Resolution 1-F15. Updating ACP Policy on Medical Student Debt

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

WHEREAS, the median educational debt amongst 2014 medical school graduates is estimated at $180,000, with 43% of students graduating with $200,000 of debt or more (1); and

WHEREAS, high debt-to-income ratio, as a feature of "loan aversion," may disincentivize medical school enrollment (2) and practice in a primary care field (3), and is furthermore associated with internal medicine (IM) resident burnout (4) and decreased career satisfaction (5); and

WHEREAS, in a 2003 American College of Physicians (ACP) policy statement, the College "advocates [for]…ease of the application process for scholarships, loan-forgiveness programs, and low-interest loan programs (6)," therefore be it

RESOLVED, that the Board of Regents provides a policy update on the topic of medical student debt in the context of a changing federal loan environment; and be it further

RESOLVED, that the Board of Regents prioritizes support for medical student, IM resident/fellow, and early career physician loan burden reduction, interest rate reform, and availability of subsidized loans; and be it further

RESOLVED, that the Board of Regents solicits a study for potential reform measures including, but not limited to:

1. **Capping interest rates on federal loans at the prime lending rate,**
2. **Favorable tax climates for private lenders supplying medical education loans at or below federal interest rates,**
3. **An online marketplace providing medical students with comparative loan interest rates (7), and**
4. **Enhanced loan forgiveness for physicians practicing outpatient internal medicine for three or more years.**

REFERENCES:

(1) 2014 AAMC Data: Medical Student Education: Debt, Costs, and Loan Repayment Fact Card.
(2) Boatman, Angela, Brent Evans, and Adela Soliz. "Applying the Lessons of Behavioral Economics to Improve the Federal Student Loan Programs: Six Policy Recommendations." (2014).
(3) Phillips, Julie P., et al. "A retrospective analysis of the relationship between medical student debt and primary care practice in the United States." The Annals of Family Medicine 12.6 (2014): 542-549.
(4) Olson, Shawn M., et al. "Burnout and Physical Activity in Minnesota Internal Medicine Resident Physicians." Journal of Graduate Medical Education 6.4 (2014): 669-674.
(5) Xu G, Veloski JJ. Debt and primary care physicians' career satisfaction. Acad Med. 1998;73(2):119
(6) Ginsburg J et al. Revitalization of Internal Medicine: Overview of the Problem and Recommendations on Reducing Medical Student Debt. Philadelphia: American College of Physicians (2003).
(7) Hauser, Daniel C., and Alison Johnston. "Public Costs, Relative Subsidies, and Repayment Burdens of Federal US Student Loan Plans: Lessons for Reform." Higher Education Policy (2014).

Resolution 2-F15. Evaluating the Feasibility, Safety, Cost Savings, and Adverse Effects of Allowing Importation of Prescription Drugs from Approved Pharmacies and Licensed Pharmacists in Canada

(Sponsor: Idaho Chapter)

WHEREAS, national health expenditure prescription drug spending increased 2.5% to $271.1 billion in 2013 and a per family increase of 13.6% in 2014 with expectations of even higher future prices[1]; and

WHEREAS, in 2013, average prescription drug prices were twice as expensive in the United States as they were in Canada, with high costs leading some Americans to skip doses or forgo filling prescriptions altogether"[2]; and

WHEREAS, President Obama has supported drug price negotiation and asked Congress to allow Medicare officials to negotiate prices with drug manufacturers[3]; and

WHEREAS, two U.S. Senators (McCain and Klobuchar) have introduced a bill (The Safe and Affordable Drugs from Canada Act) that would allow individuals to safely import prescription drugs from Canada, and create major savings for consumers by bringing greater competition into the pharmaceutical market[4]; and

WHEREAS, the Idaho Chapter previously submitted Resolution 3-F14, Advocating for Legislation Empowering the Federal Government to Negotiate Medicare Drug Prices, which was met with great interest; therefore be it

RESOLVED, that the Board of Regents supports a study by the College to evaluate the feasibility, safety, potential cost savings and potential for adverse effects of legislation that allows the importation of prescription drugs from approved pharmacies and licensed pharmacists in Canada; and be it further

RESOLVED, that if this study reflects substantial benefits to patients, the Board of Regents supports importation of prescription drugs from approved pharmacies and licensed pharmacists in Canada and considers approving legislation that pertains to importation as an increased ACP legislative priority.

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[1]Centers for Medicare and Medicaid Services. (2014). National Health Expenditure Data Fact Sheet. Retrieved May 17, 2015 from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html

[2]Roger, B. (2015). Senators McCain & Klobuchar Applaud Safe & Affordable Drugs from Canada. Retrieved May 17, 2015 from http://www.prescottenews.com/index.php/news/current-news/item/25417-senators-mccain-klobuchar-applaud-safe-affordable-drugs-from-canada

[3]*New York Times*. (2015). Runaway Drug Prices. Retrieved May 17, 2015 from http://www.nytimes.com/2015/05/05/opinion/runaway-drug-prices.html

[4]Roger, B. (2015). Senators McCain & Klobuchar Applaud Safe & Affordable Drugs from Canada. Retrieved May 17, 2015 from http://www.prescottenews.com/index.php/news/current-news/item/25417-senators-mccain-klobuchar-applaud-safe-affordable-drugs-from-canada

Resolution 3-F15. Promoting Students' Meaningful Use of the Electronic Health Record

(Sponsor: Education and Publication Committee)

WHEREAS, in 2012, the Alliance for Clinical Education (ACE) proposed educational principles related to the electronic health record that included [1]: 1) students must document in the patient's chart and their notes should be reviewed for content and format 2) students must have the opportunity to practice order entry in an EHR—in actual or simulated patient cases—prior to graduation 3) students should be exposed to the decision aids that typically accompany EHRs 4) schools must develop a set of medical student competencies related to charting in the EHR and state how they would evaluate it; and

WHEREAS, documentation of an E&M service by a student that may be referred to by the teaching physician is limited to the review of systems and/or past medical/family/social history; and

WHEREAS, the teaching physician may not refer to a student's documentation of the history or physical exam findings, or medical decision making in his or her personal note [2]; and

WHEREAS, these CMS standards significantly alter the involvement of medical students in the care of Medicare patients and many medical schools have interpreted the CMS documentation rules to forbid student access to the electronic health record; therefore be it

RESOLVED, that the Board of Regents encourages accreditation bodies such as the Liaison Committee for Medical Education to specify educational standards to ensure medical school compliance with the Alliance for Clinical Education educational principles or similar principles related to electronic health records; and be it further

RESOLVED, that the Board of Regents calls on the CMS to change the 2008 guidelines to allow teaching physicians to refer to a student's documentation of the history and physical examination findings or medical decision making in his or her personal note for documentation of an E&M service.

(1). Hammoud MM, Dalymple JL, Christner JG, Stewart RA, Fisher J, Margo K, Ali II, Briscoe GW, Pangaro LN. Medical student documentation in electronic health records: a collaborative statement from the Alliance for Clinical Education.Teach Learn Med. 2012;24(3):257-66.

(2). http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2303CP.pdf. Accessed 3/16/15

Resolution 4-F15. Addressing Educational Needs of Adult Hospital Medicine Physician Specialists

(Sponsor: Georgia Chapter)

WHEREAS, the scope of adult hospital medicine varies based on individual hospital patient population, needs, available specialty complement, individual hospitalist training, skill set and experience; and

WHEREAS, Adult Hospital Medicine Physician Specialists (AHMPS) are asked or ordered to admit and treat other specialty patients such as OB/GYN patients, neurology patients, surgery patients (e.g., plastic surgery, orthopedic surgery, neurosurgery, general surgery, otolaryngology) and other specialties; and

WHEREAS, the majority of AHMPS do not have formal training or specialty-specific competency outside of adult general medical inpatient care; and

WHEREAS, the majority of AHMPS seek opportunities for further training to provide safe and quality patient care; therefore be it

RESOLVED, that the Board of Regents addresses educational needs of Adult Hospital Medicine Physician Specialists (AHMPS) in regards to specialty care expected or demanded of AHMPS by their hospitals or employers, to provide a forum for further education and training opportunities and support for AHMPS to achieve competency within areas of need in their local practice arena; and be it further

RESOLVED, that the Board of Regents contacts and communicates concerns with relevant specialty healthcare organizations to seek collaborative efforts in AHMPS post-GME training to benefit quality patient care; and be it further

RESOLVED, that the Board of Regents fully supports and backs hospitalists, and supports the notion that hospitals accept ethical and fiduciary responsibility in helping their hospitalists gain the necessary training to care for the specialty patients, as demanded by their local care arena.

Resolution 6-F15. Recommending Principles for Populating ABIM Boards and Test Development Committees

(Sponsor: Pennsylvania Chapter)

WHEREAS, the American Medical Association and the American College of Physicians jointly came together to form the American Board of Internal Medicine (ABIM) in 1936 in order to benefit the care of patients in the day-to-day practice of medicine; and

WHEREAS, board certification in internal medicine and its subspecialties is an important reflection of the attainment of skill and knowledge in the art and science of medical practice; and

WHEREAS, recent data on the outcome of recertification examinations in internal medicine would suggest that the test may not reflect core knowledge of standard day-to-day practice of medicine; and

WHEREAS, recent controversies regarding ABIM policies and procedures concerning the maintenance of certification (MOC) have highlighted a lack of board members with significant practice experience in day-to-day patient care; and

WHEREAS, board certification ought to reflect important knowledge in the day-to-day management of patients in the specialty of internal medicine or its subspecialties; therefore be it

RESOLVED, that the Board of Regents recommends to the American Board of Internal Medicine the following principles for populating their Boards and test development committees.

1. **The members of the Board of Directors, Councils Specialty Boards, and Test Writing Committees should have extensive experience in direct patient care as reflected by at least 25% time dedicated to caring for patients independently and on a regular basis within the last 5 years.**
2. **The collective members of the Board of Directors, Councils, Specialty Boards and Exam Committees should include a diverse group of physicians from:**
    a. **academic medicine (investigators, clinical researchers, academic clinicians, division directors, chairs), based at medical schools and/or teaching hospitals**
    b. **medical education (program directors, fellowship directors, and educators), and**
    c. **community practice (from institutions without a medical school). No fewer than one third of the members of Specialty Boards and Exam Committees should be from a community practice environment defined either by at least 10 years in full time community-based practice, or current effort in community practice of at least 50%.**