from the Health and Public Policy Committee.

The MSC agreed with the intent of Resolution 4-S06, modified it to make it more clear and consistent with that intent, and submitted the following modified resolution to the BOR for it to consider at its July 2007 meeting:

> RESOLVED, that the Board of Regents continue its efforts to ensure that the ~~support modified versions of~~ the ~~Advanced Medical Home~~ Patient Centered Medical Home can

be implemented and maintained by solo practices and ~~which~~ small~~er~~ medical groups ~~can more easily introduce~~, including ensuring necessary up-front payment to capitalize the start-up/transition costs and appropriate payment to maintain needed practice capabilities.

Further, the MSC believes that the College is engaged in numerous activities aimed at ensuring that solo and small practices can make the transition to the Advanced Medical Home, now referred to as the Patient Centered Medical Home (PCMH). ACP developed the PCMH concept to be consistent with the realities of the small practice setting. College advocacy for PCMH demonstration projects is based in large part on the premise that it is necessary to test the new delivery and payment model in small practices, where the majority of care is delivered in the United States. ACP has emphasized small practices in developing and testing the PCMH model because the majority of College members practice in that environment and because Medicare demonstrations underway focus on larger physician practices and other entities. The MSC notes that the following specifically demonstrates the College's focus on small practices:

- Language in the position paper "Reform of the Dysfunctional Healthcare Payment and Delivery System" that explicitly calls for participation of small practices in demonstration studies.
- The law enacted in December 2006, the Tax Relief and Health Care Act, that directs the Centers for Medicare and Medicaid Services (CMS) to include small practices in the Congressionally-mandated Medicare medical home demonstration—which was the direct result of College advocacy.
- Discussions with private payers regarding PCMH demonstration projects have stressed the need to include small practices, including how to recognize the investment and administrative burden they face in establishing and maintaining PCMH capability.
- The College is committed to defining the recognition process for PCMH designation that includes a pathway for transition that is achievable by even solo internal medicine practices. The laddered approach towards recognition will financially reward practices for taking the first step up the ladder and calls for increasing rewards as practices attain higher levels of capability both with respect to health information technology implementation and care coordination services. ACP is working with the National Committee for Quality Assurance (NCQA) and others to accomplish this task.
- Collaboration with the efforts of the ACP Center for Practice Innovation (CPI), the College grant-funded initiative that is working with 34 solo and small practices, to develop tools and approaches to facilitate the adoption of the PCMH principles within such practices.

At its July 2007 meeting, the BOR approved the MSC recommendation.

5-F06. Considering the Impact of ACP Policy Changes on Small and Rural Medical Practices, RESOLVED, that the Board of Regents considers the impact of major policy changes on small and rural medical practices and address ways to ensure representation of these practices in development of ACP policy.

At the October 2006 Business Meeting, the BOG recommended that the BOR adopt this resolution as amended. At their October 2006 meeting, the BOR adopted and referred Resolution 5–F06 to the Executive Committee of the Board of Regents (ECBOR)for implementation.

At the January 19, 2007 ECBOR meeting, Dr. Ejnes introduced BOG Resolution 5-F06 for discussion. The ECBOR cautioned against lumping “small” and “rural” practices since they are not identical. The consensus of the ECBOR was: 1) To mention BOG Resolution 5-F06 during the Committee and Council Chairs/Vice Chairs Orientation Meeting. 2) To remind ACP staff liaisons to consider BOG Resolution 5-F06 as they prepare meeting agendas.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Medical Practice, Professionalism and Quality
In response to 5-F06, Considering the Impact of ACP Policy Changes on Small and Rural Medical Practices, subsequent policy/positions and programs have addressed the unique nature and importance of small practices.

Some recent examples:
-Policy Statement Pertaining to the Development of Accountable Care Organizations which includes the following point:

> Barriers to small practice participation within ACO demonstration and pilot projects should be addressed and minimized. These barriers include the small size of their patient panels and their limited capital, HIT and care management resources.

-State of the Nation's Health Care Address which included these comments in reference to the Affordable Care Act:

> These provisions will help to increase the primary care physician workforce. In addition, the improved primary care payments and the potential benefits of new payment models will increase the ability of primary care practices to invest in the infrastructure required to provide more patient-centered care, and care that is more effective and efficient. They need to be preserved, and as necessary expanded, to ensure a robust primary care foundation within our healthcare system.
>
> The preservation of funding to promote EHR implementation is critical, not only for cost savings, but also for improvements in care quality and safety. These funds are being used to provide incentives to physician practices to implement EHRs, to establish Regional Extension Services to help practices accomplish this implementation, and to establish regional Health Information Exchanges to promote the communication of healthcare information among providers. The benefits of increased adoption of EHRs, besides lowing costs, include improved communication and coordination among clinicians, reduced unnecessary and inappropriate tests and procedures, and an increase in the availability of current evidence-based information at the point-of-service to help inform clinical decisions.

Another example of addressing the needs of small independent practices is through the programs/products/services. A few examples:
-ACP's Medical Home Builder to support the transition to improved office operations and/or the medical home model

-ACP's AmericanEHR Partners Program to support EHR identification, selection, implementation and optimization
-ACP's Quality Improvement Programs to support maintenance of certification requirements in the small practice setting

Regulatory and Insurer Affairs
The RIA, in its involvement with regulatory agencies (e.g. CMS) and Congressional staff routinely make sure the specific needs of small practices are adequately addressed. This has most recently been demonstrated by the specific inclusion of small practices in the original Medicare PCMH demonstration, the recognition of specific small practice needs in recent health information technology (HIT) legislation and regulatory rulings, and the College's recent development (in collaboration with the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association) of a set of principles to help guide the establishment of Accountable Care Organizations---these principles were submitted to CMS to help inform the establishment of the Shared Savings/Accountable Care program included within the Affordable Care Act.

The College, through RIA, has also worked closely with the National Council for Quality Assurance, to ensure that the qualifications for PCMH recognition (at least at Level 1) can be achieved at the small practice level.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

_X_ A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___ B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___ C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___ D. Increase the number of new members and improve retention among current members.
___ E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___ F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___ G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___ H. Continue to promote the highest professional and ethical standards for our members and organization.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) MPPQ; RIA
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 11-S11. Assessing the Significance of Human Factors in EHR Implementation

(Sponsor: Arizona Chapter)

WHEREAS, the College is actively facilitating EHR (electronic health records) implementation; and

WHEREAS, EHR implementation is now mandated with emerging incentives and penalties; and

WHEREAS, the patient-physician relationship is the cornerstone of internal medicine care; and

WHEREAS, the focus on EHR implementation may draw the internist's attention away from the patient; and

WHEREAS, an understanding of the human factors, patient and physician, that facilitate, optimize or inhibit EHR performance, including enhancing the patient-physician relationship, in the internal medicine clinical practice setting have not been fully elucidated and will critically define real-life EHR utility and success; therefore be it

RESOLVED, that the Board of Regents undertakes a thorough assessment of the human factors, patient and physician, that serve to facilitate, optimize or inhibit EHR performance, including enhancing the patient-physician relationship, in the internal medicine clinical practice setting; and be it further

RESOLVED, the the Board of Regents engages members broadly in this process so as to identify directly real-life facilitators and barriers to EHR utility, concerns and impact on the patient-physician relationship.

BACKGROUND INFORMATION

Resolution 11-S11. Assessing the Significance of Human Factors in EHR Implementation

RESOLVED, that the Board of Regents undertakes a thorough assessment of the human factors, patient and physician, that serve to facilitate, optimize or inhibit EHR performance, including enhancing the patient-physician relationship, in the internal medicine clinical practice setting; and be it further

RESOLVED, the the Board of Regents engages members broadly in this process so as to identify directly real-life facilitators and barriers to EHR utility, concerns and impact on the patient-physician relationship.

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1. PREVIOUS RELATED RESOLUTIONS:

4-F07. Analyzing the Impact of the Requirements to Achieve Patient Centered Medical Home Certification, RESOLVED, that the Board of Regents instruct the business consultants retained to evaluate the Patient Centered Medical Home (PCMH) to analyze the impact of the time and expense necessary for both large and small practices to achieve and maintain recognition as a "certified patient centered medical home." This evaluation would include assessing the time and expense to complete CME-type courses the PCMH requires, to document fulfillment of the various PCMH elements, and to fulfill similar extra work to be PCMH certified; and be it further
RESOLVED, that the Board of Regents utilize data on the cost of achieving and maintaining PCMH recognition to advocate for adequate reimbursement for providing the enhanced level of patient care required; and be it further
RESOLVED, that the Board of Regents provide an ongoing assessment of the cost associated with complying with payer documentation and other requirements for receiving enhanced payment to assure that these costs are appropriately recognized, especially if the consultant is unable to determine these costs.

At the September 2007 Business Meeting, the BOG recommended that the BOR adopt Resolution 4-F07 as amended. At their October 2007 meeting, the BOR referred Resolution 4–F07 to the Medical Service Committee (MSC) for study and report back with recommendations.

The MSC decided to recommend that the BOR approve a modified version of this Resolution (strikeouts indicate deletions and underlined text indicates additions):

> RESOLVED, that the Board of Regents instruct the business consultants retained to evaluate the Patient Centered Medical Home (PCMH) to analyze the impact of the time and expense necessary for both large and small practices to achieve and maintain recognition as a "certified patient centered medical home." This evaluation would include assessing the time and expense to complete CME-type courses the PCMH requires, to document fulfillment of the various PCMH elements, and to fulfill similar extra work to be PCMH certified ~~and reimbursed~~; and be it further

RESOLVED, that the Board of Regents utilize data on the cost of achieving and maintaining PCMH recognition to advocate for adequate reimbursement for providing the enhanced level of patient care required.; and it be further

RESOLVED, that the Board of Regents provide an ongoing assessment of the cost associated with complying with payer documentation and other requirements for receiving enhanced payment to assure that these costs are appropriately recognized, especially if the consultant is unable to determine these costs.

The Urban Institute-led research team with which ACP has contracted is working with practices of varying size and sophistication to obtain the data to determine the costs of establishing and maintaining a PCMH. The data collection effort will focus on identifying the resources needed to meet the requirements of the National Committee for Quality Assurance (NCQA) Physician Practice Connections-PCMH (PPC-PCMH) practice recognition. The research team's assessment will include the costs in time and expense associated with completing the NCQA PPC-PCMH recognition module. It will also include the costs of any courses/additional training required to receive credit for the PPC-PCMH elements.

A primary purpose of identifying PCMH costs is to help determine the appropriate payment to adequately fund and reward PCMH practices. ACP will use the project costs results to advocate that Medicare and other payers testing the PCMH model provide appropriate payments. ACP will also use the results to inform future College policy.

The MSC decided to add a third "resolved" clause policy statement to ensure that the College continues to assess whether payments made by health plans are adequate to recognize the costs associated with PCMH recognition. Ongoing assessment is appropriate in case the research team is unable to fully document the costs associated with PCMH practice recognition and because health plan qualification requirements can change over time. At its May 2008 meeting, the BOR approved the MSC recommendation to adopt a modified version of this Resolution 4-F07.

24-S05. Addressing Internist Concerns through ACP Involvement in Demonstration Programs and through Communication with Members, RESOLVED, that the Board of Regents communicates regularly concerning involvement in demonstration initiatives, focusing constant attention on the concerns of practicing internists. This involvement should include addressing concerns regarding the cost in dollars and time involved in adopting a paperless office; concerns about the loss of the narrative, humanistic value of the medical history; concerns that performance evaluation based on outcomes data or patient satisfaction has significant potential for abuse; concerns that case management reimbursement is still poorly understood and also has potential for abuse; and concern that the "team approach" to medical management is still not clearly defined, especially in small practices; and be it further
RESOLVED, that the Board of Regents maintains a consistent policy of insisting that these concerns are addressed as it cooperates in demonstration programs for new initiatives; and be it further
RESOLVED, that the Board of Regents provides feedback over the next year to ACP members through at least one major article in the ACP Observer, as well as through other appropriate

means, illustrating the ways in which the ACP is working to ensure that such concerns are being addressed. Through these means, the membership will be better able to understand what the organization is doing for its members in a proactive, constructive way and will be better able to participate in such efforts.

At the April 2005 Business Meeting, the BOG recommended that the BOR adopt Resolution 24-S05 as amended. At its April 2005 meeting, the BOR referred Resolution 24-S05 to the Medical Service Committee (MSC) for study and report back.

At its May 2005 meeting, the MSC discussed ways in which ACP currently attempts to address the concerns stated in the resolution, including: the staff vetting of proposed Medicare demonstration projects to assess their consistency with ACP policies; and the communication of new demonstration projects and the extent of ACP involvement in existing projects through articles in the *ACP Observer*, *Observer Weekly*; and postings on the ACP website. At its September 2005 meeting, noting the additional recent activities that ACP has initiated consistent with the intent of the resolution and the importance of maintaining a dialogue with College members to understand and address their concerns, the MSC decided to recommend that the Board of Regents adopt this resolution. At its October 2005 meeting, the BOR adopted Resolution 24-S05. Subsequent to BOR adoption of the resolution, ACP has published information for members regarding its ideas for pilot testing an alternate delivery model, referred to as the Advanced Medical Home, that enhances the physician-patient relationship and provides financial incentives to the physician to provide coordinated, longitudinal care that focuses on the needs of the patient.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Center for Ethics and Professionalism
The Center for Ethics and Professionalism is working on a policy with the Council of Associates on digital professionalism issues, and updating the *Ethics Manual* and developing a case study on "copying and pasting" in medical records. The *Ethics Manual* contains several statements about the importance of maintaining confidentiality when using electronic records.

Medical Practice, Professionalism and Quality
This Resolution calls for fundamental clinical research on a very broad and difficult subject. Hundreds of papers have already been published on various aspects, but they have not led to implementable conclusions. Staff believe that the Office of the National Coordinator for Health Information Technology (ONC) and the Agency for Healthcare Research & Quality (AHRQ) are planning further study of the subject area. This is a major challenge of informatics scholarship, and there is a lot of dispute over how to do it and what to do with any results obtained. The only current ACP work underway that might contribute towards the goals of this resolution is the AmericanEHR Partners survey tool. ACP does collect information about EHR performance, user satisfaction and other factors which is used to generate ratings that are posted on the website (along with educational information and guidance). These data contribute to our understanding of the current healthcare environment as it relates to electronic health records, but is unlikely to shed much light on the issues of human factors and the patient-physician relationship.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
_X_H. Continue to promote the highest professional and ethical standards for our members and organization.
___I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) Ethics
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
___X_ Significant ($50,000 - $100,000) MPPQ
___X_ Substantial ($100,000 or more) MPPQ

Resolution 12-S11. Providing Internists Regular Input about the Yield of their Office-Based Secondary Prevention Efforts

(Sponsor: Colorado Chapter)

WHEREAS, a general internist devotes substantial time to management of asymptomatic conditions like hypertension and diabetes in order to prevent complications such as myocardial infarction and stroke; and

WHEREAS, an individual internist can never know whether these secondary preventive efforts promote successful outcomes for individual patients and one can never know which individual patient has a stroke or coronary event prevented or forestalled by these clinical efforts; and

WHEREAS, tangible benefits for patients quite naturally represent a source of career satisfaction for physicians, yet careful efforts at secondary prevention do not provide these gratifying experiences for physicians; and

WHEREAS, busy clinicians might benefit from tangible, authoritative updates about the yield of preventive efforts in their practice setting; therefore be it

RESOLVED, that the Board of Regents designates a group of experts to apply data from the medical literature in order to generate quarterly messages to ACP members that will estimate the number of patients in the member's practice who have been spared serious clinical events during a certain time frame, say the preceding 3-5 years.**

(** An example: 'Excellent work! Based on current medical evidence, the ACP and other scientific groups estimate that for patients in your practice with diabetes and baseline blood pressure > 160 mmHg systolic, < 90 mmHg diastolic treated over the past five years, you, as an individual practicing internist, have prevented four people from having a stroke.')

Estimate based on achieving a BP goal of > 20 mmHg below baseline or < 160 mmHg if initial systolic BP > 180 mmHg; Estimate also assumes a patient panel size = 1600.)

BACKGROUND INFORMATION

Resolution 12-S11. Providing Internists Regular Input about the Yield of their Office-Based Secondary Prevention Efforts

RESOLVED, that the Board of Regents designates a group of experts to apply data from the medical literature in order to generate quarterly messages to ACP members that will estimate the number of patients in the member's practice who have been spared serious clinical events during a certain time frame, say the preceding 3-5 years.**

(** An example: 'Excellent work! Based on current medical evidence, the ACP and other scientific groups estimate that for patients in your practice with diabetes and baseline blood pressure > 160 mmHg systolic, < 90 mmHg diastolic treated over the past five years, you, as an individual practicing internist, have prevented four people from having a stroke.')

Estimate based on achieving a BP goal of > 20 mmHg below baseline or < 160 mmHg if initial systolic BP > 180 mmHg; Estimate also assumes a patient panel size = 1600.)

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1. PREVIOUS RELATED RESOLUTIONS:

None.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Medical Education and Publishing Division/Department of Clinical Policy
ACP currently does not have any product that physicians can utilize to generate reports calculating the number of patients in their practice who have been spared serious clinical events during a certain time frame with the application of current evidence-based standards of care.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?

(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.

___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.
_X_I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_____ None (0-$999)
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
___X__ Substantial ($100,000 or more)

Resolution 13-S11. Using Name, Age, and Gender in the Patient Introduction

(Sponsor: Michigan Chapter)

WHEREAS, all patients are persons, identifiable simply by name, age, and gender, suffering from and seeking help for a specific medical concern; and

WHEREAS, the medical profession has, over many years, fallen into the habit of adding racial/ethnic, lifestyle, sexual orientation and/or medical status descriptors to the introductions of patients being discussed or presented for educational purposes (e.g., "This XX year old white/black/Hispanic/Burmese/Arabian/Ashkenazi Jewish/etc., man/woman"; This XX year old intravenous drug-using/alcoholic/unemployed/ imprisoned man/woman"; "This XX year old gay/homosexual/sexually promiscuous/transgendered/etc., etc., man/woman"; "This XX year old dialysis requiring/obese/paraplegic/incontinent/schizophrenic etc., man/woman")[4]; and

WHEREAS, while such added descriptors may have been well-intentioned efforts to provide a "background sketch" of the patient prior to stating the patient's issue of concern and medical history and may very well be important to include later in a patient's History of Present Illness (or if not central to solving the patient's primary problem, in another appropriate section of the patient's Medical History), they detract from the straightforward identification of the human being seeking help for his/her concerning medical problem[5]; and

WHEREAS, the medical usefulness of knowing a patient's assumed or self-identified race (the most common of the above-stated descriptors usually included in patient introductions) is not supported by analyses of the human genome, there being no sharp genetic boundaries between any of the traditional, racially-defined groups of human beings extant on planet earth [6] [7]; therefore be it

RESOLVED, that the Board of Regents for all educational materials and scientific offerings in which a patient is characterized, will use only patient name/initials, age, and gender in the patient introduction (which usually precedes the patient's Chief Complaint/Concern [CC] and History of Present Illness [HPI]), and will reserve any further pertinent descriptors (e.g. race, ethnicity, lifestyle, sexual orientation, medical status, etc.), when relevant, for the subsequent HPI or other sections of the medical history. The affected ACP publications or offerings should be taken to include journals, books, MKSAP materials, videos, and the In-Training Exam, as well as verbal or written case presentations and clinical vignettes used in ACP or ACP-associated conferences and meetings.

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[4] Sheagren JN. The Importance of Etiquette-Based Medicine in Bedside Teaching: Part 2 – Proper Patient Introductions in Case Presentations. .DOC (Grand Rapids Medical Education and Research Center for Health Professions Newsletter). Fall 2009 Issue: p 4-5. http://www.grmerc.net/education/documents/Fall2009.pdf

[5] Wynia MK, Ivey SL, Hasnain-Wynia R. Collection of data on patients' race and ethnic group by physician practices. N Engl J Med 2010; 362:846-50.

[6] Collins FS. What we do and don't know about 'race', 'ethnicity', genetics and health at the dawn of the genome era. Nature Genetics Suppl. 2004; 36: S13-5.

[7] Rotimi CN, Jorde LB. Ancestry and Disease in the Age of Genomic Medicine. N Engl J Med 2010; 363:1551-1558.

BACKGROUND INFORMATION

Resolution 13-S11. Using Name, Age, and Gender in the Patient Introduction

RESOLVED, that the Board of Regents for all educational materials and scientific offerings in which a patient is characterized, will use only patient name/initials, age, and gender in the patient introduction (which usually precedes the patient's Chief Complaint/Concern [CC] and History of Present Illness [HPI]), and will reserve any further pertinent descriptors (e.g. race, ethnicity, lifestyle, sexual orientation, medical status, etc.), when relevant, for the subsequent HPI or other sections of the medical history. The affected ACP publications or offerings should be taken to include journals, books, MKSAP materials, videos, and the In-Training Exam, as well as verbal or written case presentations and clinical vignettes used in ACP or ACP-associated conferences and meetings.

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1. PREVIOUS RELATED RESOLUTIONS:

(See Resolution 8-S11 for previous related Resolution 1-S08.)

13-F09. Implementing Further Steps to Eliminate the Use of the Term "Provider" and RESOLVED, that the Board of Regents implements further steps to eliminate the use of the term "provider" and "prescriber" in lieu of "physician" in all publications, advertising for courses, and communications it sponsors alone or in affiliation with other organizations. For example, use "physicians" when we mean "physicians," use "clinicians" when we mean "physicians and other health care professionals who provide direct care to patients," and use "providers" when we have a broader meaning, for example, pharmacies and DME purveyors.

At the October 2009 Business Meeting, the BOG recommended that the BOR adopt Resolution 13-F09 as amended. At its October 2009 meeting, the BOR adopted and referred Resolution 13-F09 to the MSC for implementation with input from the Marketing and Communications Committee.

The MSC supports the emphasis on striving for more precision in the use of terminology describing physicians as evidenced by the College's adoption of two Resolutions related to this issue within 18 months (the Board of Governors previously adopted Resolution 1-S08, Differentiating between Physicians and Other Health Care Providers). The MSC is implementing Resolution 13-F09 through the following activities:

- Adhering to the policy when crafting papers and other College documents, including description of MSC-sponsored Internal Medicine annual scientific session courses;
- Including reference to the policy in the staff internal reference document for finalization and posting of documents;
- Sharing the policy with ACP Editorial Production—the department that edits ACP papers—so that it can make corrections consistent with the policy that were not previously identified;

- Pursuing terminology changes consistent with the policy in joint communications with other organizations to the extent practicable; and
- Recommending that this policy be distributed widely within the College.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Center for Ethics and Professionalism
Ethics case studies and policy documents using case studies include descriptions in the case history as relevant to topic discussion. This may include race, medical status or other factors as relevant.

Medical Education and Publishing Division
Faculty for ACP live meetings are not instructed how to present patient-related data. If ACP guidelines were developed, they could be given to faculty at the time they are invited to present at a live meeting, e.g., Internal Medicine 20XX, postgraduate courses, etc. For chapter live meetings, faculty invitations and instructions are the responsibility of the chapter.

The Self-Assessment Programs Department has always encouraged authoring committees to use only age and gender in patient introductions associated with multiple-choice questions that appear in MKSAP and the Internal Medicine In-Training Examination. In the fall of 2010, while updating its style guide, the department formalized this guideline, which is now being followed consistently. As a result, MKSAP 15 Update 2 and all future content produced by Self-Assessment Programs will follow this guideline. The first major MKSAP edition to follow this guideline consistently will be MKSAP 16. The first IM-ITE to follow the guideline consistently will be the 2011 examination. Self-Assessment includes guidelines on this consistent approach to race/ethnicity and avoidance of any other type of labeling language in its editorial style guide, which the editors follow when editing content. The associated language on this policy is included below:

MCQS (MULTIPLE CHOICE QUESTIONS)

Specify race/ethnicity only when clinically relevant. A patient's natural skin color, ethnicity, or any other ethnographic feature should be deleted unless the author or the reviewing committee considers such information to be essential for answering the question. (see *Race/Ethnicity* for proper terminology when including this information.) Include race if race is essential for making therapeutic, prognostic, or preventive decisions, or if it is the educational objective for the question. Avoid race if it is included for purely epidemiologic reasons (e.g., prostate cancer is more common in black patients) but does not affect management.

Avoiding labeling patients in patient introductions:
(A proposed resolution received by Self-Assessment Programs) prohibits the use of any "labeling"-type language, such as racial/ethnic, life style, sexual orientation, and/or medical status descriptors in the introductions of patients being discussed or presented for educational purposes. Therefore, instead of using such descriptors as part of the MCQ's introductory

sentence, when such information is deemed pertinent to answering the question, it should be stated as part of the history. This also pertains to country or origin and immigrant status.

A 24-year-old woman is evaluated for chest pain. She is of Asian descent, or she emigrated from China. (not *A 24-year-old Chinese woman is evaluated*…)

A 52-year-old woman undergoes evaluation for hypertension. The patient is of Ashkenazi Jewish descent. (not *A 52-year-old woman of Ashkenazi Jewish descent undergoes evaluation.*…)

A 50-year-old man is evaluated during a routine follow-up examination. His medical history is significant in that he is black and has diabetes mellitus. (not *A 50-year-old black man.*…)

A 28-year-old man is evaluated for anorexia and muscle aches. . . . He has had multiple male sexual partners and infrequently uses condoms. (not *A 28-year-old gay man is evaluated...*)

A 57-year-old man is evaluated in the emergency department for syncope. He has diabetes and hypertension. (not *A 57-year-old diabetic man is evaluated.*…)

A 32-year-old man is admitted to the hospital with a 2-week history of fever and chills. He has AIDS, and a recent CD4 cell count was 6/µL. (not *A 32-year-old man with AIDS and a recent CD4 cell count of 6/µL is admitted to the hospital with a 2-week history* …)

25-year-old woman undergoes a new-patient evaluation. She is pregnant, at 25 weeks' gestation. (not *A 25-year-old pregnant woman at 25 weeks' gestation undergoes a new-patient evaluation.*)

The IM-ITE follows MKSAP's approach, although on occasion has included a disease in the opening sentence of a lead-in (for example, a 25-year-old woman who recently underwent chemotherapy for stage II breast cancer) to condense the question because of the timed nature of the exam. However, beginning with the current examination under development (2011), IM-ITE will follow the same policy as that used in MKSAP, including no reference to the disease in the introductory sentence.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?
(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.

___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.

X_H. Continue to promote the highest professional and ethical standards for our members and organization.

___I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) Ethics
___X_ Minimal ($1,000-$14,999) Medical Education and Publishing Division
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

Resolution 14-S11. Supporting Federal Legislation and/or Regulations that Require Clearly Labeling Food with Genetically Engineered Ingredients

(Sponsor: Indiana Chapter)

WHEREAS, ACP has as a strategic theme "to promote the highest professional and ethical standards for our members and organization; and

WHEREAS, the Physicians Charter of Professionalism calls on physicians to provide "expert advice to society on matters of health"; and

WHEREAS, lack of labeling denies health professionals the ability to trace potential toxic [1] or allergic reactions [2] [3] [4] to, and other adverse health effects [5] [6] [7] from, genetically engineered food; and

WHEREAS, the World Health Organization issued warnings on the use of antibiotic resistance marker genes in genetically engineered food [8]; and

WHEREAS, in order to make informed decisions, the public needs to be made aware of the contents of their food just as patients need to be aware of the risks, benefits and alternatives to their medical and surgical treatments; and

WHEREAS, crop scientists complain that they must ask biotechnology corporations for permission before conducting or publishing independent research on genetically engineered crops [9] [10]; and

WHEREAS, 40 countries require labeling of genetically engineered food, including the European Union, Australia, Japan, Russia, China, New Zealand, Brazil and South Africa [11]; and

WHEREAS, the American Public Health Association [12], American Nurses Association [13], the British Medical Association [14] and the Irish Medical Organization [15] support the labeling of genetically engineered food products; and

WHEREAS, Catholic Healthcare West (a network of 41 hospitals and 10,000 physicians) avoids genetically engineered food and advocates for public policies that include the labeling of genetically engineered food [16]; and

WHEREAS, 304 U.S. hospitals and medical centers have signed the Healthy Food in Health Care Pledge, encouraging vendors to supply food that is produced without genetic modification [17]; and

WHEREAS, surveys of the U.S. public consistently show overwhelming support for the labeling of genetically engineered food [18] [19]; therefore be it

RESOLVED, that the Board of Regents supports legislation and/or federal regulatory action which requires all foods containing genetically engineered ingredients to be clearly labeled.

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2. EPA Scientific Advisory Panel, "Bt Plant-Pesticides Risk and Benefits Assessments," March 12, 2001, p. 76. Available from: http://www.epa.gov/scipoly/sap/meetings/2000/october/octoberfinal.pdf
3. Bernstein *et al*. Immune responses in farm workers after exposure to *Bacillus thuringiensis* pesticides. *Environmental Health Perspectives*. 1999; 107: 575-82.
4. Zolla, L., Rinalducci, S., Antonioli, P., and P.G. Righetti "Proteomics as a Complimentary Tool for Identifying Unintended Side Effects Occurring in Transgenic Maize Seeds as a Result of Genetic Modifications." *Journal of Proteome Research.* August 6, 2007.
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6. Velmirov, A.; Binter, C.; and Zentek, J. "Biological effects of transgenic maize NK603 x MON810 fed in long term reproduction studies in mice." Federal Ministry for Health, Families and Youth, Government of Austria, October 2008. Available from:: bmgfj.cms.apa.at - forschungsbericht_3-2008_letztfassung.pdf
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11. Kimbrell A. Your Right to Know: Genetic Engineering and the Secret Changes in Your Food. Earth Aware Editions. 2007: 116-117
12. American Public Health Association Policy Statement Database. Support of the Labeling of Genetically Modified Foods. Available from: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=250
13. House of Delegates Resolution: Healthy food in health care Silver Spring, MD: American Nurses Association. 2008. Available from: http://www.nursingworld.org/MainMenuCategories/OccupationalandEnvironmental/environmentalhealth/PolicyIssues/HealthyFoodinHealthCare.aspx
14 Rick Weiss, British Report; Label Gene-Modified Food: Call by U.K. Doctors Group Adds to Trade Tensions With U.S., Brings Strong Reaction on Hill; Washington Post Tuesday, May 18, 1999; Page A02
15. General Motion #29 passed by the 1997 Irish Medical Association Annual General Meeting "That this AGM calls for full and proper labeling of foods, which either contain genetically engineered ingredients or have been produced using genetically engineered technology, irrespective of whether these foods are substantially equivalent to existing foods or not".
16. Catholic Healthcare West Presses Suppliers to Prohibit Animal Cloning and Genetically Engineered Foods. Available from: http://www.chwhealth.org/stellent/groups/public/@xinternet_con_sys/documents/webcontent/194274.pdf
17. Healthy Food in Health Care Pledge signers: Available from: http://noharm.org/us_canada/issues/food/signers.php
18. Figuring Out What's in Your Food: Consumers Are Left to Wonder Which Genetically-Modified Foods They Might Be Eating, Available from: http://www.cbsnews.com/stories/2008/05/11/eveningnews/main4086518.shtml
19. *Americans and GM Food: Knowledge, Opinion and Interest in 2004;* Food Policy Institute, Cook College – Rutgers, The State University of New Jersey; Publication number RR-1104-007

BACKGROUND INFORMATION

Resolution 14-S11. Supporting Federal Legislation and/or Regulations that Require Clearly Labeling Food with Genetically Engineered Ingredients

RESOLVED, that the Board of Regents supports legislation and/or federal regulatory action which requires all foods containing genetically engineered ingredients to be clearly labeled.

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1. PREVIOUS RELATED RESOLUTIONS:

6-S10. Supporting Legislation and/or Regulation that Requires Clearly Labeling Food with Genetically Engineered Ingredients, RESOLVED, that the Board of Regents supports legislation and/or federal regulatory action which requires all foods containing genetically engineered ingredients to be clearly labeled.

At the April 21, 2010, BOG Business Meeting, the BOG voted not to adopt this resolution. Reference Committee A heard a majority of testimony against Resolution 6-S10 and recommended non-adoption given the intent falls outside the ACP's purview and would not be an appropriate use of College resources.

18-F09. Promoting Education, Developing Policy, and Supporting Legislation that Addresses the Prevention, Diagnosis and Treatment of Diet-related Disease and Makes a Healthy Diet Available and Affordable for the U.S. Population, RESOLVED, that the Board of Regents promotes patient and physician education campaigns, develops policy, and supports legislation that addresses the prevention, diagnosis and treatment of diet-related disease and makes a healthy diet more familiar to, more desired by, more available to, and affordable for the U.S. population.

At the October 2009 Business Meeting, the BOG recommended that the BOR adopt Resolution 18-F09. At its October 2009 meeting, the BOR adopted and referred Resolution 18-F09 to the HPPC for implementation with input from the Education Committee and the ACP Foundation.

HPPC requested that staff review the diet-related disease policies of the American Medical Association (AMA) and draft a report regarding the AMA's efforts. A report was presented to HPPC members with the recommendation that the resolution be approved and that the College works with the AMA to support efforts to address diet-related disease. The Education Committee also reviewed the resolution and recommended that efforts to address diet-related disease should be presented through public health models, that diet-related disease information be presented in a single place on ACP's website, and that entities such as the ACP Foundation consider creating education materials.

15-S03. Disclosure of Food Allergens by Restaurants, RESOLVED, that the Board of Regents recommend to the American Public Health Association or a similar organization, the need for public education and possible legislation regarding the disclosure of food ingredients by restaurants on their menus.

At the April 2003 Business Meeting, the BOG recommended that the BOR adopt Resolution 15-S03 as amended. At its April 2003 Organizational Meeting, the BOR adopted and referred Resolution 15-S03 to the Health and Public Policy Committee for implementation.

The HPPC considered Resolution 15-S03 at its meetings in 2003 and February 2004. Staff prepared letters expressing the intent of the resolution for the ACP President's signature. These letters were sent to the heads of the American Public Health Association and the FDA.

16-S99. Regulation of Genetically Engineered Food, RESOLVED, that the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) strongly encourage the study of the long-term impact of genetic engineering on the food supply and human health.

The BOG recommended that the BOR adopt substitute Resolution 16-S99. At its April 1999 meeting, the BOR accepted the BOG recommendation to adopt Resolution 16-S99 as official College policy to be entered into the Policy Compendium, as appropriate, with the directive portion of the resolution to be carried out by staff and reported to the BOR and BOG.

The Medical Service Committee reviewed this resolution at its May 1999 meeting and discussed the possibility of a study with the IOM. Resolution 16-S99 was also added to the ACP-ASIM Policy Compendium as official College policy, under the subheading, Public Health: Regulation of Genetically Engineered Food.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Policy Analysis and Research
The College does not have any relevant policy on genetically engineered foods or food labeling. The College does support warning labels on tobacco products and efforts to raise revenue for enhanced nutrition education in schools and communities.

3. WHAT STRATEGIC THEME DOES THIS RESOLUTION SUPPORT?

(Please check the one that best applies.)

___A. Assure that the number of specialists in all fields of internal medicine effectively meets the healthcare needs in the U.S.
___B. Improve access to care and eliminate disparities, with a focus on expanding health insurance coverage.
___C. Promote the development and implementation of effective models of health care delivery and financing, such as the Patient-Centered Medical Home (PCMH).
___D. Increase the number of new members and improve retention among current members.
___E. Enhance and assess the effectiveness and vitality of ACP Chapters.
___F. Develop and deliver innovative education and information resources that are essential for specialists in all fields of internal medicine.
___G. Increase international collaborations that foster learning from other perspectives and expansion of educational resources, health care delivery innovations, and membership beyond the U.S.
___H. Continue to promote the highest professional and ethical standards for our members and organization.

_X__I. None of the above.

4. FINANCIAL IMPACT ESTIMATE:

_X___ None (0-$999) PAR
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)