Spring 2025 BOG Resolutions

Resolution 1-S25. Calling for Research and Advocacy Related to and Opposing Stand Your Ground Laws
(Sponsor: New Mexico Chapter)

Resolution 2-S25. Advocating for Evidence-based Medical Practices Surrounding Kratom Use and Proper Regulation of Kratom
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(Sponsor: Oregon Chapter; Co-sponsors: Atlantic Provinces, British Columbia, Northern California, Southern California I, Southern California II, Southern California III, Colorado, Hawaii, Montana, New Mexico, Prairie Provinces, Quebec, and Vermont Chapters)

Resolution 6-S25. Ensuring ACP Accessibility for All Members
(Sponsor: Oregon Chapter)

Resolution 7-S25. Waiving ACP IM Registration Fees for All Doctor’s Dilemma Participants
(Sponsor: New York Chapter)

Resolution 1-S25. Calling for Research and Advocacy Related to and Opposing Stand Your Ground Laws

(Sponsor: New Mexico Chapter)

WHEREAS, more than half of U.S. states have Stand Your Ground laws;[2] and

WHEREAS, ACP is a national leader on evidence-based policy and advocacy on reducing firearm injuries and deaths;[1] and

WHEREAS, emerging evidence has highlighted the public and individual risk of injury and death in states with Stand Your Ground laws, which remove the duty to retreat before using lethal force if a person feels there is imminent risk of bodily harm;[3,4] and

WHEREAS, these laws have been found to worsen racial injustices;[5] and

WHEREAS, the Johns Hopkins' Center for Gun Violence Solutions describes these laws as "allowing people to avoid criminal prosecution for the use of deadly force even when the person could easily and safely retreat;"[6] and

WHEREAS, Everytown For Gun Safety has described these laws as "Shoot First laws" that "encourage avoidable escalation of violence;" [7] therefore be it

RESOLVED, that the Board of Regents develop policy on Stand Your Ground laws and call for additional research on the health consequences of these laws.

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Resolution 2-S25. Advocating for Evidence-based Medical Practices Surrounding Kratom Use and Proper Regulation of Kratom

(Sponsor: New Mexico Chapter)

WHEREAS, kratom (*Mitragyna speciosa*) is an emerging recreational substance widely available in gas stations, tobacco and vape shops, and online, that, at varying doses, has stimulant, opioid-like, or sedative effects[1,2]; and

WHEREAS, there are reports demonstrating consumer products containing disease-causing microbes, dangerous amounts of lead, or other heavy metals, and the US FDA does not report any approved uses of kratom[3,4]; and

WHEREAS, only six states have banned kratom (Alabama, Arkansas, Indiana, Tennessee, Vermont, and Wisconsin), and only five states have consumer protection legislation in place (Arizona, Georgia, Nevada, Oklahoma, and Utah)[5]; and

WHEREAS, patients utilizing kratom have varying motivations for use, including chronic pain management, alleviating psychiatric symptoms, as a way to avoid over-the-counter (OTC) or prescription medications, to improve mood/energy, or to self-treat other substance use disorders (SUDs) [2,6]; and

WHEREAS, kratom is thought to be addictive, with reports of tolerance, dependence, and withdrawal upon cessation; and patients can experience withdrawal within 12-48 hours of cessation, characterized by hostility, emotional liability, and delusions, with withdrawal protocols not being standardized[7,8]; and

WHEREAS, kratom use has also been associated with various medical complications including cardiac arrest, prolonged QT interval, intracerebral hemorrhage, liver and kidney injury, posterior reversible encephalopathy syndrome (PRES), seizures, coma, aphasia, neonatal abstinence syndrome, and death[9–11]; therefore be it

RESOLVED, that the Board of Regents, along with other stakeholders, advocate for research into evidence-based care of people using kratom; and be it further

RESOLVED, that the Board of Regents, along with other stakeholders, advocate for legislation to regulate kratom use.

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Resolution 3-S25. Supporting State-Funded Programs to Provide Access to Healthcare Coverage for Immigrants

(Sponsor: Illinois Chapter; Co-sponsor: California Southern III Chapter)

WHEREAS, the ACP has no existing policy on state-level programs to provide free or low-cost healthcare coverage to low-income undocumented immigrants; and

WHEREAS, based on federal survey data, as of 2022, there were 45.5 million immigrants residing in the U.S., including 21.2 million noncitizens who accounted for about 7% of the total population; and

WHEREAS, noncitizen immigrants, particularly likely undocumented immigrants, are significantly more likely to report being uninsured than citizens. As of 2023, half (50%) of likely undocumented immigrants and one in five (18%) lawfully present immigrants say they are uninsured compared to 6% of naturalized citizens and 8% of U.S.-born citizens; and

WHEREAS, noncitizen immigrants are less likely to have access to care. In one survey, 38% of likely undocumented immigrants reported no usual source of care besides the emergency room vs 18% of lawfully present immigrants and 12% of naturalized citizens; and

WHEREAS, undocumented immigrants are not eligible to enroll in federally funded coverage including Medicaid, CHIP, or Medicare or to purchase coverage through the ACA Marketplaces; and

WHEREAS, legislation was introduced in the 118th Congress in 2023 to remove barriers to access to healthcare for immigrants, S.2646 - HEAL for Immigrant Families Act of 2023; and

WHEREAS, in 2020 Illinois became the first state in the country to ensure healthcare access for adults shut out of federally funded Medicaid and Medicare programs. Since then, five other states and D.C. have followed suit in providing healthcare coverage to adults and an additional twelve states and D.C. provide coverage for children; and

WHEREAS, funding of state-level healthcare coverage for immigrants can be unreliable and inconsistent, as evidenced by the state of Illinois' moratorium on new enrollees in their immigrant healthcare program in 2023; and

WHEREAS, access to preventive care and care of chronic medical conditions is cost-effective in maintaining people's health, ability to work, pay taxes and provide care to their dependents; and

WHEREAS, when patients lack coverage for primary care services, they often inappropriately seek care for non-urgent health conditions and maintenance of their chronic health conditions in settings such as emergency departments and federally qualified health centers, which are legally mandated to care for them, but will not be adequately reimbursed for their services; and

WHEREAS, the state-level health benefit programs for immigrants provide essential compensation to safety-net providers for the care they deliver. Lack of access to these programs increases the uncompensated costs and threaten the viability of these crucial healthcare providers of care to many of our most vulnerable communities; and

WHEREAS, undocumented immigrants pay taxes through their employment, thereby contributing to the support of Medicare, Social Security, and unemployment insurance, as well as state, federal and local taxes, but are currently not allowed to enroll in Medicare, Medicaid or other federal healthcare programs; therefore be it

RESOLVED, that the Board of Regents develop and adopt policy in support of state-funded programs to provide access to free or low-cost healthcare to low-income immigrants, regardless of documentation or asylum status or health condition; and be it further

RESOLVED, that the Board of Regents continue to develop and adopt policy in support of federal legislation to provide free or low-cost healthcare to low-income immigrants, such as allowing immigrants to enroll in Medicaid, Medicare or receive premium tax credits/cost-sharing reduction for marketplace-based coverage, regardless of documentation or asylum status or health condition.

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Tax Payments by Undocumented Immigrants – ITEP

Immigration adds to economy WP

Resolution 4-S25. Reconsidering the Ethics Surrounding the "Aid in Dying Act"

(Sponsor: New York Chapter)

WHEREAS, the American College of Physicians (ACP) has historically maintained a stance against physician-assisted death, citing ethical concerns and potential ramifications for patient care[1]; and

WHEREAS, the ACP's goals include: "To establish and promote the highest clinical standards and ethical ideals… and To welcome, consider and respect the many diverse voices of internal medicine and its subspecialties and work together for the benefit of the public, patients, our members, and our profession[2];" and

WHEREAS, Aid in Dying has sparked significant debate within the medical community and society at large regarding end-of-life care and the role of physicians in facilitating patient autonomy; and

WHEREAS, there is a growing recognition of the need for ACP to reassess its position on the question of "Medical Aid in Dying" in light of evolving societal attitudes, legislative developments, and advances in medical ethics; and

WHEREAS, many National and State organizations support (Table 1), at minimum, a neutral stance for patients' aid-in-dying; therefore be it

RESOLVED, that the Board of Regents thoroughly study and evaluate the ethical, legal, and practical implications of the "Aid in Dying Act" and consider taking a neutral stance on Aid in Dying, formerly known as physician-assisted suicide; and be it further

RESOLVED, that the Board of Regents prioritizes enhancing its educational resources to continue to assist physicians in navigating complex end-of-life care decisions, including the potential role of physician-assisted death.

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Resolution 5-S25. Taking a Neutral Stance and Developing Legal and Health Policy on Legislation Regarding Medical Aid in Dying (MAiD)

(Sponsor: Oregon Chapter; Co-sponsors: Atlantic Provinces, British Columbia, Northern California, Southern California I, Southern California II, Southern California III, Colorado, Hawaii, Montana, New Mexico, Prairie Provinces, Quebec, and Vermont Chapters)

WHEREAS, the majority of U.S. and Canadian voters are in favor of legalizing MAiD for adults within strict limits and guidelines (2, 3, 4) leading to introduction and passage of legislation to allow MAiD for adults by ballot measure, by court decision, or by state legislatures (5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16); and

WHEREAS, there is evidence of broad physician support for legalization of MAiD (17, 18, 19, 20, 21, 22, 23); and

WHEREAS, worldwide there are a growing number of countries, states, and regions where Medical Aid in Dying (MAiD) is currently legal, including 14 countries and parts of the U.S. (ten U.S. states and Washington D.C.) (1, 50); and

WHEREAS, 20 ACP Chapters/Regions (including Oregon, Washington, California's four Chapters, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Vermont, Washington D.C., Colombia, and Canada's five Chapters) are located in states or countries where MAiD is currently legal (1, 50); and

WHEREAS, lawmakers in 19 U.S. states are considering bills that would legalize MAiD (58, 59); and

WHEREAS, in Canada, Colombia, Germany and Italy and in one U.S. state, legalization of MAiD has come through the courts without the benefit of prior legislative development and review (1, 2, 45); and

WHEREAS, ACP needs to represent all our members, their patients, and the collective healthcare community including those living and working in regions where MAiD is legal; and

WHEREAS, it is crucial to avoid confusion by clearly and correctly defining and distinguishing the difference between patients' and clinician's choices at end of life, including *physician-assisted suicide (PAS)* (when a physician prescribes a medication, to be self ingested, to help a patient terminate their own life); *medical aid in dying (MAiD)* (when the patient is already dying and asks for assistance through the dying process); and *euthanasia* (not technically a patient choice, rather a clinician's unilateral action to end another's life for the purpose of alleviating suffering)(30, 56, 63, 64, 65); and

WHEREAS, ACP policy published in 2017 that was specifically in opposition to Physician Assisted Suicide (PAS) (49) does not explain nuances of various terms in use and, while addressing ethical principles around patient choices at end of life, does not address or advise on policy concerns which might influence the increasing legalization of MAiD that has added states or territories which are home to 20 ACP chapters/regions; and

WHEREAS, there is a distinct difference between euthanasia and MAiD in practice and in intent, both ethically and legally (30, 31, 32, 33, 56), and incorrectly using the above terms interchangeably when discussing patient choice to request MAiD may be particularly painful for populations whose forebears have been subjected to attempts at genocide; and

WHEREAS, 26 years of experience in Oregon and the accumulated experience in other places where MAiD is legal do not bear out the concern that MAiD leads to euthanasia, nor the concern that legalizing MAiD will lead to large numbers of patients or physicians participating in MAiD, nor do they bear out concerns regarding a disproportionate use for those who live with physical or mental disabilities, for minorities, or for those with fewer resources or who are less educated (34, 35, 36, 37, 56); and

WHEREAS, a neutral stance on MAiD can balance the painful history of mistreatment of some populations in this country with the wishes of patients requesting this voluntary option at the end of their lives; and a neutral stance by ACP does not imply support for or require advocacy for MAiD while allowing ACP to provide policy guidance to safeguard physicians and the public; and

WHEREAS, those locations with legal MAiD have seen growth in the use of palliative care, hospice and other compassionate end-of-life care which has far exceeded the growth in practice of MAiD (38, 39, 40, 41); and

WHEREAS, in Oregon, the U.S. state with the longest experience with legal MAiD, the medical community, partnering with patients, has worked diligently since 1994 to improve the quality of care at the end of life and has recently been shown to have superior palliative, hospice, and end-of-life care (39, 42); and

WHEREAS, the existing U.S. and Canadian laws allowing MAiD include *significant protections* for patients to prevent the practice of euthanasia and the abuse of or inappropriate use of MAiD, but legalization through court action may not (45, 46, 62); and

WHEREAS, no current or proposed law allowing MAiD has ever *required* a physician or other healthcare professional to practice MAiD (43, 44); and

WHEREAS, the existing U.S. and Canadian laws allowing MAiD include legal guidelines and protections for physicians who choose not to participate in MAiD or who choose to ease dying with or without MAiD (47, 48); and

WHEREAS, amongst others, between 2009 - 2024 Oregon Medical Association, California Medical Association, Massachusetts Medical Society, American Academy of Family Physicians (AAFP), the British Royal College of Physicians, and the British Medical Association have changed their policy positions from opposition to neutral regarding MAiD (24, 25, 26, 27, 28, 29, 66); and

WHEREAS, the American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) issued a policy position on physician assisted suicide in 2019 affirming that “physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations” (53, 54, 55); and

WHEREAS, the American Academy of Hospice and Palliative Medicine has taken a position of “studied neutrality on the subject of whether [Physician-Assisted Dying] should be legally permitted or prohibited….” and additionally points out that, “any statutes legalizing PAD and related regulations must include safeguards to appropriately address … concerns” (51); and

WHEREAS, the International Association for Hospice and Palliative Care believes that “no country or state should consider the legalization of euthanasia or [physician assisted suicide] until it ensures universal access to palliative care services and to appropriate medications, including opioids for pain and dyspnea” (52); therefore be it

RESOLVED, in response to the growing recognition of and legal support for a patient's right to choose medical aid in dying (MAiD) as one of their options at the end of life, that the Board of Regents review its position on MAiD from a legal and health policy standpoint and:

1. **Revise ACP's stance from one of opposition to Physician Assisted Suicide to a neutral stance on Medical Aid in Dying; and**
2. **Develop policy and legal guidance to ensure that appropriate legal safeguards are included in legislation and regulations to protect patients from misuse of MAiD and to protect healthcare professionals who choose to participate or not to participate in MAiD where MAiD is legal or becomes legal; and**
3. **Provide educational resources on current policy and practice around MAiD for ACP members; and be it further**

RESOLVED, that the Board of Regents advocate for better public and professional education on and payment for the following:

1. **Eliciting, updating and documenting advance care planning and patient/family goals of care, especially in patients with serious illness, and**
2. **Palliative care: management of the stress, symptoms, and suffering in serious illness regardless of age of patient or stage of illness, and**
3. **End-of-life care including hospice.**

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Resolution 6-S25. Ensuring ACP Accessibility for All Members

(Sponsor: Oregon Chapter)

WHEREAS, ACP has 161,000 members which we serve; and

WHEREAS, the CDC states, as of 2022, that 28.7% of Americans live with disabilities, and 12.2% live with a mobility disability (1); and

WHEREAS, this means up to 46,000 domestic members may be living with disabilities and close to 20,000 live with a mobility disability; and

WHEREAS, CDC data shows in the U.S. 6.2% of people live with hearing disabilities and 5.5% live with visual disabilities (1); and

WHEREAS, this means up to 10,000 domestic members live with hearing disabilities and nearly 9,000 members live with visual disabilities; and

WHEREAS, in 1990 the Federal Government passed the American with Disabilities Act (ADA), which was subsequently updated and amended, to prevent discrimination against people living with disabilities (2); and

WHEREAS, under the ADA, regulations have been developed by the Department of Justice that state/local governments and many businesses must follow to ensure that they do not discriminate against people living with disabilities (2); and

WHEREAS, the AMA has policy that established an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities (9); and

WHEREAS, the College 2024-2027 Strategic Priorities include:

- Membership and Engagement Enhancements
  Design and implement infrastructure innovations to advance membership, increase engagement across the profession, and enhance products and services to meet the evolving needs of internal medicine physicians; and

WHEREAS, ACP goals include:

- To promote and respect diversity, inclusion, and equity in all aspects of the profession
- To welcome, consider and respect the many diverse voices of internal medicine
- To serve the professional needs of the membership, support healthy lives for physicians
- To advocate responsible positions on individual health and on public policy related to health care for the benefit of our members; and

WHEREAS, ACP Values include:

- Compassion:
  We respect the dignity of others and are sensitive and empathic to their needs.
- Inclusion:
  We embrace diversity and inclusion to foster engagement, belonging, and respect in all that we do.

- Equity and Justice:
  We create a just and equitable culture without barriers or limits to our members, patients, and the profession.
- Wellbeing:
  We cultivate a culture of caring for and about each other, and we advocate for and create systems changes that promote personal and professional fulfillment; and

WHEREAS, the letter of the ADA law, though in contract language, is not always adhered to and advocacy is needed in this area (10); and

WHEREAS, we currently rely on members with disabilities to request assistance rather than fully anticipating needs and advertising available assistance thus it is hard to know how many members decide against attending events due to difficulties with disabilities; and

WHEREAS, in the current era we have multiple technologic and audio-visual options to assist people living with mobility and communication disabilities (4, 5, 6); and

WHEREAS, College events are located in facilities with varying adherence to the ADA and with varying event space staff attention to the needs of members living with mobility disabilities or communications disabilities and to correct this may mean touring and inspecting facilities and technology with a different lens going forward; therefore be it

RESOLVED, that the Board of Regents studies the needs and numbers of members living with disabilities as part of our new and ongoing membership data infrastructure work, and shares the results with the BOG at the end of the current 3-year strategic cycle; and be it further

RESOLVED, that the Board of Regents form an advisory group (composed at least in part of ACP members who themselves have a disability) to:

- **Promote inclusivity for physicians and medical students with disabilities in all ACP activities;**
- **Update the College on advancements in technology that could further facilitate inclusivity and engagement;**
- **Identify or develop educational materials, resources, toolkits for Chapters regarding accommodations for members with disabilities; and**
- **Provide ongoing input related to the planning and adaptation of all ACP events so that ACP members or guests living with permanent or temporary disabilities feel welcome and encouraged to participate; and be it further**

RESOLVED, that the Board of Regents partners with other organizations to advocate for updating, adhering to, and enforcing ADA and other local, regional, state, and federal regulations and requirements that ensure adequate access for people living with disabilities to public spaces, facilities, events, and other venues.

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Resolution 7-S25. **Waiving ACP IM Registration Fees for All Doctor's Dilemma Participants**

(Sponsor: New York Chapter)

WHEREAS, the annual Doctor's Dilemma (DD) competition is a hallmark program for ACP and brings together some of the brightest residents from all over the world for a friendly but highly competitive event; and

WHEREAS, to participate in the competition, a team must be nominated by its local ACP Chapter and the ACP Resident/Fellow Members who comprise the teams compete for up to 3 days with the aim of winning the coveted ACP Osler Cup; and

WHEREAS, studies have shown that a significant proportion of residents have substantial debt, and it is a common source of stress and anxiety. Strategies or programs aimed at reducing debt burden felt by residents are of great value (1); and

WHEREAS, studies have suggested that a substantial portion of graduate students and postdoctoral trainees experience significant food insecurity in part due to lack of financial means (2); and

WHEREAS, the American College of Physicians requires all Doctor's Dilemma (DD) participants to register/pay for the DD competition and also pay the annual ACP IM meeting registration fee; and

WHEREAS, most Doctor's Dilemma participants attend the Doctor's Dilemma competition only and do not attend the multi-day Annual ACP IM meeting because of on-call duties, inability to take several consecutive days off, and other scheduling challenges; and

WHEREAS, some chapters may provide limited funding (i.e., local DD competition winner reward, travel reimbursement policy, special circumstances, etc.); and

WHEREAS, Chapter funding is often insufficient to cover the required IM meeting registration fee and Doctor's Dilemma participation fee, leaving significant out-of-pocket costs for lodging and meals; therefore be it

RESOLVED, that the Board of Regents agree to waive the ACP IM Annual Meeting registration fee for Doctor's Dilemma team participants competing in the ACP Doctor's Dilemma competition that takes place during ACP's IM Annual Meeting.

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