

## Memorandum

**To:** ACEP Council

**From:** Dean Wilkerson, JD, MBA, CAE  
Council Secretary

**Date:** August 23, 2010

**Subj:** Action on 2007 Resolutions

The attached report summarizes the actions taken by the Board of Directors on the 27 resolutions adopted by the 2007 Council. Seven resolutions were referred to the Board of Directors. The Council also adopted one amendment to the Council Standing Rules, which did not require adoption by the Board.

The actions on resolutions are also included on the ACEP Web site.  
<http://www.acep.org/aboutus.aspx?id=32406>

### HEADQUARTERS

Post Office Box 619911  
Dallas, Texas 75261-9911

1125 Executive Circle  
Irving, Texas 75038-2522

972-550-0911  
800-798-1822  
972-580-2816 (FAX)  
[www.acep.org](http://www.acep.org)

### BOARD OF DIRECTORS

Angela F. Gardner, MD, FACEP  
*President*

Sandra M. Schneider, MD, FACEP  
*President-Elect*

David P. Sklar, MD, FACEP  
*Chair of the Board*

Kathleen M. Cowling, DO, MS, FACEP  
*Vice President*

Andrew E. Sama, MD, FACEP  
*Secretary-Treasurer*

Nicholas J. Jouriles, MD, FACEP  
*Immediate Past President*

Andrew I. Bern, MD, FACEP

Michael J. Gerardi, MD, FACEP

Jay A. Kaplan, MD, FACEP

Ramon W. Johnson, MD, FACEP

Rebecca B. Parker, MD, FACEP

Alexander M. Rosenau, DO, FACEP

David C. Seaberg, MD, CPE, FACEP

Robert C. Solomon, MD, FACEP

### COUNCIL OFFICERS

Arlo F. Weltge, MD, MPH, FACEP  
*Speaker*

Marco Coppola, DO, FACEP  
*Vice Speaker*

### EXECUTIVE DIRECTOR

Dean Wilkerson, JD, MBA, CAE

## Action on 2007 Council Resolutions

### Resolution 1 Commendation for Frederick C. Blum, MD, FACEP, FAAP

*Action:* A framed resolution was presented to Dr. Blum.

### Resolution 2 Commendation for Cherri D. Hobgood, MD, FACEP

*Action:* A framed resolution was presented to Dr. Hobgood.

### Resolution 3 Commendation for Todd B. Taylor, MD, FACEP

*Action:* A framed resolution was presented to Dr. Taylor.

### Resolution 4 In Memory of Reinald Leidelmeyer, MD

*Action:* A framed resolution was presented to a representative of Dr. Leidelmeyer's family.

### Resolution 5 In Memory of William Jay Levin, MD

*Action:* A framed resolution was presented to a representative of Dr. Levin's family.

### Resolution 6 In Memory of Charles "Chuck" Thomas, MD, FACEP

*Action:* A framed resolution was presented to a representative of Dr. Thomas's family.

### Resolution 7 Age Requirement for Retired Membership

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.4 – Life Members, be amended to read:

Any person who has: 1) held active, inactive, or international membership in the College for a minimum of 15 years and who has attained the age of sixty (60); or 2) held active, inactive, or international membership in the College for a minimum of 10 years and who has attained the age of seventy (70); or 3) held active, inactive, or international membership in the College for a minimum of 20 years ~~and who has attained the age of 55~~ and who is retired from medical practice; or 4) becomes permanently disabled, may on application to and approval by the Board of Directors be classified as a life member.

*Action:* The Bylaws were updated.

### Resolution 9 Clarification of the Duties of the Board and Powers of the Council

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 2 – Powers of the Council, be amended to read:

The Council shall have the right and ~~power~~ responsibility to advise and ~~to~~ instruct the Board of Directors regarding any matter ~~that might affect~~ of importance to the College. ~~The Board of Directors shall be required to comply with and implement any and all resolutions, by means of Bylaws and non-Bylaws resolutions, including amendments to the College Manual, and other~~ actions or appropriations enacted by the Council. ~~except that the Board of Directors may overrule or amend such instructions, except for changes to the Council Standing Rules, by a three-fourths vote of the entire Board of Directors, provided that such an amendment shall not change the intent or basic content of the resolution. Such actions to overrule or amend should include the positions and vote of each member of the Board and be presented at the next meeting of the Council Steering Committee. The Council Steering Committee may approve the language of the Board to amend, in which case the resolution becomes amended and implemented. Conversely, if the Council Steering Committee disapproves the language of the Board, the resolution is considered overruled, and a report is returned to the Council at the next annual meeting. The Board of Directors must respond to all questions presented by the Council-~~ shall act on all resolutions adopted by the Council no later than the second Board meeting following the annual meeting and shall address all other matters referred to the Board within such time and manner as the Council ~~shall~~ may determine, ~~except that the Board of Directors may postpone action on Council resolutions for no more than one Board meeting.~~

The Board of Directors shall take one of the following actions regarding a non-Bylaws resolution adopted by the Council:

1. Implement the resolution as adopted by the Council.
2. Overrule the resolution by a three-fourths vote. The vote and position of each Board member shall be reported at the next meetings of the Steering Committee and the Council.
3. Amend the resolution in a way that does not change the basic intent of the Council. At its next meeting, the Steering Committee must either accept or reject the amendment. If accepted, the amended resolution shall be implemented without further action by the Council. If the Steering Committee rejects the amendment, the Board at its next meeting shall either implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.

The Council shall have, in addition, the following powers:

1. To prepare and control its own agenda.
2. To ~~consider~~ **act on** any matter brought before it by a councillor or the Board of Directors.
3. To originate and ~~consider~~ **act on** resolutions.
4. To form, develop, ~~direct~~, and utilize committees.
5. To elect the president-elect of the College.
- ~~56.~~ To elect the **members of the** Board of Directors.
- ~~67.~~ To elect the speaker and vice speaker of the Council ~~and the president-elect of the College.~~
- ~~78.~~ To amend ~~these Bylaws~~ or the Articles of Incorporation.
9. To develop, adopt, and amend the Council Standing Rules and procedures for the conduct of Council business, which do not require action by the Board of Directors.

The speaker of the Council shall act as presiding officer of the Council.

*Action:* The Bylaws were updated.

### **Resolution 10 Complimentary Members in Section Councillor Allocation**

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 1 – Composition of the Council, be amended to read:

Each chartered chapter shall have a minimum of one councillor. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one. The councillors shall be elected or appointed to two-or three-year terms by their respective chapters.

The Emergency Medicine Residents' Association (EMRA) shall be entitled to four councillors, each of whom shall be a candidate or active member of the College.

Each chartered section of membership shall be entitled to one councillor if the number of section dues-paying **and complimentary candidate** members meets the minimum number established by the Board of Directors for the charter of that section based on the membership rolls of the College on December 31 of the preceding year. A councillor may not serve simultaneously as a councillor from a chapter and a section.

Each component body, to include EMRA and each chapter and section, shall also elect or appoint alternate councillors who will be empowered to assume the rights and obligations of the sponsoring body's councillor at Council meetings at which such councillor is not available to participate.

Councillors shall be certified by their sponsoring body to the Council secretary on a date no less than 60 days before the annual meeting.

*Action:* The Bylaws were updated.

### **Resolution 11 Fellowship 9 (as amended)**

RESOLVED, That the ACEP Bylaws Article V – Fellowship, Section 1 – Fellow Status be amended as follows:

Fellows of the College shall **meet one of the following two sets of criteria:**

**I. ~~b~~Be active, life, honorary, or international members for three continuous years immediately prior to election and ~~shall both be currently~~ **must have been** certified in emergency medicine **at the time of election** by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics, ~~and be and remain current members of the College.~~ **Maintenance of Fellow status requires continued membership in the College.** ~~Current Fellows who develop a disability precluding recertification will be deemed to maintain the certification criteria.~~ In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application.**

- ~~1.A.~~ At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
- ~~2.B.~~ Satisfaction of at least three of the following individual criteria during their professional career:
  - ~~A.1.~~ active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
  - ~~B.2.~~ active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
  - ~~C.3.~~ active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
  - ~~D.4.~~ active involvement in emergency medicine administration or departmental affairs;
  - ~~E.5.~~ active involvement in an emergency medical services system;
  - ~~F.6.~~ research in emergency medicine;
  - ~~G.7.~~ active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
  - ~~H.8.~~ member of a national ACEP committee, the ACEP Council, or national Board of Directors;
  - ~~I.9.~~ examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
  - ~~J.10.~~ reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

**II. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:**

- A. At least ~~six ten~~ years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;**
- B. Satisfaction of at least three of the following individual criteria, ~~of which one of the three must be number 7 or number 8,~~ during their professional career:**
  - 1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;**
  - 2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;**
  - 3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;**
  - 4. active involvement in emergency medicine administration or departmental affairs;**
  - 5. active involvement in an emergency medical services system;**
  - 6. research in emergency medicine;**
  - 7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;**
  - 8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;**

**9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;**

**10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.**

**In addition, the candidate must provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.**

Provision of documentation of the satisfaction of the above criteria is the responsibility of the candidate, and determination of the satisfaction of these criteria shall be by the Board of Directors of ACEP or its designee.

~~Fellows or former Fellows having demonstrated by application that they meet the criteria for Fellow status will retain their Fellow status as long as they maintain certification in emergency medicine by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics, and be and remain current members of the College. Current Fellows, who develop a disability precluding recertification in emergency medicine, may retain their title of Fellow by providing evidence of that disability to the College.~~

Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

#### **Section 2—Life Fellow**

~~A Fellow of the American College of Emergency Physicians will be called a Life Fellow when that member either: (a) has been certified in emergency medicine by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or in pediatric emergency medicine by the American Board of Pediatrics (ABP) and maintains status as a Fellow for a period of not less than 21 years; or (b) has been certified by ABEM or AOBEM or ABP for a period of not less than 11 years and meets the criteria for life membership in ACEP; or (c) currently holds that status.~~

*Action:* The Bylaws were updated. Member Services developed a plan to promote the revised requirements to members that are now eligible for fellowship.

The 2008 Council adopted a resolution requiring that “candidates must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010.”

#### **Resolution 12 Membership Eligibility**

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 1 – Eligibility be amended to read:

Membership in the College is contingent upon the applicant or member showing a significant interest in emergency medicine and being of good moral and professional character. Members agree to abide by the “Principles of Ethics for Emergency Physicians,” which are contained in the current “Code of Ethics for Emergency Physicians.” No person shall be denied membership because of sex, race, age, ~~or~~ political or religious beliefs, **sexual orientation, or real or perceived gender identity.**

*Action:* The Bylaws were updated.

#### **Resolution 14 Procedures for Addressing Charges of Ethical Violations and Other Misconduct (as amended)**

RESOLVED, That the College Manual be amended by substitution of the “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” approved by the ACEP Board of Directors in June 2007.

#### **Procedures for Addressing Charges of Ethical Violations and Other Misconduct**

Guiding Principle: Ethics charges and other disciplinary charges are important and will be addressed in accordance with College policy.

## A. Complaint Received

A complaint may be initiated by an ACEP member, chapter, committee, or section. No others have standing to present a complaint.

1. Must be in writing and signed by the complainant ~~complaining party~~;
2. Must specify in reasonable detail the alleged violation by an ACEP member of ACEP Bylaws, current ACEP “Principles of Ethics for Emergency Physicians,” other current ACEP ethics policies, or other conduct believed by the complainant ~~complaining party~~ to justify warrant censure, suspension, or expulsion;
3. Must state that the ~~complaining party~~ complainant has personal, first-hand knowledge or actual documentation of the alleged violation, and all documentation must accompany the complaint; Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient’s name, address, social security number, patient identification number, or any identifying information related to members of the patient’s family;
4. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, the Ethics Committee, the Board of Directors, and to the respondent should the complaint be forwarded to the respondent;
- 5.4. Must be submitted to the ACEP Executive Director.

## B. Executive Director

1. Sends a written acknowledgement to the ~~complaining party to~~ complainant confirming the ~~complaining party’s~~ complainant’s intent to file a complaint and identifying the ~~issues~~ elements that ~~need to be clarified~~ must be addressed in an ethics complaint.
2. Confirms ~~that requirements under Section A.1 and A.2 are satisfied, and sends a copy of the document receipt of an acknowledgement signed by the complainant specifying an intent to file an ethics complaint and to be bound by the~~ “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” ~~to the complaining party.~~
3. Notifies the ACEP President and the chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint;
- 4.5.
  - a. Determines, in consultation with the ACEP President and the chair of the Ethics and/or Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the Code of Ethics for Emergency Physicians or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or
  - b.a. Determines, in consultation with the Ethics Committee chair, ~~whether~~ that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics for Emergency Physicians*, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or
  - c.b. Determines, in consultation with the Bylaws Committee chair, ~~whether~~ that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and ~~if so~~, forwards the complaint and response together, as soon as both are received, to each member of the ~~Board of Directors~~ Bylaws Committee, or at the discretion of the Chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or
  - d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Board of Directors will review the President’s action at the next regularly scheduled Board meeting. The President’s action can be overturned by a majority vote of the Board.

- 5.4.** Within five **working business** days after actions specified in Section B.~~2.4.a. or B.4.b.~~, forwards the complaint to the respondent by registered U.S. mail with a copy of the document, “Procedures for Addressing Charges of Ethical Violations and Other Misconduct” and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the **allegation(s) complaint, the reasons for the review action,** that no determination has **yet** been made **on the complaint, that ACEP is not yet proposing that an adverse action be taken,** and **that if the Board decides not to dismiss the complaint,** the respondent has the right to request a hearing ~~if the complaint process proceeds based on ACEP’s determination that the complaint alleges a violation sufficient to justify censure, suspension, or expulsion.~~ **A copy of the complaint and all supporting documentation will be included in this communication. Such notice must also include a summary of the respondent’s rights in the hearing, and a list of the names of the members of the ACEP Ethics Committee or the ACEP Bylaws Committee, as appropriate, or subcommittee that will be reviewing the complaint, and the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.**
- 6.** **When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics Committee, the Bylaws Committee, or the subcommittee appointed to review the complaint as appropriate.**

**C. Bylaws Committee**

- 1. Reviews the written record of any complaint which alleges a violation of the ACEP Bylaws and the accompanying response.**
- 2. Determines the need to solicit in writing additional information from the parties, third parties, or experts regarding the complaint and makes all reasonable efforts to investigate and obtain all facts necessary to review the complaint.**
- 3. Discusses the complaint and response by telephone conference call;**
- 4. Considers whether:**
  - a. Current ACEP Bylaws apply.**
  - b. Alleged behavior constitutes a violation of current ACEP Bylaws.**
  - c. Alleged conduct warrants censure, suspension, or expulsion.**
- 5. Proceeds to develop its recommendation based solely on the written record.**
- 6. The Bylaws Committee will deliver its report to the ACEP Executive Director for transmittal to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:**
  - a. Dismiss the complaint; or**
  - b. Take disciplinary action, the specifics of which shall be included in the committee’s report.**
- 7. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of three or more members of the Bylaws Committee. Such subcommittee and its chair shall be appointed by the Bylaws Committee chair and may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, its report and recommendations shall be delivered to the Board of Directors.**

**D.C. Ethics Committee [within thirty (30) days of action specified in Section B.5.4.a. above]**

- 1. Discusses the complaint and response by telephone conference call;**
- 2. ~~Determines~~ Considers whether:**
  - a. Current ACEP “Principles of Ethics for Emergency Physicians” or other current ACEP ethics policies apply.**
  - b. Alleged behavior constitutes a violation of current ACEP “Principles of Ethics for Emergency Physicians” or other current ACEP ethics policies.**
  - c. Alleged conduct justifies warrants censure, suspension or expulsion.**
- 3. Determines the need to solicit in writing additional information from the parties, third parties, or experts regarding the complaint.**

4. ~~If the determination in C.2 above is in the affirmative, p~~Proceeds to develop its recommendation based solely on the written record.
5. Develops a ~~consensus~~ report ~~recommending the action to be taken~~ regarding the complaint and recommendation for action. Minority reports may also be presented.
6. The Ethics Committee will deliver its ~~consensus~~ report and minority reports, if any, to the ACEP Executive Director for transmittal to the Board of Directors. ~~The~~ In its report, the Ethics Committee's ~~recommendation~~ shall ~~be that~~ recommend that the Board of Directors:
  - a. Dismiss the complaint;
  - b. Take disciplinary action, the specifics of which shall be included in the committee's ~~recommendation report~~; or
  - c. Gather additional information ~~to determine the veracity of~~ regarding the complaint and the advisability of disciplinary action. The methods of gathering additional information, and any further consideration of the complaint, shall be the Board's responsibility and at its discretion and may include conducting a hearing.
7. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. Such subcommittee and its chair shall be appointed by the Ethics Committee chair and may ~~include~~ seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, its ~~findings report~~ and recommendations shall be ~~reported to the full committee for consideration and approval or modification prior to being~~ delivered to the Board of Directors.

**E.D. Board of Directors**

1. ~~a.~~ Receives the ~~recommendation report~~ of the Ethics Committee ~~about alleged violations of ethics policies or principles~~ or b. Bylaws Committee and ~~R~~receives the complaint and response.
2. May request further information in writing from the ~~complaining party~~ complainant and/or ~~alleged violator~~ respondent.
3. ~~Based on information received and/or additional information obtained subsequently, the Board may decide~~ Decides to:
  - a. Dismiss the complaint; or
  - b. ~~Provide the respondent with the option of:~~ Render a decision to impose disciplinary action based on the written record.
4. If the Board determines to impose a disciplinary action pursuant to E.3b., the respondent will be provided with notification of the Board's determination and the option of:
  - ~~1.a.~~ A hearing; or
  - ~~2.b.~~ AThe imposition of the Board decision based solely on the written record.
  - ~~c.~~ The respondent shall be given written notice by registered U.S. mail of this option and must respond with a request for a hearing within fifteen (15) business days of receipt of such notice or the Board will render its decision based on the written record and the recommendation of the Ethics Committee.

**F.E. Right of Respondent to Request a Hearing**

If the Board chooses option E.3.b. above, the Executive Director will send to ~~T~~the respondent ~~will receive~~ a written notice by registered U.S. mail of the right to request a hearing ~~pursuant to Section D.3.e above, that lists the respondent's hearing rights as set forth in Section F. below.~~ or to have the Board decide based solely on the written complaint. This notice will list the respondent's hearing rights as set forth in Section G. below. The respondent's request for a hearing must be submitted in writing to the ACEP Executive Director within ~~fifteen~~ thirty (1530) business days of receipt of the notice of right to a hearing. ~~If a hearing is requested, any actions of the ACEP Board of Directors will be stayed pending the results of the hearing~~ In the event of no response, the ACEP President may determine the manner of proceeding.

**G.F. Hearing Procedures**

1. If the ~~Board elects to conduct a hearing or if the~~ respondent requests a hearing by the Board of Directors, ~~all parties~~ the complainant and respondent will be



- notified in writing by registered U.S. mail by the **ACEP** Executive Director within ten (10) business days of such ~~election or~~ request. Such notice will include a list of witnesses, if any, that **ACEP** the Board or its subcommittee intends to call in the hearing.
2. The **ACEP** Executive Director will send a notification of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing by registered U.S. mail to the last known address(es) of the parties.
  3. The time set for the hearing will not be less than thirty (30) days nor more than six (6) months after the date on which notice of hearing was received by the respondent.
  4. ~~Either or both parties to the complaint~~ The complainant and respondent each may be represented by counsel or any other person of ~~the party's~~ his/her choice. Each party will bear the expense of his or her own counsel.
  5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.
  6. The hearing parties to the complaint have the right to call and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer of the hearing even if the evidence would not otherwise be admissible in a court of law. may be conducted by the entire Board or by a subcommittee of three to five members of the Board of Directors, at the discretion of and as appointed by the Chair of the Board of Directors. The Chair of the Board of Directors will act as the presiding officer throughout the hearing unless the Chair is unable to serve or disqualified from serving, in which case the ACEP President will designate a member of the Board of Directors to chair the hearing. If a subcommittee of the Board conducts the hearing, such hearing must take place with all of the parties and all the members of the subcommittee present in person. If the full Board conducts the hearing, all of the parties, and a quorum of the Board, must be present in person. Hearings may not take place by telephone conference call.
  7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
  - ~~8.7.~~ The Board or its appointed subcommittee will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing ~~and within thirty (30) days thereafter, render a decision.~~
  - ~~8.-~~ ~~The affirmative vote of two-thirds of the members of the Board Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws shall be required to take disciplinary action against the respondent. If the Board cannot achieve a two-thirds vote of eligible directors with a quorum present, the respondent shall automatically be exonerated. Members of the Board entitled to vote include members of the Board who attend the entire hearing either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.~~
  9. In the event that the hearing is conducted by a subcommittee of the Board, such subcommittee will, within thirty (30) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee's recommendation, to the Board of Directors. Within thirty (30) days after receiving this subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board cannot achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall automatically be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing.
  - ~~10.9.~~ The decision of the Board will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board's decision will be sent by registered U.S. mail to the respondent and complainant within thirty (30) days of the decision. Such decision will include a statement of the basis for the recommendation of the Ethics Committee or Bylaws Committee, as applicable, and the Board's decision.

## H. **Board Decision without a Hearing**

If the respondent chooses option D.3.b.2. above, that is, a Board decision based solely on the written record, the Board will consider the written record and make its decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board cannot achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall automatically be exonerated. Directors entitled to vote include members of the Board who are present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.

## I.G. **Disciplinary Action: Censure, Suspension, or Expulsion**

1. Censure
  - a. Private Censure: a private letter of censure ~~may be used to~~ inform a member ~~whose~~ that his or her conduct is not in conformity with the College's ethical standards; it may ~~that his/her conduct was found wanting; may~~ detail the manner in which the Board expects the member to behave (~~or refrain from behaving~~) in the future and may explain that, while the conduct does not, at present, ~~appear to~~ warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. The content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be disclosed.
  - b. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards; ~~in contrast with the private letter, the content of the public letter of censure shall be disclosed~~ set forth in Section A.2. above.
2. Suspension from ACEP membership shall be for a period of twelve months; the dates of commencement and completion of the suspension shall be determined by the Board of Directors. At the end of the twelve-month period of suspension, the suspended member shall be offered reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues).
3. Expulsion from ACEP membership shall be for a period of five years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors.

## J.H. **Disclosure**

1. Nature of Disciplinary Action
  - a. Private censure: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.
  - b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.
  - c. Suspension: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a synopsis of the findings of fact that led to suspension, shall be disclosed. ~~ACEP is required to report the suspension of membership to the National Practitioner Data Bank. ACEP is also required to report the suspension of~~ membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which may result in a report of such action to the National Practitioner Data Bank.
  - d. Expulsion: the date of expulsion, along with a synopsis of the findings of fact that led to expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition. ~~ACEP is required to report the expulsion from membership to the National Practitioner Data Bank. ACEP is also required to report the expulsion from membership and a~~ description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.
2. Scope and Manner of Disclosure
  - a. Any member may transmit to the Executive Director a request for information regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or

former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section HJ.1.

- b. The Board of Directors will publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. If any person makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director may refer that person to the published announcement of that disciplinary action in an ACEP publication.**

#### **K.I. Ground Rules**

- ~~1.~~ ~~The ACEP Executive Director will not initiate the procedures for issues that are appropriately addressed through judicial or administrative avenues. If the Executive Director determines the issue is more appropriately addressed through judicial or administrative avenues, the Executive Director will refer the~~  
~~matter to the ACEP President for review. If the President also determines the issue is more appropriately addressed through judicial or administrative avenues, the issue will not be considered. The Board of Directors will review the President's action at the next regularly scheduled Board of Directors meeting. The President's decision can be overturned by a majority vote of the Board.~~
- 1.2. All proceedings are confidential until final disposition of the complaint is rendered, at which time by the Board of Directors<sup>2</sup>, at which time the decision will be available upon request by a member of ACEP members, to the extent specified in Section J. The file Files of this matter these proceedings, including written submissions and hearing record will be kept confidential.
- ~~2.3.~~ Timetable guidelines are counted by calendar days unless otherwise specified.
- 3.4. The Ethics Committee, the Bylaws Committee, and the Board of Directors, and their appointed subcommittees, as appropriate, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the committee's, ~~or~~ Board's, or subcommittee's overall time to complete its task. However, such requests and the responses thereto shall not extend the ~~Ethics Committee's~~ time to ~~formulate~~ deliver a recommendation to the Board beyond ninety (90) days from the date the complaint is ~~received~~ forwarded to the appropriate committee or subcommittee.
- 4.5. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
- 5.6. If a participant in this process (such as a member of the Ethics Committee or Board of Directors) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that ~~participant person shall will not be involved in the process of resolution,~~ recuse himself or herself from the process except as a complaining party or respondent. Any person who might have such issues should recuse himself or herself from participation and will not be counted in the determination of the quorum.
- 6.7. Once the Board has ~~rendered a verdict~~ made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
- ~~8.~~ ~~ACEP is required to report adverse actions to the National Practitioners Data Bank if such actions are related to a physician's competence or professional conduct and where such conduct affects or could affect adversely the health or welfare of a patient or patients.~~
- 7.9. The Board's decision to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
- 8.10. If The failure of a respondent fails to respond to a complaint, to notice of the right to request a hearing, or to a request for information, ~~request will be grounds for default and the forfeiture of the right to a hearing~~ the Board may make a decision on the complaint solely on the basis of the information it has received.

Action: The College Manual was updated.

#### **Resolution 15 Apology**

RESOLVED, That ACEP support legislation to protect and make non-discoverable the apology or expression of sympathy or regret, or any reference thereto, during any legal proceedings that might take place.

*Action:* Assigned to Public Affairs staff for federal lobbying activities and Chapter & State Relations staff to work with chapters to communicate ACEP's position and for state lobbying activities. At least 30 states have now enacted laws that offer varying degrees of liability protection for the apology or expression of sympathy or regret by a health care provider to a patient. States with "I'm Sorry" laws include Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming, and the District of Columbia. Generally these laws protect health care providers who express sympathy to a patient for an unanticipated outcome from having such statement used against the physician in a subsequent lawsuit.

### **Resolution 19 Joint Commission (JC) Requirements for Medication Reconciliation in the Emergency Department (ED) (as amended)**

RESOLVED, That ACEP work with the Joint Commission to clarify and modify existing medication reconciliation standards pertaining to the ED, to include distinguishing these standards from those required of non ED patient care settings.

*Action:* Assigned to Emergency Medicine Practice staff to work with The Joint Commission (TJC) liaison representatives. TJC held a meeting on September 25, 2007, to discuss this issue. TJC agreed to clarify the application of medication reconciliation in the ED. The 2009 National Patient Safety Goal (NPSG). 08.04.01 specifically addresses, "... settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed." The ED is specifically mentioned in the rationale for this NPSG. The modification emphasizes the importance of obtaining a list of medications that a patient is taking but obtaining information on the dose, route, and frequency is not required. Further clarification for compliance with this patient safety goal is provided in the Elements of Performance for this NPSG.

### **Resolution 22 Information Systems for Emergency Care – ACEP Policy**

RESOLVED, That ACEP develop a comprehensive policy on Information Systems for Emergency Care; and be it further

RESOLVED, That ACEP convene a task force, or other suitable group, to produce within the next 12 months a "white paper" outlining the state of the art and needs assessment of information systems for emergency care and a formal plan to educate the membership on the evaluation and implementation of emergency department information systems.

*Action:* The resolution was assigned to the Emergency Medical Informatics Section and a task force was appointed in February 2008. The task force included members who authored the resolution. In August 2008, the Board of Directors approved the policy statement, "Health Information Technology." The policy was added to the ACEP Web site and included in the Policy Compendium. In October 2008, the Board received an interim report from the task force and an outline of the white paper. The outline was also distributed to the Council. In January 2009 the task force completed a draft of the paper and it was provided to the Board for review and comment. The final paper was approved by the Board in April 2009. The paper was distributed to the 2009 Council and assigned to Reference Committee B for comments. No comments were offered on the report. The report is also available on the ACEP Web site.

### **Resolution 23 Standards and Regulations of Retail Health Clinics (as amended)**

RESOLVED, That ACEP develop policy defining appropriate procedures for care of patients presenting to retail health clinics who are believed to have an emergency medical condition and require transfer to a higher level of care.

*Action:* Assigned to the Emergency Medicine Practice Committee. The Board approved the policy statement "Retail-Based Clinics" in April 2008. The policy was added to the Web site and included in the Policy Compendium.

### **Resolution 25 Disparity of Service**

RESOLVED, That ACEP and EMF promote studies and research in the area of hospital flow, as it relates to daily discrepancies in hospital services, and its impact on capacity and patient safety, and be it further

RESOLVED, That ACEP work with regulatory agencies and the American Hospital Association to identify and correct barriers to quality care, regardless of time or day of week.

*Action:* Assigned to Emergency Medicine Practice staff and Public Affairs staff. ACEP's leadership met with the leadership of the American Hospital Association (AHA) on April 30, 2008, and discussed issues that relate to this resolution. Public Affairs staff have contacted the Senior Vice President of AHA's Quality Center to follow up on the meeting and to discuss boarding and crowding. Communication with regulatory agencies and the AHA is ongoing. The Emergency Medicine Practice staff has worked with the Joint Commission to raise awareness regarding the disparity of services and its impact on patient flow. TJC has been encouraged to have their surveyors address the problems lack of services on off hours or weekends can cause on efficient patient flow throughout the hospital.

#### **Resolution 26 Hallway Beds (as amended)**

RESOLVED, That ACEP revise the policy on Boarding of Admitted and Intensive Care Patients in the ED to state that in the interest of public safety, when the number of patients needing evaluation or treatment in an ED is equal to or exceeds the ED's treatment-space capacity, admitted patients should be distributed to inpatient units regardless of bed availability; and be it further

RESOLVED, That ACEP work with appropriate state and national organizations to promote the adoption of such policies by hospitals nationwide; and be it further

RESOLVED, That ACEP collate and distribute information to its membership and other appropriate organizations gleaned from research studies related to patient safety and outcomes, including increased morbidity and mortality, caused by the boarding of admitted patients in the ED.

*Action:* Assigned to the Emergency Medicine Practice Committee to revise the policy. Assigned to Public Affairs staff and Chapter & State Relations staff to communicate ACEP's position and promote adoption of such policies. The Board approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the ED" in April 2008.

In August 2007, a Boarding Solutions Task Force was appointed to develop 3-5 low-cost or no-cost solutions to the practice of boarding. The task force was charged with proposing solutions to address the growing crisis that is harming the public's access to lifesaving emergency care. In the report, a boarded patient was defined as a patient remaining in the ED after the decision to admit has been made. The Board approved the task force report, "Emergency Department Crowding: High-Impact Solutions," in April 2008 for wide distribution to the membership, public, and other organizations. ACEP's leadership met with the leadership of the American Hospital Association (AHA) on April 30, 2008, and provided a copy of the report. The AHA agreed to share the report with its member hospitals and continue to work with ACEP on solutions to crowding and boarding. The report was publicized in the May 7, 2008, Leadership Report and is available on the ACEP Web site. The report was also provided to the 2008 Council.

#### **Resolution 27 Hospital Leadership Actions to Ameliorate Crowding (as amended)**

RESOLVED, That ACEP develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate overcrowding and treatment delays affecting ED and other hospital patients; and be it further

RESOLVED, That this position paper include discussion of the following elements:

1. Leadership strategies by hospital Boards of Directors, Chief Executive Officers, Chief Operational Officers, and Chief Nursing Officers, that are necessary to enact improvements in the process of patient flow
2. Return on investment (ROI) that is realized by hospital-led improvements in patient flow and hospital operations.
3. Information technology systems
4. Internal communication and coordination
5. Effective discharge planning, including early discharge
6. Smoothing of elective surgery scheduling and diagnostic/therapeutic procedures
7. Other evidence-based operational strategies that have been demonstrated to improve the process of care in hospitals.; and be it further

RESOLVED, That ACEP disseminate this position paper to its membership and appropriate outside organizations with the intention of facilitating hospital core culture change.

*Action:* Assigned to the Emergency Medicine Practice Committee. (See also action on Resolution 26.) The committee reviewed the Crowding Task Force Report and determined that much of the intent of the resolution was met by the report. The committee supplemented the issues not addressed in the task force report by developing talking points for discussions with hospital administrators regarding potential lost revenue due to crowding and boarding issues. The talking points address return on investment that is realized by hospital-led improvements in patient flow and hospital operations. On September 24, the Board of Directors affirmed the recommendations of the Emergency Medicine Practice Committee.

The committee is also charged with monitoring developments and the dissemination of additional tools and information through the ACEP Web site on crowding and boarding. The committee developed the information paper, "Optimizing ED Front End Operation" in January 2008, "Crowding and Surge Capacity Resources for the ED" in April 2007 and another information paper, "Approaching Full Capacity in the ED," in October 2006.

#### **Resolution 28 Members as Expert Witnesses (as amended)**

RESOLVED, That ACEP expand the Standard of Care Review process to include review of expert witness reports felt by members to include egregious statements and conclusions; and be it further

RESOLVED, That ACEP will publicize and promote the Standard of Care Review process and ACEP members' options to pursue further actions including referral to the ACEP Ethics Committee.

*Action:* Assigned to the Standard of Care Review Panel and to Emergency Medicine Practice staff. The Board approved the revisions to the "Procedure for Review of Testimony Regarding Standard of Care in Emergency Medicine" in January 2008. The process is promoted to the membership through the ACEP Web site.

#### **Resolution 32 Emergency Ultrasound Credentialing and Accreditation**

RESOLVED, That ACEP, in cooperation with all established College liaisons and relationships with other medical specialty societies, the American Medical Association, the Alliance for Specialty Medicine, the Coalition for Patient-Centric Imaging, and other interested parties actively and fully opposes the imposition upon the specialty of Emergency Medicine of any accreditation programs developed, offered, and/or governed solely by other specialties; and be it further

RESOLVED, That the Board of Directors of ACEP submit a comprehensive report to the Council at the 2008 Council Meeting regarding the adoption and execution of a strategic plan to address the long and short-term accreditation issues relating to the performance and interpretation of imaging studies by emergency physicians and, specifically, emergency ultrasound.

*Action:* Assigned to the Ultrasound Section for development of a strategic plan. The Emergency Ultrasound Accreditation Strategic Plan was approved by the Board of Directors in October 2008 and was distributed to the Council. Members of the section continue to actively address accreditation and certification with a variety of outside entities such as the American Institute of Ultrasound in Medicine, MedPAC, and the American Society for Echocardiography. The development of the content for the accreditation Web site has concluded and key section leaders are in the process of developing an Internet or Web-based platform to be used by those entities seeking emergency ultrasound accreditation. The accreditation program involves submission of documents from a physician representing their ED to the College to support compliance with established guidelines for safe and effective use of ultrasound in the department. The reviewers will evaluate the documents to determine if these materials support and demonstrate compliance with the guidelines in areas such as training, patient safety, and quality. The reviewers will make a recommendation to the accreditation board and a decision will be made as to whether or not to accredit. Work on the accreditation program is continuing and anticipated to begin in 2011.

#### **Resolution 34 Patient Support Services Addressing the Gaps (by substitution)**

RESOLVED, That ACEP supports that hospitals develop resources to improve emergency department patients' access to outpatient community health and support services.

*Action:* The resolution is a policy statement. It was added to the Web site and included in the Policy Compendium.

**Resolution 36 Training and Credentialing of Emergency Physicians for Various Forms of Patient “Sedation” in the Emergency Department (ED) (as amended)**

RESOLVED, That ACEP actively and fully opposes the imposition upon the specialty of Emergency Medicine of any credentials developed, offered, and/or governed solely by other specialties; and be it further

RESOLVED That ACEP work with the Joint Commission and the American Hospital Association to recognize that board certified emergency physicians (EPs) are adequately trained and qualified to properly administer sedative agents along the continuum of sedation levels, including moderate and deep sedation, and as qualified to credential themselves for hospital privileges relating to administering all sedative medications along the continuum.

*Action:* This resolution is addressed in current ACEP policy and clinical policies. The resolution was assigned to Emergency Medicine Practice Department staff to continue working with The Joint Commission (TJC) and American Hospital Association (AHA) liaisons to communicate ACEP’s position. Staff, through various venues, continues to promote, support, and insure that accrediting and credentialing bodies recognize that emergency physicians are trained and qualified to administer sedative agents. Additionally, staff have provided support to individual members, chapters, and other professional organizations regarding the need for emergency physicians to provide this service and that the administration of sedation in by emergency physicians helps provide safe and timely care to patients.

**Resolution 37 In Memory of Stephen Charles Romisher, MD, FACEP**

*Action:* A framed resolution was presented to a representative of Dr. Romisher’s family.

**Resolution 38 In Memory of Timothy H. Geno, MD**

*Action:* A framed resolution was presented to a representative of Dr. Geno’s family.

**Resolution 39 CMS Arbitrary Regional Interpretations (as amended)**

RESOLVED, That ACEP continue to investigate discrepancies in the interpretation of billing requirements by regional carriers and Medicare Administrative Contractors (MACs), and be it further

RESOLVED, That ACEP continue to intervene with CMS to assure that reasonable and equitable billing and documentation guidelines are explicitly provided for physicians participating in federal programs under its administrative agents’ oversight and that the guidelines are uniformly implemented by their carriers.

*Action:* Assigned to Reimbursement Department staff and Public Affairs staff. The Reimbursement Committee and the Coding & Nomenclature Committee continually monitor the CMS contractors and Medicare Area Contractors (MACs) for problems or vagaries in interpreting national rules. Recent activity has been noted in Virginia and Utah and ACEP is working with the chapters to verify the exact nature of the problem and take appropriate steps for resolution. The biggest issue remains the Trailblazer Health policy to refuse to honor the “All other systems negative” documentation shortcut in recording a patient’s medical history, although this has been less of a problem recently and now some CMS carriers sometimes follow private payer trends of bundling more separately billable procedures into the ED E/M service. ACEP will continue to monitor and intervene with CMS on regional interpretations of this nature. ACEP is also working with the Texas carrier medical director for over two years trying to overturn or at least soften this position as well as monitor its spread outside of Texas. That effort continues as Trailblazer transitions to the MAC contractor for region four and stops service in several east coast states. ACEP is also monitoring a shift from the use of documentation guidelines by carriers to a “general sense” of what level of service a chart supports.

**Resolutions Referred to the Board of Directors**

**Resolution 18 Futile Care**

RESOLVED, That ACEP petition the federal government to require that all acute care and convalescent hospitals establish a Futile Care Committee, consisting of physicians, nurses, medical ethicist, religious leaders and lay people to determine when care is futile and therefore “medically unnecessary;” and be it further

RESOLVED, When the Futile Care Committee determines that care is futile and therefore medically unnecessary, “acute care” will be provided for 72 hours to allow the patient and their families to decide if they wish to pay for additional acute care from their personal financial resources; and be it further

RESOLVED, That ACEP refer this policy to the American Medical Association for adoption as AMA policy.

*Action:* Assigned to Public Affairs staff to develop background information on any legislative or regulatory initiatives and provide a summary to the Emergency Medicine Practice Committee. Assigned to the Emergency Medicine Practice Committee to review the legislative/regulatory summary and provide a recommendation to the Board. The committee reviewed the available information on futile care committees and their use and concluded:

- Utilization of an ethics or futile care committee for care being provided in the ED is not practical. Futile Care Committees that were discussed in the literature were convened for patients that were admitted to the hospital.
- Futile care is an important issue and emergency physicians should be engaged in the discussion.
- Discussion of futile care should be conducted in the house of medicine and ACEP should participate but not lead.
- The current ACEP policies, *Ethical Issues of Resuscitation, Non-Beneficial (Futile) Emergency Medical Interventions*, and *Ethical Issues in Emergency Department Care at the End of Life*, affirm ACEP's current stance on futile care.

The committee recommended: 1) The terms futile care, advanced directives, palliative care, and DNR are often interchanged in conversation and should be clarified. [The committee developed a list of definitions that included these terms as well as living will, health care proxy, and durable power of attorney.] 2) ACEP should not develop a policy about futile care committees. 3) Emphasize that it is the physician in collaboration with the patient and the family who should make care decisions. Advocacy efforts to lead the discussion about futile care and futile care committees was not recommended. 4) ACEP should continue to be involved in the discussion with other organizations, like the American Medical Association, to reach consensus on this difficult issue. The Board approved the committee's recommendations in June 2008.

### **Resolution 21 Single-Payer Health Insurance**

RESOLVED, That the American College of Emergency Physicians supports the adoption of a single-payer health insurance program in the United States; and be it further

RESOLVED, That the American College of Emergency Physicians explore opportunities to partner with other like-minded organizations that favor the approach to providing health insurance to all Americans.

*Action:* Assigned to the Federal Government Affairs Committee to provide a recommendation to the Board regarding further action on this resolution. It should be noted that in 2005 the Council also referred Resolution 34 Single-Payer Health Insurance. In January 2006, the Board endorsed a set of reform principles calling for universal healthcare coverage. Those principles did not specify a financing mechanism or a specific approach, but served instead as the basis for further work. In August 2007, the Board reaffirmed its support for the principles and agreed that no further action on Resolution 34(05) was needed in light of the reform principles and other policies of ACEP. The Board further expressed the view that health care reform was and will continue to be a critical issue in the years to come and that further debate over the merits of various proposals to reform health care should be explored.

In January 2008, the ACEP Board of Directors discussed ACEP's position on health care reform. The Board reviewed the results of a survey of the Executive Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee on specific components of a health care reform proposal. The survey included questions that involve system reform as well as coverage issues. The survey was revised to include questions about liability reform, EMTALA, and health information technology. There was consensus from the Board that system reform and health care coverage are ACEP's primary goals in the health care debate. The revised survey was distributed to the Council e-list and the responses were discussed by the Steering Committee in May 2008. Specifically regarding a single-payer system, 51.1% of the survey respondents were opposed, 44.5% indicated support, and 4.4% indicated no opinion. The information from the survey was used to assist the ACEP president and the Board of Directors in refining ACEP's health care reform policy and assess national, state, and local reform initiatives.

The Michigan Chapter submitted another resolution to the 2008 Council on single-payer health insurance. The Council adopted a substitute resolution directing that "the Board of Directors derive a list of essential components to be included in any new healthcare system and create a white paper."

The "Principles for Reform of the U.S. Health Care System" adopted by the Board and several other medical specialties, contains the essential components called for in this resolution. In June 2009, the Board of



Directors had a comprehensive discussion regarding ACEP's health care reform positions on some of the most controversial items currently under consideration in the reform debates. For many of the items, the Board believed it would need more information on how emergency medicine might be impacted before taking a definitive public position. ACEP, along with many other medical specialty societies, were actively engaged in the hearing and drafting stages of health care reform. ACEP's President sent a letter to the Senate Finance Committee commenting on an options paper that was released. The goals ACEP embraces such as universal coverage, quality, affordability, etc., were addressed in the comprehensive bills that were in development.

ACEP was successful in advancing several emergency medicine priorities and securing these provisions in various sections of the House and Senate health care reform bills being considered. These measures included:

- Identification of ED services as part of the essential health care benefits package;
- Medicare physician payment reforms (addressing the underlying problems of the sustainable growth rate (SGR) including resetting the budget baseline for the Medicare payment system, eliminating the current debt accrued under the SGR, removing physician-administered drugs from the SGR, and providing increased payments for physicians who provide E&M services);
- Emphasis on ED patient through-put as a measure used to determine quality improvement;
- Authorization of the Emergency Care Coordination Center (ECCC) within the HHS Office of the Assistant Secretary of Preparedness and Response (ASPR), as well as the ECCC Council on Emergency Medicine and a requirement that the ECCC provide an annual report to Congress on its programs (with a focus on ED crowding and boarding);
- Grants to conduct at least four emergency care/trauma regionalization pilot projects;
- Grants for economically troubled trauma centers;
- HHS incentive payments to states that establish medical liability reforms, such as Certificate of Merit and/or "early offer;" and
- HHS demonstration project to reimburse privately owned psychiatric hospitals that provide EMTALA services to Medicaid beneficiaries.
- Senate adoption of patients' bill of rights language (i.e. the prudent layperson standard)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). According to the Congressional Budget Office (CBO), Public Law 111-148, the number of uninsured residents in the United States will drop from current levels (as many as 45 million) to 32 million by 2019. CBO estimates those still without insurance include as many as 23 million undocumented aliens, others who either opt not to enroll in Medicaid or those who elect to pay the penalty for not obtaining coverage.

Through the many months of debate on the act, several law makers voiced their support for a single payer system, such as Medicare for all. Representative John Conyers (D-MI) and 87 colleagues introduced the United States National Health Care Act (also known as the Expanded and Improved Medicare for All Act) on January 26, 2009. No action was taken on this bill during the First Session and Second Session of the 111<sup>th</sup> Congress. Similar bills beginning with the 108<sup>th</sup> Congress were introduced but were never considered.

At various times during House debate on health reform legislation, Speaker Pelosi (D-CA) said she would allow a vote on a single-payer option. Rep. Anthony Weiner (D-NY) had been an ardent single-payer proponent and had planned to offer an amendment during a committee mark-up of the health reform bill. He withdrew his proposed amendment in exchange for a promise of a floor vote. That vote never came. In both instances, the leadership of the House calculated that support for a single payer system even if significant could jeopardize the ultimate success and enactment of a bill.

Supporters of the single-payer concept argue that it would greatly improve the efficiency of the U.S. health care system by eliminating the need for some 1,200 different insurance companies. They argue this adds to the bureaucratic complexity and cost of the U.S. health care system and that the reduced administrative costs would offset the cost of providing expanded coverage to the poor and uninsured. Supporters also point out that the U.S. system is a high-cost, over-specialized system that doesn't deliver care to all of its citizens.

Single-payer proponents point to Canada, the United Kingdom, and other industrialized nations as examples of single-payer successes. At the same time however, as those systems have come under pressure to control costs and expand services, waiting times for certain procedures have grown. Opponents of the single-payer system point to those countries as examples of what not to do.

Opposition to the single-payer system approach is equally entrenched in its support for market-based system solutions. They point out that after 30 years of government intervention, the Canadian system suffers from long waiting times for critical procedures, lack of access to current technology, increasing costs to taxpayers and patients, and a "brain drain" of doctors, who head south for better working conditions and more money.

Opponents also point out the explicit rationing of resources that inevitably arises in such a system and the inadequate investment in medical technology and new drugs – all strengths of the market-based approach.

The Michigan Chapter has submitted a resolution to the 2010 Council regarding “Medicare-for-All Health Insurance.” It has essentially the same elements of previously submitted resolutions on single-payer health insurance.

#### **Resolution 24 Baby Boomers**

RESOLVED, That ACEP study the impact of the baby boomer generation on our nation’s Emergency Departments; and be it further

RESOLVED, That a report of this study be made to the 2008 Council.

*Action:* Assigned to the Geriatric Emergency Medicine Section. In October 2008, the Board accepted the section’s report “The Future of Geriatric Care in our Nation’s Emergency Departments: Impact and Implications.” The report was also distributed to the Council and is available on the ACEP Web site.

#### **Resolution 29 Physician Rights Regarding Malicious and Sham Peer Review**

RESOLVED, That ACEP develop policies regarding the appropriate rights of an accused physician in the peer review process, including the right to notification and involvement in the process; and be it further

RESOLVED, That ACEP work to assure that physicians subjected to peer review and quality assessment efforts be allowed reasonable due process; and be it further

RESOLVED, That ACEP solicit member input and address issues as related to misuse of peer review process or disruptive physicians policies by health care facilities or peer review entities; and be it further

RESOLVED, That ACEP work to educate and inform members about the potential misuse of peer review and provide appropriate guidelines for peer reviewer expectations and reasonable standards; and be it further

RESOLVED, That ACEP work to end the use of “disruptive physicians” policies which are extended to non-patient care issues (such as economic credentialing, failure to support marketing or business plans of the hospital or health care facility, or are used as a punitive recourse against physicians who have raised serious quality or patient safety issues regarding the facility).

*Action:* Assigned to the Medical-Legal Committee to provide a recommendation to the Board. This resolution was assigned to the committee as an objective for FY 08-09 and was continued in the 09-10 committee year. The committee plans to submit a recommendation to the Board of Directors for their September 25, 2010, meeting.

#### **Resolution 30 Advanced Directives**

RESOLVED, That ACEP develop an advanced directive form for the benefit of its members; and be it further

RESOLVED, That ACEP promote the use of advanced directives by including the ACEP approved “advanced directive” as part of the syllabus of all ACEP sponsored educational programs.

*Action:* Assigned to the Emergency Medicine Practice Committee to provide a recommendation to the Board. The committee reviewed available information on advance directives and the forms required. Given that legislation for advance directives differ by state and the forms required vary across the nation, developing one form for use by ACEP members was not recommended.

The Joint Commission standards, under which the majority of hospitals are accredited, address the hospitals’ obligation to comply with the wishes of the patient relating to end-of-life decisions. Standard RI.2.80 EP 12 states that, “Upon request, the organization helps patients formulate medical advance directives or refers them for assistance.” Since this is a responsibility of the facility, each hospital should have access to resources applicable to the residents of that state. The committee recommended that ACEP provide links to patient oriented Web pages that already exist such as the one developed by the American Academy of Family Physicians (AAFP) that has information and forms for all 50 states and the District of Columbia. The amount of effort to develop and maintain such a Web site would be excessive and duplicative of existing resources. Consumer information about advance directives was considered appropriate content for the ACEP Foundation Web site. The Board accepted the committee’s recommendations in June 2008.

### **Resolution 31 Defining the Practice of Emergency Medicine (EM) in a Hospital's Emergency Department**

RESOLVED, That ACEP add to its existing "Definition of Emergency Medicine" document, language which expands the scope and more completely defines the practice of Emergency Medicine, to include oversight for ED administrative, operational and budget management, and ED policy setting, non-physician staffing and "Front" and "Back" End ED patient flow processes.

*Action:* Assigned to the Emergency Medicine Practice Committee to provide a recommendation to the Board. The Board approved the revised policy statement "Definition of Emergency Medicine" in April 2008. The policy was added to the Web site and included in the Policy Compendium.

### **Resolution 35 Regionalized Acute Care Services**

RESOLVED, That ACEP develop guiding principles and policies for effective state level regionalization of high intensity acute care services, initially focused on stroke care, based upon the existing state trauma systems, to include regional oversight, statewide registries available to health services researchers, financial support for physicians and hospitals willing to provide this care, absence of undue bureaucratic regulations on emergency physicians, and appropriate level of regulation and policies, based upon existing science or reasonable extrapolation of existing data, for integration within the existing state health care system; and be it further

RESOLVED, That ACEP develop state level model legislative language for stroke regionalization within the context of its guiding principles.

*Action:* Assigned to the State Legislative/Regulatory Committee to provide a recommendation to the Board. The State Legislative/Regulatory Committee was assigned an objective in FY 07-08 to track and compile state legislative developments related to regionalization of emergency care. The committee surveyed chapters and conducted independent research with state health officials to identify current state efforts to regionalize acute care services (with particular emphasis on efforts related to STEMI and stroke) and identified pre-hospital and hospital protocols and procedures utilized by the states.

ACEP also supported federal legislation introduced in July 2007 by Senator Barack Obama and Representative Henry Waxman, entitled the "Improving Emergency Medical Care and Response Act of 2007" (S. 1873 and H.R. 3173). The legislation called for the development of four regional demonstration programs aimed at designing, implementing and evaluating a regionalized, accountable emergency care system.

The State Legislative/Regulatory Committee recommended that the Board establish a task force of various College experts to develop guiding principles for regionalization programs. The task force was appointed in June 2008. The materials developed and reviewed by the State Legislative/Regulatory Committee as a result of the committee objective were submitted to the new task force for assistance in moving forward on this project.

The task force report was approved by the Board in October 2009. It was distributed to the 2009 Council and assigned to Reference Committee B for comments. No comments were offered on the report. The report was also made available on the ACEP Web site.

## **Standing Rules Resolutions**

*Standing Rules resolutions do not require adoption by the Board of Directors.*

### **Resolution 13 Nominations and Election Procedures**

*Action:* The Standing Rules were updated.