American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

COUNCIL MEETING

October 3-4, 2026

McCormick Place West - Chicago
Chicago, IL

Scientific Assembly CHICAGO 26

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved September 2025

Antitrust

Revised September 2025

Reaffirmed January 2019, June 2013 and October 2007

Revised October 2001 and June 1996

Approved April 1994

The American College of Emergency Physicians (ACEP) is a national not-for-profit professional organization that exists to support quality emergency medical care and to promote the interest of emergency physicians. The College may not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or organizations.

The College provides a forum for exchange of ideas in a variety of settings including its annual meeting, educational programs, committee meetings, and Board meetings.

In order to ensure that the College and its members comply with the antitrust laws, ACEP endorses these principles:

- ACEP or any committee, section, chapter, or activity of the College shall not be used for the purpose of bringing about or attempting to bring about any understanding or agreement, written or oral, formal or informal, expressed or implied, among two or more members or other competitors with regard to prices or terms or conditions of contracts for services or products. Therefore, discussions and exchanges of information about such topics will not be permitted at College meetings or other activities.
- There will be no discussions discouraging or withholding patronage or services from or encouraging exclusive dealing with any health care professional or group of health care professionals, any supplier or purchaser or group of suppliers or purchasers of health care products or services, any actual or potential competitor or group of actual potential competitors, any patients or group of patients, or any private or governmental reimburser.
- There will be no discussions about allocating or dividing geographic or service markets, customers, or patients.
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.

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- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's bylaws.
- Certain activities of the College and its members are deemed protected from antitrust laws under the First Amendment right to petition government. The antitrust exemption for these activities, referred to as the Noerr-Pennington Doctrine, protects ethical and proper actions or discussions by members designed to influence: 1) legislation at the national, state, or local level; 2) regulatory or policy-making activities (as opposed to commercial activities) of a governmental body; or 3) decisions of judicial bodies. However, the exemption does not protect actions constituting a "sham" to cover anticompetitive conduct.
- Speakers at committees, educational meetings, and other business meetings of the College shall be informed that they must comply with the College's antitrust policy in the preparation and the presentation of their remarks. Meetings will follow a written agenda approved in advance by the College or its legal counsel.
- Meetings will follow a written agenda. Minutes will be prepared after the meeting to provide a concise summary of important matters discussed and actions taken or conclusions reached.

At informal discussions at the site of any College meeting all participants are expected to observe the same standards of personal conduct as are required of the College in its compliance.

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American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved April 2023

Conflict of Interest

Revised April 2023, January 2017, June 2011, June 2008

Reaffirmed October 2001

Revised September 1997

Originally approved January 1996

All Key Leaders (defined below) of the American College of Emergency Physicians (ACEP) and others acting on behalf of the College have a fiduciary duty to the College, including the duties of loyalty, diligence, and confidentiality. The following groups or individuals are defined as Key Leaders:

1. Officers
2. Board of Directors
3. Past Presidents, Past Speakers, Past Chairs of the Board
4. Councillors, Alternate Councillors
5. Committee Chairs and Members
6. Section and Task Force Chairs
7. Section and Task Force Members who participate in the development of policy and resources on behalf of the College
8. Editors of ACEP-sponsored publications (e.g., *Annals of Emergency Medicine*, *JACEP Open*, *ACEP Now*, various podcasts)
9. ACEP staff leadership, including its Executive Director, Chief Operating Officer, and members of the Senior Management Team

Those in positions of responsibility must act in utmost good faith on behalf of the College. In accepting their positions, they promise to give the College the benefit of their work and best judgment. They should exercise the powers conferred solely in the interest of the College and should not use their role or position for their own personal interest or that of any other organization or entity. Even the perception of conflict can potentially compromise the confidence and trust of College members and the public in the stewardship of its leaders.

Conflicts of interest arise when participants in positions of responsibility have personal, financial, business, or professional interests or responsibilities that may interfere with their duties on behalf of the College. The immediacy and seriousness of various conflicts of interest situations may vary. Of basic importance is the degree to which the interest would tend one toward bias or pre-disposition on an issue or otherwise compromise the interests of the College.

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A conditional, qualified, or potential conflict of interest can arise when the outside interest is not substantial or does not relate significantly to any contemplated action of the College. For example, a person might hold a minor financial interest in a company wishing to do business with the College. Disclosure is ordinarily sufficient to deal with this type of potential conflict of interest, provided that there is no expectation that one's duty to the College would be affected.

Direct conflicts of interest arise, for example, when an individual engages in a personal transaction with the College or holds a material interest or position of responsibility in an organization involved in a specific transaction with the College or that may have interests at variance or in competition with the College. The appropriate and necessary course of action in such cases is to disclose the conflict and recuse oneself, during the deliberations and the vote on the issue.

In rare circumstances, an individual may have such a serious, ongoing, and irreconcilable conflict, where the relationship to an outside organization so seriously impedes one's ability to carry out the fiduciary responsibility to the College, that resignation from the position with the College or the conflicting entity is appropriate.

Dealing effectively with actual, perceived, or potential conflicts of interest is a shared responsibility of the individual and the organization. The individual and organizational roles and responsibilities with regard to conflicts of interest follow.

A. General

1. All individuals who serve in positions of responsibility within the College need not only to avoid conflicts of interest, but also to avoid the appearance of a conflict of interest. This responsibility pertains to Key Leaders and other elected or appointed leaders, and staff. Decisions on behalf of the College must be based solely on the interest of the College and its membership. Decisions must not be influenced by desire for personal profit, loyalty to other organizations, or other extraneous considerations.
2. Key Leaders shall annually sign a statement acknowledging their fiduciary responsibility to the College and agree to avoid conflicts of interest or the appearance of conflicts of interest. The issue of conflicts of interest with regard to the remainder of the staff shall be the responsibility of the Executive Director. The issue of adherence to this policy regarding conflicts of interest of Section and Task Force Members who participate in the development of policy and resources on behalf of the College shall be the responsibility of the Section and Task Force Chairs.
3. Key Leaders shall annually complete a form designated by the Board of Directors that includes the disclosure of pertinent financial and career-related information and shall update that information as necessary to continuously keep it current and active.
4. Key Leaders shall annually sign a statement acknowledging that they may have access to confidential information and agree to protect the confidentiality of that information.
5. Officers, Board Members, the Executive Director, Chief Operating Officer, and members of the Senior Management Team shall annually agree to clarify their position when speaking on their own behalf as opposed to speaking on behalf of the College, or as an Officer or member of the Board of Directors or members of the Senior Management Team.
6. Officers, Board Members, the Executive Director, the General Counsel, or their designees will periodically review the conflict of interest disclosure statements submitted to the College to be aware of potential conflicts that may arise with others.
7. When an Officer, Board Member, the Executive Director, or General Counsel believes that an individual has a conflict of interest that has not been properly recognized or resolved, the Officer, Board Member, Executive Director, or General Counsel will raise that issue and seek proper resolution.

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8. Any member may raise the issue of conflict of interest by bringing it to the attention of the Board of Directors through the President or the Executive Director. The final resolution of any conflict of interest shall rest with the Board of Directors.

B. Disclosure Form
   1. Key Leaders shall acknowledge that their service to the College requires annual completion of a Conflict of Interest Disclosure Form related to certain affiliations and interests that discloses the following:
      a. Name of employer. Positions of employment, including the nature of the business of the employer, the position held, and a description of the daily employment.
      b. Positions of leadership in other organizations, chapters, commissions, groups, coalitions, agencies, and/or entities (eg, Board of Director positions, committees, and/or_spokesperson roles). Include a brief description of the nature and purposes of the organization or entity.
      c. Family members who are non-physicians, currently or formerly employed in an emergency department or urgent care center, providing care to patients, including, but not limited to nurse practitioners, physician assistants, or certified nurse specialists. Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, sibling-in-law, child-in-law, parent-in-law, stepparent, stepchild, guardian, ward, or a member of the individual's household.
      d. Outside relationship with any person(s) or entity from which the College obtains goods and services, or which provides services that compete with the College where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicity traded company; c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.
      e. Financial interests or positions of responsibility in any entity providing goods or services in support of the practice of emergency medicine (eg, physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.
      f. Outside relationship with any health plan, health insurance company, delegated payer, health insurance company administrative service organization, or health insurance company related philanthropic organization or entity where such relationship involves: a) holding any position of responsibility; b) an equity interest (other than a less than 1% interest in a publicity traded company); c) any stipend, contribution, gift, gratuities, lodging, dining or entertainment valued at more than $100.
      g. Industry-sponsored research support within the preceding twenty-four (24) months.
      h. Speaking fees from non-academic entities during the preceding twenty-four (24) months.
      i. The receipt of any unusual gifts or favors from an outside entity or person, or the expectation that a future gift or favor will be received in return for a specific action, position, or viewpoint taken, in regard to the College or its products.
      j. Any other interest the Key Leader believes may create a conflict with the fiduciary duty to the membership of the College or that may create the appearance of a conflict of interest.
   2. Key Leaders shall acknowledge and agree to the following on the Conflict of Interest Disclosure Form:
      a. Fiduciary responsibility to the College to avoid conflict of interest or the appearance of conflict of interest.
      b. Access to confidential information and to protect the confidentiality of that information.
      c. Clarify position when speaking on own behalf as opposed to speaking on behalf of the College.
      d. To abide by the terms and requirements of the ACEP Conflict of Interest Policy.
      e. Recognize the obligation to notify the appropriate individual as required by the Conflict of Interest Policy should a possible conflict of interest arise in responsibilities to the College. To

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abstain from participation in any business of the College that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so, how that conflict may be resolved. If any relevant changes occur that would be reasonably viewed as requiring disclosure, there is a continuing obligation to file an amended Conflict of Interest Disclosure Form.

3. Except as provided in Section 5 below, completed disclosure forms shall be submitted to the President and the Executive Director, or other designee(s), no later than thirty (30) days prior to commencement of the annual meeting of ACEP's Council. For Officers and Board Members newly elected during a meeting of ACEP's Council, the forms shall be submitted no later than thirty (30) days following their election if they were not previously submitted. Any Key Leader who has not submitted a completed disclosure form by the applicable deadline will be ineligible to participate in those specific College activities for which they have been appointed or elected until their completed disclosure forms have been received and reviewed as set forth in this policy.
4. Information disclosed by Officers, Board Members, and the Executive Director pursuant to this policy will be placed in the General Reference Notebook available at each Board meeting for review by Officers and Board Members. Committee, Section, and Task Force Chairs will have access to the disclosure forms of the members of the entity they chair. In addition, any College member may request a copy of a Key Leader's disclosure form upon written request to the ACEP President.
5. Completed disclosure forms required from Section and Task Force Members will be submitted to the relevant Section or Task Force staff liaison, or other designee(s), within thirty (30) days of appointment or assignment.
6. The College may provide to its members and the public the disclosure forms of its Key Leaders and anyone who speaks at the Council meeting.

C. Additional Rules of Conduct
   1. Prior to participating in any deliberation or vote on an issue in which they may have a conflict, Key Leaders shall disclose the existence of any actual or possible interest or concern of:
      a. The individual;
      b. A member of that individual's immediate family; or
      c. Any party, group, or organization to which the individual has allegiance that can cause the College to be legally or otherwise vulnerable to criticism, embarrassment, or litigation.
   2. After disclosure of the interest or concern that could result in a conflict of interest as defined in this policy and all material facts, the individual shall leave the Board, Committee, Section, or Task Force meeting while the determination of a conflict of interest is discussed and voted upon. The remaining Board, Committee, Section, or Task Force members shall decide by majority vote if a conflict of interest exists. If a conflict of interest is determined to exist, the individual having the conflict shall retire from the room in which the Board, Committee, Section, or Task Force is meeting and shall not participate in the deliberation or decision regarding the matter under consideration. However, that individual shall provide the Board, Committee, Section, or Task Force with any and all relevant information requested.
   3. The minutes of the Board, Committee, Section, or Task Force meeting shall contain:
      a. The name of the individual who disclosed or otherwise was found to have an interest or concern in connection with an actual or possible conflict of interest, the nature of the interest, any action taken to determine whether a conflict of interest was present, and the Board's, Committee's, Section's, or Task Force's decision as to whether a conflict of interest existed;
      b. The extent of such individual's participation in the relevant Board, Committee, Section, or Task Force meeting on matters related to the possible conflict of interest; and
      c. The names of the individuals who were present for discussion and votes relating to the action, policy, or arrangement in question, the content of the discussion including alternatives to the proposed action, policy, or arrangement, and a record of any votes taken in connection therewith.

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American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2018

Meeting Conduct Policy

Originally approved June 2018

Background

The American College of Emergency Physicians (ACEP) is committed to providing a safe, productive and harassment-free environment at its Scientific Assemblies, educational meetings, conferences, and other ACEP-sponsored events. These events are designed to enable clinicians and researchers to convene for informational and educational sessions regarding the latest advances in treatment and care, and to promote learning, professional development, and networking opportunities. ACEP meetings also allow attendees to learn about and debate the latest scientific advances and to enjoy the company of professional colleagues in an environment of mutual respect. ACEP promotes equal opportunities and treatment for all participants. All participants are expected to treat others with respect and consideration, follow venue rules, and alert staff or security when they have knowledge of dangerous situations, violations of this Meeting Conduct Policy, or individuals in distress.

Prohibited Behavior

ACEP prohibits any form of harassment, sexual or otherwise, as set forth in its Non-Discrimination and Harassment Policy. Accordingly, some behaviors are specifically prohibited, whether directed at other attendees, ACEP staff, speakers, exhibitors, or event venue staff:

- Harassment or discrimination based on race, religion, gender, sexual orientation, gender identity, gender expression, disability, ethnicity, national origin, or other protected status.
- Sexual harassment or intimidation, including unwelcome sexual attention, stalking (physical or virtual), or unsolicited physical contact.
- Yelling at, threatening, or personally insulting speakers (verbally or physically).

Participants asked to stop engaging in hostile or harassing behavior are expected to comply immediately.

Application of Rules

These conduct rules apply to all attendees and participants at any ACEP-sponsored event, as well as ACEP-sponsored meeting social events (for example,

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opening and closing parties at Scientific Assembly). **All who register to participate, attend, speak at, or exhibit at an ACEP event agree to comply with this Policy.**

Reporting Prohibited Behavior

Harassment or other violations of this Meeting Conduct Policy should be reported immediately to ACEP Meetings staff either in person, in writing by email at conduct@acep.org or other means of reporting. ACEP may involve event security and/or local law enforcement, as appropriate based on the specific circumstances. Event attendees and participants must also cooperate with any ACEP investigation into reports of a violation of this Meeting Conduct Policy by providing all relevant information requested by ACEP.

Potential Consequences

- ACEP reserves the right to remove any participant whose social attentions become unwelcome to another and who persists in such attentions after their unwelcome nature has been communicated.
- ACEP also reserves the right to remove any participant or attendee who appears inebriated and who engages in conduct that interferes with the ability of other attendees to participate in and enjoy the conference.
- ACEP may remove any individual from attendance or other participation in any ACEP-sponsored event, without prior warning or refund, if in its reasonable judgment, ACEP determines a violation of this Meeting Conduct Policy has occurred.
- If ACEP, in its reasonable judgment, determines that an individual has violated this Meeting Conduct Policy, ACEP may also prohibit the individual from attending or participating in future ACEP events.
- ACEP will also report on the outcome of any investigation to individuals who have reported a violation of this Meeting Conduct Policy.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Meeting Schedule of Events

Marriott Marquis Chicago
McCormick Place Convention Center West (MPCC)
October 2-4, 2026
Chicago, IL

Friday, October 2

3:00 pm – 8:00 pm	Councillor Credentialing – MPCC, North Pre-Function (Level 4)
4:30 pm – 6:00 pm	Candidate Forum Subcommittee – Marriott Marquis, Probability Room (Level 3)
6:00 pm – 7:00 pm	Steering Committee Meeting – Marriott Marquis, Probability Room (Level 3)
7:00 pm – 8:00 pm	Tellers, Credentials, & Elections Committee – Marriott Marquis, Physiology Room (Level 3)
7:00 pm – 8:00 pm	Reference Committee Briefing – Marriott Marquis, Probability Room (Level 3)

Saturday, October 3

7:30 am – 5:30 pm	Councillor Credentialing – MPCC, North Pre-Function (Level 4)
8:00 am – 9:40 am	Council Meeting – MPCC, Skyline Ballroom W375 CDE (Level 3)
10:00 am – 1:00 pm	Reference Committee A – W178 AB (Level 1)
10:00 am – 1:00 pm	Reference Committee B – W179 AB (Level 1)
10:00 am – 1:00 pm	Reference Committee C – W181 AB (Level 1)
11:00 am – 12:30 pm	Reference Committee Boxed Luncheon – W178 AB Foyer (Level 1)
1:00 pm – 2:15 pm	Reference Committee Executive Sessions A – W178 AB (Level 1) B – W179 AB (Level 1) C – W181 AB (Level 1)
1:00 pm – 1:30 pm	Return to main Council meeting room – Skyline Ballroom W375 CDE (Level 3)
1:30 pm – 2:15 pm	Candidate Forum – President Elect Candidates – Skyline Ballroom W375CDE (Level 3)
2:30 pm – 3:45 pm	Candidate Forum – Board of Directors Candidates *Candidates will rotate through each of the Reference Committee meeting rooms.*
2:30 pm – 3:45 pm	Candidate Waiting Room (Candidates and "entourage" members only) – MPCC, W180 (Level 1)
4:00 pm – 5:10 pm	Council Meeting Reconvenes – MPCC, Skyline Ballroom W375 CDE (Level 3)
5:30 pm – 6:30 pm	Candidate Reception – Marriott Marquis, Glessner House ABC (Level 3)

Sunday, October 4

7:00 am – 5:30 pm	Councillor Credentialing – MPCC, North Pre-Function (Level 4)
8:00 am – 12:00 pm	Council Meeting – MPCC, Skyline Ballroom, W375 CDE (Level 3)
12:00 pm – 1:30 pm	Council Awards Luncheon – Marriott Marquis, Grand Horizon Ballroom A-D (Level 4)
1:45 pm – 5:45 pm	Council Reconvenes – MPCC, Skyline Ballroom W375 CDE (Level 3)
5:10 pm – 5:40 pm	Elections – MPCC, Skyline Ballroom, W375 CDE (Level 3)

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting

October 3-4, 2026
Pre-Meeting Events Occur Friday Evening, October 2, 2026
McCormick Place Convention Center (MPCC) – West Building
Skyline Ballroom, W375CDE (Level 3)
Chicago, IL

TIMED AGENDA

Saturday, October 3, 2026

Continental breakfast available – North Prefunction (MPCC, Level 3)		***7:30 am***
1. Call to Order	Dr. McCrea	8:00 am
A. Meeting Dedication	Dr. McCrea	
B. Pledge of Allegiance	Dr. McCrea	
C. National Anthem	Dr. Wiltz	
2. Introductions	Dr. McCrea	8:10 am
3. Welcome from IL Chapter President	Dr. Donaldson	8:12 am
4. Tellers, Credentials, & Election Committee	Dr. Veitinger	8:14 am
A. Credentials Report		
B. Meeting Etiquette		
5. Changes to the Agenda	Dr. McCrea	8:16 am
6. Council Meeting Website Overview	Dr. McCrea	8:16 am
7. EMF Council Challenge	Dr. Wilcox	8:21 am
8. NEMPAC Council Challenge	Dr. Parker	8:23 am
9. Review and Acceptance of Minutes	Dr. McCrea	8:25 am
A. Council Meeting – September 5-6, 2026		
10. Approval of Steering Committee Actions	Dr. McCrea	8:26 am
A. Steering Committee Meeting – January 29, 2026		
B. Steering Committee Meeting – April 26, 2026		
11. Executive Director's Report	Dr. Fraser	8:27 am
12. Call for and Presentation of Emergency Resolutions	Dr. McCrea	8:47 am
13. Steering Committee's Report on Late Resolutions	Dr. McCrea	8:50 am
A. Reference Committee Assignments of Allowed Late Resolutions		
B. Disallowed Late Resolutions		
14. Nominating Committee Report	Dr. McCrea	8:55 am
A. Board of Directors		
1. Slate of Candidates		
2. Call for Floor Nominations		
B. President-Elect		
1. Slate of Candidates		
2. Call for Floor Nominations		

Saturday, October 3, 2026 (*Continued*)

15. Candidate Opening Statements	Dr. Traill	
A. Board of Directors Candidates (2 minutes each)		9:00 am
B. President-Elect Candidates (5 minutes each)		9:20 am
16. Reference Committee Assignments	Dr. McCrea	9:35 am
BREAK		***9:40 am – 10:00 am***
17. Reference Committee Hearings		10:00 am – 1:00 pm
A – Governance & Membership – *W178 AB (Level 1)*		
B – Advocacy & Public Policy – *W179 AB (Level 1)*		
C – Emergency Medicine Practice – *W181 AB (Level 1)*		
Boxed Lunches Available – Reference Committee Meeting Rooms Foyer (Level 1)		***11:00 am – 12:30 pm***
18. Reference Committee Executive Sessions		1:00 pm – 2:15 pm
A – *W178 AB (Level 1)*		
B – *W179 AB (Level 1)*		
C – *W181 AB (Level 1)*		
BREAK – Return to main Council meeting room – Skyline Ballroom W375CDE (Level 3)		***1:00 pm – 1:30 pm***
19. Candidate Forum for President-Elect Candidates	Dr. Traill	1:30 pm – 2:15 pm
BREAK – Return to Reference Committee meeting rooms *W178 AB, W179 AB, W181 AB (Level 1)*		***2:15 pm – 2:30 pm***
20. Candidate Forum for Board of Directors		2:30 pm – 3:45 pm
Candidates rotate through Reference Committee meeting rooms.		
BREAK – Return to main Council meeting room – Skyline Ballroom W375CDE (Level 3)		***3:45 pm – 4:00 pm***
21. Speaker's Report	Dr. McCrea	4:00 pm
22. In Memoriam	Dr. McCrea	4:15 pm
A. Reflection and Moment of Silence	Dr. Traill	
Adopt memorial resolutions by observing a moment of silence.		
23. EMRA Report	Dr. Wiltz	4:25 pm
24. ABEM Report	Dr. Ankel	4:35 pm
25. AMA Section Council on Emergency Medicine Report	Dr. Epstein/Dr. Heine	4:40 pm
26. Secretary-Treasurer's Report	Dr. Mehrotra	4:45 pm
27. President's Address	Dr. Cirillo	4:50 pm
RECESS		***5:10 pm***

Candidate Reception ● 5:30 pm – 6:30 pm ● Marriott, Glessner House ABC (Level 3)

Sunday, October 4, 2026

Continental breakfast available – North Prefunction (MPCC, Level 3)		***7:30 am***
1. Call to Order	Dr. McCrea	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Veitinger	8:00 am
3. Electronic Voting A. Electronic Voting Testing	Dr. Veitinger	8:05 am
4. EMF Report	Dr. Hirshon	8:30 am
5. NEMPAC Report	Dr. Parker	8:35 am
6. Submitting Amendments Electronically	Dr. McCrea	8:40 am
7. Reference Committee Reports A. Reference Committee ___ B. Reference Committee ___		8:45 am
8. Awards Luncheon – *Marriott, Grand Horizon A-D (Level 4)*		12:00 pm
A. Welcome	Dr. McCrea	12:40 pm
1. Recognition of Past Speakers and Past Presidents		
2. Recognition of Current and Past Board Members		
3. Recognition of Chapter Executives		
B. ACEP Awards Announcements	Dr. Cirillo	
C. Reading and Presentation of Commendation Resolutions *Adopt by acclamation.*	Dr. McCrea/Dr. Traill	
D. Council Award Presentations	Dr. McCrea/Dr. Traill	
1. Council Service Milestone Awards – *5, 10, 15, 20, 25, 30, 35, 40+ Year Councillors*		
2. Council Teamwork Award		
3. Council Horizon Award		
4. Council Champion in Access, Belonging, & Community Award		
5. Council Curmudgeon Award		
6. Council Meritorious Service Award		
LUNCHEON ADJOURNS – Return to main Council meeting room – Skyline Ballroom (Level 3)		***1:30 pm***
9. Tellers, Credentials, & Elections Committee Report	Dr. Veitinger	1:45 pm
10. Reference Committee Reports Continue C. Reference Committee ___		1:50 pm
11. President-Elect's Address	Dr. Stanton	4:45 pm
12. Installation of President	Dr. Cirillo/Dr. Stanton	5:05 pm
13. Tellers, Credentials, & Elections Committee Report	Dr. Veitinger	5:10 pm
14. Elections A. Board of Directors B. President-Elect	Dr. Veitinger	5:10 pm
15. Announcements	Dr. McCrea	5:40 pm
ADJOURN		***5:45 pm***

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting

Table of Contents

TAB

01 2026 Council Steering Committee Members

02 Procedures for Councillor and Alternate Seating

03 Councillor Seating Chart

04 Councillor Roster

05 Councillor Handbook

06 Council Standing Rules

07 Bylaws

08 College Manual

09 Minutes
- a. Council Meeting Minutes – September 5-6, 2025
- b. Steering Committee Meeting Minutes – January 29, 2026
- c. Steering Committee Meeting Minutes – April 26, 2026

10 Definition of Council Actions

11 Reference Committee Assignments

12 2026 Resolutions

13 Reports from the Board of Directors
- ACEP Composition Annual Report
- Compensation Committee Report

14 Board Action on 2025 Council Resolutions

15 Board Action on 2024 Council Resolutions

16 Board Action on 2023 Council Resolutions

17 President-Elect Candidates
- Heidi C. Knowles, MS, MD, FACEP
- Kristin B. McCabe-Kline, MD, FACEP
- James L. Shoemaker, Jr., MD, FACEP

18 Board of Directors Candidates
- Torree M. McGowan, MD, FACEP
- Abhi Mehrotra, MD, MBA, FACEP
- Heather S. Owen, MD, FACEP
- Henry Z. Pitzele, MD, FACEP
- Alexandra Nicole Thran, MD, FACEP

19 2026 Award Recipients

20 Strategic Plan

21 Emergency Medicine Foundation Report

22 National Emergency Medicine Political Action Committee Report

23 Emergency Medicine Residents' Association Report

24 Secretary-Treasurer's Report

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Steering Committee

Updated January 2026



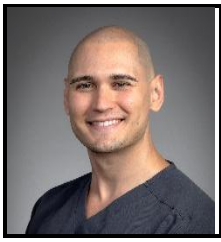
Michael J. McCrea, MD, FACEP
- Speaker

Perrysburg, OH



Larisa M. Traill, MD, FACEP
Vice Speaker

Commerce Township, MI



Joshua S. da Silva, DO, FACEP

Columbus, OH



Herbert C. Duber, MD, MPH, FACEP

Seattle, WA



Puneet Gupta, MD, FACEP

Long Beach, CA



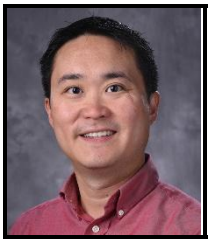
Steven Hochman, MD, FACEP

Montclair, NJ



Jolie C. Holschen, MD, FACEP

Chicago, IL



Antony Hsu, MD, ACEP

Ann Arbor, MI



Greg A. Juhl, MD, FACEP

Reno, NV



David Nestler, MD, MS, FACEP

Rochester, MN



Jennifer Savino, DO, FACEP

Lilly, PA



Aaron Snyder, MD

Albuquerque, NM



Sophia Spadafore, MD, MA

New York, NY



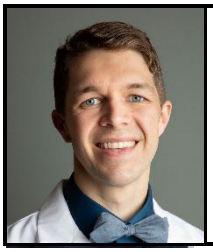
Daniel S. Udrea, MD, FACEP

Indianapolis, IN



Nicole A. Veitinger, DO, FACEP

Columbus, OH



William Weber, MD, MPH, FACEP

Minneapolis, MN



Carole Wright Becker, MD, MBA, FACEP

Morgantown, WV



Ian Brodka, MD,
(EMRA REP to Steering Committee)

Ypsilanti, MI

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Procedures for Councillor and Alternate Seating

Councillor Credentialing

All certified councillors and alternates must be officially credentialed at the annual meeting.

1. A master list of all certified councillors and alternates will be maintained at councillor credentialing.

2. If a councillor is not certified on the master list, the following steps will be followed:

    a. Only the component body (chapter president or executive staff, section chair or staff, EMRA president or staff, AACEM president or staff, CORD president or staff, SAEM president or staff, ACOEP president or staff), also known as sponsoring body, can certify a member to be credentialed as a councillor. The component body must also identify whom the new councillor will replace. No councillor will be certified without final confirmation from the component body.

    b. If the chapter president, section chair, EMRA president, AACEM president, CORD president, SAEM president, ACOEP president, or staff executive of the component body is not available, seating will be denied. Only a certified alternate councillor may be seated on the Council floor.

    c. If no certified councillor or alternate of a component body is present at the meeting, a member of that sponsoring body may be seated as a councillor pro tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council.

As stated in the Bylaws, Article VIII – Council, Section 5 – Voting Rights:

> "Each sponsoring body shall deposit with the secretary of the Council a certificate certifying its councillor(s) and alternate(s). The certificate must be signed the president, secretary, or chairperson of the sponsoring body. No councillor or alternate shall be seated who is not a member of the College. College members not specified in the sponsoring body's certificate may be certified and credentialed at the annual meeting in accordance with the Council Standing Rules.
>
> ACEP Past Presidents, Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."
>
> Whenever the term "present" is used in these Bylaws with respect to councillor voting, it shall mean credentialed as certified by the chair of the Tellers, Credentials, & Elections Committee."

Only councillors or alternates certified by the component body may be seated on the Council floor. Only the appropriate individual from a component body may authorize seating of their non-certified councillors. All of the College's past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor. A past president, past Council speaker, or past Chair is only permitted to vote when serving as a certified councillor.

If the appropriate individual from the component body is not present to authorize seating of a non-certified councillor or alternate, then the request for seating must be made directly to the chair of the Tellers, Credentials, & Elections Committee.

Seating of Past Presidents, Past Council Speakers, and Past Chairs of the Board

1. Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor.

2. Each past president, Council speaker, and past Chairs of the Board sitting with their delegation should be credentialed and are required to wear the appropriate identification giving them access to the Council floor.

3. Past leaders have the full privilege of the floor, including the proposal of motions and amendments, except that they may not vote unless serving as a regular voting councillor or alternate.

Voting Cards and Electronic Voting

1. Each credentialed councillor will receive a voting card with their name and component body.

2. Voting will be conducted by either voting card, online electronic voting, keypads (if applicable), or voice votes at the discretion of the Speaker.

3. The Tellers, Credentials, & Elections Committee will periodically check the Council delegations to ensure that only the authorized voting cards and keypads (if applicable) are used.

Seating Exchange Between Credentialed Councillors and Alternates

1. No exchange between a councillor and alternate is permitted during the Council meeting while a motion is on the floor of the Council. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

2. To make an exchange, the councillor should leave their voting card and keypad (if applicable) on the table. The alternate may then proceed to take the seat of the designated councillor, unless debate is occurring on the Council floor. **No exchange is permitted until final action is taken on a particular issue.**

3. If a councillor is leaving the floor of the Council, and there will **not** be an alternate replacement, the councillor must return the voting card and keypad (if applicable) to staff at councillor credentialing. Once the councillor returns, the voting card and keypad (if applicable) will be returned to the councillor. If debate is occurring on the Council floor, the councillor should wait until final action has been taken on a particular issue before returning to the seat on the Council floor.

2026 Councillor Seating Chart

SECRETARY PARLIAMENTARIAN SPEAKER VICE SPEAKER

	PROJECTION STAFF		**441 + 40 Leaders=481**	
1	AACEM=1 ABC=1 AAWEP=1 AirMed=1 AK=2 AL=5 AR=3	AZ = 10 Careers =1 Critical Care = 1 Cruise Ship =1	CA=15	1
2	CO=8 CORD=1 DE=2 Democratic=1 Disaster=1 Dual=1	CT-7 DC=4 Early Career=1 EMS=1 Event Med=1	CA=15	2
3	EMRA=8 FL=7	Government Svcs=14 Explore Retirement=1	CA=9 EMPHP=1 Forensics=1 Freestanding=1 Geriatric=1 Global EM=1	3
4	FL=15	GA=10 ID=3	IA=3 KS=3 KY=4 LA=4	4
5	FL=6 HI=2 Informatics=1 IN=6	IL=13 Locums=1	MI=15	5
6	MD=8 ME=3 Med Director=1 Med Humanities=1	MA=10 Observation=1 Pain Management=1 Palliative=1	MI=5 NH=2 NY=5	6
7	MN=8 MS=3 Peds=1 Prof Well Being=1 QIPS=1	MO=7 MT=2 NE=2 NV=4	NY=15	7
8	NJ=12 Research=1 Rural=1	NM=5 ND=1 OH=9	NY=13 Tactical=1 Telehealth=1	8
9	NC=13 PR=2	OH=10 OK=5	TN=5 TX=10	9
10	OR=5 PA=10	RI=3 Social EM=1 SC=5 SD=1 Sports Med=1 UT=4	TX=15	10
11	PA=10 SAEM=1 Toxicology=1 Trauma=1 Ultrasound=1	VA=11 VT=2	Undersea=1 WA=10 Wilderness=1	11
12	WV=4 WI=6 Workforce=1 WY=1	BOD		12
13		BOD		13

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Past Presidents, Past Council Speakers, and Past Chairs of the Board Seating

Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor (see seating chart). The 2026 councillor seating chart includes the following:

Alabama	4 councillors + 1 past leader attending not serving as a councillor = 5 seats
Arizona	8 councillors + 2 past leaders attending not serving as councillors = 10 seats
California	34 councillors + 5 past leaders attending not serving as councillors = 39 seats
Colorado	7 councillors + 1 past leader attending not serving as councillors =8 seats
Connecticut	5 councillors + 2 past leaders attending not serving as councillors = 7 seats
District of Columbia	4 councillors + 1 past leader attending not serving as councillor = 5 seat
Florida	23 councillors + 4 past leaders attending not serving as councillors = 27 seats
Georgia	9 councillors + 1 past leaders attending not serving as councillors = 10 seats
Government Services	12 councillors + 2 past leaders attending not serving as councillors = 14 seats
Maryland	6 councillors + 2 past leaders attending not serving as councillors = 8 seats
New Jersey	11 councillors +1 past leaders attending and not serving as councillors = 12 seats
New Mexico	3 councillors + 2 past leaders attending and not serving as councillors = 5 seats
New York	32 councillors + 1 past leader attending not serving as councillors = 33 seats
North Carolina	12 councillors + 1 past leader attending not serving as councillors = 13 seats
Ohio	16 councillors + 3 past leaders attending not serving as councillors = 19 seats
Oklahoma	4 Councillors + 1 past leader attending not serving as a councillors = 5 seats
Pennsylvania	19 councillors + 1 past leader attending not serving as a councillors = 20 seats
Texas	22 councillors + 3 past leaders attending not serving as councillors = 25 seats
Virginia	9 councillors + 2 past leaders attending not serving as councillors = 11 seats
Washington	7 councillors + 3 past leaders attending not serving as councillors = 10 seats
West Virginia	3 councillors + 1 past leader attending not serving as councillors = 4 seats

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2026 COUNCILLORS & ALTERNATE COUNCILLORS

Chapter/Section	Position	Name
AACEM	Councillor	Mary Tanski, MD, FACEP
	Alternate	Susan B Promes, MD, MBA, FACEP
ALABAMA CHAPTER	Councillor	Brandon Buchel, MD
	Councillor	Stephen William Knight, MD, FACEP
	Councillor	Therese Michelle Medalle, MD, FACEP
	Councillor	Benjamin Von Schweinitz, MD, FACEP
	Alternate	Melissa Wysong Costello, MD, FACEP
	Alternate	William Randall Davis, MD
	Alternate	Shea A Duerring, MD, FACEP
ALASKA CHAPTER	Councillor	Helen Call Adams, MD, FACEP
	Councillor	Diana M Biggs, MD
ARIZONA CHAPTER	Councillor	Lawrence A DeLuca, Jr, MD, FACEP
	Councillor	Olga Gokova, MD, FACEP
	Councillor	Nicole R Hodgson, MD, FACEP
	Councillor	Paul Andrew Kozak, MD, FACEP
	Councillor	Wendy Ann Lucid, MD, FACEP
	Councillor	Wayne A Martini, Jr, MD, FACEP
	Councillor	Megan L McElhinny, MD, FACEP
	Councillor	Anthony C Wong, MD, FACEP
ARKANSAS CHAPTER	Councillor	J Shane Hardin, MD, PhD, FACEP
	Councillor	Brian L Hohertz, MD, FACEP
	Councillor	Robert Thomas VanHook, MD, FACEP
CALIFORNIA CHAPTER	Councillor	Jailyn Avila, MD, RDMS
	Councillor	Karen Chung, MD
	Councillor	Nida F Degesys, MD, FACEP
	Councillor	Fred Dennis, MD, MBA, FACEP
	Councillor	Cassandra Morgan Dewitt, MD
	Councillor	Sukhjit Dhillon, MD
	Councillor	Adam P Dougherty, MD, FACEP
	Councillor	Robert Edward Dunn, MD
	Councillor	Larry Anthony Eseberre, MD
	Councillor	Nicole Elizabeth Exeni McAmis, MD
	Councillor	Douglas Everett Gibson, MD, FACEP
	Councillor	Alicia Mikolaycik Gonzalez, MD, FACEP
	Councillor	Hannah Gordon, MD, MPH
	Councillor	Kamara W Graham, MD, FACEP
	Councillor	Jason Greenspan, MD, FACEP
	Councillor	Aaron J Harries, MD
	Councillor	Macklin Iliff, DO
	Councillor	Andy Hung-Yi Lee, MD, MBA, FACEP
	Councillor	Christopher Libby, MD, MPH, FACEP
	Councillor	Patrick J Maher, MD, FACEP
	Councillor	Aimee K Moulin, MD, FACEP



2026 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Valerie C Norton, MD, FACEP
	Councillor	Comfort Arinola Adeola Orebayo, DO
	Councillor	Kelly E Quinley, MD
	Councillor	Vivian Reyes, MD, FACEP
	Councillor	Patrick K Shanovich, MD, FACEP
	Councillor	Susanne J Spano, MD, FACEP
	Councillor	Katherine Laurinda Staats, MD, FAEMS, FACEP
	Councillor	Thomas Jerome Sugarman, MD, FACEP
	Councillor	Gary William Tamkin, MD, FACEP
	Councillor	Alexander Tran, MD
	Councillor	Neelou Weeker, DO
	Councillor	Lori D Winston, MD, FACEP
	Councillor	Anna L Yap, MD
	Alternate	Amy P Anton, MD, FACEP
	Alternate	Rodney W Borger, MD, FACEP
	Alternate	Marc Gautreau, MD, FACEP
	Alternate	Vikant Gulati, MD, FACEP
	Alternate	Maricarmen Hernandez, DO
	Alternate	Leslie Mukau, MD, FACEP
	Alternate	Brenda Odamen Oiyemhonlan, MD, MHSA, MPH
	Alternate	Vineet K. Sharma, MD, FACEP
	Alternate	Paul-Thomas Tremoulet, MD, FACEP
	Alternate	Patrick Um, MD, FACEP
	Alternate	Bradley Alan Zlotnick, MD, FACEP
COLORADO CHAPTER	Councillor	Jacob Mark Altholz, MD
	Councillor	Jasmeet Singh Dhaliwal, MD MPH MBA, FACEP
	Councillor	Ramnik S Dhaliwal, MD, JD
	Councillor	Laura Edgerley-Gibb, MD, FACEP
	Councillor	Anna Engeln, MD, FACEP
	Councillor	Kristen Nordenholz, MD, FACEP
	Councillor	Megan Purdy, MD
	Alternate	Marc Andrew Doucette, MD
	Alternate	Douglas M Hill, DO, FACEP
	Alternate	William Martin Hilty, MD
	Alternate	Carla Elizabeth Murphy, DO, FACEP
	Alternate	James D Thompson, MD, FACEP
CONNECTICUT CHAPTER	Councillor	Carlos Patrick Holden, MD, FACEP
	Councillor	Vivek L Parwani, MD, FACEP
	Councillor	Gregory L Shangold, MD, FACEP
	Councillor	Douglas Anthony Smith, DO, FACEP
	Councillor	Kevin Joseph Sprague, II, MD
	Alternate	Michael L Carius, MD, FACEP
	Alternate	Christopher L Moore, MD, FACEP
	Alternate	Elizabeth Schiller, MD, FACEP
	Alternate	David E Wilcox, MD, FACEP



2026 COUNCILLORS & ALTERNATE COUNCILLORS

CORD	Councillor	Jason Cass Wagner, MD, FACEP
	Alternate	Jaime Jordan, MD, FACEP
DELAWARE CHAPTER	Councillor	Kathryn Groner, MD, FACEP
	Councillor	John T Powell, MD, MHCDS, FACEP
	Alternate	Lee Colaianni, MD, FACEP
DISTRICT OF COLUMBIA CHAPTER	Councillor	Christopher T Clifford, MD
	Councillor	Rita A Manfredi-Shutler, MD, FACEP
	Councillor	Natasha N Powell, MD MPH MEd, FACEP
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Councillor	Brittany Botticelli, MD
	Councillor	Ian Brodka, MD
	Councillor	Grace Katherine Bunemann, DO
	Councillor	Anna Siobhan Heffron, MD
	Councillor	Kailey Denise Jacobson, DO
	Councillor	Alexandra Frances Sappington, DO
	Councillor	David Wilson, MD
	Councillor	Pauline Wiltz, DO
	Alternate	Nicholas Sebastian Imperato, DO, MPH
	Alternate	Katarina Jones, MD
	Alternate	Jacqueline King, MD
	Alternate	Kelsey Mercedes Morgan, MD
	Alternate	Elizabeth Anne Nisper, MD
	Alternate	Kirstin W Scott, MD, MPhil, PhD
	Alternate	Miranda Teixeira, MD
	Alternate	Louisa James Weindruch, DO
	Alternate	Sydni Iman Williams, MD, MSc
FLORIDA CHAPTER	Councillor	Dania Abu-Jubara, DO
	Councillor	Patrick R Anderson, DO
	Councillor	Andrew I Bern, MD, FACEP
	Councillor	Kevin Bertrand, DO
	Councillor	Blake Buchanan, MD, FACEP
	Councillor	Stuart James Bumgarner, MD
	Councillor	Damian E Caraballo, MD, FACEP
	Councillor	Jordan Celeste, MD, FACEP
	Councillor	Brandon Joseph Chavez, DO
	Councillor	Taylor Norelle Craig, MD
	Councillor	Anton Gomez, DO, FACEP
	Councillor	Kelly Gray-Eurom, MD, MMM, FACEP
	Councillor	Shayne M Gue, MD, FACEP
	Councillor	Saundra A Jackson, MD, FACEP
	Councillor	Joseph M King, MD
	Councillor	Mike Lozano, Jr, MD, MSHI, FACEP
	Councillor	Ryan T McKenna, DO, FACEP
	Councillor	Brandy Milstead, MD
	Councillor	Jeremy K Selley, DO, FACOEP, FACEP



2026 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Topazio Sherer Almonte, MD
	Councillor	Todd L Slesinger, MD, FACEP
	Councillor	Ian David Storch, MD, FACEP
	Councillor	Josef George Thundiyil, MD, MPH, FACEP
GEORGIA CHAPTER	Councillor	Matthew R Astin, MD, FACEP
	Councillor	Brett H Cannon, MD JD MBA, FACEP
	Councillor	Shamie Das, MD, MBA, MPH, FACEP
	Councillor	James Joseph Dugal, MD, FACEP(E)
	Councillor	Matthew Taylor Keadey, MD, FACEP
	Councillor	Jeffrey F Linzer, Sr, MD, FACEP
	Councillor	James L Smith, Jr, MD, FACEP
	Councillor	Johnny L Sy, DO, FACEP
	Councillor	Matthew J Watson, MD, FACEP
	Alternate	Mark A Griffiths, MD, FACEP
	Alternate	Brendan Hawthorn, MD, FACEP
	Alternate	Benjamin Lefkove, MD, FACEP
	Alternate	Laura Oh, MD, FACEP
	Alternate	Alison Ruch, MD, FACEP
	Alternate	Matthew Rudy, MD, FACEP
	Alternate	Carmen D. Sulton, MD, FACEP
	Alternate	Kathryn West, MD, FACEP
	Alternate	John L Wood, MD, FACEP
GOVT SERVICES CHAPTER	Councillor	Michael Joel Chiappone, DO, FACEP
	Councillor	Christine A DeForest, DO, FACEP
	Councillor	Alan Jeffrey Hirshberg, MD, MPH, FACEP
	Councillor	Aicha M Hull, FACEP, MD
	Councillor	Micaela A LaRose, MD
	Councillor	David S McClellan, MD, FACEP
	Councillor	Torree M McGowan, MD, FACEP
	Councillor	Evan Miller, DO
	Councillor	Mike Ramirez, MD
	Councillor	Paul James Diggins Roszko, MD, FACEP
	Councillor	Cynthia Shen, DO, FACEP
	Councillor	Justine K Stremick, MD, FACEP
	Alternate	Katey Osborne, MD, FACEP
	Alternate	Gillian Schmitz, MD, FACEP
	Alternate	Sean Stuart, DO, FACEP
HAWAII CHAPTER	Councillor	Nathan Angle, MD
	Councillor	John M Gallagher, MD, FACEP
	Alternate	Thinh Tien Nguyen, MD, FACEP
IDAHO CHAPTER	Councillor	Ken John Gramyk, MD, FACEP
	Councillor	Christian Menard, MD, PhD, FACEP
	Alternate	Lauren E Apgar, DO
	Alternate	Heather S Hammerstedt, MD, FACEP

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2026 COUNCILLORS & ALTERNATE COUNCILLORS

ILLINOIS CHAPTER	Councillor	Halleh Akbarnia, MD, MPH, FACEP
	Councillor	Nicholas Paul Cozzi, MD, MBA, FACEP
	Councillor	Kristen M Donaldson, MD, MPH, FACEP
	Councillor	Kelly Jester Geldmacher, MD, FACEP
	Councillor	Samantha A Hay, MD
	Councillor	Adnan Hussain, MD, FACEP
	Councillor	Jason A Kegg, MD, FACEP
	Councillor	Joshua J Miksanek, MD, FACEP
	Councillor	Joseph S Palter, MD
	Councillor	Monika Pitzele, MD, PhD, FACEP
	Councillor	Yanina Purim-Shem-Tov, MD, MS, FACEP
	Councillor	Willard W Sharp, MD, PhD, FACEP
	Councillor	Deborah E Weber, MD, FACEP
	Alternate	Huda Abughannam, DO
	Alternate	Shruthi Bhuma, MD
	Alternate	Anirudh Dhananjay Chitale, MD
	Alternate	Charmayne Gail Cooley, MD
	Alternate	Katarzyna Maria Gore, MD, FACEP
	Alternate	Jolie C Holschen, MD, FACEP
	Alternate	Janet Lin, MD, FACEP
INDIANA CHAPTER	Councillor	Michael D Bishop, MD, FACEP
	Councillor	Timothy A Burrell, MD, MBA, FACEP
	Councillor	Kyle D English, MD, FACEP
	Councillor	Tracy Rene Rahall, MD, FACEP
	Councillor	Nicholas George Sansone, DO, FACEP
	Councillor	Eric B Yazel, MD, FACEP
	Alternate	Sara Ann Brown, MD, FACEP
	Alternate	Benjamin Chastain, MD
	Alternate	Daniel W Elliott, MD, FACEP
	Alternate	Emily M Fitz, MD, FACEP
	Alternate	Christian Ross, MD, FACEP
	Alternate	Daniel S Udrea, MD, FACEP
	Alternate	Lindsay Zimmerman, MD, FACEP
IOWA CHAPTER	Councillor	Thomas E Benzoni, DO, FACEP
	Councillor	Amanda K Irish, MD, MPH, MS, DTMH, FACEP
	Councillor	Gabe D Lancaster, MD
	Alternate	Gary Thomas Hemann, DO, FACP, FACEP
	Alternate	Hans Roberts House, MD, FACEP
	Alternate	Thomas Michael Wernimont, MD, FACEP
KANSAS CHAPTER	Councillor	Joshua J Davis, MD
	Councillor	Trevor S Mattox, MD
	Councillor	Matthew S Sinnwell, MD, FACEP
	Alternate	Nancy Blanchat, MD, FACEP
	Alternate	Howard Chang, MD, FACEP
KENTUCKY CHAPTER	Councillor	Christopher W Pergrem, MD, FACEP



2026 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Isaac Shaw, MD, FACEP
	Councillor	Hugh W Shoff, MD MS, FACEP
	Councillor	Beth Spurlin, MD, PhD, MBA, FAAP
	Alternate	Steven Joseph Stack, MD, MBA, FACEP
LOUISIANA CHAPTER	Councillor	Deborah D Fletcher, MD, FACEP
	Councillor	Jamie Kuo, MD, MHLA, FACEP
	Councillor	Phillip Luke LeBas, MD, FACEP
	Councillor	Michael D Smith, MD MBA CPE, FACEP
	Alternate	Genevieve Schult Krajewski, MD
	Alternate	Daniel J Sessions, MD
	Alternate	Jordan N Vaughn, MD
MAINE CHAPTER	Councillor	Garreth C Debiegun, MD, FACEP
	Councillor	Brandon E Giberson, DO, FACEP
	Councillor	James B Mullen, III, MD, FACEP
	Alternate	Andrew Ehrhard, MD, FACEP
	Alternate	E Chin Mak, MD
	Alternate	Kelly Ann Meehan-Coussee, MD, FACEP
	Alternate	Laurel Parker, MD, FACEP
	Alternate	Jessica Stevens, MD, MPH
MARYLAND CHAPTER	Councillor	Kyle Fischer, MD, MPH, FACEP
	Councillor	Daniel Benjamin Gingold, MD, MPH, FACEP
	Councillor	Jonathan Lewis Hansen, MD, FACEP
	Councillor	Carolina Mendoza, MD, MBA
	Councillor	Debra Michele Ravert, MD, FACEP
	Councillor	Richard Gentry Wilkerson, MD, FACEP
	Alternate	Michael C Bond, MD, FACEP
	Alternate	Kerry Forrestal, MD, FACEP
MASSACHUSETTS CHAPTER	Councillor	Olyn A Andrade, MD
	Councillor	Maureen Canellas, MD, MBA, FACEP
	Councillor	Amy Costigan, MD, FACEP
	Councillor	Stephen K Epstein, MD, MPP, FACEP
	Councillor	Gayle Marie Galletta, MD, FACEP
	Councillor	Kathleen Kerrigan, MD, FACEP
	Councillor	Joseph William Kopp, MD, FACEP
	Councillor	Allison Ramler, MD, FACEP
	Councillor	Michele Schroeder, MD, FACEP
	Councillor	Jake Whitney, MD
MICHIGAN CHAPTER	Councillor	Michael J Baker, MD, FACEP
	Councillor	Abigail Brackney, MD, FACEP
	Councillor	Miriam A Bukhsh, MD, MPH
	Councillor	Sara S Chakel, MD, FACEP
	Councillor	Pamela N Coffey, MD, FACEP
	Councillor	Bram A Dolcourt, MD, FACEP
	Councillor	Frank Y Duncan, III, MD, FACEP



2026 COUNCILLORS & ALTERNATE COUNCILLORS

	Councillor	Gregory Gafni-Pappas, DO, FACEP
	Councillor	Antony P Hsu, MD, FACEP
	Councillor	Rami R Khoury, MD, FACEP
	Councillor	Robert T Malinowski, MD, FACEP
	Councillor	Emily M. Mills, MD, FACEP
	Councillor	James C Mitchiner, MD, MPH, FACEP
	Councillor	David T Overton, MD, FACEP
	Councillor	Diane Paratore, DO, MBA, MEd, FACEP
	Councillor	Luke Christopher Saski, MD, FACEP
	Councillor	Andrew Taylor, DO, FACEP
	Councillor	Michael Tupper, MD, FACEP
	Councillor	Bradley J Uren, MD, FACEP
	Councillor	Bradford L Walters, MD, FACEP
	Alternate	Michaelina R Bolton, MD, FACEP
	Alternate	Matthew J Boutorwick, DO
	Alternate	Kathleen Cowling, DO, MS, MBA, FACEP
	Alternate	Eric Davis, MD
	Alternate	David Eisenbrey, MD, FACEP
	Alternate	Brittany M Garza, DO
	Alternate	Jeffrey McGowan, DO, FACEP
	Alternate	Igor Middlebrook, DO, MS, FACEP
	Alternate	Henry E Moss, DO
	Alternate	Rupinder K Sekhon, MD, FACEP
	Alternate	Sara Urquhart, MD
	Alternate	Helena H Wang-Flores, DO, FACEP
MINNESOTA CHAPTER	Councillor	Paul C Allegra, MD, FACEP
	Councillor	Heather Ann Heaton, MD, FACEP
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Councillor Handbook

Councillor Handbook

Table of Contents

I. COMPOSITION OF THE COUNCIL 3
Introduction 3
What is the Council? 3
What Does the Council Do? 3

II. COUNCILLOR PREPARATION 3
How Does a Councillor Prepare for the Annual Meeting? 3
How Does the Council Conduct its Business? 4
What is a Resolution? 4
Amendments to Resolutions 5
Emergency Resolutions 5
Late Resolutions 5
What if I Have Questions About the Council? 5
How are Nominations and Elections Conducted? 5
What is the Steering Committee? 6

III. COUNCIL REFERENCE COMMITTEES 6
Asynchronous Testimony 6
Procedures 7
Proceedings 7
Reports 8

IV. GUIDELINES AND DEFINITIONS OF COUNCIL ACTIONS TO ASSIST THE COUNCIL IN CONSIDERING REPORTS OF REFERENCE COMMITTEES. 9
Adopt 9
Adopt as Amended 9
Refer 9
Not adopt 9

V. BASIC RULES GOVERNING MOTIONS 10

VI. INCIDENTAL MOTIONS 11

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS 11
Questions 11

VIII. PARLIAMENTARY MOTIONS GUIDE 12-13

I. COMPOSITION OF THE COUNCIL

Introduction

This handbook is updated annually to help councillors understand how they can best be prepared to participate in the annual meeting. The councillor who knows how the Council functions, who takes the time to understand issues affecting the College and the specialty, and who makes a point of talking with individual candidates for office about their objectives is a model representative.

What is the Council?

The Council is a body composed of emergency physicians who directly represent the 53 chartered chapters of the American College of Emergency Physicians, the Emergency Medicine Residents' Association (EMRA), the Association of Academic Chairs in Emergency Medicine (AACEM), the American College of Osteopathic Emergency Physicians (ACOEP), the Council of Emergency Medicine Residency Directors (CORD), the Society for Academic Emergency Medicine (SAEM), and the College's sections of membership. The Council meets annually, just prior to the ACEP annual meeting. The Council may meet more often, but special meetings must be duly called as specified in the ACEP Bylaws.

The number of councillors representing a chapter in a given year is determined by the number of members in that chapter as shown by the average membership roll of the College of the preceding calendar year. The average is calculated by using the count of primary members in each chapter on the first day of the month then adding together each month's total and dividing by 12. Each chapter is represented by at least one councillor; an additional councillor is allowed for each 100 members in the chapter. EMRA is allocated eight voting councillors; AACEM, ACOEP, CORD, and SAEM, are each allocated one voting councillor; and each section of membership is allocated one voting councillor.

What Does the Council Do?

The Council elects the Board of Directors, Council officers, and the president-elect of the College. The Council shares responsibility with the Board of Directors for initiating policy, and councillors shape the strategic plan of the College by providing comments on behalf of the constituencies they represent. The Council also provides a participatory environment where policies already established or under consideration by the Board of Directors can be debated.

So that the Board of Directors can manage change for the good of the membership, the specialty, and the public, the Council serves as a sounding board and communication network. Councillors are expected to be aware of environmental changes, see association goals as essential to the continued vitality of the specialty, and understand the rationale behind decisions made by the Board of Directors.

The Council officers (speaker and vice speaker) chair the annual meeting and participate in all meetings of the Board of Directors as representatives of the Council.

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

Councillors are certified by their component body (chapter, EMRA, AACEM, ACOEP, CORD, SAEM, or section) no later than 60 days before the annual meeting. Component bodies are also referred to as sponsoring bodies in the Bylaws.

Comprehensive materials are distributed to councillors at least 30 days before the annual meeting. These materials contain the meeting agenda, current strategic plan, minutes of the previous annual meeting, and annual committee reports. All resolutions submitted by the deadline are also provided with background information and cost implications developed by staff.

Councillors are expected to review the materials carefully and to meet with the leadership of the component bodies they represent to discuss issues that will be addressed at the annual meeting. The component body leadership may want to instruct the councillor on how to vote on various resolutions, but the councillor should

be open to receiving additional information at the meeting and then make the best decision on behalf of the College.

How Does the Council Conduct its Business?

Regular business or business casual attire is appropriate for the Council meeting.

Most of the work of the Council is conducted in Reference Committee hearings. The hearings provide a system for gathering information and expediting business. Each resolution submitted to the Council is referred to a Reference Committee, which holds a hearing to gather information from all interested councillors and other College members. The Reference Committees then recommend a specific course of action for the Council on each resolution. Reference Committees are composed of councillors selected by the Council officers. Guidelines for reference committee hearings are provided on pages 5-7. All Reference Committee meetings are open to the membership, except for the executive session. When the executive session is called, the chair will inform the audience of the time frame of the session.

As previously stated, the Council elects the Board of Directors, Council officers, and the president-elect; initiates policy; and shapes the strategic plan of the College. The Council also identifies issues for study and evaluation by the Board and the committees of the Board. There is usually a tremendous amount of business to be conducted during the two-day meeting and several tools are used to facilitate that business.

The Bylaws of the College specifies basic procedures that must be followed by the Council. These procedures include how nominations and elections must be conducted, how resolutions must be submitted and handled, and how the Bylaws may be amended. The most current Bylaws are provided with the Council meeting materials.

Standing Rules for the conduct of the meeting change little, if any, from one year to the next and cover general procedures such as how debate, credentialing, and elections will be handled. The Standing Rules are amendable only by resolution. The most current Standing Rules are provided with the Council meeting materials.

Except when superseded by the Bylaws or the Standing Rules, the rules in *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure* govern the Council in all applicable cases. A chart describing parliamentary rules is provided on pages 12-13.

A councillor is not expected to memorize the Bylaws, Standing Rules, or *The Standard Code;* however, a quick review of these documents will give the first-time councillor a basic understanding of how business is conducted on the floor of the Council. The most important rule that a councillor should remember is that a "point of personal privilege" is always in order. If a councillor does not understand what is happening, the point of personal privilege should be used to request clarification. An orientation session is always held the night before the Council meeting and the basics of parliamentary procedure are reviewed.

What is a Resolution?

New policies and changes to existing policy are recommended to the Council in the form of resolutions. Resolutions usually pertain to issues affecting the practice of emergency medicine, advocacy and regulatory issues, Bylaws amendments, Council Standing Rules amendments, and College Manual amendments.

"Resolutions" are considered formal motions that if adopted will become official Council policy and will apply not only to the present meeting but also to future business of the Council.

Resolutions must be submitted in writing by at least two members on or before 90-days prior to the annual Council meeting. These resolutions are known as "regular resolutions." Resolutions may also be submitted by chapters, sections, committees, or the Board of Directors. Resolutions sponsored by a chapter or section must be accompanied by an endorsement of the sponsoring body. Resolutions sponsored by national ACEP committees must first be approved by the Board of Directors for submission to the Council. Upon approval by the Board, the resolution will then include the endorsement of the committee and the Board. Regular resolutions will be referred to an appropriate Reference Committee for consideration.

Amendments to Resolutions

All motions for substantial amendments to resolutions must be submitted to the speaker in writing prior to being introduced verbally. When appropriate, the amendment will be projected on a screen for viewing by the Council.

Late Resolutions

Resolutions submitted after the 90-day submission deadline, but not less than 24 hours prior to the beginning of the annual Council meeting, are known as "late resolutions." Late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual Council meeting. The Steering Committee is empowered to decide whether a late submission is justified. Late submission is justified when events giving rise to the resolution occur after the filing deadline for resolutions. If a majority of the voting members of the Steering Committee vote to waive the filing and transmittal requirements, the resolution is presented to the Council at its opening session and assigned to a Reference Committee. When the Steering Committee votes unfavorably, the reason for such action shall be reported to the Council at its opening session. Disallowed late resolutions are not considered by the Council unless the Council, by a two-thirds vote of councillors present and voting, overrides the Steering Committee's recommendation**.**

Emergency Resolutions

Resolutions submitted less than 24 hours prior to, or after the beginning of the annual Council meeting, are known as "emergency resolutions." Emergency resolutions are limited to substantive issues that could not have been considered by the Steering Committee prior to the Council meeting because of their acute nature, or resolutions of commendation that become appropriate during the course of the Council meeting.

Emergency resolutions must be submitted in writing to the speaker who will then present the resolution to the Council for its consideration. The originator of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the councillors to determine the importance of the resolution. Without debate, a majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, upon acceptance by the Council, it will be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution will be debated on the floor of the Council at a time chosen by the speaker.

What if I Have Questions About the Council?

Questions about the Council can be directed to national ACEP staff in the Office of the Executive Director. They work closely with the Council officers in planning and executing the annual meeting and helping members to develop resolutions for consideration by the Council. Information about the Council, including important dates regarding the annual Council meeting, are posted on the ACEP website.

How are Nominations and Elections Conducted?

Each year the Council elects four members to the Board of Directors to terms of three years. The Council speaker and vice-speaker, who serve two-year terms, are elected by the Council every other year. The Council also elects the president-elect of the College annually for a one-year term.

Nomination procedures and the composition of the nominating committees are specified in the Bylaws. Councillors may submit nominations from the floor at the annual meeting, but nominations are closed on the first day of the annual meeting. Closing the nominations assures that all candidates will have the opportunity to share their viewpoints during an open forum with councillors. The elections are the last item of business on the second day of the Council meeting. The Tellers, Credentials, & Elections Committee, which is appointed by the Council officers, conducts the elections. A majority of votes cast is required for election. Election procedures are described in the Council Standing Rules and the Bylaws.

With the exception of the president-elect, the Board of Directors elects its own officers (chair, vice presidents,

and secretary-treasurer) each year during the first Board meeting after the Council meeting.

Each year a Candidate Forum is held. The Candidate Forum for the president-elect candidates is held in the main Council meeting room following the Town Hall meeting. The Candidate Forum for the Council officer candidates (every other year) and Board of Directors candidates is held in each of the Reference Committee meeting rooms with the candidates rotating between rooms. Members of the Candidate Forum Subcommittee moderate each session with the candidates. Candidates answer questions and declare their views on issues facing emergency medicine. An informal reception is held for members to personally meet and speak with candidates. All councillors are encouraged to attend the Candidate Forum and the reception that follows.

The Candidate Campaign Rules prohibit the scheduling of candidate receptions by any component body during the annual Council meeting. This position was adopted by the Council and the Board of Directors.

What is the Steering Committee?

The Council officers appoint the members of the Steering Committee. The Steering Committee conducts the business of the Council between the annual meeting. Attempts are made to limit service on the committee to two years, with about half of the committee membership replaced each year. Care is taken to assure adequate geographic representation on the committee.

The Steering Committee may identify resolution topics to stimulate discussion of key issues by the Council, plans the Council agenda, and advises and assists the Council officers with meeting logistics. The Steering Committee has the authority, rarely invoked, to take positions on behalf of the Council subject to ratification by the Council at the next annual meeting. Members of the Council Steering are listed here on the ACEP website.

III. COUNCIL REFERENCE COMMITTEES

The duty of a Reference Committee is to hold hearings, deliberate on various resolutions and proposals, and recommend a particular course of action on each to the Council.

It may not be possible for each councillor to be fully informed or to have an opinion on every resolution. Therefore, the Reference Committee is designated to investigate and deliberate on the issues. By dividing the proposals between several Reference Committees, the Council can transact more business than if the entire Council had to discuss all of the pros and cons of each resolution.

Members of the Reference Committees are appointed by the speaker. They are chosen on the basis of their activities in the College and their expertise on particular issues. They are not chosen because of their stand on particular issues.

Asynchronous Testimony

Resolutions that have been submitted by the deadline and assigned to a Reference Committee will be available for asynchronous testimony on the ACEP website not less than 30 days prior to the Council meeting. Important dates regarding the annual Council meeting are posted on the ACEP website. Asynchronous testimony is open to all members of the College.

Comments posted as online testimony are prohibited from being copied and pasted as comments in other forums and/or used in a manner in which the comments could be taken out of context. By participating in this asynchronous testimony, all members acknowledge and agree to abide by ACEP's Meeting Conduct Policy. Please include the following information when commenting:

1. Whether you are commenting on behalf of yourself or your component body (i.e., chapter, section, AACEM, CORD, EMRA, or SAEM).
2. Whether you are commenting in support of the resolution, opposed to the resolution, or suggesting an amendment.
3. Any additional information to support your position.

Comments should be concise so as to not exceed an equivalent of 2 minutes of oral testimony. Comments from the asynchronous testimony will be used to develop preliminary Reference Committee reports.

The asynchronous platform is the only method to introduce testimony until the live Reference Committee meetings. Opinions posted elsewhere will not be considered in the Reference Committee deliberations. Proper Council decorum is expected within the asynchronous testimony platform. All comments should be addressed to the Reference Committee Chair or the Speaker. **Do not direct any communications to another member**, **including those who have posted before you, with whom you may or may not agree.** The Council Speaker and Vice Speaker will do their best to monitor testimony and encourage corrections to any breaches.

Procedures

The preliminary Reference Committee reports will be the starting point for the Reference Committee hearings that occur on the first day of the Council meeting. The testimony heard in Reference Committee hearings will be added to the asynchronous testimony to form the consent report submitted to the Council.

Reference Committee hearings are open to all members of the College, its committees, and invited guests of the Reference Committee. Members of the College, its committees, and/or invited guests are privileged to present written testimony or to speak to the committee on the resolution under consideration. Non-members may be permitted to speak upon recognition by the chair. The chair is privileged to call upon anyone attending the hearing if the individual may have information that would be helpful to the committee.

The Reference Committee hearings are held **concurrently** on the first day of the Council meeting. Written testimony may be submitted to the Reference Committee if time overlaps occur.

Proceedings

Equitable hearings are the responsibility of the Reference Committee chair. The committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements, etc. The Reference Committee hearing is the proper forum for discussion of controversial items of business. While it is recognized that the concurrence of Reference Committee hearings may create difficulties in this respect, as does service by councillors on other Reference Committees, the submission of written testimony can alleviate these problems. In the event of extensive written testimony, the Reference Committee chair will report to the Reference Committee the number of written testimony received in favor and in opposition to the resolution. The Reference Committee chair has the discretion to read any written testimony, especially testimony that provides information not previously presented in other written or in-person testimony. All written testimony will be made available electronically to the Council unless determined by the Speaker to contain inaccurate information or inappropriate comments. The reading of any written testimony shall not exceed the time limits set by the chair for providing testimony on any particular resolution.

The chair will decide the order and/or grouping of resolutions and will post times to start each discussion. Before beginning discussion on the first resolution, the chair will ask if there is a "pressing need" for any resolutions to be taken out of order to allow individuals to provide testimony to a particular issue. **Determination of a "pressing need" will be left to the discretion of the chair**. The chair will ask if the primary author(s) of the resolution is present or if another individual is present who may speak to the intent of the resolution, and if the individual wishes to provide guidance to the committee. Reference Committees may take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.

If an individual arrives to present testimony before or after the time the resolution was scheduled for discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When presenting testimony, the individual should state their name, component body, and whether speaking in support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular expertise for their testimony.

Following the open hearing and after all testimony is given, the Reference Committee will go into executive session to deliberate and construct its final report. Others are permitted to be in attendance only upon approval

from the chair and may not address the committee unless requested by the chair for clarification of testimony or to answer questions by committee members.

Reports

Reference Committee reports comprise the bulk of the official business of the Council. The reports need to be constructed swiftly and succinctly after completion of the hearing so that they can be processed and made available to the councillors as far in advance of formal presentation as possible. Reference Committees have wide latitude in facilitating expression of the will of the majority on the matters before them and in giving credence to the testimony they hear. They may amend resolutions, consolidate kindred resolutions by constructing substitutes, and recommend the usual parliamentary procedures for disposition of the business before them, such as adoption, not for adoption, amendment, and referral. Minority reports from Reference Committees are in order.

When the Reference Committee presents its report to the Council, each report or resolution that has been accepted by the Council as its business is the matter which is before the Council for disposition together with the committee's recommendation in that regard. If a number of closely related items have been considered by the committee and consolidation or substitution is proposed by the committee, the substitute resolution will be the matter before the Council for discussion.

Each item referred to a Reference Committee will be placed on a consent agenda grouped by the recommended action and is reported to the Council as follows:

1. identify the resolution by number and title
2. state concisely the committee's recommendation
3. comment, as appropriate, on the testimony presented at the hearing
4. incorporate evidence supporting the recommendation of the committee

Each Reference Committee will make recommendations on each resolution assigned to it in a written report. The speaker will open for discussion each resolution or matter which is the immediate subject of the Reference Committee report. The effect is to permit full consideration of the business at hand, unrestricted to any specific motion for its disposal. Any appropriate motion for amendment or disposition may be made from the floor. In the absence of such a motion, the speaker will state the question and provide the recommendation of the Reference Committee. If the recommendation is referral or amended language, the primary motion on the table is the recommendation of the Reference Committee.

Examples of our common variants employing the procedure are:

1. The Reference Committee recommends that a resolution not be adopted. The speaker places the resolution before the Council for discussion. In the absence of other motions from the floor, the speaker places the question on adoption of the resolution, making it clear that the Reference Committee has recommended that it not be adopted (a negative vote).

2. The Reference Committee recommends amending a resolution by adding, striking out, inserting, or substituting. The matter that is placed before the Council for discussion is the amended version as presented by the Reference Committee together with the recommendation for its adoption. It is then in order for the Council to apply to this Reference Committee version amendments in the usual fashion. Such procedure is clear and orderly and does not preclude the possibility that an individual may wish to restore the matter to its original unamended form. This may be accomplished quite simply by moving to amend the Reference Committee version by restoring the original language.

3. The Reference Committee recommends referral of a resolution to the Board of Directors, Council Steering Committee, or Bylaws Interpretation Committee of the College. The speaker places the motion to refer before the Council for discussion. Adoption of the motion to refer removes the matter from consideration by the Council. If the motion to refer is not adopted, the resolution comes before the body for discussion. The Council is then free to adopt, not adopt, or amend the resolution.

4. The Reference Committee recommends consolidation of two or more kindred resolutions into a single resolution, or it recommends adoption of one of these items in its own right as a substitute for the rest. The matter before the Council consideration is the recommendation of the Reference Committee or the substitute or consolidate version. A motion to adopt this substitute is the main motion. If the Reference Committee's version is not adopted the entire group of proposals has been rejected but it is in order for any councillor to then propose consideration and adoption of any one of the original resolutions or reports.

IV. GUIDELINES AND DEFINITIONS OF COUNCIL ACTIONS TO ASSIST THE COUNCIL IN CONSIDERING REPORTS OF REFERENCE COMMITTEES.

Summary of Council Actions on Reference Committee Reports

Matter Before the Council for Discussion from the Reference Committee's Report	Reference Committee's Recommendation	Speaker Action (Failing Council Action)
Original Resolution	1.To adopt or to not adopt	Puts question on adoption, clearly stating the Reference Committee's recommendation
Original Resolution	2. To refer	Puts question on referral
Committee Substitute (amending original by adding, striking out, inserting, or substituting)	3. To adopt	Puts question on adoption of the committee's substitute resolution
Committee Substitute Resolution (combining several like resolutions)	4. To adopt	Puts question on adoption of the committee's substitute resolution

Definition of Council Action

For the ACEP Board of Directors to act in accordance with the wishes of the Council, the actions of the Council must be definitive. To avoid any misunderstanding, the officers have developed the following definitions for Council action:

ADOPT
Approve resolution as recommendation implemented through the Board of Directors

ADOPT AS AMENDED
Approve resolution with additions, deletions and/or substitutions, as recommendation to be implemented through the Board of Directors.

REFER
Send resolution to the Board of Directors for consideration, perhaps by a committee, the Council Steering Committee, or the Bylaws Interpretation Committee.

NOT ADOPT
Defeat (or reject) resolution in original or amended form.

V. BASIC RULES GOVERNING MOTIONS

Order of precedence[1]	Can interrupt?	Requires second?	Debatable?[2]	Amendable	Vote Required?	Applies to what other motions?	Can have what other motions applied to it?[3]	Renewable?
Privileged Motions								
1. Adjourn	No	Yes	No	Yes	Majority	None	Amend, close debate	Yes
2. Recess	No	Yes	No	Yes	Majority	None	Amend, close debate	Yes
3. Question of privilege	Yes	No	No	No	None	None	None	Yes
Subsidiary Motions								
4. Table	No	Yes	No	No	2/3	Main motion	None	No
5. Close debate and vote immediately	No	Yes	No	Yes	2/3	Amendable, debatable motions	Amend	Yes
6. Limit or extend debate	No	Yes	No	Yes	2/3	Amendable, debatable motions	Amend, close debate	Yes
7. Postpone (to a certain time)	No	Yes	Yes	Yes	Majority[4]	Main motion with pending subsidiary motions	Amend, limit debate, close debate	Yes
8. Refer to committee	No	Yes	Yes	Yes	Majority	Main motion with pending amendments	Amend, limit debate, close debate	Yes
9. Amend	No	Yes	Yes[5]	Yes	Majority	Rewordable motions	Amend, limit debate close debate	Yes[6]
Main Motions								
10. a. The main motion	No	Yes	Yes	Yes	Majority	None	Subsidiary motions	No
b. Specific purpose main motions								
Adopt in lieu of	No	Yes	Yes	Yes	Majority	Designated motions	Subsidiary motions	No
Amend a previous action	No	Yes	Yes	Yes	Same vote	Adopted main motion	Subsidiary motions	No
Ratify	No	Yes	Yes	No	Same vote	Adopted main motion	Subsidiary motions except amend	No
Recall from a committee	No	Yes	Yes	No	Majority	Referred main motion	Close debate, limit debate	Yes
Reconsider	Yes[7]	Yes	Yes	No	Majority	Main motion, some specific-purpose main motions[8]	Close debate, limit debate	No
Rescind	No	Yes	Yes	No	Same vote	Adopted main motion	Subsidiary motions except amend	No

[1] Motions are in order only if no motion higher on the list is pending.
[2] Debate must always be germane to the pending motion.
[3] Note that the Motion to Withdraw can be applied to all motions.
[4] Postpone and make a special order requires 2/3 vote.
[5] Is not debatable when applied to an undebatable motion.
[6] At the discretion of the presiding officer.
[7] Can interrupt proceedings, but not a speaker.
[8] Adopt in lieu of, Amend a Previous Action, Ratify, and Rescind
[9] Only if it requires an immediate answer.

VI. INCIDENTAL MOTIONS

No order of precedence	Can interrupt	Requires second?	Debatable	Amendable	Vote Required?	Applies to what other motions	Can have what other motions applied to it?	Renewable?
Motions								
Appeal	Yes[7]	Yes	Yes	No	2/3*	Ruling of chair	Close debate, limit debate	No
Suspend Rules	No	Yes	No	No	2/3	Procedural rules	None	Yes
Consider by paragraph	No	Yes	No	No	Majority	Main motion	None	Yes
Counted vote	Yes	Yes	No	No	Majority	Vote with an unclear outcome	None	No
Requests								
Point of Order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes[9]	No	No	No	None	All motions	None	No
Withdraw a motion	Yes	No	No	No	None	All motions	None	No
Division of question	No	No	No	No	None	Divisible motions	None	No
Division of assembly	Yes	No	No	No	None	Vote with an unclear outcome	None	No

Per the Council Standing Rules

[1] Motions are in order only if no motion higher on the list is pending.
[2] Debate must always be germane to the pending motion.
[3] Note that the Motion to Withdraw can be applied to all motions.
[4] Postpone and make a special order requires 2/3 vote.
[5] Is not debatable when applied to an undebatable motion.
[6] At the discretion of the presiding officer.
[7] Can interrupt proceedings, but not a speaker.
[8] Adopt in lieu of, Amend a Previous Action, Ratify, and Rescind
[9] Only if it requires an immediate answer.

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

The Guidelines for Writing Resolutions are available on the ACEP website. A Resolution Preparation Checklist is also available to provide additional guidance in preparing resolutions.

Questions

Please contact Sonja Montgomery at ACEP Headquarters, by email smontgomery@acep.org, or call 469-499-0282, for further information about preparation of resolutions.

VIII.

ACEP Parliamentary Motions Guide

Based on *American Institute of Parliamentarians Standard Code of Parliamentary Procedure (2nd Ed.)*[1]

The motions below are listed in order of precedence.
Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(173) Close meeting	I move that we **adjourn**	No	Yes	Yes	Yes	Majority
(171) Take break	I move to **recess** for	No	Yes	Yes	Yes	Majority
(167) Register complaint	I rise to a **question of personal privilege (or question of privilege affecting the assembly)**	Yes	No	No	No	None
(164) Kill motion without debate	I move that the main motion be **tabled**	No	Yes	No	No	2/3
(160) Close debate and vote immediately	I move to **close debate and vote immediately**	No	Yes	No	No	2/3
(157) **Limit or extend debate**	I move to limit debate to ...	No	Yes	Yes	Yes	2/3
(153) **Postpone to certain time**	I move to postpone the motion until ...	No	Yes	Limited	Yes	Majority
(149) **Refer** to committee	I move to refer the motion to …	No	Yes	Limited	Yes	Majority
(135) Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes, unless undebatable motion	Yes	Majority
(115) Propose action to assembly (a **main motion**)	I move that …	No	Yes	Yes	Yes	Majority

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[1] As modified by the ACEP Council Standing Rules

ACEP Parliamentary Motions Guide

Based on *American Institute of Parliamentarians Standard Code of Parliamentary Procedure (2nd Ed.)*[1]

Incidental Motions - no order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(179) Suspend rules	I move to **suspend…**	No	Yes	No	No	2/3
(183) Enforce rules	**Point of order**	Yes	No	No	No	None
(186) Submit matter to assembly	I **appeal** the ruling of the chair	Yes	Yes	Yes	No	2/3
(189) Parliamentary question	I rise to a **parliamentary inquiry**	Yes	No	No	No	None
(189) Factual inquiry	I rise to a request for information	Yes	No	No	No	None
(193) Request to **withdraw motion**	I withdraw my motion	Yes	No	No	No	Majority
(196) **Divide motion**	I request that the motion be divided …	No	No	No	No	None
(200) Demand rising vote	I call for a **division of the assembly**	Yes	No	No	No	None

Specific-Purpose Main Motions - no order of precedence. Introduce only when nothing else pending.

(121) Adopt one of several similar motions	I move the adoption of … in lieu of …	No	Yes	Yes	Yes	Majority
(123) **Amend a previous action**	I move to amend the motion that was …	No	Yes	Yes	Yes	Same as original
(125) Confirm prior action	I move to **ratify …**	No	Yes	Yes	No	Same as original
(127) Recall referred matter	I mot to **recall …**	No	Yes	Yes	Yes	Majority
(129) Reconsider main motion	I move to **reconsider** ...	No	Yes	Yes	No	Majority
(132) Cancel previous action	I move to **rescind** ...	No	Yes	Yes	No	Same as original

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[1] As modified by the ACEP Council Standing Rules



Council Standing Rules

Revised October 2024

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules

Revised October 2024

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed. A councillor or an alternate councillor may not serve simultaneously as an alternate councillor for more than one component body.

If the number of alternate councillors is insufficient to fill all councillor positions for a component body, then a member of that component body may be seated as a councillor pro-tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, and component bodies are responsible for abiding by the campaign rules.

Conflict of Interest Disclosure

All councillors and alternate councillors will be familiar with and comply with ACEP's Conflict of Interest policy. Individuals who have a financial interest in a commercial enterprise, which interest will be materially affected by a matter before the Council, will declare their conflict prior to providing testimony.

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by component body and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate councillor. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials, & Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials, & Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

Councillors, members of the Board of Directors, past presidents, past speakers, and past chairs of the Board wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, past chair, etc.), and whether they are speaking "for" or "against" the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been granted by the presiding officer. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the presiding officer, alternate councillors not currently seated and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual's name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot, which may include remote communication and voting technology. There shall be no write-in voting. Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, & Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off

will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

**NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.*

The chair of the Tellers, Credentials, & Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, & Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, & Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Electronic Devices

All electronic devices must be kept in "quiet" mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of electronic devices for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Leadership Development Advisory Committee

The Leadership Development Advisory Committee (LDAC) is a Council Committee charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAC will offer to interested members guidance in opportunities for College leadership and, when applicable, in how to obtain and submit materials necessary for consideration by the Nominating Committee.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. ***See also Debate and Voting Immediately.***

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, past speaker, or past chair of the Board, after which nominations will be closed and shall not be reopened.

Members not nominated by the Nominating Committee may self-nominate by declaring themselves "floor candidates" at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the speaker of intent to seek nomination, whichever date is later. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure* will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Limiting Debate and Voting Immediately.***

Any councillor may call for a "point of personal privilege," "point of order," or "parliamentary inquiry" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege," etc. to interject debate is out of order.

Past Presidents, Past Speakers, and Past Chairs of the Board Seating

Past presidents, past speakers, and past chairs of the Board of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Policy Review

The Council Steering Committee will report annually to the Council the results of a periodic review of non-Bylaws resolutions adopted by the Council and approved by the Board of Directors.

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council, except for commendation and memorial resolutions. Reference Committee meetings are open to all members of the College, its committees, and invited guests.

Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is not adopted, the speaker shall state the original resolution.

Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

Reports

Committee and officer reports to be included in the Council minutes must be submitted in writing to the Council secretary. Authors of reports who petition or are requested to address the Council should note that the purpose of these presentations are to elaborate on the facts and findings of the written report and to allow for questions. Debate on relevant issues may occur subsequent to the report presentation.

Resolutions

"Resolutions" are considered formal motions that if adopted by a majority vote of the Council and ratified by the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a two-thirds vote of the Board of Directors.

Resolutions must be submitted in writing by at least two members or by component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body. All resolution sponsors and cosponsors must be confirmed at least 45 days in advance of the Council meeting.

All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.

Background information, including financial analysis, will be prepared by staff on all resolutions, except for commendation and memorial resolutions, submitted on or before 90 days prior to the annual meeting.

- ***Regular Non-Bylaws Resolutions***

Non-Bylaws resolutions submitted on or before 90 days prior to the annual meeting are known as "regular resolutions" and will be referred to an appropriate Reference Committee for consideration at the annual meeting.

Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as "Late Resolutions."

- ***Bylaws Resolutions***

Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of order under parliamentary authority, will not be permitted.

- ***Late Resolutions***

Resolutions submitted after the 90-day submission deadline, but at least 24 hours prior to the beginning of the annual meeting are known as "late resolutions." These late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual meeting. The Steering Committee is empowered to decide whether a late submission is justified due to events that occurred after the filing deadline. An author of the late resolution shall be given an opportunity to inform the Steering Committee why the late submission was justified. If a majority of the Steering Committee votes to accept a late resolution, it will be presented to the Council at its opening session and assigned to a Reference Committee, except for commendation and memorial resolutions. If the Steering Committee votes unfavorably and rejects a late resolution, the reason for such action shall be reported to the Council at its opening session. The Council does not consider rejected late resolutions. The Steering Committee's decision to reject a late resolution may be appealed to the Council. When a rejected late resolution is appealed, the speaker will state the reason(s) for the ruling on the late resolution and without debate, the ruling may be overridden by a two-thirds vote.

- ***Emergency Resolutions***

Emergency resolutions are resolutions that do not qualify as "regular" or "late" resolutions. They are limited to substantive issues that because of their acute nature could not have been anticipated prior to the annual meeting or resolutions of commendation that become appropriate during the course of the Council meeting. Resolutions not meeting these criteria may be ruled out of order by the speaker. Should this ruling be appealed, the speaker will state the reason(s) for ruling the emergency resolution out of order and without debate, the ruling may only be overridden by a two-thirds vote. ***See also Appeals of Decisions from the Chair.***

Emergency resolutions must be submitted in writing, signed by at least two members, and presented to the Council secretary. The author of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the Council to determine its merits. Without debate, a simple majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, it shall upon acceptance by the Council be referred to the appropriate Reference Committee, except for commendation and memorial resolutions. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution shall be debated on the floor of the Council at a time chosen by the speaker.

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate.

All resolutions assigned to a Reference Committee shall be placed on a Unanimous Consent Agenda.

The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, amendment, substitution, or not for adoption for each resolution listed. A request for extraction of any resolution from the Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

A motion to "vote immediately" may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting. Councillors are out of order who move to "vote immediately" during or immediately following their presentation of testimony on that motion. The motion to "vote immediately" applies only to the immediately pending matter, therefore, motions to "vote immediately on all pending matters" is out of order. The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to "vote immediately" will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, including remote communication technology, voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue. Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

BYLAWS

Revised September 2025

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Bylaws

Table of Contents

ARTICLE I — NAME 1

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES 1
- Section 1 — Mission 1
- Section 2 — Purposes and Objectives 1

ARTICLE III — COLLEGE MEETINGS 1

ARTICLE IV — MEMBERSHIP 1
- Section 1 — Eligibility 1
- Section 2 — Classes of Membership 2
- Section 2.1 — Regular Members 2
- Section 2.2 — Honorary Members 2
- Section 2.3 — Candidate Members 2
- Section 2.4 — International Members 3
- Section 3 — Agreement 3
- Section 4 — Disciplinary Action 3
- Section 5 — Dues, Fees, and Assessments 3
- Section 6 — Official Publications 4

ARTICLE V — ACEP FELLOWS 4
- Section 1 — Eligibility 4
- Section 2 — Fellow Status 5

ARTICLE VI — CHAPTERS 6
- Section 1 — Charters 6
- Section 2 — Chapter Bylaws 6
- Section 3 — Qualifications 6
- Section 4 — Component Branches 6
- Section 5 — Charter Suspension - Revocation 6
- Section 6 — Ultimate Authority by College 7

ARTICLE VII — SECTIONS 7

ARTICLE VIII — COUNCIL 7
- Section 1 — Composition of the Council 7
- Section 2 — Powers of the Council 8
- Section 3 — Meetings 8
- Section 4 — Quorum 9
- Section 5 — Voting Rights 9
- Section 6 — Resolutions 9
- Section 7 — Nominating Committee 9
- Section 8 — Board of Directors Actions on Resolutions 9

ARTICLE IX — BOARD OF DIRECTORS 10
Section 1 — Authority 10
Section 2 — Composition and Election 10
Section 3 — Meetings 10
Section 4 — Removal 11
Section 5 — Vacancy 11

ARTICLE X —OFFICERS/EXECUTIVE DIRECTOR 11
Section 1 — Officers 11
Section 2 — Election of Officers 11
Section 3 — Removal 11
Section 4 — Vacancy 12
Section 4.1 — President 12
Section 4.2 — President-Elect 12
Section 4.3 — Chair, Vice President & Secretary-Treasurer 12
Section 4.4 — Council Officers 12
Section 4.5 — Vacancy by Removal of a Board Officer 12
Section 4.6 — Vacancy by Removal of a Council Officer 13
Section 5 — President 13
Section 6 — Chair 13
Section 7 — Vice Presidents 13
Section 8 — President-Elect 13
Section 9 — Secretary-Treasurer 13
Section 10 — Immediate Past President 14
Section 11 — Speaker 14
Section 12 — Vice Speaker 15
Section 13 — Executive Director 14
Section 14 -— Assistant Secretary-Treasurer 14

ARTICLE XI — COMMITTEES 14
Section 1 — General Committees 14
Section 2 — Executive Committee 15
Section 3 — Steering Committee 15
Section 4 — Bylaws Interpretation Committee 15
Section 5 — Finance Committee 16
Section 6 — Bylaws Committee 16
Section 7 — Compensation Committee 16

ARTICLE XII — ETHICS 16

ARTICLE XIII — AMENDMENTS 16
Section 1 — Submission 16
Section 2 — Notice 17
Section 3 — Amendment Under Initial Consideration 17
Section 4 — Contested Amendment 17

ARTICLE XIV — MISCELLANEOUS 17
Section 1 — Inspection of Records 17
Section 2 — Annual Report 17
Section 3 — Parliamentary Authority 18
Section 4 — College Manual 18

ARTICLE XV – MANDATORY INDEMNIFICATION 18
Section 1 — Policy of Indemnification and Advancement of Expenses 18
Section 2 — Definitions 18
Section 3 — Non-Exclusive; Continuation 18
Section 4 — Insurance or Other Arrangement 18
Section 5 — Exclusion of Certain Acts from Indemnification 19

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

BYLAWS

September 2025

ARTICLE I — NAME

This corporation, an association of physicians active in emergency medicine organized under the laws of the State of Texas, shall be known as the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (hereinafter sometimes referred to as "ACEP" or the "College"). The words "physician" or "physicians" as used herein include both medical and osteopathic medical school graduates.

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

The American College of Emergency Physicians exists to support quality emergency medical care and to promote the interests of emergency physicians.

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

1. To establish guidelines for quality emergency medical care.
2. To encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.
3. To encourage and facilitate training and education in emergency medicine for all medical students.
4. To promote education in emergency care for all physicians.
5. To promote education about emergency medicine for our patients and for the general public.
6. To promote the development and coordination of quality emergency medical services and systems.
7. To encourage emergency physicians to assume leadership roles in out-of-hospital care and disaster management.
8. To evaluate the social and economic aspects of emergency medical care.
9. To promote universally available and cost effective emergency medical care.
10. To promote policy that preserves the integrity and independence of the practice of emergency medicine.
11. To encourage and support basic and clinical research in emergency medicine.
12. To encourage emergency physician representation within medical organizations and academic institutions.

ARTICLE III — COLLEGE MEETINGS

All meetings of the Board of Directors of the College (the "Board of Directors" or the "Board"), the Council, and College committees shall be open to all members of the College. A closed session may be called by the Board of Directors, the Council, or any College committee for just cause, but all voting must be in open session.

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

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 "Code of Ethics for Emergency Physicians." No person shall be denied membership because of sex, race, age, political or religious beliefs, sexual orientation, or real or perceived gender identity.

Section 2 — Classes of Membership

All members shall be elected or appointed by the Board of Directors to one of the following classes of membership: (1) regular member; (2) candidate member; (3) honorary member; or (4) international member. The qualifications required of the respective classes, their rights and obligations, and the methods of their election or appointment shall be set forth in these Bylaws or as otherwise determined by the Board of Directors in the extraordinary case of an individual who does not satisfy all of the criteria of any particular class. Benefits for each class of membership shall be determined by the Board of Directors.

Section 2.1 — Regular Members

Regular members of the College are physicians who devote a significant portion of their medical endeavors to emergency medicine. All regular members must meet one of the following criteria: 1) satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); 2) satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country; 3) satisfactory completion of a subspecialty training program in pediatric emergency medicine accredited by the ACGME; 4) primary board certification by an emergency medicine certifying body recognized by ACEP; or 5) eligibility for active membership in the College (as defined by the College Bylaws then in force) at any time prior to close of business December 31, 1999.

Regular members shall be assigned by the Board of Directors to one of the following statuses: (1) active, (2) inactive, or (3) retired. Members who qualify will additionally be assigned to life status. All applicants for regular membership shall, hold a current, active, full, valid, unrestricted, and unqualified license to practice medicine in the state, province, territory, or foreign country in which they practice, or be serving in a governmental medical assignment. All regular members must either continue to maintain a valid license to practice medicine or have voluntarily relinquished the license upon leaving medical practice. A license to practice medicine shall not be considered voluntarily relinquished if it was surrendered, made inactive, or allowed to expire under threat of probation or suspension or other condition or limitation upon said license to practice medicine by a licensing body in any jurisdiction.

Regular members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

Regular members who have retired from medical practice for any reason shall be assigned to retired status.

Any regular member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain life status.

Regular members, with the exception of those in inactive status, may hold office, may serve on the Council, and may vote in committees on which they serve. Regular members in inactive status shall not be eligible to hold office, to serve on the Council, or serve on committees.

Section 2.2 — Honorary Members

Persons of distinction who are not members of the College, but have rendered outstanding service to the College or to the specialty of emergency medicine may be elected to honorary membership by the Board of Directors. Individual members and Council component bodies may propose candidates for honorary membership in the College to the Board of Directors. Honorary members cannot be eligible for other categories of College membership. Honorary members are considered members for life and shall not be required to pay any dues. Honorary members may not hold office and may not serve on the Council. Honorary members may vote in committees on which they serve.

Section 2.3 — Candidate Members

Candidate members must meet one of the following criteria: 1) medical student or intern interested in emergency medicine; 2) physician participating in an emergency medicine residency training program; 3) physician participating in a

fellowship training program immediately following an emergency medicine residency; 4) physician participating in a pediatric emergency medicine fellowship training program; or 5) physician in the uniformed services while serving as general medical officer. General medical officers shall be eligible for candidate membership for a maximum of four years. All candidate members will be assigned by the Board of Directors to either active or inactive status.

The rights of candidate members at the chapter level are as specified in their chapter's bylaws. At the national level, candidate members shall not be entitled to hold office, but physician members may serve on the Council. Candidate members appointed to national committees shall be entitled to vote in committees on which they serve.

Candidate members whose training is interrupted for any reason may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application. Candidate members in inactive status shall not be eligible to hold office, serve on the Council, or serve on committees.

Section 2.4 — International Members

Any physician interested in emergency medicine who is not a resident of the United States or a possession thereof, and who is licensed to practice medicine by the government within whose jurisdiction such physician resides and practices, shall be eligible for international membership. All international members will be assigned by the Board of Directors to either active or inactive status. Members who qualify will additionally be assigned to life status.

International members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

Any international member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain life status.

International members may not seek election to or serve on the national Board of Directors, may not seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate councillor, and may not serve on a Council committee. With the exception of those in inactive status, international members may serve as voting members of College committees to which they are appointed but may not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a section officer except for the positions of councillor and alternate councillor.

Section 3 — Agreement

Acceptance of membership in the College shall constitute an agreement by the member to comply with the ACEP Bylaws. The Board of Directors shall serve as the sole judge of such member's right to be or to remain a member, subject to Article IV, Section 4 of these Bylaws and the due process as described in the College Manual.

All right, title, and interest, both legal and equitable, of a member in and to the property of this organization shall cease in the event of any of the following: a) the expulsion of such member; b) the striking of the member's name from the roll of members; c) the member's death or resignation.

Section 4 — Disciplinary Action

Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors**,** or a designated body appointed by the Board of Directors for such purpose, for good cause. Procedures for such disciplinary action shall be stated in the College Manual.

Section 5 — Dues, Fees, and Assessments

Application fees and annual dues shall be determined annually by the Board of Directors. Assessments of members may not be levied except upon recommendation of the Board of Directors and by a majority vote of the Council. Notice of any proposed assessment shall be sent to each member of the College by mail or official publication at least 30

days before the meeting of the Council at which the proposed assessment will be considered. The Board of Directors shall establish uniform policies regarding dues, fees, and assessments.

Any member whose membership has been canceled for failure to pay dues or assessments shall lose all privileges of membership. The Board of Directors may establish procedures and policies with regard to the nonpayment of dues and assessments.

Section 6 — Official Publications

Each member shall receive *Annals of Emergency Medicine* and *ACEP Now* as official publications of the College as a benefit of membership.

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician or regular member for three continuous years immediately prior to election.
2. Be 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.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
    A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
    B. Satisfaction of at least three of the following individual criteria 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.

Distinguished Fellows of the College shall meet the following criteria:

1. Have held FACEP status for at least 12 years.
2. Maintained certification:
    A. In emergency medicine by the American Board of Emergency Medicine, or the American Osteopathic Board of Emergency Medicine, or
    B. In pediatric emergency medicine by the American Board of Pediatrics, or
    C. Have achieved FACEP through the ACEP Legacy track.
3. Meet a minimum number of points within the following requirements demonstrating evidence of commitment to emergency medicine:
    A. Research and scholarship, as evidenced by grant awards, peer-reviewed publication, or review or authorship of books or other professional resources.

B. Teaching and mentorship, as evidenced by teaching history, faculty status, student or resident advisement, or residency/fellowship/clerkship leadership.
C. Service and leadership, as evidenced by leadership within their emergency department, hospital, staffing group, state or local medical societies, community health planning, or other roles which have advanced the field.
D. Clinical excellence, as evidenced by clinical or industry awards, letters of support from their chair or medical director, or participation in quality, safety, or wellness activities.

4. Meet a minimum number of points within the following requirements demonstrating evidence of commitment to ACEP.
   A. Leadership activities, including participation or leadership within ACEP sections, committees, chapters, delegations, advocacy groups, task forces, Member Interest Groups, Board of Directors, or Council.
   B. Education activities, including participation as faculty or course directors in ACEP in-person or virtual educational offerings.
   C. Public awareness activities, including active involvement in ACEP's online communities, media relations or spokesperson network, or promotion of College wins and activities on social media.
   D. Recognitions, including individual receipt of ACEP awards or hospital/employer receipt of ACEP accreditation status.

International Fellows of the College shall meet the following criteria:

1. Be an international member of ACEP for at least three years immediately prior to election.
2. Be certified in emergency medicine by an internationally recognized certifying body, or have completed the minimum training standards to practice emergency medicine within their country (if certification is not available).
3. Provide a letter of support from an established authority such as their institution medical director, training program director, or emergency medicine society.
4. Satisfy at least three of the following individual requirements demonstrating commitment to emergency medicine:
   A. Active involvement in organized medicine, as evidenced by three years of membership or leadership within any local, national, or regional society dedicated to advancing emergency medicine.
   B. Active involvement in local hospital affairs, such as medical staff committees.
   C. Active involvement in the formal training of future emergency medicine physicians.
   D. Active involvement in departmental or governmental administration or affairs.
   E. Active involvement in EMS systems or disaster preparedness planning activities.
   F. Research or scholarly publication in emergency medicine.
5. Satisfy at least one of the following individual requirements demonstrating involvement with ACEP:
   A. Active participation in ACEP sections, committees, or other leadership bodies.
   B. Participation in the development, delivery, or promotion of ACEP educational offerings and resources within home country.
   C. Participation in ACEP educational or research activities (such as in-person attendance at ACEP Scientific Assembly meeting(s), scholarly publication in emergency medicine in *Annals of Emergency Medicine* or *JACEP Open*, etc.).
   D. Other contributions to 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.

Section 2 — Fellow Status

Fellows shall be authorized to use the letters FACEP, FACEP(D), or (i)FACEP in conjunction with professional activities. Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status. Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

ARTICLE VI — CHAPTERS

Section 1 — Charters

This corporation may grant charters to chapters of the College according to procedures described in the College Manual.

Section 2 — Chapter Bylaws

A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and current approved chapter bylaws guidance documents. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College. A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.

No chapter is permitted to act on behalf of, or to appear to third parties to be acting on behalf of, the College. In accepting or retaining a charter as a chapter of the College, the chapter and its members acknowledge the fact that the chapter is not an agent of the College notwithstanding that the College has the authority to establish rules governing actions of the chapter which may give the appearance of a principal-agent relationship.

Section 3 — Qualifications

The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter's jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to a new chapter, dues for the new chapter shall not be required until the member's next anniversary date.

A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who retires from medical practice regardless of membership class and changes state of residence may retain membership in a chapter of prior professional practice/residence.

A member of a chapter who changes residential or professional location may remain a member of that chapter if there is no chapter at the new location.

Section 4 — Component Branches

A chapter may, under provisions in its bylaws approved by the Board of Directors, charter branches in counties or districts within its area. Upon the approval of the Board of Directors of the College, such component branches may include adjacent counties or districts.

Section 5 — Charter Suspension – Revocation

The charter of any chapter may be suspended or revoked by the Board of Directors when the actions of the chapter are deemed to be in conflict with the Bylaws, or if the chapter fails to comply with all the requirements of these Bylaws or with any lawful requirement of the College.

On revocation of the charter of any chapter by the Board of Directors, the chapter shall take whatever legal steps are necessary to change its name so that it no longer suggests any connection with the American College of Emergency Physicians. After revocation, the former chapter shall no longer make any use of the College name or logo.

Section 6 — Ultimate Authority by College

Where these Bylaws and the respective chapter bylaws are in conflict, the provisions of these Bylaws shall be supreme. When, due to amendment, these Bylaws and the chapter bylaws are in conflict, the chapter shall have two years from written notice of such conflict to resolve it through amendment of chapter bylaws.

ARTICLE VII — SECTIONS

The College may have one or more groups of members known as sections to provide for members who have special areas of interest within the field of emergency medicine.

Upon the petition of 100 or more members of the College, the Board of Directors may charter such a section of the College. Minimum dues and procedures to be followed by a section shall be determined by the Board of Directors.

ARTICLE VIII — COUNCIL

The Council is an assembly of members representing ACEP's chartered chapters, sections, the Emergency Medicine Residents' Association (EMRA), the American College of Osteopathic Emergency Physicians (ACOEP), the Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), and the Society for Academic Emergency Medicine (SAEM). These component bodies, also known as sponsoring bodies, shall elect or appoint councillors to terms not to exceed three years. Any limitations on consecutive terms are the prerogative of the sponsoring body.

Section 1 — Composition of the Council

Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the average membership roll of the College of the preceding calendar year. The average will be calculated by using the count of primary members in each chapter on the first day of the month then adding together each month's total and dividing by 12. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies.

An organization currently serving as, or seeking representation as, a component body of the Council must meet, and continue to meet, the criteria stated in the College Manual. These criteria do not apply to chapters or sections of the College.

EMRA shall be entitled to eight councillors, each of whom shall be a candidate or regular member of the College, as representative of all of the members of EMRA.

ACOEP shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of ACOEP.

AACEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of AACEM.

CORD shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of CORD.

SAEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of SAEM.

Each chartered section shall be entitled to one councillor as representative of all of the members of such chartered section 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 representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Each component body 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. An alternate councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

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

Section 2 — Powers of the Council

The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions and other actions or appropriations enacted by the Council. Notwithstanding any other provision of these Bylaws, the Council shall have the right to amend the College Bylaws and College Manual, amend or restate or repeal the College Articles of Incorporation, and to elect the Council officers, the president-elect, and the members of the Board of Directors.

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

1. To prepare and control its own agenda.
2. To act on any matter brought before it by a councillor or the Board of Directors.
3. To originate and act on resolutions.
4. To form, develop, and utilize committees.
5. To develop, adopt, and amend its rules of procedure (the Council Standing Rules) and other procedures for the conduct of Council business, which do not require action by the Board of Directors.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the Bylaws, amendment of the College Manual, amendment or restatement or repeal of the Articles of Incorporation, and election of the Council officers, the president-elect, and the members of the Board of Directors, are vested exclusively in members currently serving as councillors and are specifically denied to all other members. These rights are not applicable at the chapter level unless specifically permitted in a chapter's bylaws.

Section 3 — Meetings

An annual meeting of the Council shall be held within or outside of the State of Texas at such time and place as determined by the Board of Directors. Notice for the annual meeting is not required. Whenever the term "annual meeting" is used in these Bylaws, it shall mean the annual meeting of the Council.

Special meetings of the Council may be held within or outside of the State of Texas and may be called by an affirmative vote of two-thirds of the entire Board of Directors, by the speaker with concurrence of a two-thirds vote of the entire Steering Committee, or by a petition of councillors comprised of signatures numbering one-third of the number of councillors present at the previous annual meeting, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee, provided that the time and place of such meeting shall be announced not less than 40 nor more than 50 days prior to the meeting.

Voting by proxy shall be allowed only at special meetings of the Council. The proxy of any councillor can be revoked by that councillor at any time. The results of any vote that includes proxy ballots will have the same force as any other vote of the Council.

Councillors eligible to vote at a special meeting of the Council are those who were credentialed by the Tellers, Credentials, & Elections Committee at the previous annual meeting of the Council.

All members of the College shall be notified of all Council meetings by mail or official publication.

Section 4 — Quorum

A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or these Bylaws.

Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to councillor voting, "present" is defined as either in person or participating by approved remote communication technology.

Section 5 — Voting Rights

Each sponsoring body shall deposit with the secretary of the Council a certificate certifying its councillor(s) and alternate(s). The certificate must be signed the president, secretary, or chairperson of the sponsoring body. No councillor or alternate shall be seated who is not a member of the College. College members not specified in the sponsoring body's certificate may be certified and credentialed at the annual meeting in accordance with the Council Standing Rules.

ACEP Past Presidents, Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."

Whenever the term "present" is used in these Bylaws with respect to councillor voting, it shall mean credentialed as certified by the chair of the Tellers, Credentials, & Elections Committee.

Section 6 — Resolutions

Resolutions pertinent to the objectives of the College or in relation to any report by an officer or committee of the College shall be submitted in writing at least 90 days in advance of the Council meeting at which they are to be considered. Resolutions submitted within 90 days of the Council meeting shall be considered only as provided in the Council Standing Rules**.** Each resolution must be signed by at least two members of the College.

In the case of a resolution submitted by a component body of the Council or by a committee of the College, such resolution must be accompanied by a letter of endorsement from the president or chairperson representing the submitting body. Upon approval by the Council, and except for changes to the Council Standing Rules, resolutions shall be forwarded immediately to the Board of Directors for its consideration.

Section 7 — Nominating Committee

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members, at least one of which shall be a young physician, defined as a member under the age of 40 or within the first ten years of practice, and the president shall appoint the president-elect plus two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor.

Section 8 — Board of Directors Action on Resolutions

The Board of Directors shall act on all resolutions adopted by the Council, unless otherwise specified in these Bylaws, 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 may determine.

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 implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.

The ACEP Council Speaker and Vice Speaker or their designee shall provide to the College a written summary of the Council meeting within 45 calendar days of the adjournment of the Council meeting. This summary shall include:

1. An executive summary of the Council meeting.
2. A summary and final text of each passed and referred resolution.

Thereafter, the Board of Directors shall provide to the College written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution. A summary of the Board of Directors' intent, discussion, and decision for each referred resolution shall be included. These communications shall be provided at quarterly intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section.

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

ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

The management and control of the College shall be vested in the Board of Directors, subject to the restrictions imposed by these Bylaws.

Section 2 — Composition and Election

Election of Directors shall be by majority vote of the Councillors present and voting at the annual meeting of the Council.

The Board shall consist of 12 elected directors, plus the president, president-elect, immediate past president, and chair if any of these officers is serving following the conclusion of an elected term as director. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council. In no instance may a member of the Board of Directors sit as a member of the Council.

The term of office of directors shall be three years and shall begin at the conclusion of the Board meeting following the annual meeting at which their elections occur and shall end at the conclusion of the Board meeting following the third succeeding annual meeting. No director may serve more than two consecutive three-year terms unless specified elsewhere in these Bylaws.

Section 3 — Meetings

The Board of Directors shall meet at least three times annually. One of these meetings shall take place not later than 30 days following the annual meeting of the College. The other meetings shall take place at such other times and places as the Board may determine. Meetings may take place within or outside of the State of Texas. A majority of the Board shall constitute a quorum.

Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors, members of the Board of Directors may participate in and hold additional meetings of such Board by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting, except where a director participates in such meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

Any action required or permitted to be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action to be taken, shall be signed by all of the members of the Board of Directors and Council officers, and such a consent shall have the same force and effect as a unanimous vote of the members of the Board of Directors at a meeting of the Board of Directors.

Special meetings of the Board of Directors may be called by the president or the chair of the Board with not less than 48 hours notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.

Section 4 — Removal

Any member of the Board of Directors may be removed from office at any meeting of the Council by a three-quarters vote of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee. A removal must be initiated by a petition signed by councillors present at that meeting. The number of signatures on the removal petition shall be not less than one-third of the number of councillors present at the meeting at which the member of the Board of Directors was elected, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee.

Section 5 — Vacancy

Any vacancy filled shall be for the remainder of the unexpired term.

A vacancy created by removal shall be filled by a majority vote of the councillors present and voting at the Council meeting at which the removal occurs. Nominations for such vacancy shall be accepted from the floor of the Council.

Vacancies created other than by removal may be filled by a majority vote of the remaining Board if more than 90 days remain before the annual Council meeting. If there are more than three concurrent vacancies, the Council shall elect directors to fill all vacancies via special election. If fewer than 90 days remain before the annual Council meeting, then the vacancies will not be filled until the annual Council meeting.

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice presidents, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of Directors may appoint other officers as described in these Bylaws.

Section 2 — Election of Officers

The chair, vice-presidents, and secretary-treasurer shall be elected by a majority vote at the Board meeting immediately following the annual meeting. The president-elect shall be elected each year and the speaker and vice speaker elected every other year by a majority vote of the councillors present and voting at the annual meeting.

Section 3 — Removal

Any officer of the Council, the president, and the president-elect may be removed from office at any meeting of the Council by a three-quarters vote of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee. A removal must be initiated by a petition signed by councillors present at that meeting. The number of signatures on the removal petition shall be not less than one-third of the number of councillors present at the meeting at which the Council officer was elected, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee.

Removal of an individual from the position of chair, vice president, or secretary-treasurer without removal as a member of the Board of Directors shall be carried out by the Board of Directors. Removal as chair shall also remove that individual from the Board of Directors if the chair is serving only by virtue of that office. Removal shall require a three-quarters vote of the full Board excluding the officer under consideration. Replacement shall be by the same process as for regular elections of these Board officers.

Section 4 — Vacancy

Vacancies in the offices of the Board of Directors and the Council occurring for reasons other than removal shall be filled in accordance with sections 4.1 through 4.4 of this Article X. Vacancies occurring by removal shall be filled in accordance with sections 4.5 and 4.6 of this Article X. Succession or election to fill any vacated office shall not count toward the term limit for that office.

Section 4.1 — President

In the event of a vacancy in the office of the president, the president-elect shall immediately succeed to the office of the president for the remainder of the unexpired term, after which their regular term as president shall be served.

Section 4.2 — President-Elect

In the event of a vacancy in the office of the president-elect, the Board of Directors, speaker, and vice speaker may fill the vacancy by majority vote for the remainder of the unexpired term from among the members of the Board. If the vacancy in the office of president-elect is filled in such a manner, at the next annual Council meeting, the Council shall, by majority vote of the credentialed councillors, either ratify the elected replacement, or failing such ratification, the Council shall elect a new replacement from among the members of the Board. The Council shall, in the normal course of Council elections, elect a new president-elect to succeed the just-ratified or just-elected president-elect only when the latter is succeeding to the office of president at the same annual meeting.

Section 4.3 — Chair, Vice President, & Secretary-Treasurer

In the event of a vacancy in the office of chair, vice president, or secretary-treasurer, election to the vacant office shall occur as the first item of business, after approval of the minutes, at the next meeting of the Board of Directors.

Section 4.4 — Council Officers

In the event of a vacancy in the office of vice speaker, the Steering Committee shall nominate and elect an individual who meets the eligibility requirements of these Bylaws to serve as vice speaker. This election shall occur as the first item of business, following approval of the minutes, at the next meeting of the Steering Committee, by majority vote of the entire Steering Committee. If the vacancy occurs during the first year of a two-year term, the vice speaker will serve until the next meeting of the Council when the Council shall elect a vice speaker to serve the remainder of the unexpired term.

In the event of a vacancy in the office of speaker, the vice speaker shall succeed to the office of speaker for the remainder of the unexpired term, and an interim vice speaker shall then be elected as described above.

In the event that the offices of both speaker and vice speaker become vacant, the Steering Committee shall elect a speaker to serve until the election of a new speaker and vice speaker at the next meeting of the Council.

Section 4.5 — Vacancy by Removal of a Board Officer

In the event of removal of an officer of the Board of Directors, excluding the president, replacement shall be conducted by the same process as for regular elections of those officers. If the president is removed, the vacancy shall be filled by the president-elect for the remainder of the unexpired term, after which their regular term as president shall be served.

Section 4.6 — Vacancy by Removal of a Council Officer

In the event of removal of a Council officer, nominations for replacement shall be accepted from the floor of the Council, and election shall be by majority vote of the councillors present and voting at the Council meeting at which the removal occurs. In the event that the speaker is removed and the vice speaker is elected to the office of speaker, the office of vice speaker shall then be filled by majority vote at that same meeting, from nominees from the floor of the Council.

Section 5 — President

The president shall be a member of the Board of Directors, and shall additionally hold ex-officio membership in all committees. The president's term of office shall begin at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated.

Section 6 — Chair

The chair shall be a member of and shall chair the Board of Directors. Any director shall be eligible for election to the position of chair and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The chair's term of office shall begin at the conclusion of the meeting at which the election as chair occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No director may serve more than one term as chair.

Section 7 — Vice Presidents

There shall be two vice president positions. The vice presidents shall be members of the Board of Directors. A director shall be eligible for election to a position of vice president if at least one year remains as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. A vice president's term of office shall begin at the conclusion of the meeting at which the election as a vice president occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected.

Section 8 — President-Elect

Any member of the Board of Directors excluding the president, president-elect, and immediate past president shall be eligible for election to the position of president-elect by the Council. The president-elect shall be a member of the Board of Directors. The president-elect's term of office shall begin at the conclusion of the meeting at which the election as president-elect occurs and shall end with succession to the office of president. The president-elect shall be elected by a majority vote of the councillors present and voting at the annual meeting of the Council. The president-elect shall succeed to the office of president at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated.

Section 9 — Secretary-Treasurer

The secretary-treasurer shall be a member of the Board of Directors. The secretary-treasurer shall cause to be kept adequate and proper accounts of the properties, funds, and records of the College and shall perform such other duties as prescribed by the Board.

A director shall be eligible for election to the position of secretary-treasurer if at least one year remains on the Board as an elected director and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The secretary-treasurer's term of office shall begin at the conclusion of the meeting at which the election as secretary-treasurer occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No secretary-treasurer may serve more than two consecutive terms.

The secretary-treasurer shall deposit or cause to be deposited all monies and other valuables in the name and to the credit of the College with such depositories as may be designated by the Board of Directors. The secretary-treasurer shall disburse the funds of the College as may be ordered by the Board of Directors; shall render to the Board of Directors,

whenever it may request it, an account of all transactions as treasurer, and of the financial condition of the College; and shall have such powers and perform such other duties as may be prescribed by the Board of Directors or these Bylaws. Any of the duties of the secretary-treasurer may, by action of the Board of Directors, be assigned to the executive director.

Section 10 — Immediate Past President

The immediate past president shall remain a member of the Board of Directors for a period of one year following the term as president, or until such time as the regular term as a Board member shall expire, whichever is longer. The term of the immediate past president shall commence at the conclusion of the second annual meeting of the Council following the meeting at which the election of president-elect occurred and shall end at the conclusion of the third annual meeting following the election. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council.

Section 11 — Speaker

The term of office of the speaker of the Council shall be two years. The speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The speaker shall preside at all meetings of the Council, except that the vice speaker may preside at the discretion of the speaker. The speaker shall prepare, or cause to be prepared, the agendas for the Council. The speaker may appoint committees of the Council and shall inform the councillors of the activities of the College. The speaker's term of office shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. The speaker shall not have the right to vote in the Council except in the event of a tie vote of the councillors. During the term of office, the speaker is ineligible to accept nomination to the Board of Directors of the College. No speaker may serve consecutive terms.

Section 12 — Vice Speaker

The term of office of the vice speaker of the Council shall be two years. The vice speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The vice speaker shall assume the duties and responsibilities of the speaker if the speaker so requests or if the speaker is unable to perform such duties. The term of the office of the vice speaker shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. During the term of office, the vice speaker is ineligible to accept nomination to the Board of Directors of the College. No vice speaker may serve consecutive terms.

Section 13 — Executive Director

An executive director shall be appointed for a term and at a stipend to be fixed by the Board of Directors. The executive director shall, under the direction of the Board of Directors, perform such duties as may be assigned by the Board of Directors. The executive director shall keep or cause to be kept an accurate record of the minutes and transactions of the Council and of the Board of Directors and shall serve as secretary to these bodies. The executive director shall supervise all other employees and agents of the College and have such other powers and duties as may be prescribed by the Board of Directors or these Bylaws. The executive director shall not be entitled to vote.

Section 14 — Assistant Secretary-Treasurer

Annually, the ACEP Board of Directors shall appoint an individual to serve as assistant secretary-treasurer. The assistant secretary-treasurer shall serve as an officer of the corporation without authority to act on behalf of the corporation, except (i) to execute and file required corporate and financial administrative and franchise type reports to state, local, and federal authorities, or (ii) pursuant to any authority granted in writing by the secretary-treasurer. All other duties of the secretary-treasurer are specifically omitted from this authority and are reserved for the duly elected secretary-treasurer. The assistant secretary-treasurer shall not be a member of the Board of Directors.

ARTICLE XI — COMMITTEES

Section 1 — General Committees

The president shall annually appoint committees and task forces to address issues pertinent to the College as

deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board. A majority of the voting membership of a committee shall constitute a quorum.

The president shall appoint annually committees on Compensation, Bylaws, and Finance.

Section 2 — Executive Committee

The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice presidents, secretary-treasurer, immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board**,** subject to ratification by the Board at its next meeting.

Meetings of the Executive Committee shall be held at the call of the chair or president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.

Section 3 — Steering Committee

A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall consist of at least 15 members, each appointed annually for a one-year term. It shall be the function of the committee to represent the Council between Council meetings. The committee shall be required to meet at least two times annually, and all action taken by the committee shall be subject to final approval by the Council at the next regularly scheduled session. The speaker of the Council shall be the chair of the Steering Committee.

The Steering Committee cannot overrule resolutions, actions, or appropriations enacted by the Council. The Steering Committee may amend such instructions of the Council, or approve amendments proposed by the Board of Directors, provided that such amendment shall not change the intent or basic content of the instructions. Such actions to amend, or approve amendment, can only be by a three-quarters vote of all the members of the Steering Committee and must include the position and vote of each member of the Steering Committee. Notice by mail or official publication shall be given to the membership regarding such amendment, or approval of amendment, of the Council's instructions. Such notice shall contain the position and vote of each member of the Steering Committee regarding amendment of or approval of amendment.

Section 4 — Bylaws Interpretation Committee

In addition to the College Bylaws Committee, there shall also be a Bylaws Interpretation Committee, appointed annually and consisting of five ACEP members. The president shall appoint two of the members and the Council speaker shall appoint three members. The chair of this committee shall be chosen by a vote of its members. When petitioned to do so, the Bylaws Interpretation Committee shall be charged with the definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of these Bylaws. Interpretation of other articles of these Bylaws shall be by the Board of Directors.

Any member shall have the right to petition the Bylaws Interpretation Committee for an opinion on any issue within its purview. If the petition alleges an occurrence of improper action, inaction, or omission, such petition must be received by the executive director no more than 60 days after the occurrence. In the event of a question regarding whether the subject of the petition is addressed by a portion of the Bylaws which falls within the committee’s jurisdiction, or a question of whether the time limit has been met, such question shall be resolved jointly by the president and the speaker. The committee shall then respond with an interpretation within 30 days of receipt of the petition. An urgent interpretation can be requested by the president, the Board of Directors, the speaker, or the Council in which case the interpretation of the committee shall be provided within 14 days. The Board shall provide the necessary funds, if requested by the committee, to assist the committee in the gathering of appropriate data and opinions for development of any interpretation. The Bylaws Interpretation Committee shall render its response to the petitioner as a written interpretation of that portion of the Bylaws in question. That response shall be forwarded to the petitioner, the officers of the Council, and the Board of Directors.

Section 5 — Finance Committee

The Finance Committee shall be appointed by the president. The committee shall be composed of the president-elect, secretary-treasurer, speaker of the Council or the speaker's designee, and at least eight members at large. The chair shall be one of the members at large. The Finance Committee is charged with an audit oversight function and a policy advisory function and may be assigned additional objectives by the president. As audit overseers, the committee performs detailed analysis of the College budget and other financial reports ensuring due diligence and proper accounting principles are followed. In addition, expenses incurred in attending official meetings of the Board, shall be reimbursed consistent with amounts fixed by the Finance Committee and with the policies approved by the Board.

Section 6 — Bylaws Committee

The Bylaws Committee shall be appointed by the president. The Bylaws Committee is charged with the ongoing review of the College Bylaws for areas that may be in need of revision and also charged with the review of chapter bylaws. The Bylaws Committee may be assigned additional objectives by the president or Board of Directors.

Section 7 — Compensation Committee

College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board's proposed compensation, the Compensation Committee's recommendation will then take effect.

ARTICLE XII — ETHICS

The "Code of Ethics for Emergency Physicians" shall be the ethical foundation of the College. Charges of violations of ethical principles or policies contained in the "Code of Ethics for Emergency Physicians" may be brought in accordance with procedures described in the College Manual.

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

Any member of the College may submit proposed amendments to these Bylaws. Each amendment proposal must be signed by at least two members of the College. In the case of an amendment proposed by a component body of the Council or by a committee of the College, each amendment proposal must be accompanied by a letter of endorsement from the president or chairperson representing the submitting body. Such submissions must be presented to the Council secretary of the College at least 90 days prior to the Council meeting at which the proposed amendments are to be considered. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the submitters, may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

If a proposed Bylaws amendment is a Contested Amendment, as hereinafter defined, then such Contested Amendment shall be considered already to have fulfilled the submission obligation.

Section 2 — Notice

For any proposed Bylaws amendment, including a Contested Amendment as hereinafter defined, the executive director of the College shall give notice to the members of the College, by mail or official publication, at least 30 days prior to the Council meeting at which any such proposed Bylaws amendment is to be considered for adoption.

Section 3 — Amendment Under Initial Consideration

A proposed Bylaws amendment which, at any meeting of the Council, has received an affirmative vote of at least two-thirds of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee, shall be deemed an Amendment Under Initial Consideration. The Board of Directors must vote upon an Amendment Under Initial Consideration no later than the conclusion of the Board's second meeting following said Council meeting. If the Amendment Under Initial Consideration receives the affirmative vote of at least two-thirds of the members of the Board of Directors, then it shall be adopted and these Bylaws shall be so amended immediately.

Section 4 — Contested Amendment

If an Amendment Under Initial Consideration fails to receive an affirmative vote of at least two-thirds of the members of the Board of Directors, then such proposed Bylaws amendment shall be deemed a Contested Amendment. The positions and vote of each member of the Board regarding such Contested Amendment shall be presented to the Council's Steering Committee at the Steering Committee's first meeting following said vote of the Board of Directors. The Council's component bodies and councillors shall be notified within 30 days of the Board action. The Steering Committee shall not have the authority to amend or adopt a Contested Amendment. The speaker may call a special meeting of the Council to consider a Contested Amendment. The time and place of such meeting shall be announced no less than 40 and no more than 50 days prior to the meeting.

The Contested Amendment, identical in every way to its parent Amendment Under Initial Consideration, and the positions and vote of each member of the Board of Directors regarding such Contested Amendment, shall be presented to the Council at the Council's first meeting following said vote of the Board of Directors.

If the unmodified Contested Amendment receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the chair of the Tellers, Credentials, & Elections Committee, then such proposed Bylaws amendment shall be adopted, and these Bylaws shall be so amended immediately.

If a Contested Amendment is modified in any way, and then receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the Tellers, Credentials, & Elections Committee, such Contested Amendment shall then be deemed an Amendment Under Initial Consideration and be subject to the process for adoption defined herein.

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

The minutes of the proceedings of the Board of Directors and of the Council, the membership books, and books of account shall be open to inspection upon the written demand of any member at any reasonable time, for any purpose reasonably related to the member's interest as a member, and shall be produced at any time when requested by the demand of 10 percent of the members at any meeting of the Council. Such inspection may be made by the member, agent, or attorney, and shall include the right to make extracts thereof. Demand of inspection, other than at a meeting of the members, shall be in writing to the president or the secretary-treasurer of the College.

Section 2 — Annual Report

The Board of Directors shall make available to the members as soon as practical after the close of the fiscal year, audited financial statements, certified by an independent certified public accountant.

Section 3 — Parliamentary Authority

The parliamentary authority for meetings of the College shall be the current edition of *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, except when in conflict with the Bylaws of the College or the Council Standing Rules.

Section 4 — College Manual

The College shall have a College Manual to address such matters as may be deemed suitable by the Board of Directors and the Council.

Amendments to the College Manual may be made by majority vote of both the Council and the Board of Directors.

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

To the full extent permitted by the Texas Business Organizations Code, as amended from time to time, the College shall indemnify all Directors, Officers, and all Employees of the College against judgments, penalties (including excise and similar taxes), fines, settlements and reasonable expenses (including court costs and attorneys' fees) actually incurred by any such person who was, is or is threatened to be made a named defendant or respondent in a proceeding because the person is or was a Director, Officer, or Employee of the College and the College shall advance to such person(s) such reasonable expenses as are incurred by such person in connection therewith.

Section 2 — Definitions

For purposes of this Article XV:

1. "Director" means any person who is or was a director of the College and any person who, while a director of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.
2. "Officer" means any person who is or was an officer of the College and any person who, while an officer of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.
3. "Employee" means an individual:
    a. Selected and engaged by ACEP;
    b. To Whom wages are paid by ACEP;
    c. Whom ACEP has the power to dismiss; and
    d. Whose work conduct ACEP has the power or right to control.
4. "Proceeding" means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, arbitrative, or investigative, any appeal in such action, suit, or proceeding, and any inquiry or investigation that could lead to such an action, suit, or proceeding.

Section 3 — Non-Exclusive; Continuation

The indemnification provided by this Article XV shall not be deemed exclusive of any other rights to which the person claiming indemnification may be entitled under any agreement or otherwise both as to any action in the individual's official capacity and as to any action in another capacity while holding such office, and shall continue as to a person who shall have ceased to be a Director, Officer, or Employee of the College engaged in any other enterprise at the request of the College and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 4 — Insurance or Other Arrangement

The College shall have the power to purchase and maintain insurance or another arrangement on behalf of any

person who is or was a Director, Officer, or Employee of the College, or who is or was not a Director, Officer, or Employee of the College but is or was serving at the request of the College as a Director, Officer, or Employee or any other capacity in another corporation, or a partnership, joint venture, trust or other enterprise, against any liability asserted against such person and incurred by such person in such capacity, arising out of such person's status as such, whether or not such person is indemnified against such liability by the provisions of this Article XV.

Section 5 — Exclusion of Certain Acts from Indemnification

Notwithstanding any other provision of this Article XV, no Director, Officer, or Employee of the College shall be indemnified for any dishonest or fraudulent acts, willful violation of applicable law, or actions taken by such person when acting outside of the scope of such person's office, position, or authority with or granted by the College or the Board of Directors.



COLLEGE MANUAL

Revised September 2025



College Manual

Table of Contents

I. Applications for Membership 1

II. Procedures for Addressing Charges of Ethical Violations and Other Misconduct 1
- A. Definitions 1
- B. Complaint Received 1
- C. Executive Director 2
- D. Ethics Complaint Review Process 3
- E. Bylaws Complaint Review Process 3
- F. Right of Respondent to Request a Hearing 4
- G. Hearing Procedures 4
- H. Notice to the Board of Directors 4
- I. Possible Disciplinary Action and Disclosure to ACEP Members 5
- J. Ground Rules 6

III. Chartering Chapters 7

IV. Charter Suspension-Revocation 7

V. Filling Board Vacancies Created by Other Than Removal 8

VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council 8

VII. Amendments 9

College Manual

Revised September 2025

I. Applications for Membership

All applications for membership will be in writing on an application form approved by the Board of Directors. Each member will receive a certificate of membership in such form as may be determined by the Board of Directors. The title to such a certificate shall remain, at all times, with the College.

II. 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. Definitions

1. ACEP means the American College of Emergency Physicians.
2. *Code of Ethics* means the *Code of Ethics for Emergency Physicians.*
3. *Procedures* means the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct.*
4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee with no conflicts of interest in each pending matter – in matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee.
5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.
6. Board Hearing Panel conducts all hearings and consists of an ACEP Vice President, Chair of the Board, and Board Liaison to the Ethics Committee.
7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

B. 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;
2. Must specify in reasonable detail an alleged violation by an ACEP member of an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, ACEP *Code of Ethics,* other ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ten (10) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating 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 any protected health information or any identifying information related to members of the patient's family;

5. Must state that the complainant is willing to have their name disclosed to the ACEP Executive Director and any additional ACEP review body listed in these *Procedures,* should the complaint be forwarded to the respondent; and
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, any additional ACEP review body listed in these *Procedures,* and the respondent should the complaint be forwarded to the respondent; and
6. Must be submitted to the ACEP Executive Director.

C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.
   b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming complainant's intent to file a complaint. Includes a copy of ACEP's *Procedures* providing guidelines and timetables that will be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the *Procedures*.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the *Procedures.*
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. Determines, in consultation with the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, along with other committee designee(s) as appropriate given the subject matter of the complaint, that:
   a. The charges and conduct set forth in the complaint, as alleged by the complainant, do not allege an actionable violation of a policy or principle included in the *Code of Ethics* or 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. The complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics*, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics Complaint Review Panel after membership on the Ethics Complaint Review Panel has been confirmed; or
   c. The complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, after both are received, to each member of the 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 and that has been screened for conflicts of interest; 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 Ethics Complaint Review Panel or the Bylaws Committee, as appropriate, will review the President's recommendation to reject the complaint. The President's action can be overturned by a majority vote of the applicable ACEP review body or adopted by the body.
5. Within ten (10) business days after the determination specified in Section C.4.b. or Section C.4.c. of these *Procedures*, forwards the complaint to the respondent by USPS Certified Mail with a copy of these *Procedures* 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 complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the applicable ACEP review body decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant 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 applicable

ACEP review body, including 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-Complaint Review Panel or the Bylaws Committee appointed to review the complaint, as appropriate.

D. Ethics Complaint Review Process. Within sixty (60) days of the forwarding of the complaint/ response specified in Section C.4.b. above, the Ethics Complaint Review Panel:

1. Reviews the written record of any complaint that alleges a violation of the ACEP *Code of Ethics* or other ACEP ethics policies as they existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference or web conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Renders a decision to impose disciplinary action, based on the written record.
6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:
   a. A hearing; or
   b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.
7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

E. Bylaws Complaint Review Process. Within sixty (60) days of the forwarding of the complaint/ response specified in Section C.4.c. above, the Bylaws Committee:

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference or web conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Applicable version of the ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. Renders a decision to impose disciplinary action, based solely on the written record.
6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.

7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

F. Right of Respondent to Request a Hearing

If the Ethics Complaint Review Panel or Bylaws Committee chooses to impose disciplinary action, the Executive Director will send to the respondent a written notice by USPS Certified Mail of the right to request a hearing. The respondent may request a hearing to appeal the disciplinary decision or the sanction imposed. This respondent's request for a hearing must be submitted in writing to the Executive Director within thirty (30) days of receipt of the notice of right to a hearing. In the event of no response, the applicable ACEP review body will implement its final decision.

G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail 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.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel. 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, audio, recording, or video recording at the expense of the requesting party. A copy of any such record must be provided to the Executive Director.
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is impractical for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.
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. Any documents or materials to be provided or presented during the hearing not already in the record, including written documents, handouts, or slide presentations, must be provided to the presiding officer 14 days prior to the hearing to assess if the material and information contained therein are relevant to the proceedings. 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. The Board Hearing Panel 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.
9. The decision of the Board Hearing Panel 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 Hearing Panel's decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board Hearing Panel's decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the applicable ACEP review body in its review of the complaint. The Board shall review the *Procedures* used in the complaint review process but will not review the facts or merits of the case. Should the Board decide

these *Procedures* were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. Possible Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Action
   a. Censure
      i. Private Censure: a private letter of censure informs a member that his or her conduct does not conform with the College's ethical standards; it may detail the manner in which ACEP expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the letter will not be provided.

         Private censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards but appears to be a minor isolated incident. The member's actions are not egregious in nature but fall outside of acceptable conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for single ethical violations in the course of a single legal case.
      ii. 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 set forth in Section B.2. above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action, disclosure of which shall be subject to the discretion of the Executive Director.

         Public censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and demonstrates a pattern of unethical behavior or a single example of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for multiple ethical violations in the course of a single legal case.
   b. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the-ACEP President. At the end of the twelve (12) month period of suspension, the suspended member may request 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). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action, disclosure of which shall be subject to the discretion of the Executive Director. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to the Board 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.

      Suspension is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations across more than one legal case.

c. Expulsion from ACEP membership shall be for a period of five (5) 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. The expulsion announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by and shall inform ACEP members that they may request further information about the disciplinary action, disclosure of which shall be subject to the discretion of the Executive Director. 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.

   Expulsion is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct to a degree warranting discipline beyond the suspension available under I.1.b. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations over multiple legal cases.

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. The letter shall specify the name of the member or former member who is the subject of the request. The Executive Director may disclose, in writing, the relevant information as described in Section I.1.
   b. Disclosure to Non-Members: If a non-member makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided. If a non-member makes a request for information about disciplinary actions against a member who has received private censure, the Executive Director shall inform the individual that no published announcement of disciplinary action is available but shall not indicate or confirm that a private censure has been imposed.

J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section I. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel, 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 ACEP review body's overall time to complete its task.
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel) 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 person shall recuse himself or herself from the process except as a complaining party or respondent, at which time the ACEP President will appoint a replacement.
6. Once the Ethics Complaint Review Panel or the Bylaws Committee has made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.

7. The Ethics Complaint Review Panel or the Bylaws Committee's decision to impose a disciplinary action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the review process.
8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a request for information, the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.
9. If a respondent seeks to voluntarily resign their ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

III. Chartering Chapters

Upon petition of any five members of the College or one third of the members within the petitioning jurisdiction, whichever number is greater, the Board may issue a charter for a chapter of the College. No more than one chapter will be chartered in any one state, territory, or commonwealth. The Board of Directors may issue a charter for a government services chapter without geographic restrictions upon petition of five or more active members of the College serving in government medical assignments.

Chapters will be in such form as will be approved by the Board of Directors. Each chapter in a state, territory, or commonwealth in which incorporation is possible will incorporate within one year of receiving its charter.

Each chapter will have power to acquire, lease, own, and convey property; to invest in financial instruments sanctioned by its Board of Directors; to fund and carry on research; to issue publications and distribute information by various electronic means; to establish, conduct, and maintain schools, courses, museums, libraries, and other institutions for study in and teaching of emergency patient care and emergency services; to retain professional legislative analysts; to retain legal counsel; and to use any reasonable means for attainment of objectives to fulfill the mission of the College.

IV. Charter Suspension-Revocation

Any member of the College may file written charges against any chapter with the executive director of the College. Such charges must be signed, and must specify the acts of conduct for which the complaint is made. The executive director of the College must present the charges to the Board of Directors at its next meeting. The Board of Directors will then act upon the charges and will either dismiss them or proceed as hereinafter set forth.

If the Board fails to dismiss the charges it will within 10 days thereafter cause a copy of the charges to be served upon the accused chapter by sending it by registered United States mail to the secretary or other officer of the chapter. The Board will notify the accuser at the same time and in the same manner.

A hearing will be convened not less than 15 days nor more than 90 days after service of charges. The Board will, after having given the accused and the accuser reasonable opportunity to be heard in person or by counsel and to present all evidence and proofs, conclude the hearing and within 30 days render a decision. The affirmative vote of a majority of the members of the Board present and voting will constitute the decision of the Board, which may either dismiss the charges or take such actions as it deems appropriate. In either event the Board will make known its decision in a written resolution signed by the secretary and president. In the former event the Board will furnish the accused and the accuser with a copy of the resolution. In the latter event its resolution will be read at the next regular meeting of the Board or at a special meeting duly called for that purpose, provided that a copy of the decision will be delivered to the accused in the same manner provided for the service of charges at least 15 days before such meeting. The accused and the accusers will be given reasonable opportunity to be heard at the meeting of the Board of Directors where the decision is read. A two-thirds majority vote of the entire Board of Directors will be required to suspend or to revoke the charter.

On revocation of the charter of any chapter by the Board of Directors, the chapter will take whatever legal steps are necessary to change its name so that it no longer suggests any connection with the American College of Emergency Physicians. After revocation, the former chapter will no longer make any use of the College name or logo.

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

Nominations: A slate of one or more nominees for each vacant position will be developed by the Nominating Committee.

Eligibility*:* Eligibility for a vacancy election nomination shall be in accordance with Article IX, Section 2 of the Bylaws.

Order of Elections: If there are multiple vacancies with varying lengths of unexpired terms, the longest term will be elected first, then followed in succession to the shortest term.

Term of Office: When elected by the Council, the replacement director's term will begin at the conclusion of the Board meeting following the annual meeting at which their election occurs or immediately upon election if elected at any other Council meeting. If elected by the Board, the term shall begin at the conclusion of the Board meeting at which their election occurs. In all instances the term shall be for the remainder of the unexpired term to which they have been elected.

Election by the Board of Directors (when applicable in accordance with the Bylaws): When selecting nominees for election by the Board of Directors, the Nominating Committee will give special consideration to unelected nominees from the most recent Board and Council Officer elections. The election may occur at any Board meeting more than 90 days before the annual meeting and shall be by a majority vote of the remaining directors (i.e. total number of directors). The Board shall consider each vacant position separately. Board members may choose to abstain from voting for any particular nominee. If a nominee fails to achieve a majority vote after being considered for all vacant positions, the nominee shall be removed from consideration and additional nominees from the Nominating Committee considered until all vacant positions have been filled. No floor nominations are allowed.

Election by the Council (when applicable in accordance with the Bylaws): The election will comply with the usual Council election process as closely as possible except as noted. A special meeting of the Council may be held in accordance with the Bylaws to elect replacement directors. If the election is at the annual Council meeting, the Council will hold the vacancy election following the regular elections and elect the replacement director from the remaining slate of nominees (including Speaker and Vice Speaker nominees when applicable).

VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council

Organizations that seek representation as a component body in the Council of the American College of Emergency Physicians (ACEP) must meet, at the time the Council representation is sought, and continue to meet, the following criteria:

A. Non-profit.
B. Impacts the practice of emergency medicine, the goals of ACEP, and represents a unique contribution to emergency medicine that is not already represented in the Council.
C. Not in conflict with the Bylaws and policies of ACEP.
D. Physicians comprise the majority of the voting membership of the organization.
E. A majority of the organization's physician members are ACEP members.
F. Established, stable, and in existence for at least 5 years prior to requesting representation in the ACEP Council.

G. National in scope, membership not restricted geographically, and members from a majority of the states. If international, the organization must have a U.S. branch or chapter in compliance with these guidelines.
H. Seek representation as a component body through the submission of a Bylaws amendment.

The College will audit these component bodies every two years to ensure continued compliance with these guidelines.

VII. Amendments

The method of amending the College Manual shall be specified in the College Bylaws.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Meeting
September 5-6, 2025
Hyatt Regency Salt Lake City Hotel
Salt Lake City, UT

Minutes

The 54th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:00 am Mountain time on Friday, September 5, 2025, by Speaker Melissa W. Costello, MD, FACEP.

Seated at the table were: Melissa W. Costello, MD, FACEP, speaker; Michael McCrea, MD, FACEP, vice speaker; Sandra M. Schneider, MD, FACEP, interim Council secretary and interim executive director; and Jim Slaughter, JD, CPP, parliamentarian.

Dr. Costello welcomed everyone. She provided a meeting dedication and led the Council in reciting the Pledge of Allegiance. Pauline Wiltz, MD, sang the National Anthem.

A video from Alison Smith MD, FACEP, president of the Utah Chapter, welcomed councillors and other meeting attendees.

Douglas Char, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 356 councillors of the 436 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Dr. Costello provided an overview of the Council meeting website and explained its functionality.

David E. Wilcox, MD, FACEP, addressed the Council regarding the Emergency Medicine Foundation (EMF) Council Challenge.

Bradley J. Uren, MD, FACEP, addressed the Council regarding the National Emergency Medicine Political Action Committee (NEMPAC) Council Challenge.

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2025 Council meeting:

AACEM	Ian B K Martin, MD, MBA, FACEP
ALABAMA CHAPTER	Jeffrey D Anderson, MD, FACEP William Randall Davis, MD Stephen William Knight, MD, FACEP Sean Vanlandingham, MD, FACEP
ALASKA CHAPTER	Camilla Sulak, MD, FACEP
ARIZONA CHAPTER	Olga Gokova, MD, FACEP Nicole R Hodgson, MD, FACEP Paul Andrew Kozak, MD, FACEP Wendy Ann Lucid, MD, FACEP Wayne A Martini, Jr, MD, FACEP Megan L McElhinny, MD, FACEP Rebecca B Parker, MD, FACEP Anthony C Wong, MD, FACEP

ARKANSAS CHAPTER	J Shane Hardin, MD, PhD, FACEP Leslie Jewett, MD Yusuke Kishimoto, MD
CALIFORNIA CHAPTER	Amy P Anton, MD, FACEP Jailyn Avila, MD, RDMS Rodney W Borger, MD, FACEP Missy Brown, MD Karen Chung, MD Nida F Degesys, MD, FACEP Fred Dennis, MD, MBA, FACEP Cassandra Morgan Dewitt, MD Adam P Dougherty, MD, FACEP Nicole Elizabeth Exeni McAmis, MD Jorge A Fernandez, MD, FACEP Marc Allan Futernick, MD, FACEP Marc Gautreau, MD, FACEP Douglas Everett Gibson, MD, FACEP Alicia Mikolaycik Gonzalez, MD, FACEP Kamara W Graham, MD, FACEP Jason Greenspan, MD, FACEP Vikant Gulati, MD, FACEP Puneet Gupta, MD, FACEP Aaron J Harries, MD Christopher Libby, MD, MPH, FACEP Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Valerie C Norton, MD, FACEP Comfort Arinola Adeola Orebayo , DO Bing S Pao, MD, FACEP Matthew Richard, MD, FACEP Susanne J Spano, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP Ashley Tarchione, MD Patrick Um, MD, FACEP Lori D Winston, MD, FACEP Anna L Yap, MD
COLORADO CHAPTER	Ramnik S Dhaliwal, MD, JD Laura Edgerley-Gibb, MD, FACEP Douglas M Hill, DO, FACEP William Martin Hilty, MD Carla Elizabeth Murphy, DO, FACEP Kristen Nordenholz, MD, FACEP Parth Shah, DO
CONNECTICUT CHAPTER	Daniel Freess, MD, FACEP Carlos Patrick Holden, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP Douglas Anthony Smith, DO, FACEP Listy Anam Thomas, MD, FACEP
CORD	Laura Roff Hopson, MD
DELAWARE CHAPTER	Kathryn Groner, MD, FACEP John T Powell, MD, MHCDS, FACEP

DISTRICT OF COLUMBIA CHAPTER	Christopher T Clifford, MD Rita A Manfredi-Shutler, MD, FACEP Natasha N Powell, MD MPH MEd, FACEP
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Jacob Mark Altholz, MD Anna Siobhan Heffron, MD Katarina Jones, MD Kelsey Mercedes Morgan, MD Joe-Ann Moser, MD Morgan Danielle Sweere, MD David Wilson, MD Pauline Wiltz, DO
FLORIDA CHAPTER	Patrick R Anderson, DO Andrew I Bern, MD, FACEP Blake Buchanan, MD, FACEP Stuart James Bumgarner, MD Damian E Caraballo, MD, FACEP Jordan Celeste, MD, FACEP Taylor Norelle Craig, MD Edward A Descallar, MD, FACEP Anton Gomez, DO, FACEP Gabriel Gomez, DO Kelly Gray-Eurom, MD, MMM, FACEP Shayne M Gue, MD, FACEP Saundra A Jackson, MD, FACEP Steven B Kailes, MD, FACEP Joseph M King, MD Mike Lozano, Jr, MD, MSHI, FACEP Ryan T McKenna, DO, FACEP Brandy Milstead, MD Ashley Norse, MD, FACEP Todd L Slesinger, MD, FACEP Ian David Storch, MD, FACEP Zachary C Terwilliger, MD
GEORGIA CHAPTER	Matthew R Astin, MD, FACEP Brett H Cannon, MD JD MBA, FACEP Shamie Das, MD, MBA, MPH, FACEP James Joseph Dugal, MD(E), FACEP(E) Matthew Taylor Keadey, MD, FACEP Jeffrey F Linzer, Sr, MD, FACEP James L Smith, Jr, MD, FACEP Johnny L Sy, DO, FACEP Matthew J Watson, MD, FACEP
GOVT SERVICES CHAPTER	Michael Joel Chiappone, DO Christine A DeForest, DO, FACEP Alan Jeffrey Hirshberg, MD, MPH, FACEP Aicha M Hull, MD Micaela A LaRose, MD David S McClellan, MD, FACEP Torree M McGowan, MD, FACEP Evan Miller, DO Mike Ramirez, MD Justine K Stremick, MD, FACEP Sean Stuart, DO, FACEP

HAWAII CHAPTER	Mark Baker, MD, FACEP John M Gallagher, MD, FACEP
IDAHO CHAPTER	Ken John Gramyk, MD, FACEP Darin J Lee, MD Christian Menard, MD, PhD, FACEP
ILLINOIS CHAPTER	Halleh Akbarnia, MD, MPH, FACEP, FACEP Amit D Arwindekar, MD, FACEP Kristen M Donaldson, MD, MPH, FACEP Katarzyna Maria Gore, MD, FACEP Samantha A Hay, MD Adnan Hussain, MD, FACEP Jason A Kegg, MD, FACEP Janet Lin, MD, FACEP Monika Pitzele, MD, PhD, FACEP Yanina Purim-Shem-Tov, MD, MS, FACEP Willard W Sharp, MD, PhD, FACEP Deborah E Weber, MD, FACEP William Weber, MD, MPH, FACEP
INDIANA CHAPTER	Michael D Bishop, MD, FACEP Timothy A Burrell, MD, MBA, FACEP Kyle D English, MD, FACEP Emily M Fitz, MD, FACEP Tracy Rene Rahall, MD, FACEP Eric B Yazel, MD, FACEP
IOWA CHAPTER	Thomas E Benzoni, DO, FACEP Ryan M Dowden, MD, FACEP
KANSAS CHAPTER	Joshua J Davis, MD Trevor S Mattox, MD Matthew S Sinnwell, MD, FACEP
KENTUCKY CHAPTER	Christopher W Pergrem, MD, FACEP Isaac Shaw, MD, FACEP Hugh W Shoff, MD MS, FACEP Beth Spurlin, MD, PhD, MBA, FAAP
LOUISIANA CHAPTER	Blake Denley, MD Deborah D Fletcher, MD, FACEP Phillip Luke LeBas, MD, FACEP Michael D Smith, MD MBA CPE, FACEP
MAINE CHAPTER	Garreth C Debiegun, MD, FACEP Brandon E Giberson, DO, FACEP, FACEP James B Mullen, III, MD, FACEP
MARYLAND CHAPTER	Michael C Bond, MD, FACEP Gregory Scott Corcoran, MD Daniel Benjamin Gingold, MD, MPH, FACEP Jonathan Lewis Hansen, MD, FACEP Edana Denise Mann, MD, FACEP Patrick McCarville, MD Debra Michele Ravert, MD, FACEP

MASSACHUSETTS CHAPTER	Amy Costigan, MD, FACEP Stephen K Epstein, MD, MPP, FACEP Gayle Marie Galletta, MD, FACEP Kathleen Kerrigan, MD, FACEP Matthew B Mostofi, DO, FACEP Mark D Pearlmutter, MD, FACEP Allison Ramler, MD, FACEP Sundeep Shukla, MD, MBA, FACEP Natalie Strokes, DO Joseph C Tennyson, MD, FACEP
MICHIGAN CHAPTER	Michael J Baker, MD, FACEP Abigail Brackney, MD, FACEP Sara S Chakel, MD, FACEP Pamela N Coffey, MD, FACEP Bram A Dolcourt, MD, FACEP Michael P Doyle, DO, FACEP Gregory Gafni-Pappas, DO, FACEP Michael Vincent Gratson, MD, FACEP Antony P Hsu, MD, FACEP Robert T Malinowski, MD, FACEP Therese G Mead, DO, FACEP Emily M. Mills, MD, FACEP James C Mitchiner, MD, MPH, FACEP David T Overton, MD, FACEP Luke Christopher Saski, MD, FACEP Jennifer B Stevenson, DO, FACEP Andrew Taylor, DO, FACEP Larisa May Traill, MD, FACEP Bradley J Uren, MD, FACEP Bradford L Walters, MD, FACEP
MINNESOTA CHAPTER	Paul C Allegra, MD, FACEP Matthew E Herold, MD, FACEP Kurt M Isenberger, MD, FACEP Erin R Karl, MD Benjamin Knutson, MD, FACEP Donald L Lum, MD, FACEP David Nestler, MD, MS, FACEP Lisa M Roazen, MD, FACEP
MISSISSIPPI CHAPTER	Lisa M Bundy, MD, FACEP Frederick B Carlton, Jr, MD, FACEP Chester Duane Shermer, MD, FACEP
MISSOURI CHAPTER	Jeanise Marie Butterfield, MD, FACEP Douglas Mark Char, MD, FACEP Kene A Chukwuanu, MD, FACEP Leslie A Hueschen, MD, FACEP Timothy J Koboldt, MD, FACEP Marc Mendelsohn, MD, MPH, FACEP Robert Francis Poirier, Jr, MD, MBA, FACEP
MONTANA CHAPTER	Harry Eugene Sibold, MD, FACEP
NEBRASKA CHAPTER	Andrew R Barnett, MD John Ukadike, DO MPH

NEVADA CHAPTER	Sabina A Braithwaite, MD, FACEP Gregory Alan Juhl, MD, FACEP Nehal S Naik, MD, FACEP Erin Simmers Pearson, MD, FACEP
NEW HAMPSHIRE CHAPTER	Kathleen J Clem, MD, FACEP Scott Weston Rodi, MD, MPH, FACEP
NEW JERSEY CHAPTER	Navin Ariyaprakai, MD, NRP, FAEMS, FACEP Tanisha Arora, MD, FACEP Kimberly T Baldino, MD, FACEP Chris Bryczkowski, MD, FACEP Rachelle Ann Greenman, MD, FACEP Patrick Blaine Hinfey, MD, FACEP Steven M Hochman, MD, FACEP Marjory E Langer, MD, FACEP J Mark Meredith, MD, FACEP Scott H Pasichow, MD, MPH, FACEP, FAEMS Chirag N Shah, MD, FACEP
NEW MEXICO CHAPTER	Lionel Michael Candelaria, Jr, MD Lucas Maestas, MD Aaron Snyder, MD
NEW YORK CHAPTER	David O Andonian, MD, FACEP Brahim Ardolic, MD, FACEP Joseph Basile, MD, FACEP Kirby Black, MD, FACEP Erik Blutinger, MD, MSc, FACEP Robert M Bramante, MD, FACEP Jay Miller Brenner, MD, FACEP Lauren J Curato, DO, FACEP Mark Curato, DO, FACEP, FACEP Sydney E DeAngelis, MD, FACEP Ugo A Ezenkwele, MD, FACEP Sanjey Gupta, MD, FACEP Abbas Husain, MD, FACEP Adam Huynh, MD Laura Iavicoli, MD, FACEP Marc P Kanter, MD, FACEP Stuart Gary Kessler, MD, FACEP Penelope Lema, MD, FACEP, FPD-AEMUS Sophia D Lin, MD, FACEP Kurien Mathews, DO MBA, FACEP Laura D Melville, MD Nestor B Nestor, MD, FACEP Norman Liang Ng, DO MBA, FACEP Daniel A Novak, DO Casey Lynn Palmer, MD Eli Rogers, MD Carly M Rosen, MD Livia M Santiago-Rosado, MD, FACEP Virgil W Smaltz, MD, FACEP Jeffrey J Thompson, MD, FACEP Asa Viccellio, MD, FACEP

NORTH CAROLINA CHAPTER	Melanie R Artho, MD, FACEP Jill Lynn Benson, MD, FACEP Thomas N Bernard, III, MD, FACEP Scott W Brown, MD, FACEP Gregory J Cannon, MD, FACEP Christopher Allen Griggs, MD, MPH, FACEP Eric Evan Maur, MD, FACEP Swarup Misra, DO, FACEP Madjimbaye Charles Namde, MD, MBA, FACEP Bret A Nicks, MD, MHA, FACEP Stephen A Small, MD, FACEP
NORTH DAKOTA CHAPTER	James R Humble, MD, FACEP
OHIO CHAPTER	Andrew Aten, MD, FACEP Eileen F Baker, MD, PhD, FACEP Marina N Boushra Freiberg, MD Christina Campana, DO, FACEP Joshua S da Silva, DO, FACEP Joanna Elizabeth Henry, DO Thomas W Lukens, MD, MS, PhD, FACEP Anthony T Martella, MD Daniel R Martin, MD, MBA, FACEP Jesse A Park, DO John R Queen, MD, FACEP RJ Sontag, MD, FACEP Ryan Squier, MD, FACEP K Robert Thompson, III, MD, MBA, FACEP Somy Monica Thottathil, MD, FACEP Nicole Ann Veitinger, DO, FACEP
OKLAHOMA CHAPTER	Aimee Renee Blagovich, DO, FACEP Laura Janneck, MD, FACEP Derek Martinez, DO Kurtis A Mayz, JD, MD, MBA, FACEP
OREGON CHAPTER	Brittany N Arnold, MD, FACEP Patsy Chenpanas, MD John C Moorhead, MD, FACEP C Craig Rudy, MD, FACEP Christian Smith, MD, FACEP
PENNSYLVANIA CHAPTER	Lauren Altomare, DO Blake C Bailey, DO, FACEP Christopher L Berry, MD, FACEP Monisha Bindra, DO, MPH, FACEP Jason R Burkett, DO, FACEP Ankur A Doshi, MD, FACEP Eric Eustice, DO Adriana Facchiano, MD Todd Fijewski, MD, FACEP Avram Flamm, DO, FACEP Richard Hamilton, MD, MBA, FACEP Brian Kelly, DO Zeenah Mansour, MD Scott Mueller, DO, FACEP Jennifer L Savino, DO, FACEP Holly A Stankewicz, DO, FACEP

	Elizabeth Barrall Werley, MD, FACEP Christopher J Wilson, MD, FACEP Zinta L Zapp, MD, FACEP
PUERTO RICO CHAPTER	Natalia N. Rivera Mendoza, MD Eddie Gabriel Rodriguez, MD, FACEP
RHODE ISLAND CHAPTER	Nadine T Himelfarb, MD, FACEP Achyut B Kamat, MD, FACEP Jessica Smith, MD, FACEP
SOCIETY OF ACADEMIC EMERGENCY MEDICINE	Michelle Lall, MD, FACEP
SOUTH CAROLINA CHAPTER	Matthew D Bitner, MD, FACEP Allison Leigh Harvey, MD, FACEP Angel Rochester, MD, FACEP Andriana Slavica Saric, DO Dawn Angela Louise Zellner, MD, FACEP
SOUTH DAKOTA CHAPTER	Donald Neilson, MD
TENNESSEE CHAPTER	Stanton Elseroad, MD, MBA, FACEP Sanford H Herman, MD, FACEP Kenneth L Holbert, MD, FACEP Kito Lord, MD MBA CHCQM-PHYADV, FACEP Sullivan K Smith, MD, FACEP
TEXAS CHAPTER	Sara Andrabi, MD, FACEP Jessica Ann Best, MD, FACEP Angela Pettit Cornelius, MD, FACEP Bryan M Dunn, MD, FACEP Hilary E Fairbrother, MD, FACEP Diana L Fite, MD, FACEP Robert D Greenberg, MD, FACEP Robert Hancock, Jr, DO, FACEP Doug Jeffrey, MD, FACEP Alexander J Kirk, MD, FACEP Ben Leeson, MD, FACEP Kimberly Leeson, MD, FACEP Laura N Medford-Davis, MD, FACEP Ira R Nemeth, MD, FACEP Heather S Owen, MD, FACEP Michael D Parsa, MD, FACEP R Lynn Rea, MD, FACEP Marcus Lynn Sims, II, DO, FACEP Theresa Tran, MD, FACEP Gerad A Troutman, MD, FACEP Sandra Williams, DO, MPH, FACEP
UTAH CHAPTER	Bennion D Buchanan, MD MBA FACEP David Brent Mabey, MD Jordan Mabey, MD Sean D Slack, DO, FACEP
VERMONT CHAPTER	Matthew S Siket, MD, FACEP Alexandra Nicole Thran, MD, FACEP

VIRGINIA CHAPTER	Benjamin Blackwood, MD Caroline Hollis Cox, MD Joshua Easter, MD Joshua Lesko, MD, FACEP Brooke Harris Lindborg, MD, FACEP Katherine Dickerson Mayes, MD, PhD Todd Parker, MD, FACEP Jesse D Spangler, MD, FACEP Theodore J Tzavaras, MD Lauren Webb, MD, FACEP
WASHINGTON CHAPTER	Herbert C Duber, MD, MPH, FACEP Joshua R Frank, MD, FACEP Sarah M Hansen, MD Erika Schroeder, MD Vasisht Srinivasan, MD, FACEP Jessica J Wall, MD, MPH, MSCE, FACEP Aine Yore, MD, FACEP
WEST VIRGINIA CHAPTER	Christopher S Goode, MD, FACEP Mark Gustafson, DO, FACEP Carol Lea Wright Becker, MD, MBA, FACEP
WISCONSIN CHAPTER	Bradley Burmeister, MD, FACEP William D Falco, MD, MS, MBA, FACEP Susan E Good, MD, MBA, FACEP Lisa J Maurer, MD, FACEP Christopher Torkilsen, DO, FACEP Stephanie J Wagner, MD, FACEP
WYOMING CHAPTER	Russell Lauver, DO
AAWEP SECTION	Jayne M Kendall, MD, FACEP
ACCESS, BELONGING, AND COMMUNITY SECTION	Christopher L Smith, MD, FACEP
AIR MEDICAL TRANSPORT SECTION	Woodrow James Sams, MD
CAREERS IN EMERGENCY MEDICINE SECTION	Skyler E Smith, DO
CRITICAL CARE MEDICINE SECTION	Katherine Allison Pollard, MD, FACEP
CRUISE SHIP MEDICINE SECTION	Cai Glushak, MD, FACEP
DEMOCRATIC GROUP PRACTICE SECTION	David G Hall, MD, FACEP
DISASTER MEDICINE SECTION	Kylie Hayes Klemann, MD
DUAL TRAINING SECTION	Allyssa M Abel, MD, MPH
EM PRACTICE MGMT & HEALTH POLICY SECTION	Robert M McNamara, MD
EMERGENCY MEDICAL INFORMATICS SECTION	Tricia Smith, MD, FACEP
EMERGENCY MEDICINE LOCUM TENENS SECTION	Jamila Goldsmith, MD, FACEP
EMERGENCY MEDICINE WORKFORCE SECTION	Ricki A Brown, MD

EMERGENCY TELEHEALTH SECTION	Iyesatta Massaquoi Emeli, MD, MPH, FACEP
EMERGENCY ULTRASOUND SECTION	Tobias Kummer, MD, FACEP
EMS-PREHOSPITAL CARE SECTION	Matthew J Levy, DO, MSc, FACEP
EVENT MEDICINE SECTION	Melissa D Kohn, MD, FACEP
EXPLORING RETIREMENT SECTION	Charles F Pattavina, MD, FACEP
FORENSIC MEDICINE SECTION	Jessica Elizabeth Hobbs, DO, FACEP
FREESTANDING EMERGENCY CENTERS	Leo Huynh, DO, FACEP
GERIATRIC EMERGENCY MEDICINE SECTION	Angel Li, MD, MBA
INTERNATIONAL EMERGENCY MEDICINE SECTION	Andres M Patino, MD, FACEP
MEDICAL DIRECTORS SECTION	Bruce M Lo, MD, MBA, RDMS, FACEP
MEDICAL HUMANITIES SECTION	Diane M Birnbaumer, MD, FACEP
OBSERVATION SERVICES SECTION	Joseph D Lykins, V, MD
PAIN MANAGEMENT SECTION	Rachel Haroz, MD
PALLIATIVE MEDICINE SECTION	Daniel Boron-Brenner, DO
PEDIATRIC EMERGENCY MEDICINE SECTION	Paula Jo Whiteman, MD, FACEP
QUALITY IMPROVEMENT & PT SAFETY SECTION	Collin Michels, MD
RESEARCH, SCHOLARLY ACTIVITY, & INNOVATION SECTION	Charles B Kemmler, MD, PhD, FACEP
RURAL EMERGENCY MEDICINE SECTION	Ashley Kochanek Weisman, MD, FACEP
SOCIAL EMERGENCY MEDICINE SECTION	Kelli L Jarrell, MD, MPH
SPORTS MEDICINE SECTION	Katie Dolbec, MD, FACEP
TACTICAL AND LAW ENFORCEMENT SECTION	James R Waymack, MD, FACEP
TOXICOLOGY SECTION	Jennifer Hannum, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Gregory Luke Larkin, MD, FACEP
UNDERSEA & HYPERBARIC MEDICINE SECTION	Drue Orwig, DO, MBA
WELLNESS SECTION	Harry W Severance, MD, FACEP
WILDERNESS MEDICINE SECTION	Dana R Mathew, MD, FACEP
YOUNG PHYSICIANS SECTION	Sophia Spadafore, MD, MA

In addition to the credentialed councillors, the following past leaders attended all or part of the Council meeting and were not serving as councillors:

Past Presidents

Nancy J. Auer, MD, FACEP
Brooks F. Bock, MD, FACEP (CO)
Vidor E. Friedman, MD, FACEP (CO)
Angela F. Gardner, MD, FACEP (TX)
Michael J. Gerardi, MD, FACEP (NJ)
Nicholas J. Jouriles, MD, FACEP (OH)
Christopher S. Kang, MD, FACEP (WA)
Paul D. Kivela, MD, FACEP (AL)
George R. Molzen, MD, FACEP (NM)
Mark S. Rosenberg, DO, MBA, FACEP (NJ)
Andrew E. Sama, MD, FACEP (NY)
Robert W. Schafermeyer, MD, FACEP (NC)
Gillian R. Schmitz, MD, FACEP (GS)
Sandra M. Schneider, MD, FACEP (TX)
Richard L. Stennes, MD, FACEP (CA)

Past Speakers

Michael J. Bresler, MD, FACEP (CA)
Peter M. Fahrney, MD, FACEP (VA)
Peter J. Jacoby, MD, FACEP (CT)
Gary R. Katz, MD, MBA, FACEP (OH)
Todd B. Taylor, MD, FACEP (AZ)
Dennis C. Whitehead, MD, FACEP (MI)

Past Chairs of the Board

Stephen H. Anderson, MD, FACEP (WA)
John D. Bibb, MD, FACEP (CA)
Jon Mark Hirshon, MD, PhD, FACEP (MD)
Ramon W. Johnson, MD, FACEP (CA)
David P. Sklar, MD, FACEP (NM)

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The Council Standing Rules were distributed to the councillors prior to the meeting and were not read aloud.

Council Standing Rules

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed. A councillor or an alternate councillor may not serve simultaneously as an alternate councillor for more than one component body.

If the number of alternate councillors is insufficient to fill all councillor positions for a component body, then a member of that component body may be seated as a councillor pro-tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, and component bodies are responsible for abiding by the campaign rules.

Conflict of Interest Disclosure

All councillors and alternate councillors will be familiar with and comply with ACEP's Conflict of Interest policy. Individuals who have a financial interest in a commercial enterprise, which interest will be materially affected by a matter before the Council, will declare their conflict prior to providing testimony.

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by component body and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate councillor. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials, & Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials, & Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

Councillors, members of the Board of Directors, past presidents, past speakers, and past chairs of the Board wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, past chair, etc.), and whether they are speaking "for" or "against" the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been granted by the presiding officer. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the presiding officer, alternate councillors not currently seated and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual's name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot, which may include remote communication and voting technology. There shall be no write-in voting. Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies

between votes and notify the speaker.

When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, & Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

**NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.*

The chair of the Tellers, Credentials, & Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, & Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, & Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Electronic Devices

All electronic devices must be kept in "quiet" mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of electronic devices for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Leadership Development Advisory Committee

The Leadership Development Advisory Committee (LDAC) is a Council Committee charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAC will offer to interested members guidance in opportunities for College leadership and, when applicable, in how to obtain and submit materials necessary for consideration by the Nominating Committee.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. ***See also Debate and Voting Immediately.***

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, past speaker, or past chair of the Board, after which nominations will be closed and shall not be reopened.

Members not nominated by the Nominating Committee may self-nominate by declaring themselves "floor candidates" at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the speaker of intent to seek nomination, whichever date is later. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure* will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Limiting Debate and Voting Immediately.***

Any councillor may call for a "point of personal privilege," "point of order," or "parliamentary inquiry" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege," etc. to interject debate is out of order.

Past Presidents, Past Speakers, and Past Chairs of the Board Seating

Past presidents, past speakers, and past chairs of the Board of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Policy Review

The Council Steering Committee will report annually to the Council the results of a periodic review of non-Bylaws resolutions adopted by the Council and approved by the Board of Directors.

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council, except for commendation and memorial resolutions. Reference Committee meetings are open to all members of the College, its committees, and invited guests.

Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is not adopted, the speaker shall state the original resolution.

Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

Reports

Committee and officer reports to be included in the Council minutes must be submitted in writing to the Council secretary. Authors of reports who petition or are requested to address the Council should note that the purpose of these presentations are to elaborate on the facts and findings of the written report and to allow for questions. Debate on relevant issues may occur subsequent to the report presentation.

Resolutions

"Resolutions" are considered formal motions that if adopted by a majority vote of the Council and ratified by the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a two-thirds vote of the Board of Directors.

Resolutions must be submitted in writing by at least two members or by component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body. All resolution sponsors and cosponsors must be confirmed at least 45 days in advance of the Council meeting.

All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.

Background information, including financial analysis, will be prepared by staff on all resolutions submitted on or before 90 days prior to the annual meeting.

- ***Regular Non-Bylaws Resolutions***

  Non-Bylaws resolutions submitted on or before 90 days prior to the annual meeting are known as "regular resolutions" and will be referred to an appropriate Reference Committee for consideration at the annual meeting.

  Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as "Late Resolutions."

- ***Bylaws Resolutions***

  Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

  Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of order under parliamentary authority, will not be permitted.

- ***Late Resolutions***

  Resolutions submitted after the 90-day submission deadline, but at least 24 hours prior to the beginning of the annual meeting are known as "late resolutions." These late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual meeting. The Steering Committee is empowered to decide whether a late submission is justified due to events that occurred after the filing deadline. An author of the late resolution shall be given an opportunity to inform the Steering Committee why the late submission was justified. If a majority of the Steering Committee votes to accept a late resolution, it will be presented to the Council at its opening session and assigned to a Reference Committee. If the Steering Committee votes unfavorably and rejects a late resolution, the reason for such action shall be reported to the Council at its opening session. The Council does not consider rejected late resolutions. The Steering Committee's decision to reject a late resolution may be appealed to the Council. When a rejected late resolution is appealed, the Speaker will state the reason(s) for the ruling on the late resolution and without debate, the ruling may be overridden by a two-thirds vote.

- ***Emergency Resolutions***

  Emergency resolutions are resolutions that do not qualify as "regular" or "late" resolutions. They are limited to substantive issues that because of their acute nature could not have been anticipated prior to the annual meeting or resolutions of commendation that become appropriate during the course of the Council meeting. Resolutions not meeting these criteria may be ruled out of order by the speaker. Should this ruling be appealed, the speaker will state the reason(s) for ruling the emergency resolution out of order and without debate, the ruling may only be overridden by a two-thirds vote. ***See also Appeals of Decisions from the Chair.***

Emergency resolutions must be submitted in writing, signed by at least two members, and presented to the Council secretary. The author of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the Council to determine its merits. Without debate, a simple majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, it shall upon acceptance by the Council be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution shall be debated on the floor of the Council at a time chosen by the speaker.

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate.

All resolutions assigned to a Reference Committee shall be placed on a Unanimous Consent Agenda.

The Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, amendment, substitution, or not for adoption for each resolution listed. A request for extraction of any resolution from the Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

A motion to "vote immediately" may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting. Councillors are out of order who move to "vote immediately" during or immediately following their presentation of testimony on that motion. The motion to "vote immediately" applies only to the immediately pending matter, therefore, motions to "vote immediately on all pending matters" is out of order. The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to "vote immediately" will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, including remote communication technology, voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue. Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. However, points of order related to perceived or potential mass discrepancies in voting are still in order. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the speaker.

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The councillors reviewed and accepted the minutes of the October 6-7, 2024, Council meeting and approved the actions of the Steering Committee taken at their January 21, 2025, and April 27, 2025, meetings.

Dr. Schneider, interim executive director and interim Council secretary, addressed the Council. She introduced Michael Fraser, PhD, MS, CAE, who will become ACEP's executive director effective November 1, 2025, and he addressed the Council.

Dr. Costello called for submission of emergency resolutions. The emergency resolution "In Memory of Frank L. Zwemer, Jr., MD, FACEP, was accepted by the Council. Commendation and memorial resolutions are not assigned to a Reference Committee for testimony. The emergency resolution "Support and Endorsement of Current Vaccine Guidelines by Fellow Medical Professional Organizations" was accepted by the Council. It was numbered 90 and assigned to Reference Committee C.

Dr. Costello reported that nine late resolutions were received and reviewed by the Steering Committee. Eight memorial resolutions were accepted by the Steering Committee. Commendation and memorial resolutions are not

assigned to a Reference Committee for testimony. One late resolution was accepted for submission to the Council. The late resolution "Support for Scientific Integrity in Medicine and Public Health" was numbered 89 and assigned to Reference Committee B.

Dr. Costello presented the Nominating Committee report.

Dr. McCrea was the only nominee for Speaker of the Council. Dr. Costello called for floor nominations. There were no floor nominees. The nominations were then closed. With no objections, Dr. McCrea, was declared as the 2025-27 speaker of the Council.

Three members were nominated for Council Vice Speaker: Kurtis A. Mayz, MD, JD, FACEP; Larisa M. Traill, MD, FACEP; and Aine Yore, MD, FACEP. Dr. Gray-Eurom called for floor nominations. There were no floor nominees. The nominations were then closed.

Five members were nominated for four positions on the Board of Directors: Daniel Freess, MD, FACEP; Robert Hancock, DO, FACEP; Steven B. Kailes, MD, FACEP; Kristin McCabe-Kline, MD, FACEP; and Bing S. Pao, MD, FACEP. Dr. Costello called for floor nominations. There were no nominees. The nominations were then closed.

Two members were nominated for President-Elect: Jeffrey M. Goodloe, MD, FACEP, and Gabor D. Kelen, MD, FACEP. Dr. Costello called for floor nominations. Ryan A. Stanton, MD, FACEP, was nominated from the floor. The nominations were then closed.

Dr. Costello explained the Candidate Forum procedures. The candidates then made their opening statements to the Council.

The Alabama Chapter requested to withdraw Resolution 42. There were no objections and the resolution was withdrawn.

The Council recessed at 9:50 am for the Reference Committee hearings. The resolutions considered by the 2025 Council appear below as submitted.

2025 Council Resolutions

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends Melissa Wysong Costello, MD, FACEP, for her service as Council Vice Speaker and Council Speaker and for her enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians commends and expresses its deepest appreciation to the John A. Hartford Foundation and its President, Terry Fulmer, PhD, RN, FAAN, who is stepping down after 10 years of dedicated service to the foundation, for their exceptional leadership, dedication, and support of geriatric emergency care on behalf of the College.

RESOLUTION 3

RESOLVED, That the American College of Emergency Physicians commends Gene Scruggs for his outstanding service and commitment to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for his extraordinary contributions.

RESOLUTION 4

RESOLVED, That the American College of Emergency Physicians commends Michael J. Lemanski, MD, FACEP, for his outstanding dedication and contributions on behalf of the specialty of emergency medicine and to the CPT Editorial Panel.

RESOLUTION 5

RESOLVED, That the American College of Emergency Physicians commends and expresses its deepest

appreciation to West Health and its CEO Shelley Lyford for their exceptional leadership, dedication, and support of geriatric emergency care on behalf of the College.

RESOLUTION 6

RESOLVED, That the American College of Emergency Physicians commends Aisha T. Terry, MD, MPH, FACEP, for her exceptional leadership, enduring contributions to the specialty of emergency medicine, and her unwavering dedication to the mission and values of ACEP and the patients we serve.

RESOLUTION 7

RESOLVED, That the American College of Emergency Physicians commends Richard E. Wolfe, MD, FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency medicine.

RESOLUTION 8

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by James B. Broselow, MD, as one of the leaders in advancing pediatric emergency care, pediatric readiness, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of James B. Broselow, MD, his wife Millie, his family, and his friends our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of North Carolina and the United States.

RESOLUTION 9

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Vinod K. Chettur, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his mother Jayanthi Menon, his father Govindan Chettur, his sister Rema Makhija, and his nephew Aran our heartfelt gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 10

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognizes the outstanding dedication and contribution of Terry A. Conklin, MD, FACEP, to the specialty of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further

RESOLVED, That the American College of Emergency Physicians and the Alaska Chapter extends to the family of Terry A. Conklin, MD, FACEP, his colleagues, partners, former residents, and all friends our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Alaska, where his impact will be felt for generations to come.

RESOLUTION 11

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the lifetime of service that Gregory L. Henry, MD, FACEP gave to the specialty of emergency medicine, generations of emergency physicians, and the patients we serve as a clinician, educator, leader, orator, advocate, and scholar; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Henry, MD, FACEP, especially his wife Margene, his three children, and his two grandchildren, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, the United States, and the world, where his impact will be felt for generations to come.

RESOLUTION 12

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Richard T. Hostelley, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Linda of 49 years, his sister Bissie Miller, and numerous nieces and nephews gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

RESOLUTION 13

RESOLVED, That the American College of Emergency Physicians extends its deepest sympathy to the family, friends, and colleagues of Frank J. Jehle, Jr., MD, MPH, FACEP, FAAP; and be it further

RESOLVED, That ACEP gratefully acknowledges and honors the legacy of Frank J. Jehle, Jr., MD, MPH, FACEP, FAAP, a physician of extraordinary compassion, wisdom, and integrity that touched innumerable live, whose wisdom will be passed down for generations and made lasting contributions to the field of pediatric emergency medicine.

RESOLUTION 14

RESOLVED, That the American College of Emergency Physicians honors the legacy of Roger B. Lim, MD, and recognizes his extraordinary contributions to emergency medicine, his dedication to the countless lives he saved, and the compassion that defined his practice; and be it further

RESOLVED, That the American College of Emergency Physicians extends our deepest sympathies to the family, friends, and colleagues and remembers the profound impact Roger B. Lim, MD, made and that his memory will continue to inspire all who follow in his footsteps.

RESOLUTION 15

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Lidio W. Medina, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Patricia of 53 years, his son Jim (wife Stacie), and daughter Michelle Medina-Smuck (husband Darryl), as well as his numerous grandchildren, gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 16

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Joesph Moellman, MD, who dedicated himself to his patients, his trainees, his profession, and his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Ohio College of Emergency Physicians extends to his wife Kim, his sons Josh Moellman and Jordan Moellman, gratitude for his tremendous service as an emergency physician at the University of Cincinnati, as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 17

RESOLVED, That the American College of Emergency Physicians extends to the family of Frank S. Orth DO, FACEP, his friends, and his colleagues our condolences and gratitude for his service to his community and the countless patients that benefited from his care.

RESOLUTION 18

RESOLVED, That the American College of Emergency Physicians honors the memory of Jan Reisinger, MBA, CAE; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to her husband Greg, her mother Maxine, her sister Ann, and her extended family, as well as countless professional colleagues and personal friends, gratitude for her service to the specialty of emergency medicine.

RESOLUTION 19

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Ronald D. Stewart, MD, FACEP, FAEMS; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his sister Donalda (James) Davis, and his countless friends, colleagues, and students gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

RESOLUTION 20

RESOLVED, That the American College of Emergency Physicians honors the memory of Todd Thomas, CPC, CCS-P, and extends its deepest sympathies to his family, friends, and colleagues, and gratitude for his commitment and contributions to the specialty of emergency medicine.

RESOLUTION 21

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility and Section 2 – Fellow Status be amended to establish a "Distinguished Fellow of ACEP" [FACEP(D)] that is based on objective, points-based criteria and awarded to members who have held FACEP status for a minimum of 12 years and demonstrated continued commitment to ACEP and the specialty of emergency medicine:

ARTICLE V — ACEP FELLOWS
Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, regular, or international members for three continuous years immediately prior to election.
2. Be 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.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria 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.

Distinguished Fellows of the College shall meet the following criteria:

1. **Have held FACEP status for at least 12 years.**
2. **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.**
3. **Meet a minimum number of points within the following requirements demonstrating evidence of commitment to emergency medicine:**
   A. Research and scholarship, as evidenced by grant awards, peer-reviewed publication, or review or authorship of books or other professional resources.
   B. Teaching and mentorship, as evidenced by teaching history, faculty status, student or resident advisement, or residency/fellowship/clerkship leadership.
   C. Service and leadership, as evidenced by leadership within their emergency department, hospital, staffing group, state or local medical societies, community health planning, or other roles which have advanced the field.
   D. Clinical excellence, as evidenced by clinical or industry awards, letters of support from their chair or medical director, or participation in quality, safety, or wellness activities.
4. **Meet a minimum number of points within the following requirements demonstrating evidence of commitment to ACEP.**

A. **Leadership activities, including participation or leadership within ACEP sections, committees, chapters, delegations, advocacy groups, task forces, Member Interest Groups, Board of Directors, or Council.**
B. **Education activities, including participation as faculty or course directors in ACEP in-person or virtual educational offerings.**
C. **Public awareness activities, including active involvement in ACEP's online communities, media relations or spokesperson network, or promotion of College wins and activities on social media.**
D. **Recognitions, including individual receipt of ACEP awards or hospital/employer receipt of ACEP accreditation status.**

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.

Section 2 – Fellow Status

Fellows shall be authorized to use the letters FACEP **or FACEP(D)** in conjunction with professional activities. Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status. Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

RESOLUTION 22

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility and Section 2 – Fellow Status be amended to establish an "International Fellow of ACEP" FACEP(I) and awarded to members who live and practice outside of the United States:

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, **or** regular~~, or international~~ member for three continuous years immediately prior to election.
2. Be 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.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria 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.

International Fellows of the College shall meet the following criteria:

1. **Be an international member of ACEP for at least three years immediately prior to election.**

2. **Be certified in emergency medicine by an internationally recognized certifying body, or have completed the minimum training standards to practice emergency medicine within their country (if certification is not available).**
3. **Provide a letter of support from an established authority such as their institution medical director, training program director, or emergency medicine society.**
4. **Satisfy at least three of the following individual requirements demonstrating commitment to emergency medicine:**
   A. **Active involvement in organized medicine, as evidenced by three years of membership or leadership within any local, national, or regional society dedicated to advancing emergency medicine.**
   B. **Active involvement in local hospital affairs, such as medical staff committees.**
   C. **Active involvement in the formal training of future emergency medicine physicians.**
   D. **Active involvement in departmental or governmental administration or affairs.**
   E. **Active involvement in EMS systems or disaster preparedness planning activities.**
   F. **Research or scholarly publication in emergency medicine.**
5. **Satisfy at least one of the following individual requirements demonstrating involvement with ACEP:**
   A. **Active participation in ACEP sections, committees, or other leadership bodies.**
   B. **Participation in the development, delivery, or promotion of ACEP educational offerings and resources within home country.**
   C. **Participation in ACEP educational or research activities (such as in-person attendance at ACEP Scientific Assembly meeting(s), scholarly publication in emergency medicine in *Annals of Emergency Medicine* or *JACEP Open*, etc.).**
   D. **Other contributions to 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.

Section 2 – Fellow Status

Fellows shall be authorized to use the letters FACEP **or FACEP(I)** in conjunction with professional activities. Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status. Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

RESOLUTION 23

RESOLVED, That the Council Standing Rules – Councillor Allocation for Sections of Membership be amended to read:

"To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, ~~or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting~~ **as defined in the Bylaws**. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting."

RESOLUTION 24

RESOLVED, That the College Manual be amended by substitution of the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to read:

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. Definitions

1. ACEP means the American College of Emergency Physicians.
2. *Code of Ethics* means the *Code of Ethics for Emergency Physicians.*
3. *Procedures* means the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct.*
4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee **with no conflicts of interest in each pending matter** – in

matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee.

5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.
6. Board Hearing Panel conducts all hearings and consists of ~~the~~ **an** ACEP Vice President, Chair of the Board, and Board Liaison to the Ethics Committee.
7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

B. 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;
2. Must specify in reasonable detail an alleged violation by an ACEP member of an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, ACEP *Code of Ethics*, other ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ten (10) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating 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~~ **any protected health information** or any identifying information related to members of the patient's family;
5. Must state that the complainant is willing to have ~~his or her~~ **their** name disclosed to the ACEP Executive Director~~,~~ **and** any additional ACEP review body listed in these *Procedures*, ~~and the respondent~~ should the complaint be forwarded to the respondent; and
6. Must be submitted to the ACEP Executive Director.

C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.
   b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming complainant's intent to file a complaint. Includes a copy of ACEP's *Procedures* providing guidelines and timetables that will be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the *Procedures*.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the *Procedures.*
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. **Determines, in consultation with the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, along with other committee designee(s) as appropriate given the subject matter of the complaint, that:**
   a. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, the Bylaws Committee, or other committee designee, that t~~**T**he **charges and conduct set forth in the** complaint**, as alleged by the complainant,** ~~is frivolous, inconsequential, or~~ do~~es~~ not allege an actionable violation of a policy or principle included in the *Code of Ethics* or 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. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, or other committee designee, that t~~**T**he complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics*, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics Complaint Review Panel **after membership on the Ethics Complaint Review Panel has been confirmed;** or
   c. ~~Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee, or other committee designee, that t~~**T**he complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, after both are received, to each member of the 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 **and that has been screened for conflicts of interest;** 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. T~~the Ethics Complaint Review Panel or the Bylaws Committee**, as appropriate,** will review the President's ~~action~~ **recommendation to reject the complaint**. The President's action can be overturned by a majority vote of the applicable ACEP review body **or adopted by the body**.

5. Within ten (10) business days after the determination specified in Section C.4.b. or Section C.4.c. of these *Procedures*, forwards the complaint to the respondent by USPS Certified Mail with a copy of these *Procedures* 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 complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the applicable ACEP review body decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant 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 applicable ACEP review body, including 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 Complaint Review Panel or the Bylaws Committee appointed to review the complaint, as appropriate.

D. Ethics Complaint Review Process. ~~w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Ethics Complaint Review Panel:

1. Reviews the written record of any complaint that alleges a violation of the ACEP *Code of Ethics* or other ACEP ethics policies as they existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference **or web conference** call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. ~~Ethics Complaint Review Panel r~~**R**enders a decision to impose disciplinary action, based on the written record.
6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:
   a. A hearing; or
   b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.
7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

E. Bylaws Complaint Review Process ~~w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Bylaws Committee:

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference **or web conference** call.
3. Determines the need to solicit in writing additional information or documentation from the parties,

third parties, or experts regarding the complaint.

4. Considers whether:
   a. Applicable version of the ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. ~~Bylaws Committee r~~**R**enders a decision to impose disciplinary action, based solely on the written record.
6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.
7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

F. Right of Respondent to Request a Hearing

If the Ethics Complaint Review Panel or Bylaws Committee chooses to impose disciplinary action, the Executive Director will send to the respondent a written notice by USPS Certified Mail of the right to request a hearing. ~~This~~ **The respondent may request a hearing to appeal the disciplinary decision or the sanction imposed. 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 Executive Director within thirty (30) days of receipt of the notice of right to a hearing. In the event of no response, the applicable ACEP review body will implement its final decision.

G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail 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.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel ~~or any other person of their 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, audio~~tape~~, **recording,** or video~~tape~~ **recording** at the expense of the requesting party. **A copy of any such record must be provided to the Executive Director.**
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is ~~impossible or commercially impracticable~~ **impractical** for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.
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. **Any documents or materials to be provided or presented during the hearing not already in the record, including written documents, handouts, or slide presentations, must be provided to the presiding officer 14 days prior to the hearing to assess if the material and information contained therein are relevant to the proceedings.** 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. The Board Hearing Panel 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.
9. The decision of the Board Hearing Panel 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 Hearing Panel's decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board Hearing Panel's decision and a

statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the applicable ACEP review body in its review of the complaint. The Board shall review the *Procedures* used in the complaint review process but will not review the facts or merits of the case. Should the Board decide these *Procedures* were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. Possible Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Action
   a. Censure
      i. Private Censure: a private letter of censure informs a member that his or her conduct does not conform with the College's ethical standards; it may detail the manner in which ACEP expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the letter will not be provided. **Private censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards but appears to be a minor isolated incident. The member's actions are not egregious in nature but fall outside of acceptable conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for single ethical violations in the course of a single legal case.**
      ii. 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 set forth in Section B.2. above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**.
      Public censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and demonstrates a pattern of unethical behavior or a single example of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for multiple ethical violations in the course of a single legal case.
   b. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the-ACEP President. At the end of the twelve (12) month period of suspension, the suspended member may request 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). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to the Board 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.
      Suspension is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations across more than one legal case.
   c. Expulsion from ACEP membership shall be for a period of five (5) 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. The

expulsion announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**. 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.
Expulsion is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct to a degree warranting discipline beyond the suspension available under I.1.b. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations over multiple legal cases.

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. ~~Such~~ **The** letter shall specify the name of the member or former member who is the subject of the request. The Executive Director ~~shall~~ **may** disclose, in writing, the relevant information as described in Section I.1.
   b. Disclosure to Non-Members: If a non-member makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided. **If a non-member makes a request for information about disciplinary actions against a member who has received private censure, the Executive Director shall inform the individual that no published announcement of disciplinary action is available but shall not indicate or confirm that a private censure has been imposed.**

J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section I. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel, 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 ACEP review body's overall time to complete its task.
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel) 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 person shall recuse himself or herself from the process except as a complaining party or respondent, at which time the ACEP President will appoint a replacement.
6. Once the Ethics Complaint Review Panel or the Bylaws Committee has made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The Ethics Complaint Review Panel or the Bylaws Committee's decision to impose ~~an adverse~~ **a disciplinary** 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~~ **review** process.
8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a request for information, the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.
9. If a respondent seeks to voluntarily resign ~~his/her~~ **their** ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the

complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

RESOLUTION 25

RESOLVED, That the Board of Directors amend the "Policy on Sections of Membership" to require that a charter for any section of membership may only be suspended or revoked by a two-thirds vote of the Board of Directors.

RESOLUTION 26

RESOLVED, That ACEP reaffirm its commitment to the core principles of diversity, equity, and inclusion, recognizing their fundamental role in promoting patient-centered care, health equity, and a thriving, representative workforce by reaffirming its previous policy statement supporting diversity, equity, and inclusion as essential to the College's mission and the practice of emergency medicine.

RESOLUTION 27

RESOLVED, That ACEP reaffirm its commitment to promoting and maintaining equal access to care in the emergency department, ensuring that all patients and staff are treated with respect, dignity, and fairness; and be it further

RESOLVED, That ACEP advocate for the implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; and be it further

RESOLVED, That ACEP support the continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; and be it further

RESOLVED, That ACEP support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and be it further

RESOLVED, That ACEP call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics/

RESOLUTION 28

RESOLVED, That ACEP create and implement a comprehensive mentorship program accessible to all members; and be it further

RESOLVED, That ACEP's mentorship program include resources to support the mentorship of members from marginalized and underrepresented communities in medicine.

RESOLUTION 29

RESOLVED, That ACEP develop strategies and report annually on efforts to provide equal access to leadership for all members regardless of background.

RESOLUTION 30

RESOLVED, That ACEP work with the Emergency Medicine Foundation to develop research grant opportunities that require applicants to be ACEP members.

RESOLUTION 31

RESOLVED, That ACEP initiate an internal review of the quality and impact of articles published in both its official journals, *Annals of Emergency Medicine* and *JACEP Open*; and be it further

RESOLVED, That ACEP survey its membership to assess perceptions regarding ACEP's affiliation with an open access journal with publication charges; and be it further

RESOLVED, That the findings from both a journal quality assessment and a member survey of membership perceptions regarding an open access journal be reported to the ACEP Council within 12 months of resolution adoption, along with any recommendations for future editorial direction or affiliation.

RESOLUTION 32

RESOLVED, That ACEP publicly release its current guidelines on restricted or censored topics; and be it further

RESOLVED, That ACEP refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards; and be it further

RESOLVED**,** That any restriction of vendors or speakers at Scientific Assembly be subject to review and approval by the Council to ensure transparency and accountability.

RESOLUTION 33

RESOLVED, That ACEP identify and work with other key stakeholders to develop a public education campaign targeted to help patients better understand which complaints are appropriate for an urgent care center environment versus an emergency department to help streamline their care and costs.

RESOLUTION 34

RESOLVED, That ACEP recognize public media as a public health necessity, which is a vital component of a well-informed public and public health infrastructure; and be it further

RESOLVED, That ACEP support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

RESOLUTION 35

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and the Emergency Medicine Review Committee to advocate for required representation from dual trained physicians in writing requirements or create a separate Combined Emergency Medicine Review Committee.

RESOLUTION 36

RESOLVED, That ACEP reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," established by Council Resolution 22(23) recognizing the value of and supporting continued accreditation of both three- and four-year emergency medicine residency programs; and be it further

RESOLVED, That ACEP oppose any mandate requiring exclusive transition to three-year or four-year emergency medicine residency training without clear, substantial evidence of benefit of one training length; and be it further

RESOLVED, That the Board of Directors reaffirm their commitment to represent ACEP policy statements when making public statements on behalf of the College.

RESOLUTION 37

RESOLVED, That ACEP advocate for changes in Centers for Medicare & Medicaid Services policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

RESOLUTION 38

RESOLVED, That ACEP advocate for the American Board of Emergency Medicine to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements; and be it further

RESOLVED, That ACEP collaborate with the American Board of Emergency Medicine to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification; and be it further

RESOLVED, That ACEP and the American Board of Emergency Medicine work toward implementing the criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

RESOLUTION 39

RESOLVED, That ACEP actively engage with the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and the American Board of Medical Specialties to advocate for the recognition of board certification as an exemption for relevant state-mandated CME requirements; and be it further

RESOLVED, That ACEP, in collaboration with American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and the American Board of Medical Specialties, and other relevant medical organizations, initiate a proactive effort to work with state medical boards and legislatures to ensure that mandated continuing medical education topics for non-boarded physicians are evidence-based, specialty-relevant, and

aligned with the principles of best medical practice; and be it further

RESOLVED, That ACEP create and distribute educational materials to its members highlighting the potential pitfalls of poorly designed state-mandated "merit badge" continuing medical education and the benefits of relying on American Board of Medical Specialties board certification for ensuring physician competence and support its members in their efforts to educate and advocate to state legislatures on this issue.

RESOLUTION 40

RESOLVED, That ACEP provide and encourage ongoing education for members on implicit bias, systemic inequities, culturally responsive, and equal access to care for all as part of its life-long learning commitment.

RESOLUTION 41

RESOLVED, That ACEP support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders and legal experts to advocate for legislative and regulatory changes that shift medical liability from a fault-based system to a no-fault compensation model; and be it further

RESOLVED, That ACEP promote a reevaluation of the legal definition of negligence in health care, advocating for a standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and aligns with the American Law Institute's updated guidelines to better reflect modern health care practice and patient safety goals.

RESOLUTION 42 *(This resolution was withdrawn.)*

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, physician advocacy groups, and regulatory bodies, to conduct a focused feasibility study on the implementation of occurrence-based malpractice insurance as a new industry standard for emergency physicians; and be it further

RESOLVED, That ACEP use the results of a feasibility study on the implementation of occurrence-based malpractice insurance to advocate for malpractice insurance models that prioritize long-term physician security, accountability, and the sustainability of the emergency medicine workforce.

RESOLUTION 43

RESOLVED, That ACEP develop and make available publicly a generic support letter that emergency physicians may use during contract negotiations to advocate for the removal of non-compete clauses that prohibit clinical practice within a defined region; and be it further

RESOLVED, That ACEP clearly state in a generic support letter that emergency physicians can use during contract negotiations that non-compete clauses restricting the clinical practice of medicine, as opposed to limiting contractual competition for hospital coverage, are fundamentally unfair, ethically problematic, and harmful to public health and physician well-being; and be it further

RESOLVED, That ACEP continue monitoring and updating members on state and federal developments regarding non-compete reform and support physician advocacy efforts on this issue.

RESOLUTION 44

RESOLVED, That ACEP direct its delegates to the American Medical Association to introduce and support AMA policy that prioritizes addressing workplace violence in health care as a top national advocacy issue; and be it further

RESOLVED, That ACEP direct its delegates to the American Medical Association to advocate for mandatory, standardized reporting of workplace violence incidents across all health care settings and support the aggregation and public dissemination of this data to inform research, benchmarking, and national policy development; and be it further

RESOLVED, That ACEP direct its delegates to the American Medical Association to advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce.

RESOLUTION 45

RESOLVED, That ACEP continue to advocate for the full preservation and expansion of the Medicaid program as an essential component of equitable access to emergency care; and be it further

RESOLVED, That ACEP create a unified policy statement affirming strong support for Medicaid and its importance as a safety net insurance to emergency medicine, and include within it the current policy statements

"Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid Beneficiaries" to create a single, robust policy statement on Medicaid; and be it further

RESOLVED, That ACEP policy affirm ACEP's opposition to administrative or financial barriers that reduce timely access to emergency care for Medicaid beneficiaries and promotes emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

RESOLUTION 46

RESOLVED, That ACEP advocate for federal and state Medicaid funding levels that allow for comprehensive benefit coverage for the poor, regardless of pregnancy, parental, or work status; and be it further

RESOLVED, That ACEP publicly affirm support for comprehensive Medicaid benefits for patients across the United States.

RESOLUTION 47

RESOLVED, That ACEP recognize the Disproportionate Share Hospital cuts are of specific concern to emergency physicians as they have been shown to increase the amount of rural hospital closures; and be it further

RESOLVED, That ACEP partner with relevant organizations such as America's Essential Hospitals to further the cause of protecting Disproportionate Share Hospital payments; and be it further

RESOLVED, That ACEP advocate for H.R. 2665, the Supporting Safety Net Hospitals Act, to repeal or delay the Medicaid Disproportionate Share Hospital cuts scheduled for fiscal years 2026 through 2028.

RESOLUTION 48

RESOLVED, That ACEP update its policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' unwavering ethical and legal obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; and be it further

RESOLVED, That ACEP affirm that federal EMTALA obligations supersede conflicting state laws or mandates that would prevent emergency physicians from providing medically necessary stabilizing treatment for emergency medical conditions; and be it further

RESOLVED, That ACEP advocate for clear federal protections for emergency physicians providing care in accordance with EMTALA requirements, particularly when such care conflicts with state laws; and be it further

RESOLVED, That ACEP work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and be it further

RESOLVED, That ACEP provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

RESOLUTION 49

RESOLVED, That ACEP support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate and ensure that patients requiring transfer to a higher level of care are not inappropriately denied or delayed; and be it further

RESOLVED, That ACEP investigate legislation to replace or update EMTALA with a more contemporary alternative that reflects the current practice of emergency medicine and better ensures that patients receive the medical care they need in a safe and timely manner.

RESOLUTION 50

RESOLVED, That ACEP advocate for strict enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present.

RESOLUTION 51

RESOLVED, That ACEP support state and federal legislative and regulatory efforts to require that a physician, ideally a board-certified or eligible emergency physician, be physically present and available in every emergency department at all times, which includes but is not limited to developing draft legislation on this topic.

RESOLUTION 52

RESOLVED, That ACEP investigate the potential advantages, disadvantages, feasibility, and practical aspects that would be inherent if states were to require licensure of health care administrators; and be it further

RESOLVED, That if investigation supports that health care administrators should be licensed, ACEP will develop model state legislation and advocate for such licensure, while asking the National Emergency Medicine Political Action Committee (NEMPAC) and the various state chapters' political action committees (PACs) to support enactment of appropriate state legislation on this matter; and be it further

RESOLVED, That if investigation supports that health care administrators should be licensed, ACEP will collaborate with other stakeholders, such as but not limited to the American Medical Association, to advocate for state licensure of health care administrators; and be it further

RESOLVED, That ACEP consider adding a course at a future Scientific Assembly to inform members about the case to be made in support of state licensure of health care administrators/

RESOLUTION 53

RESOLVED, That ACEP support federal and state legislative and regulatory efforts to reform prior authorization processes, with the goal of reducing care delays that result in emergency department visits or hospitalizations; and be it further

RESOLVED, That ACEP advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings.

RESOLUTION 54

RESOLVED, That ACEP study the feasibility and potential impact of a complete restructuring or replacement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey and specifically its linkage to Medicare reimbursement, with the aim of developing recommendations that better balance the goals of patient-centered care, physician autonomy, and sustainable health system payment.

RESOLUTION 55

RESOLVED, That ACEP conduct a comprehensive review of The Joint Commission and other health care regulatory bodies' regulatory requirements to identify mandates and interpretations of standards that do not demonstrably improve patient care in the emergency department setting; and be it further

RESOLVED, That ACEP collaborate with The Joint Commission and other health care regulatory bodies to advocate for the elimination or modification of such non-beneficial requirements, aiming to streamline processes, reduce administrative burdens on emergency physicians, and allow more time for direct patient care.

RESOLUTION 56

RESOLVED, That ACEP advocate for legislation at the state and federal levels requiring that artificial intelligence-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel; and be it further

RESOLVED, That ACEP support prohibiting health insurers from relying solely on artificial intelligence-based algorithms to deny, delay, or modify health care claims or services and urge both CMS and state regulatory agencies to establish policies requiring human oversight in these decisions; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that artificial intelligence algorithms used in health care decision-making are transparent, accountable, and subject to oversight by qualified health care professionals.

RESOLUTION 57

RESOLVED, That ACEP advocate for the repeal of Certificate of Need (CON) laws in states where such laws exist and develop a toolkit to support legislative action aimed at eliminating these laws, including evidence-based arguments and strategies for engaging policymakers; and be it further

RESOLVED, That ACEP collaborate with other health care organizations to raise public awareness and educate state policymakers on the negative impacts of Certificate of Need (CON) laws on patient access to emergency care, including overcrowding, boarding, and limited capacity, and advocate for the removal of these regulatory barriers to improve patient flow and health care access.

RESOLUTION 58

RESOLVED, That ACEP acknowledge its prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the emergency department as a valuable foundation, and recognize the continuing potential impact of ICE enforcement actions within emergency departments on patient care and public health; and be it further

RESOLVED, That ACEP advocate for the development and dissemination of clear guidelines and training programs for emergency department staff to manage interactions with U.S. Immigration and Customs Enforcement officials, ensuring the protection of patient rights and the provision of uncompromised medical care; and be it further

RESOLVED, That ACEP support collaboration with legal experts, hospital administrations, and community organizations to establish policies that delineate the role of emergency departments in relation to U.S. Immigration and Customs Enforcement activities, emphasizing the importance of patient trust, safety, and confidentiality.

RESOLUTION 59

RESOLVED, That ACEP support and advocate for federal and state legislative efforts to allow physicians with a permanent and unrestricted medical license in one U.S. state to provide telemedicine services to patients in any state without requiring additional state-specific licensure; and be it further

RESOLVED, That ACEP work with relevant stakeholders to establish a national telemedicine licensure framework modeled after Florida's successful telehealth registration system; and be it further

RESOLVED, That ACEP advocate for permanent regulatory changes at both federal and state levels to expand access to emergency telemedicine services across state lines while ensuring patient safety and physician accountability.

RESOLUTION 60

RESOLVED, That ACEP engage with state chapters to encourage and support legislation promoting the minimum requirement of board certified/board eligible emergency physician-led care for all EDs noting that care can be led and supported virtually for sites designated as small rural, frontier, or extreme frontier in the ACEP Rural Emergency Care Task Force 2020 Report; and be it further

RESOLVED, That ACEP provide clarification to Amended Resolution 42(23) On-Site Physician Staffing in Emergency Departments that all medium rural, medium/large rural, or greater sized emergency departments are expected to maintain a minimum of 24/7 on-site and on-duty board certified/board eligible emergency physician coverage, as endorsed through the ACEP Rural Emergency Care Task Force 2020 Report to the ACEP Board of Directors.

RESOLUTION 61

RESOLVED, That ACEP acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices; and be it further

RESOLVED, That ACEP encourage the education of emergency physicians, other medical personnel, pharmacists, and patients regarding:

- the environmental impact of metered-dose inhalers, including the differences among canister weights and associated propellant volumes;
- the availability and appropriateness of dry powder inhalers as an alternative, when clinically indicated; and
- proper disposal and recycling protocols for metered-dose inhalers, including the importance of incineration to deactivate remaining hydrofluoroalkane propellants; and be it further

RESOLVED, That ACEP support collaboration with health care systems, manufacturers, insurers, and public health organizations to promote policies that facilitate lower-emission alternatives to metered-dose inhalers and inhaler recycling.

RESOLUTION 62

RESOLVED, That ACEP support efforts to reduce unnecessary waste and carbon emissions in emergency departments (EDs) through education, policy development, and support for sustainable clinical practices; and be it further

RESOLVED, That ACEP encourage hospitals and emergency departments to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate; and be it further

RESOLVED, That ACEP develop resources to help emergency physicians and emergency departments achieve the aim of reducing waste and carbon emissions form the emergency department.

RESOLUTION 63

RESOLVED, That ACEP advocate for the development and implementation of evidence-based screening tools and protocols within emergency departments to identify victims of bullying and provide appropriate resources

and referrals; and be it further

RESOLVED, That ACEP support the integration of education and training on bullying recognition, intervention, and trauma-informed care into emergency medicine residency programs and continuing medical education courses.

RESOLUTION 64

RESOLVED, That ACEP endorse the use of electronic discharge instructions for patients with access to electronic medical records and electronic communication capabilities; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt policies and technologies that support the secure, timely, and environmentally responsible electronic delivery of discharge instructions in compliance with HIPAA regulations and best practices.

RESOLUTION 65

RESOLVED, That ACEP develop a policy statement opposing the following practices:

- the establishment of collaborative practice agreements without the specific and informed authorization of the supervising physician;
- the execution of collaborative practice agreements by employers, hospitals, or contract groups on behalf of emergency physicians;
- the imposition of collaborative practice agreements as a mandatory condition of employment for emergency physicians.

RESOLUTION 66

RESOLVED, That ACEP endorse a national door-to-doctor benchmark of no less than 30 minutes to prevent increasingly unrealistic targets that undermine clinical judgment and operational sustainability; and be it further

RESOLVED, That ACEP oppose practices that encourage unsafe or unsustainable door-to-doctor expectations without adequate staffing or clear evidence of improved patient care.

RESOLUTION 67

RESOLVED, That ACEP work with stakeholders including the Forensic Medicine Section, American College of Surgeons – Committee on Trauma (ACS-COT), International Association of Forensic Nursing (IAFN), Academy of Forensic Nursing (AFN), and Emergency Nurses Association (ENA), to implement a standard of forensic programs at all Level 1 and Level 2 trauma centers.

RESOLUTION 68

RESOLVED, That ACEP amend its policy statement "Firearm Safety and Injury Prevention" to include support for the integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education programs; and be it further

RESOLVED, That ACEP develop or identify and disseminate a physician-facing clinical guide to support emergency physicians in conducting brief, trauma-informed firearm safety counseling, particularly for high-risk patients, alongside both printable and digital format, evidence-based patient handouts suitable for emergency department use, potentially leveraging existing materials and partnerships where appropriate and consistent with ACEP's firearm safety policies.

RESOLUTION 69

RESOLVED, That ACEP investigate and report on best practices, operational models, and potential legislative or regulatory approaches to promote timely and direct communication between referring outpatient clinicians and emergency departments when patients are referred for emergency care.

RESOLUTION 70

RESOLVED, That ACEP work with likeminded organizations, such as the Emergency Nurses Association and the Lorna Breen Foundation, to develop an emergency department violence reporting system; and be it further

RESOLVED, That ACEP facilitate the collection of violence prevention initiatives that hospitals and health systems have implemented to address emergency department violence and develop best practices.

RESOLUTION 71

RESOLVED, That ACEP curate existing and future educational materials and webinars focused on best practices in employment negotiation, guidance on assessing contract provisions, malpractice insurance fundamentals with particular emphasis on securing tail coverage provisions, and responding to employer insolvency and have these

resources available in an organized, user-friendly, centralized and member-accessible hub that is easily identifiable on the ACEP website.

RESOLUTION 72

RESOLVED, That ACEP endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

RESOLUTION 73

RESOLVED, That ACEP develop a plan to promote and facilitate the initiation of nation-wide emergency department programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating medication for opioid use disorder, and rapid clinical referrals to outpatient treatment; and be it further

RESOLVED, That ACEP potentially work with other organizations such as the American Medical Association, state medical associations, Bridge to Treatment, MATTERS, American Society of Addiction Medicine, American College of Academic Addiction Medicine and potentially others, to obtain funding for substance use disorder programs from federal, state, and/or private sources; and be it further

RESOLVED, That ACEP report back to the Council in 2026 on the development of a plan to promote and facilitate the initiation of nation-wide emergency department programs to improve substance use disorder treatment and any progress made on the goals of the plan.

RESOLUTION 74

RESOLVED, That ACEP acknowledge there is a standard of care for certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available for continued care after discharge from the emergency department, and that deviation from this established standard of care may put a patient's organ function or life at risk; and be it further

RESOLVED, That ACEP develop a list of key classes of medications that patients could receive as facility-provided medications upon discharge from the emergency department; and be it further

RESOLVED, That ACEP coordinate legislative resources to assist state chapters in addressing legislation aimed at preventing certain medications to be dispensed from the emergency department during off-hours when pharmacies are not available.

RESOLUTION 75

RESOLVED, That ACEP develop a policy to ensure that the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours; and be it further

RESOLVED, That in the interest of public transparency, ACEP develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the emergency department while it is open, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

RESOLUTION 76

RESOLVED, That ACEP support the development and publication of nationally recognized guidelines for transgender care in emergency medicine; and be it further

RESOLVED, That ACEP advocate for the protection of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities.

RESOLUTION 77

RESOLVED That ACEP support and, if feasible, conduct or commission a study to investigate the geographic and clinical practice patterns of nurse practitioners and physician assistants in states with independent practice authority and use the findings of that study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

RESOLUTION 78

RESOLVED, That ACEP reaffirm its commitment to physician-led emergency medicine teams and opposes independent practice by advanced practice providers (APPs) in emergency departments, while supporting structured training and supervised clinical practice as a means to enhance APP competency within team-based care models; and be it further

RESOLVED, That ACEP work with the Society of Emergency Medicine Physician Assistants (SEMPA) and

the American Academy of Emergency Nurse Practitioners (AAENP), and other relevant stakeholders to develop and advocate for the implementation of a standardized, accredited emergency medicine training program for advanced practice providers as a prerequisite for clinical practice in emergency departments, with a legacy process for experienced advanced practice providers based on documented experience and continuing education.

RESOLUTION 79

RESOLVED, That ACEP work collaboratively with the American Psychiatric Association to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

RESOLUTION 80

RESOLVED, That a comprehensive elective surgery scheduling toolkit developed by ACEP include evidence-based guidelines, best practices, case studies, and data-driven models demonstrating successful implementation of elective surgery smoothing, with specific recommendations tailored to different hospital settings and resource levels; and be it further

RESOLVED, That ACEP advocate for the adoption of elective surgery smoothing principles as part of broader hospital-wide patient flow improvement initiatives, recognizing its role in reducing ED crowding, improving patient outcomes, and enhancing health care efficiency.

RESOLUTION 81 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians mourns the loss and expresses its deep sorrow at the passing of Joshua Alinger, MD, and extends heartfelt condolences to his family, friends, colleagues, and the Northwestern University Emergency Medicine community.

RESOLUTION 82 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians honors the memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), and his extraordinary contributions to emergency medicine, education, and community service; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), acknowledging that though he may be gone, his remarkable achievements and enduring impact will be remembered with gratitude and admiration.

RESOLUTION 83 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians honors the memory of Elizabeth B. Jones, MD, FACEP, and her extraordinary contributions to emergency medicine, patient advocacy, academic excellence, and integrity in research and clinical care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Elizabeth B. Jones, MD, FACEP, acknowledging that though she may be gone, her remarkable achievements and enduring impact will be remembered with gratitude and admiration.

RESOLUTION 84 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians and the California Chapter recognizes the extraordinary contributions of Brian Wai Lin, MD, to the specialty of emergency medicine as a physician, educator, innovator, and mentor; and be it further

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Brian Wai Lin, MD, especially his beloved children Isaiah, Elliot, and Daphne, along with his loved ones, friends, students, residents, and colleagues our heartfelt condolences and deepest appreciation for his lasting impact on the specialty of emergency medicine and the lives of those he touched with generosity and grace.

RESOLUTION 85 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Forrest Daniel McCoig, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Virginia College of Emergency Physicians extends to his devoted wife Katharine (married in 1958) of 23 years, and mother to their children James, Amy, and Laura, and his wife Janet (married in 1991) of 34 years, and mother to Kelly, gratitude for his service as an emergency physician, as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 86 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jack A. Henriquez, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his sons Eric W. Henriquez, Ryan S. Henriquez, his wife, and four grandchildren gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 87 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Carl S. Werne, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his daughters Joanna Werne and Emily Kennerley, his sister Dr. Joellen Werne, his partner Dr. Amy Zimet, and his first wife Patricia Daly Vance and extended family gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 88 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jamie Shandro, MD, MPH; and be it further

RESOLVED, That the American College of Emergency Physicians and the Washington Chapter extends to her children Nina and Kai, husband Hans, mother Cathy, brother Tim, extended family, friends, and colleagues our heartfelt gratitude for her service as an emergency physician as well as for her dedication and commitment to the specialty of emergency medicine.

RESOLUTION 89 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP recognize and commend Debra Houry, MD, FACEP; Demetre Daskalakis, MD; and Daniel Jernigan, MD, MPH, for their principled stand in defense of science-based medical practice and patient safety; and be it further

RESOLVED, That ACEP urgently and strongly publicly oppose any partisan political interference in the leadership, operations, and recommendations of critical public health agencies such as the CDC, thus affirming the definitional roles of scientific independence and adherence to known facts and evidence-based medicine guidance in safeguarding the practice of medicine and public health.

RESOLUTION 90 *(This emergency resolution was accepted by the Council.)*

RESOLVED, That ACEP promptly create a policy statement endorsing the use of typical vaccine schedules as outlined in and based upon the recommendations and vaccine schedules published by the American Academy of Pediatrics on August 19, 2025, the American College of Cardiology on August 26, 2025, and the American College of Obstetrics and Gynecology on August 27, 2025.

RESOLUTION 91 *(This emergency resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians honors and remembers the profound impact made by Frank L. Zwemer, Jr., MD, MBA, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Laura Brewer; his children, Dr. Catherine Zwemer and Jonathan Zwemer, his mother Ann, sisters Mimi Freeman and Kim McCart, and his Aunt Joan our heartfelt condolences and gratitude for sharing him with us all of these years and acknowledges his impact and care will ripple through generations of emergency physicians.

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Commendation and memorial resolutions were not assigned to a Reference Committee.

Resolutions 21-40 were assigned to Reference Committee A. Susanne J. Spano, MD, FACEP, chaired Reference Committee A and other members were: Shayne M. Gue, MD, FACEP; Torree M. McGowan, MD, FACEP; Diane Paratore, MD, MEd, MBA, FACEP; Michael D. Smith, MD, MBA, CPE, FACEP; Carol Wright Becker, MD, MBA, FACEP; Amanda Pairitz-Campo; and Laura Lang, JD.

Resolutions 41-60 and 89 were assigned to Reference Committee B. Erik Blutinger, MD, MSc, FACEP, chaired Reference Committee B and other members were: Brett H. Cannon, MD, JD, MBA, FACEP; Carrie de Moor,

MD, FACEP; Comfort A. Orebayo, DO; George RJ Sontag, MD, FACEP; James C. Mitchiner, MD, MPH, FACEP; Brianna Hanson, MPH; and Ryan McBride, MPP.

Resolutions 61-80 and 90 were assigned to Reference Committee C. Angela P. Cornelius, MD, FACEP, chaired Reference Committee C and other members were: Greg Gafni-Pappas, DO, FACEP; Puneet Gupta, MD, FACEP; Amanda Irish, MD, MPH, MS; Jeffrey F. Linzer, MD, FACEP; Aaron Snyder, MD; Travis Schulz, MLS, AHIP; and George Solomon, MHS, FP-C, CCP-C, TP-C.

A Town Hall Meeting was convened at 1:15 pm The topic was "Emergency Department Accreditation: Why ED Accreditation is Right for Your ED!" Michael J. McCrea, MD, FACEP, served as the moderator and the discussants were: Jonathan Fisher, MD, FACEP; Marianne Gausche-Hill, MD, FACEP; Paul D. Kivela, MD, MBA, FACEP; and Gillian R. Schmitz, MD, FACEP.

The Candidate Forum for the president-elect candidates began at 2:05 pm with the president-elect candidates in the main Council meeting room. The Candidate Forum for the Board of Directors candidates began at 2:45 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:45 pm Dr. Costello addressed the Council and then reviewed the procedure for the adoption of the 2025 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Costello then read the resolveds of the memorial resolutions for: Joshua Alinger, MD; James B. Broselow, MD; Vinod K. Chettur, MD; Terry A. Conklin, MD, FACEP; Donald J. Gordon, MD, PhD, FACEP; Jack A. Henriquez, MD, FACEP; Gregory L. Henry, MD, FACEP; Richard T. Hostelley, MD, FACEP; Franke J. Jehle, Jr., MD, MPH, FACEP; Elizabeth B. Jones, MD, FACEP; Roger B. Lim, MD; Forrest Daniel McCoig, MD; Lidio W. Medina, MD; Joseph Moellman, MD; Brian Wai Lin, MD; Frank S. Orth, DO, FACEP; Janice E. Reisinger, MBA, CAE; Jamie Shandro, MD, MPH; Ronald D. Stewart, MD, FACEP, FAEMS; Todd Thomas, CPC, CCS-P; Carl S. Werne, MD; and Frank L. Zwemer, Jr., MD, FACEP.

The Council honored the memory of those who passed away since the last Council meeting and adopted the memorial resolutions by observing a moment of silence.

David Wilson, MD, president of the Emergency Medicine Residents' Association, addressed the Council.

James D. Thomas, MD, president of the American Board of Emergency Medicine, addressed the Council.

Stephen K. Epstein, MD, FACEP, chair of the American Medical Association Section Council on Emergency Medicine, and Marilyn J. Heine, MD, FACEP, member of the American Medical Association's Board of Trustees, addressed the Council.

Heidi C. Knowles, MD, FACEP, presented the secretary-treasurer's report.

ACEP President Alison J. Haddock, MD, FACEP, addressed the Council. She reflected on the past year as ACEP president and highlighted the successes of the College.

The Council recessed at 6:12 pm for the candidate reception and reconvened at 8:07 am on Saturday, September 4, 2025.

Dr. Char reported that 430 councillors of the 436 eligible for seating had been credentialed.

Theresa Q. Tran, MD, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

Rebecca B. Parker, MD, FACEP, addressed the Council regarding the activities of NEMPAC and the 911 Network.

Dr. Costello reviewed the procedure for submitting resolution amendments electronically.

Dr. Costello announced that the Reference Committee reports would be discussed in the following order: Reference Committee A, Reference Committee B, and Reference Committee C.

REFERENCE COMMITTEE A

Dr. Spano presented the report of Reference Committee A. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolutions 24, Resolution 25, Resolution 34, and Resolution 38.

For adoption as amended or substituted: Amended Resolution 21, Amended Resolution 22, Amended Resolution 32, Substitute Resolution 33, and Amended Resolution 36.

Not for adoption: Resolution 28, Resolution 29, Resolution 30, Resolution 31, Resolution 35, and Resolution 39.

For referral to the Board of Directors: Resolution 26, Resolution 27, Resolution 37, and Resolution 40.

For referral to the Council Steering Committee: Resolution 23.

Resolution 26, Resolution 27, Resolution 30, Amended Resolution 32, Substitute Resolution 33, and Resolution 35 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 21

RESOLVED, THAT THE ACEP BYLAWS ARTICLE V – ACEP FELLOWS, SECTION 1 – ELIGIBILITY AND SECTION 2 – FELLOW STATUS BE AMENDED TO ESTABLISH A "DISTINGUISHED FELLOW OF ACEP" [FACEP(D)] THAT IS BASED ON OBJECTIVE, POINTS-BASED CRITERIA AND AWARDED TO MEMBERS WHO HAVE HELD FACEP STATUS FOR A MINIMUM OF 12 YEARS AND DEMONSTRATED CONTINUED COMMITMENT TO ACEP AND THE SPECIALTY OF EMERGENCY MEDICINE:

ARTICLE V — ACEP FELLOWS
SECTION 1 – ELIGIBILITY

FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING CRITERIA:

1. BE CANDIDATE PHYSICIAN, REGULAR, OR INTERNATIONAL MEMBERS FOR THREE CONTINUOUS YEARS IMMEDIATELY PRIOR TO ELECTION.
2. BE 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.
3. MEET THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF HIGH PROFESSIONAL STANDING AT SOME TIME DURING THEIR PROFESSIONAL CAREER PRIOR TO APPLICATION.
    A. AT LEAST THREE YEARS OF ACTIVE INVOLVEMENT IN EMERGENCY MEDICINE AS THE PHYSICIAN'S CHIEF PROFESSIONAL ACTIVITY, EXCLUSIVE OF RESIDENCY TRAINING, AND;
    B. SATISFACTION OF AT LEAST THREE OF THE FOLLOWING INDIVIDUAL CRITERIA 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.

DISTINGUISHED FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING CRITERIA:

1. **HAVE HELD FACEP STATUS FOR AT LEAST 12 YEARS.**
2. **MAINTAINED CERTIFICATION:**
   - **A. IN EMERGENCY MEDICINE BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, OR THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR**
   - **B. IN PEDIATRIC EMERGENCY MEDICINE BY THE AMERICAN BOARD OF PEDIATRICS, OR**
   - **C. HAVE ACHIEVED FACEP THROUGH THE ACEP LEGACY TRACK.**
3. **MEET A MINIMUM NUMBER OF POINTS WITHIN THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF COMMITMENT TO EMERGENCY MEDICINE:**
   - **A. RESEARCH AND SCHOLARSHIP, AS EVIDENCED BY GRANT AWARDS, PEER-REVIEWED PUBLICATION, OR REVIEW OR AUTHORSHIP OF BOOKS OR OTHER PROFESSIONAL RESOURCES.**
   - **B. TEACHING AND MENTORSHIP, AS EVIDENCED BY TEACHING HISTORY, FACULTY STATUS, STUDENT OR RESIDENT ADVISEMENT, OR RESIDENCY/FELLOWSHIP/CLERKSHIP LEADERSHIP.**
   - **C. SERVICE AND LEADERSHIP, AS EVIDENCED BY LEADERSHIP WITHIN THEIR EMERGENCY DEPARTMENT, HOSPITAL, STAFFING GROUP, STATE OR LOCAL MEDICAL SOCIETIES, COMMUNITY HEALTH PLANNING, OR OTHER ROLES WHICH HAVE ADVANCED THE FIELD.**
   - **D. CLINICAL EXCELLENCE, AS EVIDENCED BY CLINICAL OR INDUSTRY AWARDS, LETTERS OF SUPPORT FROM THEIR CHAIR OR MEDICAL DIRECTOR, OR PARTICIPATION IN QUALITY, SAFETY, OR WELLNESS ACTIVITIES.**
4. **MEET A MINIMUM NUMBER OF POINTS WITHIN THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF COMMITMENT TO ACEP.**
   - **A. LEADERSHIP ACTIVITIES, INCLUDING PARTICIPATION OR LEADERSHIP WITHIN ACEP SECTIONS, COMMITTEES, CHAPTERS, DELEGATIONS, ADVOCACY GROUPS, TASK FORCES, MEMBER INTEREST GROUPS, BOARD OF DIRECTORS, OR COUNCIL.**
   - **B. EDUCATION ACTIVITIES, INCLUDING PARTICIPATION AS FACULTY OR COURSE DIRECTORS IN ACEP IN-PERSON OR VIRTUAL EDUCATIONAL OFFERINGS.**
   - **C. PUBLIC AWARENESS ACTIVITIES, INCLUDING ACTIVE INVOLVEMENT IN ACEP'S ONLINE COMMUNITIES, MEDIA RELATIONS OR SPOKESPERSON NETWORK, OR PROMOTION OF COLLEGE WINS AND ACTIVITIES ON SOCIAL MEDIA.**
   - **D. RECOGNITIONS, INCLUDING INDIVIDUAL RECEIPT OF ACEP AWARDS OR HOSPITAL/EMPLOYER RECEIPT OF ACEP ACCREDITATION STATUS.**

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.

SECTION 2 – FELLOW STATUS

FELLOWS SHALL BE AUTHORIZED TO USE THE LETTERS FACEP **OR FACEP(D)** IN CONJUNCTION WITH PROFESSIONAL ACTIVITIES. MEMBERS PREVIOUSLY DESIGNATED AS ACEP FELLOWS UNDER ANY PRIOR CRITERIA SHALL RETAIN FELLOW STATUS. MAINTENANCE OF FELLOW STATUS REQUIRES CONTINUED MEMBERSHIP IN THE COLLEGE. FEES, PROCEDURES FOR ELECTION, AND REASONS FOR TERMINATION OF FELLOWS SHALL BE DETERMINED BY THE BOARD OF DIRECTORS.

AMENDED RESOLUTION 22

RESOLVED, THAT THE ACEP BYLAWS ARTICLE V – ACEP FELLOWS, SECTION 1 – ELIGIBILITY AND SECTION 2 – FELLOW STATUS BE AMENDED TO ESTABLISH AN "INTERNATIONAL FELLOW OF ACEP" [**(I)**FACEP~~(I)~~] AND AWARDED TO MEMBERS WHO LIVE AND PRACTICE OUTSIDE OF THE UNITED STATES:

SECTION 1 – ELIGIBILITY

FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING CRITERIA:

1. BE CANDIDATE PHYSICIAN, **OR** REGULAR~~, OR INTERNATIONAL~~ MEMBER~~S~~ FOR THREE CONTINUOUS YEARS IMMEDIATELY PRIOR TO ELECTION.
2. BE 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.
3. MEET THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF HIGH PROFESSIONAL STANDING AT SOME TIME DURING THEIR PROFESSIONAL CAREER PRIOR TO APPLICATION.
   A. AT LEAST THREE YEARS OF ACTIVE INVOLVEMENT IN EMERGENCY MEDICINE AS THE PHYSICIAN'S CHIEF PROFESSIONAL ACTIVITY, EXCLUSIVE OF RESIDENCY TRAINING, AND;
   B. SATISFACTION OF AT LEAST THREE OF THE FOLLOWING INDIVIDUAL CRITERIA 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.

INTERNATIONAL FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING

CRITERIA:

1. **BE AN INTERNATIONAL MEMBER OF ACEP FOR AT LEAST THREE YEARS IMMEDIATELY PRIOR TO ELECTION.**
2. **BE CERTIFIED IN EMERGENCY MEDICINE BY AN INTERNATIONALLY RECOGNIZED CERTIFYING BODY, OR HAVE COMPLETED THE MINIMUM TRAINING STANDARDS TO PRACTICE EMERGENCY MEDICINE WITHIN THEIR COUNTRY (IF CERTIFICATION IS NOT AVAILABLE).**
3. **PROVIDE A LETTER OF SUPPORT FROM AN ESTABLISHED AUTHORITY SUCH AS THEIR INSTITUTION MEDICAL DIRECTOR, TRAINING PROGRAM DIRECTOR, OR EMERGENCY MEDICINE SOCIETY.**
4. **SATISFY AT LEAST THREE OF THE FOLLOWING INDIVIDUAL REQUIREMENTS DEMONSTRATING COMMITMENT TO EMERGENCY MEDICINE:**
   - **A. ACTIVE INVOLVEMENT IN ORGANIZED MEDICINE, AS EVIDENCED BY THREE YEARS OF MEMBERSHIP OR LEADERSHIP WITHIN ANY LOCAL, NATIONAL, OR REGIONAL SOCIETY DEDICATED TO ADVANCING EMERGENCY MEDICINE.**
   - **B. ACTIVE INVOLVEMENT IN LOCAL HOSPITAL AFFAIRS, SUCH AS MEDICAL STAFF COMMITTEES.**
   - **C. ACTIVE INVOLVEMENT IN THE FORMAL TRAINING OF FUTURE EMERGENCY MEDICINE PHYSICIANS.**
   - **D. ACTIVE INVOLVEMENT IN DEPARTMENTAL OR GOVERNMENTAL ADMINISTRATION OR AFFAIRS.**
   - **E. ACTIVE INVOLVEMENT IN EMS SYSTEMS OR DISASTER PREPAREDNESS PLANNING ACTIVITIES.**
   - **F. RESEARCH OR SCHOLARLY PUBLICATION IN EMERGENCY MEDICINE.**
5. **SATISFY AT LEAST ONE OF THE FOLLOWING INDIVIDUAL REQUIREMENTS DEMONSTRATING INVOLVEMENT WITH ACEP:**
   - **A. ACTIVE PARTICIPATION IN ACEP SECTIONS, COMMITTEES, OR OTHER LEADERSHIP BODIES.**
   - **B. PARTICIPATION IN THE DEVELOPMENT, DELIVERY, OR PROMOTION OF ACEP EDUCATIONAL OFFERINGS AND RESOURCES WITHIN HOME COUNTRY.**
   - **C. PARTICIPATION IN ACEP EDUCATIONAL OR RESEARCH ACTIVITIES (SUCH AS IN-PERSON ATTENDANCE AT ACEP SCIENTIFIC ASSEMBLY MEETING(S), SCHOLARLY PUBLICATION IN EMERGENCY MEDICINE IN ANNALS OF EMERGENCY MEDICINE OR JACEP OPEN, ETC.).**
   - **D. OTHER CONTRIBUTIONS TO 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.

AMENDED RESOLUTION 36

RESOLVED, THAT ACEP REAFFIRM THE POLICY STATEMENT "LENGTH OF RESIDENCY IN TRAINING IN EMERGENCY MEDICINE," ESTABLISHED BY COUNCIL RESOLUTION 22(23) RECOGNIZING THE VALUE OF AND SUPPORTING CONTINUED ACCREDITATION OF BOTH THREE- AND FOUR-YEAR EMERGENCY MEDICINE RESIDENCY PROGRAMS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP OPPOSE ANY MANDATE REQUIRING EXCLUSIVE TRANSITION TO THREE-YEAR OR FOUR-YEAR EMERGENCY MEDICINE RESIDENCY TRAINING WITHOUT CLEAR, SUBSTANTIAL EVIDENCE OF BENEFIT OF ONE TRAINING LENGTH; AND BE IT FURTHER~~

RESOLVED, THAT THE BOARD OF DIRECTORS REAFFIRM THEIR COMMITMENT TO REPRESENT ACEP POLICY STATEMENTS WHEN MAKING PUBLIC STATEMENTS ON BEHALF OF THE COLLEGE.

The committee recommended that Amended Resolution 32 be adopted.

It was moved THAT AMENDED RESOLUTION 32 BE ADOPTED:

RESOLVED, THAT ACEP PUBLICLY RELEASE ITS CURRENT GUIDELINES ON RESTRICTED OR CENSORED TOPICS; AND BE IT FURTHER

RESOLVED, THAT ACEP REFRAIN FROM RESTRICTING OR CENSORING VENDORS OR SPEAKERS AT SCIENTIFIC ASSEMBLY UNLESS SUCH RESTRICTION IS NECESSARY TO UPHOLD LEGAL OR SAFETY STANDARDS; AND BE IT FURTHER

RESOLVED**,** THAT ANY RESTRICTION OF VENDORS OR SPEAKERS AT SCIENTIFIC ASSEMBLY BE SUBJECT TO REVIEW ~~AND APPROVAL~~ BY THE COUNCIL TO ENSURE TRANSPARENCY AND ACCOUNTABILITY.

It was moved THAT RESOLUTION 32 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Substitute Resolution 33 be adopted.

It was moved THAT SUBSTITUTE RESOLUTION 33 BE ADOPTED:

~~RESOLVED, THAT ACEP IDENTIFY AND WORK WITH OTHER KEY STAKEHOLDERS TO DEVELOP A PUBLIC EDUCATION CAMPAIGN TARGETED TO HELP PATIENTS BETTER UNDERSTAND WHICH COMPLAINTS ARE APPROPRIATE FOR AN URGENT CARE CENTER ENVIRONMENT VERSUS AN EMERGENCY DEPARTMENT TO HELP STREAMLINE THEIR CARE AND COSTS.~~

RESOLVED, THAT ACEP WORK WITH KEY STAKEHOLDERS TO DEVELOP PATIENT GUIDANCE ON PRESENTING COMPLAINTS, COMORBIDITIES, AND THE NEED FOR TIMELY ACCESS FOR TIME-SENSITIVE CONDITIONS THAT WOULD BE BETTER MANAGED IN AN EMERGENCY DEPARTMENT COMPARED TO AN URGENT CARE SETTING; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP PATIENT GUIDANCE ON THE PRUDENT LAYPERSON STANDARD AND THE PROTECTIONS IT PROVIDES TO PATIENTS.

It was moved THAT RESOLUTION 33 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

It was moved THAT EACH RESOLVED BE VOTED ON SEPARATELY. The motion was not adopted.

The main motion was then voted on and was not adopted.

The committee recommended that Resolution 30 not be adopted.

It was moved THAT RESOLUTION 30 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 35 not be adopted.

It was moved THAT RESOLUTION 35 BE ADOPTED.

It was moved THAT THE WORDS “AT LEAST ONE” BE ADDED BEFORE THE WORD “DUAL” AND DELETE THE WORDS “IN WRITING REQUIREMENTS OR CREATE A SEPARATE COMBINED EMERGENCY MEDICINE REVIEW COMMITTEE.”

It was moved THAT RESOLUTION 35 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The motion was then voted on and was not adopted.

It was moved THAT RESOLUTION 35 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and was not adopted.

The committee recommended that Resolution 26 be referred to the Board of Directors.

It was moved THAT RESOLUTION 26 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 27 be referred to the Board of Directors.

It was moved THAT RESOLUTION 27 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE B

Dr. Blutinger presented the report of Reference Committee B. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 43, and Resolution 58.

For adoption as amended or substituted: Amended Resolution 41, Amended Resolution 44, Amended Resolution 45 in lieu of Resolutions 45 and 46, Amended Resolution 47, Amended Resolution 48, Amended Resolution 49, Amended Resolution 50, Amended Resolution 51, Amended Resolution 53, Amended Resolution 55, Amended Resolution 56, Amended Resolution 57, Amended Resolution 59, and Amended Resolution 89.

Not for adoption: Resolution 52, Resolution 54, and Resolution 60.

Amended Resolution 41, Amended Resolution 45, Amended Resolution 49, Amended Resolution 56, Amended Resolution 59, and Amended Resolution 89 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 44

RESOLVED, THAT ACEP ~~DIRECT~~ **ENCOURAGE** ITS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION TO INTRODUCE AND SUPPORT AMA POLICY THAT PRIORITIZES ADDRESSING WORKPLACE VIOLENCE IN HEALTH CARE AS A TOP NATIONAL ADVOCACY ISSUE; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~DIRECT~~ **ENCOURAGE** ITS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION TO ADVOCATE FOR MANDATORY, STANDARDIZED REPORTING OF WORKPLACE VIOLENCE INCIDENTS ACROSS ALL HEALTH CARE SETTINGS AND SUPPORT THE AGGREGATION AND PUBLIC DISSEMINATION OF THIS DATA TO INFORM RESEARCH, BENCHMARKING, AND NATIONAL POLICY DEVELOPMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~DIRECT~~ **ENCOURAGE** ITS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION TO ADVOCATE FOR THE DEVELOPMENT, FUNDING, AND IMPLEMENTATION OF EVIDENCE-BASED, TRAUMA-INFORMED STRATEGIES TO PREVENT WORKPLACE VIOLENCE AND PROTECT THE HEALTH CARE WORKFORCE.

AMENDED RESOLUTION 47

RESOLVED, THAT ACEP RECOGNIZE THE DISPROPORTIONATE SHARE HOSPITAL CUTS ARE OF SPECIFIC CONCERN TO EMERGENCY PHYSICIANS AS THEY HAVE BEEN SHOWN TO INCREASE THE AMOUNT OF RURAL HOSPITAL CLOSURES; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH RELEVANT ORGANIZATIONS SUCH AS AMERICA'S ESSENTIAL HOSPITALS TO FURTHER THE CAUSE OF PROTECTING DISPROPORTIONATE SHARE HOSPITAL PAYMENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR ~~H.R. 2665, THE SUPPORTING SAFETY NET HOSPITALS ACT,~~ **EXISTING AND FUTURE LEGISLATION** TO REPEAL OR DELAY THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL CUTS SCHEDULED FOR FISCAL YEARS 2026 THROUGH 2028.

AMENDED RESOLUTION 48

RESOLVED, THAT ACEP AFFIRM THAT FEDERAL EMTALA OBLIGATIONS **SHOULD** SUPERSEDE CONFLICTING STATE LAWS OR MANDATES THAT WOULD PREVENT EMERGENCY PHYSICIANS **AND ALL MEMBERS OF THE MEDICAL STAFF** FROM PROVIDING MEDICALLY NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR CLEAR FEDERAL PROTECTIONS FOR EMERGENCY PHYSICIANS **AND ALL MEMBERS OF THE MEDICAL STAFF** PROVIDING CARE IN ACCORDANCE WITH EMTALA REQUIREMENTS, PARTICULARLY WHEN SUCH CARE CONFLICTS WITH STATE LAWS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH RELEVANT FEDERAL AGENCIES, MEDICAL SOCIETIES, AND STAKEHOLDERS TO ENSURE CONSISTENT INTERPRETATION AND ENFORCEMENT OF EMTALA REQUIREMENTS THAT PROTECT BOTH PATIENTS AND PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE EDUCATIONAL RESOURCES AND SUPPORT TO EMERGENCY PHYSICIANS NAVIGATING COMPLEX LEGAL LANDSCAPES WHILE MAINTAINING THEIR PROFESSIONAL AND ETHICAL OBLIGATIONS TO PROVIDE EMERGENCY MEDICAL CARE.

AMENDED RESOLUTION 50

RESOLVED, THAT ACEP ADVOCATE FOR STRICT**ER** ENFORCEMENT OF THE FEDERAL REGULATION REQUIRING HOSPITALS WITHOUT 24/7 ON-SITE PHYSICIAN COVERAGE TO CLEARLY POST SUCH NOTICES, INCLUDING AN EXPLANATION OF HOW EMERGENCY MEDICAL NEEDS WILL BE ADDRESSED WHEN A PHYSICIAN IS NOT PRESENT**, AND THAT ACEP WORK WITH JOINT COMMISSION AND OTHER REGULATORY BODIES TO ADVANCE EDUCATIONAL AND REGULATORY INITIATIVES THAT IMPROVE TRANSPARENCY FOR PATIENTS IN THE EMERGENCY SETTING**.

AMENDED RESOLUTION 51

RESOLVED, THAT ACEP **REAFFIRM CURRENT POLICY THAT THE GOLD STANDARD FOR EMERGENCY DEPARTMENT CARE IS PROVIDED BY AN EMERGENCY PHYSICIAN, AND** SUPPORT STATE AND FEDERAL LEGISLATIVE AND REGULATORY EFFORTS TO REQUIRE THAT A PHYSICIAN~~, IDEALLY A BOARD-CERTIFIED OR ELIGIBLE EMERGENCY PHYSICIAN, BE PHYSICALLY PRESENT AND AVAILABLE IN EVERY EMERGENCY DEPARTMENT AT ALL TIMES, WHICH INCLUDES BUT IS NOT LIMITED TO DEVELOPING DRAFT LEGISLATION ON THIS TOPIC~~ **BE PRESENT AND AVAILABLE IN EVERY EMERGENCY DEPARTMENT**.

AMENDED RESOLUTION 53

RESOLVED, THAT ACEP SUPPORT FEDERAL AND STATE LEGISLATIVE AND REGULATORY EFFORTS TO REFORM PRIOR AUTHORIZATION PROCESSES, WITH THE GOAL OF REDUCING CARE DELAYS THAT RESULT IN **AVOIDABLE** EMERGENCY DEPARTMENT VISITS OR HOSPITALIZATIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP **COLLABORATE WITH RELEVANT STAKEHOLDERS TO** ADVOCATE FOR REAL-TIME TRANSPARENCY, STANDARDIZATION, AND ACCOUNTABILITY IN PRIOR AUTHORIZATION PRACTICES TO PROMOTE TIMELY, EQUITABLE, AND EFFICIENT PATIENT CARE ACROSS ALL HEALTH CARE SETTINGS.

AMENDED RESOLUTION 55

~~RESOLVED, THAT ACEP CONDUCT A COMPREHENSIVE REVIEW OF THE JOINT COMMISSION AND OTHER HEALTH CARE REGULATORY BODIES' REGULATORY REQUIREMENTS TO IDENTIFY MANDATES AND INTERPRETATIONS OF STANDARDS THAT DO NOT DEMONSTRABLY IMPROVE PATIENT CARE IN THE EMERGENCY DEPARTMENT SETTING; AND BE IT FURTHER~~

RESOLVED, THAT ACEP COLLABORATE WITH ~~THE~~ JOINT COMMISSION AND OTHER HEALTH CARE REGULATORY BODIES TO **REVIEW AND** ADVOCATE FOR THE ELIMINATION OR MODIFICATION ~~OF SUCH NON-BENEFICIAL REQUIREMENTS, AIMING TO STREAMLINE PROCESSES, REDUCE ADMINISTRATIVE BURDENS ON EMERGENCY PHYSICIANS, AND ALLOW MORE TIME FOR DIRECT PATIENT CARE~~ **OF REQUIREMENTS THAT DO NOT**

DEMONSTRABLY IMPROVE THE CARE OF EMERGENCY DEPARTMENT PATIENTS.

AMENDED RESOLUTION 57

~~RESOLVED, THAT ACEP ADVOCATE FOR THE REPEAL OF CERTIFICATE OF NEED (CON) LAWS IN STATES WHERE SUCH LAWS EXIST AND DEVELOP A TOOLKIT TO SUPPORT LEGISLATIVE ACTION AIMED AT ELIMINATING THESE LAWS, INCLUDING EVIDENCE-BASED ARGUMENTS AND STRATEGIES FOR ENGAGING POLICYMAKERS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP COLLABORATE WITH OTHER HEALTH CARE ORGANIZATIONS TO RAISE PUBLIC AWARENESS AND EDUCATE STATE POLICYMAKERS ON THE ~~NEGATIVE~~ IMPACTS OF CERTIFICATE OF NEED (CON) LAWS ON PATIENT ACCESS TO EMERGENCY CARE, INCLUDING OVERCROWDING, BOARDING, AND LIMITED CAPACITY, AND ADVOCATE FOR THE REMOVAL OF THESE REGULATORY BARRIERS TO IMPROVE PATIENT FLOW AND HEALTH CARE ACCESS.

The committee recommended that Amended Resolution 41 be adopted.

It was moved THAT AMENDED RESOLUTION 41 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT THE DEVELOPMENT AND IMPLEMENTATION OF A NO-FAULT MEDICAL LIABILITY SYSTEM THAT PRIORITIZES PATIENT COMPENSATION AND SYSTEMIC HEALTH CARE IMPROVEMENTS OVER PHYSICIAN PUNISHMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT STAKEHOLDERS AND LEGAL EXPERTS TO **IDENTIFY MODELS THAT** ~~ADVOCATE FOR LEGISLATIVE AND REGULATORY CHANGES THAT~~ SHIFT MEDICAL LIABILITY FROM A FAULT-BASED SYSTEM TO A NO-FAULT COMPENSATION MODEL; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~PROMOTE A REEVALUATION OF THE LEGAL DEFINITION OF NEGLIGENCE IN HEALTH CARE, ADVOCATING~~ **ADVOCATE** FOR A **LEGAL** STANDARD THAT RECOGNIZES SYSTEMIC CONTRIBUTIONS TO MEDICAL ERRORS, ENCOURAGES ROOT CAUSE ANALYSIS OVER INDIVIDUAL BLAME, AND ~~ALIGNS WITH THE AMERICAN LAW INSTITUTE'S UPDATED GUIDELINES TO~~ BETTER REFLECTS MODERN HEALTH CARE PRACTICE AND PATIENT SAFETY GOALS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE AND ADVOCATE FOR AN ELEVATION OF THE CIVIL TORT BURDEN OF PROOF FOR EMTALA-RELATED CARE FROM A PREPONDERANCE OF EVIDENCE TO CLEAR AND CONVINCING EVIDENCE.

The motion was adopted.

The committee recommended that Amended Resolution 45 be adopted.

It was moved THAT AMENDED RESOLUTION 45 BE ADOPTED:

RESOLVED, THAT ACEP CONTINUE TO ADVOCATE FOR THE FULL PRESERVATION AND EXPANSION OF THE MEDICAID PROGRAM AS AN ESSENTIAL COMPONENT OF EQUITABLE ACCESS TO EMERGENCY CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP CREATE A UNIFIED POLICY STATEMENT **THAT RECOGNIZES** ~~AFFIRMING STRONG SUPPORT FOR~~ MEDICAID**'S** ~~AND ITS~~ IMPORTANCE AS A SAFETY NET INSURANCE TO EMERGENCY MEDICINE, AND INCLUDE WITHIN IT THE **CONCEPTS OF THE** CURRENT POLICY STATEMENTS "WORK REQUIREMENTS FOR MEDICAID BENEFICIARIES," "MEDICAID EXPANSION," AND "OPPOSITION TO COPAYS FOR MEDICAID BENEFICIARIES" TO CREATE A SINGLE, ROBUST POLICY STATEMENT ON MEDICAID; AND BE IT FURTHER

RESOLVED, THAT ACEP POLICY AFFIRM ACEP'S OPPOSITION TO ADMINISTRATIVE OR FINANCIAL BARRIERS**, INCLUDING THIRD-PARTY ADMINISTRATOR INTERFERENCE,** THAT REDUCE TIMELY ACCESS TO EMERGENCY CARE FOR MEDICAID BENEFICIARIES AND PROMOTES EMERGENCY PHYSICIANS' ROLES AS KEY STAKEHOLDERS IN MEDICAID POLICY DEVELOPMENT AND REFORM.

RESOLVED, THAT ACEP ADVOCATE FOR FEDERAL AND STATE MEDICAID FUNDING LEVELS THAT ALLOW FOR COMPREHENSIVE BENEFIT COVERAGE FOR

PATIENTS.

It was moved THAT THE FOURTH RESOLVED BE AMENDED BY ADDING "ADEQUATE" BEFORE THE WORD "FEDERAL" AND DELETING THE WORDS "THAT ALLOW FOR COMPREHENSIVE BENEFIT COVERAGE." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 49 be adopted.

It was moved THAT AMENDED RESOLUTION 49 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT LEGISLATIVE, REGULATORY, AND POLICY REFORMS TO STRENGTHEN THE EMTALA MANDATE AND ENSURE THAT PATIENTS REQUIRING TRANSFER TO A HIGHER LEVEL OF CARE ARE NOT INAPPROPRIATELY DENIED OR DELAYED.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP INVESTIGATE LEGISLATION TO REPLACE OR UPDATE EMTALA WITH A MORE CONTEMPORARY ALTERNATIVE THAT REFLECTS THE CURRENT PRACTICE OF EMERGENCY MEDICINE AND BETTER ENSURES THAT PATIENTS RECEIVE THE MEDICAL CARE THEY NEED IN A SAFE AND TIMELY MANNER.~~

It was moved THAT THE FIRST RESOLVED BE AMENDED BY ADDING "REGARDING TRANSFERS AND ADVOCATE TO REDUCE BARRIERS THAT CREATE DELAYS IN TRANSFERRING PATIENTS TO A LEVEL OF CARE" AFTER THE WORD "MANDATE" AND DELETING THE WORDS "REQUIRING TRANSFER TO A HIGHER LEVEL OF CARE ARE NOT INAPPROPRIATELY DENIED OR DELAYED." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 56 be adopted.

It was moved THAT AMENDED RESOLUTION 56 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE FOR LEGISLATION AT THE STATE AND FEDERAL LEVELS REQUIRING THAT ~~ARTIFICIAL INTELLIGENCE-ASSISTED~~ REIMBURSEMENT **DENIALS** OR **NEGATIVE** COVERAGE DECISIONS **BY INSURERS** BE REVIEWED AND APPROVED BY QUALIFIED HUMAN PERSONNEL **WHO ARE BOARD-CERTIFIED PHYSICIANS IN THE RELEVANT SPECIALTY OR SUB-SPECIALTY WITH AN UNRESTRICTED AND ACTIVE LICENSE, AND ARE PROVIDED NO ADDITIONAL FINANCIALS FOR DENIALS OF CARE**; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT PROHIBITING HEALTH INSURERS FROM RELYING SOLELY ON ARTIFICIAL INTELLIGENCE-BASED ALGORITHMS TO DENY, DELAY, OR ~~MODIFY~~ **DOWNCODE** HEALTH CARE CLAIMS OR SERVICES AND URGE BOTH CMS AND STATE REGULATORY AGENCIES TO ESTABLISH POLICIES REQUIRING HUMAN OVERSIGHT IN THESE DECISIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT STAKEHOLDERS, INCLUDING INSURERS, TECHNOLOGY PROVIDERS, AND REGULATORS, TO ENSURE THAT ARTIFICIAL INTELLIGENCE ALGORITHMS USED IN HEALTH CARE DECISION-MAKING **AND THE DATASETS THEY ARE TRAINED ON** ARE TRANSPARENT, ACCOUNTABLE, **BASED ON ACCURATE AND UP-TO-DATE CLINICAL CRITERIA DERIVED FROM NATIONAL MEDICAL SPECIALTY SOCIETY GUIDELINES AND PEER REVIEWED CLINICAL LITERATURE,** AND SUBJECT TO OVERSIGHT BY QUALIFIED HEALTH CARE PROFESSIONALS.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY REPLACING THE WORDS "PROVIDED NO ADDITIONAL FINANCIALS FOR DENIALS OF" WITH THE WORDS "NOT INCENTIVIZED TO DENY PAYMENT FOR." The motion was adopted.

It was moved THAT THE FIRST RESOLVED BE VOTED ON SEPARATELY. The motion was not adopted.

It was moved THAT AMENDED RESOLUTION 56 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The amended main motion was then voted on and adopted.

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:47 pm on Saturday, September 6, 2025.

The Council then resumed discussion of the report of Reference Committee B.

The committee recommended that Amended Resolution 59 be adopted.

It was moved THAT AMENDED RESOLUTION 59 BE ADOPTED:

~~RESOLVED, THAT ACEP SUPPORT AND ADVOCATE FOR FEDERAL AND STATE LEGISLATIVE EFFORTS TO ALLOW PHYSICIANS WITH A PERMANENT AND UNRESTRICTED MEDICAL LICENSE IN ONE U.S. STATE TO PROVIDE TELEMEDICINE SERVICES TO PATIENTS IN ANY STATE WITHOUT REQUIRING ADDITIONAL STATE-SPECIFIC LICENSURE; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS TO **ADVOCATE FOR STATES TO ESTABLISH A SPECIAL PURPOSE TELEHEALTH REGISTRY OR LICENSE** ~~ESTABLISH A NATIONAL TELEMEDICINE LICENSURE FRAMEWORK MODELED AFTER FLORIDA'S SUCCESSFUL TELEHEALTH REGISTRATION SYSTEM~~; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE ~~FOR PERMANENT REGULATORY CHANGES AT BOTH FEDERAL AND STATE LEVELS~~ TO EXPAND ACCESS TO EMERGENCY TELEMEDICINE SERVICES **WITH LICENSURE RECOGNITION** ACROSS STATE LINES WHILE ENSURING PATIENT SAFETY AND PHYSICIAN ACCOUNTABILITY.

It was moved THAT EACH RESOLVED BE VOTED ON SEPARATELY. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 89 be adopted.

It was moved THAT AMENDED RESOLUTION 89 BE ADOPTED:

RESOLVED, THAT ACEP RECOGNIZE AND COMMEND DEBRA HOURY, MD, FACEP; DEMETRE DASKALAKIS, MD**; JENNIFER LAYDEN, MD, PHD**; AND DANIEL JERNIGAN, MD, MPH, FOR THEIR PRINCIPLED STAND IN DEFENSE OF SCIENCE-BASED MEDICAL PRACTICE AND PATIENT SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~URGENTLY AND STRONGLY PUBLICLY~~ OPPOSE ~~ANY PARTISAN POLITICAL~~ INTERFERENCE IN THE LEADERSHIP, OPERATIONS, AND RECOMMENDATIONS OF CRITICAL PUBLIC HEALTH AGENCIES SUCH AS THE CDC, THUS AFFIRMING THE DEFINITIONAL ROLES OF SCIENTIFIC INDEPENDENCE AND ADHERENCE TO KNOWN FACTS AND EVIDENCE-BASED MEDICINE GUIDANCE IN SAFEGUARDING THE PRACTICE OF MEDICINE AND PUBLIC HEALTH.

It was moved THAT THE WORD "STRONGLY" BE ADDED BEFORE THE WORD "OPPOSE" IN THE SECOND RESOLVED. The motion was adopted.

It was moved THAT THE WORDS "THUS AFFIRMING" BE DELETED FROM THE SECOND RESOLVED. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 60 not be adopted.

It was moved THAT RESOLUTION 60 BE ADOPTED.

It was moved THAT THE SECOND RESOLVED BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP CLARIFY ITS CURRENT POLICY THAT THE GOLD STANDARD FOR EMERGENCY DEPARTMENT CARE IS PROVIDED BY AN EMERGENCY PHYSICIAN TO INCLUDE FURTHER GUIDANCE THAT, FOR SITES DESIGNATED AS SMALL RURAL, FRONTIER, OR EXTREME FRONTIER IN THE ACEP RURAL EMERGENCY CARE TASK FORCE 2020 REPORT ONLY, IF A TRAINED EMERGENCY PHYSICIAN IS NOT ON-SITE, A QUALIFIED EMERGENCY PHYSICIAN SHOULD BE AVAILABLE FOR REAL-TIME CONSULTATION VIA TELEHEALTH. The motion was not adopted.

The main motion was then voted on and was not adopted.

It was moved THAT DEBATE ON ALL REMAINING RESOLUTIONS BE LIMITED TO 90 SECONDS. The motion was adopted.

It was clarified that debate on all remaining resolutions is limited to 90 seconds per speaker.

REFERENCE COMMITTEE C

Dr. Cornelius presented the report of Reference Committee C. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 72 and Resolution 76.

For adoption as Amended or Substituted: Amended Resolution 61, Amended Resolution 62, Amended Resolution 64, Substitute Resolution 65, Amended Resolution 66, Amended Resolution 67, Amended Resolution 68, Amended Resolution 71, Amended Resolution 73, Substitute Resolution 74, Amended Resolution 79, Amended Resolution 80, and Amended Resolution 90.

Not for adoption: Resolution 63, Resolution 69, Resolution 70, Resolution 75, and Resolution 78.

For referral to the Board of Directors: Resolution 77.

Resolution 70 and Resolution 75 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 61

~~RESOLVED, THAT ACEP ACKNOWLEDGE THE ENVIRONMENTAL IMPACT OF METERED-DOSE INHALERS AND SUPPORTS EFFORTS TO REDUCE THEIR CARBON FOOTPRINT THROUGH SUSTAINABLE PRACTICES; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ENCOURAGE THE EDUCATION OF EMERGENCY PHYSICIANS, OTHER MEDICAL PERSONNEL, PHARMACISTS, AND PATIENTS REGARDING: THE ENVIRONMENTAL IMPACT OF METERED-DOSE INHALERS, INCLUDING THE DIFFERENCES AMONG CANISTER WEIGHTS AND ASSOCIATED PROPELLANT VOLUMES; THE AVAILABILITY AND APPROPRIATENESS OF DRY POWDER INHALERS AS AN ALTERNATIVE, WHEN CLINICALLY INDICATED; AND PROPER DISPOSAL AND RECYCLING PROTOCOLS FOR METERED-DOSE INHALERS, INCLUDING THE IMPORTANCE OF INCINERATION TO DEACTIVATE REMAINING HYDROFLUOROALKANE PROPELLANTS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ACKNOWLEDGE THE ENVIRONMENTAL IMPACT OF METERED-DOSE INHALERS AND SUPPORTS EFFORTS TO REDUCE THEIR CARBON FOOTPRINT THROUGH SUSTAINABLE PRACTICES.

AMENDED RESOLUTION 62

~~RESOLVED, THAT ACEP SUPPORT EFFORTS TO REDUCE UNNECESSARY WASTE AND CARBON EMISSIONS IN EMERGENCY DEPARTMENTS (EDS) THROUGH EDUCATION, POLICY DEVELOPMENT, AND SUPPORT FOR SUSTAINABLE CLINICAL PRACTICES; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE HOSPITALS ~~AND EMERGENCY DEPARTMENTS~~ TO IMPLEMENT ENVIRONMENTALLY RESPONSIBLE PRACTICES, INCLUDING BUT NOT LIMITED TO PROPER WASTE SEGREGATION, DEVELOPMENT OF RECYCLING PROGRAMS, REDUCTION OF LOW-VALUE MEDICAL INTERVENTIONS, AND THE USE OF SUSTAINABLE ALTERNATIVES WHEN CLINICALLY APPROPRIATE; ~~AND BE IF FURTHER~~.

~~RESOLVED, THAT ACEP DEVELOP RESOURCES TO HELP EMERGENCY PHYSICIANS AND EMERGENCY DEPARTMENTS ACHIEVE THE AIM OF REDUCING WASTE AND CARBON EMISSIONS FORM THE EMERGENCY DEPARTMENT.~~

AMENDED RESOLUTION 64

RESOLVED, THAT ACEP ENDORSE THE USE OF ELECTRONIC DISCHARGE INSTRUCTIONS FOR PATIENTS WITH ACCESS TO ELECTRONIC MEDICAL RECORDS AND ELECTRONIC COMMUNICATION CAPABILITIES; AND BE IT FURTHER

RESOLVED, THAT ACEP ENCOURAGE EMERGENCY DEPARTMENTS TO ADOPT POLICIES AND TECHNOLOGIES THAT SUPPORT ~~THE~~ **PATIENT-CENTERED,** SECURE, TIMELY, AND ENVIRONMENTALLY RESPONSIBLE ELECTRONIC DELIVERY OF DISCHARGE INSTRUCTIONS IN COMPLIANCE WITH HIPAA REGULATIONS ~~AND BEST PRACTICES~~.

SUBSTITUTE RESOLUTION 65

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT OPPOSING THE ESTABLISHMENT OF COLLABORATIVE PRACTICE AGREEMENTS WITHOUT THE SPECIFIC AND INFORMED AUTHORIZATION OF THE SUPERVISING PHYSICIAN; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE THE EXECUTION OF COLLABORATIVE PRACTICE AGREEMENTS BY EMPLOYERS, HOSPITALS, OR CONTRACT GROUPS ON BEHALF OF EMERGENCY PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT THE PRIOR DISCLOSURE OF COLLABORATIVE PRACTICE AGREEMENTS WHEN REQUIRED FOR EMPLOYMENT OF EMERGENCY PHYSICIANS.

~~RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT OPPOSING THE FOLLOWING PRACTICES:~~

- ~~THE ESTABLISHMENT OF COLLABORATIVE PRACTICE AGREEMENTS WITHOUT THE SPECIFIC AND INFORMED AUTHORIZATION OF THE SUPERVISING PHYSICIAN;~~
- ~~THE EXECUTION OF COLLABORATIVE PRACTICE AGREEMENTS BY EMPLOYERS, HOSPITALS, OR CONTRACT GROUPS ON BEHALF OF EMERGENCY PHYSICIANS;~~
- ~~THE IMPOSITION OF COLLABORATIVE PRACTICE AGREEMENTS AS A MANDATORY CONDITION OF EMPLOYMENT FOR EMERGENCY PHYSICIANS.~~

AMENDED RESOLUTION 66

~~RESOLVED, THAT ACEP ENDORSE A NATIONAL DOOR-TO-DOCTOR BENCHMARK OF NO LESS THAN 30 MINUTES TO PREVENT INCREASINGLY UNREALISTIC TARGETS THAT UNDERMINE CLINICAL JUDGMENT AND OPERATIONAL SUSTAINABILITY; AND BE IT FURTHER~~

RESOLVED, THAT ACEP OPPOSE PRACTICES THAT ENCOURAGE UNSAFE OR UNSUSTAINABLE DOOR-TO-DOCTOR EXPECTATIONS ~~WITHOUT ADEQUATE STAFFING OR CLEAR EVIDENCE OF IMPROVED PATIENT CARE~~.

AMENDED RESOLUTION 67

RESOLVED, THAT ACEP WORK WITH **RELEVANT** STAKEHOLDERS ~~INCLUDING THE FORENSIC MEDICINE SECTION, AMERICAN COLLEGE OF SURGEONS – COMMITTEE ON TRAUMA (ACS-COT), INTERNATIONAL ASSOCIATION OF FORENSIC NURSING (IAFN), ACADEMY OF FORENSIC NURSING (AFN), AND EMERGENCY NURSES ASSOCIATION (ENA)~~ TO IMPLEMENT A **COLLABORATIVE** STANDARD OF FORENSIC PROGRAMS AT ALL LEVEL 1

AND LEVEL 2 TRAUMA CENTERS.

AMENDED RESOLUTION 68

RESOLVED, THAT ACEP AMEND ITS POLICY STATEMENT "FIREARM SAFETY AND INJURY PREVENTION" TO INCLUDE ~~SUPPORT FOR THE~~ INTEGRATION OF FIREARM INJURY PREVENTION, SAFE STORAGE, AND COUNSELING EDUCATION INTO EMERGENCY MEDICINE RESIDENCY TRAINING AND CONTINUING MEDICAL EDUCATION ~~PROGRAMS~~; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP OR IDENTIFY ~~AND DISSEMINATE A~~ **EASILY ACCESSIBLE** ~~PHYSICIAN~~ **MEMBER**-FACING CLINICAL ~~GUIDE~~ **INFORMATION** TO SUPPORT EMERGENCY PHYSICIANS IN CONDUCTING BRIEF, TRAUMA-INFORMED FIREARM SAFETY COUNSELING, PARTICULARLY FOR HIGH-RISK PATIENTS~~, ALONGSIDE BOTH PRINTABLE AND DIGITAL FORMAT, EVIDENCE-BASED PATIENT HANDOUTS SUITABLE FOR EMERGENCY DEPARTMENT USE, POTENTIALLY LEVERAGING EXISTING MATERIALS AND PARTNERSHIPS WHERE APPROPRIATE AND~~ CONSISTENT WITH ACEP'S FIREARM SAFETY POLICIES.

AMENDED RESOLUTION 71

RESOLVED, THAT ACEP CURATE EXISTING AND FUTURE EDUCATIONAL MATERIALS AND WEBINARS FOCUSED ON BEST PRACTICES IN EMPLOYMENT NEGOTIATION~~, GUIDANCE ON ASSESSING CONTRACT PROVISIONS, MALPRACTICE INSURANCE FUNDAMENTALS WITH PARTICULAR EMPHASIS ON SECURING TAIL COVERAGE PROVISIONS, AND RESPONDING TO EMPLOYER INSOLVENCY AND HAVE THESE RESOURCES AVAILABLE IN AN ORGANIZED, USER-FRIENDLY,~~ **INTO A** CENTRALIZED ~~AND~~ MEMBER-ACCESSIBLE ~~HUB~~ **RESOURCE** THAT IS EASILY IDENTIFIABLE ON THE ACEP WEBSITE.

AMENDED RESOLUTION 73

RESOLVED, THAT ACEP DEVELOP A PLAN TO PROMOTE AND FACILITATE THE INITIATION OF NATION~~-~~ WIDE EMERGENCY DEPARTMENT PROGRAMS TO IMPROVE SUBSTANCE USE DISORDER TREATMENT INCLUDING, BUT NOT LIMITED TO, STAFF TRAINING, DISPENSING HARM REDUCTION MATERIALS, INITIATING **EVIDENCE-BASED** MEDICATION ~~FOR OPIOID USE DISORDER~~ **WHERE APPLICABLE**, AND RAPID CLINICAL REFERRALS TO OUTPATIENT TREATMENT **WHERE AVAILABLE**; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~POTENTIALLY~~ WORK WITH ~~OTHER~~ **RELEVANT STAKEHOLDER** ORGANIZATIONS ~~SUCH AS THE AMERICAN MEDICAL ASSOCIATION, STATE MEDICAL ASSOCIATIONS, BRIDGE TO TREATMENT, MATTERS, AMERICAN SOCIETY OF ADDICTION MEDICINE, AMERICAN COLLEGE OF ACADEMIC ADDICTION MEDICINE AND POTENTIALLY OTHERS,~~ TO OBTAIN FUNDING FOR SUBSTANCE USE DISORDER PROGRAMS ~~FROM FEDERAL, STATE, AND/OR PRIVATE SOURCES~~; AND BE IT FURTHER

RESOLVED, THAT ACEP REPORT BACK TO THE COUNCIL IN ~~2026~~ **A TIMELY MANNER** ON THE DEVELOPMENT OF A PLAN TO PROMOTE AND FACILITATE THE INITIATION OF NATION~~-~~ WIDE EMERGENCY DEPARTMENT PROGRAMS TO IMPROVE SUBSTANCE USE DISORDER TREATMENT AND ANY PROGRESS MADE ON THE GOALS OF THE PLAN.

SUBSTITUTE RESOLUTION 74

RESOLVED, THAT ACEP DEVELOP STRATEGIES TO ADDRESS BARRIERS PREVENTING THE DISPENSATION OF ESSENTIAL MEDICATIONS IN SUFFICIENT QUANTITY UPON DISCHARGE FROM THE EMERGENCY DEPARTMENT DURING OFF HOURS AND WHEN PHARMACIES ARE NOT AVAILABLE.

AMENDED RESOLUTION 79

RESOLVED, THAT ACEP WORK COLLABORATIVELY WITH ~~THE AMERICAN PSYCHIATRIC ASSOCIATION~~ **RELEVANT STAKEHOLDERS** TO DEVELOP CONSENSUS RECOMMENDATIONS AND BEST PRACTICES REGARDING TRANSPORT REQUIREMENTS FOR PATIENTS BEING TRANSFERRED TO PSYCHIATRIC FACILITIES, WITH SPECIFIC ATTENTION TO THE TRANSFERRING FACILITY DETERMINING CLINICAL STABILITY, RESTRAINT USE, AND ACCEPTABLE MEANS OF TRANSPORTATION.

AMENDED RESOLUTION 80

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT STAKEHOLDERS, INCLUDING THE AMERICAN COLLEGE OF SURGEONS AND THE AMERICAN HOSPITAL ASSOCIATION, TO DEVELOP AND DISSEMINATE A COMPREHENSIVE ELECTIVE SURGERY SCHEDULING TOOLKIT AIMED AT GUIDING HOSPITALS IN IMPLEMENTING EFFECTIVE SCHEDULING PRACTICES TO MITIGATE ED CROWDING~~; AND BE IT FURTHER~~**.**

~~RESOLVED, THAT A COMPREHENSIVE ELECTIVE SURGERY SCHEDULING TOOLKIT DEVELOPED BY ACEP INCLUDE EVIDENCE-BASED GUIDELINES, BEST PRACTICES, CASE STUDIES, AND DATA-DRIVEN MODELS DEMONSTRATING SUCCESSFUL IMPLEMENTATION OF ELECTIVE SURGERY SMOOTHING, WITH SPECIFIC RECOMMENDATIONS TAILORED TO DIFFERENT HOSPITAL SETTINGS AND RESOURCE LEVELS; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ADVOCATE FOR THE ADOPTION OF ELECTIVE SURGERY SMOOTHING PRINCIPLES AS PART OF BROADER HOSPITAL-WIDE PATIENT FLOW IMPROVEMENT INITIATIVES, RECOGNIZING ITS ROLE IN REDUCING ED CROWDING, IMPROVING PATIENT OUTCOMES, AND ENHANCING HEALTH CARE EFFICIENCY.~~

AMENDED RESOLUTION 90

RESOLVED, THAT ACEP PROMPTLY CREATE A POLICY STATEMENT ENDORSING THE USE OF ~~TYPICAL~~ **HIGH-QUALITY EVIDENCE-BASED** VACCINE SCHEDULES AS OUTLINED IN AND BASED UPON THE **MOST CURRENT** RECOMMENDATIONS AND VACCINE SCHEDULES **AS** PUBLISHED BY THE AMERICAN ACADEMY OF PEDIATRICS ~~ON AUGUST 19, 2025~~, THE AMERICAN COLLEGE OF CARDIOLOGY ~~ON AUGUST 26, 2025~~, AND THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY ~~ON AUGUST 27, 2025~~.

The committee recommended that Resolution 70 not be adopted:

It was moved THAT RESOLUTION 70 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 75 not be adopted:

It was moved THAT RESOLUTION 75 BE ADOPTED.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY REPLACING THE WORDS “IS USED EXCLUSIVELY TO DESCRIBE FACILITIES WHERE A PHYSICIAN IS PHYSICALLY PRESENT ON-SITE AT ALL TIMES DURING OPERATIONAL HOURS” WITH THE WORDS “ENSURING IT ACCURATELY REFLECTS THAT THE LEVEL OF CARE PROVIDED ALIGNS WITH BOTH FEDERAL EXPECTATIONS AND PUBLIC UNDERSTANDING, AND TO EXCLUSIVELY DESCRIBE FACILITIES WHERE A PHYSICIAN IS PHYSICALLY PRESENT AT ALL TIMES” AND ADDING A NEW SECOND RESOLVED TO READ:

RESOLVED, THAT ACEP REQUEST THAT REGULATORY AND ACCREDITING BODIES, SUCH AS CMS AND JOINT COMMISSION ENFORCE APPROPRIATE USE OF FACILITY TITLES SUCH AS “EMERGENCY DEPARTMENT” OR “URGENT CARE”, ENSURING THAT SUCH DESIGNATIONS ARE CONSISTENT WITH THE SERVICES AND STAFFING REQUIREMENTS AS DESCRIBED IN THE CODE OF FEDERAL REGULATIONS, IN ACCORDANCE WITH SERVICES PROVIDED, PARTICULARLY WITH REGARD TO THE AVAILABILITY OF PHYSICIAN-ON-SITE EMERGENCY CARE; AND BE IT FURTHER

It was moved THAT RESOLUTION 75 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

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ACEP President-Elect L. Anthony Cirillo, MD, FACEP, addressed the Council.

Dr. Char reported that 436 councillors of the 436 eligible for seating had been credentialed.

The Tellers, Credentials, & Elections Committee conducted the Vice Speaker election. Dr. Traill was elected.

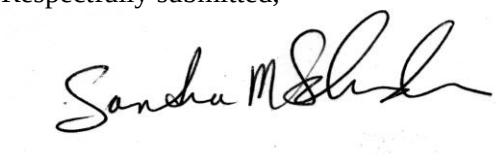
The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Freess, Dr. Kailes, and Dr. Pao were elected to a three-year term. Dr. McCabe-Kline was re-elected to a three-year term.

The Tellers, Credentials, & Elections Committee conducted the president-elect election. Dr. Stanton was elected.

There being no further business, Dr. Costello adjourned the 2025 Council meeting at 5:08 pm on Saturday, September 6, 2025.

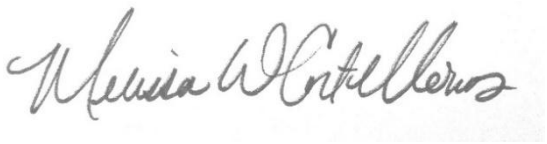
The next meeting of the ACEP Council is scheduled for October 3-4, 2026, at the Marriott Marquis Hotel, in Chicago, IL.

Respectfully submitted,



Sandra M. Schneider, MD, FACEP
Interim Council Secretary and Interim Executive Director

Approved by,



Melissa W. Costello, MD, FACEP
Council Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
January 29, 2026
Virtual Meeting

Minutes

Speaker Michael McCrea, MD, FACEP, called to order a meeting of the Council Steering Committee of the American College of Emergency Physicians at 9:02 am Central time on Thursday, January 29, 2026.

Steering Committee members present for all or portions of the meeting were Ian Brodka, MD; Joshua da Silva, DO, FACEP; Herbert Duber, MD, MPH, FACEP; Puneet Gupta, MD, FACEP; Jolie Holschen, MD, FACEP; Antony Hsu, MD, FACEP; Greg A. Juhl, MD, FACEP; Michael McCrea, MD, FACEP, speaker; David Nestler, MD, MS, FACEP; Jennifer Savino, MD, FACEP; Aaron Snyder, MD, FACEP; Sophia Spadafore, MD, MA; Larisa M. Traill, MD, FACEP, vice speaker; Daniel Udrea, MD, FACEP; Nicole Veitinger, DO, FACEP; William Weber, MD, MPH, FACEP; Carol Wright Becker, MD, FACEP; and Randall Young, MD, FACEP.

Other members and guests present for all or portions of the meeting were: L. Anthony Cirillo, MD, FACEP, president; Daniel Freess, MD, FACEP; C. Ryan Keay, MD, FACEP; Chadd K. Kraus, DO, DrPH, CPE, FACEP, chair of the Board; Diana Nordlnd, DO, JD, FACEP; James L. Shoemaker, Jr., MD, FACEP; and Ryan Stanton, MD, FACEP, president-elect.

Staff present for all or portions of the meeting were: Jonathan Fisher, MD, FACEP; Mary Ellen Fletcher, CPC, CEDC, CAE; Michael Fraser, PhD, MS, CAE; Ashlee Glasco; Cameron Hogan; CAE; Laura Lang, JD; Sonja Montgomery; Sandra Schneider, MD, FACEP; Julie Wassom; Amber Williams; and Laura Wooster, MPH.

Officer and Staff Reports
Speaker

Dr. McCrea welcomed everyone and thanked them for their participation and commitment to the College. He reported on the Board retreat that was held in early November and gave a brief recap of the January 27-28, 2026, Board meeting. The 2026 Council committees have been appointed and are now beginning their work and a Council Task Force on Voting & Elections has been appointed to review the voting method used for elections conducted by the Council and consider whether an alternative voting method should be proposed for the Council's consideration. Dr. McCrea announced the nominations for the Board of Directors are now open as well as nominations for ACEP's 2026 awards

Vice Speaker

Dr. Traill reported on her role as a member of the Finance Committee as the speaker's designee and summarized ACEP's current financial operations.

President

Dr. McCrea stated Dr. Cirillo will be joining the meeting later because he is currently in flight to the National Association of EMS Physicians (NAEMSP) meeting in Tampa, FL.

President-Elect

Dr. Stanton discussed his attendance at the AMA Interim Meeting and ACEP's Accelerate Conference in San Diego. He encouraged everyone to attend next year's Accelerate Conference in Orlando, FL. He will also be attending the NAEMSP meeting in Tampa with Dr. Cirillo. He provided an update on scope of practice issues in Kentucky and the Board's changes to the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." He reported that the Board approved a 3% dues increase effective July 1, 2026.

Executive Director

Dr. Fraser discussed his background and prior positions before joining ACEP. He highlighted key discussions from the January 27-28, 2026, Board meeting, including the review of ACEP's strategic priorities, the goal to enhance non-dues revenue, expanding and streamlining the accreditation programs, and increasing participation in the Clinical Emergency Data Registry. A new AI platform, AskSonja, is being tested among staff and a few members and will eventually be available to members and all staff. The AI tool will assist in researching ACEP resources and information.

Steering Committee Expectations

Dr. McCrea reminded the Steering Committee of their expectation to attend the April 26, 2026, Steering Committee meeting and the Leadership & Advocacy Conference April 26-28. 2026, in Washington, DC. The Steering Committee will also meet at 6:00 pm on Friday, October 2, 2026, in Chicago, IL, the evening prior to the Council meeting. It is expected that Steering Committee members will be serving as councillors or alternate councillors at the annual Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. McCrea reviewed the Tellers, Credentials, & Elections Committee report from the 2025 Council meeting. There were 436 councillors allocated and 436 were credentialed. All chapters and sections were represented at the meeting.

Electronic voting was conducted using online voting software from www.associationvoting.com. The electronic voting software was programmed with the unique membership numbers of councillors prior to the Council meeting and was updated onsite as needed to accommodate any last-minute changes to delegations. The electronic voting system worked effectively for voting on resolutions and the elections. There were problems with the hotel's Wi-Fi service provider that impacted the ability to submit motions electronically and caused delays in voting. ACEP's onsite Technology Services staff improvised a solution using mobile hotspots. Councillors were also able to use their cell phones for voting. ACEP's contract with the hotel contained a performance clause for Wi-Fi service and 100% of the cost was refunded to ACEP. The 2026 Council meeting will be held at McCormick Place Convention Center in Chicago and staff have already held meetings with the personnel to address Wi-Fi capacity and service needs.

Councillor Allocation

Dr. McCrea reported that the total councillor allocation for the 2026 Council meeting is 441 based on the average total membership as of December 31, 2025. This is 5 additional councillors than were allocated for the 2025 meeting. The average membership was used for the calculation based on the adoption of Amended Resolution 13(24) Allocation of Councillors. The following chapters gained one councillor this year: Alaska, Florida, Government Services, Iowa, Montana, New York, North Carolina, and Texas. The following chapters lost councillor(s) based on the average membership calculation this year: Connecticut, Maryland, and Virginia.

All sections met the minimum membership requirement of 100 members and will have a councillor for the 2026 Council meeting. ACEP staff will work with membership to identify the decline in section memberships for 2026.

2025 Council Meeting

Dr. McCrea reviewed various aspects of the 2025 Council meeting and requested feedback about potential changes for the 2026 meeting.

There was consensus to continue allowing asynchronous testimony on resolutions submitted for the 2026 Council meeting. Some Steering Committee members expressed support for revising the preliminary Reference Committee reports to include recommendations for disposition of the resolutions and amended or substituted language similar to the format of the final Reference Committee reports instead of providing the information in the summary of the asynchronous testimony. The Annual Meeting Subcommittee will discuss this further and provide a recommendation for the April 26, 2026, Steering Committee meeting.

The Town Hall meeting topic was “Emergency Department Accreditation (EDAC): Why ED Accreditation is Right for Your ED!” Several potential topics were proposed for this year. It was also suggested that the Town Hall meeting be discontinued for this year unless there is a breaking issue that needs to be addressed. The Annual Meeting Subcommittee will discuss the Town Hall meeting and provide a recommendation to the Steering Committee for discussion at the April 26, 2026, meeting.

The second day of the Council meeting was live streamed to provide all members an opportunity to observe the Council meeting. There were no privileges to speak during the meeting, and the chat function was disabled. There were only 28 remote observers, however, attendance may have been impacted by the connectivity issues experienced during the Council meeting and the continual broadcast interruptions. The Steering Committee supported continuing to live stream the second day. Staff are currently investigating the cost. The live-stream capability will be promoted to all members, and chapters will also be encouraged to highlight this feature in their communications.

The 2026 Council meeting will be held at McCormick Place West Convention Center in Chicago, which is connected via skybridge to the Marriott Marquis Hotel Chicago. Meetings occurring the evening prior to the Council meeting will be held at the Marriott Marquis Hotel Chicago.

Dr. McCrea announced that the councillor orientation session, traditionally held at 8:00 pm the evening prior to the Council meeting, will be discontinued this year based on declining attendance over the past several years. Factors potentially affecting attendance include the time of the meeting and many chapters conduct their own orientation sessions for new councillors and alternates. The Council officers will participate in a Council 101 webinar on April 10, 2026. The webinar is open to all members and includes similar information that is reviewed at the councillor orientation session. A link to the webinar recording will be shared with the Council and chapters.

2026 Council Meeting Agenda

The Steering Committee reviewed the draft 2026 Council meeting agenda. The Annual Meeting Subcommittee will review the Council meeting agenda and provide suggestions for any changes at the April 26, 2026, meeting.

Electronic Voting

Dr. McCrea reviewed the electronic voting system. The Steering Committee did not identify any issues or concerns about continuing to use the Association Voting platform for electronic voting during the 2026 Council meeting. It was recommended that electronic voting be used during discussions about sensitive or potentially contentious issues.

Elections Process

The Steering Committee discussed the format of the Candidate Forum and did not identify any potential changes. Dr. McCrea informed the Steering Committee about a campaign issue that occurred last year prior to the Council meeting regarding an individual posting a message in an online community of another emergency medicine organization highlighting the attributes of one candidate. The executive director of the organization requested ACEP to consider updating the Candidate Campaign Rules to prohibit this activity. The Candidate Forum Subcommittee will discuss potential changes to the Candidate Campaign Rules and provide their recommendations for discussion at the April 26, 2026, Steering Committee meeting.

Council Task Force on Voting & Elections

Dr. McCrea announced a Council Task Force on Voting & Election has been appointed and Dr. da Silva is serving as the chair. The purpose of the task force is to review the current method of voting for ACEP’s elections as codified in the Council Standing Rules and consider whether an alternative voting method should be proposed for the Council’s consideration. Dr. da Silva summarized the discussions from the initial task force meeting on January 14, 2026. A follow-up meeting will be held in February. The task force will submit a report to the Steering Committee for discussion at the April 26, 2026, meeting.

Council Champion in Diversity & Inclusion Award

The Steering Committee reviewed proposed changes to the Council Champion in Diversity & Inclusion Award title, purpose, and criteria. The changes are consistent with the renaming of the Access, Belonging, & Community Committee; the Access, Belonging, & Community Section; and the Leon Haley, Jr., Award for Access, Belonging, & Community. Ms. Lang explained the reasons the changes are needed. The proposed changes reinforce ACEP's commitment to equal opportunity to practice emergency medicine and equal access to leadership and do not alter the intent of the award.

> It was moved THAT THE STEERING COMMITTEE APPROVE THE REVISED DESCRIPTION AND CRITERIA FOR THE COUNCIL CHAMPION IN DIVERSITY & INCLUSION AWARD AND RENAME THE AWARD THE "COUNCIL CHAMPION IN ACCESS, BELONGING, & COMMUNITY AWARD." The motion was adopted.

Referred Resolution 23(25) Councillor Allocations for Sections of Membership

Multiple changes to the Bylaws and the Council Standing Rules over the years have resulted in the language being slightly different regarding councillor allocations for sections. The Steering Committee submitted a resolution to the 2025 Council with the intent of reconciling the language. The Council referred Resolution 23(25) Councillor Allocations for Sections of Membership to the Steering Committee. The Bylaws & Council Standing Rules Subcommittee will review the referred resolution and provide a recommendation to the Steering Committee for discussion at the April 26, 2026, meeting.

Commendation and Memorial Resolutions

The Steering Committee discussed the potential of establishing criteria to limit submission of commendation and memorial resolutions to ACEP members or former members and staff only and include a level of leadership eligibility, such as chapter or national Board of Directors, committee service, councillor/alternate councillor status, or membership tenure. It was acknowledged that the number of memorial resolutions will likely continue to increase over the next few years. There was some support for limiting commendations to members/former members and staff only and continue to allow memorial resolutions without restrictions.

The Steering Committee also discussed the cost implications of framing commendation and memorial resolutions and the time required to read the resolveds of the memorial resolutions during the Council meeting. Some committee members supported discontinuing framing memorial resolutions and reading the resolveds during the "In Memoriam" portion of the Council meeting.

The Bylaws & Council Standing Rules Subcommittee will review these issues and provide recommendations for discussion the April 26, 2026, Steering Committee meeting. It was noted that Bylaws and/or Council Standing Rules amendments may be needed if changes are made regarding submission of commendation and memorial resolutions.

Board Action on Six Resolutions

Dr. McCrea informed the Steering Committee about actions on six resolutions the Board of Directors discussed at their January 27-28, 2026, meeting.

- Amended Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events: The Board approved a new policy statement "Hospital Boarding and Crowding Must Be Included in Formal Event Reviews and Quality Improvement Processes."
- Referred Amended Resolution 40(24) Telehealth Emergency Physician Standards: The "Emergency Medicine Telehealth" policy statement was revised referred back to the Emergency Medicine Practice Committee for further review to ensure alignment with the updated "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement and telehealth supervision of PAs and NPs.

- Referred Resolution 52(24) Delegation of Critical Care to Non-Physician Practitioners: The "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement was updated.
- Amended Resolution 36(25) Reaffirming Support for 3-Year and 4-Year EM Residency Program Accreditation: The Board formally reaffirmed the "Length of Residency in Training in Emergency Medicine" policy statement with an effective date of September 10, 2025.
- Amended Resolution 66(25) Endorsing a Realistic Door-to-Doctor Standard: The "Standards for Measuring and Reporting ED Wait Times" policy statement was revised and it was referred back to the Quality Improvement & Patient Safety Committee for further revisions.
- Resolution 72(25) Naloxone Access and Education in Public Schools: Approved endorsing the National School Overdose Preparedness Campaign.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2025, 2024, and 2023 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

Subcommittee Volunteers and Appointments

Dr. McCrea announced that three subcommittees will be appointed: Annual Meeting Subcommittee, Bylaws & Council Standing Rules Subcommittee, and Candidate Forum Subcommittee. All Steering Committee members should plan to serve on at least two subcommittees. All second year Steering Committee members are typically appointed to the Candidate Forum Subcommittee unless planning to seek nomination to the Board of Directors or as a Council officer or if they are planning to assist a candidate in their campaign. Ms. Montgomery will distribute the subcommittee objectives and deadlines and ask for volunteers to serve on each subcommittee. The subcommittee reports will be discussed at the April 26, 2026, Steering Committee meeting.

Next Meeting

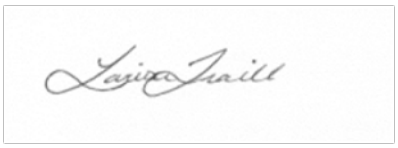
The next meeting of the Council Steering Committee is scheduled for Sunday, April 26, 2026, during the Leadership & Advocacy Conference in Washington, DC.

With no further business, the meeting was adjourned at 1:44 pm Central time on Thursday, January 29, 2026.

Respectfully submitted,



Michael J. McCrea, MD, FACEP
Council Speaker and Chair



Larisa M. Traill, MD, FACEP
Council Vice Speaker and Vice Chair

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
April 26, 2026
Grand Hyatt Hotel
Washington, DC

Minutes

Speaker Michael McCrea, MD, FACEP, called to order a meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:01 am Eastern time on Sunday, April 26, 2026.

Steering Committee members present for all or portions of the meeting were Ian Brodka, MD; Joshua da Silva, DO, FACEP; Puneet Gupta, MD, FACEP; Steven Hochman, MD, FACEP; Jolie Holschen, MD, FACEP; Antony Hsu, MD, FACEP; Greg A. Juhl, MD, FACEP; Michael McCrea, MD, FACEP, speaker; David Nestler, MD, MS, FACEP; Jennifer Savino, MD, FACEP; Aaron Snyder, MD; Sophia Spadafore, MD, MA; Larisa M. Traill, MD, FACEP, vice speaker; Daniel Udrea, MD, FACEP; Nicole Veitinger, DO, FACEP; William Weber, MD, MPH, FACEP; and Carol Wright Becker, MD, FACEP.

Other members and guests present for all or portions of the meeting were: L. Anthony Cirillo, MD, FACEP, president; Melissa Costello, MD, FACEP; Carl Heine, MD, FACEP; Steven Kailes, MD, FACEP; C. Ryan Keay, MD, FACEP; Rami Khoury, MD, FACEP; Heidi Knowles, MS, MD, FACEP; Abhi Mehrotra, MD, MBA, FACEP; Rebecca Parker, MD, FACEP; Henry Pitzele, MD, FACEP; Luke Saski MD, FACEP; James L. Shoemaker, Jr., MD, FACEP; and Ryan Stanton, MD, FACEP, president-elect.

Staff present for all or portions of the meeting were: Jonathan Fisher, MD, FACEP; Mary Ellen Fletcher, CPC, CEDC, CAE; Michael Fraser, PhD, MS, CAE; Laura Lang, JD; and Sonja Montgomery.

Minutes

The minutes of the January 29, 2026, Steering Committee meeting were approved as written.

Officer and Staff Reports
Speaker

Dr. McCrea welcomed everyone and thanked them for their participation and commitment to the College. He announced the candidates for election at the 2026 Council meeting:

President-Elect
Heidi C. Knowles, MS, MD, FACEP
Kristin B. McCabe-Kline, MD FACEP
James L. Shoemaker, Jr., MD, FACEP

Board of Directors Candidates (4 positions to be filled)
Torree M. McGowan, MD, FACEP – GS
Abhi Mehrotra, MD, MBA, FACEP – NC (incumbent)
Heather S. Owen, MD, FACEP – TX
Henry Z. Pitzele, MD, FACEP – IL (incumbent)
Alexandra Nicole Thran, MD, FACEP – VT

He reported the Council Awards Committee has selected the 2026 award recipients. An announcement about all 2026 award recipients will be posted on the Council engagED after the April 29, 2026, Board of Directors meeting and all recipients have been notified.

Dr. McCrea reminded everyone that a Council 101 webinar was held on April 10, 2026, and a link to the recording was posted on the Council engagED. The webinar replaces the "New Councillor Orientation" that has traditionally been held the evening prior to the Council meeting.

Vice Speaker

Dr. Traill reported on her role as a member of the Finance Committee as the speaker's designee and summarized ACEP's current financial operations.

President

Dr. Cirillo reported thanked Dr. Fraser and staff for their work. He highlighted several key initiatives of the College.

President-Elect

Dr. Stanton discussed his goals for during his year as president.

Executive Director

Dr. Fraser shared information about the new approach for ACEP's advocacy and communications strategies and the "Built on Results" communications campaign. He has been assessing ACEP's infrastructure and systems over the past six months and worked with staff to develop realigned strategic priorities for FY 2026-27. The strategic priorities were approved by the Board in March and will guide ACEP's work and budget for the next fiscal year. He expressed the importance of mapping all ACEP activities to the strategic priorities, identifying any gaps, and the need to evaluate and potentially eliminate activities/initiatives that do not align.

Annual Meeting Subcommittee Report

Dr. Nestler presented the subcommittee's report on their assigned objectives.

The subcommittee reviewed the Council meeting agenda and supports discontinuing the Town Hall meeting this year, unless there is a breaking issue that requires discussion. The subcommittee recommended revising the Council meeting timed agenda to end by 5:15 pm on Saturday, October 3, 2026, and holding the Candidate Reception 5:30 – 6:30 pm. The Steering Committee supported the subcommittee's recommendation.

The subcommittee reviewed the current format of preliminary Reference Committee reports, which includes recommendations and amended language in the summary of asynchronous testimony, and the previous format used 2020-2022, that included recommendations for the disposition of each resolution similar to the format of the final Reference Committee reports. The subcommittee recommended returning to the previous format to include recommendations for the disposition of each resolution with amended or substituted language based on the asynchronous testimony. It was noted that Reference Committee instructions need to be clear that the starting point for discussion during the in-person Reference Committee hearing will be based on the recommendations and proposed amended or substituted language in the preliminary report. Amendments to the resolutions in the final reports will be based on the original resolution and not any amended or substituted version from the preliminary report.

> It was moved THAT THE STEERING COMMITTEE APPROVE THE SUBCOMMITTEE'S RECOMMENDATION FOR THE PRELIMINARY REFERENCE COMMITTEE REPORTS TO INCLUDE RECOMMENDATIONS FOR THE DISPOSITION OF EACH RESOLUTION WITH AMENDED OR SUBSTITUTED LANGUAGE BASED ON THE ASYNCHRONOUS TESTIMONY. The motion was adopted.

The subcommittee reviewed the implementation actions on 2023, 2024, and 2025 resolutions. Questions were raised about implementation action on some resolutions from 2024 and 2023. Staff are following up to address the questions raised. Updates to the implementation action on the resolutions can be accessed on the ACEP website by all members. https://www.acep.org/what-we-believe/actions-on-council-resolutions/

The subcommittee provided suggestions for questions that should be considered to use as survey questions during the Council meeting. The Council officers will determine the final survey questions this summer.

Bylaws & Council Standing Rules Subcommittee Report

Dr. da Silva presented the subcommittee's report on their assigned objectives.

The subcommittee discussed Referred Resolution 23(25) Councillor Allocations for Sections of Membership and reviewed the language in the Bylaws Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) and the Council Standing Rules (CSR), Councillor Allocation for Sections of Membership. There was consensus to simplify the language in the Bylaws and the CSR to reflect that a section must have the minimum number of members established by the Board of Directors. The subcommittee believes these are housekeeping changes and should not require extensive discussion by the Council. A draft Bylaws amendment and a draft CSR amendment were submitted to the Steering Committee for consideration. There was consensus from the Steering Committee to submit the resolutions to the 2026 Council. It was noted that the Bylaws and CSR language are included in the "Policy on Sections of Membership" and will need to be updated if the amendments are adopted by the Council.

The subcommittee discussed commendation and memorial resolutions and agreed that criteria should not be developed to limit the resolutions to former or current members and staff and criteria should not be developed to include a level of leadership eligibility, such as chapter or national Board of Directors, committee service, councillor/alternate councillor status, or membership tenure. The subcommittee believes members should have the ability to recognize their colleagues through commendation and memorial resolutions without restriction and regardless of whether the individual is a current or previous ACEP member. The subcommittee recommended discontinuing framing memorial resolutions and reading the resolveds during the Council meeting. The "In Memoriam" slide presentation should continue to display the photos of individuals for whom a memorial resolution was submitted. Memorial resolutions should be prepared "suitable for framing" and sent to the family in a presentation folder. Additionally, the subcommittee recommended continuing to frame commendation resolutions, reading the resolveds during the Council Awards luncheon, and presenting them to the individuals being recognized.

> It was moved THAT THE STEERING COMMITTEE APPROVE THE SUBCOMMITTEE'S RECOMMENDATION REGARDING COMMENDATION AND MEMORIAL RESOLUTIONS. The motion was adopted.

The subcommittee reviewed the CSR for any other potential amendments and none were identified.

Candidate Forum Subcommittee Report

Dr. Traill presented the subcommittee's report on their assigned objectives.

The subcommittee discussed candidate meetings with chapters and whether there should be limitations regarding when the meetings are held. Previous candidates have provided feedback to the Council officers about the number of virtual meetings they were invited to attend and the challenges with their availability. Some candidates expressed concern about potentially creating a negative perception if they are unable to attend meetings. The subcommittee discussed whether there should be limitations and a variety of potential options. The subcommittee determined that changes to the Candidate Campaign Rules with guidance regarding chapter meetings should not be proposed this year since many chapters have already scheduled their meetings. It was suggested to obtain feedback from this year's candidates and potentially review the concerns with the National/Chapter Relations Committee.

The subcommittee was informed about a campaign issue that occurred last year prior to the Council meeting regarding an individual posting a message in an online community of another emergency medicine organization highlighting the attributes of one candidate. The emergency medicine organization informed ACEP about the post and requested ACEP to consider updating the Candidate Campaign Rules (CCR) to prohibit this activity. The subcommittee also discussed whether candidates should have the ability to display campaign materials at the upcoming Leadership & Advocacy Conference. It was noted the CCR are explicit about no campaign materials at the Council meeting or any

Council sponsored events, but do not address other ACEP events. The subcommittee submitted proposed changes to the CCR pertaining to Rule #10 and Rule #14.

> It was moved THAT CANDIDATE CAMPAIGN RULE #10 BE AMENDED TO DELETE "(PRINTED MATERIAL, BUTTONS, PINS, SIGNS, ETC.)," INCLUDE THAT "NO TANGIBLE CAMPAIGN ITEMS MAY BE DISTRIBUTED OR DISPLAYED AT ANY ACEP NATIONAL, CHAPTER, OR ANY OTHER ORGANIZATION EVENT OR CONFERENCE," AND DELETE THE REFERENCE TO THE NEW COUNCILLOR ORIENTATION AND RECEPTION. The motion was adopted.
>
> It was moved THAT CANDIDATE CAMPAIGN RULE #10 BE AMENDED TO INCLUDE "NO PAID PROMOTIONAL MATERIAL OR PAID ADVERTISING IS ALLOWED."
>
> It was moved THAT THE DISCUSSION PERTAINING TO PAID PROMOTIONAL MATERIAL OR PAID ADVERTISING BE POSTPONED TO THE JANUARY 2027 STEERING COMMITTEE MEETING. The motion was adopted.

There was consensus to revise Rule #14.g. to read: "Candidates, or entities and individuals acting on behalf of any candidate(s), are prohibited from posting campaign messages or materials in an online community of another medical organization."

The remainder of the subcommittee's objectives will be completed this summer and during the 2026 Council meeting. The subcommittee will meet immediately following the April 26, 2026, Steering Committee meeting to finalize the candidate written questions and to review the assignments for moderators, coordinators, and door monitors. A virtual meeting will be held prior to the Council meeting to develop the Candidate Forum questions. The subcommittee will meet 4:30 – 6:00 pm in Chicago on Friday, October 2, 2026, to review the format for the Candidate Forum, review the final questions for the Candidate Forum, and meet with the candidates.

Council Task Force on Voting & Elections

Dr. da Silva presented the task force's final report. After careful review of the various voting methods, the task force recommended that no changes be made to the current voting method for conducting the elections of the president-elect, Board of Directors, and Council officers during the Council meeting. The Steering Committee supported the task force recommendation.

Board Actions on Resolutions

Dr. McCrea informed the Steering Committee about a new policy statement that was developed to address Amended Resolution 45(25) Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid Related Policies. The policy statement will be discussed by the Boarding during their April 29, 2026, meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Friday, October 2, 2026, during the Scientific Assembly in Chicago, IL.

With no further business, the meeting was adjourned at 10:51 am Eastern time on Sunday, April 26, 2026.

Respectfully submitted,



Michael J. McCrea, MD, FACEP
Council Speaker and Chair



Larisa M. Traill, MD, FACEP
Council Vice Speaker and Vice Chair

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DEFINITION OF COUNCIL ACTIONS

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ADOPT
Approve resolution exactly as submitted as recommendation implemented through the Board of Directors.

ADOPT AS AMENDED
Approve resolution with additions, deletions, and/or substitutions, as recommendation to be implemented through the Board of Directors.

NOT ADOPT (DEFEAT)
Defeat (or reject) the resolution in original or amended form.

REFER
Send resolution to the Board of Directors for consideration, perhaps by a committee, the Council Steering Committee, or the Bylaws Interpretation Committee.

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2026 Council Meeting
Reference Committees

Reference Committee A – Governance, Education, & Wellness
Resolutions 12-23

Jennifer L. Savino, DO, FACEP (PA) – Chair
Jacob M. Altholz, MD (CO)
Marina N. Boushra-Freiberg, MD (OH)
Daniel S. Udrea, MD, FACEP (IN)
Will Weber, MD, MPH, FACEP (MN)
Sandra Williams, DO, MPH, FACEP (TX)

Laura Lang, JD
Amber Williams, MSOL

Reference Committee B – Advocacy & Public Policy
Resolutions 24-41

George RJ Sontag, MD, FACEP (OH) – Chair
Brittany Arnold, MD, FACEP (OR)
Blake Denley, MD, FACEP (LA)
Mike Lozano, MD, MSHI, FACEP (FL)
Micaela LaRose, MD (GS)
Christopher Pergrem, MD, FACEP (KY)

Brianna Hanson, MPH
Annalane Miller, MPH

Reference Committee C – Emergency Medicine Practice
Resolutions 42-56

Hilary Fairbrother, MD, FACEP (TX) – Chair
Patsy Chenpanas, MD (OR)
Frank Y. Duncan, III, MD, FACEP (MI)
Laura Janneck, MD, MPH, MS (OK)
Ira R. Nemeth, MD, FACEP (TX)
Monika Pitzele, MD, PhD, FACEP (IL)

Joya Coffman MS, CHES, ASQ-CQIA
Travis Schulz, MLS, AHIP

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INTRODUCTION

2026 Annual Council Meeting
Friday Evening, October 2, 2026, through Sunday, October 4, 2026
Marriott Marquis Hotel Chicago and McCormick Place West Convention Center

Background information has been prepared on the resolutions that were submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting. Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council.

Only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements and background sections are informational or explanatory. Only the resolutions adopted by the Council and ratified by the Board of Directors become official. Council Standing Rules become official upon adoption by the Council.

Asynchronous testimony will open on Friday, September 4, for all resolutions assigned to a Reference Committee. An announcement with the link to the 2026 resolutions will be posted on the Council engagED when asynchronous testimony opens. After clicking on the link provided:

- login with your ACEP username and password
- the list of resolutions will display
- click the resolution of interest
- scroll to the bottom of the resolution to submit your comment

The asynchronous testimony platform is open to all members. When commenting please include the following:

1. Whether you are commenting on behalf of yourself or your component body
   a. chapter, section, AACEM, CORD, EMRA, or SAEM
2. Whether you are commenting in support, opposition, or suggesting an amendment to the resolution
3. Any additional information to support your position.

The asynchronous platform is the only method to introduce testimony until the live Reference Committee hearings in Chicago. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. All comments should be addressed to the Reference Committee Chair or the Council Speaker. **Please do not direct any communications to another member, including anyone who has posted comments before you, with whom you may or may not agree.** Proper decorum is expected within the asynchronous testimony platform as well as the in-person Reference Committee hearings during the Council meeting.

Comments should be concise so as to not exceed an equivalent of 2 minutes of oral testimony. Comments posted as online testimony are prohibited from being copied and pasted as comments in other forums and/or used in a manner in which the comments could be taken out of context. By participating in this online testimony for the Council meeting, you hereby acknowledge and agree to abide by ACEP's Meeting Conduct Policy.

Asynchronous testimony will close at 12:00 noon Central time on Monday, September 21. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary reports will be distributed to the Council on Friday, September 25 and will be the starting point for the live Reference Committee hearings during the Council meeting in Chicago, on Saturday, October 3.

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You can download and print the entire Council notebook compendium, or

individual section tabs from the Table of Contents. You will also find separate compendiums of the President-Elect candidates, the Board of Directors candidates, and the resolutions. Additional documents may be added over the next several days, so please check again if what you need is not currently available.

We are looking forward to seeing everyone in Chicago!

Your Council Officers,

Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

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2026 Council Meeting
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Laura Lang, JD
Amber Williams, MSOL

Reference Committee B – Advocacy & Public Policy
Resolutions 24-41

George RJ Sontag, MD, FACEP (OH) – Chair
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Micaela LaRose, MD (GS)
Christopher Pergrem, MD, FACEP (KY)

Brianna Hanson, MPH
Annalane Miller, MPH

Reference Committee C – Emergency Medicine Practice
Resolutions 42-56

Hilary Fairbrother, MD, FACEP (TX) – Chair
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Joya Coffman MS, CHES, ASQ-CQIA
Travis Schulz, MLS, AHIP

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2026 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Jeffrey M. Goodloe, MD, FACEP *Oklahoma College of Emergency Physicians*	
2	Commendation for Alison J. Haddock, MD, FACEP *Texas College of Emergency Physicians* *Washington Chapter*	
3	Commendation for Gabor D. Kelen, MD, FACEP *Maryland Chapter*	
4	Commendation for Chadd K. Kraus, DO, DrPH, CPE, FACEP *Pennsylvania College of Emergency Physicians*	
5	In Memory of Stanley R. Gold, MD, FACEP *Nicholas J. Jouriles, MD, FACEP* *Richard L. Stennes, MD, MBA, FACEP* *California Chapter*	
6	In Memory of Deno S. Gualtieri, DO *Pennsylvania College of Emergency Physicians*	
7	In Memory of Charles Eugene Jessup, DO, FACEP *Michigan College of Emergency Physicians*	
8	In Memory of Laura Pimental, MD *Maryland Chapter*	
9	In Memory of Francis P. Renzi, MD *Massachusetts College of Emergency Physicians*\\	
10	In Memory of Gary S. Rudolph, MD, FACEP *New York Chapter*	
11	In Memory of William Snover, MD, FACEP *Pennsylvania College of Emergency Physicians*	
12	Councillor Allocation for Sections of Membership – Bylaws Amendment *Council Steering Committee*	A
13	Councillor Allocation for Sections of Membership – Housekeeping Change – Council Standing Rules Amendment *Council Steering Committee*	A
14	Codifying the Audit Committee in the Bylaws – Bylaws Amendment *Bylaws Committee* *Board of Directors*	A
15	Proposed Bylaws Changes – Bylaws Amendment *Bylaws Committee* *Board of Directors*	A

Resolution #	Subject/Submitted by	Reference Committee
16	Emergency Medicine Recommendations for Guidelines on Occupational Ergonomics *New York Chapter*	A
17	Importance of the Arts and Humanities as Applied to Emergency Medicine *Medical Humanities Section* *Professional Well Being Section*	A
18	Emergency Physician Specific Peer-to-Peer Support Programs Across Emergency Medicine Practice Settings *Colorado Chapter* *District of Columbia Chapter* *Utah Chapter* *AAWEP Section* *Medical Humanities Section* *Professional Wellness Section*	A
19	Public Identification of Physicians in Training *New York Chapter*	A
20	Simulation-Based Continuing Education Certification *New York Chapter*	A
21	Exploring the Feasibility of Renewably Powered EMS Vehicles *Tim Boardman, MD, FACEP* *Eric Dickson, MD, FACEP* *Gary Gaddis, MD, FACEP* *Gayle Galletta, MD, FACEP* *William Porcaro, MD, FACEP* *Massachusetts College of Emergency Physicians*	A
22	Reducing Unnecessary Non-Sterile Glove Use in Emergency Departments *Mark Futernick, MD, FACEP* *Gary Gaddis, MD, FACEP* *Gayle Galletta, MD, FACEP* *Alison Hayward, MD, FACEP* *Hillary Irons, MD, FACEP* *Bridget Lee, MD* *Emily Sbiroli, MD* *Alexandra Nicole Thran, MD, FACEP* *Massachusetts College of Emergency Physicians* *Vermont Chapter*	A
23	Incorporating ED Climate Resilience and Sustainability into ACEP's ED Accreditation Program *Gary Gaddis, MD, FACEP* *Gayle Galletta, MD, FACEP* *Alison Hayward, MD, fACEP* *Bridget Lee, MD* *Hilary Irons, MD, FACEP* *Niki Thran, MD, FACEP* *Massachusetts College of Emergency Physicians* *Vermont Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
24	Advocating for Scientific Integrity in Government Health Leadership *Washington Chapter*	B
25	Response Time Standards for Insurance-Based Transfer and Admission Authorization Requests *Maryland Chapter*	B
26	Addressing Insurer Bad Behavior *Louisiana Chapter* *New York Chapter* *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
27	Conditional Support for a Single-Payer Health Care Financing System *Washington Chapter*	B
28	Creation of a Workgroup to Advance an ED-Based Medicare Three-Day Rule Waiver *Maryland Chapter*	B
29	Federal Tax Relief for EMTALA-Mandated Care *Michigan College of Emergency Physicians*	B
30	Inclusion of Physicians as Protected Persons Eligible for Personal Information Protection *Government Services Chapter*	B
31	Protecting International Medical Graduates and Ensuring Stability of the Emergency Medicine Workforce *Illinois College of Emergency Physicians* *Washington Chapter*	B
32	Protection of the Right of Licensed Healthcare Professionals to Render Emergency Care at Law Enforcement Controlled Scenes *California Chapter* *Iowa Chapter* *Minnesota Chapter* *Early Career Physicians Section*	B
33	Regulatory Governance of AI Independent Practice of EM *Jeffrey Nielson, MD, FACEP* *Todd B. Taylor, MD, FACEP* *Emergency Medicine Informatics Section*	B
34	Support of Safe and Physician Directed Care in Hyperbaric Medicine *Christopher M. Allen, MD* *Undersea and Hyperbaric Section*	B
35	Standardized Signage Identifying When a Physician is Not Present On-Site in the ED *Charles Pattavina, MD, FACEP* *Alabama Chapter* *Louisiana Chapter* *New Mexico Chapter* *Mississippi Chapter* *Pennsylvania College of Emergency Physicians* *South Carolina College of Emergency Physicians*	B

Resolution #	Subject/Submitted by	Reference Committee
36	Transparency in Emergency Department Physician Staffing *Alabama Chapter*	B
37	Development of a HIPAA-Compliant Anonymous Database for Reporting Clinical Management Events Involving Non-Physicians *Charles Pattavina, MD, FACEP* *Louisiana Chapter* *Mississippi Chapter* *New Mexico Chapter* *South Carolina College of Emergency Physicians*	B
38	Establishing Whistleblower Protections for Reporting Financial Mismanagement of Liability Reserves *Aaron Snyder, MD* *Scott Mueller, DO, FACEP* *Riemer Praamsma, MD* *Louisiana Chapter* *New Mexico Chapter* *Early Career Physicians Section*	B
39	Safeguarding Physician Liability Reserves and Continuity of Professional Protection *Scott Mueller, DO, FACEP* *Riemer Praamsma, MD* *Aaron Snyder, MD* *Louisiana Chapter* *New Mexico Chapter* *Early Career Physicians Section*	B
40	Opposing Settlement of Medical Malpractice Claims Without Consent of the Defendant Physician *Alabama Chapter* *Louisiana Chapter* *Mississippi Chapter* *New Mexico Chapter* *Pennsylvania College of Emergency Physicians* *South Carolina College of Emergency Physicians*	B
41	Transparency of Financial Solvency for Employer-Mandated Liability Coverage *Scott Mueller, DO, FACEP* *Riemer Praamsma, MD* *Aaron Snyder, MD* *Louisiana Chapter* *New Mexico Chapter* *Early Career Physicians Section,*	B
42	Clarification and Revision of ACEP Policy on Medical Cannabis in the Era of Emerging Psychoactive Cannabinoids *Pennsylvania College of Emergency Physicians*	C
43	ED-Initiated Pharmacotherapy Pathways for Alcohol Use Disorder *Michigan College of Emergency Physicians*	C

Resolution #	Subject/Submitted by	Reference Committee
44	Contraceptive Provision is Within the Scope of Emergency Medicine Practice *Jessica Army, MD* *Rebecca Barron, MD* *Morgan Bowling, DO* *Melissa Fleegler, Md, FACEP* *Lauren Fine, MD, FACEP* *Priya Ghelani, DO* *Micaela LaRose, MD* *Laura Melville, MD* *Rebecca Nerenberg, MD* *Tiffany Sigal, MD, FACEP* *Juhi Varshney, MD*	C
45	Medical Management of Early Pregnancy Loss in the Emergency Department *Emily Ager, MD, MPH* *Michael Bresler, MD, FACEP* *Jacqueline Dziedzic, DO, FACEP* *Lauren Fine, MD, FACEP* *Alicia Gonzalez, MD, FACEP* *Laura Melville, MD* *Carl Preiksaitis, MD, MEd* *Kelly Quinley, MD* *Monica Saxena, MD, JD* *California Chapter*	C
46	Strengthening ACEP Educational Resources and Guidelines on the Ultrasonographic Diagnosis of Early Pregnancy Loss *Jessica Army, MD* *Rebecca Barron, MD* *Morgan Bowling, DO* *Jonathan Brewer, MD, FACEP* *Lauren Fine, MD, FACEP* *Melissa Fleegler, MD, FACEP* *Priya Ghelani, DO* *Scott Kurpiel, MD, MBA, FACEP* *Micaela LaRose, MD* *Laura Melville, MD* *Mathew Nelson, DO, FACEP* *Rebecca Nerenberg, MD* *Whitney Potomac, DO, MS* *Kelly Quinley, MD* *Tiffany Sigal, MD, FACEP* *Julie Varshney, MD* *New York Chapter* *Emergency Ultrasound Section* *Social Emergency Medicine Section*	C
47	ED of the Future *Tom Benzoni, MD, FACEP* *Virgil Smaltz, MD, FACEP* *Peter Viccellio, MD, FACEP*	C
48	No-Cost Solutions to ED Boarding *Tom Benzoni, MD, FACEP* *Chirag Shah, MD, FACEP* *Peter Viccellio, MD, FACEP*	C

Resolution #	Subject/Submitted by	Reference Committee
49	Ensuring Transparency and Accountability in Emergency Department Staffing Proposals *Oregon Chapter*	C
50	Law Enforcement Presence in the Emergency Department *Emergency Medicine Residents' Association*	C
51	Physician Staffing Requirements for Pediatric Ready Designation *Kentucky College of Emergency Physicians*	C
52	Prioritizing Inpatient Medical Admission for Geriatric Psychiatric Patients When Psychiatric Beds Are Unavailable *Amy Costigan, MD, MBA, FACEP* *Joseph Tennyson, MD, MHCM, FACEP, FAEMS* *Massachusetts College of Emergency Physicians*	C
53	Protecting Emergency Physician Privacy in Hospital Identification and Directories *Government Services Chapter*	C
54	Radiology Turn-Around Time *Thomas Benzoni, MD, FACEP* *Fred Dennis, MD, FACEP* *Nicholas Jouriles, MD, FACEP* *James Mitchiner, MD, FACEP* *Chirag Shah, MD, FACEP* *Peter Viccellio, MD, FACEP*	C
55	Responsible Use of AI in Emergency Medicine Documentation *Washington Chapter*	C
56	Strengthening ACEP Policy on the Appropriate Use of Emergency Department Patient Experience Surveys *Virginia College of Emergency Physicians*	C
	Late Resolutions	
57	In Memory of Peter L. Sawchuk, MD, JD, MBA *Michael Gerardi, MD, FACEP* *Jay Kaplan, MD, FACEP* *David McKenzie* *Arizona College of Emergency Physicians* *New Jersey Chapter*	
58	In Memory of Annalee Morgan Baker, MD, FACEP *Florida College of Emergency Physicians* *Minnesota Chapter* *New Jersey Chapter*	
59	In Memory of Fran K. Kratz, MD, FACEP *Pennsylvania College of Emergency Physicians*	
60	In Memory of Paul W. Sokoloski, MD, FACEP *Pennsylvania College of Emergency Physicians*	
61	In Memory of David L. Morgan, MS, MD, FACEP *Texas College of Emergency Physicians*	
62	In Memory of Robert K. Anzinger, MD, FACEP Illinois College of Emergency Physicians	

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 1(26)

SUBMITTED BY: Oklahoma College Of Emergency Physicians

SUBJECT: Commendation for Jeffrey M. Goodloe, MD, FACEP

WHEREAS, Jeffrey M. Goodloe, MD, FACEP, has served the American College of Emergency Physicians with distinction since joining as a member in 1991; and

WHEREAS, Dr. Goodloe provided outstanding leadership to the Oklahoma College of Emergency Physicians, serving on its Board of Directors from 2009–Present and as Chapter President from 2016–2018, demonstrating an enduring commitment to emergency medicine in Oklahoma; and

WHEREAS, Dr. Goodloe served as President of the Emergency Medicine Residents' Association (EMRA) from 1996–1997 and on its Board of Directors from 1995–1998, reflecting a career-long dedication to the development of future emergency physician leaders; and

WHEREAS, Dr. Goodloe was elected to the national ACEP Board of Directors in 2019, was re-elected in 2022, and served with distinction through 2025, including as Secretary-Treasurer 2021–2022, Chair of the Board 2023–2024, and Vice President for Communications 2024–2025; and

WHEREAS, Dr. Goodloe served as Board Liaison to numerous national ACEP committees, including the Audit Committee, Awards Committee, Bylaws Committee, Communications Committee, EMS Committee, Excited Delirium Task Force, Finance Committee, Membership Committee, Pediatric Emergency Medicine Committee, and the Rural Emergency Medicine Task Force; and

WHEREAS, Dr. Goodloe served as Board Liaison to multiple ACEP sections, including the Cruise Ship Medicine Section, EMS Section, Geriatric Emergency Medicine Section, Pediatric Emergency Medicine Section, Sports Medicine Section, Tactical and Law Enforcement Emergency Medicine Section, and the Trauma and Injury Prevention Section; and

WHEREAS, Dr. Goodloe served as a Councillor and Alternate Councillor to the ACEP Council across multiple terms spanning nearly three decades, including service on the Nominating Committee; and

WHEREAS, Dr. Goodloe served as Chair of the Emergency Medicine Foundation Board of Trustees and as a Trustee from 2019–2025, as well as on the Geriatric ED Accreditation Board of Governors, demonstrating his commitment to the advancement and infrastructure of the specialty; and

WHEREAS, Dr. Goodloe served as a Liaison Representative to the American Association of Emergency Nurse Practitioners (AAENP) from 2020–2023 and to the American College of Surgeons Committee on Trauma (ACS-COT) from 2020–2026, strengthening interdisciplinary collaboration in emergency and trauma care; and

WHEREAS, Dr. Goodloe is widely recognized for his expertise in emergency medical services, and tactical and law enforcement emergency medicine, and has been a steadfast advocate for emergency physicians, their patients, and the communities they serve; and

WHEREAS, Dr. Goodloe has served the specialty with integrity, wisdom, and an unwavering commitment to excellence throughout his career; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Jeffrey M. Goodloe, MD, FACEP, for his extraordinary service, leadership, and steadfast dedication to the College, the Oklahoma College of Emergency Physicians, the specialty of emergency medicine, and the patients and communities we are privileged to serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 2(26)

SUBMITTED BY: Texas College of Emergency Physicians
Washington Chapter

SUBJECT: Commendation for Alison J. Haddock, MD, FACEP

WHEREAS, Alison J. Haddock, MD, FACEP, has demonstrated unwavering dedication to the advancement of emergency medicine and to the mission of the American College of Emergency Physicians (ACEP) throughout her distinguished career; and

WHEREAS, Dr. Haddock has served the College with distinction at both the chapter and national levels, including service on the Texas College of Emergency Physicians (TCEP) Board of Directors from 2016 – 2019 and the Emergency Medicine Residents' Association (EMRA) Board of Directors from 2010 – 2012; and

WHEREAS, Dr. Haddock served as the President of national ACEP from 2024 – 2025, providing visionary leadership during a transformative period for emergency medicine and the health care system; and

WHEREAS, Throughout her presidency and Board service, Dr. Haddock remained a steadfast advocate for physician autonomy, leading the Employee Protection Workgroup to identify solutions that protect emergency physicians from loss of compensation and professional liability coverage in the event of a group bankruptcy, culminating in the development of the "Professional Liability Coverage Gold Standard" policy statement, which was approved by Board of Directors in April 2026; and

WHEREAS, Dr. Haddock has provided invaluable leadership and expertise through extensive service on numerous ACEP committees and workgroups, including the Federal Government Affairs Committee, the State Legislative/Regulatory Committee, which she chaired from 2015 – 2017, the Education Committee, the Emergency Medicine Practice Committee, and multiple task forces focused on telehealth, accreditation, physician well-being, and alternative payment models; and

WHEREAS, Dr. Haddock has played a significant role in shaping College policy and governance through her service to the ACEP Council, including participation on the Steering Committee, Reference Committee, and Candidate Forum Subcommittee; and

WHEREAS, Dr. Haddock has championed the growth and development of emergency physicians across the specialty through her service as Board Liaison to numerous ACEP sections, including the American Association of Women Emergency Physicians, Critical Care Medicine, Palliative Medicine, Telehealth, Wellness, Young Physicians, and Undersea & Hyperbaric Medicine Sections; and

WHEREAS, Dr. Haddock's commitment to advocacy, education, leadership development, and physician wellness, and the advancement of emergency medicine has earned the respect, admiration, and gratitude of her colleagues throughout the specialty; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Alison J. Haddock, MD, FACEP, for her exceptional leadership, enduring contributions to the specialty of emergency medicine, and unwavering dedication to the mission, values, and members of ACEP, as well as to the patients and communities served by emergency physicians.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 3(26)

SUBMITTED BY: Maryland ACEP Chapter

SUBJECT: Commendation for Gabor D. Kelen, MD, FACEP

WHEREAS, Gabor D. Kelen, MD, FACEP, joined the American College of Emergency Physicians in 1983 and has been a dedicated member of the Maryland Chapter; and

WHEREAS**,** Dr. Kelen has served ACEP with distinction as a member of the National ACEP Board of Directors from 2019 to 2025, having been elected in 2019 and re-elected in 2022; and

WHEREAS, Dr. Kelen served as Chair of the National ACEP Board of Directors for 2024–2025, providing steady leadership and thoughtful guidance to the College during a time of continued change and challenge for emergency medicine; and

WHEREAS, Dr. Kelen has contributed extensively to ACEP through national committee service, including service to the Associate Membership Task Force, Awards Committee, Emergency Medicine Workforce Task Force, Emergency PA/NP Utilization Task Force, and as Board Liaison to the Clinical Policies, Disaster Preparedness & Response, Ethics, Medical-Legal, Research, and Well-Being Committees; and

WHEREAS, Dr. Kelen gave many years of service to ACEP's Public Health Committee, including service as Chair from 1991-94 and Co-Chair from 1994-95, reflecting his long-standing commitment to the public health role of emergency medicine; and

WHEREAS, Dr. Kelen served the ACEP Council as an alternate councillor, councillor, member of the Council Steering Committee, and member of the 2023 Nominating Committee; and

WHEREAS, Dr. Kelen has supported the work of ACEP sections through Board Liaison service to the Careers, Critical Care, Disaster Medicine, Exploring Retirement, Medical Humanities, Research, and Wellness Sections; and

WHEREAS, Dr. Kelen has further advanced the academic, scientific, and professional mission of emergency medicine through service as Board Liaison to *Annals of Emergency Medicine* and *JACEP Open*, as President of the Association of Academic Chairs in Emergency Medicine, as a member of the Emergency Medicine Foundation Board of Trustees, and as recipient of ACEP's Research Award; and

WHEREAS, Throughout his decades of service, Dr. Kelen has exemplified the highest ideals of leadership, scholarship, professionalism, and service to the specialty of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commend Gabor D. Kelen, MD, FACEP, for his extraordinary service to ACEP, the Maryland Chapter, the ACEP Council, the ACEP Board of Directors, and the specialty of emergency medicine, and express its sincere appreciation for his leadership, dedication, and lasting contributions to the College and the patients and physicians it serves.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 4(26)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Commendation for Chadd K. Kraus, DO, DrPH, CPE, FACEP

WHEREAS, Chadd K. Kraus, DO, DrPH, CPE, FACEP, has served the American College of Emergency Physicians with distinction since joining as a member in 2007; and

WHEREAS, Dr. Kraus previously served on the EMRA Board of Directors 2011-13; and

WHEREAS, Dr. Kraus served the Pennsylvania College of Emergency Physicians (PACEP) with distinction, including as an elected member of the PACEP Board of Directors 2018-24 and as PACEP President 2022-23; and

WHEREAS, Dr. Kraus has served on numerous ACEP committees, including the Awards Committee 2024-25, the Clinical Emergency Data Registry Committee 2015-19, the Clinical Resources Review Committee 2019-20, the Ethics Committee 2013-22, the Research Committee 2021-23, and the State Legislative/Regulatory Committee from 2013-023, and served as chair of the State Legislative/Regulatory Committee 2017-19; and

WHEREAS, Dr. Kraus has been deeply engaged in ACEP Council service, including as a councillor in 2012, 2014-15, and 2017-22, as an alternate councillor in 2013 and 2016, as a member of the Council Steering Committee from 2017-19, the Candidate Forum Subcommittee in 2018, a Reference Committee in 2018, and the Tellers, Credentials, & Elections Committee from 2018-23, and served as chair of the Tellers, Credentials, & Elections Committee from 2021-22; and

WHEREAS, Dr. Kraus served as chair of the ACEP Young Physicians Section in 2017-18; and

WHEREAS, Dr. Kraus was elected to the national ACEP Board of Directors in 2023 and served as Chair of the Board from 2025-26; and

WHEREAS, Dr. Kraus served as ACEP Board Liaison to several committees, including the Research Committee and State Legislative/Regulatory Committee; and

WHEREAS, Dr. Kraus served as A Board Liaison to the Locum Tenens Section from 2024-26, the Research Section from 2023-26, the Rural Section from 2023-26, and the Toxicology Section from 2023-24; and

WHEREAS, Dr. Kraus served as Board Liaison to *Annals of Emergency Medicine* and *JACEP Open* from 2025-26; and

WHEREAS, Dr. Kraus served on the Emergency Medicine Foundation Board of Trustees from 2020-25; and

WHEREAS, Dr. Kraus is passionately devoted to advancing emergency medicine, scientific research of the specialty, the education of future physician leaders and students, and dedication to his patients and all aspects of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends and thanks Chadd K. Kraus, DO, DrPH, CPE, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 5(26)

SUBMITTED BY: Nicholas J. Jouriles, MD, FACEP
Richard L. Stennes, MD, MBA, FACEP
California Chapter

SUBJECT: In Memory of Stanley R. Gold, MD, FACEP

WHEREAS, Emergency medicine lost one of emergency medicine's pioneers and early leaders when Stanley Gold, MD, FACEP passed away on April 2, 2026; and

WHEREAS, Dr. Gold was a member of the American College of Emergency Physicians from 1969 to 2026; and

WHEREAS, Dr. Gold served as President of the California Chapter and also served on the national ACEP Board of Directors; and

WHEREAS, Dr. Gold served as the second Editor in Chief of *JACEP* and he assisted its transition to the leading scholarly journal that *Annals of Emergency Medicine* has become; and

WHEREAS, Dr. Gold was part of the first faculty at the first ever academic department of emergency medicine at the University of Southern California; and

WHEREAS, Dr. Gold was an early leader in pre-hospital care, founding the first EMT training program in California; and

WHEREAS, Dr. Gold and his daughter, Claudia Gold Repper, MD, FACEP, were the first father/daughter duo to become Diplomates of the American Board of Emergency Medicine; and

WHEREAS, Dr. Gold continued to practice emergency medicine until age 80; and

WHEREAS, Dr. Gold served his country in the U.S. Navy; and

WHEREAS, Dr. Gold enjoyed travel, good food, music, art, and especially all things Peanuts; and

WHEREAS, Dr. Gold used his skills in engineering and entertainment to make medicine a more holistic endeavor; and

WHEREAS, Dr. Gold leaves behind his wife Helen and his four children: Claudia, Jennifer, Phil and Richard; therefore be it

RESOLVED, That the American College of Emergency Physicians expresses our enduring appreciation to Stanley R. Gold, MD, FACEP, as a pioneering leader and a champion for emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Stanley R. Gold, MD, FACEP, our condolences along with our profound gratitude for his lifetime of service and leadership to the specialty of emergency medicine.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 6(26)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Deno S. Gualtieri, DO

WHEREAS, The specialty of Emergency Medicine lost an exceptional physician when Deno S. Gualtieri, DO, passed away on January 14, 2026 at the age of 44; and

WHEREAS, Dr. Gualtieri graduated from the University of New England College of Osteopathic Medicine in 2007; and

WHEREAS, He completed his internship at Maimonides Medical Center in New York; and

WHEREAS, He then completed his residency at St. Luke's in Fountain Hill, Pennsylvania; and

WHEREAS, He worked for many years as an attending physician in the emergency department and served as the Director of Emergency Medicine for the past nine years at Jefferson Health Lansdale Hospital; and

WHEREAS, He served as medical director for Quick Response Service programs and worked with numerous fire departments and EMS agencies like Upper Gwynedd Fire Department, North Penn Volunteer Fire Company, and VMSC Emergency Medical Services; and

WHEREAS, He served as medical director and board vice president of the Community Ambulance Association of Ambler; and

WHEREAS, He was an active member of the Montgomery County Medical Advisory Committee; and

WHEREAS, He prioritized educational efforts on basic life support care, especially in pediatric emergencies, and was known for expertise in hyperthermia, dehydration, and other heat-related emergencies; and

WHEREAS, He will be remembered for his calm and steady presence in emergencies, his mentorship within the EMS community, and his advocacy for high-quality prehospital and emergency care; and

WHEREAS, In his free time, he enjoyed annual trips to Maine, building the best sandcastle on the beach, and always had the best dad jokes; and

WHEREAS, His compassion, leadership, and selflessness touched countless lives in the community; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Deno S. Gualtieri, DO; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife of 20 years Karen Gualtieri, his children Deno James, Alex, and Laura, his parents Deno and Shelane, his brother Dominic and other extended family members gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of Emergency Medicine.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 7(26)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Charles Eugene Jessup, DO, FACEP

WHEREAS, With the passing of Charles "Charlie" Eugene Jessup, DO, FACEP, on January 27, 2026, emergency medicine lost a pioneer, leader, and teacher in the field of emergency medicine; and

WHEREAS, Dr. Jessup received his bachelor's degree from Albion College in 1960 and his medical degree from Chicago College of Osteopathy in 1964, completed his internship at Lansing General Hospital in Lansing, Michigan in 1965, and began a family medicine practice in Bay City, MI for several years; and

WHEREAS, Dr. Jessup developed an interest in emergency medicine while covering shifts in the department at Mercy Hospital and served as medical director of EMS Services in Bay City, MI, instrumental in implementing EMS services for the Tri-County Region; and

WHEREAS, Dr. Jessup joined the staff of St. Mary's of Michigan as an Emergency Physician in 1981 seeing patients for over three decades in the emergency department there, cofounded the first area all emergency medicine board certified group in 1982 known as Timberline Emergency Physicians, PC, served as president and vice-president through 2007; and

WHEREAS, Dr. Jessup served in numerous administrative leadership roles at St. Mary's including chair of the Emergency Department, Chief of Staff, chair of the hospital board, chair of quality and patient safety, served as the EMS Medical Director for the Saginaw Medical Control Authority, and received the Spirit of St. Vincent Award from the Ascension St. Mary's Foundation for his long-time commitment in improving care for the community; and

WHEREAS, Dr. Jessup became a Diplomate of the American Board of Emergency Physicians (ABEM) and a Fellow of the American College of Emergency Physicians; and Associate Clinical Professor of Emergency Medicine at Michigan State University College of Human Medicine; and

WHEREAS, Dr. Jessup believed in continuous learning and professional development, and assisted with starting an emergency medicine residency program in Saginaw, MI, taught many residents and students in the area throughout his career over the years, and one of his proudest honors was the receipt of the "Physician of the Year" award from the Michigan College of Emergency Physicians in 1999; and

WHEREAS, Dr. Jessup served on the MCEP's Health-Finance Committee, and encouraged many in his group to become engaged in advocacy for the practice of emergency medicine through MCEP; and

WHEREAS, Dr. Jessup was thought of as a father figure, mentor, and friend who made every individual crossing his path feel like family and an important member of his entourage; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the outstanding love for and contributions to emergency medicine of Charles E Jessup, DO, FACEP, to the specialty of Emergency Medicine as a clinician, partner, educator, leader, and mentor; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Charles E Jessup, DO, FACEP, especially his son Tom, an emergency medicine physician assistant, and his daughter Debbie, his colleagues, partners, former staff, and friends, our condolences along

with our profound gratitude for his lifetime of service to his patients and the specialty of emergency ,medicine in Michigan, where his impact will be felt for generations to come.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 8(26)

SUBMITTED BY: Maryland Chapter

SUBJECT: In Memory of Laura Pimentel, MD

WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Laura Pimentel, MD, passed away surrounded by her family and loved ones on June 23, 2026; and

WHEREAS, Dr. Pimentel graduated from Georgetown University School of Medicine and the Madigan Army Medical Center Emergency Medicine Residency with a Master's Degree in Medical Management from Carnegie Mellon University and a Certificate from the Johns Hopkins Business of Medicine program; and

WHEREAS, Dr. Pimentel was a respected leader, mentor, educator, and colleague whose commitment to the advancement of emergency medicine profoundly impacted her department, her specialty, and the many physicians and professionals she guided; and

WHEREAS, Dr. Pimentel spent her emergency career working in emergency departments throughout Maryland; and

WHEREAS, She led the emergency department at Bon Secours from 1993 to 1994; and

WHEREAS, She led the emergency department at Mercy Medical Center from 1995 to 2007; and

WHEREAS, She led the emergency department at Upper Chesapeake Medical Center from 2007 to 2008; and

WHEREAS, She was the Vice President & CEO of the Maryland Emergency Medicine Network in 2009; and

WHEREAS, She was named the Emergency Medicine Physician of the Year by the chapter for her work as Chair of its Public Policy Committee in 2009; and

WHEREAS, Dr. Pimentel was the President of the Maryland Chapter of the American College of Emergency Physicians from 2011-2013; and

WHEREAS, Dr. Pimentel was a Board Member of the Maryland Chapter of the American College of Emergency Physicians from 2004 to 2013; and

WHEREAS, Dr. Pimentel participated as Alternate Councillor representing the Maryland Chapter of the American College of Emergency Physicians from 2004 to 2008; and

WHEREAS, She was the Clinical Professor of Emergency Medicine & CEO of the Maryland Emergency Medicine Network in 2018; and

WHEREAS, She received a teaching award by the Department of Emergency Medicine for the design and implementation of a Leadership Curriculum; and

WHEREAS, Dr. Pimentel leaves behind an extraordinary legacy of clinical excellence, visionary leadership, and dedicated service to emergency medicine throughout Maryland; and

WHEREAS, through her expertise in emergency medicine operations, administration, and health policy, Dr.

Pimentel contributed meaningfully to the growth and improvement of emergency care delivery, while sharing her knowledge through teaching, mentorship, and lectures on professional development and emergency department administration; and

WHEREAS, throughout his decades of service, Dr. Pimentel has exemplified the highest ideals of leadership, scholarship, professionalism, and service to the specialty of emergency medicine; and

WHEREAS, Dr. Pimentel's passion for leadership, education, and the future of emergency medicine has left an enduring mark on our specialty and the communities she served; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Laura Pimentel, MD; and be it further

RESOLVED, That the American College of Emergency Physicians, the Maryland ACEP Chapter, extends to her husband Rick Howard of 26 years, her sister Patrice Brink (Bob), brother Frank Pimentel (Gretchen), stepdaughters Brianna Howard, Chloe Hagopian (Alek), and numerous nieces, nephews, cousins, her beloved black Labrador Nebo, gratitude for her service as an emergency physician at multiple hospitals in Maryland as well as for her dedication and commitment of over 43 years to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 9(26)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: In Memory of Francis P. Renzi, MD

WHEREAS, Francis P. Renzi, MD, dedicated his professional life to the practice of emergency medicine and provided compassionate, expert care to countless patients throughout his distinguished career; and

WHEREAS, Dr. Renzi graduated from the University of Massachusetts Medical School in 1981 and completed his residency training in Emergency Medicine at Penn State Milton S. Hershey Medical Center from 1981 to 1984, entering the specialty during its formative years and contributing to its growth and development; and

WHEREAS, In 1987 Dr. Renzi became the founding Residency Program Director of the University of Massachusetts Emergency Medicine Residency Program, helping to establish and shape a program that has trained hundreds of emergency physicians and leaders in the specialty; and

WHEREAS, Dr. Renzi devoted more than twenty-six years of service to the University of Massachusetts, where he served as Professor of Emergency Medicine and for 12 years as Residency Program Director, was a dedicated educator, mentor, and role model to generations of residents, fellows, and faculty; and

WHEREAS, Dr. Renzi was an active member of both the American College of Emergency Physicians and the Massachusetts College of Emergency Physicians from 1981 until his retirement in 2012, demonstrating a lifelong commitment to the specialty of emergency medicine and the advancement of emergency care; and

WHEREAS, Through his leadership in graduate medical education, Dr. Renzi helped advance the development of academic emergency medicine in Central Massachusetts and contributed to the growth and recognition of emergency medicine as a specialty; and

WHEREAS, Dr. Renzi was widely respected for his professionalism, integrity, compassion, and unwavering dedication to patient care, medical education, and service to others, and through his mentorship and example left a lasting legacy that continues to influence the physicians he trained and the patients they serve; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Massachusetts College of Emergency Physicians honor the memory of Francis P. Renzi, MD, and gratefully recognize his enduring contributions to emergency medicine, graduate medical education, and patient care; and be it further

RESOLVED, That ACEP and MACEP express their deepest sympathy to Dr. Renzi's family, friends, colleagues, former trainees, and all who were privileged to learn from and work alongside him; and be it further

RESOLVED, That the legacy of Francis P. Renzi, MD, will endure through the generations of emergency physicians he trained, mentored, and inspired, and through the continued success of the residency program he helped establish.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 10(26)

SUBMITTED BY: New York Chapter

SUBJECT: In Memory of Gary S. Rudolph, MD, FACEP

WHEREAS, The specialty of emergency medicine has suffered an immense loss with the passing of Gary S. Rudolph, MD, FACEP, a truly dedicated clinician, an exceptionally respected leader, and committed educator; and

WHEREAS, Dr. Rudolph received his medical degree from Cornell University Medical College in 1981, subsequently completing his residency training in Internal Medicine at North Shore University Hospital; and

WHEREAS, Dr. Rudolph demonstrated his commitment to patient care and education, exemplified by his dual-board certification in both Internal Medicine and Emergency Medicine; and

WHEREAS, Dr. Rudolph served with distinction in the Department of Emergency Medicine at North Shore University Hospital for over 30 years, including two decades as Associate Chairman, and then served as Northwell Health's Vice President for the emergency medicine service line prior to his retirement; and

WHEREAS, Dr. Rudolph held significant academic appointments, including Assistant Professor of Emergency Medicine at the New York University School of Medicine and later at the Hofstra Northwell School of Medicine; and

WHEREAS, Dr. Rudolph was a tireless and passionate advocate for the advancement of the emergency medicine specialty, serving with distinction on the Board of Directors for the New York Chapter of the American College of Emergency Physicians (NYACEP) for over a decade and providing invaluable leadership as chair of its Education Committee; and

WHEREAS, Dr. Rudolph's leadership extended to regional medical advisory committees and various quality improvement and performance coordinating groups, where he championed patient safety and elevated clinical standards; and

WHEREAS, Dr. Rudolph was a prolific and inspirational educator and mentor, who dedicated himself to shaping and guiding generations of medical students, residents, fellows, and junior faculty, leaving an incredible mark on their careers and the future of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians solemnly recognizes and honors the memory and legacy of Gary S. Rudolph, MD, FACEP; affirming his impact on the practice, education, and leadership within the specialty of emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians and the New York Chapter extends its deepest condolences to his beloved family, devoted colleagues, and cherished friends, while expressing profound gratitude for his extraordinary lifetime of selfless service to his patients and his contributions that have shaped the specialty of emergency medicine; and be it further

RESOLVED, That the principles of dedication, integrity, mentorship, and advocacy exemplified by Dr. Rudolph throughout his distinguished career will be an inspiration for all current and future emergency medicine physicians.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 11(26)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of S. William Snover, MD, FACEP

WHEREAS, The specialty of Emergency Medicine lost an exceptional physician when S. William Snover, MD, FACEP passed away on September 15, 2025 at the age of 79; and

WHEREAS, Bill was a 1964 graduate of William Tennent High School in Warminster, Pennsylvania. He then obtained his Bachelor of Science degree from Muhlenberg College in Allentown, Pennsylvania in 1968. He continued on to earn his medical degree from George Washington University in Washington, D.C., in 1972; and

WHEREAS, Dr. Snover completed his residency in Internal Medicine at Geisinger Medical Center in 1975; and

WHEREAS, Dr. Snover was triple board certified by the American Board of Emergency Medicine, the American Board of Internal Medicine, and the American Board of Preventative Medicine/Occupational Medicine; and

WHEREAS, After completing his residency, he and Dr. Tom Royer created the Department of Emergency Medicine at Geisinger Medical Center in Danville, PA; and

WHEREAS, Throughout his career, Dr. Snover served as a staff physician for over 20 years and eventually became the Director of Emergency Medicine. He concluded his career working in community medicine at the Geisinger clinics in Milton and Lewisburg, PA; and

WHEREAS, Dr. Snover served as the former Medical Director of the North Central Pennsylvania Regional EHS Council; and

WHEREAS, He held faculty appointments at the Milton S. Hershey School of Medicine and Thomas Jefferson University Medical School; and

WHEREAS, He was a Fellow of the American College of Emergency Physicians and active in the Pennsylvania Chapter of the American College of Emergency Physicians; and

WHEREAS, Additionally, he was a past president of the American Heart Association; and

WHEREAS, Outside of medicine, Bill was an active member at his local church and was involved in the chapel choir and the director of the hand bell choir; and

WHEREAS, In his retirement years he enjoyed mowing fields, taking naps in his hammock, and drinking milkshakes with his grandchildren and friends; and

WHEREAS, He will be remembered for telling good stories and dispensing humorous words of wisdom; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of S. William Snover, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife of 57 years Jeanine Dulaney Snover, his daughter Dr. Amy Snover, his sons David and Steven Snover, as well as his grandchildren, his great-grandson, and other extended family members gratitude for this service as an Emergency Physician as well as for his dedication and commitment to the specialty of Emergency Medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting
Reference Committee Members

Reference Committee A – Governance, Education, & Wellness
Resolutions 12-23

Jennifer L. Savino, DO, FACEP (PA) – Chair
Jacob M. Altholz, MD (CO)
Marina N. Boushra-Freiberg, MD (OH)
Daniel S. Udrea, MD, FACEP (IN)
Will Weber, MD, MPH, FACEP (MN)
Sandra Williams, DO, MPH, FACEP (TX)

Laura Lang, JD
Amber Williams, MSOL

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 12(26)

SUBMITTED BY: Council Steering Committee

SUBJECT: Councillor Allocation for Sections of Membership – Housekeeping Change

PURPOSE: Amends the Bylaws to eliminate potential confusion regarding "dues paying and complimentary candidate members."

FISCAL IMPACT: Budgeted staff resources to update the Bylaws and to monitor section compliance.

WHEREAS, The Bylaws – Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) specifies that sections are 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.; and

WHEREAS, The Council Standing Rules, Councillor Allocation for Sections of Membership, specifies "a section must have 100 dues-paying members, or the minimum number established by the Board of Directors…"; and

WHEREAS, The difference in the language can be confusing; therefore be it

RESOLVED, That the Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph 8, be amended to read:

Each chartered section shall be entitled to one councillor as representative of all of the members of such chartered section 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.

Background

This resolution amends the Bylaws to eliminate potential confusion regarding "dues paying and complimentary candidate members." A companion Council Standing Rules amendment has also been submitted.

While reviewing councillor allocations for the 2025 Council, staff raised a question pertaining to the differences in language in the Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph 8, and the Council Standing Rules (CSR), Councillor Allocation for Sections of Membership, and the confusion regarding dues-paying and complimentary candidate members. Multiple changes to the Bylaws and the Council Standing Rules over the years have resulted in the language being slightly different regarding councillor allocations for sections. The Steering Committee submitted a Council Standing Rules resolution to the 2025 Council to reconcile the language with the Bylaws. Testimony supported the resolution's intent and raised questions regarding what qualifies as a "dues-paying" member. The Young Physicians Section raised additional concerns regarding ambiguities negatively affecting section councillor allocations if complimentary section memberships are disregarded. Amendments were offered to include "those exempted from dues" and additionally to refer the qualification to seat a credentialed councillor to the criteria set forth in the Bylaws. The Young Physicians Section offered additional testimony suggesting that the language in the Bylaws does not resolve the ambiguity and suggested further review of the language to resolve the potential conflict. The Council referred the resolution to the Council Steering Committee for further analysis.

There was consensus from the Steering Committee to simplify the language in the Bylaws and the CSR to reflect that a section must have the minimum number of members established by the Board of Directors. The Steering Committee believes these are housekeeping changes. It was noted that the Bylaws and CSR language are included in the "Policy on Sections of Membership" and will need to be updated if the amendments are adopted by the Council.

ACEP Strategic Plan Reference

The Bylaws is a governing document of the College. There are no specific references in the Strategic Plan regarding governing documents.

Fiscal Impact

Budgeted staff resources to update the Bylaws and to monitor section compliance.

Prior Council Action

Resolution 23(25) Councillor Allocations for Sections of Membership referred to the Council Steering Committee.

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships are to be included when determining section eligibility for a councillor and limited this allocation to candidate members only.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. This Council Standing Rules resolution made comprehensive housekeeping changes throughout the document including non-substantive updated language to the Councillor Allocation for Sections of Membership.

Amended Resolution 6(99) Council Standing Rules adopted. This resolution revised the Council Standing Rules based on the streamlined Bylaws and stipulated that future changes to the Council Standing Rules can only be made through submission of resolutions to the Council. *Note: Changes to the Council Standing Rules prior to 2000 were proposed by the Council Steering Committee and approved by the Council at the next annual meeting.*

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

October 1997, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of December 31 each year.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted. This Bylaws amendment specified that sections must have 100 dues-paying members as of December 31 of the preceding year.

September 1992, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 1(90) Voting Privilege for Section Councillors adopted. This Bylaws amendment granted voting privileges to section councillors.

September 1990, approved the Council Standing Rules with the addition of one non-voting councillor for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 11(89) Councillor Allotment for Sections of Membership adopted. This resolution allocated one councillor per section without the right to vote.

Substitute Resolution 13(88) Sections of Membership adopted. This resolution amended the ACEP Constitution to establish sections of membership.

Prior Board Action

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships are to be included when determining section eligibility for a councillor and limited this allocation to candidate members only.

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted.

Note: Prior to 1993 the Board of Directors did not take action on Bylaws amendments.

Background Information Prepared by: Sonja Montgomery
Governance Operations Director

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules Amendment

RESOLUTION: 13(26)

SUBMITTED BY: Council Steering Committee

SUBJECT: Councillor Allocation for Sections of Membership – Housekeeping Change

PURPOSE: Amends the Council Standing Rules to clarify that a section must the minimum number of members as defined in the Bylaws, eliminate potential confusion regarding "dues paying members."

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules and to monitor section compliance.

WHEREAS, The Bylaws – Article VIII – Council, Section 1 – Composition of the Council (paragraph 8) specifies that sections are 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.; and

WHEREAS, The Council Standing Rules, Councillor Allocation for Sections of Membership, specifies "a section must have 100 dues-paying members, or the minimum number established by the Board of Directors…"; and

WHEREAS, The difference in the language can be confusing; therefore be it

RESOLVED, That the Council Standing Rules – Councillor Allocation for Sections of Membership be amended to read:

To be eligible to seat a credentialed councillor, a section must have ~~100 dues-paying members, or~~ the minimum number **of members** established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Background

This resolution amends the Council Standing Rules to clarify that a section must the minimum number of members as defined in the Bylaws and eliminate potential confusion regarding "dues paying members." A companion Bylaws amendment has also been submitted.

While reviewing councillor allocations for the 2025 Council, staff raised a question pertaining to the differences in language in the Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph 8, and the Council Standing Rules (CSR), Councillor Allocation for Sections of Membership, and the confusion regarding dues-paying and complimentary candidate members. Multiple changes to the Bylaws and the Council Standing Rules over the years have resulted in the language being slightly different regarding councillor allocations for sections. The Steering Committee submitted a Council Standing Rules resolution to the 2025 Council to reconcile the language with the Bylaws. Testimony supported the resolution's intent and raised questions regarding what qualifies as a "dues-paying" member. The Young Physicians Section raised additional concerns regarding ambiguities negatively affecting section councillor allocations if complimentary section memberships are disregarded. Amendments were offered to include "those exempted from dues" and additionally to refer the qualification to seat a credentialed councillor to the criteria set forth in the Bylaws. The Young Physicians Section offered additional testimony suggesting that the language in the Bylaws does not resolve the ambiguity and suggested further review of the language to resolve the potential conflict. The Council referred the resolution to the Council Steering Committee for further analysis.

There was consensus from the Steering Committee to simplify the language in the Bylaws and the CSR to reflect that a section must have the minimum number of members established by the Board of Directors. The Steering Committee believes these are housekeeping changes. It was noted that the Bylaws and CSR language are included in the "Policy on Sections of Membership" and will need to be updated if the amendments are adopted by the Council.

ACEP Strategic Plan Reference

The Council Standing Rules is a governing document of the College. There are no specific references in the Strategic Plan regarding governing documents.

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules and to monitor section compliance.

Prior Council Action

Resolution 23(25) Councillor Allocations for Sections of Membership referred to the Council Steering Committee.

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships are to be included when determining section eligibility for a councillor and limited this allocation to candidate members only.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. This Council Standing Rules resolution made comprehensive housekeeping changes throughout the document including non-substantive updated language to the Councillor Allocation for Sections of Membership.

Amended Resolution 6(99) Council Standing Rules adopted. This resolution revised the Council Standing Rules based on the streamlined Bylaws and stipulated that future changes to the Council Standing Rules can only be made through submission of resolutions to the Council. *Note: Changes to the Council Standing Rules prior to 2000 were proposed by the Council Steering Committee and approved by the Council at the next annual meeting.*

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

October 1997, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of December 31 each year.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted. This Bylaws amendment specified that sections must have 100 dues-paying members as of December 31 of the preceding year.

September 1992, approved the Council Standing Rules with voting capability for section councillors for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 1(90) Voting Privilege for Section Councillors adopted. This Bylaws amendment granted voting privileges to section councillors.

September 1990, approved the Council Standing Rules with the addition of one non-voting councillor for sections with at least 100 dues-paying members as of June 1 each year.

Resolution 11(89) Councillor Allotment for Sections of Membership adopted. This resolution allocated one councillor per section without the right to vote.

Substitute Resolution 13(88) Sections of Membership adopted. This resolution amended the ACEP Constitution to establish sections of membership.

Prior Board Action

The Board does not approve changes to the Council Standing Rules.

Resolution 9(09) Bylaws Housekeeping Changes adopted. This resolution made several editorial revisions to the Bylaws for consistency with the Texas Business Organizations Code and included a revision to the language pertaining to section councillors.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships are to be included when determining section eligibility for a councillor and limited this allocation to candidate members only.

Amended Resolution 4(99) Streamlining Bylaws adopted. This Bylaws amendment simplified the Bylaws by placing procedural provisions in either the Council Standing Rules or a College manual.

Amended Resolution 3(96) Councillor Allocations for Sections of Membership adopted.

Note: Prior to 1993 the Board of Directors did not take action on Bylaws amendments.

Background Information Prepared by: Sonja Montgomery
Governance Operations Director

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 14(26)

SUBMITTED BY: Bylaws Committee
Board of Directors

SUBJECT: Codifying the Audit Committee in the Bylaws

PURPOSE: Amends the Bylaws to codify the Audit Committee in the Bylaws.

FISCAL IMPACT: Budgeted staff resources for updating the Bylaws. Budgeted committee and staff resources to facilitate the work of the Audit Committee.

WHEREAS, The Audit Committee has been functioning pursuant to an approved Audit Committee Charter and has become an important component of ACEP's financial oversight structure; and

WHEREAS, Codifying the Audit Committee in the ACEP Bylaws will improve transparency, continuity, and governance by formally recognizing the committee's role and composition; and

WHEREAS, The proposed amendment reflects existing organizational practices and provides greater clarity regarding oversight of the College's audit functions; therefore be it

RESOLVED, That the ACEP Bylaws Article XI – Committees. Section 1 – General Committees be amended as follows and by addition of a new Section 8 – Audit Committee:

ARTICLE XI — COMMITTEES
(No changes are proposed for Sections 2 or 5-7.)

Section 1 — General Committees

The president shall ~~annually~~ appoint committees and task forces **annually** to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board. A majority of the voting membership of a committee shall constitute a quorum.

The president shall appoint annually committees on **Audit,** ~~Compensation,~~ Bylaws, **Compensation,** and Finance.

Section 8 – Audit Committee

The Audit Committee shall consist of the Audit Committee chair, who must also serve concurrently on the Finance Committee, the Finance Committee chair, the secretary-treasurer of the College, and two additional members of the Finance Committee. A sixth member may be considered by the president and may or may not serve concurrently on the Finance Committee. The Audit Committee shall oversee the audit functions of the College as outlined in the Audit Committee Charter.

Background

This resolution amends the Bylaws to codify the Audit Committee in the Bylaws. The proposed language is consistent with the Audit Committee's charter.

ACEP first established a formal Audit Committee in 2003 following enactment of the American Competitiveness and Corporate Accountability Act of 2002, commonly known as the Sarbanes-Oxley Act (SOX), on July 30, 2002. The SOX is a U.S. federal law enacted to protect investors from corporate fraud following major financial scandals at companies like Arthur Anderson, Enron, WorldCom, and Tyco. It was written primarily to regulate publicly traded, for-profit corporations and established strict reforms to increase corporate transparency, improve financial disclosures, and prevent accounting errors. Although SOX does not apply to non-profit organizations, there are two exceptions that apply to all corporate entities, including non-profit organizations:

- Whistleblower Protection (Section 1107): It is a federal crime to retaliate against, discharge, demote, or harass an employee who provides truthful information to law enforcement regarding any federal offense.
- Document Retention and Destruction (Section 802): It is illegal to alter, destroy, conceal, or falsify documents with the intent to obstruct or influence an ongoing or potential federal investigation or bankruptcy proceeding.

Many non-profit boards voluntarily adopt certain SOX-inspired internal controls as governance best practices, including:

- Maintaining independent audit committees.
- Establishing formal document retention and destruction policies.
- Creating formal conflict-of-interest policies.
- Auditing financial statements independently each year.

Some state laws may impose SOX-like financial governance requirements on non-profits operating in those jurisdictions. The Texas Business Organizations Code (TBOC) does not require non-profit organizations to comply with SOX, or require establishing an Audit Committee; however, non-profits operating in Texas must consider the following overlapping legal and compliance requirements:

- Corporations must maintain current, accurate financial records following Generally Accepted Accounting Principles (GAAP).
- Certain non-profits must make their financial records, books, and annual reports available for public inspection under Section 22.353. Failure to do so can result in a Class B misdemeanor.

Additionally, IRS Form 990 asks whether a non-profit has adopted SOX-inspired policies, such as a formal Whistleblower Policy and a Document Retention/Destruction Policy. Many Texas non-profits adopt such policies and establish independent audit committees voluntarily to maintain transparency and donor confidence.

ACEP Strategic Plan Reference

The Bylaws is a governing document of the College. There are no specific references in the Strategic Plan regarding governing documents.

Fiscal Impact

Budgeted staff resources for updating the Bylaws. Budgeted committee and staff resources to facilitate the work of the Audit Committee.

Prior Council Action

None

Prior Board Action

June 2026, discussed the Bylaws Committee recommendation to codify the Audit Committee in the Bylaws and approved cosponsoring the Bylaws amendment for submission to the 2026 Council.

January 2026, approved the revised Audit Committee charter.

October 2004, approved the "Fraudulent or Dishonest Conduct and Whistleblower" internal operational policy statement.

Background Information Prepared by: Sonja Montgomery
Governance Operations Director

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 15(26)

SUBMITTED BY: Bylaws Committee
Board of Directors

SUBJECT: Proposed Bylaws Changes

PURPOSE: Amend the Bylaws to specify that the president cannot serve more than one term as president, vice presidents may serve unlimited terms, removes the Assistant Secretary-Treasurer position, change the minimum notice requirements for a special meeting of the Council to consider a contested Bylaws amendment, and several other non-substantive changes.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, A routine review of the ACEP Bylaws was conducted by the Bylaws Committee; and

WHEREAS, The Bylaws Committee found several areas in the ACEP Bylaws that were imprecise, inconsistent and potentially confusing; and

WHEREAS, The Bylaws Committee recommends certain clarifications and editorial revisions of the ACEP Bylaws; and

WHEREAS, The ACEP Bylaws Committee considers these changes to be non-substantive in nature and these changes only serve to clarify current ACEP practices and the ACEP Bylaws document itself; therefore be it

RESOLVED, That the ACEP Bylaws be amended as follows:

ARTICLE IV – MEMBERSHIP

(No changes are proposed for Sections 1 – 4 or 6.)

Section 5 – Dues, Fees, and Assessments

Application fees and annual dues shall be determined annually by the Board of Directors. Assessments of members may not be levied except upon recommendation of the Board of Directors and by a majority vote of the Council. Notice of any proposed assessment shall be sent to each member of the College by mail**, electronic mail,** or **other** official **ACEP communication** at least 30 days before the meeting of the Council at which the proposed assessment will be considered. The Board of Directors shall establish uniform policies regarding dues, fees, and assessments.

ARTICLE VI – CHAPTERS

(No changes are proposed for Sections 1 or 3-6.)

Section 2 — Chapter Bylaws

A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and current approved chapter bylaws guidance documents. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its

bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College **or its designee**. ~~A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.~~

No chapter is permitted to act on behalf of, or to appear to third parties to be acting on behalf of, the College. In accepting or retaining a charter as a chapter of the College, the chapter and its members acknowledge the fact that the chapter is not an agent of the College notwithstanding that the College has the authority to establish rules governing actions of the chapter which may give the appearance of a principal-agent relationship.

ARTICLE VIII – COUNCIL

(No changes are proposed for Sections 1, 2 or 5-8.)

Section 3 — Meetings

An annual meeting of the Council shall be held within or outside of the State of Texas at such time and place as determined by the Board of Directors **in conjunction with the Council officers**. Notice for the annual meeting is not required. Whenever the term "annual meeting" is used in these Bylaws, it shall mean the annual meeting of the Council.

Special meetings of the Council may be held within or outside of the State of Texas and may be called by an affirmative vote of two-thirds of the entire Board of Directors, by the speaker with concurrence of a two-thirds vote of the entire Steering Committee, or by a petition of councillors comprised of signatures numbering one-third of the number of councillors present at the previous annual meeting, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee, provided that the time and place of such meeting shall be announced not less than ~~40~~ **10** nor more than ~~50~~ **60** days prior to the meeting.

Voting by proxy shall be allowed only at special meetings of the Council. The proxy of any councillor can be revoked by that councillor at any time. The results of any vote that includes proxy ballots will have the same force as any other vote of the Council.

Councillors eligible to vote at a special meeting of the Council are those who were credentialed by the Tellers, Credentials, & Elections Committee at the previous annual meeting of the Council.

All members of the College shall be notified of all Council meetings by mail**, electronic mail** or **other** official ~~publication~~ **ACEP communication**.

Section 4 — Quorum

A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee during each session of ~~the~~ **any** Council meeting shall constitute a quorum for that session. The vote of a majority of councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or these Bylaws.

Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to councillor voting, "present" is defined as either in person or participating by approved remote communication technology.

ARTICLE IX – BOARD OF DIRECTORS

(No changes are proposed for Sections 1, 2, 4, or 5.)

Section 3 – Meetings

The Board of Directors shall meet at least three times annually. One of these meetings shall take place not later than 30 days following the annual meeting of the ~~College~~ **Council**. The other meetings shall take place at such other times and places as the Board may determine. Meetings may take place within or outside of the State of Texas. A

majority of the Board shall constitute a quorum.

Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors, members of the Board of Directors may participate in and hold additional meetings of such Board by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting, except where a director participates in such meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

Any action required or permitted to be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action to be taken, shall be signed by all of the members of the Board of Directors and Council officers, and such a consent shall have the same force and effect as a unanimous vote of the members of the Board of Directors at a meeting of the Board of Directors.

Special meetings of the Board of Directors may be called by the president or the chair of the Board with not less than 48 hours notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

(No changes are proposed for Sections 1-4, 6, or 8-13.)

Section 5 — President

The president shall be a member of the Board of Directors, and shall additionally hold ex-officio membership in all committees. The president's term of office shall begin at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated. **No president may serve more than one term as president.**

Section 7 — Vice Presidents

There shall be two vice president positions. The vice presidents shall be members of the Board of Directors. A director shall be eligible for election to a position of vice president if at least one year remains as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. A vice president's term of office shall begin at the conclusion of the meeting at which the election as a vice president occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. **Vice Presidents may serve unlimited terms.**

~~**Section 14 — Assistant Secretary-Treasurer**~~

~~Annually, the ACEP Board of Directors shall appoint an individual to serve as assistant secretary-treasurer. The assistant secretary-treasurer shall serve as an officer of the corporation without authority to act on behalf of the corporation, except (i) to execute and file required corporate and financial administrative and franchise type reports to state, local, and federal authorities, or (ii) pursuant to any authority granted in writing by the secretary-treasurer. All other duties of the secretary-treasurer are specifically omitted from this authority and are reserved for the duly elected secretary-treasurer. The assistant secretary-treasurer shall not be a member of the Board of Directors.~~

ARTICLE XI — COMMITTEES

(No changes are proposed for Sections 2 or 5-7.)

Section 1 — General Committees

The president shall ~~annually~~ appoint committees and task forces **annually** to address issues pertinent to the

College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board. A majority of the voting membership of a committee shall constitute a quorum.

The president shall appoint annually committees on ~~Compensation,~~ Bylaws, **Compensation, and** Finance.

Section 3 — Steering Committee

A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall consist of at least 15 members, each appointed annually for a one-year term. It shall be the function of the committee to represent the Council between Council meetings. The committee shall ~~be required to~~ meet at least two times annually, and all action taken by the committee shall be subject to final approval by the Council at the next regularly scheduled session. The speaker of the Council shall be the chair of the Steering Committee.

The Steering Committee cannot overrule resolutions, actions, or appropriations enacted by the Council. The Steering Committee may amend such instructions of the Council, or approve amendments proposed by the Board of Directors, provided that such amendment shall not change the intent or basic content of the instructions. Such actions to amend, or approve amendment, can only be by a three-quarters vote of all the members of the Steering Committee and must include the position and vote of each member of the Steering Committee. Notice by mail or official publication shall be given to the membership regarding such amendment, or approval of amendment, of the Council's instructions. Such notice shall contain the position and vote of each member of the Steering Committee regarding amendment of or approval of amendment.

Section 4 — Bylaws Interpretation Committee

In addition to the College Bylaws Committee, there shall also be a Bylaws Interpretation Committee, appointed ~~annually~~ **when petitioned** and consisting of five ACEP members. The president shall appoint two of the members and the Council speaker shall appoint three members. The chair of this committee shall be chosen by a vote of its members. When petitioned to do so, the Bylaws Interpretation Committee shall be charged with the definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of these Bylaws. Interpretation of other articles of these Bylaws shall be by the Board of Directors.

Any member shall have the right to petition the Bylaws Interpretation Committee for an opinion on any issue within its purview. If the petition alleges an occurrence of improper action, inaction, or omission, such petition must be received by the executive director no more than 60 days after the occurrence. In the event of a question regarding whether the subject of the petition is addressed by a portion of the Bylaws which falls within the committee's jurisdiction, or a question of whether the time limit has been met, such question shall be resolved jointly by the president and the speaker. The committee shall then respond with an interpretation within 30 days of receipt of the petition. An urgent interpretation can be requested by the president, the Board of Directors, the speaker, or the Council in which case the interpretation of the committee shall be provided within 14 days. The Board shall provide the necessary funds, if requested by the committee, to assist the committee in the gathering of appropriate data and opinions for development of any interpretation. The Bylaws Interpretation Committee shall render its response to the petitioner as a written interpretation of that portion of the Bylaws in question. That response shall be forwarded to the petitioner, the officers of the Council, and the Board of Directors.

ARTICLE XIII — AMENDMENTS

(No changes are proposed for Sections 1-3.)

Section 4 — Contested Amendment

If an Amendment Under Initial Consideration fails to receive an affirmative vote of at least two-thirds of the members of the Board of Directors, then such proposed Bylaws amendment shall be deemed a Contested Amendment. The positions and vote of each member of the Board regarding such Contested Amendment shall be presented to the Council's Steering Committee at the Steering Committee's first meeting following said vote of the Board of Directors. The Council's component bodies and councillors shall be notified within 30 days of the Board action. The Steering

Committee shall not have the authority to amend or adopt a Contested Amendment. The speaker may call a special meeting of the Council to consider a Contested Amendment. The time and place of such meeting shall be announced no less than ~~40~~ **10** and no more than ~~50~~ **60** days prior to the meeting.

The Contested Amendment, identical in every way to its parent Amendment Under Initial Consideration, and the positions and vote of each member of the Board of Directors regarding such Contested Amendment, shall be presented to the Council at the Council's first meeting following said vote of the Board of Directors.

If the unmodified Contested Amendment receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the chair of the Tellers, Credentials, & Elections Committee, then such proposed Bylaws amendment shall be ~~so~~ amended immediately.

If a Contested Amendment is modified in any way, and then receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the Tellers, Credentials, & Elections Committee, such Contested Amendment shall then be deemed an Amendment Under Initial Consideration and be subject to the process for adoption defined herein.

Background

This resolution amends the Bylaws to specify that the president cannot serve more than one term as president, vice presidents may serve unlimited terms, removes the Assistant Secretary-Treasurer position, change the minimum notice requirements for a special meeting of the Council to consider a contested Bylaws amendment, and several other non-substantive changes.

Currently, the Bylaws do not include a provision limiting the president to a single term. The proposed change in Article X – Officers/Executive Director, Section 5 – President provides that specificity. Article IX – Board of Directors, Section 2 – Composition and Election, paragraph three states: “No director may serve more than two consecutive three-year terms unless specified elsewhere in these Bylaws.” Technically, someone could be elected to the Board of Directors again after waiting at least one year and then seek another term as president-elect, followed by succession to the office of president, although this has not happened in ACEP’s history.

There are two vice president positions codified in the Bylaws. Members of the Board could seek election to either position of vice president if at least one year remains in their term as an elected director. The proposed change to Article X – Officers/Executive Director, Section 7 — Vice Presidents allows for directors to serve unlimited terms as vice president if eligible.

The Assistant Secretary-Treasurer position is recommended to be removed in Article X – Officers/Executive Director, Section 14, because the position is no longer needed. The Assistant Secretary-Treasurer position was added to the Bylaws in 2010 because of reporting guideline changes in some jurisdictions that required a corporate officer named in the Bylaws to execute certain documents, including corporate and financial reports on behalf of the College. Designating the Chief Financial Officer as Assistant Secretary-Treasurer, and working under the direction of the Secretary-Treasurer, permitted the documents to be filed expeditiously. ACEP’s *Compendium of Financial Policies and Operational Guidelines* was updated after the Bylaws amendment was adopted in 2010 to reflect the Chief Financial Officer as the Assistant Secretary-Treasurer. This position was later removed from the *Compendium* because it was no longer needed, however, it has remained in the Bylaws.

Electronic communications are considered a standard means of communication and allow for prompt delivery of information. The proposed change to Article XIII – Amendments, Section 4 — Contested Amendment would change the minimum and maximum notice requirements. Proxy voting is allowed during special meetings of the Council and provides the ability for any councillor to have their vote recorded if unable to attend a special meeting.

The remainder of the proposed Bylaws changes are non-substantive.

ACEP Strategic Plan Reference

The Bylaws is a governing document of the College. There are no specific references in the Strategic Plan regarding governing documents.

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

Resolution 4(10) Assistant-Secretary-Treasurer adopted. The resolution designated an Assistant Secretary-Treasurer officer position to delegate executing certain corporate and financial documents to ensure state and federal imposed deadlines are met.

Prior Board Action

Resolution 4(10) Assistant-Secretary-Treasurer adopted.

April 2010, discussed the Bylaws Committee recommendation to designate an Assistant Secretary-Treasurer position in the Bylaws and approved cosponsoring a Bylaws amendment for submission to the 2010 Council.

Background Information Prepared by: Sonja Montgomery
Governance Operations Director

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 16(26)

SUBMITTED BY: New York Chapter

SUBJECT: Emergency Medicine Recommendations for Guidelines on Occupational Ergonomics

PURPOSE: Develop specialty-specific ergonomics guidelines to reduce work-related musculoskeletal injury among emergency physicians and encourage emergency medicine residency programs and EDs to incorporate ergonomics education into training and departmental safety initiatives.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Developing specialty-specific ergonomics guidelines would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. The scope of work for literature review, expert panel convening, guideline drafting, peer review, and dissemination is estimated at 0.25 – 0.50 FTE with additional costs for subject matter expert consultants or a vendor-supported guideline development process. Estimated costs $75,000 – $150,000 or more over the development period, depending on whether an outside ergonomics consultant or formal guideline methodology vendor is engaged. Additional funding for educational integration, simulation, and faculty development will be ongoing, potentially for several years, requiring dedicated committee and staff resources and collaboration with the Council of Residency Directors in Emergency Medicine (CORD).

WHEREAS, Emergency physicians routinely perform physically demanding clinical tasks that are often performed in unpredictable, crowded, time-sensitive, and space-limited environments, including hallways, resuscitation bays, and other space constrained clinical spaces; and

WHEREAS, Emergency physicians frequently work in non-neutral postures, including neck flexion or rotation, shoulder abduction, wrist deviation, prolonged standing, awkward reaching, repetitive hand use; and

WHEREAS, Other societies, such as American Society for Gastrointestinal Endoscopy (ASGE), have developed a specialty-specific ergonomics guideline to reduce injury among endoscopists; and

WHEREAS, Emergency medicine similarly involves repeated exposure to procedures and bedside tasks that may place physicians, at risk for work-related musculoskeletal injury; and

WHEREAS, ASGE made a strong recommendation for ergonomics education because of the high priority placed on preventing clinician harm and the relatively low cost of most ergonomics education interventions; and

WHEREAS, Emergency medicine training and departmental operations currently lack a widely adopted, specialty-specific ergonomic framework addressing emergency department procedures, resuscitation, ultrasound, documentation, workstation design, patient positioning, equipment placement, and recovery practices; therefore be it

RESOLVED, That ACEP develop guidelines to reduce work-related musculoskeletal injury among emergency physicians and that the guidelines address, emergency department procedural ergonomics, airway management, cardiopulmonary resuscitation, point-of-care ultrasound, patient positioning, monitor and equipment placement, workstation and documentation ergonomics, prolonged standing, and be it further

RESOLVED**,** That ACEP encourage emergency medicine residency programs and emergency departments to incorporate ergonomics education into procedural training, ultrasound training, simulation, faculty development, and departmental quality and safety initiatives.

Background

This resolution asks the College to develop specialty-specific ergonomics guidelines to reduce work-related musculoskeletal injury among emergency physicians, and to encourage emergency medicine residency programs and emergency departments to incorporate ergonomics education into procedural training, ultrasound training, simulation, faculty development, and departmental quality and safety initiatives.

Emergency physicians and other ED personnel face extremely high rates of back, neck, and shoulder injuries. Work-related musculoskeletal disorders (WMSDs) are a recognized occupational hazard in the emergency department. The Occupational Safety and Health Administration (OSHA) identifies the emergency department as a high-risk environment for WMSDs, noting that the urgency often present in treating patients in the ED may increase the potential for ergonomic hazards, and that healthcare employees perform frequent lifting and reaching for patients during their transfers. Poor ED layout can create awkward postures, such as twisting, hyper-extending, or leaning over beds and these are the primary catalysts for WMSDs. ED design publications and building guidelines mitigate WMSD risks through several foundational architectural and spatial interventions:

ACEP's publication *Emergency Department Design: A Practical Guide to Planning for the Future* focuses extensively on optimizing sightlines, layout proximity, and traffic patterns. Designing "I-beam" configurations with centralized staff zones reduces the physical footprint and can, drastically mitigate physical fatigue. A study published in *Annals of Emergency Medicine* highlighted the ergonomic danger of poor person-to-space interfaces. Recent publications advocate for absolute standardization of supplies at patient bedsides so clinicians do not have to stretch or leave the bedside during critical interventions. [1, 2, 4, 5] Other publications specify ergonomic standards for centralized and decentralized nursing stations. This includes the integration of adjustable-height desks, placement of diagnostic monitors at eye level, and tailored ambient lighting to prevent visual fatigue and awkward neck strain during long charting sessions.[1, 2, 3, 4, 5]

Across all industries, WMSDs account for more than 30% of all nonfatal occupational injury and illness cases each year, costing employers an estimated $20 billion annually in direct workers' compensation payments, with OSHA estimating indirect costs, such as hiring and training replacement workers, at up to five times that amount. Emergency physicians are exposed to these risks in a particularly demanding form: they routinely perform physically demanding clinical tasks in unpredictable, crowded, time-sensitive, and space-limited environments, including hallways, resuscitation bays, and other constrained clinical spaces. These tasks frequently require non-neutral postures, including neck flexion or rotation, shoulder abduction, wrist deviation, prolonged standing, awkward reaching, and repetitive hand use, which may place physicians at risk for WMSDs. Despite this exposure, emergency medicine training and departmental operations currently lack a widely adopted, specialty-specific ergonomic framework addressing these risks.

Other procedural specialties have begun to address this gap with formal, evidence-based guidelines. In 2023, the American Society for Gastrointestinal Endoscopy (ASGE) published a clinical practice guideline on the role of ergonomics for prevention of endoscopy-related injury, developed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) framework. The ASGE guideline found that studies based on survey data reported a 39% to 89% prevalence of endoscopy-related injuries in practicing gastroenterologists and a 20% to 47% prevalence in gastroenterology trainees. The guideline recommends formal ergonomics education and neutral posture during the performance of endoscopy, achieved through adjustable monitor and optimal procedure table position, and suggests taking microbreaks and scheduled macrobreaks and using antifatigue mats during procedures to prevent injury. The ASGE guideline addresses ergonomics training, monitor and table positions, antifatigue mats, and use of ancillary devices. This model translates directly to the emergency medicine context, where analogous tasks such as airway management, cardiopulmonary resuscitation, point-of-care ultrasound, patient positioning, and documentation carry comparable ergonomic risk. OSHA similarly recognizes that focusing solely on "proper body mechanics" during lifting is not sufficient to prevent WMSDs, and that safe patient handling programs and policies that limit or prohibit manual lifting have been shown to be effective in reducing MSDs in hospital and nursing staff and this finding has direct implications for emergency department design and workflow.

ACEP has not previously developed a clinical guideline or policy statement specifically addressing occupational ergonomics for emergency physicians. The College's policy statement "Well Workplace" addresses workplace

conditions generally, but does not provide specialty-specific ergonomic guidance for the clinical tasks performed in the emergency department. The Council adopted Amended Resolution 82(21) directing ACEP to develop policy defining an accurate job description for emergency physicians that reflects the true physical and cognitive demands of the specialty and the Emergency Medicine Practice Committee developed the policy statement "Defining the Job Description of an Emergency Physician" and the Policy Resource and Education Paper "Physical and Cognitive Skills Required for the Practice of Clinical Emergency Medicine." These documents establish a foundation acknowledging the physical demands of emergency medicine practice but do not address ergonomic risk mitigation or injury prevention. No prior Council resolution has addressed occupational ergonomics or WMSD prevention specifically for emergency physicians.

ACEP Strategic Plan Reference

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

> Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.
>
> Objective 3: Expand wellness, peer support, and burnout prevention resources to promote the well-being, health, and resilience needs of emergency physicians.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Developing specialty-specific ergonomics guidelines would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. The scope of work for literature review, expert panel convening, guideline drafting, peer review, and dissemination is estimated at 0.25 – 0.50 FTE with additional costs for subject matter expert consultants or a vendor-supported guideline development process. Estimated costs $75,000 – $150,000 or more over the development period, depending on whether an outside ergonomics consultant or formal guideline methodology vendor is engaged. Additional funding for educational integration, simulation, and faculty development will be ongoing, potentially for several years, requiring dedicated committee and staff resources and collaboration with the Council of Residency Directors in Emergency Medicine (CORD).

Prior Council Action

None specific to occupational ergonomics or work-related musculoskeletal injury prevention for emergency physicians.

Amended Resolution 82(21) Defining the Job Description of an Emergency Physician adopted. Directed ACEP to work with appropriate stakeholders and the insurance industry to develop ACEP policy defining an accurate job description for all emergency physicians and that can be used to support appeals of long-term disability claim denials.

Prior Board Action

April 2024, approved the policy statement "Well Workplace."

October 2022, reviewed the Policy Resource and Education Paper "Physical and Cognitive Skills Required for the Practice of Clinical Emergency Medicine."

September 2022, approved the policy statement "Defining the Job Description of an Emergency Physician."

Amended Resolution 82(21) Defining the Job Description of an Emergency Physician adopted.

Background Information Prepared by: Stephen Simalchik, MBA
Director, Resident & Early Career Physician Engagement

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 17(26)

SUBMITTED BY: Medical Humanities Section
Professional Wellness Section

SUBJECT: Importance of the Arts and Humanities as Applied to Emergency Medicine

PURPOSE: Formally recognize the importance and relevance of the arts and humanities to emergency medicine and to support the application, evaluation, and dissemination of arts and humanities-based approaches across the spectrum of emergency medicine education and training, with the goals of enhancing clinical care and promoting emergency physician well-being.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Implementation would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Developing a formal position statement or recognition document, identify and curate existing arts and humanities resources for dissemination, and support any related educational programming and content development would require approximately 0.50 – 1.0 FTE, $75,000 – $150,000, depending on the scope of dissemination and programming activities pursued.

WHEREAS, The Arts and Humanities (A&H) have been recognized as integral to the practice of healthcare by organizations such as the Association of American Medical Colleges, the World Health Organization, National Academies of Sciences, Engineering, and Medicine, and the Accreditation Council for Graduate Medical Education; and

WHEREAS, A robust evidence base demonstrates the positive impact of A&H education and engagement on skills and attributes that are crucial to the delivery of effective patient care in emergency departments, including observation skills, written and verbal communication skills, mitigation of cognitive bias in decision-making, empathetic and person-centered care, interprofessional practice, tolerance of uncertainty, and application of ethical principles; and

WHEREAS, Existing evidence also indicates that the A&H provide effective frameworks to enhance emergency physician well-being and resilience and may mitigate the pervasive impacts of secondary trauma, moral injury, and emotional exhaustion to which emergency physicians are uniquely prone, therefore enhancing the longevity and health of emergency physicians; and

WHEREAS, While emergency medicine, as a specialty, is emerging as a leader in the A&H as applied to healthcare, the full potential of the A&H to enhance emergency department patient care and support emergency physician well-being has not yet been fully realized; therefore be it

RESOLVED, That ACEP recognize the importance and relevance of the arts and humanities to emergency medicine; and be it further

RESOLVED, That ACEP support the application, evaluation, and dissemination of arts and humanities-based approaches across the spectrum of emergency medicine education and training towards enhancing clinical care and emergency physician well-being.

Background

This resolution asks the College to formally recognize the importance and relevance of the arts and humanities to emergency medicine and to support the application, evaluation, and dissemination of arts and humanities-based

approaches across the spectrum of emergency medicine education and training, with the goals of enhancing clinical care and promoting emergency physician well-being.

The arts and humanities, encompassing disciplines such as narrative medicine, visual arts-based education, history of medicine, bioethics, and the social sciences, have gained significant recognition as integral to health professions education over the past decade. The Association of American Medical Colleges (AAMC) launched its Fundamental Role of Arts and Humanities in Medical Education (FRAHME) initiative, which provides resources to help medical educators integrate arts and humanities into their teaching and has commissioned a scoping review of 769 publications on the subject. The AAMC's FRAHME monograph describes the role arts and humanities play in educating a physician workforce to meet 21st-century health care needs, including enhancing the patient experience, improving population health, reducing costs, and promoting clinician well-being. The Accreditation Council for Graduate Medical Education (ACGME), the World Health Organization, and the National Academies of Sciences, Engineering, and Medicine have similarly recognized the relevance of arts and humanities to health professions training. By integrating arts and humanities throughout medical education, trainees and physicians can develop stronger observation and interpretive skills, empathy, communication, and teamwork and these competencies are directly applicable to the emergency department environment.

Emergency medicine presents a distinctive clinical context that makes arts and humanities integration particularly relevant. The emergency department demands rapid decision-making under uncertainty, care for patients who arrive unscheduled and often in crisis, and the ability to communicate effectively across diverse patient populations without the benefit of an established therapeutic relationship. A growing evidence base demonstrates that arts and humanities-based education can support these competencies: studies have shown benefits in observation skills, written and verbal communication, mitigation of cognitive bias in high-stakes decision-making, empathetic and person-centered care, interprofessional practice, tolerance of uncertainty, and application of ethical principles. Despite this evidence, a 2022 multisite study of emergency medicine residents published in AEM Education and Training titled "A sorely neglected field" found that humanities exposure during residency training remains limited and inconsistent across programs, suggesting that the specialty has not yet systematically incorporated arts and humanities into graduate medical education. A small number of academic emergency medicine programs have begun to address this gap; Johns Hopkins Medicine's Department of Emergency Medicine, for example, has established a Health Humanities Fellowship, described as the first of its kind, designed to equip emergency physicians with foundational knowledge in the health humanities and to develop leaders in education, scholarship, and advocacy in this area. These institutional efforts remain isolated, and no national framework currently exists to encourage broader adoption. ACEP does not currently have a policy statement or formal position on the arts and humanities as applied to emergency medicine.

The well-being dimension of this resolution is equally grounded in documented need. Emergency medicine has historically had among the highest burnout rates of any medical specialty. Data cited in prior ACEP Council resolutions indicate that upwards of 65 % of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers, and that approximately 15-17% of emergency physicians, and upwards of 20% of emergency medicine residents, met diagnostic criteria for PTSD as of 2019. More recent data from the 2025 Medscape Physician Mental Health Report indicate that overall physician burnout has been trending downward (47 % in 2025, compared to 53 % in 2023), reflecting the impact of deliberate organizational and practice-level interventions; however, emergency medicine continues to carry a disproportionate burden. Moral injury, which is the distress arising from actions or inactions that violate a physician's moral code, has been identified as a distinct and compounding factor in emergency physician well-being, driven by administrative burden, resource constraints, and the emotional weight of high-acuity, high-volume practice. ACEP has addressed physician well-being through multiple prior Council resolutions, legislative advocacy (including the Dr. Lorna Breen Health Care Provider Protection Act, signed into law in March 2022), and the creation of the Emergency Medicine Wellness Center of Excellence Award in 2019. Arts and humanities-based frameworks, including narrative medicine, reflective writing, and visual arts engagement, have been identified in the literature as effective tools for processing secondary trauma, building resilience, and mitigating emotional exhaustion, offering a complementary and evidence-informed approach to the well-being interventions ACEP already supports.

ACEP Strategic Plan Reference

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical

standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.

Objective 7: Encourage and facilitate training and education in emergency medicine for all medical students.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 4: Develop educational and other resources to prepare emergency physicians for roles in evolving and emerging administrative, clinical, and educational settings.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 3: Expand wellness, peer support, and burnout prevention resources to promote the well-being, health, and resilience needs of emergency physicians.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Implementation would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Developing a formal position statement or recognition document, identify and curate existing arts and humanities resources for dissemination, and support any related educational programming and content development would require approximately 0.50 – 1.0 FTE, $75,000 – $150,000, depending on the scope of dissemination and programming activities pursued.

Prior Council Action

None specific regarding the arts and humanities as applied to emergency medicine.

Prior Board Action

April 2024, approved the policy statement "Well Workplace."

April 2019 - Board approved creation of the Emergency Medicine Wellness Center of Excellence Award to recognize excellence in promotion and identification of wellness and resiliency best practices in emergency medicine.

Background Information Prepared by: Tracy Napper
Editorial Director, *Annals of Emergency Medicine* and *JACEP Open*

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 18(26)

SUBMITTED BY: Colorado Chapter
District of Columbia Chapter
Utah Chapter
AAWEP Section
Medical Humanities Section
Professional Wellness Section

SUBJECT: Emergency Physician Specific Peer-to-Peer Support Programs Across Emergency Medicine Practice Settings

PURPOSE: Recognize confidential emergency physician specific peer-to-peer support programs as a crucial practice for promoting well-being; continue developing and disseminating resources for such programs; support implementation of these programs across all emergency medicine practice settings within five years; and annually assess and report progress through existing wellness, workforce, or practice-related committees.

FISCAL IMPACT: Ongoing committee and staff resources for current initiatives. Expanding beyond the current scope of work is unbudgeted and would require diverting resources from other work to support this effort or including funds in the next fiscal year budget. Potential additional staff resources (estimated 0.25 – 0.5 FTE annually) and potential vendor or technology support for program toolkits and outreach are estimated in the range of $25,000 – $75,000 per year depending on the scope of work. (Three scenarios are highlighted in the fiscal impact details below.)

WHEREAS, Emergency medicine consistently ranks at or near the top of all specialties for physician burnout, with the 2024 Medscape report placing it first at 63%; and

WHEREAS, Emergency physician attrition exceeds that of most other specialties, with annual attrition rates exceeding 5% and reaching nearly 9% during the COVID-19 pandemic; and

WHEREAS, Physicians' mental health challenges, including suicide, represent a significant threat to the emergency medicine workforce; and

WHEREAS, Burnout is a cause of increased patient safety incidents, reduced quality of care, increased career regret, and greater intention to leave clinical practice; and

WHEREAS, Physician burnout results in substantial economic losses through turnover, reduced clinical effort, recruitment costs, and lost productivity, with replacement costs for a single physician estimated between $500,000 and $1,000,000; and

WHEREAS, Peer-to-peer physician support programs have demonstrated effectiveness in reducing burnout, depressive symptoms, and intent to leave practice; and

WHEREAS, Emergency physicians identify confidential peer support from fellow emergency physicians as a preferred form of emotional support following critical events, professional stressors, and personal crises; and

WHEREAS, Peer support programs represent a low-cost, scalable intervention with the potential to improve physician well-being, patient safety, workforce retention, and organizational financial performance; therefore be it

RESOLVED, That ACEP recognize confidential emergency physician specific peer-to-peer support programs as a crucial practice for promoting emergency physician well-being, professional satisfaction, and sustainability; and be

it further

RESOLVED, That ACEP continue development and dissemination of resources for emergency physician specific peer-to-peer support programs; and be it further

RESOLVED, That ACEP support implementation of emergency physician specific peer-to-peer support programs in all emergency medicine practice settings (groups, departments or practice entities) by 2031; and be it further

RESOLVED, That ACEP annually assess and report progress toward implementation of emergency physician specific peer-to-peer support programs in all emergency medicine practice settings through existing wellness, workforce, or practice-related committees.

Background

This resolution asks the College to formally recognize confidential emergency physician specific peer-to-peer support programs as a crucial practice for promoting well-being, professional satisfaction, and sustainability; to continue developing and disseminating resources for such programs; to support their implementation across all emergency medicine practice settings within five years of adoption; and to annually assess and report progress through existing wellness, workforce, or practice-related committees.

Emergency medicine has historically ranked at or near the top of all specialties for physician burnout. The 2024 Medscape Physician Burnout and Depression Report placed emergency medicine first at 63%, and the 2025 Medscape Physician Mental Health Report found that overall physician burnout had declined to 47%, down from 53% in 2023, with emergency medicine following the same downward trend. Researchers and practitioners attribute this improvement to deliberate organizational interventions, including wellness programs, reduced documentation burden, and improved mental health access, underscoring that burnout rates respond when the right interventions are applied. Notwithstanding this progress, emergency medicine continues to carry a disproportionate burden: upwards of 65% of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers, and approximately 15-17% of emergency physicians, and upwards of 20% of emergency medicine residents, met the diagnostic criteria for PTSD in 2019. Data suggest that in a recent year, as many as 6,000 emergency physicians contemplated suicide and up to 400 attempted to take their own life; ACEP estimates that approximately 300 to 400 physicians die by suicide in the United States each year. Emergency physician attrition exceeds that of most other specialties, with annual attrition rates exceeding 5% and reaching nearly 9% during the COVID-19 pandemic. Burnout is associated with increased patient safety incidents, reduced quality of care, career regret, and greater intention to leave clinical practice. The economic cost is substantial: replacement costs for a single physician are estimated between $500,000 and $1,000,000.

A significant barrier to addressing these mental health challenges is the reluctance of emergency physicians to seek care. A 2020 ACEP/Morning Consult poll found that nearly half (45%) of the nation's emergency physicians do not feel comfortable seeking mental health treatment, and nearly three in five (57%) reported they would be concerned for their job if they were to seek such treatment. Intrusive mental health questions on state licensing applications and credentialing processes have historically deterred physicians from seeking care. As of January 2026, 70 state licensure boards and more than 1,194 hospitals have removed invasive mental health questions from licensing applications; this is a meaningful structural change that reduces one of the most cited barriers to individual seeking help.

Peer-to-peer physician support programs have demonstrated effectiveness in reducing burnout, depressive symptoms, and intent to leave practice. Peer support involves structured, supportive interactions between individuals with shared experiences, offering a safe space for clinicians to share challenges and decompress, helping to alleviate emotional exhaustion. Teams that implement active peer support programs report reduced turnover rates and improved job satisfaction. By reducing isolation and fostering open dialogue, peer support also mitigates suicide risk. Individuals who engage with peer support often feel more comfortable and empowered to seek professional assistance when needed, and these programs foster a healthier workplace culture by reducing the stigma around mental health issues. A Kaiser Permanente study published in PLOS ONE (November 2023) evaluated the Peer Outreach Support Team (POST) program across two hospitals over three years, reaching 530 physicians. Among survey respondents who had

a peer support interaction, the majority reported that the support was helpful, improved their well-being, and made them more comfortable talking about their work-related emotions; nearly 85% said they would recommend the program to another department. Notably, the POST program was specifically tailored to physicians rather than all health care providers and was department-based, ensuring support came from colleagues who understood the specific clinical environment. Emergency physicians identify confidential peer support from fellow emergency physicians as a preferred form of emotional support following critical events, professional stressors, and personal crises. Such programs are considered a low-cost, scalable intervention with the potential to improve physician well-being, patient safety, workforce retention, and organizational financial performance.

ACEP has an existing and growing foundation in this area and maintains multiple resources on physician wellness in the Physician Wellness Hub on the ACEP website. ACEP has implemented a confidential Peer-To-Peer Support for Emergency Physicians platform that connects emergency physicians with trained emergency physician volunteers who understand the unique pressures of emergency medicine. ACEP has also partnered with the National Alliance on Mental Illness (NAMI) to develop PeER Connect, a program that equips emergency physicians with peer support skills through "train the trainer" workshops led by fellow emergency physicians, incorporating the "NURSE" framework (Name, Understand, Respect, Support, and Explore) to enhance empathetic communication.

The Professional Well-Being Committee has been working on a member wellness peer-to-peer program to expand and facilitate interactive, real-time, online communities that provide a safe forum for members to share challenges and solutions. The committee has the following objective for the 2026-27 committee year:

Support and expand ACEP's Peer-to-Peer Emergency Physician Support Program to increase access, standardize best practices, and promote national adoption.

- Serve as faculty for peer-to-peer support trainings and collaborate with ACEP Chapters to conduct local or regional training sessions.
- Support expansion of the peer supporter network with a goal of training additional peer supporters.
- Develop and disseminate best practices and implementation guidance for peer support programs in emergency medicine workplaces.
- Explore development of peer support resources in additional languages to expand program accessibility.

The Board of Directors approved the "Well Workplace" policy statement in April 2024 and it addresses wellness in the emergency medicine workplace. The College has also advocated for and supported the Dr. Lorna Breen Health Care Provider Protection Act, signed into law in March 2022, which has funded dozens of grants totaling more than $100 million for organizations to develop programs and resources for frontline health care workers. The Professional Well-Being Committee is also collaborating with the Lorna Breen Heroes' Foundation to change concerning language in medical credentialing to protect physicians who seek mental health care.

ACEP Strategic Plan Reference

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Objective 2: Address workforce solutions to ensure emergency physicians set the course for the future of the specialty.

Objective 3: Expand wellness, peer support, and burnout prevention resources to promote the well-being, health, and resilience needs of emergency physicians.

Fiscal Impact

Current peer support initiatives are supported within existing committee and staff resources. Expanding beyond the current scope of work is unbudgeted and would require diverting resources from other work to support this effort or

including funds in the next fiscal year budget. Estimated costs depend on the scope of work to "support implementation in all emergency medicine practice settings by 2031." Three scenarios are provided for consideration.

Scenario A: Enhanced resource development and dissemination. Continued toolkit development, best-practices guidance, PeER Connect trainings on request, and progress reporting through existing committee and survey mechanisms. Estimated 0.25–0.5 FTE plus vendor and technology support costs of $25,000–$75,000 per year.

Scenario B: Structured national rollout through chapters. Establishing at least one trained peer support program in every chapter over approximately three years: chapter seed grants (~$3,000–$5,000 each, ~18 chapters per year), train-the-trainer cohorts, 0.5–0.75 FTE central coordination, and technology support costs. Estimated $129,000–$190,000 per year during rollout, with lower sustaining costs thereafter.

Scenario C: Direct implementation support in all practice settings by 2031. There are approximately 4,500–4,800 hospital emergency departments in the U.S., plus freestanding EDs and additional practice entities. Distribution of toolkits, one training contact, and follow-up per site across this denominator, phased over five years, is estimated at 1,000 sites/year × $450–$1,400 per site = $450,000–$1,400,000 per year, plus 1.0–2.0 FTE. This funds capacity to reach approximately 1,000 sites per year; actual implementation depends on voluntary uptake by practice settings.

Prior Council Action

Amended Resolution 58(22) Removing Intrusive Medical Exams and Questionnaires from Employment Contracts adopted. Directed ACEP to support the cessation of intrusive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking and continuing employment beyond that necessary to confirm ability to perform duties associated with the individual's role as hired.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted. Directed ACEP to: 1) promote awareness of current ACEP policy statement that supports decreasing the barriers, perceived or real, to physicians to feel safe seeking treatment for mental health, substance use, and other issues; 2) work with the American Medical Association, the Federation of State Medical Boards, and state medical societies to advocate for a change at state medical boards for protections for licensure for physicians to seek help and treatment for mental health, substance use, and other disorders; and 3) partner with appropriate stakeholders to investigate the effectiveness and quality of evidence of Physician Health Programs (PHPs) across the states and produce a white paper that reports on the findings.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted. Directed ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about physician's mental health.

Resolution 16(18) No More Emergency Physician Suicides adopted. Directed ACEP to study the unique specialty-specific factors leading to depression and suicide in emergency physician and develop an action plan to address them.

Substitute Resolution 43(88) Emergency Physician Wellness adopted. Directed ACEP to endorse the concept of promoting emergency physician wellness and for the Board to report back to the Council Steering Committee on their actions related to the Wellness Working Group report.

Amended Resolution 29(82) Physician Impairment adopted. Directed ACEP to establish a committee to develop a program on addiction education for members and a program to encourage colleagues with substance use disorders to seek help and provide a report to the 1983 Council about the progress on these efforts.

Prior Board Action

January 2026, approved the revise policy statement "Physician Impairment;" revised and approved September 2025, February 2020, October 2013, October 2006, and April 1994; reaffirmed September 1999; originally approved September 1990.

April 2024, approved the policy statement "Well Workplace."

Amended Resolution 58(22) Removing Intrusive Medical Exams and Questionnaires from Employment Contracts adopted.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted.

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted.

Resolution 16(18) No More Emergency Physician Suicides adopted.

Substitute Resolution 43(88) Emergency Physician Wellness adopted.

Amended Resolution 29(82) Physician Impairment adopted.

Background Information Prepared by: Stephen Simalchik, MBA
Director, Resident & Early Career Physician Engagement

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 19(26)

SUBMITTED BY: New York Chapter

SUBJECT: Public Identification of Physicians in Training

PURPOSE: Work with other organizations to develop policy discouraging the unnecessary public identification of physicians in training in media reports, public statements, and external institutional communications related to patient care events or allegations, unless disclosure is legally required or necessary to protect the public.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated 0.10 – 0.15 FTE with a projected cost range of $10,000 – $25,000. Additional costs could incur depending on the number of partner organizations engaged and whether external facilitation or legal review is needed.

WHEREAS, Physicians in training, including resident physicians, fellows, and medical students, provide essential emergency care within supervised educational programs and institutional systems; and

WHEREAS, Physicians in training often have less institutional power, less control over clinical assignments, and less ability to respond publicly to allegations or media coverage than hospitals, health systems, or senior physicians; and

WHEREAS, Publicly naming physicians in training in connection with unproven allegations or complex patient care events may create disproportionate reputational, professional, emotional, and personal safety harms; and

WHEREAS, Public identification of physicians in training may expose trainees to online harassment, threats, doxxing, discrimination, and

WHEREAS, Premature or unnecessary identification of trainees may undermine psychological safety, discourage incident reporting, and weaken a just culture approach to patient safety and quality improvement; and

WHEREAS, Physicians in training should not be used as public-facing proxies for broader institutional, supervisory, operational, or systems-level failures; therefore be it

RESOLVED, That ACEP work with other organizations to develop policy discouraging the unnecessary public identification of physicians in training in media reports, public statements, and external institutional communications related to patient care events or allegations, unless disclosure is legally required or necessary to protect the public.

Background

This resolution asks the College to work with other organizations to develop policy discouraging the unnecessary public identification of physicians in training in media reports, public statements, and external institutional communications related to patient care events or allegations, except where disclosure is legally required or necessary to protect the public.

ACEP has existing policy supporting the well-being of emergency physicians and the integrity of the training environment, including the policy statement "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided," which affirms that quality improvement efforts depend on peer protection and blame-free disclosure. However, no current ACEP policy statement or other resources specifically

address the public identification of physicians in training in the context of media coverage or institutional communications.

Physicians in training provide essential emergency care within supervised educational programs and institutional systems. ACEP's own code of ethics affirms that emergency medicine residents, medical students, and other health care professionals in training must not be mistreated, abused, or coerced, and that teaching physicians must fulfill their obligation to provide appropriate levels of supervision. Unlike attending physicians, trainees typically have less institutional power, less control over their clinical assignments, and limited ability to respond publicly to allegations or media coverage. The Accreditation Council for Graduate Medical Education (ACGME) does not adjudicate individual disputes between persons in residency or fellowship programs or their sponsoring institutions, meaning trainees have few formal channels through which to contest or respond to public characterizations of their conduct.

When trainees are named publicly in connection with unproven allegations or complex patient care events, the resulting reputational, professional, emotional, and personal safety harms can be disproportionate to their role and level of responsibility. Online harassment of physicians is not a new phenomenon: a 2019 report found that 23.3% of physicians surveyed had experienced some form of online harassment. More recently, there has been a documented uptick in doxxing incidents, which is the purposeful release of personal information online with the intent to harm, against healthcare personnel, with incidents involving residents specifically. In one documented case from 2021, a psychiatry resident who shared a photo of themselves taking mental health medication as part of a destigmatization campaign had their personal information leaked online, raising concerns about their ability to continue training. Doxxing can cause distress, identity theft, and physical abuse or violence. In October 2022, three organizations (the American Medical Association, American Academy of Pediatrics, and the Children's Hospital Association) representing more than 270,000 physicians wrote to the U.S. Attorney General requesting that the Department of Justice investigate threats to physicians, reflecting the scale of the problem.

The harms of public identification extend beyond the individual trainee. Emergency medicine residents already face significant mental health burdens: upwards of 65% of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers, and upwards of 20% of emergency medicine residents met the diagnostic criteria for PTSD in 2019. Premature or unnecessary public identification of trainees in connection with adverse events can compound these pressures, undermine psychological safety in training environments, and discourage incident reporting. The landmark Institute of Medicine report "To Err Is Human: Building a Safer Health System" (2000) established that medical errors are primarily systems issues rather than individual failures, and that creating an environment where clinicians can report and examine patient safety events is essential to improving care. ACEP's policy statement "A Culture of Safety in EMS Systems" supports the Just Culture approach to facilitate honest and prompt reporting of risk and error. ACEP's policy statement "Disclosure of Medical Errors" recognizes that fear of punitive consequences, including reputational exposure, is a substantial obstacle to the free disclosure of errors. Naming trainees publicly in connection with adverse events or allegations, before any formal review process has concluded, is inconsistent with these principles and may deter reporting behaviors that fuels patient safety. Trainees should not serve as public-facing proxies for broader institutional, supervisory, operational, or systems-level failures.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

> Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Objective 3: Expand wellness, peer support, and burnout prevention resources to promote the well-being, health, and resilience needs of emergency physicians.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated 0.10 – 0.15 FTE with a projected cost range of $10,000 – $25,000. Additional costs could incur depending on the number of partner organizations engaged and whether external facilitation or legal review is needed.

Prior Council Action

None addressing the public identification of physicians in training in media reports or institutional communications.

Prior Board Action

None addressing the public identification of physicians in training in media reports or institutional communications.

March 2023, approved the revised policy statement "Disclosure of Medical Errors;" revised and approved April 2017 and April 2010; originally approved September 2003.

June 2022, approved the policy statement "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided."

April 2021, approved the revised policy statement "A Culture of Safety in EMS Systems;" originally approved March 2014.

Background Information Prepared by: Stephen Simalchik, MBA
Director, Resident & Early Career Physician Engagement

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 20(26)

SUBMITTED BY: New York Chapter

SUBJECT: Simulation-Based Continuing Education Certification

PURPOSE: Directs ACEP to work with ABEM to advocate that participation in emergency medicine simulation (cadaver, virtual reality, high-fidelity) counts toward ABEM Maintenance of Certification requirements, and to develop a simulation-based continuing certification pathway that allows qualified simulation activities to satisfy a portion of MyEMCert or Practice Improvement requirements.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated 0.10 – 0.20 FTE staff time, $15,000 – $30,000. Advocacy with ABEM would require sustained engagement across multiple certification cycles.

WHEREAS, Emergency medicine requires ongoing competence in high-acuity, low-frequency procedures, resuscitation, crisis resource management, and clinical decision-making under uncertainty; and

WHEREAS, Many critical emergency medicine skills are difficult to maintain through clinical practice alone because rare procedures and uncommon resuscitation scenarios occur unpredictably; and

WHEREAS, Simulation-based education allows emergency physicians to practice rare, complex, and high-risk clinical scenarios in a structured environment without risk to patients; and

WHEREAS, Recognizing simulation-based education for ABEM Maintenance of Certification credit would encourage emergency physicians to engage in meaningful, practice-relevant, competency-based learning activities; therefore be it

RESOLVED, That ACEP work with the American Board of Emergency Medicine (ABEM) to advocate that participation in emergency medicine simulation (cadaver, virtual reality, high-fidelity) counts toward ABEM Maintenance of Certification requirements; and be it further

RESOLVED, That ACEP work with the American Board of Emergency Medicine to develop a simulation-based continuing certification pathway that allows qualified emergency medicine simulation activities to satisfy a portion of MyEMCert or Practice Improvement requirements.

Background

This resolution directs ACEP to work with the American Board of Emergency Medicine (ABEM) to advocate that participation in emergency medicine simulation (cadaver labs, virtual reality, and high-fidelity mannequin scenarios) counts toward ABEM Maintenance of Certification (MOC) requirements, and to develop a simulation-based continuing certification pathway that allows qualified simulation activities to satisfy a portion of MyEMCert or Practice Improvement requirements.

Emergency medicine is distinguished from many other specialties by its requirement for ongoing competence in high-acuity, low-frequency procedures and clinical scenarios (resuscitation, airway management, procedural sedation, crisis resource management, trauma care) that occur unpredictably and cannot be reliably maintained through routine clinical exposure alone. Simulation-based medical education (SBME) addresses this gap directly: it refers to instructional methods that replace or amplify real patient interactions with guided experiences using physical models, standardized

patients, task trainers, or high-fidelity mannequins, and in emergency medicine the scope extends from single-skill procedural training such as endotracheal intubation or central line placement to full-team crisis resource management exercises replicating mass casualty events. Research published in peer-reviewed literature, including a 2011 meta-analysis by McGaghie et al., has documented that simulation-trained residents reach clinical competency milestones faster than those trained exclusively through direct supervised practice. The Accreditation Council for Graduate Medical Education (ACGME) has integrated simulation into its Program Requirements for Graduate Medical Education in Emergency Medicine, specifying that residents must demonstrate competency in procedural skills that may be initially acquired in simulation environments. ACEP has published policy statements endorsing simulation as a core modality for both training and maintenance of certification.

Despite this educational foundation, ABEM's current continuing certification framework does not recognize simulation-based activities as a pathway to satisfy MyEMCert or Practice Improvement (IMP) requirements. As of 2021, all new and renewing ABEM-certified emergency physicians are on a five-year certification cycle; continuing certification requirements include MyEMCert knowledge modules, Lifelong Learning and Self-Assessment (LLSA) tests, professionalism attestation, and IMP activities. ABEM has stated that the purpose of continuing certification is "to maintain the highest standards of Emergency Medicine by partnering with physicians in their ongoing professional development; maintaining core knowledge, judgement, and skills; and integrating new medical advances in patient-centered care." ABEM has also expressed the view that multiple-choice examinations are the most efficient and cost-effective tools for evaluating cognitive knowledge. The current framework's emphasis on cognitive assessment does not provide a formal mechanism for recognizing the procedural and team-based competency development that simulation uniquely supports.

ACEP is a CME partner for an ABEM MyEMCert module on resuscitation, demonstrating an existing collaborative relationship with ABEM on continuing certification content. The Society for Simulation in Healthcare (SSH) accredits simulation programs through its Council for Accreditation of Healthcare Simulation Programs, establishing peer-reviewed standards across eight defined areas of program function; accreditation through SSH signals that a program meets benchmarks independent of the host institution's credentialing processes, which could provide a quality framework for any ABEM-recognized simulation pathway. ACEP's policy statement "CME Burden" states that "CME requirements as part of maintenance of board certification should be self-determined by the specialty organization and by practicing emergency physicians to reflect their practice environments."

ACEP's policy statement, "ACEP Recognized Certifying Bodies in Emergency Medicine," affirms that the College "recognizes and supports the American Board of Emergency Medicine (ABEM) as the sole American Board of Medical Specialties (ABMS) certifying body for emergency medicine."

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians (Bylaws #2, #4).

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff and committee resources to coordinate outreach and advocacy with ABEM,

estimated, .10 – 0.20 FTE of staff time, approximately $15,000 – $30,000. Advocacy with ABEM would require sustained engagement across multiple certification cycles.

Prior Council Action

None that is specific to ACEP working with ABEM regarding emergency medicine simulation and Maintenance of Certification (MOC) requirements or developing a simulation-based continuing certification pathway that allows qualified simulation activities to satisfy a portion of MyEMCert or Practice Improvement requirements.

Amended Resolution 24(17) Maintenance of Competence for Practicing Emergency Physicians referred to the Board of Directors. Directed ACEP to study the needs and cost-effective evidence-based requirements to support practicing board-certified emergency physicians in demonstrating ongoing competence and skills necessary for their own practice setting; develop appropriate guidelines for "maintenance of competence" with minimum and legitimate barriers to continued practice; and develop a report for the 2018 Council.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted. Directed ACEP to communicate appreciation to ABEM for sensitivity in interpreting ABMS mandates; develop policy supporting ABMS MOC as appropriate support for state medical license Maintenance of Licensure, but actively oppose mandates linking MOC as a requirement for ongoing Maintenance of Licensure; and develop policy opposing efforts of specialty boards to become independent sole-source, for-profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy for emergency physicians.

Prior Board Action

April 2023, approved the revised policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine;" revised and approved February 2020 and June 2014; reaffirmed April 2014, October 2008, October 2002; originally approved March 1998.

January 2022, approved the revised policy statement "CME Burden;' originally approved April 2016.

October 2016, approved recommendations regarding Amended Resolution 31(15) to: (1) communicate appreciation to ABEM for its efforts in the realm of ABMS mandates; (2) take no further action at this time regarding development of a policy opposing mandates linking maintenance of certification as the only path to maintenance of licensure; and (3) take no further action at this time regarding development of a policy opposing specialty boards as the sole source mandating continuing education credit.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

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Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 21(26)

SUBMITTED BY: Tim Boardman, MD, FACEP
Eric Dickson, MD, FACEP
Gary Gaddis, MD, FACEP
Gayle Galletta, MD, FACEP
William Porcaro, MD, FACEP
Massachusetts College of Emergency Physicians

SUBJECT: Exploring the Feasibility of Renewably-Powered EMS Vehicles

PURPOSE: Engage with international EMS leaders who have implemented renewable-powered EMS vehicles to identify best practices and lessons applicable to U.S. EMS systems; evaluate and summarize strategies used to overcome operational, financial, and infrastructure barriers to implementation; and share those strategies with EMS leaders and other stakeholders to support informed consideration of renewable-powered EMS vehicles in the U.S.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources, estimated 0.5 FTE for six months or longer, to conduct outreach to international EMS leaders, compile findings, and develop a summary report for dissemination. Direct costs are estimated at $50,000 – $75,000 for staff labor, potential travel or virtual meeting costs, and publication/dissemination expenses. Alternatively, an outside consultant could be utilized to perform the work.

WHEREAS, A 2022 report from the Commonwealth Fund noted that in the United States, the health care industry contributes about 8.5% of our nation's greenhouse gas (GHG) emissions[1]; and

WHEREAS, American Medical Association (AMA) policy D-135.966, most recently updated in 2022, declared climate change to be a public health crisis, while committing the AMA for advocacy for policies that: a) limit global warming to no more than 1.5 degrees Celsius; b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050; and c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens; and

WHEREAS, AMA Resolution 404-A-26, adopted at the AMA House of Delegates at its June 2026 Annual Meeting, provided clear directives regarding the need for the health care sector to reduce its "greenhouse gas" emissions, stating:

> "RESOLVED: That our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on educating physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions; and be it further
> RESOLVED: That our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems; and be it further
> RESOLVED: That our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities; and be it further
> RESOLVED: That our AMA facilitates collaboration and sharing of best practices among healthcare professionals and institutions committed to addressing climate change and promoting sustainability;" and

WHEREAS, Ambulances contribute significantly to health care's GHG burden, because they are large,

petroleum-powered, CO_2-emitting vehicles; and

WHEREAS, If it could be demonstrated that it is feasible in the United States to replace current Emergency Medical Services (EMS) vehicles with renewably-powered ones, this change could represent an opportunity to decrease the "carbon footprint" of healthcare in the United States; and

WHEREAS, The National Health Service (NHS) of the United Kingdom has moved beyond study of the matter, and in 2021 began to purchase or lease only "Low Emission" and "Ultra Low Emission" EMS vehicles, as older petroleum-powered EMS vehicles become retired from service, toward the goal that 90% of the NHS fleet will be low-emission or ultra-low emissions vehicles by 2028, with this specifically including electric-powered ambulances; and

WHEREAS, Germany, Norway, and Sweden have also already begun to implement electric powered EMS vehicles; and

WHEREAS, Delivery vehicles similar in size to ambulances and powered by renewable energy (electricity) are already in current use in urban areas by the delivery services UPS[3] and FedEx[4], further suggesting that at least in some areas of our nation it may be feasible for the United States to follow the examples of the UK, Germany, Norway, and Sweden regarding implementing renewably-powered EMS vehicles; and

WHEREAS, Formal consultation by leaders of the EMS community of the United States with those international leaders who have guided successful implementation of "Low Emission" and "Ultra Low Emission" vehicles into EMS service could represent an opportunity to facilitate implementation of a similar initiative in the United States; therefore be it

RESOLVED, That ACEP engage with international EMS leaders who have implemented renewable-powered EMS vehicles to identify best practices and lessons applicable to EMS systems in the United States; and be it further

RESOLVED, That ACEP evaluate and summarize strategies used to overcome operational, financial, and infrastructure barriers to renewable-powered EMS vehicle implementation; and be it further

RESOLVED, That ACEP share learned strategies of renewable-powered EMS vehicles with EMS leaders and other stakeholders to support informed consideration of renewable-powered EMS vehicles in the United States.

Resolution References

1. Commonwealth Fund "Explainer". How the U.S. Health Care System Contributes to Climate Change. Issued April 9, 2022. https://www.commonwealthfund.org/publications/explainer/2022/apr/how-us-health-care-system-contributes-climate-change. Accessed March 15, 2024
2. NHS England. Delivering a "Net Zero" National Health Service. https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf. Accessed March 15, 2024
3. United Parcel System. Delivering for Our Planet. https://about.ups.com/us/en/our-impact/ups-sustainability-and-social-impact-report/delivering-for-our-planet.html. Accessed March 15, 2024
4. Federal Express. FedEx Commits to Carbon-Neutral Operations by 2040. March 3, 2021. https://investors.fedex.com/news-and-events/investor-news/investor-news-details/2021/FedEx-Commits-to-Carbon-Neutral-Operations-by-2040/. Accessed March 15, 2024

Background

This resolution asks the College to engage with international EMS leaders who have implemented renewable-powered EMS vehicles, evaluate and summarize strategies used to overcome operational, financial, and infrastructure barriers to implementation, and share those strategies with EMS leaders and other stakeholders to support informed consideration of renewable-powered EMS vehicles in the United States.

The health care sector's contribution to greenhouse gas (GHG) emissions is substantial and well-documented. A 2022 Commonwealth Fund report found that the U.S. health care industry contributes approximately 8.5% of the nation's GHG emissions, nearly 25% of the global health care sector's total, and that Scope 3 emissions from the health care supply chain, including energy usage, comprise over 80% of the sector's carbon footprint, with those emissions having increased by 6% between 2010 and 2018. Ambulances are a meaningful component of this burden: they are large,

petroleum-powered vehicles that operate continuously, often at high idle, and are not subject to the same electrification pressures as personal or commercial vehicles. The AMA's Academic Physicians Section Resolution 2 (A-24), introduced by one of the current resolution's co-authors, called on the AMA to study the feasibility of replacing urban petroleum-powered ambulances with renewably powered electric vehicles, citing the same Commonwealth Fund data and noting that delivery vehicles of comparable size to ambulances, such as those operated by UPS and FedEx, are already being deployed in urban areas using electric power. The AMA resolution was referred for study at the 2024 Annual Meeting; no final AMA policy has been adopted on this specific question to date.

The feasibility question for U.S. EMS systems has begun to receive peer-reviewed attention. A June 2026 study published in Prehospital Emergency Care (Maher, Gonzalez, and D'Arcy) used 2024 National Emergency Medical Services Information System (NEMSIS) data to model EV ambulance feasibility across urban, suburban, rural, and frontier settings. The study found that estimated mileage fell within range requirements for the vast majority of dispatches, from 99.9% of urban dispatches using a higher-capacity vehicle to 97.6% of frontier dispatches using a lower-capacity vehicle, and that both Level-2 and Level-3 at-hospital charging stations restored significant fractions of total energy used during the time an ambulance is typically parked at the hospital between calls. The authors concluded that EV adoption in U.S. ambulance fleets is operationally feasible in most settings, with frontier environments presenting the greatest range challenges. This study represents the first retrospective analysis of NEMSIS data applied to this question and provides a data-grounded foundation for the engagement and information sharing activities this resolution proposes.

International experience offers additional context. The National Health Service (NHS) of England moved beyond feasibility study in 2021, committing to purchase or lease only "Low Emission" and "Ultra Low Emission" vehicles as older petroleum-powered ambulances are retired, with a goal that 90% of the NHS fleet will meet that standard by 2028. In October 2020, the NHS became the world's first health system to commit to reaching net zero emissions, setting targets of net zero by 2040 for emissions it directly controls and net zero by 2045 for emissions it influences. The NHS fleet is the second largest in the United Kingdom, comprising more than 20,000 vehicles traveling over 460 million miles per year and is a central focus of the NHS Net Zero Travel and Transport Strategy (2023), which addresses ambulance trusts specifically and documents the public health, financial, and societal case for fleet decarbonization. The West Midlands Ambulance Service NHS Foundation Trust's Green Plan 2025-2028 illustrates active implementation, noting that NHS ambulance emissions are currently equivalent to approximately 4% of England's total carbon footprint and that fleet replacement programs are underway. Germany, Norway, and Sweden have also begun implementing electric-powered EMS vehicles, though detailed operational data from those programs are not yet widely published in English-language literature.

Key barriers to U.S. implementation identified in the emerging literature include upfront vehicle acquisition costs, the need for charging infrastructure at ambulance stations and hospital bays, range anxiety in rural and frontier settings, and the power demands of onboard medical equipment. The AMA resolution noted that the 15-20 minutes an ambulance is typically out of service at a hospital during patient delivery represents a natural opportunity for rapid recharging, once ambulance bays are equipped with fast-charging stations. The NEMSIS-based study corroborates this, finding that at-hospital charging is a viable operational model for most U.S. EMS environments. Concerns about electrical grid outages during extreme weather events have also been raised; the AMA resolution noted that the wide availability of petroleum-powered generators at hospitals and government buildings should make such concerns manageable for urban systems.

ACEP has an established and growing record of engagement on health care sustainability. In 2022, ACEP joined the Medical Society Consortium on Climate and Health, a coalition of 25 state networks and 56 major medical societies representing over one million health professionals, which advocates for public and policy awareness of climate change as a health threat. ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" supports collaborating with public health agencies and other stakeholders to raise awareness of the short- and long-term implications of climate change in population health and its effect on the practice of emergency medicine.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 4: Evaluate the social and economic aspects of emergency medical care to inform advocacy positions and policy recommendations.

Priority 2: Clinical Excellence, Research and Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 5: Promote the development and coordination of quality emergency medical services and systems and encourage emergency physicians to assume leadership roles in out-of-hospital care and disaster management.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources, estimated 0.5 FTE for six months or longer, to conduct outreach to international EMS leaders, compile findings, and develop a summary report for dissemination. Direct costs are estimated at $50,000 – $75,000 for staff labor, potential travel or virtual meeting costs, and publication/dissemination expenses. Alternatively, an outside consultant could be utilized to perform the work.

Prior Council Action

Amended Resolution 45(24) Climate Change Research and Education in Emergency Medicine adopted. The resolution directed ACEP to encourage and support comprehensive research efforts on the health effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; call for and promote initiatives to facilitate data collection on climate-related health emergencies; and support the introduction of curricula addressing climate change in medical schools and residency programs.

Resolution 21(20) Medical Society Consortium on Climate and Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate and Health and pay registration and travel expenses for an ACEP member to attend the annual meeting.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

Amended Resolution 45(24) Climate Change Research and Education in Emergency Medicine adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

Resolution 21(20) Medical Society Consortium on Climate and Health adopted.

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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

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Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 22(26)

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SUBJECT: Reducing Unnecessary Non-Sterile Glove Use in Emergency Departments

PURPOSE: Endorse efforts such as the "Gloves Off!" campaign to reduce unnecessary non-sterile glove use in EDs; and encourage incorporation of evidence-based, sustainable glove use practices into institutional policies and clinical guidelines, highlighting associated hand hygiene compliance, environmental benefits, and cost savings.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated at 40 – 80 staff hours, approximately $4,000 – $8,000. Additional resources may be needed depending on the scope of effort to encourage incorporating sustainable glove use practices into institutional policies and clinical guidelines. Updating current ACEP policy statements to reflect this initiative could require an additional estimated 40 – 80 staff hours, approximately $4,000 – $8,000.

WHEREAS, American Medical Association (AMA) Resolution 404-A-26, adopted at the AMA House of Delegates at its June 2026 Annual Meeting, provided clear directives regarding the need for the health care sector to reduce its "greenhouse gas" emissions; and

WHEREAS, Non-sterile examination gloves are among the most frequently used single-use items in emergency care, with studies estimating that up to 60% of glove use is unnecessary,[1-2] contributing to increased health care costs, excess waste, and avoidable greenhouse gas emissions; and

WHEREAS, Interventional research demonstrates that targeted education and behavior change strategies can significantly reduce unnecessary glove use (from approximately 60% to 23%), while maintaining patient safety and reducing supply costs and environmental impact; and

WHEREAS, Multiple studies have demonstrated a paradoxical association between routine or unnecessary glove use and decreased hand hygiene compliance, with inappropriate glove use potentially increasing cross-contamination risk when hand hygiene is omitted before and after glove use; and

WHEREAS, Quality improvement initiatives and international campaigns have demonstrated that reducing glove overuse can eliminate tens of thousands of gloves per clinical unit annually, decrease CO_2 emissions, and generate meaningful cost savings without compromising infection prevention; and

WHEREAS, The "Gloves Off!" campaign[5] is supported by international emergency medicine and sustainability organizations, including the European Society for Emergency Medicine, the Royal College of Emergency Medicine, the Australasian College of Emergency Medicine, the Canadian Association of Emergency Physicians, and Global Green

and Healthy Hospitals, and aligns with principles of high-value, evidence-based, and environmentally responsible care; therefore be it

RESOLVED That ACEP endorse efforts such as the "Gloves Off!" campaign to reduce unnecessary non-sterile glove use in emergency departments; and be it further

RESOLVED That ACEP encourage incorporation of evidence-based, sustainable glove use practices into institutional policies and clinical guidelines, highlighting associated hand hygiene compliance, environmental benefits and cost savings.

Resolution References

1. Wilson J, Prieto J, Singleton J, O'Connor V, Lynam S, Loveday H. The misuse and overuse of non-sterile gloves: application of an audit tool to define the problem. J Infect Prev. 2015 Jan;16(1):24-31. doi: 10.1177/1757177414558673.
2. Wilkie-Miskin T, Acost MA, Browning S, et al. Gloves off!: Environmental and financial impacts of an educational intervention to improve hand hygiene. A quality improvement study, Infection, Disease & Health, Volume 31, Issue 1, 2026.
3. Fuller C, Savage J, Besser S, Hayward A, Cookson B, Cooper B, Stone S. "The dirty hand in the latex glove": a study of hand hygiene compliance when gloves are worn. Infect Control Hosp Epidemiol. 2011 Dec;32(12):1194-9. doi: 10.1086/662619.
4. Kurtz SL. Identification of low, high, and super gelers and barriers to hand hygiene among intensive care unit nurses. Am J Infect Control. 2017 Aug 1;45(8):839-843. doi: 10.1016/j.ajic.2017.04.004.
5. "Gloves Off!" Campaign. www.SustainableEmergencyCare.org. Accessed May 15,2026.

Background

This resolution asks the College to endorse efforts such as the "Gloves Off!" campaign to reduce unnecessary non-sterile glove use in emergency departments, and to encourage incorporation of evidence-based, sustainable glove use practices into institutional policies and clinical guidelines, with attention to hand hygiene compliance, environmental benefits, and cost savings.

Non-sterile examination gloves are among the most frequently used single-use items in emergency care. Studies estimate that up to 60% of glove use in clinical settings is unnecessary, contributing to increased health care costs, excess waste, and avoidable greenhouse gas emissions. Wilson et al (2015), using a validated glove audit tool, documented the extent of glove misuse and overuse across clinical settings, establishing the evidence base for targeted intervention. Interventional research, including a quality improvement study by Wilkie-Miskin et al (2026), found that the targeted education campaign, the "Gloves Off!" initiative, reduced unnecessary glove use by 37%, with associated reductions in carbon footprint, plastic waste, and supply costs.

Multiple studies have documented a paradoxical association between routine or unnecessary glove use and decreased hand hygiene compliance. Fuller et al. (2011) demonstrated that hand hygiene is more frequently omitted before and after glove use when gloves are worn inappropriately, potentially increasing cross-contamination risk rather than reducing it. The World Health Organization reinforced this concern in a May 2025 World Hand Hygiene Day statement, noting that "medical gloves can reduce the risk of infection, but they are never a replacement for hand hygiene," and that improper glove use "not only undermines infection prevention and control practices but also adds significantly to health-care waste." The WHO further noted that every $1 invested in hand hygiene can yield up to $24.60 in economic returns, underscoring the cost-effectiveness of prioritizing hand hygiene over reflexive glove use.

The environmental and financial case for reducing unnecessary glove use is supported by a growing body of implementation evidence. The "Gloves Off!" campaign, first launched in Wales by Cardiff and Vale University Health Board and now spreading across the UK and internationally, has produced measurable results. Early Welsh rollout data reported avoidance of approximately 19,200 gloves, eliminating roughly 500 kg of CO_2 equivalent, cutting 83 kg of plastic waste, and saving an estimated £9,000 in a single fiscal year. University College London Hospitals (UCLH) reported a reduction of 2.75 million gloves in 2024 compared to 2023, equating to a 27-tonne CO_2 saving. Parallel studies from UK pediatric hospitals showed a 33% drop – approximately 3.7 million fewer gloves per year – saving £90,000 and 18 metric tons of CO_2 equivalent. These results were achieved without any rise in health care-associated infections and with hand hygiene audit scores remaining at approximately 80%. This evidence base supports the resolution's framing of glove reduction as simultaneously an infection prevention measure, an environmental stewardship measure, and a cost-reduction strategy.

The broader health care sustainability context is relevant. U.S. health care operations account for approximately 8-8.5% of national greenhouse gas emissions, and single-use medical devices represent a substantial share of the sector's carbon footprint across their full lifecycle from manufacture to disposal. American hospitals produce approximately 29 pounds of waste per bed per day, equating to roughly 5 million tons annually. Non-sterile gloves, as one of the highest-volume single-use items in emergency care, represent a meaningful and addressable contributor to this waste stream.

The "Gloves Off!" campaign (www.SustainableEmergencyCare.org) is supported by international emergency medicine and sustainability organizations, including the European Society for Emergency Medicine, the Royal College of Emergency Medicine, the Australasian College of Emergency Medicine, the Canadian Association of Emergency Physicians, and Global Green and Healthy Hospitals. ACEP has not taken a position specifically on non-sterile glove overuse; however, the College has adopted several resolutions related to environmental sustainability in emergency care.

ACEP has established policy and organizational collaborations to address environmental waste, emphasizing its harmful effects on community health and health care costs. Central to this effort is the policy statement "Reducing Waste in the Emergency Department," which recognizes that health care waste inflates financial expenditures and negatively impacts public health globally. To mitigate these impacts, ACEP has encouraged hospital emergency departments to adopt environmentally responsible practices, including proper waste segregation, recycling programs for metal and plastic materials, food composting initiatives, and formal protocols to safely restock or donate unused clinical items.

Beyond standalone internal policy development, ACEP has integrated sustainability into its broader coalition building and strategic partnerships. In 2022, ACEP joined the Medical Society Consortium on Climate and Health, aligning with more than 56 major medical societies and 25 state network groups representing over one million physicians to advocate for climate-smart health care policies and mitigate climate change risks. Furthermore, committees such as the Public Health and the Ethics Committee have systematically updated overarching policy statements, including "Impact of Climate Change on Public Health and Implications for Emergency Medicine" urging emergency medicine professionals and health systems to prioritize energy conservation, waste reduction, and sustainable operational stewardship.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of health care quality.
>
> Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources for research, develop brief educational content or web resources, and potentially coordinate with international sustainability partners. Estimated at 40 – 80 staff hours, approximately $4,000 – $8,000. Additional resources may be needed depending on the scope of effort to encourage incorporating sustainable glove use practices into institutional policies and clinical guidelines. Updating current ACEP policy statements to reflect this initiative could require an additional estimated 40 – 80 staff hours, approximately $4,000 – $8,000.

Prior Council Action

Amended Resolution 62(25) Promoting Environmental Sustainability and Waste Reduction in the ED adopted. The resolution directed ACEP to encourage hospitals and emergency departments to implement environmentally responsible practices, including proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate; and to develop resources to help emergency physicians and EDs reduce waste and carbon emissions.

Amended Resolution 61(25) Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers adopted. The resolution directed ACEP to acknowledge the environmental impact of metered-dose inhalers and support efforts to reduce their carbon footprint; encourage education of emergency physicians, other medical personnel, pharmacists, and patients on sustainable inhaler practices; and support collaboration with health care systems, manufacturers, and insurers to promote lower-emission alternatives and inhaler recycling.

Resolution 59(24) Tap Water is Sufficient Treatment adopted. Directed ACEP to: 1) advocate to transition to hospital tap water in the U.S. for wound irrigation to decrease the carbon footprint of ED; 2) emphasize the importance of research and education within the emergency medicine community and raise awareness of the financial and environmental benefits of tap water for wound irrigation; and 3) urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted. Directed ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and 2) work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Resolution 21(20) Medical Society Consortium on Climate & Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate & Health and pay registration and travel expenses for one ACEP member to attend the annual meeting starting in 2021.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address the impact of climate change on patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, and patient care.

Prior Board Action

June 2026, approved the policy statement "Reducing Waste in the Emergency Department."

Amended Resolution 62(25) Promoting Environmental Sustainability and Waste Reduction in the ED adopted.

Amended Resolution 61(25) Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers adopted.

Resolution 59(24) Tap Water is Sufficient Treatment adopted.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

Resolution 21(20) Medical Society Consortium on Climate & Health adopted.

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PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 23(26)

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SUBJECT: Incorporating ED Climate Resilience and Sustainability into ACEP's ED Accreditation Program

PURPOSE: Incorporate climate resilience and sustainability standards into ACEP's planned general ED accreditation program, using evidence-based metrics; and collaborate with international and other relevant organizations to identify best practices and opportunities for harmonization of sustainability and climate resilience initiatives in emergency medicine.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Estimated 0.25 – 0.5 FTE, to develop standards, coordinate with international partners, and manage accreditation review processes. Estimated costs range from $50,000 – $150,000 annually, depending on whether external subject matter experts or vendors are engaged. Additional funds may be needed based on the scope of research required and changes to the accreditation application system.

WHEREAS, Climate change increasingly impacts emergency department operations, patient volumes, disaster response, and community health through extreme weather events, heat illness, air pollution, infectious diseases, and other climate-related health threats; and

WHEREAS, Emergency departments are significant consumers of energy and resources and have demonstrated opportunities to reduce waste, improve resource stewardship, enhance operational resilience, and lower costs while maintaining high-quality patient care; and

WHEREAS, Accreditation programs provide a proven framework for establishing standards, recognizing excellence, promoting continuous quality improvement, and disseminating best practices across emergency departments; and

WHEREAS, American Medical Association (AMA) Resolution 404-A-26, adopted at the AMA House of Delegates at its June 2026 Annual Meeting, provided clear directives regarding the need for the health care sector to reduce its "greenhouse gas" emissions; and

WHEREAS, The Royal College of Emergency Medicine (RCEM) developed GreenED, a tiered sustainability accreditation program for emergency departments that has demonstrated measurable environmental and operational benefits and has expanded beyond the United Kingdom to include Ireland and pilot implementation in Australasia; and

WHEREAS, The International Federation for Emergency Medicine (IFEM) provides an established platform for global collaboration on climate resilience, environmental sustainability, and emergency care system improvement; and

WHEREAS, ACEP has successfully advanced quality improvement and patient-centered care through accreditation and certification programs including the Geriatric Emergency Department Accreditation (GEDA), the Clinical Ultrasound Accreditation Program (CUAP), Pain and Addiction Care in the Emergency Department (PACED), and the Emergency Department Accreditation Program (EDAP); and

WHEREAS, ACEP is currently in the process of a creating a general emergency department accreditation program; therefore be it

RESOLVED, That ACEP include climate resilience and sustainability into the planned general emergency department accreditation program, utilizing evidence-based standards and measurable performance metrics to promote environmental sustainability, climate resilience, and operational stewardship in emergency care; and be it further

RESOLVED, That ACEP collaborate with the International Federation for Emergency Medicine, the Royal College of Emergency Medicine, the Australasian College for Emergency Medicine, and other relevant organizations to identify best practices and opportunities for harmonization of sustainability and climate resilience initiatives in emergency medicine.

Background

This resolution asks the College to incorporate climate resilience and sustainability standards into the planned general emergency department accreditation program, using evidence-based metrics and measurable performance indicators, and to collaborate with the International Federation for Emergency Medicine (IFEM), the Royal College of Emergency Medicine (RCEM), the Australasian College for Emergency Medicine (ACEM), and other relevant organizations to identify best practices and opportunities for harmonization of sustainability and climate resilience initiatives in emergency medicine.

Emergency departments are both contributors to health care's environmental footprint and increasingly vulnerable to climate-related operational disruptions. U.S. health care operations account for approximately 8–8.5% of national greenhouse gas emissions, or an estimated 655 million metric tons of CO_2 equivalent annually. Supply-chain and product-lifecycle emissions comprise more than 80% of the sector's carbon footprint, and U.S. hospitals generate approximately 29 pounds of waste per bed per day. At the same time, extreme weather, rising temperatures, air pollution, and shifting infectious disease patterns are increasing ED patient volumes and straining operational capacity. A 2025 narrative review in the *Annals of Translational Medicine* confirmed significant climate-related impacts on health care systems, particularly emergency services.

The economic case for action is also substantial. Climate-smart practices, including low-carbon procurement, energy and water efficiency, waste reduction, and resilience strategies, can reduce operating costs while supporting continuity during extreme weather events and other disruptions. Comprehensive sustainability efforts have been estimated to save health care institutions up to $15 billion over 10 years, including billions through waste reduction and operational efficiency.

International precedent exists for an accreditation-based approach. RCEM launched GreenED in 2023 as a tiered sustainability accreditation program for emergency departments, with bronze, silver, and gold levels. The program is designed to reduce the environmental impact of EDs while improving efficiency and maintaining or improving patient care. GreenED has expanded beyond the United Kingdom to Ireland and pilot implementation in Australasia, and accredited sites have reported average annual savings of approximately £10,000.

ACEP has an established record of engagement on climate and sustainability. The College joined the Medical Society Consortium on Climate and Health in 2022, and ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" directs the College to advocate for reducing the carbon footprint of emergency departments through energy conservation and health care waste reduction. The AMA House of Delegates adopted Resolution 404-A-26 in June 2026, further reinforcing health care sector efforts to reduce greenhouse gas emissions.

ACEP's Emergency Department Accreditation Board of Governors (EDAc BoG) considered the RCEM GreenED framework and its potential relationship to EDAc and the Blue Ribbon Recognition Program in June 2026. The BoG reached consensus that direct incorporation of climate and environmental criteria into EDAc or Blue Ribbon Recognition would be premature at this time. Physician leaders identified considerations related to program scope, operational readiness, alignment with ACEP policy, and the potential effect of additional requirements on accreditation participation and implementation. There are currently approximately 40 EDAc applications already in process and BoG members noted that adding a new body of requirements before the necessary standards, review processes, and infrastructure are established could delay current applicants and the rollout of the core program. A key consideration is the distinction between standards that can reasonably be implemented and controlled by an individual ED and those requiring broader hospital or health-system authority. Some GreenED actions are relevant to emergency care, including reducing unnecessary pathology and radiology testing, cannulation and venipuncture, treatments, and certain single-use products. Other criteria involve institution-level functions, such as sourcing most electricity from renewable sources, adopting sustainable procurement policies, reducing the environmental impact of hospital catering, supporting active staff travel, and implementing broader hospital sustainability initiatives. These activities may depend on hospital leadership, facilities management, capital planning, energy contracting, procurement, food services, and other functions over which an ED has limited or no independent authority.

The EDAc BoG noted that incorporating hospital-wide environmental requirements into an ED-specific accreditation program could result in an otherwise high-performing ED being unable to achieve accreditation because of institutional decisions outside its control. It could also increase the coordination, resources, and time required to pursue EDAc, potentially delaying or discouraging participation for reasons unrelated to the quality of emergency care. Members also noted that broader facility sustainability is already addressed through established frameworks, including the U.S. Green Building Council's LEED rating system, The Joint Commission's Sustainable Healthcare Certification, EPA ENERGY STAR benchmarking and certification, ANSI/ASHRAE/ASHE Standard 189.3 for sustainable high-performance health care facilities, and Practice Greenhealth's facility- and health-system-level sustainability pathways. These programs generally address building, hospital, or organizational-level sustainability, reinforcing the question of whether duplicating those functions is appropriate within an accreditation program focused specifically on the emergency department.

Accordingly, the EDAc BoG favors continued evaluation. Potential future approaches include incorporating selected ED-specific sustainability practices into the Blue Ribbon Recognition Program after the core program is established; developing a separate, voluntary environmental or "Green Ribbon" recognition; or offering a voluntary self-assessment approach without making hospital-wide environmental performance a condition of EDAc accreditation.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 2: Expand ACEP's accreditation programs to further recognize excellence in the delivery of emergency care.
>
> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Incorporating climate resilience and sustainability criteria into the planned general ED accreditation program would require significant staff time, estimated 0.25 – 0.5 FTE, to develop standards, coordinate with international partners, and manage accreditation review processes. Estimated costs range from $50,000 – $150,000 annually, depending on whether external subject matter experts or vendors are engaged. Additional funds may be needed based on the scope of research required and changes to the accreditation application system.

Prior Council Action

Amended Resolution 62(25) Promoting Environmental Sustainability and Waste Reduction in the ED adopted. The resolution directed that ACEP encourage hospitals to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate.

Amended Resolution 61(25) Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers adopted. Directed that ACEP acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices.

Resolution 59(24) Tap Water is Sufficient Treatment adopted. Directed ACEP to: 1) advocate to transition to hospital tap water in the U.S. for wound irrigation to decrease the carbon footprint of ED; 2) emphasize the importance of research and education within the emergency medicine community and raise awareness of the financial and environmental benefits of tap water for wound irrigation; and 3) urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted. Directed ACEP to: 1) encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and 2) work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Amended Resolution 45(24) Climate Change Research and Education in Emergency Medicine adopted. The resolution directed ACEP to encourage and support comprehensive research efforts on the health effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; call for and promote initiatives to facilitate data collection on climate-related health emergencies; and support the introduction of curricula addressing climate change in medical schools and residency programs.

Resolution 21(20) Medical Society Consortium on Climate and Health adopted. The resolution directed ACEP to become a member of the Medical Society Consortium on Climate and Health and pay registration and travel expenses for an ACEP member to attend the annual meeting.

Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to research and develop a policy statement to address impact of climate change on the patient health and well-being, and utilize the policy statement to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Prior Board Action

Amended Resolution 62(25) Promoting Environmental Sustainability and Waste Reduction in the ED adopted.

Amended Resolution 61(25) Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers adopted.

January 2026, approved the revised Blue Ribbon Recognition Criteria for the ED Accreditation Program; revised and approved Blue Ribbon Recognition framework June 2025.

April 2024, approved the revised ED Accreditation Program Criteria and all levels of applications; revised and approved January 2024; originally approved criteria October 2023.

February 2023, approved establishing an ED Accreditation Program based on the business plan and preliminary criteria and tiers for the accreditation program.

Amended Resolution 45(24) Climate Change Research and Education in Emergency Medicine adopted.

Resolution 59(24) Tap Water is Sufficient Treatment adopted.

Amended Resolution 58(24) Reducing Waste in Our Emergency Departments adopted.

September 2024, approved the revised policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine;" originally approved June 2018.

Resolution 21(20) Medical Society Consortium on Climate and Health adopted.

Background Information Prepared by: Joya Coffman, MS, CHES, ASQ-CQIA
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Reviewed by: Michael J. McCrea, MD, FACEP
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Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 24-41

George RJ Sontag, MD, FACEP (OH) – Chair
Brittany Arnold, MD, FACEP (OR)
Blake Denley, MD, FACEP (LA)
Mike Lozano, MD, MSHI, FACEP (FL)
Micaela LaRose, MD (GS)
Christopher Pergrem, MD, FACEP (KY)

Brianna Hanson, MPH
Annalane Miller, MPH

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 24(26)

SUBMITTED BY: Washington Chapter

SUBJECT: Advocating for Scientific Integrity in Government Health Leadership

PURPOSE: Advocate that individuals appointed to senior government health care and scientific leadership positions possess relevant qualifications and demonstrate commitment to evidence-based medicine, scientific integrity, and established public health standards, and incorporate these principles into ACEP's federal advocacy efforts.

FISCAL IMPACT: Current and ongoing staff and committee resources for advocacy work related to evidence-based medicine, scientific integrity, and public health policy. Expanding the scope of this work to include a deeper review and extend the review to the hundreds of governmental leaders in scientific positions, additional staff resources or external consultants would be required to accomplish the work. Potential costs could range from .50 – 1.0 FTE, $75,000 – $150,000, or consultant fees in the same range.

WHEREAS, Federal, state, territorial, tribal, and local government agencies including the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the Office of the Surgeon General exert substantial influence on emergency care delivery, public health preparedness, biomedical research, health care financing, and patient outcomes; and

WHEREAS, Leadership of these agencies requires substantial expertise in medicine, public health, biomedical science, health policy, or related scientific disciplines; and

WHEREAS, Public trust in health care institutions depends upon transparent adherence to scientific evidence, established public health principles, and ethical professional standards; and

WHEREAS, Dissemination of health misinformation or rejection of established scientific consensus by individuals occupying senior government health care leadership positions may undermine public confidence, worsen health outcomes, impair emergency preparedness, and threaten the physician-patient relationship; and

WHEREAS, Emergency physicians routinely manage the downstream consequences of health misinformation, inadequate public health infrastructure, and erosion of confidence in evidence-based medical care; therefore be it

RESOLVED, That ACEP advocate that individuals appointed to senior government health care and scientific leadership positions should possess relevant education, training, expertise, and professional experience in health care, medicine, biomedical science, public health, or related scientific fields; and be it further

RESOLVED, That ACEP support the principle that leaders of government health care and scientific agencies demonstrate commitment to evidence-based medicine, scientific integrity, ethical public communication, and established standards of public health practice; and be it further

RESOLVED, That ACEP incorporate into its advocacy efforts the principles that individuals appointed to senior government health care and scientific leadership positions possess relevant expertise and demonstrate commitment to evidence-based medicine, scientific integrity, ethical public communication, and established standards of public health practice, including through communications with policymakers, participation in national and state medical coalitions, and public statements related to government health care leadership and public health policy.

Background

This resolution directs the College to advocate that individuals appointed to senior government health care and scientific leadership positions possess relevant qualifications and demonstrate commitment to evidence-based medicine, scientific integrity, and established public health standards, and to incorporate these principles into ACEP's federal advocacy efforts.

Federal agencies including HHS, CMS, CDC, NIH, and the Office of the Surgeon General exert substantial influence over emergency care delivery, public health preparedness, biomedical research, health care financing, and patient outcomes. The quality and scientific credibility of leadership at these agencies directly affects the policies and guidance that emergency physicians rely upon in clinical practice. Emergency physicians routinely manage the downstream consequences of inadequate public health infrastructure, erosion of confidence in evidence-based medical care, and the spread of health misinformation, including vaccine hesitancy, delayed care-seeking, and rejection of established treatment protocols, all of which increase emergency department volume and acuity.

Concerns about the qualifications and scientific independence of senior government health officials have intensified in recent years. The 2025 ACEP Council addressed a related dimension of this issue through Amended Resolution 89(25), which directed ACEP to strongly oppose interference in the leadership, operations, and recommendations of critical public health agencies such as the CDC, and to affirm the roles of scientific independence and evidence-based medicine in safeguarding public health. This resolution seeks to build on that foundation by focusing specifically on the qualifications and professional standards that should be expected of individuals appointed to senior government health care and scientific leadership roles, and by directing ACEP to embed these principles into its ongoing federal advocacy work.

Currently, staff conduct a limited review about an individual's beliefs or prior actions that would "demonstrate" adherence to evidence-based science as part of ACEP's advocacy work. These beliefs are generally known through news reporting and/or statements the individuals make during their nomination or appointment process. Conducting additional research on the background of individual government leaders and their prior or current thoughts on the use of evidence-based science/medicine would require additional staff time and potential access to these individuals' CVs, research or writing, public statements, and/or other materials to confirm whether they are or are not advocates for evidence-based science/medicine. At certain times of year, for example when a new Administration starts, this may require significant staff resources if there are multiple nominees, such as for federal advisory committees, which technically are part of government and could be considered "leaders." It is unclear from the resolution how deep the research would go into scientific leadership positions. If the intent is to include the hundreds of governmental leaders in scientific positions, additional staff resources or external consultants would be required to accomplish the work.

ACEP has engaged directly on the importance of evidence-based federal health policy. In January 2026, ACEP expressed concern about changes to the CDC's recommended childhood immunization schedule, emphasizing that vaccine recommendations should be based on scientific evidence, developed with input from independent experts, and established through an open and transparent process. In August 2026, ACEP again publicly opposed efforts to weaken the evidence-based vaccination schedule, emphasizing that immunization recommendations reflect decades of rigorous, independent scientific review and should be shielded from political or commercial interference. ACEP called on policymakers to protect the independence of the scientific process underlying vaccination policy and emphasized that emergency physicians see firsthand the consequences when population immunity falls. These statements demonstrate ACEP's ongoing advocacy for evidence-based medicine, scientific independence, and public health decisions grounded in the best available evidence.

ACEP, along with other emergency medicine organizations, sent letters to the Office of Management and Budget in July 2026, urging the agency to preserve scientific independence and strengthen accountability and transparency in the federal grant process.

Scientific integrity in government health leadership is currently reflected in the governance of the National Emergency Medicine PAC (NEMPAC), a voluntary, nonprofit, unincorporated association operating as a separate, segregated fund of ACEP. NEMPAC provides individuals interested in the future of emergency medicine an opportunity to voluntarily contribute to the support of candidates for federal office who have demonstrated their

support for principles important to emergency medicine. NEMPAC's candidate evaluation process reflects principles related to science, evidence, and factual integrity. The NEMPAC Board of Trustees adopted Candidate Evaluation Criteria stating that candidates and incumbents who receive NEMPAC support are expected to "exhibit behavior and actions consistent with the mission, vision, and values of ACEP and uphold the principles of the democratic process and orderly governance." Additionally, "NEMPAC supported candidates should affirm science, evidence, and fact in their words and actions." NEMPAC's political engagement is closely aligned with ACEP's federal advocacy efforts. In evaluating candidates and incumbents for NEMPAC support, the NEMPAC Board of Trustees considers their demonstrated support for emergency medicine priorities, including their legislative records, positions on ACEP-supported legislation, and actions such as cosponsoring or voting on legislation important to emergency medicine. Although NEMPAC operates as a separate, segregated fund and is governed by its own Board of Trustees, Article VIII, Section 1 of the NEMPAC Articles of Association provides that NEMPAC is subject to the ultimate authority of the National ACEP Board of Directors. The existing NEMPAC candidate evaluation criteria provide relevant context for ACEP's broader commitment to evidence-based medicine, scientific integrity, and responsible public policy. This resolution would apply these principles to ACEP's advocacy concerning individuals appointed to senior government health care and scientific leadership positions.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Fiscal Impact

Current and ongoing staff and committee resources for advocacy work related to evidence-based medicine, scientific integrity, and public health policy. Expanding the scope of this work to include a deeper review and extend the review to the hundreds of governmental leaders in scientific positions, additional staff resources or external consultants would be required to accomplish the work. Potential costs could range from .50 – 1.0 FTE, $75,000 – $150,000, or consultant fees in the same range.

Prior Council Action

Amended Resolution 89(25) Support for Scientific Integrity in Medicine and Public Health adopted. Directed ACEP to recognize and commend public health leaders who resigned in defense of science-based medical practice, and to strongly oppose interference in the leadership, operations, and recommendations of critical public health agencies such as the CDC, affirming the roles of scientific independence and evidence-based medicine in safeguarding public health.

Prior Board Action

Amended Resolution 89(25) Support for Scientific Integrity in Medicine and Public Health adopted.

Background Information Prepared by: Jeanne Slade
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Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 25(26)

SUBMITTED BY: Maryland Chapter

SUBJECT: Response Time Standards for Insurance-Based Transfer and Admission Authorization Requests

PURPOSE: Advocate for enforceable standards requiring insurers to provide an initial response to emergency transfer and admission authorization requests within one hour and a final determination within two hours, with deemed approval if deadlines are not met; to support state and federal legislation or regulation codifying these standards and requiring public reporting of insurer authorization metrics; and to urge state insurance commissioners and other regulators to monitor and publish annual insurer compliance reports.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources, estimated 0.25 – 0.50 FTE, to develop policy positions, engage federal and state regulators, and monitor compliance reporting requirements. Additional committee and staff resources and outside legal or regulatory counsel may be needed. Estimated cost $30,000 – $75,000 for staff time, coalition engagement, and external support.

WHEREAS, Emergency physicians are obligated under the Emergency Medical Treatment and Labor Act (EMTALA) to provide medical screening examinations and stabilizing treatment to all patients regardless of insurance status; and

WHEREAS, Some insurance plans require prior authorization or approval numbers before out-of-network admission or transfer, often involving multiple calls, repeated clinical review, and delayed insurer callbacks; and

WHEREAS, These delays contribute to emergency department boarding, crowding, diversion of physician time, delayed definitive care, and potential adverse patient outcomes; and

WHEREAS, Delays in transfer authorization may place the originating facility at risk of EMTALA violations when appropriate care cannot be provided in a timely manner; and

WHEREAS, There is no standardized expectation or systematic public reporting of insurer response times, denial rates, or authorization delays for emergency transfer or admission requests; therefore be it

RESOLVED, That ACEP advocate for policy supporting enforceable emergency transfer and admission authorization standards requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours, and deemed approval if those deadlines are not met; and be it further

RESOLVED, That ACEP advocate for state and federal legislation or regulation codifying emergency transfer and admission authorization standards requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours, and deemed approval if those deadlines are not met and requiring insurers to publicly report emergency transfer and admission authorization metrics, including response times, denial rates, and deemed approvals; and be it further

RESOLVED, That ACEP advocate for state insurance commissioners and other regulators to monitor insurer compliance with emergency transfer and admission authorization standards requiring insurers to provide an initial

response within one hour, a final determination including an authorization number if approved within two hours, and deemed approval if those deadlines are not met and publish annual compliance reports.

Background

This resolution directs ACEP to advocate for enforceable standards requiring insurers to provide an initial response to emergency transfer and admission authorization requests within one hour and a final determination within two hours, with deemed approval if those deadlines are not met; advocate for state and federal legislation or regulation codifying these standards and requiring public reporting of insurer authorization metrics; and to urge state insurance commissioners and other regulators to monitor and publish annual insurer compliance reports.

Emergency physicians are obligated under the Emergency Medical Treatment and Labor Act (EMTALA) to provide a medical screening examination (MSE) and stabilizing treatment to every patient who presents to an emergency department, regardless of insurance status or ability to pay. Hospitals cannot delay providing an appropriate MSE or stabilizing medical treatment for any reason, including to ask about an individual's health insurance status. ACEP's policy statement "Third-party Payers and Emergency Medical Care" reinforces this principle, stating that individuals requesting medical care at an emergency department must be provided a medical screening examination and any necessary stabilizing treatment as defined by federal law and state law, as applicable, and that this requirement applies to all individuals, including managed care patients, regardless of any payment authorization determination.

Despite these legal protections, some insurance plans require prior authorization or approval numbers before out-of-network admission or transfer can proceed. This creates a structural conflict: the treating emergency physician is legally required to act immediately, while the insurer's authorization process operates on a separate, often slower timeline. If third-party payers have a system for post-stabilization case management, it must be readily accessible at all times (24/7). In practice, however, emergency physicians and nurses report that obtaining authorization often involves multiple calls, repeated clinical review, and delayed insurer callbacks, which consume physician and nursing time that would otherwise be directed at patient care.

The downstream consequences of authorization delays are well documented. The issue of patient transfers given the constraints of the EMTALA mandate remains an area of concern and persistent challenge for overwhelmed EDs. In some cases, an ED with insufficient resources or ability to care for a patient with complex needs is unable to transfer that patient to a receiving hospital because that facility is also overwhelmed with boarding patients, full units, or insufficient staff. Some hospital systems have developed transfer centers or flow centers, which attempt to coordinate patient movement to the best site of care within the system. But for independent, and particularly smaller and rural hospitals, the process of finding an accepting hospital for patients needing transfer is a huge burden that involves placing one phone call or digital request at a time. Authorization delays compound this burden by extending the time a patient requiring a higher level of care remains in an ED that cannot provide it, increasing the risk of adverse outcomes and potential EMTALA liability for the originating facility.

The federal government regulates ERISA plans and states regulate non-ERISA plans. No uniform federal standard currently exists specifically for emergency transfer and admission authorization response times, and there is no systematic public reporting requirement for insurer response times, denial rates, or authorization delays in the emergency transfer context.

ACEP has a long-standing position that insurer authorization processes must not interfere with the delivery of emergency care. The College's policy statement "Appropriate Interfacility Patient Transfer" states "payment for transport should not be retrospectively denied by insurance companies" and "agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer." Furthermore, if there is a disagreement regarding the need for post-stabilization care, the emergency physician who is evaluating the patient has the final authority to determine disposition of the patient.

ACEP's policy statement "Prior Authorization" states "prior authorization rules instituted by third party payers must not pose a barrier to patients seeking access to timely emergency care, and that an insured patient should be granted the expectation of coverage when seeking emergency care. ACEP further asserts that insurance companies have an

obligation to pay for necessary evaluation, stabilizing treatments, and/or appropriate consultation, admission, or transfer."

ACEP's policy statement "Protection of Emergency Physicians from Coercion in Patient Transfers" calls for the establishment of clear institutional and regulatory safeguards to protect emergency physicians from coercion and to promote ethical decision-making processes, which include policy enforcement, reporting mechanisms, accountability, education, and advocacy.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources, estimated 0.25 – 0.50 FTE, to develop policy positions, engage federal and state regulators, and monitor compliance reporting requirements. Additional committee and staff resources and outside legal or regulatory counsel may be needed. Estimated cost $30,000 – $75,000 for staff time, coalition engagement, and external support.

Prior Council Action

Amended Resolution 49(25) Support for EMTALA Reform to Ensure Timely Access to Definitive Care adopted. Directed ACEP to support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate and ensure that patients requiring transfer to a higher level of care are not inappropriately denied or delayed.

Substitute Resolution 36(24) EMTALA Reform to Improve Patient Access to Necessary Care adopted. Directed ACEP to collaborate with the Arizona and Connecticut Chapters and others to develop model state policy, regulation, and legislation, that requires reporting of ED/Hospital Crowding & Inter-Hospital Transfer data to a relevant state entity (e.g., State Dept of Health) and develop a statewide system to facilitate inter-facility transfers.

Amended Resolution 53(23) Treating Physician Determines Patient Stability adopted. Directed ACEP to adopt policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and develop an additional policy statement regarding the implications of coercion or threats of financial penalties to the emergency physician who has not personally evaluated the patient to coerce or threaten financial penalties to force the treating emergency physician to transfer a patient when the treating physician believes that the patient is unstable and such a transfer may compromise patient safety.

Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted. Directed ACEP to advocate for improvements to the EMTALA interhospital transfer process, including facilitating access to receiving facility information.

Prior Board Action

April 2026, approved the revised policy statement ""Third-party Payers and Emergency Medical Care;" revised and approved October 2020, April 2014, June 2007 with current title, July 2000, January 1999 titled "Managed Health Care Organizations and Emergency Care," and March 1993; originally approved September 1987, titled "Managed Health Care Plans and Emergency Care."

Amended Resolution 49(25) Support for EMTALA Reform to Ensure Timely Access to Definitive Care adopted.

April 2025, approved the policy statement "Protection of Emergency Physicians from Coercion in Patient Transfers."

Substitute Resolution 36(24) EMTALA Reform to Improve Patient Access to Necessary Care adopted.

Amended Resolution 53(23) Treating Physician Determines Patient Stability adopted.

Resolution 28(23) Facilitating EMTALA Interhospital Transfers adopted.

June 2023, approved the revised policy statement "Prior Authorization;" revised and approved April 2017, April 2010 and February 2003; originally approved October 1998.

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

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American College of Emergency Physicians®
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RESOLUTION: 26(26)

SUBMITTED BY: Louisiana Chapter
New York Chapter
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Addressing Insurer Bad Behavior

PURPOSE: Develop model legislation for chapters to combat the automatic or algorithmic downcoding of ED encounters, including downcoding facilitated by AI or similar evolving technology, and assist chapters in coordinating cross-state responses when insurer behaviors cross state lines,

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources, estimated 0.25 – 0.50 FTE, $30,000 – $60,000 annually, committee resources, and potential outside legal/legislative drafting costs of an additional $15,000 – $40,000.

WHEREAS, CMS sets insurance reimbursement standards that other commercial insurers often follow; and

WHEREAS, The 2023 CMS E/M coding guidelines state that E/M coding should not be based on the final diagnosis of an emergency department encounter; and

WHEREAS, "The Prudent Layperson Standard requires insurance companies to provide coverage for emergency care based on symptoms, not the final diagnosis."; and

WHEREAS, "90 percent of urgent and nonurgent symptoms overlap, and in many cases doctors don't know if your symptoms require emergency treatment without medical examination and testing;" and

WHEREAS, An increasing number of insurers are utilizing the Low Acuity Non-Emergent (LANE) algorithm, or similar, to automatically downcode emergency department encounters based on discharge diagnosis to a lower level E/M code, regardless of the risk factors or other complexity involved in the medical decision making of an encounter; and

WHEREAS, Algorithms used to code emergency department encounters based on discharge diagnosis have been shown to "lack congruence and are imperfect predictors of visit acuity;" and

WHEREAS, Some states have already drafted legislation to combat downcoding of medical encounters, including emergency department encounters, "without clear justification or transparency;" and

WHEREAS, Some states have already drafted legislation to combat the use of Artificial Intelligence to facilitate downcoding of medical encounters, including emergency department encounters; therefore be it

RESOLVED, That ACEP develop model legislation to be adapted for state legislative efforts to combat the automatic or algorithmic downcoding of medical encounters, including emergency department encounters; and be it further

RESOLVED, That ACEP develop model legislation to be adapted for state legislative efforts to combat the use of artificial intelligence or similar evolving technology used to facilitate the automatic or algorithmic downcoding of medical encounters, including emergency department encounters; and be it further

RESOLVED, That ACEP assist state chapters in coordinating efforts with other chapters when insurer behaviors cross state lines.

Resolution References

1. https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs
2. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
3. https://www.emergencyphysicians.org/article/access/prudent-layperson-standard
4. https://providers.highmark.com/content/dam/highmark/en/providerresourcecenter/rp-drafts/rp-037-de-pa-wv.pdf
5. https://providers.highmark.com/communications-hub/news-and-updates/low-acuity-non-emergent-professional-claim-review.html
6. Chen AT, Muralidharan M, Friedman AB. Algorithms identifying low-acuity emergency department visits: A review and validation study. *Health Serv Res*. 2022;57(4):979-989. doi:10.1111/1475-6773.14011
7. https://www.ilga.gov/Legislation/BillStatus?GAID=18&DocNum=3114&DocTypeID=SB&LegId=165735&SessionID=114
8. https://www.palegis.us/legislation/bills/2025/hb1925

Background

This resolution directs the College to develop model legislation for chapters to combat the automatic or algorithmic downcoding of emergency department encounters, including downcoding facilitated by artificial intelligence or similar evolving technology, and to assist chapters in coordinating cross-state responses when insurer behaviors cross state lines.

Insurer downcoding of emergency department evaluation and management (E/M) claims is a growing practice. Downcoding occurs when an insurer unilaterally changes the CPT code submitted by a provider to one of lower complexity or lower reimbursement. For example, an emergency physician may bill a 99285 (high-complexity visit), supported by documentation that meets or exceeds all required elements, yet the insurer may adjust the claim to a lower level. Insurers often justify this by claiming that the medical record did not support the higher code level, i.e., the patient was not as sick as initially thought after a full diagnostic workup, but these determinations are frequently made algorithmically, without any human review or clinical context. Since 2023, ED E/M level assignment under CMS guidelines is based solely on medical decision-making (MDM), rather than on a combination of history, exam, and MDM.

The legal foundation for opposing diagnosis-based downcoding is the Prudent Layperson Standard (PLP). Maryland enacted the first PLP law in 1993, and ACEP and the Emergency Department Practice Management Association (EDPMA) lobbied for federal protections beginning in the mid-1990s. The PLP standard was first enacted into federal law in the Balanced Budget Act of 1997 and made applicable to Medicare and Medicaid programs. As of 2026, 49 states and the District of Columbia have adopted a PLP law covering access to emergency medical care. Notwithstanding this broad legal framework, insurers have continued to try to reduce payments for emergency care they deem to be non-emergent. Some health insurance plans retrospectively deny or downcode claims for emergency department visits based on a patient's final diagnosis rather than the presenting symptoms. ACEP continues to advocate for a national prudent layperson emergency care standard that provides coverage based on a patient's presenting symptoms, rather than the final diagnosis.

The deployment of algorithmic and AI-driven tools by payers continues to increase downcoding and denials. An increasing number of insurers are utilizing the Low Acuity Non-Emergent (LANE) algorithm, or similar tools, to automatically downcode ED encounters based on discharge diagnosis to a lower-level E/M code, regardless of the risk factors or other complexity involved in the medical decision-making of the encounter. ACEP's advocacy record illustrates the stakes: in June 2021, ACEP condemned UnitedHealthcare's policy to retroactively and automatically deny patients' emergency care claims if the insurer determined via algorithm that the visit was not an emergency. After fierce scrutiny from ACEP, patient groups, and Congressional champions, the insurer walked back the policy in only six days. Despite that episode, algorithmic and AI-facilitated downcoding, as distinct from outright denial, has continued to spread across payers and states.

ACEP has previously developed model prudent layperson state legislation, approved by the Board in 2020, which included a provision that health plans must reimburse any undisputed amount while review of disputed portions of a claim is underway. However, that model legislation did not specifically address downcoding, and it predates the current generation of AI-assisted downcoding tools. This resolution identifies a gap in ACEP's existing legislative toolkit: the need for model language specifically targeting algorithmic and AI-facilitated downcoding of ED encounters, and for a

coordinated cross-state response mechanism when insurer behaviors cross state lines. Several states, including Illinois and Pennsylvania, have introduced legislation to address these practices. EDPMA has developed model downcoding legislation (2024) as well as the American Medical Association (2025) which could be used as a basis for ACEP's model legislation.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy. Connection:

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine..

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 3: Monitor and evaluate the impact of artificial intelligence, telehealth, and other emerging technologies on emergency care delivery and physician practice.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources, estimated 0.25 – 0.50 FTE, $30,000 – $60,000 annually, committee resources, and potential outside legal/legislative drafting costs of an additional $15,000 – $40,000.

Prior Council Action

Amended Resolution 56(25) Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions adopted. Directed ACEP to advocate for legislation requiring AI-assisted reimbursement denials or negative coverage decisions be reviewed and approved by qualified, board-certified physicians with no financial incentive for denials; to support prohibiting health insurers from relying solely on AI-based algorithms to downcode health care claims; and to collaborate with stakeholders to ensure AI algorithms used in health care decision-making are transparent, accountable, and subject to oversight by qualified health care professionals.

Amended Resolution 41(23) Use of Medical Coders in Payment Arbitration adopted. Directed ACEP to advocate for the use of qualified medical coders in the independent dispute resolution process under the No Surprises Act and to continue efforts to prevent insurer downcoding in the arbitration context.

Amended Resolution 29(21) Downcoding adopted. Directed ACEP to develop strategies to assist chapters in identifying if downcoding is occurring in their state; to work with CMS and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and to work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. Directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement, and to work with allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts, and to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal prudent layperson laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Prior Board Action

Amended Resolution 56(25) Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions adopted.

Amended Resolution 41(23) Use of Medical Coders in Payment Arbitration adopted.

June 2023, approved the revised policy statement "Fair Payment for Emergency Department Services" revised and approved June 2022 and April 2016; originally approved April 2009.

June 2023, approved the revised policy statement "Fair Reimbursement When Services are Mandated;" revised and approved April 2017 titled "Fair Coverage When Services ae Mandated;" reaffirmed April 2011 and September 2005; originally approved September 1992 titled "Compensation When Services are Mandated."

June 2023, approved the revised policy statement "Prior Authorization;" revised and approved April 2017, April 2010, and February 2003; originally approved October 1998.

Amended Resolution 29(21) Downcoding - Board adopted October 24, 2021.

June 2021, approved an RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on EMTALA-related mandates and associated reimbursement issues.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

April 2026, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved October 2020, April 2014, June 2007 with current title, July 2000, and January 1999 titled "Managed Health Care Organizations and Emergency Care," and March 1993; originally approved September 1987 titled "Managed Health Care Plans and Emergency Care."

February 2020, approved prudent layperson model state legislation stipulating that the health plan shall reimburse any undisputed amount while review of disputed portions of the claim is underway.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

Resolution 43(97) Prudent Layperson Legislation adopted 1997.

Background Information Prepared by: Adam Krushinskie
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Reviewed by: Michael J. McCrea, MD, FACEP
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Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

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American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

RESOLUTION: 27(26)

SUBMITTED BY: Washington Chapter

SUBJECT: Conditional Support for a Single-Payer Health Care Financing System

PURPOSE: Develop a policy statement of conditional support for a single-payer health care financing system, contingent upon adequate reimbursement for emergency services, meaningful medical liability reform, formal physician input into payment and governance, and provisions addressing physician educational debt; and to communicate this position to Congress and relevant stakeholders.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget to develop a policy statement, conduct stakeholder engagement, and communicate the position to Congress. Estimated 0.25 – 0.50 FTE annually, $40,000 – $80,000. Potential additional costs for consultant services to develop communication materials and assist with strategy development.

WHEREAS, ACEP has long affirmed that all Americans must have health care coverage and has advocated for universal access to quality emergency care as a fundamental principle of health care reform; and

WHEREAS, The current multi-payer health care financing system has failed to achieve universal coverage, leaving millions of Americans uninsured or underinsured, with emergency departments serving as the primary safety net for those without adequate coverage; and

WHEREAS, The evolving policy landscape, including federal legislation enacted in 2025, has substantially reduced Medicaid eligibility and funding, with projections indicating a significant increase in the number of uninsured Americans and a corresponding rise in uncompensated emergency care; and

WHEREAS, Emergency physicians are uniquely and disproportionately burdened by uncompensated care obligations under EMTALA, bearing a safety-net mission that imposes financial burdens not shared equitably across the health care system; and

WHEREAS, a single-payer financing model has the potential to address coverage gaps, reduce administrative burden, and ensure universal access to health care services including emergency care; and

WHEREAS, ACEP's Health Care Financing Task Force previously concluded that elements of single-payer systems strongly adhere to ACEP's core principles for health care reform, and that ACEP should continue to propose meaningful ideas for health care financing reform; and

WHEREAS, current single-payer proposals such as Medicare for All do not fully address inadequate Medicare payment rates, which have not kept up with inflation and do not fully cover the cost of providing emergency care, or meaningful liability reform, threatening the financial viability of emergency medicine practice; and

WHEREAS, ACEP has also advocated that any health care financing reform preserve physician autonomy, patient choice of provider, and access to graduate medical education funding; and

WHEREAS, Establishing a formal conditional policy position would provide ACEP with a principled framework for engaging with federal legislators, including sponsors of single-payer legislation, regarding the conditions under which ACEP could offer support, and would strengthen ACEP's voice in national health care financing debates; and

WHEREAS, ACEP has previously stated that "ACEP shall focus on securing access to coverage for our patients and their families for acute unscheduled care services in any health care financing model, including single payer," and a formal conditional policy position is consistent with that commitment; therefore be it

RESOLVED, That ACEP develop a policy statement of conditional support for a single-payer health care financing system, contingent upon the following criteria being met in any such legislation:

1) reimbursement rates for emergency services that fully cover the cost of providing care, including automatic inflation-based updates to prevent future erosion of payment adequacy;
2) inclusion of meaningful medical liability reform that reduces the burden of defensive medicine on emergency physicians and the health care system;
3) formal mechanisms for physician specialty organization input into payment rate-setting, benefit design, and program governance; and
4) provisions to address physician educational debt; and be it further

RESOLVED, That ACEP communicate conditional support for a single-payer health care system to Congress, including to sponsors of single-payer legislation, and engage with relevant stakeholders to advocate for the inclusion of specific criteria included in a policy statement developed by ACEP regarding single-payer in any single-payer proposal, consistent with ACEP's broader commitment to universal health care coverage and adequate reimbursement for emergency services.

Background

This resolution requests ACEP to develop a policy statement of conditional support for a single-payer health care financing system, contingent upon adequate reimbursement for emergency services, meaningful medical liability reform, formal physician input into payment and governance, and provisions addressing physician educational debt, and to communicate that position to Congress and relevant stakeholders.

The question of how the United States finances health care has been a recurring subject of ACEP Council debate for more than three decades. The current multi-payer system relies on a combination of employer-sponsored private insurance, public programs such as Medicare and Medicaid, and uncompensated care for those without coverage. Despite incremental expansions of public coverage, including the Affordable Care Act's Medicaid expansion, which as of June 2024 covered over 20 million people representing nearly a quarter of total Medicaid enrollment, millions of Americans remain uninsured or underinsured, and emergency departments continue to serve as the primary safety net for those without adequate coverage.

The policy landscape shifted significantly in 2025. The One Big Beautiful Bill Act (P.L. 119-21), signed into law on July 4, 2025, contains major changes to federal Medicaid financing, including community engagement (work) requirements for the ACA expansion population, a freeze and reduction of state provider tax authority, and other provisions that are projected to substantially reduce Medicaid enrollment. Independent analyses project that the law will result in approximately 10.5 to 16 million Americans losing health coverage, with a corresponding sharp rise in emergency department uncompensated care estimated at $18.9 billion nationally. ACEP issued statements in May and July 2025 warning that the legislation "will carry serious, long-term consequences for the emergency care safety net, the broader health care system, and most importantly, the patients we serve," and urging Congress to reject provisions that "would increase the number of uninsured, further strain emergency departments, and diminish the pipeline of future emergency physicians." ACEP joined coalitions of 42 and 31 national medical organizations, respectively, in letters to congressional leadership opposing the Medicaid changes. As of the date of this resolution, some legislators are seeking modifications to the law's Medicaid provisions, and further budget reconciliation action targeting federal health programs has not been ruled out.

Emergency physicians bear a disproportionate share of the uncompensated care burden created by coverage gaps. Under the Emergency Medical Treatment and Labor Act (EMTALA), emergency departments are legally required to screen and stabilize any patient who presents for care, regardless of ability to pay or insurance status. This obligation applies even as Medicaid and Medicare payment rates have not kept pace with the cost of providing care. ACEP's 2025 Leadership & Advocacy Conference highlighted continued financial threats to the viability of emergency medicine

through declining Medicare reimbursements that do not account for inflation, declining commercial payments, and Medicaid payment rates that are well below the costs of providing care. A 2025 RAND Corporation report, "Strategies for Sustaining Emergency Care in the United States," found that emergency departments offer significant value to stakeholders but that, because of the stresses EDs have faced over the past decade, the viability of emergency care as currently structured is at risk.

ACEP has long supported universal health care coverage as a foundational principle. The policy statement "Universal Health Care Coverage" states that all Americans must have health care coverage and that any benefit package must provide for timely, unrestricted access to quality emergency care. However, ACEP has historically distinguished universal coverage from a single-payer system specifically, noting that "ACEP's support of universal coverage is support of the concept that everyone in America should have insurance coverage of some sort (government or private) and that emergency physicians should be paid for the medical care they provide." In 2016, the Council directed ACEP to create a Health Care Financing Task Force to study alternative financing models, including single-payer. The task force concluded that ACEP "shall focus on securing access to coverage for our patients and their families for acute unscheduled care services in any health care financing model, including single payer," and identified nine principles – including access, budget, and physician input – against which any financing model should be evaluated. The task force studied the merits and weaknesses of single-payer systems and its report served as the foundation for the 2018 Council Town Hall Meeting. The Board reviewed an interim report in May 2018 and directed the task force to develop specific recommendations regarding elements of single-payer systems that should be adopted if ACEP decides to advocate for other types of health care financing reform.

Despite this body of prior work, ACEP has not adopted a formal policy position on single-payer financing. The Council has considered and declined to adopt outright support for single-payer on multiple occasions citing concerns about inadequate Medicare payment rates, physician autonomy, and the risk that government control over payment would leave physicians with limited recourse. This resolution does not ask ACEP to endorse any specific single-payer proposal and instead asks ACEP to articulate the conditions under which it could offer support, providing a principled framework for engagement with federal legislators, including sponsors of single-payer legislation such as Medicare for All. Conditional support tied to specific criteria represents a different posture than prior resolutions that sought unconditional endorsement, and that the conditions specified (adequate reimbursement, liability reform, physician input into rate-setting, and educational debt relief) reflect longstanding ACEP advocacy priorities that have not been satisfied by existing single-payer proposals.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1 – Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 4 – Evaluate the social and economic aspects of emergency medical care to inform advocacy positions and policy recommendations.

Objective 5 – Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget to develop a policy statement, conduct stakeholder engagement, and communicate the position to Congress. Estimated 0.25 – 0.50 FTE annually, $40,000 – $80,000. Potential additional costs for consultant services to develop communication materials and assist with strategy development

Prior Council Action

Resolution 37(19) Single-Payer Health Insurance not adopted. The resolution directed ACEP to support the adoption of a single-payer health insurance program that finances care for all Americans while fostering competition, preserving patient choice, and recognizing the essential value of emergency medicine and explore opportunities to partner with other organizations that favor single-payer approach to providing universal health care to all Americans.

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to establish a Health Care Financing Task Force to study alternative health care financing models, including single-payer, and provide a report to the 2017 Council.

Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Resolution 26(11) Single-Payer Universal Health Insurance not adopted. The resolution supported the adoption of single-payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The original resolution Supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a taskforce to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the Board to endorse the concept of a single-payer system for the United States, saying it would reduce administrative costs, thereby offsetting the costs of providing expanded coverage to the poor and uninsured.

Prior Board Action

January 2021, reaffirmed the policy statement "Universal Health Care Coverage;" reaffirmed June 2015; revised and approved August 2009; originally approved December 1999.

September 2018, accepted the final report of the Health Care Financing Task Force, established pursuant to Amended Resolution 19(16). The report was distributed to the Council and served as the foundation for the 2018 Council Town Hall Meeting.

Amended Resolution 19(16) Health Care Financing Task Force adopted.

Substitute Resolution 31(14) Financing Health Insurance adopted.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP's primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

Amended Resolution 38(94) Single-Payer System adopted.

Background Information Prepared by: Hanna Ahmaripour
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 28(26)

SUBMITTED BY: Maryland Chapter

SUBJECT: Creation of a Workgroup to Advance an ED-Based Medicare Three-Day Rule Waiver

PURPOSE: Create a member workgroup to develop an actionable ED-based Medicare Skilled Nursing Facility 3-day rule waiver proposal using existing CMS waiver models and quality safeguards, and prepare that proposal for submission to PTAC, CMMI, CMS, HHS, or another appropriate federal pathway, with the goal of allowing eligible Medicare beneficiaries to transfer directly from the ED or observation setting to skilled nursing, rehabilitation-capable SNF, or swing-bed care without an avoidable inpatient admission.

FISCAL IMPACT: Creation of a workgroup is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Depending on the scope of the total work, forming and staffing a member workgroup, developing a waiver proposal, and engaging federal agencies (PTAC, CMMI, CMS, HHS) would require an estimated 200-400 staff hours annually, approximately $20,000 – $40,000 in staff time, plus potential outside health policy or legal consultant costs of $15,000 – $50,000. Total estimated range: $35,000 – $90,000 with ongoing staff support.

WHEREAS, Emergency Department boarding remains a national crisis that harms patients, worsens hospital crowding, increases costs and contributes to emergency physician and staff burnout; and

WHEREAS, The 61-year-old Medicare Skilled Nursing Facility three-day rule may force medically stable ED or observation patients into avoidable inpatient admissions solely to qualify for post-acute skilled nursing or rehabilitation care and does not reflect modern medical practice; and

WHEREAS, CMS already permits three-day rule waivers in selected models, including MSSP/ACO REACH and TEAM as waiver pathways, certain Accountable Care Organizations and episode-based payment models, demonstrating that the rule can be waived with appropriate safeguards; and

WHEREAS, Existing waiver pathways are limited to accountable care and bundled-payment arrangements initiated by an inpatient or outpatient procedure, and no current CMS model authorizes a three-day rule waiver triggered by an Emergency Department or observation-setting disposition, leaving a gap that directly affects ED boarding; and

WHEREAS, Multiple evaluations of Medicare's waiver of the three-day qualifying stay requirement during the COVID-19 pandemic found that eliminating the requirement increased flexibility in patient placement, reduced unnecessary inpatient utilization, and did not result in increased Medicare expenditures, with several analyses demonstrating overall cost savings through reduced hospital use; and

WHEREAS, ACEP has repeatedly supported repeal or reform of the three-day rule, but emergency physicians and patients still lack a practical ED-based waiver pathway; therefore be it

RESOLVED, That ACEP create a member workgroup, with appropriate staff support, to develop an actionable Emergency Department–based Medicare Skilled Nursing Facility three-day rule waiver proposal using existing CMS waiver models, safeguards, and quality requirements for submission to Physician-Focused Payment Model Technical Advisory Committee (PTAC), the Center for Medicare and Medicaid Innovation (CMMI), the Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health and Human Services (HHS), or another appropriate federal pathway, with the goal of allowing participating hospitals to transfer eligible Medicare beneficiaries directly from the

Emergency Department or observation setting to appropriate skilled nursing, rehabilitation-capable skilled nursing, or swing-bed care without an avoidable inpatient admission.

Background

This resolution directs ACEP to create a member workgroup, with appropriate staff support, to develop an actionable Emergency Department-based Medicare Skilled Nursing Facility (SNF) three-day rule waiver proposal using existing CMS waiver models, safeguards, and quality requirements, and to prepare that proposal for submission to PTAC, CMMI, CMS, HHS, or another appropriate federal pathway.

The Medicare three-day inpatient stay requirement as a prerequisite for SNF coverage has been part of Medicare since its inception in 1965, codified in Section 1861(i) of the Social Security Act. The rule requires that a Medicare beneficiary be hospitalized as an inpatient for at least three consecutive calendar days, not counting time spent in the emergency department or under outpatient observation status, before Medicare will cover post-acute skilled nursing or rehabilitation care. As medical practice has evolved over six decades, this requirement has increasingly been recognized as an arbitrary, time-based threshold that no longer reflects modern clinical practice or care delivery. Acute and chronic medical care previously rendered almost exclusively in the inpatient hospital setting is now routinely delivered in SNFs, rehabilitation hospitals, or at home. The rule operates today as a structural barrier to appropriate patient disposition from the emergency department, compelling avoidable inpatient admissions for patients who are medically stable and appropriate for SNF-level care but cannot access that care without first satisfying the three-day inpatient requirement.

ED boarding is the practice of holding admitted patients in the emergency department because no inpatient beds are available and it is a major patient safety issue and a primary driver of ED overcrowding. The three-day rule compounds the boarding problem by creating a category of patients who must be admitted to the hospital not because their clinical condition requires inpatient care, but solely to qualify for Medicare SNF coverage. This dynamic consumes inpatient beds, extends ED boarding times, increases costs, and contributes to emergency physician and staff burnout. ACEP has identified removal of the three-midnight rule as a key policy solution for addressing ED boarding in its Policy Solutions to ED Boarding document.

CMS has repeatedly demonstrated that care quality and program integrity can be maintained without the three-day requirement. CMS currently permits three-day rule waivers for certain Accountable Care Organizations participating in the Medicare Shared Savings Program (MSSP) in advanced performance-based risk tracks, allowing health care providers to admit a beneficiary to a SNF directly from the community or after only one or two days in a hospital. A report published by CMMI found that average SNF length of stay for direct and one-to-two-day stays was consistently lower than non-waiver SNF stays, and that adverse outcome rates for direct waiver stays and one-to-two-day stays were consistently lower than or similar to three-day non-waiver stays overall. CMS has also waived the requirement in multiple CMMI alternative payment models, including the Next Generation ACO model and, most recently, the Transforming Episode Accountability Model (TEAM). During the COVID-19 public health emergency, CMS broadly waived the three-day requirement nationwide pursuant to Section 1812(f) and Section 1135 authority. A 2026 study published in JAMA Internal Medicine (Chen et al., Brown University School of Public Health) examined changes in inpatient and SNF care following the reinstatement of the three-day rule after the public health emergency ended in May 2023, finding that reinstatement was associated with increases in inpatient admissions and changes in SNF utilization patterns, providing direct empirical evidence that the rule drives avoidable hospitalizations. In all waiver contexts, participating organizations reported improved care transitions, reduced costs, and improved or maintained quality outcomes.

A critical gap remains: no current CMS model authorizes a three-day rule waiver triggered specifically by an Emergency Department or observation-setting disposition. Existing waiver pathways are limited to accountable care and bundled payment arrangements initiated by an inpatient or outpatient procedure. This ED specific gap directly affects boarding, as patients who are medically stable and appropriate for SNF level care cannot be transferred directly from the ED or observation setting to skilled nursing, rehabilitation-capable SNF, or swing-bed care without an avoidable inpatient admission. Because the three-day requirement is set in statute, CMS lacks authority to permanently eliminate it through rulemaking; permanent elimination requires congressional action. However, CMS

retains authority to waive the requirement under CMMI's Section 1115A authority, making a PTAC or CMMI submission a viable near-term pathway for an ED-based waiver model.

Elimination of the three-day rule has been a priority on ACEP's legislative and regulatory agenda for approximately 20 years. ACEP has supported every congressional proposal and related regulatory action to rescind or ameliorate the rule's effects, including the bipartisan Improving Access to Medicare Coverage Act (H.R. 3954/S. 4641), which would count time spent under observation status toward the three-day requirement. While there is significant industry and stakeholder support for changing this policy, Congress has not yet acted on this legislation. Legislators and advocates had hoped that CMS would make the COVID-19 public health emergency waiver permanent, but CMS indicated it did not have the authority to do so, and the waiver expired with the end of the public health emergency declaration in May 2023. As there is now a greater body of evidence from the pandemic experience that revising the three-day stay rule leads to better outcomes for patients without increasing costs, ACEP and coalition advocates have renewed the push for Congress to act.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy. Connection:

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine..

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 1: Identify and support the practice models for emergency physicians that expand the field of acute, unscheduled care.

Objective 2: Support the creation of innovative practice models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

Creation of a workgroup is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Depending on the scope of the total work, forming and staffing a member workgroup, developing a waiver proposal, and engaging federal agencies (PTAC, CMMI, CMS, HHS) would require an estimated 200-400 staff hours annually, approximately $20,000 – $40,000 in staff time, plus potential outside health policy or legal consultant costs of $15,000 – $50,000. Total estimated range: $35,000 – $90,000 with ongoing staff support.

Prior Council Action

Resolution 24(24) Address ED Boarding and the Medicare Three-Midnight Rule for Post-Acute Rehabilitation adopted. The resolution directed ACEP to prioritize advocacy to have the Medicare three-midnight rule for skilled nursing placement removed, citing its compounding effects on the ED boarding crisis and its obsolescence relative to modern medical practice.

Resolution 25(15) Medicare 3-Day Rule not adopted. Requested that ACEP develop a paper describing the barriers of the Medical 3- Day Rule, the costs it creates for the health care system and costs that are often transferred to patients; partner with the AMA and other organizations to develop the paper and work together to eliminate the rule and make elimination of the rule a top legislative priority.

Amended Resolution 36(05) Medicare Requirement of Three-Night Hospital Stay referred to the Board of Directors. As amended, the resolution directed ACEP to work to amend Medicare legislation to eliminate the three-night hospital stay requirement as a prerequisite for skilled care facility coverage, engage other health care organizations to persuade Congress, work with CMS to create screening criteria for appropriate placement of Medicare patients in skilled care facilities directly from EDs, and develop a policy statement for appropriate and timely placement of patients in skilled care facilities directly from emergency departments or following short stay admissions.

Prior Board Action

January 2025, approved the legislative and regulatory priorities for the first session of the 119th Congress, which continued to include encouraging the use of waivers to restrictive payment policies such as the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency.

March 2024, February 2023, January 2022, and January 2021, approved supporting legislation to rescind the Medicare 3-day inpatient stay before becoming eligible for Skilled Nursing Facility (SNF) services and encouraging the use of waivers to restrictive payment policies such as the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency.

February 2020, approved supporting legislation to rescind the Medicare 3-day inpatient stay before becoming eligible for SNF services and encouraging the use of waivers to restrictive payment policies such as the 3-day SNF rule.

January 2019, approved supporting waivers to the 3-day SNF rule that are included in Medicare payment models.

February 2018, January 2017, and February 2016, approved supporting expanded exemption for integrated payment models regarding Medicare policy that requires a 3-day inpatient stay before becoming eligible for SNF services.

January 2015, January 2014, and February 2013, approved supporting legislation to rescind the Medicare 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January 2012, approved continuing advocacy efforts to count time in observation toward the Medicare 3-day stay rule, and/or waiving the rule for ACOs.

January 2011, approved continuing advocacy efforts to count time in observation toward the Medicare 3-day stay rule.

September 2008, approved a moderate commitment of resources to continue efforts with key stakeholders, such as AARP, nursing homes, and beneficiary groups, to advocate for a change in the Medicare 3-day stay law.

August 2007, supported continuing state and federal advocacy efforts to rescind the Medicare 3-day stay rule.

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Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 29(26)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Federal Tax Relief for EMTALA-Mandated Care

PURPOSE: Advocate for federal legislation providing targeted tax relief for income derived from EMTALA-mandated care, recognizing such care as a federally required public service.

FISCAL IMPACT: Expanding current federal advocacy initiatives regarding EMTALA-mandated care would require diverting budgeted resources from other work or including funds in the next fiscal year budget. Additional unbudgeted annual costs of $25,000 – $75,000+ for consultants with expertise in physician compensation and taxation would be required to research, author, and conduct an intensive legislative campaign to advocate for changes to tax law.

WHEREAS, The Emergency Medical Treatment and Labor Act (EMTALA) is a federal statute that mandates hospitals and physicians to provide emergency medical screening, stabilization, and transfer services regardless of a patient's insurance status or ability to pay; and

WHEREAS, EMTALA represents a unique and ongoing unfunded federal mandate compelling emergency physicians, on-call specialists, and hospitals to deliver immediate, life-saving care as an essential public service; and

WHEREAS, EMTALA-mandated care is frequently uncompensated or undercompensated, and payment is often delayed or denied, despite rising patient acuity and clinical complexity; and

WHEREAS, Emergency physician compensation has not kept pace with inflation due to decreasing reimbursement rates, increasing administrative burden, workforce shortages, and rising practice costs, despite increasing demand for emergency services; and

WHEREAS, Hospitals across the United States are experiencing growing difficulty in securing specialty on-call coverage for EMTALA-mandated care, threatening timely access to emergency and specialty services; and

WHEREAS, EMTALA-mandated emergency care functions as critical national healthcare infrastructure and a foundational component of the country's public health and safety net; and

WHEREAS, Federal tax policy routinely provides exemptions, credits, and preferential treatment to corporations and industries to offset the costs of activities deemed essential to national priorities or required by law; and

WHEREAS, The federal government regularly uses the tax code as a policy tool to recognize and support mandated essential activities without increasing direct government spending; and

WHEREAS, Emergency physicians, on-call consultants, and hospitals providing EMTALA-mandated care receive no analogous tax recognition for income derived from fulfilling this federally required obligation; and

WHEREAS, Targeted federal tax relief for EMTALA-mandated care would represent a fiscally responsible approach to workforce stabilization and access preservation without increasing patient costs or requiring higher reimbursement from public or private payers; therefore be it

RESOLVED, That ACEP advocate for federal legislation providing targeted tax relief for income derived from EMTALA-mandated care, recognizing such care as a federally required public service.

Background

This resolution asks the College to advocate for federal legislation providing targeted tax relief for income derived from EMTALA-mandated care, recognizing such care as a federally required public service obligation.

Emergency departments are unique in that anyone who has an emergency must be treated or stabilized, regardless of their insurance status or ability to pay, which is a protection made possible by the Emergency Medical Treatment and Labor Act (EMTALA). Emergency physicians are firmly committed to providing care for everyone who needs it, but a large portion of that care goes uncompensated and undercompensated, frequently leaving physicians with unrecouped losses that add layers of complexity and resource constraints to an already difficult job. Nearly 70% of emergency care services are uncompensated or undercompensated, with the April 2025 RAND Report, "Strategies for Sustaining Emergency Care in the United States" noting that "20% of all U.S. ED physician expected payments went unpaid across all payer types, totaling roughly $5.9 billion per year of unpaid ED physician services." Despite this longstanding federal mandate, emergency physicians, on-call specialists, and hospitals receive no corresponding tax recognition for income earned in fulfillment of this obligation, even as federal tax policy routinely provides exemptions, credits, and preferential treatment to other industries and activities deemed essential to national priorities.

The financial burden of EMTALA compliance is substantial and well documented. The increasing costs of complying with EMTALA requirements have created ongoing financial burdens for physicians and hospitals, as many of the patients screened and stabilized are either uninsured or underinsured. Managed care plans and the Medicaid and Medicare programs have a history of denying claims for emergency services as well, in spite of the inclusion of prudent layperson language for both programs in the Balanced Budget Act of 1997. Data from 2000 show that emergency physicians reported 61 percent of their bad debt was related to EMTALA-mandated care, and for 27.7 percent of emergency physicians, EMTALA was the only source of bad debt. Across all specialties, EMTALA-related bad debt amounted to $12,300 per self-employed physician in 2000, or nearly $4.2 billion in the aggregate. Efforts to have EMTALA compliance costs recognized and funded in the Medicare physician fee schedule as a legitimate practice expense have been unsuccessful. The combination of growth in emergency department volume, closure of emergency departments across the nation, significant reductions in physician payment under the Medicare fee schedule, and large increases in costs of medical liability coverage have combined to stretch the resources of the emergency medical system to the breaking point.

The on-call specialist crisis compounds the problem. The growing liability exposure and subsequent premiums associated with EMTALA-mandated services threaten to reduce the availability of emergency and on-call physicians in communities. Without relief, the nation will continue to see sharp declines in on-call specialist availability and the relocation of emergency physicians to areas of the country where the liability environment is more favorable. The tax code approach proposed in this resolution is distinct from prior legislative efforts focused on direct reimbursement or liability protection by using the federal tax system, a tool the government regularly deploys to recognize and support mandated essential activities, to offset the economic burden of EMTALA compliance without increasing direct government spending or patient costs.

ACEP has a long history of advocating for legislative and regulatory remedies to address uncompensated and undercompensated EMTALA-mandated care. In addition to efforts to secure funding for EMTALA-mandated services through the physician fee schedule, ACEP has been involved in a number of coalition efforts to address various aspects of EMTALA requirements, enforcement, and payment issues. ACEP's policy statement "Fair Reimbursement When Services Are Mandated" supports the principle that any entity mandating a service should also mandate an adequate source of funding for that service. This concept has also been explored by the ACEP Federal Government Affairs (FGA) Committee in the 2025-26 committee year in fulfilling its annual objectives, and has developed a policy paper on this proposal (among many others) to help augment ongoing federal advocacy. These policy papers are pending review and approval by the Board of Directors.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 4: Evaluate the social and economic aspects of emergency medical care to inform advocacy positions and policy recommendations.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Fiscal Impact

Expanding current federal advocacy initiatives regarding EMTALA-mandated care would require diverting budgeted resources from other work or including funds in the next fiscal year budget. Additional unbudgeted annual costs of $25,000 – $75,000+ for consultants with expertise in physician compensation and taxation would be required to research, author, and conduct an intensive legislative campaign to advocate for changes to tax law.

Prior Council Action

Resolution 27(11) Tax Relief for Uncompensated/Undercompensated Medical Care referred to the Board of Directors. It directed ACEP to investigate avenues for federal tax relief for medical professionals providing services to uninsured and underinsured patients. Extensive testimony was heard overwhelmingly in favor of the concept; the referral was intended to give the Board flexibility to determine the most appropriate timing and approach.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted. Directed the College to seek federal legislation to fund uncompensated EMTALA-mandated medical services and to form a coalition including the AMA and other medical organizations to lobby for new funds addressing physician costs of complying with EMTALA requirements.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Called for ACEP to champion the principle that emergency care is an essential public service.

Amended Resolution 11(92) Payment for Mandated Services adopted. Directed the College to support that any government agency, legislative body, insurance carrier, third party payer, or any other entity which mandates that a service or product be provided by emergency physicians or other providers, also mandate an adequate source of funding to ensure appropriate compensation for those services or products and to pursue appropriate legislation to ensure that any governmental agency, legislative body, insurance carrier, third party payer, or any other entity which mandates the provision of medical services or products, also provides for appropriate compensation for that service or product.

Prior Board Action

June 2023, approved the revised policy statement "Fair Reimbursement When Services Are Mandated" with the current title; revised and approved April 2017 titled "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005; originally approved June 1999 titled "Compensation When Services Are Mandated."

April 2012, reaffirmed ACEP's commitment to continue advocacy efforts on uncompensated/undercompensated EMTALA care following referral of Resolution 27(11) Tax Relief for Uncompensated/Undercompensated Medical Care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Director, Federal Government Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 30(26)

SUBMITTED BY: Government Services Chapter

SUBJECT: Inclusion of Physicians as Protected Persons Eligible for Personal Information Protections Online

PURPOSE: Develop model legislation for states to include emergency physicians among the categories of protected persons eligible for personal-information protections, including public records home address exemptions, anti-doxxing statutes, and address confidentiality programs.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Developing model legislation will require staff time (estimated 0.10 – 0.20 FTE), potential engagement of outside legislative counsel or a legal vendor to draft and review model statutory language, and committee resources. Estimated costs range $15,000 – $40,000, depending on the scope of legal review and the number of state-specific variations developed.

WHEREAS, Emergency physicians experience high rates of threats and violence — and this risk increasingly includes off-premises harassment directed at physicians and their families enabled through the publication of home addresses and other personal information online; and

WHEREAS, Workplace violence statistics rank health care practitioners, including emergency physicians, among the occupational groups with the highest rates of workplace violence, along with protective service occupations such as law enforcement, judges and social workers; and

WHEREAS, Data brokers and other entities aggregate and make readily available the home addresses, telephone numbers, and other personal information of physicians, creating a pathway by which anyone can locate and target emergency physicians away from the workplace; and

WHEREAS, A growing number of states protect law enforcement officers, judges, and prosecutors from disclosure of their home addresses through public records exemptions and anti-doxxing protected person statutes, and several states have extended comparable protections to health care workers, including Colorado's House Bill 22-1041 (2022), which added health care workers to a protected persons framework originally established for peace officers; and

WHEREAS, ACEP currently has no policy addressing physician personal information exposure, or doxxing, and existing health worker protections in many states remain limited to reproductive health or public health contexts rather than emergency physicians generally; therefore be it

RESOLVED, That ACEP develop model legislation for states to include emergency physicians among the categories of protected persons eligible for personal information protections, including public records home address exemptions, anti-doxxing statutes, and address confidentiality programs, under applicable state and federal law.

Background

This resolution asks the College to develop model legislation for states to include emergency physicians among the categories of protected persons eligible for personal information protections online, including public records home address exemptions, anti-doxxing statutes, and address confidentiality programs.

Emergency physicians face well documented and escalating rates of workplace violence, and that threat is increasingly extending beyond the hospital walls. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at work, with the majority of those assaults occurring within the previous year. In a follow-up ACEP survey in 2022, 85% of emergency physicians indicated that they believe the rate of violence experienced in emergency departments has increased over the past five years. A poll of members in January 2024 found that 91% of emergency physicians reported that they or a colleague were victims of violence in the past year, with ACEP gathering more than 800 troubling stories directly from emergency physicians highlighting the prevalence of workplace violence in emergency settings.

The threat environment has expanded beyond the physical workplace through the practice of doxxing, which is the purposeful release of personal information on the internet with the intent to harm. Doxxing comes from the concept of "document tracing" or collecting documents to learn more about a person or company; generally, any personal information, even if publicly available, that is released with the intent to harm falls under the umbrella of doxxing. Doxxing can have long-term impacts on victims due to the release of sensitive personal information, and may cause distress, identity theft, or even physical abuse and violence. Physicians have been the target of doxxing due to increased focus on healthcare during prominent events such as the COVID-19 pandemic. Doxxing, which can mean publishing private information such as doctors' home addresses or license numbers online, is also a problem, and can include contacting doctors' employers and licensing boards. In response to the increasing number of threats to physicians and healthcare systems, three organizations representing more than 270,000 physicians sent a letter in October 2022 to Attorney General Merrick Garland requesting the Department of Justice to investigate those making threats to physicians.

The AMA's Women Physicians Section introduced a resolution at the 2024 AMA Interim Meeting (Resolution 002, I-24) calling for anti-doxxing data privacy protections for physicians, reflecting growing recognition across organized medicine that the existing legal framework is inadequate to protect physicians from targeted personal information exposure.

The legislative landscape for doxxing protections is fragmented and uneven. While some states criminalize or provide civil actions in response to doxxing by name (Alabama, Arkansas, Illinois, Washington), others target unconsented disclosure of private and personally identifying information without using the term "doxxing" (Arizona, California, Kentucky, Nevada, Oregon, Texas, Utah, Virginia), and still others criminalize doxxing only for certain professions or population subgroups (Colorado, Minnesota, Oklahoma, West Virginia). Thirteen states have adopted statutes to protect members of the public and/or those in certain professional occupations from doxxing; ten states protect all persons, Minnesota applies only to law enforcement officials, and Colorado and Oklahoma apply to a specific list of government officials. Colorado's law includes protections for "public health workers" and Oklahoma's law applies to "public health officials." Ohio law requires public records of designated public service workers, including EMTs, medical director or member of a cooperating physician advisory board of an emergency medical service organization, emergency service telecommunicator, forensic mental health provider, mental health evaluation provider, regional psychiatric hospital employee, to be confidential (Section 149.43). Emergency physicians are not specifically enumerated as a protected class in any state's doxxing or protected person statute identified in available research.

ACEP does not currently have a policy statement addressing physician personal information exposure or doxxing. The Florida College of Emergency Physicians strongly supported Florida's SB 268/HB 251, which would have created an exemption for personal identifying and location of current or former emergency physicians and their spouses and children, including home address, phone number, dates of birth, places of schooling or employment, and photographs; however, the bills did not move forward. The "Protection from Violence and the Threat of Violence in the Emergency Department" policy statement addresses workplace safety measures within the ED environment, but that policy does not extend to off premises personal information protections. Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts, and ACEP has helped inform and supports the "Workplace Violence Prevention Act for Health Care and Social Service Workers" (H.R. 2663/S.1176), which would compel OSHA to issue federal standards requiring health care and social service employers to create and implement workplace violence prevention plans. However, no model legislation addressing protected person status, address confidentiality, or anti-doxxing protections specifically for emergency physicians has been developed to date.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting budgeted committee and staff resources from other work to support this effort or include funds in the next fiscal year budget. Developing model legislation will require staff time (estimated 0.10 – 0.20 FTE), potential engagement of outside legislative counsel or a legal vendor to draft and review model statutory language, and committee resources. Estimated costs range $15,000 – $40,000, depending on the scope of legal review and the number of state-specific variations developed.

Prior Council Action

The Council has discussed and adopted many resolutions pertaining to workplace violence. There have been no previous resolutions submitted addressing physician personal information protections, doxxing, or protected person status for emergency physicians.

Resolution 70(25) Mandated Reporting of ED Violence not adopted. Directed ACEP to partner with other organizations to develop an ED violence reporting system and facilitate collection of violence prevention initiatives implemented by hospitals and health systems and develop best practices

Amended Resolution 41(24) Workplace Violence Data Collection adopted. Directed ACEP to advocate for and support the ability of victims and witnesses to report workplace violence events without repercussion and recriminations and create a mechanism for tracking workplace violence reports to help identify the scope of the problem.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted. Directed ACEP to advocate for legislation at the state and federal level that includes clear language outlining consequences for those who assault a healthcare worker at the workplace.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state, and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Prior Board Action

Amended Resolution 41(24) Workplace Violence Data Collection adopted.

Amended Resolution 35(22) Workplace Violence Towards Health Care Workers adopted.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997.

Resolution 55(17) Workplace Violence adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Background Information Prepared by: Brianna Hanson, MPH
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Reviewed by: Michael J. McCrea, MD, FACEP
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American College of Emergency Physicians®
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RESOLUTION: 31(26)

SUBMITTED BY: Illinois College of Emergency Physicians
Washington Chapter

SUBJECT: Protecting International Medical Graduates and Ensuring Stability of the Emergency Medicine Workforce

PURPOSE: Affirm ACEP's commitment to protecting the legal immigration status and continued medical training of IMGs; advocate and support any federal or state immigration policy, rule, or enforcement action that does not disrupt, terminate, or jeopardize the visa status, training continuity, or employment of physicians in training or attending physicians holding international status; and engage with the relevant federal agencies to establish clear, durable protections for physicians in training, attending physicians, and medical students holding international status.

FISCAL IMPACT: Staff resources for ongoing advocacy work within existing budgeted federal and state advocacy initiatives to monitor immigration policy developments, engage with federal agencies, coordinate coalition efforts, and develop member communications. Estimated ongoing staff resource commitment of 0.10 – 0.20 FTE annually, $15,000 – $30,000, within current budgeted advocacy staff resources. Expanding the scope of engagement to include dedicated legislative outreach campaigns, external legal review and/or policy consultants, coalition participation, or new member-facing resources would require additional unbudgeted costs and unbudgeted 0.25 – 0.50 FTE, $50,000 – $75,000.

WHEREAS, International Medical Graduates (IMGs) constitute a vital component of the United States physician workforce and provide essential healthcare services in emergency departments, rural communities, underserved urban areas, and safety-net hospitals; and

WHEREAS, Many IMGs practice medicine under employment-based visas, including J-1 waiver programs, H-1B visas, and other immigration pathways that are subject to changing federal immigration policies and administrative practices; and

WHEREAS, Delays in visa processing, travel restrictions, administrative barriers, changes in immigration policy, and uncertainty regarding work authorization can disrupt physician recruitment, retention, and access to care; and

WHEREAS, Emergency medicine relies on a stable and adequately staffed workforce to provide timely, high-quality, and lifesaving care to patients regardless of geographic location, socioeconomic status, or insurance coverage; and

WHEREAS, Current immigration policies affect the ability of foreign-trained physicians to continue practicing if they or one of their family members are subject to new immigration standards; in some areas of the country, especially rural and underserved parts of our country, a foreign-trained physician may be the only provider available to treat a particular disease or condition, and if physicians in these areas have issues with their immigration status and are forced to leave, serious access issues could occur, exacerbating the physician shortages that already plague these communities; and

WHEREAS, In early 2026, the administration halted visa renewals, including H-1B visas, J-1 Visas and green card processing; and

WHEREAS, The impact of halting visa renewals has led to medical students and residents being pulled from rotations, practicing physicians being placed on administrative leave, detainment of resident and practicing physicians

across multiple specialties, and deportation due to visa cancellations and renewal delays, in addition to significant financial burden due to exorbitant fees to proceed with processing; and

WHEREAS, ACEP and the Emergency Medicine Residents' Association (EMRA) released a statement on the detention of an emergency medicine resident advocating for the approval of a national-interest exemption for medical students, residents and fellows, and physicians; and

WHEREAS, ACEP joined a coalition of 22 other medical societies to call for an exemption to the visa pause issued against citizens of 75 countries with the visa processing freeze for foreign physicians was lifted in May 2026; and

WHEREAS, The delay in visa processing is also impacting physician and resident recipients of Deferred Action for Childhood Arrivals (DACA), highlighting that the administrative backlog has resulted in continued delays for employment and visa renewals, which in turn has interrupted care for vulnerable patient populations and further exacerbated the growing physician shortage, especially in rural and underserved communities. This could also affect residency training pipelines and ED staffing; and

WHEREAS, New legislation is being proposed that directly impacts IMGs, requiring hospitals receiving Medicare funding for graduate medical education (GME) to report the citizenship and immigration status of their medical residents and to prohibit Medicare from funding GME costs attributable to non-citizens or non-nationals; therefore be it,

RESOLVED, That ACEP affirm its commitment to protecting the legal immigration status and continued medical training of international medical graduates who are medical students, physicians in training, or attending physicians; and be it further

RESOLVED, That ACEP continue to advocate and support any federal or state immigration policy, rule, or enforcement action that does not disrupt, terminate, or jeopardize the visa status, training continuity, or employment of physicians in training or attending physicians holding international status, particularly when such disruption would harm patient access to emergency care; and be it further

RESOLVED, That ACEP continue to engage with the relevant federal agencies to establish clear, durable protections for physicians in training, attending physicians, and medical students holding international status; including protections against abrupt visa revocation, deportation proceedings, or enforcement actions that would interrupt patient care or graduate medical education.

Background

This resolution asks the College to affirm its commitment to protecting the legal immigration status and continued medical training of international medical graduates (IMGs) serving as medical students, residents, and attending physicians; advocate and support any federal or state immigration policy, rule, or enforcement action that does not disrupt, terminate, or jeopardize the visa status, training continuity, or employment of physicians in training or attending physicians holding international status; and engage with the relevant federal agencies to establish clear, durable protections for physicians in training, attending physicians, and medical students holding international status.

IMGs are a critical component of the U.S. physician workforce. Foreign-born physicians make up approximately one in four U.S. physicians overall, and an estimated 20% of the entire health care workforce is foreign-born. IMGs are disproportionately represented in rural communities, underserved urban areas, and safety-net hospitals – precisely the settings where physician shortages are most acute. Many practice under employment-based visas, including J-1 waiver programs and H-1B visas. The J-1 waiver program, administered through the U.S. Department of Health and Human Services Exchange Visitor Program, allows foreign physicians to remain in the country after training in exchange for a commitment to work in Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs) for at least three years – a pipeline that directly addresses access-to-care gaps in communities that emergency medicine disproportionately serves.

Beginning in 2025, the Administration undertook a significant escalation of immigration enforcement, taking more than 500 immigration-related actions in the first year of the second term, including mass deportations, suspension of refugee admissions, and removal of legal status from some immigrants already in the country. A travel ban first issued in June 2025 covering 19 countries was expanded in January 2026 to cover 39 countries, freezing visa extensions, work permits, and green card adjudications for nationals of those countries. Unlike the travel ban from the first Trump term, this policy applied to people already living and working in the United States, creating significant disruption for physicians, hospitals, and patients who had built plans around stable immigration timelines. Thousands of foreign physicians were placed on administrative leave, faced losing their work authorization, or were detained after falling out of status while waiting on U.S. Citizenship and Immigration Servies (USCIS) to process their cases. Medical students and residents were pulled from rotations, and practicing physicians were placed on administrative leave or subjected to detainment and deportation proceedings due to visa cancellations and renewal delays.

The J-1 waiver program was separately affected by an administrative backlog at HHS that developed in late 2025 and into 2026. In recent years, HHS reviewed waiver applications in one to three weeks; by early 2026, a backlog of hundreds of applications had accumulated, with applications still needing review by the State Department and approval by USCIS. Immigration attorneys warned that hundreds of foreign physicians completing training would have to leave the country if applications were not processed by a July 30 deadline, and that for them to reenter the U.S., their employers would have to pay a new $100,000 fee associated with the H-1B work visa - a cost many rural and underserved-area hospitals and clinics said they could not afford. As one immigration attorney noted, “the taxpayers who pay for that training will not get the benefit of it.”

In late April 2026, USCIS confirmed that physicians are exempt from the processing hold tied to the 39-country travel ban, and that applications associated with medical physicians would continue processing. However, the broader travel ban restrictions remain in force, the exemption was issued through an informal website update with no *Federal Register* notice and can be reversed the same way it was created, and the J-1 waiver backlog at HHS has not been fully resolved. Administrative backlogs continue to cause delays in employment and visa renewals, interrupting care for vulnerable patient populations and exacerbating physician shortages in rural and underserved communities.

The immigration enforcement environment has also produced a parallel threat to health care access: a recent New York Times/KFF survey found that nearly half of undocumented adults have skipped medical care since January 2025 over concerns about immigration status, and 14% of immigrants with legal status are also avoiding the doctor. Patient no-shows are up as much as 30% in some settings, compounding staffing and care-delivery pressures on emergency departments. Researchers and health care providers have described these enforcement actions as posing twin threats to the health care system - deterring patients from seeking care while simultaneously depleting the foreign-born workforce that delivers it.

Deferred Action for Childhood Arrivals (DACA) recipients in the physician and resident workforce face additional vulnerability. A Fifth Circuit court ruling in early 2025 found the DACA program’s work-authorization component unlawful, and a Board of Immigration Appeals decision in April 2026 held that DACA status alone does not bar removal, leading to increased detention and deportation threats for DACA recipients. This has created continued delays in employment and visa renewals for DACA-recipient physicians and residents, further interrupting care for vulnerable patient populations.

After the detention of an emergency medicine resident, Rubeliz Bolivar Barrios, MD, ACEP and the Emergency Medicine Residents’ Association (EMRA) released a joint statement advocating for a national-interest exemption for medical students, residents, fellows, and physicians. The Texas College of Emergency Physicians (TCEP) and ACEP worked closely together, leveraging TCEP’s strong local relationships and on-the-ground coordination combined with the College’s national reach, legal resources, and federal advocacy expertise to help secure Dr. Bolivar Barrios’ release. ACEP also joined a coalition of more than 20 medical societies to call for an exemption to the visa processing freeze. The coalition’s advocacy contributed to the late April 2026 USCIS exemption for physicians.

In Congress, similar efforts have been proposed that could have significant impacts on the medical workforce. New legislation has been proposed that would require hospitals receiving Medicare funding for graduate medical education (GME) to report the citizenship and immigration status of their medical residents and would prohibit Medicare from

funding GME costs attributable to non-citizens or non-nationals – a policy that could significantly affect residency training pipelines and emergency department staffing.

In 2001, the Council adopted Substitute Resolution 19(01), directing ACEP to support emergency medicine educational opportunities for international physicians and to work with EMRA on information resources and exchange programs for IMGs. The current resolution addresses the legal immigration status and employment continuity of IMGs already practicing or training in the United States, rather than educational access or international exchange.

ACEP's policy statement "Global Development and Promotion of Emergency Medicine" encourages the international collaboration of specialty organizations to advance the specialty of emergency medicine around the world.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 2: Address workforce solutions to ensure emergency physicians set the course for the future of the specialty.

Fiscal Impact

Staff resources for ongoing advocacy work within existing budgeted federal and state advocacy initiatives to monitor immigration policy developments, engage with federal agencies, coordinate coalition efforts, and develop member communications. . Estimated ongoing staff resource commitment of 0.10 – 0.20 FTE annually, $15,000 – $30,000, within current budgeted advocacy staff resources. Expanding the scope of engagement to include dedicated legislative outreach campaigns, external legal review and/or policy consultants, coalition participation, or new member-facing resources would require additional unbudgeted costs and unbudgeted 0.25 – 0.50 FTE, $50,000 – $75,000.

Prior Council Action

Substitute Resolution 19(01) International Medical Graduates Participation in US Emergency Medicine Residency Programs adopted. The resolution directed ACEP to support emergency medicine educational opportunities, not related to allocation of U.S. emergency medicine residency training positions, for international physicians to enhance emergency medicine in their native countries; work with EMRA to gather and disseminate information designed specifically for international medical school graduates to guide them in pursuit of an emergency medical career in their native countries; and work with EMRA to encourage exchange program opportunities for both international and American emergency medicine residents, medical students, and emergency physicians.

Prior Board Action

June 2024, approved the revised policy statement "Global Development and Promotion of Emergency Medicine" with the current title; reaffirmed February 2018 and October 2007; originally approved June 2001 titled "International Development and Promotion of Emergency Medicine."

Substitute Resolution 19(01) International Medical Graduates Participation in US Emergency Medicine Residency Programs adopted.

Background Information Prepared by: Annalane Miller, MPH
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

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Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 32(26)

SUBMITTED BY: California Chapter
Iowa Chapter
Minnesota Chapter
Early Career Physicians Section

SUBJECT: Protecting the Right of Licensed Health Care Professionals to Render Emergency Care at Law Enforcement-Controlled Scenes

PURPOSE: Develop a policy that law enforcement should not obstruct licensed health care professionals from rendering voluntary emergency care at law enforcement-controlled scenes; urge Congress to enact federal legislation prohibiting such obstruction absent an immediate and articulable safety threat; communicate the policy to relevant federal agencies and congressional committees; and direct the ACEP AMA delegation to advance AMA policy on this issue.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources for federal legislative advocacy, estimated 0.25 – 0.5 FTE (annually, ongoing), committee and staff resources to develop a new policy statement (estimated 80-120 hours), and AMA delegation coordination. Estimated cost is $30,000 – $75,000 in year one and potentially $15,000 – $40,000 annually thereafter, depending on the scope of the project and any external costs. Additional outside consultant costs, potentially $15,000 – $50,000, may be required to draft proposed federal legislation and work with staff to finalize it.

WHEREAS, In the United States, survival from out-of-hospital cardiac arrest decreases by 7–10% for every minute without cardiopulmonary resuscitation (CPR), bystander CPR doubles or triples survival odds, and immediate CPR can be initiated by trained bystanders before emergency medical services arrival;[1,2] and

WHEREAS, Uncontrolled hemorrhage is the single largest cause of preventable death in trauma, responsible for up to 40% of trauma mortality, with 33–56% of these deaths occurring in the prehospital period where bystander hemorrhage control, including tourniquet application and wound packing, is the primary determinant of outcome[3,4]; and

WHEREAS, The Stop the Bleed campaign, administered through the U.S. Department of Defense since 2015, and the American Heart Association's Chain of Survival framework are both premised on the principle that trained bystander intervention before Emergency Medical Services (EMS) arrival is a critical and time-sensitive component of the emergency care continuum, and that licensed health care professionals present at scenes of acute injury represent a qualitatively distinct emergency care resource[3,5-7]; and

WHEREAS, Minnesota Statute §604A.01 imposes a duty to assist on any person who knows another has suffered grave physical harm and provides Good Samaritan civil immunity to those rendering emergency care in good faith, and the federal Law Enforcement Officer Good Samaritan Act (codified as a note to 28 U.S.C. § 2671) protects officers who choose to act but neither requires them to render aid nor prohibits them from preventing others from doing so, leaving a specific and actionable gap in federal law[8,9]; and

WHEREAS, American Medical Association Policy H-130.937 (Delivery of Health Care by Good Samaritans) establishes that a reasonable policy should exist whereby a bystander physician may assist in an emergency situation, affirms the obligation of bystander physicians to provide reasonable self-identification, and directs the AMA to develop model principles on Good Samaritan protections under state and federal law, yet no existing AMA policy

addresses the circumstance in which law enforcement personnel physically obstruct a self-identified licensed health care professional from rendering such voluntary emergency care[10]; and

WHEREAS, In 2026, federal law enforcement agents at two separate incidents in Minneapolis, Minnesota, documented in court filings, video evidence reviewed by multiple news organizations, and sworn witness declarations, denied access to self-identified licensed health care professionals, including a physician, a registered EMT, and a licensed pediatrician, who voluntarily sought to render emergency care to acutely injured persons at scenes under federal law enforcement control, demonstrating a pattern of federal law enforcement obstruction of emergency medical care and a specific gap in federal law that enabled this harm[11-13]; and

WHEREAS, While the documented incidents giving rise to this resolution involve federal law enforcement, the principles of unobstructed access to voluntary emergency care apply equally at scenes controlled by state, local, and other law enforcement personnel, and no comprehensive policy currently exists at any level of government to protect licensed health care professionals seeking to render such care; and

WHEREAS, ACEP has a long-standing commitment to the emergency care continuum, bystander response initiatives, and federal advocacy that advances the health and safety of all persons; therefore be it

RESOLVED, That ACEP adopt as policy that law enforcement personnel should not obstruct, interfere with, or delay emergency medical care voluntarily offered by a licensed health care professional to an acutely ill or injured person at a law enforcement-controlled scene; that such care proceed without delay except in the presence of an immediate and articulable safety threat that cannot reasonably be mitigated without temporarily restricting access; and that any such restriction be based on specific, observable conditions, use the least restrictive means necessary, be limited in scope and duration to the threat identified, and permit initial medical assessment under controlled conditions whenever feasible and that this policy be communicated to relevant federal agencies and congressional committees; and be it further

RESOLVED, That ACEP urge the United States Congress to enact federal legislation prohibiting federal law enforcement officers from obstructing a licensed health care professional's access to render emergency care absent an immediate and articulable safety threat, requiring documentation of any such restriction, and requiring basic emergency care facilitation training (defined as instruction in scene safety assessment and the activation and support of bystander emergency care) for federal law enforcement personnel; and be it further

RESOLVED, That ACEP direct its American Medical Association (AMA) delegation to work to advance AMA policy addressing law enforcement obstruction of self-identified bystander physicians and licensed health care professionals at emergency scenes, consistent with existing recognition in AMA Policy H-130.937 (Delivery of Health Care by Good Samaritans) that reasonable access frameworks for bystander physician assistance should exist.

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Background

This resolution asks the College to adopt policy that law enforcement personnel should not obstruct licensed health care professionals from rendering voluntary emergency care at law enforcement-controlled scenes; to urge Congress to enact federal legislation prohibiting such obstruction absent an immediate and articulable safety threat; to communicate that policy to relevant federal agencies and congressional committees; and to direct the ACEP AMA delegation to advance AMA policy on this issue.

Survival from out-of-hospital cardiac arrest decreases by 7-10% for every minute without CPR, and bystander CPR doubles or triples survival odds. Uncontrolled hemorrhage is the single largest cause of preventable death in trauma, responsible for up to 40% of trauma mortality, with 33-56% of those deaths occurring in the prehospital period. Both the American Heart Association's Chain of Survival framework and the Stop the Bleed campaign, administered through the U.S. Department of Defense since 2015, are premised on the principle that trained bystander intervention before EMS arrival is a critical, time-sensitive component of the emergency care continuum. Licensed health care professionals present at scenes of acute injury represent a qualitatively distinct emergency care resource within that continuum.

The precipitating events related to this resolution occurred in Minneapolis, MN, in early 2026. In January 2026, Customs and Border Protection (CBP) agents shot Alex Pretti, a 37-year-old intensive care unit nurse at the Department of Veterans Affairs. A licensed pediatrician who witnessed the shooting immediately ran to the scene and attempted to render aid, but CBP agents initially refused access, repeatedly demanding paperwork proving the witness was a health care worker. The pediatrician stated in a sworn declaration filed with a Minnesota federal court that none of the federal agents surrounding Pretti were performing CPR, and that the agents appeared to be counting his bullet wounds rather than providing emergency care. After several minutes, agents allowed the pediatrician to assess Pretti following a pat-down; the pediatrician found no pulse and immediately began CPR until EMS arrived. A second incident in Minneapolis, also involving federal law enforcement, similarly resulted in a self-identified licensed health care professional being denied access to render emergency care. These incidents were documented in court filings, video evidence reviewed by multiple news organizations, and sworn witness declarations. Minnesota Governor Tim Walz stated that "the federal government cannot be trusted to lead this investigation," and the Minnesota Bureau of Criminal Apprehension was refused access to evidence despite a signed judicial warrant.

The legal landscape reveals a specific and actionable gap. Minnesota Statute §604A.01 imposes a duty to assist on any person who knows another has suffered grave physical harm and provides Good Samaritan civil immunity to those rendering emergency care in good faith. The federal Law Enforcement Officer Good Samaritan Act (codified as a note to 28 U.S.C. § 2671) protects officers who choose to act but neither requires them to render aid nor prohibits them from preventing others from doing so. AMA Policy H-130.937 (Delivery of Health Care by Good Samaritans) establishes that a reasonable policy should exist whereby a bystander physician may assist in an emergency situation, but no existing AMA policy addresses the circumstance in which law enforcement personnel physically obstruct a self-identified licensed health care professional from rendering such voluntary emergency care.

Connecticut is the only state that mandates emergency medical care for individuals who experience a medical emergency while in direct contact with or under the custody or control of law enforcement (SB 1062, 2023). Bills introduced in Massachusetts (S 2992, 2026) and New York (A 3926, 2025) would have mandated law enforcement or correctional officers immediately allow medical personnel to commence treatment for any person who is under such officer's custody or control; however, neither bill passed through the legislature. New York also introduced a bill that would restrict law enforcement or correctional officers from interfering with the provision of medical assistance to an incarcerated individual (S 1138, 2025). California has pending legislation, as of August 17,

2026, that would make it unlawful for a law enforcement officer to deny, delay, obstruct, or fail to facilitate an individual's medical evaluation or treatment when safe and reasonable and a medical professional is requested or present and willing to provide care (AB 2318, 2026).

ACEP's "Code of Ethics for Emergency Physicians" affirms that emergency physicians have an ethical duty to respond to emergencies in the community and offer assistance, and that access to emergency medical care is a fundamental right. The College has also long supported Good Samaritan legislation designed to reduce liability exposure for emergency physicians who respond to emergencies outside the emergency department, including out-of-hospital emergencies and mass casualty incidents.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving health care environments.

Objective 5: Promote the development and coordination of quality emergency medical services and systems and encourage emergency physicians to assume leadership roles in out-of-hospital care and disaster management.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources for federal legislative advocacy, estimated 0.25 – 0.5 FTE (annually, ongoing), committee and staff resources to develop a new policy statement (estimated 80-120 hours), and AMA delegation coordination. Estimated cost is $30,000 – $75,000 in year one and potentially $15,000 – $40,000 annually thereafter depending on the scope of the project and any external costs. Additional outside consultant costs, potentially $15,000 – $50,000, may be required to draft proposed federal legislation and work with staff to finalize it.

Prior Council Action

Amended Resolution 17(13) 911 Caller Good Samaritan Laws adopted. The resolution directed ACEP to support and endorse 911 Caller Good Samaritan policies for overdose victims, support such policies through legislative or regulatory advocacy at the local, state, and national levels, and work with the AMA on 911 Caller Good Samaritan policies.

Amended Resolution 37(97) Good Samaritan Law for Hospital-Based Physicians adopted. Directed the College to explore the development of a policy that supports Good Samaritan status for emergency physicians responding to in-hospital emergencies outside of the emergency department and continue gathering information on Good Samaritan case law to provide to the membership.

Prior Board Action

January 2024, reaffirmed the policy statement "Good Samaritan Protection;" revised and approved February 2018 and June 2012; reaffirmed September 2005; originally approved September 1999.

Amended Resolution 17(13) 911 Caller Good Samaritan Laws adopted.

Amended Resolution 37(97) Good Samaritan Law for Hospital-Based Physicians adopted.

Background Information Prepared by: Brianna Hanson, MPH
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Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 33(26)

SUBMITTED BY: Jeffrey A Nielson, MD, FACEP
Todd B. Taylor, MD, FACEP
Emergency Medicine Informatics Section

SUBJECT: Regulatory Governance of Artificial Intelligence Independent Practice of Medicine

PURPOSE: Oppose the marketing and sale of pre-positioned prescription medication kits; advocate for state and federal regulation requiring a clinician-in-the-loop for AI prescribing systems; and collaborate with the AMA and develop ACEP policies addressing AI independent practice of medicine and scope of practice.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated cost of $15,000 – $30,000 for each policy statement developed and additional costs to advocate for federal and state regulations. Implementation would require potentially .50 – 1.0 FTE ($75,000 – $150,000) to conduct research, coordinate partnership efforts with the AMA, and facilitate legal review.

WHEREAS, Commercial products such as The Wellness Company's "Medical Emergency Kit" ($1,000) provide patients with more than 15 prescription medications in advance of any actual illness (dispensed following a brief virtual medical survey), circumventing established prescribing frameworks, illustrates how artificial intelligence (AI) may in the future exploit similar loopholes for AI-driven prescribing schemes; and

WHEREAS, The State of Utah announced in January 2026, a partnership with medical AI company Doctronic to prescribe medications without physician involvement, slated to expand to nearly 200 drugs, including corticosteroids, statins, antidepressants, hormones, and anticoagulant/anticlotting agents (see: The First AI Drug Prescriber, *JAMA*, May 12. 2026 Vol 33 No 18); and

WHEREAS, Arizona, Texas, and Missouri are reportedly in active discussions with Doctronic to implement similar AI prescribing programs, and Colorado, Texas, and Wyoming have each established "AI Sandbox" regulatory frameworks permitting limited testing of AI technologies under state supervision, indicating that autonomous AI prescribing is poised to rapidly expand; and

WHEREAS, Many of the medications allowed in the Utah program (see Appendix A) carry substantial risk of serious adverse events, drug interactions, and complications that frequently present to the emergency department; and

WHEREAS, The American Medical Association, at its 2026 Annual Meeting (June 5–10, 2026), in Reference Committee B, considered Resolution 238 (A-26) "Prohibiting the Independent Practice of Medicine by Artificial Intelligence"; Resolution 246 (A-26) "Artificial Intelligence Scope of Practice"; and Resolution 249 (A-26) "Bringing Physicians' Voices to the Implementation of AI Prescribers"; forwarding the attached recommendation (Appendix B) to the House of Delegates; and

WHEREAS, Emergency medicine will inevitably see the downstream consequences of both pre-positioned bulk prescribing schemes and AI-driven prescribing errors, including adverse drug events, medication interactions, and delayed recognition of underlying illness masked by self-administered medications obtained without a licensed clinician evaluation; and

WHEREAS, Existing ACEP policy does not currently specifically address the emerging risk of commercial "pre-positioned prescription" and autonomous AI prescribing authority; therefore be it

RESOLVED, That ACEP oppose the marketing and sale of prescription medication kits that provide prescription-only medications in advance of diagnosed illness even if based on a brief virtual clinical survey; and be it further

RESOLVED, That ACEP advocate for state and federal regulation requiring that artificial intelligence systems require a "clinician-in-the-loop," particularly for prescription medications, and that such oversight not be reduced, waived, or phased out without FDA Class III Medical Device Approval; and be it further

RESOLVED, That ACEP collaborate with the American Medical Association as it considers policy arising from its 2026 annual meeting related to Artificial Intelligence Independent Practice of Medicine and Scope of Practice; and the ACEP Board of Directors create ACEP polices to address these topics.

APPENDIX A
Doctronic Published Formulary (~190 medications):

- **Allergy (11):** Azelastine, Cetirizine, Cyproheptadine, Diphenhydramine, Fexofenadine, Fluticasone, Hydroxyzine, Levocetirizine, Loratadine, Mometasone, Montelukast
- **Blood Thinners (5):** Apixaban (Eliquis), Aspirin, Clopidogrel (Plavix), Rivaroxaban (Xarelto), Ticagrelor (Brilinta)
- **Digestive Health (19):** includes Esomeprazole, Famotidine, Omeprazole, Pantoprazole, Metoclopramide, Ondansetron, Mesalamine (for Crohn's/ulcerative colitis), and various laxatives/stool softeners
- **Eye Health (8):** mostly glaucoma medications — Latanoprost, Timolol, Brimonidine, Dorzolamide, Bimatoprost, etc.
- **Heart & Blood Pressure (39):** statins (Atorvastatin, Rosuvastatin, Simvastatin, Pravastatin, Lovastatin), ACE inhibitors, ARBs, beta-blockers, diuretics, and combination antihypertensives
- **Men's Health (7):** BPH/ED medications — Tamsulosin, Finasteride, Tadalafil, Sildenafil, etc.
- **Mental Health (17):** SSRIs/SNRIs (Sertraline, Escitalopram, Fluoxetine, Venlafaxine, Duloxetine), plus Bupropion, Buspirone, and dementia/Parkinson's drugs (Donepezil, Memantine, Pramipexole, Ropinirole)
- **Metabolic (12)***:* Metformin, SGLT2 inhibitors (Farxiga, Jardiance), sulfonylureas, Levothyroxine, Allopurinol, Alendronate
- **Oral Health (2):** Chlorhexidine, Sodium Fluoride
- **Pain & Inflammation (26):** NSAIDs (Ibuprofen, Naproxen, Celecoxib, Meloxicam), corticosteroids (Prednisone, Dexamethasone, Methylprednisolone, Hydrocortisone, Budesonide), muscle relaxants, and migraine drugs (Rimegepant, Rizatriptan)
- **Respiratory (10):** Albuterol, inhaled corticosteroid/LABA combinations (Symbicort, Advair, Trelegy, Breo), Tiotropium
- **Skin (2):** Clobetasol, Hydroquinone
- **Vitamins & Supplements (13):** Vitamin D, B12, iron, folic acid, melatonin, magnesium, etc.
- **Women's Health (15):** various birth control formulations, Estradiol, Medroxyprogesterone, overactive bladder drugs (Oxybutynin, Mirabegron, Solifenacin)

APPENDIX B
2026 Annual Meeting of the American Medical Association (AMA) House of Delegates June 5 to June 10, 2026

Reference Committee B Report Referencing:
Resolution 238 (A-26): Prohibiting the Independent Practice of Medicine by Artificial Intelligence
Resolution 246 (A-26): Artificial Intelligence Scope of Practice
Resolution 249 (A-26): Bringing Physicians' Voices to the Implementation of AI Prescribers

AMA: PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

RESOLVED**,** that our American Medical Association advocate for legislation and regulation related to the use of augmented and/or artificial intelligence (AI) in autonomous or semiautonomous circumstances in healthcare (including diagnostics, prescriptions, care management, or other functions) requiring that such tools must:

1. integrate with the physician-led team and be used at the direction of the treating physician,
2. respect the continuity of care and best practices related to transitions of care,
3. have transparent, auditable data demonstrating safety and efficacy,
4. be subject to relevant and appropriate regulations (including but not limited to those related to liability and documentation), and
5. adhere to our AMA policy on Augmented Intelligence in Health Care; and be it further

RESOLVED**,** that our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, and their potential impact on the profession and the physician-patient relationship.

Background

This resolution directs the College to oppose the marketing and sale of pre-positioned prescription medication kits, advocate for state and federal regulation requiring a clinician-in-the-loop for AI prescribing systems, and collaborate with the AMA to develop ACEP policies addressing AI independent practice of medicine and scope of practice.

ACEP does not currently have policy statements addressing the emerging risk of commercial pre-positioned prescription kits or autonomous AI prescribing authority. The AMA addressed related concerns at its 2026 Annual

Meeting and considered three resolutions on prohibiting the independent practice of medicine by AI, AI scope of practice, and bringing physicians' voices to the implementation of AI prescribers, forwarding recommendations to the House of Delegates.

Companies such as The Wellness Company market a "Medical Emergency Kit" containing more than 15 prescription-only medications, including antibiotics, antiparasitics, and other controlled or high-risk agents, dispensed following a brief virtual medical survey rather than a traditional physician-patient encounter. The company describes these kits as providing access to medications for future use, without the worry of shortages or difficulty accessing a pharmacy. This model circumvents established prescribing frameworks and creates a pathway for patients to self-administer potent medications without a clinician evaluation, raising direct patient safety concerns for emergency physicians who will encounter the downstream consequences.

Another evolving trend is autonomous AI prescribing. U.S. Representative David Schweikert introduced the Healthy Technology Act of 2025, on January 7, 2025. The bill designed to modify the Federal Food, Drug, and Cosmetic Act (FFDCA) concerning artificial intelligence. This bill proposes that AI, as well as machine learning technologies, can qualify as a health care practitioner eligible to prescribe drugs. If approved, section 503(b) of the FFDCA would be amended to recognize AI as an approved licensed practitioner, with the amendment language stating that "the term 'practitioner licensed by law to administer such drug' includes artificial intelligence and machine learning technology." The United States is the first country in the world to propose legislation that would permit AI to autonomously prescribe medications, and this legislation, if approved, could redefine medication therapy in healthcare as well as the role of the prescriber.

At the state level, Utah has moved furthest. A first-of-its-kind pilot program in Utah, developed by a health-technology startup company, uses artificial intelligence to automatically renew certain prescriptions for patients with chronic conditions such as hypertension and diabetes. The AI-based drug prescribing tool was launched in January on a 12-month pilot program under a "regulatory sandbox" framework established under the 2024 Artificial Intelligence Policy Act, which established an AI "learning laboratory" that provides temporary waivers or allows temporary modifications to specific state laws. Under an agreement between the Utah Office of Artificial Intelligence Policy and the startup company, after a physician oversees the first 250 AI-based prescription renewals, the AI system operates autonomously, without human oversight of individual renewal decisions. Although the program is confined to prescription renewals for 192 commonly prescribed drugs such as antidepressants and proton pump inhibitors, it could pave the way for expanded initiatives that include autonomous initial prescribing. Legal scholars have raised significant concerns: the existence of mitigation agreements and waivers under state law does not automatically render the use of unproven medical technology lawful at the federal level. A paper co-authored by researchers from the University of Illinois, Harvard Law School, and Emory University, published in the New England Journal of Medicine in April 2026, concluded that autonomous AI-based drug prescribing raises important clinical and legal issues. With AI rapidly being deployed in health care, a "move fast and break things" mentality has permeated the industry, raising complex questions about the role of the FDA in regulating these technologies.

The regulatory landscape is fragmented and rapidly shifting. According to the National Conference of State Legislatures, as of 2025 all 50 states, Puerto Rico, the Virgin Islands, and Washington, DC, have introduced legislation to regulate AI, with significant state AI legislation going into effect in 2026. However, the federal picture is unsettled. The U.S. Senate passed the 2025 reconciliation bill on July 3, 2025, leaving AI regulation to the states after the House version had initially included language that would have preempted state AI laws for ten years. Colorado, Texas, and Wyoming have each established AI sandbox regulatory frameworks permitting limited testing of AI technologies under state supervision, and Arizona, Texas, and Missouri are reportedly in active discussions to implement AI prescribing programs similar to Utah's. AI is currently capable of autonomously performing acts that constitute medical practice, including diagnosis, prognosis, therapeutic decision making, and image analysis, but the ethical, regulatory, and legal regimes that govern medical practice and medical malpractice are not designed for non-human practitioners.

The emergency medicine implications are direct. Many of the medications included in the Doctronic formulary and in commercial pre-positioned kits, including anticoagulants, corticosteroids, antidepressants, antihypertensives, and respiratory agents - carry substantial risk of serious adverse events, drug interactions, and complications. Adverse drug events from prescription medications already represent a significant driver of emergency department utilization.

Autonomous prescribing without clinician evaluation eliminates the safety checks, such as medication reconciliation, allergy review, contraindication screening, and clinical judgment, that emergency physicians rely on when evaluating patients who have self-administered medications prior to arrival. The concern that emergency physicians will see the downstream consequences of both pre-positioned bulk prescribing schemes and AI-driven prescribing errors is well-founded given these trends.

ACEP has been actively building its organizational capacity to address AI in emergency medicine. ACEP appointed an AI Task Force in June 2024 to determine the current landscape of utilization of AI in emergency medicine practice, to include an assessment of prevalence, practice type, and purpose as well as other objectives to help prepare emergency physicians and their teams for the provision of care using AI. The task force scope of work evolved and a new Artificial Intelligence Committee was appointed in 2025. The committee was assigned objectives for identifying relevant opportunities and risks in the application of AI in the practice of emergency medicine, including activities directly related to clinical practice such as documentation of care.

ACEP convened the "All Emergency Medicine AI Summit" in October 2025, bringing together members from SAEM, CORD, ACOEP, ABEM, AAEM, EMRA, AACEM and AOBEM to prepare for how AI will transform emergency medicine education, research, and clinical practice. A consensus "Statement of Principles" was developed that affirmed a shared commitment to advocate for the deployment of AI safely, ethically, and equitably. The organizations committed to working collaboratively to establish standards that protect patients and support clinicians and endorsed the following principles:

1. AI integration must be human-centered, in which emergency physicians retain authority for patient care decisions (Human-in-the-loop). AI must enhance, not replace, clinical judgment, and must preserve the physician-patient relationship.
2. AI implementation must occur under a physician-led governance framework, ensuring emergency physicians maintain primary input in the selection, design, validation, and use of AI tools in emergency care.
3. AI adoption must prioritize patient safety, care quality, and clinical outcomes.
4. Standards for AI transparency must promote equitable and safe clinical use. We further endorse shared accountability among clinicians, vendors, and institutions for patient outcomes influenced by AI.
5. Competency-based educational frameworks for AI encourage that emergency medicine trainees first demonstrate clinical reasoning and clinical skills with progressive, supervised integration of AI tools into their practice as their clinical competency develops.
6. When AI is used to support scholarly activity advancing the specialty of emergency medicine, its use must be clearly disclosed to maintain transparency and academic integrity.
7. Training emergency physicians on the safe and effective use of AI is a prerequisite to deployment and is essential to responsible use of AI in practice.
8. There must be proactive design, deployment, and monitoring of AI applications across diverse patient populations and practice settings to mitigate bias and ensure equitable patient care outcomes.
9. Policies, regulations, and organizational practices must ensure data privacy, obtain consent for data use, and promote the responsible utilization of acquired data by AI systems linking this transparency to informed consent, disclosure, and shared decision-making for patients and clinicians.
10. AI tools must be developed and validated for emergency medicine's unique environment, such as time-critical workflows, diagnostic challenges, and patient complexity. Emergency medicine organizations believe that evidence-based deployment of AI requires independent validation, real-world performance monitoring, and continuous quality improvement.

In the 2026-27 committee year, the AI Committee will operate as a subcommittee of the Health Information Technology Committee (HITC). The HITC has multiple objectives that encompass the use of AI, including:

- Lead the creation and dissemination of AI education needs assessment for resident/fellow and post-training physicians to measure AI competency gaps and work toward integrating foundational AI competencies. Collaborate with Academic Affairs Committee, EMRA, Informatics Section, and other relevant stakeholders
- Partner with relevant stakeholders to disseminate practical education on AI, clinical informatics, decision support, and digital health for emergency physicians. Deliverables may include webinars, *ACEP Now* articles,

conference programming proposals, website materials, or member-facing toolkits translating HIT/AI Committee work into actionable guidance for members.

- Develop a comprehensive strategy on how to leverage the All-EM Consensus Statement on AI (the 10 Principles of AI) to guide ACEP's governance, evaluation, and response to AI tools affecting clinical practice. Create a prioritization roadmap for future ACEP policy updates, new policy statements, and/or PREP papers. Initial efforts will focus on operationalizing Principle #10, ensuring that AI tools are specifically developed, independently validated, and continuously monitored for emergency medicine's unique, time-critical workflows and diagnostic challenges.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine. (Bylaws #9, #10)

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 3: Monitor and evaluate the impact of artificial intelligence, telehealth, and other emerging technologies on emergency care delivery and physician practice.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated cost of $15,000 – $30,000 for each policy statement developed and additional costs to advocate for federal and state regulations. Implementation would require potentially .50 – 1.0 FTE ($75,000 – $150,000) to conduct research, coordinate partnership efforts with the AMA, and facilitate legal review.

Prior Council Action

Amended Resolution 56(25) Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions adopted. The resolution directed ACEP to advocate for state and federal legislation requiring that AI-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel, to support prohibiting health insurers from relying solely on AI-based algorithms to deny, delay, or downcode claims, and to collaborate with stakeholders to ensure AI algorithms used in health care decision-making are transparent, accountable, and subject to oversight by qualified health care professionals.

Resolution 42(19) Augmented Intelligence in Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to convene an Emergency Medicine Augmented Intelligence (EMAI) Summit and/or a task force to produce an information paper on the issues and concerns surrounding augmented intelligence and make recommendations for the College. Advised the Board of Directors to consider updating the College's Strategic Plan to include augmented intelligence and be include a presentation/session on augmented intelligence in emergency medicine at LAC20 or ACEP20.

Prior Board Action

October 2025, hosted an All-Emergency Medicine AI Summit.

Amended Resolution 56(25) Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions adopted.

April 2021, approved the revised policy statement "Health Information Technology for Emergency Care" with the current title; revised and approved June 2015 and August 2008 titled "Health Information Technology;" revised and approved February 2003; originally approved October 1998 titled "Internet Access."

April 2020, reviewed a report from the Health Information Technology Committee regarding implementation of Resolution 42(19) Augmented Intelligence in Emergency Medicine.

July 2019, hosted the "HIT SUMMIT: Evolving Emergency Care with Technology" in Dallas, TX, attended by 100 participants from a broad spectrum of Health Information Technology stakeholders, with a breakout session dedicated to Artificial (Augmented) Intelligence (AI) and Clinical Decision Support. The event proceedings resulted in a comprehensive Vision Paper, including a section on AI with seven related detailed recommendations.

Background Information Prepared by: Dhruv Sharma, MS
Lead Data Scientist

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 34(26)

SUBMITTED BY: Christopher M. Allen, MD
Undersea and Hyperbaric Medicine Section

SUBJECT: Support of Safe and Physician Directed Care in Hyperbaric Medicine

PURPOSE: Support the safe practice of hyperbaric oxygen therapy by requiring physician-directed care, FDA-approved chambers, compliance with PVHO and NFPA 99 safety standards, and independent accreditation; support state and federal enforcement of hyperbaric oxygen therapy standards; and support efforts to work with the FDA to enforce existing device requirements and federal regulations.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources to develop and communicate ACEP's position to the FDA, state legislatures, and relevant federal regulators. Estimated costs of 0.10 – 0.15 FTE annually with potential consultant costs for regulatory engagement ranging from $10,000 – $30,000 per year depending on the scope of work.

WHEREAS, The use of unregulated and non-FDA approved chambers in the United States is expanding in outpatient wellness centers and stand-alone clinics and this may include "soft" inflatable chambers operating outside FDA approval for only acute mountain sickness as well as hard-sided chambers operating afoul of industry standard safety practices and lacking physician supervision; and

WHEREAS, These facilities do not comply with existing federal regulations outlining chamber construction and operation[1,2] and federal authorities may not have the resources to proactively investigate problem chambers; and

WHEREAS, Hyperbaric treatment is safe when following industry standard safety practices; and

WHEREAS, Reputable facilities can pursue voluntary accreditation with independent accreditation bodies to verify safe chamber operation and patient care and the American Medical Association has endorsed Undersea and Hyperbaric Medical Society Accreditation as a credible option[3]; and

WHEREAS, In 2025, poor safety practice at unaccredited facilities led to the death of a 5-year child in Michigan and 43-year old male in Arizona and there are countless morbid injuries from soft-chamber failure; and

WHEREAS, Emergency physicians will be front line as these injuries increase and present to their department; and

WHEREAS, ACEP has an interest in reducing preventable injuries and protecting the community in line with other professional societies that have publicly committed to the safe practice of hyperbaric medicine[4,5]; therefore be it

RESOLVED, That ACEP support the safe practice of hyperbaric oxygen therapy, to include:

- Real-time and on-site supervision by a licensed physician trained in hyperbaric medicine;
- Compliance with safety standards outlined in Pressure Vessels for Human Occupancy (PVHO) and National Fire Protection Agency (NFPA) 99 (Health Care Facilities Code, Chapter 14);
- Use of FDA approved hyperbaric chambers;
- Regular audits or accreditation from independent third party to verify compliance with PVHO, NFPA 99, federal and state law. The UHMS Accreditation program is a credible option; and be it further

RESOLVED, That ACEP support and/or endorse state level or federal efforts to enforce standards for the safe practice of hyperbaric oxygen therapy; and be it further

RESOLVED, That ACEP support efforts to work with the Food and Drug Administration to enforce existing hyperbaric oxygen therapy device requirements and federal regulations.

Resolution References

1. NFPA-99-2024 Health Care Facilities Code
2. ASME PVHO-1-2023 Safety Standard for Pressure Vessels for Human Occupancy
3. American Medical Association House of Delegates. Resolution 518 (A-25). *Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers* D-270.981. Adopted 2025.
4. American Medical Association House of Delegates. Resolution 516 (A-22). *Oppose Unsafe Use of "Mild Hyperbaric Therapy"* D-270.986. Adopted 2022.
5. UHMS (17 Apr 2025). *Ten Guidelines for Patients and Referring Physicians In Selecting Safe Hyperbaric Oxygen Treatments.*
6. In Selecting Safe Hyperbaric Oxygen Treatments

Background

This resolution directs ACEP to support the safe practice of hyperbaric oxygen therapy (HBOT) by requiring physician-directed care, FDA-approved chambers, and compliance with Pressure Vessels for Human Occupancy (PVHO) and National Fire Protection Agency (NFPA) 99 (Health Care Facilities Code, Chapter 14)safety standards; to support independent accreditation of hyperbaric facilities; to support and/or endorse state and federal enforcement of those standards; and to work with the FDA to enforce existing device requirements and federal regulations.

Hyperbaric oxygen therapy (HBOT) is the primary treatment for a number of conditions that require emergency treatment, including decompression sickness, arterial gas embolism, and acute carbon monoxide poisoning. The field has grown substantially since 2000, when undersea and hyperbaric medicine was first recognized by the American Board of Medical Specialties as a board-certified subspecialty of emergency medicine. By 2016, approximately 1,300 hyperbaric facilities were operating in the United States. Despite this proliferation, the proportion of facilities offering 24/7 emergency care has declined sharply: a Divers Alert Network report found that in 2001, 37% of centers (226 of 600) provided 24/7 availability, while by 2016 only 7% (88 of 1,300) did so. A 2011-2014 survey of 361 hyperbaric programs found that only 43 (12%) had both on-call staff and equipment to treat patients with arterial gas embolism, decompression sickness, or acute carbon monoxide poisoning, and that the average distance patients must travel to reach those centers is 96 miles. Increased time to treatment for these acute conditions can result in poorer prognosis.

A separate and growing concern is the proliferation of unregulated hyperbaric facilities operating outside established safety standards. Hyperbaric physicians and experts have described the current landscape as "absolute anarchy," with HBOT increasingly offered in wellness businesses by individuals without medical degrees or sufficient training, including chiropractors, physical therapists, and alternative medicine practitioners. The FDA has approved HBOT to be marketed as a treatment for 13 conditions, but some clinics claim to treat more than 100 conditions, including Alzheimer's disease, autism, dyslexia, and ADHD – conditions for which HBOT has not been cleared. These facilities include "soft" inflatable chambers approved by the FDA only for acute mountain sickness but marketed for a wide range of wellness and off-label uses, as well as hard-sided chambers operating without physician supervision and outside industry-standard safety practices. The hyperbaric chamber environment is inherently associated with oxygen-rich, high-pressure fire risk, making adherence to safety protocols essential.

Federal regulations governing chamber construction and operation exist, specifically American Society of Mechanical Engineers (ASME) PVHO-1 and NFPA 99 (Health Care Facilities Code, Chapter 14); however, compliance with these consensus standards is not currently mandatory under federal regulation. A December 2022 citizen petition to the FDA requested that the agency make these standards mandatory via regulation; as of the time of this resolution, the FDA has not acted on that petition. State oversight is similarly limited: most states, including Michigan, have no regulatory framework specifically governing hyperbaric chamber operation in wellness settings, and fire department inspections typically cover only fire and life-safety concerns, not chamber operation or maintenance. The Undersea and Hyperbaric Medical Society (UHMS) offers a voluntary accreditation program that verifies safe chamber operation and patient care; as of 2017, only approximately 203-205 of more than 1,400 hyperbaric centers were UHMS-accredited, a figure that reflects the absence of any regulatory or payment incentive to seek accreditation. The

American Medical Association recommends that all states require HBOT facilities to be UHMS-accredited, though no state currently does so. The AMA House of Delegates adopted Resolution 518 (A-25) in 2025 endorsing mandatory accreditation and regular inspections of hyperbaric chambers, and previously adopted Resolution 516 (A-22) in 2022 opposing unsafe use of "mild hyperbaric therapy." The UHMS published patient and physician guidance in April 2025 identifying ten criteria for selecting safe hyperbaric oxygen treatments.

The safety consequences of unregulated practice have become acute. In 2025, two people died in hyperbaric chamber fires in the United States. On January 31, five-year-old Thomas Cooper was killed when a spark ignited a fire inside a hyperbaric chamber at the Oxford Center, an alternative medicine clinic in Troy, Michigan; his mother was also seriously burned. The child was receiving HBOT for sleep apnea and ADHD and these conditions are not cleared by the FDA for this treatment. The Michigan Attorney General subsequently charged the Oxford Center's CEO and three employees with second-degree murder and involuntary manslaughter, stating that the facility "held safety among their lowest considerations" and operated "in complete disregard of vital safety measures." A second fatality occurred in Arizona in July 2025, when a man died in a similar chamber fire. In response to these incidents, the FDA issued a safety communication on August 25, 2025, reminding health care providers and facilities of the critical importance of following manufacturer instructions for safe use of HBOT devices and noting that the root causes of the fires remain under investigation. The UHMS estimates that seven people have died since 2009 due to fire, suffocation, or other adverse events in HBOT chambers, with experts anticipating further increases as the wellness-oriented hyperbaric market continues to expand without meaningful regulatory oversight.

Emergency physicians are positioned as the front-line providers who will receive patients injured by these facilities, giving ACEP a direct interest in reducing preventable harm. The Centers for Medicare and Medicaid Services (CMS) has also identified hyperbaric medicine as a priority area for oversight, listing it as the number one priority on the 2017 Office of Inspector General work plan, citing concerns about overutilization and abuse; these concerns were more likely attributable to non-emergent and non-indicated treatments at unaccredited facilities than to legitimate emergency applications of HBOT.

ACEP has previously engaged on related aspects of hyperbaric medicine policy. In 2016, the Council adopted Resolution 20(16) directing ACEP to work with UHMS and the Divers Alert Network to advocate for improved 24/7 emergency hyperbaric medicine availability. In 2017, the Council referred Resolution 35(17) to the Board, which directed ACEP to petition CMS to require facility accreditation as a condition of federal payment; the Board subsequently approved a joint letter to CMS with UHMS in February 2018 in support of that accreditation requirement. The current resolution extends that prior work by addressing the patient safety and regulatory enforcement dimensions of unregulated hyperbaric practice, which have become more urgent in light of the 2025 fatalities and the continued expansion of non-compliant wellness-oriented facilities.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards)

Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources to develop and communicate ACEP's position to the FDA, state legislatures, and relevant federal regulators. Estimated costs of 0.10 – 0.15 FTE annually with potential consultant costs for regulatory engagement ranging from $10,000 – $30,000 per year depending on the scope of work.

Prior Council Action

Resolution 35(17) Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment referred to the Board of Directors. The resolution directed ACEP to work with the Undersea & Hyperbaric Medical Society and the ACEP Undersea & Hyperbaric Medicine Section to petition and advocate for CMS to require that hyperbaric facilities be accredited to receive federal payment.

Resolution 20(16) Support & Advocacy for 24/7 Hyperbaric Medicine Availability adopted. The resolution directed ACEP to work with the Undersea & Hyperbaric Medical Society and the Divers Alert Network to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the United States to provide appropriate and timely care to patients in need.

Prior Board Action

February 2018, approved sending a joint letter with the Undersea & Hyperbaric Medical Society to CMS in support of accreditation requirements for hyperbaric facilities.

Resolution 20(16) Support & Advocacy for 24/7 Hyperbaric Medicine Availability adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Director, Federal Government Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 35(26)

SUBMITTED BY: Charles Pattavina, MD, FACEP
Alabama Chapter
Louisiana Chapter
New Mexico Chapter
Mississippi Chapter
Pennsylvania College of Emergency Physicians
South Carolina College of Emergency Physicians

SUBJECT: Standardized Signage Identifying When a Physician is Not Present On-Site in the ED

PURPOSE: Develop model standardized signage informing patients of physician on-site duty hours, advocate for its adoption by all EDs, and collaborate with TJC, DNV, CIHQ, and other accrediting organizations to incorporate the signage into accreditation standards to promote patient transparency and informed decision-making.

FISCAL IMPACT: Current advocacy initiatives are related to transparency and disclosure of ED staffing. Developing model standardized signage and advocating for its adoption by accrediting bodies (TJC, DNV, CIHQ) will require additional advocacy staff resources, committee engagement, and unbudgeted design and legal review costs estimated at $10,000 – $30,000, an additional FTE for at least one year to assist with communications testing, awareness campaign, education and promotion efforts, with estimated cost of at least $100,000.

WHEREAS, Patients presenting to an emergency department have a reasonable expectation of knowing whether a physician is physically present and immediately available to provide care; and

WHEREAS, Emergency departments across the United States employ varying staffing models, including departments staffed by non-physician practitioners without continuous on-site physician coverage; and

WHEREAS, Clear and consistent communication regarding physician availability promotes transparency, informed decision-making, and patient trust; and

WHEREAS, The Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 489, Subpart B.489.20 - Basic Commitments. Section w (5) states that signage must be posted conspicuously in a place/places likely noticed by all people entering the ED noting if the hospital does not have a MD/DO present in the hospital at all times, “Each dedicated emergency department, as that term is defined in § 489.24(b), in a hospital in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week must post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient with an emergency medical condition, as defined in § 489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital.”; and

WHEREAS, Many hospitals are not in compliance with this Federal Code of Regulations on ED signage; and

WHEREAS, Standardized signage would improve consistency across emergency departments while minimizing confusion for patients and families; and

WHEREAS, Accrediting organizations are positioned to promote uniform patient notification standards; and

WHEREAS, ACEP’s Council adopted resolution 50(25) That ACEP advocate for stricter enforcement of the

federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting; therefore be it

RESOLVED, That ACEP develop model standardized signage informing patients of physician on-site duty hours 24 hours per day, 7 days per week; and be it further

RESOLVED, That ACEP advocate for adoption of standardized signage informing patients of physician on-site duty hours 24 hours per day, 7 days per week by all emergency departments, including EDs utilizing staffing models without continuous on-site physician coverage; and be it further

RESOLVED, That ACEP collaborate with The Joint Commission (TJC), DNV (Det Norse Veritas) Healthcare, The Center for Improvement in Healthcare and Quality (CIHQ), and other hospital accrediting organizations to incorporate model standardized signage regarding physician availability into accreditation standards to provide for patient transparency and patient informed decision making for their medical care.

Background

This resolution requests the College to develop model standardized signage informing patients of physician on-site duty hours, advocate for its adoption by all emergency departments, and collaborate with accrediting organizations, including The Joint Commission (TJC), Det Norse Veritas (DNV) Healthcare, and The Center for Improvement in Healthcare and Quality (CIHQ), to incorporate such signage into accreditation standards.

This resolution builds on Resolution 50(25) Emergency Department Staffing Transparency adopted last year that directed ACEP to advocate for stricter enforcement of the existing federal posting requirement and to work with the Joint Commission and other regulatory bodies on educational and regulatory initiatives. The implementation action assigned to Advocacy and Public Affairs staff under that resolution includes meeting with CMS to discuss enforcement of federal regulations requiring hospitals without 24/7 on-site physician coverage to clearly post such notices and ways to improve transparency. This year's resolution goes further by asking ACEP to develop a specific model signage template and to seek its incorporation into accreditation standards. ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023, which includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's advocacy team, was instrumental in helping several states pass legislation that requires a physician in the ED at all times. A model signage initiative would represent a parallel effort on the transparency and disclosure side of the same policy problem.

There is currently an absence of consistent, patient-facing disclosure when a physician is not physically present in an emergency department. Recent data indicate that one in 13 emergency departments operate at times without a physician physically on-site and on duty. The 2022 National ED Inventory (NEDI)-USA survey found that 7.4%, or one in every 13, EDs did not have an attending physician on duty 24/7. This phenomenon was more frequent in critical access hospitals (89%) and rural locations (72%) with an annual visit volume greater than 10,000. These figures reflect a structural reality in which a meaningful share of patients, particularly those in rural and frontier communities, may present to an ED staffed by non-physician practitioners without continuous on-site physician coverage, without any notice that this is the case.

Patient expectations do not align with this reality. The general public reasonably expects that a visit to an "Emergency Department" will involve being evaluated by a physician. A March 2022 ACEP public opinion survey found that 72% of respondents would be concerned if no physician were available during their medical emergency. ACEP's own policy affirms this expectation: ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states that ACEP "believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams."

A federal regulatory framework already requires disclosure in certain circumstances. Under 42 C.F.R. § 489.20(w)(5), each dedicated emergency department in a hospital in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week must post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient with an emergency medical condition at a time when there is no MD/DO present in the hospital. The resolution notes that many hospitals are not in compliance with this requirement, although ACEP has not independently verified the scope of non-compliance.

The regulatory landscape around ED signage is more complex than the existing federal requirement alone suggests. Section 1866(N)(iii) of the Social Security Act details the EMTALA-required signage for all Medicare-participating hospitals offering emergency services. Additionally, CMS and the Office of the Inspector General (OIG) within HHS have indicated that some signs are *not allowed* under the law. When ACEP staff contacted the EMTALA compliance office within CMS in response to a prior resolution, CMS stated that it "has discouraged hospitals from placing additional signage in the ED or other required hospital locations that may in any way act to deter or discourage individuals from staying for medical screening examinations and stabilizing treatment. This does not mean that all signage is prohibited. If signage is identified as a concern, hospitals would be expected to demonstrate how it is in compliance with CMS requirements and does not deter or discourage individuals from staying for statutorily required medical screening examinations." CMS also notes that signs posted in an ED are evaluated on a case-by-case basis. If an individual surveyor finds that signs "deter or discourage" patients from seeking emergency care, facilities would be subject to EMTALA-related penalties/fines. While EMTALA only applies to Medicare-participating hospitals, some states, such as Texas, have laws in place that impose EMTALA-type regulations on non-Medicare facilities as well, further expanding the number of facilities that may run into difficulties with specific signage. Any model signage ACEP develops will need to be designed to satisfy the existing federal disclosure requirement while avoiding language that CMS or OIG could characterize as deterring patients from seeking care.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research and Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 2: Expand ACEP's accreditation programs to further recognize excellence in the delivery of emergency care.

Fiscal Impact

Current advocacy initiatives are related to transparency and disclosure of ED staffing. Developing model standardized signage and advocating for its adoption by accrediting bodies (TJC, DNV, CIHQ) will require additional advocacy staff resources, committee engagement, and unbudgeted design and legal review costs estimated at $10,000 – $30,000, an additional FTE for at least one year to assist with communications testing, awareness campaign, education and promotion efforts, with estimated cost of at least $100,000.

Prior Council Action

Resolution 75(25) Protecting the Term "Emergency Department" in Critical Access Hospitals referred to the Board of Directors. The resolution requests ACEP to develop policy ensuring the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times, and to promote regulation requiring Critical Access Hospitals without a physician on-site to adopt alternative terminology.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted. The resolution directed ACEP to advocate for stricter enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with The Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process and provide findings to the Council by July 1, 2022.

Resolution 27(19) Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care not adopted. Directed ACEP to oppose the use of the terms "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Prior Board Action

January 2026, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved October 2024, June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted.

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners

April 2024, approved the revised ED Accreditation Program Criteria and all levels of applications; revised and approved January 2024; originally approved criteria October 2023.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

February 2023, approved establishing an ED Accreditation Program based on the business plan and preliminary criteria and tiers for the accreditation program.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Director, Federal Government Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 36(26)

SUBMITTED BY: Alabama Chapter

SUBJECT: Transparency in Emergency Department Physician Staffing

PURPOSE: Support the development and implementation of standardized reporting of emergency department physician staffing characteristics to CMS and other accrediting or regulatory organizations, and advocate for public reporting of that information in a manner that promotes transparency for patients, communities, researchers, and policymakers.

FISCAL IMPACT: Ongoing current advocacy staff resources estimated 0.10 – 0.20 FTE (approximately $15,000 – $30,000 annually) related to Amended Resolution 50(25) Emergency Department Staffing Transparency to engage CMS and accrediting organizations on standardized reporting requirements. Any expansion of scope, such as developing a formal rulemaking petition or commissioning external research, would require additional unbudgeted funds. Unbudgeted costs for ACEP to develop the system and maintain it would require at least one direct FTE and IT/data system support, potentially $150,000 – $300,000 and ongoing annual costs.

WHEREAS, The presence of a physician in the emergency department is a fundamental structural characteristic of emergency department capability and an important component of the delivery of safe, timely, and high-quality emergency care; and

WHEREAS, Patients have little or no ability to determine whether an emergency department is continuously staffed by a physician who is physically present on site, despite physician presence representing a foundational component of emergency care delivery; and

WHEREAS, Hospital quality reporting programs administered by the Centers for Medicare & Medicaid Services (CMS) and hospital accrediting organizations routinely collect structural and operational characteristics that inform quality assessment, patient decision-making, and healthcare policy; and

WHEREAS, Standardized reporting of emergency department physician staffing characteristics would facilitate quality improvement, workforce planning, health services research, and informed policy decisions regarding emergency care delivery; and

WHEREAS, Standardized reporting of emergency department physician staffing characteristics would improve transparency for patients, policymakers, and healthcare systems and facilitate evaluation of the relationship between staffing models and patient outcomes; therefore be it

RESOLVED, That ACEP support the development and implementation of standardized reporting of emergency department physician staffing characteristics by hospitals to the Centers for Medicare & Medicaid Services (CMS) and other appropriate accrediting or regulatory organizations; and be it further

RESOLVED That ACEP advocate for public reporting of emergency department physician staffing information in a standardized, accurate, and easily understandable manner that promotes transparency for patients, communities, researchers, and policymakers.

Background

This resolution asks the College to support the development and implementation of standardized reporting of emergency department physician staffing characteristics to CMS and other accrediting or regulatory organizations,

and to advocate for public reporting of that information in a manner that promotes transparency for patients, communities, researchers, and policymakers. The resolution does not mandate a particular staffing model, but rather it seeks standardized reporting and public disclosure of staffing characteristics, which would enable patients, researchers, and policymakers to evaluate the relationship between staffing models and patient outcomes without prescribing how hospitals must staff their emergency departments.

The current CMS hospital quality reporting framework, administered through the Hospital Outpatient Quality Reporting (HOQR) program and the Outpatient Prospective Payment System (OPPS), collects and reports publicly numerous structural and operational characteristics of emergency departments, including throughput measures such as median time from ED arrival to departure and door-to-diagnostic evaluation time. However, no existing CMS reporting requirement captures whether a physician is physically present on-site during all hours of ED operation. This resolution would direct ACEP to advocate for adding physician staffing characteristics to that reporting framework, creating a new category of structural data about emergency departments available publicly.

Amended Resolution 50(25) Emergency Department Staffing Transparency, adopted last year, directed ACEP to advocate for strict enforcement of the existing federal regulation (42 C.F.R. § 489.20(w)(5)) requiring hospitals without 24/7 on-site physician coverage to clearly post such notices. ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023, which includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's advocacy team, was instrumental in helping several states pass legislation that requires a physician in the ED at all times. The AMA adopted resolution 204 in June 2024 compelling the AMA to seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED.

Physician presence in the emergency department is a foundational structural characteristic of emergency care delivery, yet no standardized federal reporting mechanism currently requires hospitals to disclose whether their emergency departments are continuously staffed by an on-site physician. Recent data cited in the background materials for Amended Resolution 50(25) indicate that 1 in 13 emergency departments operate at times without a physician physically on-site and on duty. Despite this, patients generally have no reliable way to determine the staffing model of the emergency department they are visiting before or during a visit. A March 2022 ACEP public opinion survey found that 72% of respondents would be concerned if no physician were available during their medical emergency, underscoring the gap between public expectation and actual practice at some facilities.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" affirms that "the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM)." The policy further states that if physician assistants or nurse practitioners are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician who has the real-time opportunity to be involved in the contemporaneous care of any patient seen by a PA or NP. ACEP's policy statement "Emergency Department Planning and Resource Guidelines" similarly states that "the emergency physician should serve as the leader of the ED team."

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research and Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Fiscal Impact

Ongoing current advocacy staff resources estimated 0.10 – 0.20 FTE (approximately $15,000 – $30,000 annually) related to Amended Resolution 50(25) Emergency Department Staffing Transparency to engage CMS and accrediting organizations on standardized reporting requirements. Any expansion of scope, such as developing a formal rulemaking petition or commissioning external research, would require additional unbudgeted funds. Unbudgeted costs for ACEP to develop the system and maintain it would require at least one direct FTE and IT/data system support, potentially $150,000 – $300,000 and ongoing annual costs.

Prior Council Action

Resolution 75(25) Protecting the Term "Emergency Department" in Critical Access Hospitals referred to the Board of Directors. The resolution requests ACEP to develop policy ensuring the term "Emergency Department" is used exclusively to describe facilities where a physician is physically present on-site at all times, and to promote regulation requiring Critical Access Hospitals without a physician on-site to adopt alternative terminology.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted. The resolution directed ACEP to advocate for stricter enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with The Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting.

Resolution 27(24) Continuous Physician Staffing for Rural Emergency Departments referred to the Board of Directors. The resolution requested ACEP to collaborate with the AMA to advocate that CMS modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed physician is immediately available for on-site care of emergency department patients at all times.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted. Directed ACEP to encourage all emergency departments to advertise that they are staffed by a board-certified or -eligible emergency physician where care is delivered.

Resolution 68(21) Patient's Right to Board Certified Emergency Physicians 24/7 not adopted. The resolution asked ACEP to support legislation to require all facilities with an ED to have a board-eligible/certified emergency physician onsite or via telehealth at all times.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physician Led Teams referred to the Board of Directors. The resolution called for ACEP to publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board-certified emergency physician.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification

based upon qualification of the clinician as part of the accreditation process and provide findings to the Council by July 1, 2022.

Resolution 27(19) Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care not adopted. Directed ACEP to oppose the use of the terms "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Prior Board Action

January 2026, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved October 2024, June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted.

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners

April 2024, approved the revised ED Accreditation Program Criteria and all levels of applications; revised and approved January 2024; originally approved criteria October 2023.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

April 2023, approved the revised policy statement "Definition of an Emergency Physician;" reaffirmed April 2017; originally approved June 2011.

February 2023, approved establishing an ED Accreditation Program based on the business plan and preliminary criteria and tiers for the accreditation program.

Amended Resolution 39(22) Signage at Emergency Departments With Onsite Emergency Physicians adopted.

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

Background Information Prepared by: Ryan McBride, MPP
Senior Director, Federal Government Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 37(26)

SUBMITTED BY: Charles Pattavina, MD, FACEP
Louisiana Chapter
Mississippi Chapter
New Mexico Chapter
South Carolina College of Emergency Physicians

SUBJECT: Development of a HIPAA-Compliant Anonymous Database for Reporting Clinical Management Events Involving Non-Physician Practitioners Working in EDs

PURPOSE: Study the feasibility of creating and maintaining a secure, anonymous, HIPAA-compliant repository for voluntary reporting of significant clinical events associated with non-physician practitioner care in emergency medicine, with the goal of identifying patterns, informing quality improvement, and supporting legislative advocacy on scope-of-practice policy.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Resources required include staff (policy and technology), an advisory committee, and an external technology vendor. Implementation would require a feasibility study phase with staff time estimated at 0.25-0.5 FTE, approximately $30,000 – $60,000, followed by technology and vendor costs for HIPAA-compliant database design and hosting, estimated $50,000 – $150,000, with ongoing annual maintenance and staff support estimated at $20,000 – $50,000.

WHEREAS, ACEP is committed to the highest standards of patient safety, quality improvement, and evidence-based emergency care; and

WHEREAS, Systematic collection and analysis of adverse events and near misses is a recognized method for identifying opportunities to improve patient care and healthcare systems; and

WHEREAS, Emergency physicians frequently encounter patients who experienced delayed diagnosis, inappropriate treatment, missed critical illness, or other adverse outcomes following prior evaluation by non-physician practitioners, including but not limited to nurse practitioners and physician assistants; and

WHEREAS, Emergency physicians often avoid reporting management issues for fear of employer retaliation, contributing to moral injury and burnout; and

WHEREAS, Individual anecdotal reports are difficult to aggregate, analyze, or apply toward quality improvement without a standardized reporting mechanism; and

WHEREAS**,** A secure, HIPAA-compliant reporting system could help identify recurring clinical patterns, educational opportunities, systems failures, and supervision issues while protecting patient privacy and minimizing medicolegal risk; and

WHEREAS, Such data could inform lawmakers on policy decisions regarding unsupervised medical practice; therefore be it

RESOLVED, That ACEP study the feasibility of creating and maintaining a secure, anonymous, HIPAA-compliant repository for voluntary reporting of significant clinical events associated with non-physician practitioner care in emergency medicine.

Background

This resolution asks the College to study the feasibility of creating and maintaining a secure, anonymous, HIPAA-compliant repository for voluntary reporting of significant clinical events associated with non-physician practitioner (NPP) care in emergency medicine.

The use of NPPs, including nurse practitioners (NPs) and physician assistants (PAs), in emergency departments has grown substantially over the past decade. There has been tremendous growth in the use of NPs in the emergency department. According to Medicare claims data, the number of NPs submitting emergency medicine claims each year increased 99 percent between 2012 and 2018, and it is estimated that EDs employ between 14,000 and 16,000 NPs. Community emergency departments have seen volumes increase over the years. Previously, departments responded to increases in patient volume by adding more physician coverage, but lately hospital administrations have looked to advanced practice providers such as PAs or NPs to meet volume demands.

This workforce expansion has occurred alongside a patchwork of state-level scope-of-practice laws and significant variation in NPP training standards. NPs graduate with either a master's degree or doctorate of nursing practice, and there is no standard around education or population focus required to work in the ED. While many NP programs call for 500-1,000 hours of post-bachelor's healthcare experience, this is not a standardized requirement, and there are NP programs that allow direct entry without any prior nursing experience. NPs can be hired to work in the ED immediately upon completion of schooling, as opposed to physicians who require an additional 3-4 years of residency training in emergency medicine after medical school. NP schools typically require 500 clinical hours as opposed to the 5,000 hours of medical school and 10,000 hours of EM residency. As of September 2021, only 1,514 NPs were certified as emergency NPs, meaning that approximately 90 percent of NPs working in EDs are not emergency-certified.

The evidence on patient outcomes associated with unsupervised NPP practice in the ED raises concerns. One study found that NPs increased the cost of care in the emergency department by 7 percent (approximately $66 per patient), increased length of stay by 11 percent, and raised 30-day preventable hospitalizations by 20 percent. This study leveraged data from 2017 to 2020, a period in which NPs within the Veterans Health Administration were truly practicing without physician supervision. A separate multi-hospital study published in Academic Emergency Medicine (Pines et al., 2020), drawing on 13 million ED visits from 94 hospitals across 19 states, found that APPs treated less complex visits and saw approximately half as many patients per hour compared to physicians, and identified no economies of scale from increasing APP staffing. That study found no adverse effects on ED flow or patient experience in a collaborative staffing model, illustrating that findings on NPP performance vary depending on whether NPPs are practicing with or without physician supervision, which is a distinction the existing literature does not always make clearly.

ACEP's current policy position, as stated in the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department," is that PAs and NPs serve as integral and valued members of the physician-led emergency department care team, but they do not possess the training and expertise in emergency medicine that may only be acquired through successful completion of an ACGME-accredited emergency medicine residency training program. ACEP's policy statement states unequivocally that NPs and PAs should not practice independently in the ED and ACEP believes PAs and NPs should not perform independent, unsupervised care in the ED.

Despite this policy position and the documented concerns about patient safety, there is currently no standardized mechanism for emergency physicians to report clinical management events they encounter that are associated with prior NPP care. The resolution's WHEREAS clauses note that emergency physicians frequently encounter patients who experienced delayed diagnosis, inappropriate treatment, missed critical illness, or other adverse outcomes following prior NPP evaluation, and that fear of employer retaliation discourages reporting. The American Medical Association Advocacy Resource Center is studying each of the states that granted independent practice authority to NPs, although this is not a formal academic study and does not include PAs. The study is tracking metrics for quality and patient safety and watching for information demonstrating why a physician-led team would have potentially had a better outcome. No comparable voluntary, anonymous, HIPAA-compliant reporting repository specific to NPP-

associated clinical events in emergency medicine currently exists at the national level, leaving a significant gap in the data available to inform quality improvement, educational interventions, supervision policy, and legislative advocacy.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

> Objective 2: Address workforce solutions to ensure emergency physicians set the course for the future of the specialty.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Resources required include staff (policy and technology), an advisory committee, and an external technology vendor. Implementation would require a feasibility study phase with staff time estimated at 0.25-0.5 FTE, approximately $30,000 – $60,000, followed by technology and vendor costs for HIPAA-compliant database design and hosting, estimated $50,000 – $150,000, with ongoing annual maintenance and staff support estimated at $20,000 – $50,000.

Prior Council Action

The Council has adopted multiple resolutions regarding NPs and PAs, however, none that are specific to studying the feasibility of creating and maintaining a secure, anonymous, HIPAA-compliant repository for voluntary reporting of significant clinical events associated with non-physician practitioner care in emergency medicine.

Resolution 77(25) Investigating Practice Patterns of NPs and PAs Following Independent Practice Legislation referred to the Board of Directors. Directed ACEP to investigate and report on the practice patterns, patient outcomes, and quality metrics of NPs and PAs in states that have enacted independent practice legislation.

Resolution 43(23) Adopt Terminology "Unsupervised Practice of Medicine" adopted. Directed ACEP to adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Prior Board Action

April 2025 approved the policy statement "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners"

October 2024, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and

Nurse Practitioners in the Emergency Department;" revised and approved June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Background Information Prepared by: Laura Lang, JD
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 38(26)

SUBMITTED BY: Aaron Snyder, MD
Scott Mueller, DO, FACEP
Riemer Praamsma, MD
Louisiana Chapter
New Mexico Chapter
Early Career Physicians Section

SUBJECT: Establishing Whistleblower Protections for Reporting Financial Mismanagement of Liability Reserves

PURPOSE: Advocate for federal and state safe harbor legislation protecting physicians who report suspected financial mismanagement or insolvency of employer-provided liability funds, and support policies prohibiting retaliatory contract actions against physicians who disclose underfunding of malpractice reserves in good faith.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources for federal and state legislative advocacy (estimated 0.25 – 0.5 FTE ongoing), General Counsel review of contract and legislative language, and committee engagement to develop and distribute model legislation to chapters. Estimated annual cost range is $30,000 – $75,000 in staff and committee resources.

WHEREAS, ACEP identifies the protection of professional autonomy and physician due process as core organizational principles; and

WHEREAS, The financial integrity of professional liability funds is essential to the stability of the healthcare safety net, ensuring emergency physicians can fulfill their EMTALA mandates; and

WHEREAS, Physicians who identify the siphoning or underfunding of these reserves may be deterred from reporting such mismanagement due to "termination without cause" clauses or restrictive non-disparagement agreements common in Management Services Organization (MSO) contracts; and

WHEREAS, The failure of corporate entities to maintain solvent insurance captives constitutes a threat to public safety and the long-term viability of the emergency medicine workforce; therefore be it

RESOLVED, That ACEP advocate for federal and state "safe harbor" legislation that provides comprehensive whistleblower protections for physicians who report suspected financial mismanagement or insolvency of employer-provided liability funds to appropriate regulatory authorities; and be it further

RESOLVED, That ACEP support policies that prohibit the use of contract termination, non-renewal, or other retaliatory measures against physicians acting in good faith to disclose the underfunding of malpractice reserves.

Background

This resolution asks the College to advocate for federal and state "safe harbor" legislation protecting physicians who report suspected financial mismanagement or insolvency of employer-provided liability funds, and to support policies prohibiting retaliatory contract actions against physicians who disclose the underfunding of malpractice reserves in good faith.

The financial integrity of professional liability coverage is a foundational condition for the safe practice of emergency medicine. Emergency physicians are subject to EMTALA mandates requiring them to screen and stabilize all patients regardless of ability to pay, and they must be able to rely on solvent, adequately funded liability coverage to fulfill those obligations. Medical malpractice insurance is the single largest insurance cost for most physician groups, and the commercial market for that coverage has grown increasingly expensive and restrictive. Rates have increased significantly across most specialties over the past several years, capacity in some high-risk specialties has contracted, and policy forms have grown more restrictive even as premiums have grown. (See https://www.3fcaptiveservices.com/articles/captive-insurance-for-physician-groups-and-networks) In response to these market pressures, many large physician practice management companies and Management Services Organizations (MSOs) have turned to captive insurance structures - self-funded or partially self-funded arrangements in which the employer or corporate parent retains the underwriting risk rather than transferring it to a licensed commercial carrier.

Captive insurance structures can offer legitimate benefits, including cost stabilization and customized coverage. However, they also introduce a risk that is largely invisible to the individual physician: the captive's solvency depends entirely on the financial discipline and good faith of the corporate entity managing it. Unlike licensed commercial insurers, which are subject to state insurance department oversight, reserve requirements, and solvency examinations, employer-operated captives and self-insured retention programs may be structured in ways that reduce regulatory scrutiny. When a corporate parent diverts funds from a captive reserve - whether to service debt, fund distributions, or cover operating losses elsewhere in the enterprise - the physicians whose coverage depends on that reserve may have no practical way to detect the underfunding until a claim goes unpaid or the entity enters bankruptcy. The commercial malpractice market operates almost exclusively on a claims-made basis, meaning that a physician who treated a patient under one policy but receives a claim after leaving that policy has no coverage for that claim absent tail coverage. (See: https://www.3fcaptiveservices.com/articles/captive-insurance-for-physician-groups-and-networks) If the captive or self-insured fund is insolvent at the time a claim is filed, the physician may face personal exposure.

The problem is compounded by the contractual environment in which most emergency physicians now practice. Management Services Organizations have evolved into powerful corporate vehicles for consolidating physician practices. Originally designed to handle billing, human resources, and other back-office administrative tasks, MSOs now aggregate medical groups at scale, often backed by private equity. (See https://www.milbank.org/publications/the-corporate-backdoor-to-medicine-how-msos-are-reshaping-physician-practices) Physicians who enter MSO arrangements need to carefully scrutinize the documentation and framework surrounding the arrangement to limit risks, including ensuring that termination provisions cannot be used to oust a physician without recourse. (See https://www.stevenslee.com/health-law-observer-blog/watching-your-back-protections-for-physicians-in-mso-transactions) In practice, however, "termination without cause" clauses are common in MSO and practice management contracts, and non-disparagement agreements may further restrict a physician's ability to raise concerns about financial practices. A physician who identifies that a captive reserve is being siphoned or underfunded faces a stark choice to either remain silent or risk contract termination. Recent events also illustrate the vulnerability. In June 2026, a physician-led emergency medicine group in Virginia was given a six-month termination-without-cause notice despite being halfway through a five-year agreement, with the hospital replacing them with a private equity-backed practice management company. The group's vice president noted that the ideal of standing up for independent practice "crashed headlong into the harsh realities of massive litigation costs and weak legal safeguards." (Source: MedPage Today, June 15, 2026, as reported by https://www.facebook.com/ScienceNaturePage/posts/as-corporate-interests-tighten-their-grip-on-healthcare-the-sudden-termination-o/1559662268947970)

No federal statute currently provides comprehensive whistleblower protection specifically for physicians who report the financial mismanagement of employer-provided liability reserves to state insurance regulators or other appropriate authorities. General federal whistleblower frameworks - such as those under the False Claims Act or the Sarbanes-Oxley Act - do not squarely address this scenario. Some states have enacted healthcare-specific whistleblower protections, but coverage is uneven and few, if any, address the specific context of liability reserve mismanagement. New Mexico's Health Care Consolidation Oversight Act, for example, requires covered entities to adopt whistleblower protection policies prohibiting retaliatory action against providers who report unlawful or improper acts, but that statute is limited to consolidation transactions and does not extend to reserve underfunding disclosures. (See https://www.mmclc.org/patients-and-visitors/whistleblower-protection-policy

ACEP has previously addressed related aspects of this problem. In 2021, the Council adopted Resolution 31(21), directing ACEP to submit a resolution at the AMA House of Delegates promoting whistleblower protections for physicians who report safety, harassment, or fraud concerns, and to develop model state legislation to share with chapters. ACEP introduced a resolution at the AMA's 2022 House of Delegates Annual Meeting, which was adopted, and the State Legislative/Regulatory Committee developed and distributed model legislation to chapters.

ACEP policy supports protection of emergency physicians from retaliation for speaking out about conditions that could negatively impact patient care. The policy statement "Emergency Physician Rights and Responsibilities" states in part that "Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment." The policy statement "Safer Working Conditions for Emergency Department Staff" contains a provision under the section "Leadership promotion of a culture of safety and open reporting of safety concerns" that includes "Protections and support for physicians who raise or report safety concerns." Further, ACEP's policy statement "Supporting Emergency Physician Political Advocacy" states that "Physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Objective 4: Increase transparency in the emergency medicine job market by sharing data on various employment settings and developing employer accountability initiatives.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff resources for federal and state legislative advocacy (estimated 0.25 – 0.5 FTE ongoing), General Counsel review of contract and legislative language, and committee engagement to develop and distribute model legislation to chapters. Estimated annual cost range is $30,000 – $75,000 in staff and committee resources.

Prior Council Action

Amended Resolution 31(21) Employment-Retaliation, Whistleblower, Wrongful Termination adopted. The resolution directed ACEP to submit a resolution to the AMA House of Delegates promoting whistleblower protections for physicians who report safety, harassment, or fraud concerns, and to develop model state legislation to share with chapters.

Amended Resolution 30(20) Protection and Transparency adopted. The resolution directed ACEP to establish policy encouraging employers and entities contracting for emergency physician services to provide information to non-federal physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or Contract Management Group (CMG) as a result of the physician providing his or her services without any requirement of the physician requesting it.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Called for ACEP to develop model language for emergency physician employment contracts addressing termination for any emergency physician subjected to adverse action related to involvement in quality/performance improvement, patient safety, or other medical staff activities, and specifying due process for physicians subjected to such adverse action.

Substitute Resolution 8(99) False Claims Act adopted. Directed ACEP to continue work on the subject of compliance, including the Federal False Claims Act, and increase its efforts to disseminate information on this topic to its members.

Prior Board Action

January 2026, approved the revised policy statement "Supporting Emergency Physician Political Advocacy;" originally approved October 2013 titled "Supporting Political Advocacy in the Emergency Department."

Amended Resolution 31(21) Employment-Retaliation, Whistleblower, Wrongful Termination adopted.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Amended Resolution 30(20) Protection and Transparency adopted.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

October 2004 - Board approved the internal policy "Fraudulent or Dishonest Conduct and Whistleblower Protection," establishing ACEP's own organizational whistleblower protections for reporting financial misconduct.

Substitute Resolution 8(99) False Claims Act adopted.

Background Information Prepared by: Laura Lang, JD
General Counsel

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 39(26)

SUBMITTED BY: Scott Mueller, DO, FACEP
Riemer Praamsma, MD
Aaron Snyder, MD
Louisiana Chapter
New Mexico Chapter
Early Career Physicians Section

SUBJECT: Safeguarding Physician Liability Reserves and Continuity of Professional Protection

PURPOSE: Advocate for statutory requirements mandating that all employer-sponsored liability coverage vehicles, including captives and self-insured retentions, and physician tail funds be pre-funded and held in independent, legally segregated escrow accounts.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated staff cost $15,000 – $30,000 annually with potential additional outside legal or policy consultant costs of $25,000 – $50,000 depending on the scope of work.

WHEREAS, Emergency physicians have a federal mandate under the Emergency Medical Treatment and Labor Act (EMTALA) to provide stabilizing care, creating a unique and unavoidable professional liability exposure; and

WHEREAS, Recent corporate insolvencies in the healthcare sector have demonstrated that malpractice reserves can be seized by creditors, leaving physicians without promised legal defense or "tail" coverage for care provided under federal mandate; and

WHEREAS, The sudden loss of professional liability protection disrupts the healthcare safety net, threatens the viability of the emergency medicine workforce, and compromises physician safety; therefore be it

RESOLVED, That ACEP advocate for statutory requirements mandating that all employer-sponsored liability coverage vehicles, including captives and self-insured retentions, and physician tail funds be pre-funded and held in independent, legally segregated escrow accounts.

Background

This resolution requests ACEP to advocate for statutory requirements mandating that all employer-sponsored liability coverage vehicles, including captives and self-insured retentions. and physician tail funds be pre-funded and held in independent, legally segregated escrow accounts.

Emergency physicians operate under a unique and unavoidable liability exposure created by federal law. The Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act, requires hospital emergency departments and their physicians to provide a medical screening examination for all patients regardless of insurance status or ability to pay, and to provide stabilizing treatment if an emergency medical condition is found. Because emergency physicians must treat patients they have little or no prior relationship with and often have limited access to medical history, they carry substantially higher liability exposure than most other specialties. ACEP has long recognized that this federally mandated care creates a disproportionate professional liability burden for emergency physicians and on-call specialists.

The problem addressed by this resolution is distinct from, though related to, ACEP's prior advocacy on EMTALA liability reform. Prior resolutions and legislation have focused on reducing the liability standard for EMTALA-mandated care or extending Federal Tort Claims Act protections to emergency physicians. This resolution addresses a different and more recent dimension of the problem: the structural risk that malpractice reserves and tail coverage funds held by corporate employers can be seized by creditors or rendered inaccessible when those employers enter bankruptcy, leaving physicians without the coverage they were promised for care they have already provided.

The emergency medicine employer landscape has undergone significant consolidation under contract management groups (CMGs) and private equity-backed entities in recent years. A series of high-profile corporate insolvencies beginning in 2023 brought this structural vulnerability into sharp relief. Envision Healthcare Corp., a private equity-backed emergency medicine staffing company that provided physician services to at least one-third of U.S. hospital emergency departments and employed or partnered with more than 21,000 clinicians serving nearly 30 million patient visits annually, filed voluntary Chapter 11 bankruptcy petitions in the U.S. Bankruptcy Court for the Southern District of Texas on May 15, 2023. In the same period, OPYS Physician Services also declared bankruptcy, and American Physician Partners abruptly ceased operations. The 2025 ACEP Council resolution on occurrence-based malpractice coverage (Resolution 42(25), subsequently withdrawn) documented that the bankruptcies of NES Health, American Physician Partners, and Envision Healthcare resulted in emergency physicians being left without promised tail coverage and without compensation for clinical services rendered, placing individual physicians at risk of personal financial liability and legal exposure through no fault of their own.

The mechanism of harm is rooted in how most emergency physician malpractice coverage is structured. The majority of professional liability coverage available to physicians is provided on a claims-made basis, meaning a claim is covered only if it arose out of professional services rendered during the policy term and notice of the claim is provided during that same term. When a physician's employment ends, whether voluntarily or because the employer dissolves, the claims-made policy terminates, and any subsequent claim for care rendered during employment falls outside the policy period unless a tail policy (formally, an extended reporting endorsement) is in place. Tail coverage can be costly, and employment contracts typically assign responsibility for purchasing it to the employer. When an employer enters bankruptcy, malpractice reserves and tail funds held within the corporate estate may be treated as general assets subject to creditor claims, leaving physicians without the coverage they were contractually promised and potentially personally liable for claims arising from care they provided under EMTALA's federal mandate. State level guidance, such as that issued by the Pennsylvania Insurance Department, confirms that physicians with claims-made coverage are left without primary coverage if their employer is contractually obligated to provide tail coverage but fails to do so because of bankruptcy.

ACEP has responded to the recent wave of employer insolvencies through member education and internal advocacy. ACEP President Alison Haddock, MD, FACEP, appointed a workgroup focused on how ACEP can help ensure emergency physicians do not face loss of pay or loss of malpractice coverage when their group goes out of business, using a three-pronged approach of proactive education, crisis response, and advocacy solutions. At its September 4, 2025, meeting, the ACEP Board of Directors adopted a policy statement affirming that occurrence-based malpractice insurance or claims-made malpractice insurance with a pre-paid tail is the gold standard for liability coverage for emergency physicians. The Board also supported pursuing advocacy for creation of a fund to help support the cost of tail medical liability insurance for physicians if their employer goes out of business, and for state or federal legislation obligating hospitals to provide malpractice coverage for their physicians providing EMTALA-mandated care in case of failure of group tail insurance. The American Academy of Emergency Medicine (AAEM) issued a related policy statement in April 2025 calling for all emergency medicine employment and independent contractor agreements to include clear, enforceable standards for malpractice insurance coverage, ensuring physicians are protected regardless of corporate financial stability, citing the financial collapse of major staffing firms including Envision Healthcare, NES, and APP as the impetus.

This resolution goes further than member education or voluntary contract standards by seeking statutory protections, and specifically a legal requirement, that liability reserves and tail funds be pre-funded and held in legally segregated escrow accounts that are insulated from the employer's general estate in bankruptcy. No current federal statute imposes such a requirement on employer-sponsored liability coverage vehicles, captives, or self-insured retentions in the healthcare context.

ACEP's policy statement "Professional Liability Coverage Gold Standard" states "ACEP believes occurrence-based professional liability insurance or claims-made professional liability insurance with a pre-paid tail is the gold standard for liability coverage for emergency physicians. The type and terms of coverage must be explicitly stated in the physician contract." Medical-legal resources are available on the ACEP website, including resources addressing medical liability litigation.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Objective 4: Increase transparency in the emergency medicine job market by sharing data on various employment settings and developing employer accountability initiatives.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require resources to develop an advocacy strategy, draft model statutory language, and engage federal and state legislators and regulators. Estimated staff cost $15,000 – $30,000 annually with potential additional outside legal or policy consultant costs of $25,000 – $50,000 depending on the scope of work.

Prior Council Action

None specific to statutory requirements mandating that all employer-sponsored liability coverage vehicles, including captives and self-insured retentions, and physician tail funds be pre-funded and held in independent, legally segregated escrow accounts.

Amended Resolution 26(19) EMTALA Professional Liability Coverage adopted. Directed ACEP to support and advocate for liability protection to cover EMTALA-mandated services.

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted. Directed that ACEP support individual states in passing EMTALA-related liability reform that increases the burden of proof and evidentiary standard in cases against those providing EMTALA-related care.

Amended Resolution 30(04) Medical Liability Reform – Right to Defend referred to the Board of Directors. The resolution requested ACEP to support the concept that emergency physicians should be active participants in any decision to try or settle professional liability claims brought against them.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted. Directed ACEP to study causes and scope of professional liability crisis in emergency medicine and develop short- and long-term resolutions, including tort reform.

Prior Board Action

April 2026, approved the policy statement "Professional Liability Coverage Gold Standard."

January 2021, approved the revised policy statement "Interpretation of EMTALA in Investigations, Enforcement, and Medical Malpractice Litigation;" originally approved June 2018 titled "Interpretation of EMTALA in Medical Malpractice Litigation."

Amended Resolution 26(19) EMTALA Professional Liability Coverage adopted.

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted.

Background Information Prepared by: Laura Lang, JD
General Counsel

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 40(26)

SUBMITTED BY: Alabama Chapter
Louisiana Chapter
Mississippi Chapter
New Mexico Chapter
Pennsylvania College of Emergency Physicians
South Carolina College of Emergency Physicians

SUBJECT: Opposing Settlement of Medical Malpractice Claims Without Consent of the Defendant Physician

PURPOSE: Adopt policy requiring professional liability insurers to obtain the informed written consent of an emergency physician before settling a malpractice claim on that physician's behalf and adopt policy opposing consent-to-settle provisions.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources to draft a policy statement, conduct legal and regulatory review, and coordinate any related state or federal advocacy. Estimated 200 – 300 staff hours, approximately $15,000 – $30,000, for initial policy development; additional staff resources will be needed for advocacy outreach.

WHEREAS, Medical malpractice settlements become part of a physician's permanent professional record and are reportable to the National Practitioner Data Bank (NPDB), potentially affecting credentialing, licensure, hospital privileges, employment, and professional reputation; and

WHEREAS, Many professional liability insurance policies permit insurers to settle claims without the consent of the insured physician, often for financial or business reasons unrelated to the merits of the case; and

WHEREAS, Settlements made without physician consent may create the appearance of negligence despite the absence of any judicial finding of liability or admission of wrongdoing; and

WHEREAS, Emergency physicians are uniquely vulnerable to malpractice litigation because of the high-acuity, time-sensitive, and resource-constrained nature of emergency medical practice; and

WHEREAS, Physicians have a significant professional, ethical, and reputational interest in participating in decisions that materially affect their careers and public records; therefore be it

RESOLVED, That ACEP adopt policy supporting the principle that professional liability insurers should not settle a medical malpractice claim on behalf of an insured emergency physician without that physician's informed written consent; and be it further

RESOLVED, That ACEP adopt policy opposing consent-to-settle provisions that shift financial risk to the physician, such as hammer clauses, which coerce consent rather than protect it.

Background

This resolution asks the College to adopt policy supporting the principle that professional liability insurers should not settle a medical malpractice claim on behalf of an insured emergency physician without that physician's informed

written consent and adopt policy opposing consent-to-settle provisions such as hammer clauses that shift financial risk to the physician in a way that coerces consent.

Medical liability insurance policies contain provisions, typically found in "consent to settle" or "reservation of rights" clauses, that detail which party has decision-making authority regarding the potential settlement of a liability lawsuit. Some policies vest total authority in the insured physician. Other insurance companies retain complete control over settlement decisions. Still others will allow an insured physician to overrule the insurer's recommendation to settle, but then limit their claim coverage to the amount of the settlement offer the insurer recommended, leaving the insured physician personally liable for any award above that amount. This last arrangement is commonly referred to as a "hammer clause." Many medical malpractice insurers include a hammer clause as an additional provision tucked into their consent-to-settle clause. A hammer clause states that if the insured physician goes against the carrier's settlement recommendation, the physician will then be "on the hook" for any damages and costs over what the insurance company believes the claim could have settled for.

Insurers and insured physicians may have competing interests regarding settlement decisions. An insurer may seek to limit its exposure by settling a claim, even if the physician feels that the claim is unjustified. Sometimes a physician will wish to fight a claim because they may have done nothing wrong. The insured might feel that settling a meritless suit rewards a claimant with undeserved monetary rewards. A physician may also wish to fight a claim because he or she fears that the resulting settlement will damage his or her reputation.

The consequences of a settlement, whether or not the physician consented, are significant and lasting. When an insurer decides to settle without the consent of the insured physician, the impact on the physician includes the mandatory reporting of the settlement to the National Practitioner Data Bank (NPDB). By federal law, all payments made on behalf of physicians in connection with medical liability judgments or settlements must be reported to the NPDB. The NPDB then makes the information available to various health care entities including hospitals and state licensing boards. Beyond that, a settlement will follow a physician for many years and will require disclosure in future insurance applications or in renewal of hospital privileges. As noted in an American Medical Association paper, "this mandatory reporting requirement makes it imperative that all settlement decisions be carefully evaluated, as even the settlement of a nuisance case with no real merit will be reported to the NPDB." Settlement of a case could also impact a physician's ability to obtain insurance through another carrier or could adversely impact an insurer's decision to renew a policy with that physician or his group.

Emergency physicians face particular vulnerability in this area. As the availability of medical liability insurance has decreased, some emergency physicians have found few options to obtain coverage. One option available in some areas is for emergency physicians to be covered under a hospital's liability insurance policy. However, when a physician is covered under a hospital's insurance policy, the physician's ability to control decisions regarding the settlement of suits may be further diluted, as that power may already be vested with either the insurer or the hospital. This structural dynamic in which emergency physicians are often employed by or insured through hospital-based arrangements makes the consent-to-settle issue especially acute for the specialty.

ACEP's policy statement "Reform of Tort Law" addresses broader tort reform principles and endorses in principle federal laws, state legislation, or constitutional amendments to implement tort legal reforms, including limitations on non-economic damages, controls on attorney contingency fees, and qualifications for expert witnesses. The policy statement does not address the contractual relationship between physicians and their insurers on settlement decisions such as consent-to-settle provisions or hammer clauses.

Medical-legal resources are available on the ACEP website, including resources addressing medical liability litigation.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require committee and staff resources to draft a policy statement, conduct legal and regulatory review, and coordinate any related state or federal advocacy. Estimated 200 – 300 staff hours, approximately $15,000 – $30,000, for initial policy development; additional staff resources will be needed for advocacy outreach.

Prior Council Action

Resolution 30(04) Medical Liability Reform – Right to Defend referred to the Board of Directors. The resolution requested ACEP to support the concept that emergency physicians should be active participants in any decision to try or settle professional liability claims brought against them, and to develop a policy advocating for emergency physicians' right to defend themselves in all medical liability lawsuits regardless of insurer or hospital recommendations.

Prior Board Action

October 2023, approved the revised policy statement "Reform of Tort Law;" reaffirmed April 2017; revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985).

June 2019, reviewed the revised information paper "So You Have Been Sued!"

Background Information Prepared by: Laura Lang, JD
General Counsel

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 41(26)

SUBMITTED BY: Scott Mueller, DO, FACEP
Riemer Praamsma, MD
Aaron Snyder, MD
Louisiana Chapter
New Mexico Chapter
Early Career Physicians Section

SUBJECT: Transparency of Financial Solvency for Employer-Mandated Liability Coverage

PURPOSE: Advocate for state and federal legislative and regulatory standards requiring any entity that provides physician medical malpractice coverage through a captive insurance vehicle or self-insured retention to furnish covered physicians with written disclosure of the fund's regulatory domicile, guaranty fund status, and a statement of financial risk upon any material negative change in the fund's capital reserves.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Implementation would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Estimated staff resources 0.10 – 0.20 FTE to research the captive and SIR insurance regulatory landscape, committee work to draft a policy position, and engage state and federal legislators and regulators. Total estimated cost of $15,000 – $30,000 in staff resources equivalent with an ongoing commitment for legislative and regulatory engagement.

WHEREAS, ACEP is dedicated to protecting the professional and personal security of its members as they provide essential care; and

WHEREAS, An increasing number of emergency physicians are insured through employer-sponsored liability coverage vehicles, including captives and self-insured retentions (SIRs), managed by their employers; and

WHEREAS, These insurance vehicles are often domiciled in jurisdictions with limited public financial reporting requirements, leaving physicians unable to assess the risk of coverage failure; and

WHEREAS, The financial stability of an employer's insurance vehicle directly impacts the professional standing and financial viability of the individual emergency physician; therefore be it

RESOLVED, That ACEP advocate for state and federal legislative and regulatory standards that require any entity providing medical malpractice coverage via a captive or self-insured retention to provide physicians with clear, written disclosure of the fund's precise regulatory domicile, guaranty fund status, and a statement of financial risk at the time of any material negative change in the fund's capital reserves.

Background

This resolution asks the College to advocate for state and federal legislative and regulatory standards requiring any entity that provides medical malpractice coverage through a captive insurance vehicle or self-insured retention (SIR) to furnish covered physicians with clear, written disclosure of the fund's precise regulatory domicile, guaranty fund status, and a statement of financial risk at the time of any material negative change in the fund's capital reserves.

The structure of physician employment has shifted substantially over the past decade, and with it the structure of professional liability coverage. Over the past several years, the risk landscape in health care has grown more complex, driven primarily by rising claim severity. While overall claim frequency has remained relatively stable in many

regions, the size of individual verdicts and settlements has increased significantly. As a result, the cost of insurance coverage in the traditional market has risen significantly, with higher premiums, reduced capacity, and selective underwriting making it more difficult for many providers to secure adequate coverage, as several insurers have scaled back or exited the line entirely. A 2023 report by Avalere Health and the Physicians Advocacy Institute found that, as of early 2024, nearly 78 percent of physicians were employed by hospitals, health systems, or corporate entities. As healthcare organizations have assumed direct employment of clinical staff, they have also assumed direct responsibility for managing professional liability risk and many have turned to captive insurance companies and SIRs to do so.

In the face of increasing medical malpractice premiums from traditional commercial insurance companies, health care providers, including hospitals, HMOs, and physician practice groups, have sought alternative insurance sources, one of which is a captive insurance company. In a captive insurance company, the insureds have direct involvement and influence over the captive's operations, including underwriting, claims management, and investments. This direct involvement often means that the insured can reduce its insurance costs. However, as a self-funded mechanism, if a captive does not properly plan and reserve for losses, the parent organization's financial position can be significantly impaired. To form a captive, a hospital or other health care professionals need to select a domicile in which to incorporate. Captives have several options when selecting a domicile, including on-shore in a state with legislation that permits captives, in any state if forming as a risk retention group (RRG) captive, or off-shore in a country that permits captives such as Bermuda, the Cayman Islands, or Ireland. Captives and SIRs are regulated only in their domicile jurisdiction, and their financial data is generally not publicly available in the same manner as admitted carriers. Critically, captives and SIRs are typically not backed by state guaranty funds, which means that if an employer's coverage vehicle becomes insolvent, the covered physician may have no recourse to the guaranty fund protections that would otherwise apply under a standard admitted policy.

The consequences of coverage failure for an individual physician are significant. When an insurer decides to settle without the consent of the insured physician, the impact on the physician includes the mandatory reporting of the settlement to the National Practitioner Data Bank (NPDB). By federal law, all payments made on behalf of physicians in connection with medical liability judgments or settlements must be reported to the NPDB, which then makes the information available to various health care entities including hospitals and state licensing boards. An insolvent coverage vehicle that cannot satisfy a judgment creates the same professional and financial exposure without the physician having had any warning or opportunity to seek alternative coverage. Physicians receiving an increase in premium should be cautioned about dropping a reputable carrier and going for the cheapest malpractice policy they can find, as physicians have found themselves in recent years without coverage when their carriers went broke. The same risk applies when coverage is employer-mandated and the physician has no visibility into the financial condition of the vehicle covering them.

As healthcare systems grow, their leadership teams may consider creating a captive insurance company to manage their risk and control insurance costs, and a captive allows hospitals or large physician groups to self-insure, offering unique benefits and responsibilities. All forms of self-insurance come with risks, and captives are no different. One significant risk is the potential for inaccurate predictions about future losses, which could lead to unexpected costs, and a captive may lack the resources of a traditional insurance company that handles a higher volume of claims and has greater capacity to spread costs. Physicians covered under employer-mandated captive or SIR arrangements typically have no practical way to assess the financial health of the vehicle insuring them, as the financial data is not publicly available and employers are not currently required to disclose it proactively.

The resolution's focus on disclosure at the time of a material negative change in capital reserves is consistent with the informed consent principles that govern physician-patient relationships and parallels existing disclosure obligations in other regulated industries. No current ACEP policy statement specifically addresses financial solvency disclosure requirements for employer-sponsored captive or SIR malpractice coverage vehicles.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 4: Increase transparency in the emergency medicine job market by sharing data on various employment settings and developing employer accountability initiatives.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Implementation would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Estimated staff resources 0.10 – 0.20 FTE to research the captive and SIR insurance regulatory landscape, committee work to draft a policy position, and engage state and federal legislators and regulators. Total estimated cost of $15,000 – $30,000 in staff resources equivalent with an ongoing commitment for legislative and regulatory engagement.

Prior Council Action

None specific to financial solvency disclosure requirements for employer-sponsored captive or self-insured retention malpractice coverage vehicles.

Prior Board Action

None

Background Information Prepared by: Laura Lang, JD
General Counsel

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

American College of Emergency Physicians®
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2026 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 42-56

Hilary Fairbrother, MD, FACEP (TX) – Chair
Patsy Chenpanas, MD (OR)
Frank Y. Duncan, III, MD, FACEP (MI)
Laura Janneck, MD, MPH, MS (OK)
Ira R. Nemeth, MD, FACEP (TX)
Monika Pitzele, MD, PhD, FACEP (IL)

Joya Coffman MS, CHES, ASQ-CQIA
Travis Schulz, MLS, AHIP

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 42(26)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Clarification and Revision of ACEP Policy on Medical Cannabis in the Era of Emerging Psychoactive Cannabinoids

PURPOSE: Revise "Medical Cannabis" policy statement to define "medical cannabis" with precision, distinguish among FDA-approved cannabinoid medications, state-regulated cannabis products, and non-FDA-approved hemp-derived psychoactive cannabinoids (including delta-8 THC and related compounds), address pediatric exposure risks, and advocate for standardized nomenclature, regulation, and research regarding emerging cannabinoid products.

FISCAL IMPACT: This is not a current budgeted initiative and would require diverting current committee and staff resources from other work or inclusion in the next fiscal year budget. Estimated staff resources of 80 – 120 hours (approximately 0.05-0.07 FTE), with a cost range of $8,000 – $15,000.

WHEREAS, ACEP's policy statement "Medical Cannabis" emphasizes the importance of scientifically valid, well-controlled clinical trials to assess the safety and efficacy of cannabis and cannabis derivative products; and

WHEREAS, The current policy notes that cannabis and related cannabinoids are being recommended for patient use despite limited evidence regarding appropriate indications, efficacy, dosing, and precautions; and

WHEREAS, The policy does not explicitly define the term "medical cannabis," nor does it distinguish between FDA-approved cannabinoid medications, state-regulated medical marijuana products, and non–FDA-approved hemp-derived psychoactive cannabinoids; and

WHEREAS, The 2018 Agriculture Improvement Act (Farm Bill) has enabled the rapid proliferation of hemp-derived cannabinoid products, including delta-8 tetrahydrocannabinol (Δ8-THC), delta-10 THC, THCP, THCV, and other novel psychoactive compounds, which are widely available and often marketed as "legal" or "medical" products; and

WHEREAS, These emerging cannabinoid products are frequently unregulated, inconsistently labeled, and may contain variable concentrations of psychoactive compounds and contaminants; and

WHEREAS, Emergency departments are increasingly encountering adverse events associated with these products, including central nervous system depression, agitation, and other toxic effects; and

WHEREAS, Pediatric populations are at particular risk, with rising rates of unintentional exposures to cannabinoid-containing edibles and concentrates resulting in significant morbidity; and

WHEREAS, The lack of clear terminology within ACEP policy may contribute to confusion among clinicians, policymakers, and the public regarding the safety, regulation, and appropriate use of cannabinoid products; therefore be it

RESOLVED, That ACEP revise its policy statement "Medical Cannabis" to include a clear and explicit definition of "medical cannabis," distinguishing between FDA-approved cannabinoid medications, state-regulated cannabis products, and non–FDA-approved hemp-derived psychoactive cannabinoids; and be it further

RESOLVED, That ACEP update its policy statement "Medical Cannabis" to specifically acknowledge the emergence of hemp-derived psychoactive cannabinoids (including but not limited to delta-8 THC and similar

compounds) and their associated clinical and public health risks; and be it further

RESOLVED, That ACEP incorporate language in the policy statement "Medical Cannabis" to address the risks of unintentional pediatric exposures to cannabinoid-containing products and support measures to reduce such exposures, including improved labeling, packaging, and public education; and be it further

RESOLVED, That ACEP advocate for standardized nomenclature, regulation, and research regarding emerging cannabinoid products to better inform emergency physicians and protect public health.

Background

This resolution asks the College to revise its existing policy statement on medical cannabis to distinguish between FDA-approved cannabinoid medications, state-regulated cannabis products, and non-FDA-approved hemp-derived psychoactive cannabinoids. It also aims to explicitly acknowledge the clinical and public health risks posed by the latter category, to address pediatric exposure risks, and to advocate for standardized nomenclature, regulation, and research regarding emerging cannabinoid products.

ACEP has taken steps to address cannabis-related clinical issues. The Board of Directors approved the Clinical Policy: Critical Issue Related to Harms of Cannabis Exposure in Adult Patients Presenting to the Emergency Department, Cardiovascular Considerations in September 2025, which addresses cardiovascular considerations. ACEP's "Medical Cannabis" policy statement emphasizes the importance of scientifically valid, well-controlled clinical trials to assess the safety and efficacy of cannabis and cannabis derivative products; however, the policy does not define medical cannabis, nor does it distinguish among the three distinct regulatory categories of cannabinoid products now available to patients and consumers. This gap has become clinically significant as the product landscape has changed dramatically since the policy was first developed. Neither of these policies explicitly address the definitional distinctions among FDA-approved cannabinoid medications, state-regulated cannabis products, and the rapidly expanding category of non-FDA-approved hemp-derived psychoactive cannabinoids, nor do they specifically address the nomenclature, labeling, and pediatric exposure concerns that are the focus of this resolution.

The pivotal regulatory development underlying this resolution is the Agriculture Improvement Act of 2018 (the "Farm Bill"), which removed hemp from the federal list of controlled substances and permitted the sale and use of hemp-derived products containing no more than 0.3% delta-9 THC by dry weight. However, this law does not address delta-8 THC, leading some states to ban this compound's use and sale. The result has been a proliferation of hemp-derived psychoactive cannabinoids, including delta-8 THC, delta-10 THC, THCP, THCV, and related compounds that are widely sold in convenience stores, gas stations, smoke shops, and online, without the regulatory oversight applied to either FDA-approved drugs or state-licensed marijuana dispensaries.

Delta-8 THC is one of over 100 cannabinoids produced naturally by the cannabis plant but is not found in significant amounts. As a result, concentrated amounts of delta-8 THC are typically manufactured from hemp-derived cannabidiol (CBD). Delta-8 THC exists naturally in the cannabis plant in only small quantities and is estimated to be about 50-75% as psychoactive as delta-9 THC. CBD can be synthetically converted into delta-8 THC, as well as delta-9 THC and other THC isomers to produce higher concentrations of delta-8 THC than those found naturally. This conversion process, used to produce some marketed products, may create harmful by-products that presently are not well-characterized.

The public health and emergency medicine implications of this regulatory gap are substantial. Delta-8 THC products have not been evaluated or approved by the FDA for safe use in any context. They may be marketed in ways that put the public at risk and should especially be kept out of reach of children and pets. The FDA has documented a sharp rise in adverse events. Between December 1, 2020, and February 28, 2022, the FDA received 104 reports of adverse events in patients who consumed delta-8 THC products, and national poison control centers received 2,362 exposure cases involving delta-8 THC products between January 1, 2021, and February 28, 2022. The CDC issued a Health Alert Network advisory in September 2021 to alert the public to the increased availability of cannabis products containing delta-8 THC and the potential for adverse events due to insufficient labeling of products containing THC and cannabidiol (CBD).

A particular concern for emergency physicians is the risk to pediatric patients. Most states and territories permit full or restricted hemp marketplaces that sell hemp and hemp-derived CBD products. Products sold as concentrated delta-8 THC are also available online. These products are frequently packaged as gummies, chocolates, and other edibles, and because there are no federal age restrictions on their sale, unintentional pediatric ingestions have increased. The CDC advisory noted that products labeled with only delta-9 THC content rather than total THC content likely underestimate the psychoactive potential of these products for consumers, compounding the risk of unexpected intoxication.

The labeling and product quality concerns are equally significant. Delta-8 THC products have not been evaluated or approved by the FDA for safe use and may be marketed in ways that put public health at risk. These products have not been evaluated or approved by the FDA for safe use in any context. Some concerns include variability in product formulations and product labeling, other cannabinoid and terpene content, and variable delta-8 THC concentrations. Additionally, because testing methods for synthetically derived delta-8 THC are still being developed, these products may not be systematically tested for contaminants such as heavy metals, solvents, or pesticides.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.
>
> Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 8: Promote education about emergency medicine for patients and for the general public.

Fiscal Impact

This is not a current budgeted initiative and would require diverting current committee and staff resources from other work or inclusion in the next fiscal year budget. Estimated staff resources of 80 – 120 hours (approximately 0.05-0.07 FTE), with a cost range of $8,000 – $15,000.

Prior Council Action

Resolution 30(22) Compassionate Access to Medical Cannabis Act – “Ryan’s Law” not adopted. The resolution requested that ACEP support allowing patients access to medical cannabis; endorse and support passage of Ryan’s Law across the U.S.; and, endorse, support, and assist chapters in the passage of Ryan’s Law legislation in their states.

Amended Resolution 50(21) Complications of Marijuana Use adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

Resolution 37(18) ACEP Policy Related to “Recreational” Cannabis not adopted. Called for ACEP to align with and adopt as ACEP policy relevant sections of the American Medical Association's policies on recreational use of cannabis.

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support well-controlled studies of cannabis and related cannabinoids for medical use in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy or harm, and the application of such results to the understanding and treatment of disease.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids, and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. Directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Prior Board Action

September 2025, affirmed the findings of the Clinical Policies Committee that the intent of the first resolved of Amended Resolution 50(21) Complications of Marijuana Use had been met following publication of the "Clinical Policy: Critical Issue Related to Harms of Cannabis Exposure in Adult Patients Presenting to the Emergency Department, Cardiovascular Considerations" and that no additional practice guidelines on this issue need to be developed at this time.

September 2025, approved the Clinical Policy: Critical Issue Related to Harms of Cannabis Exposure in Adult Patients Presenting to the Emergency Department, Cardiovascular Considerations.

April 2025, approved the revised policy statement "Medical Cannabis"

Amended Resolution 50(21) Complications of Marijuana Use adopted.

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis. Directed ACEP to support well-controlled studies of cannabis and related cannabinoids for medical use in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy or harm, and the application of such results to the understanding and treatment of disease.

June 2017, approved the recommendation from the Emergency Medicine Practice Committee, Ethics Committee, Medical Legal Committee, and Public Health & Injury Prevention Committee to take no further action on referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Sam Shahid, MBBS, MPH
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 43(26)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Emergency Department–Initiated Pharmacotherapy Pathways for Alcohol Use Disorder

PURPOSE: Create a policy statement on ED-initiated treatment of moderate-to-severe alcohol use disorder, including anti-craving medications, and promote multidisciplinary care models integrating medication initiation, patient education, and coordinated follow-up.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Estimated committee and staff resources of 200 – 300 hours with a cost range of $15,000 – $25,000 to create the policy statement. Additional costs of 1.0 FTE ($75,000 – $100,000) to involve multiple stakeholders, conduct environmental scans of standards and current best practices, develop consensus statements, etc. and for promotion of multidisciplinary care models, plus costs for ongoing work to implement and support efforts moving forward.

WHEREAS, Alcohol use disorder (AUD) affects approximately 29 million adults in the United States and is a major contributor to emergency department (ED) visits, injury, hospitalization, and mortality; and

WHEREAS, FDA-approved medications for alcohol use disorder, including naltrexone, acamprosate, and disulfiram, have demonstrated efficacy in reducing heavy drinking and supporting abstinence; and

WHEREAS, FDA-approved medications for alcohol use disorder have numbers needed to treat comparable to widely used chronic disease medical therapies and are recommended in national treatment guidelines; and

WHEREAS, Despite established efficacy and FDA approval, fewer than approximately 2 % of patients with alcohol use disorder receive pharmacotherapy, representing a substantial evidence-to-practice gap; and

WHEREAS, Emergency department–initiated medications for opioid use disorder, particularly buprenorphine, have demonstrated improved treatment engagement and outcomes and have established the ED as an effective site for initiating evidence-based addiction treatment; and

WHEREAS, Emergency physicians, advanced practice clinicians, addiction specialists, and multidisciplinary care teams each play important and complementary roles in delivering safe, high-quality, team-based care for patients with alcohol use disorder; and

WHEREAS, Development of structured ED-based pathways, including medication initiation, brief intervention, and coordinated follow-up, may represent an important opportunity to improve outcomes for patients with alcohol use disorder; now, therefore be it

RESOLVED, That ACEP create a policy statement for emergency department-initiated treatment of moderate-severe alcohol use disorder, including the use of anti-craving medications; and be it further

RESOLVED, That ACEP promote multidisciplinary care models, analogous to emergency department medication assisted treatment (MAT) programs for opiate use disorder, that integrate medication initiation, patient education, and coordinated follow-up for individuals with alcohol use disorder.

Background

This resolution asks ACEP to create a policy statement on emergency department-initiated treatment of moderate-to-severe alcohol use disorder (AUD), including the use of anti-craving medications. It also calls for promotion of multidisciplinary care models that integrate medication initiation, patient education, and coordinated follow-up for individuals with AUD that is analogous to existing ED medication-assisted treatment (MAT) programs for opioid use disorder.

Alcohol use disorder is a significant and growing public health problem with direct consequences for emergency medicine. AUD affects roughly 29 million individuals in the United States. Alcohol contributes to approximately 140,000 deaths annually in the United States, making it a leading preventable cause of death. From 2021 to 2023, alcohol-related ED visits accounted for approximately nine million cases, which is double the number of opioid-related visits during the same period and represent a 50% rise in alcohol-related visits since the early 2000s. For many patients with AUD, the ED serves as the primary, and sometimes only, point of contact with the health care system.

Despite this burden, EDs are substantially underutilized as settings for AUD intervention. Currently, roughly 8% of patients who present to the ED are screened for AUD, and a national survey found that 77% of ED directors reported that patients are "never" or "rarely" screened using a validated screening tool, with only 9% offering brief behavioral interventions. Medications for AUD are rarely prescribed in the ED; data indicate that fewer than 1% of AUD patients are initiated on treatment annually in the ED setting, and as of 2024, across all individuals and settings, fewer than 3% of individuals with AUD received any medication to help reduce or stop their drinking. This represents a substantial evidence-to-practice gap.

Three medications are currently FDA-approved for the treatment of AUD: naltrexone, acamprosate, and disulfiram. Multiple studies have demonstrated that both naltrexone and acamprosate are associated with reductions in return to heavy drinking. Naltrexone is particularly well-suited to ED initiation because it may retain efficacy in actively drinking patients and is available in a 30-day extended-release injectable formulation, which is advantageous for patients with reduced medication adherence. Disulfiram has less supporting efficacy data and requires abstinence from alcohol, limiting its utility in the acute ED setting. Evidence-supported treatment of AUD consists of a combination of pharmacotherapy, behavioral treatments, and community recovery support, tailored to the individual.

Early feasibility studies of ED-initiated naltrexone have shown promising results. A 2021 study published in *Annals of Emergency Medicine* implemented a protocol combining substance use navigation with oral or extended-release intramuscular naltrexone for ED patients with moderate-to-severe AUD. Among 59 patients who accepted treatment, had a brief intervention, and initiation of naltrexone resulted in a 15% follow-up rate in formal addiction treatment within 30 days. Patients who received extended-release intramuscular naltrexone had a higher 30-day follow-up rate (27.8%) than those who received oral naltrexone (9.8%). Additional research has examined the feasibility of initiating extended-release injectable naltrexone with case management in the ED, further supporting the concept that ED visits are prime opportunities to provide AUD intervention and initiate pharmacotherapy.

The resolution draws an explicit parallel to the well-established model of ED-initiated medication for opioid use disorder (OUD). Emergency physicians have led efforts to confront OUD by initiating medications such as buprenorphine in the ED. A landmark Yale study found that 78% of ED patients assigned to receive buprenorphine initiation and referral to a primary care physician were receiving treatment at 30 days. ACEP has supported ED-initiated OUD treatment through education, federal legislative advocacy, and the development of consensus guidelines on the treatment of OUD in the emergency department, approved by the Board of Directors in January 2021.

ACEP does not currently have a policy statement specifically addressing ED-initiated pharmacotherapy for AUD, although AUD is partially addressed in ACEP's policy statements "Screening for Disease and Risk Factors in the Emergency Department" and "Screening Questions at Triage." *ACEP Now* published an article in February 2026 on AUD screening tools and medications in the ED, reflecting growing interest in this topic within the emergency medicine community.

Additionally, the ACEP E-QUAL Opioid Initiative has officially expanded to integrate alcohol use disorder (AUD) content to address polysubstance use and bridge a massive gap in emergency department (ED) addiction care. This

integration transitions the program from a strict focus on opioids into a broader, comprehensive Substance Use Disorder (SUD) Initiative. The integrated E-QUAL Substance Use Disorder Toolkits now include joint webinar series, CME credits, and pocket cards designed to help ED staff seamlessly manage both substances under a unified quality improvement protocol. The expansion of the ACEP E-QUAL Substance Use Disorder Initiative incorporates four specific clinical pillars of alcohol use disorder (AUD) management directly into the emergency medicine workflow: Rapid ED-Friendly Screening Tools, Initiation of Anti-Craving Medications (MAUD), Modernized Ambulatory Withdrawal Management and Harm Reduction & Polysubstance Safety.

Resources on alcohol screening and brief interventions in the ED are available on the ACEP website. The resources provide facts and benefits of screening and providing brief intervention for patients presenting to the emergency department with alcohol problems. Screening tools and a template for locating community resources are also included.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Estimated committee and staff resources of 200 – 300 hours with a cost range of $15,000 – $25,000 to create the policy statement. Additional costs of 1.0 FTE ($75,000 – $100,000) to involve multiple stakeholders, conduct environmental scans of standards and current best practices, develop consensus statements, etc. and for promotion of multidisciplinary care models, plus costs for ongoing work to implement and support efforts moving forward.

Prior Council Action

Amended Resolution 73(25) "Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation" adopted. Directed ACEP to develop a plan to promote and facilitate the initiation of nation-wide ED programs to improve substance use disorder treatment, including staff training, dispensing harm reduction materials, initiating evidence-based medication where applicable, and rapid clinical referrals to outpatient treatment; work with relevant stakeholder organizations to obtain funding for substance use disorder programs; and report back to the Council in a timely manner on progress.

Substitute Resolution 46(23) Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder adopted. Directed ACEP to create a policy statement based on the concepts of the "American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist."

Resolution 31(19) Improving Emergency Physicians Utilization of Medication for Addiction Treatment not adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful

therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and advocate for elimination of X-waiver to initiate MAT from the ED.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted. Directed ACEP to advocate for federal/state appropriations and/or grants for use in fully funding substance abuse intervention programs that are accessible 24/7 and will be initiated in EDs, and that ACEP advocate for federal/state funding for substance abuse intervention programs that will be accessible to their full potential by all patients regardless of insurance status or ability to pay.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted. Directed ACEP to pursue legislation for federal/state appropriation funding and/or grants for initiating MAT in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient follow-up.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

Amended Resolution 21(12) Support of Non-Punitive Sobering Centers and Community Recovery Services adopted. Directed ACEP to explore the development of sobering centers, identify medical and professional needs for these community centers, and promulgate efforts to appropriately support the development of these entities in communities.

Prior Board Action

Amended Resolution 73(25) Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation adopted.

September 2025, approved the revised policy statement "Screening for Disease and Risk Factors in the Emergency Department;" originally approved April 2021.

June 2024, approved the policy statement "Care of Pregnant Individuals with Substance Use Disorder."

October 2023, approved the policy statement "Overdose Prevention Centers."

Substitute Resolution 46(23) Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder adopted.

April 2023, sunset the policy statement "Alcohol Screening in the Emergency Department;" revised and approved April 2011 and originally approved January 2005.

June 2021, reviewed the Policy Resource & Education Paper "Screening for Disease and Risk Factors in the Emergency Department."

October 2020, reviewed the information paper "Stigma in the Emergency Department."

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

October 2013, reviewed the report on Sobering Centers developed by the Public Health & Injury Prevention Committee.

Amended Resolution 21(12) Support of Non-Punitive Sobering Centers and Community Recovery Services adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

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Council Secretary and Executive Director

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American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

RESOLUTION: 44(26)

SUBMITTED BY: Jessica Army, MD
Rebecca Barron, MD
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Laura Melville, MD
Rebecca Nerenberg, MD
Tiffany Sigal, MD, FACEP
Juhi Varshney, MD

SUBJECT: Contraceptive Provision is Within the Scope of Emergency Medicine Practice

PURPOSE: Directs the Board to assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed develop an educational resource and model residency curriculum on contraceptive care in the ED and to advocate for the removal of systemic barriers, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles, that limit patient access to contraceptive services in the emergency care setting.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require resources to convene a task force or working group to develop an educational resource and model residency curriculum. Estimated 200 – 400 staff hours ($15,000 – $40,000); potential vendor or subject matter expert costs of $15,000 – $40,000), and conduct ongoing federal and state advocacy to address formulary, insurance, reimbursement, and regulatory barriers, estimated 100 – 200 staff hours annually ($10,000 – $20,000). Total estimated cost is $40,000 – $100,000 in year one. Additional costs of approximately $20,000 – $30,000 if an in-person task force or work group meeting is held. Ongoing annual advocacy costs could potentially require 1.0 FTE, approximately $150,000.

WHEREAS, Approximately half of all pregnancies in the United States are unintended, with rates exceeding 80% among women aged 19 years and younger; and

WHEREAS, Millions of people in the United States live in contraceptive deserts with limited or no access to comprehensive reproductive health services, and these barriers are intensified by Medicaid restrictions, closure of reproductive health clinics, physician shortages, and growing reproductive health inequities; and

WHEREAS, Women of reproductive age account for nearly a quarter of all emergency department (ED) visits, and female ED patients are at significantly greater risk for unintended pregnancy compared to the general population, with studies demonstrating that one-third of women presenting to the ED are either pregnant or at high risk of becoming pregnant in the next year; and

WHEREAS, Emergency departments act as the health care safety net or sole points of health care access for many underserved and marginalized populations who are also up to 50% more likely to experience unintended pregnancy than their non-marginalized peers; and

WHEREAS, Evidence demonstrates that ED patients express strong interest in receiving contraceptive services during their ED visit, with over 55% of women of childbearing age indicating a desire to access contraception services in the ED setting; and

WHEREAS, ED-initiated contraception—including counseling, prescribing oral and emergency contraception, and placement of long-acting reversible contraception (LARC) such as the subdermal implant—has been demonstrated to be feasible, safe, and effective in published peer-reviewed literature; and

WHEREAS, The ED is the only place patients can receive a prescription 24/7 for the most effective form of oral emergency contraceptive (ulipristal acetate, ella), but that medication is not readily stocked in emergency departments and pharmacies limiting the utility of ED care; and

WHEREAS, Multidisciplinary frameworks such as "ContraceptED" have shown that emergency clinicians can be successfully trained in contraception counseling, hormonal contraception prescribing, and LARC insertion, and can integrate these skills into routine ED workflow; and

WHEREAS, The provision of contraception in the ED is consistent with the core mission of emergency medicine to provide immediate, patient-centered care, reduce downstream emergencies, and address health inequities; and

WHEREAS, Emergency physicians already routinely prescribe and manage medications with comparable or greater complexity and risk profiles than contraceptive agents, and the scope-of-practice concerns related to contraception are similar to those encountered with many other medications already managed in the ED; and

WHEREAS, Unintended pregnancies have been shown to increase the risk of unplanned birth, termination of pregnancy, miscarriage, pre-term or low birth weight infants; and

WHEREAS, Unintended pregnancy confers increased risk of maternal depression, interpersonal violence, postpartum depression, and delayed prenatal care; and

WHEREAS, The American Academy of Pediatrics (AAP) has issued policy statements encouraging routine counseling and advance prescription of emergency contraception as a public health strategy; and

WHEREAS, A multicenter study of adolescents in pediatric EDs found an unintended pregnancy risk of nearly 8% per year, yet only 5.6% of those eligible for emergency contraception actually received it, demonstrating a critical gap in care; and

WHEREAS, Women with suicidal ideation, substance use disorders, or intimate partner violence populations with unintended pregnancy rates as high as 90% have even less contraceptive documentation in the ED despite disproportionately relying on emergency care; and

WHEREAS, The changing reproductive healthcare landscape, including restricted access to abortion services in many states, has increased the urgency of ensuring access to effective contraception at every point of care; and

WHEREAS, Some patients still face co-pays when filling emergency department prescriptions for contraception that are prohibitively expensive despite the Affordable Care Act's requirement that contraception be available with no cost sharing; and

WHEREAS, The ACEP policy statement on "Access to Reproductive Health Care in the Emergency Department" encourages hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based reproductive healthcare practices; and

WHEREAS, ACEP Strategic Priorities call for equipping emergency physicians with the resources and education necessary to meet the evolving needs of the populations they serve and address health inequities; and

WHEREAS, ACEP does not currently have a policy statement affirming that contraception provision, including counseling, prescribing, and initiation, is within the scope of practice of emergency medicine; therefore be it

RESOLVED, That the ACEP Board of Directors assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed to develop and publish an educational resource and model residency curriculum to equip emergency physicians with the knowledge and skills necessary to provide contraceptive care (including contraception counseling, prescribing and initiation) in the ED; and be it further

RESOLVED, That the ACEP Board of Directors advocate for the removal of systemic barriers to ED-based contraception provision, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles that limit patient access to contraceptive services in the emergency care setting.

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Background

This resolution directs the Board of Directors to assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed to develop an educational resource and model residency curriculum on contraceptive care in the ED and to advocate for the removal of systemic barriers, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles, that limit patient access to contraceptive services in the emergency care setting.

Note: The Board of Directors approved the formation of the Reproductive Health Section in January 2026. The section has reached the required minimum of 100 members and the section will approve its operational guidelines during ACEP26 in Chicago. The operational guidelines will be submitted to the Board for approval following approval by the section.

Unintended pregnancy remains a significant public health problem in the United States. According to the Guttmacher Institute, approximately half of all pregnancies in the United States are unintended, with rates disproportionately high among adolescents and young adults. Women of reproductive age account for a substantial share of all ED visits and CDC data indicate that women represent approximately 55% of emergency department visits. Published research has found that roughly one-third of women presenting to the ED are either pregnant or at elevated risk of becoming pregnant within the following year (Todd et al., Contraception, 2005). Emergency departments therefore can fill the gap in health care providing a point of contact for contraceptive services.

Access to contraception outside the ED is uneven and worsening in many parts of the country. Millions of people live in contraceptive deserts, which are areas with limited or no access to comprehensive reproductive health services, because of Medicaid restrictions, clinic closures, physician shortages, and growing reproductive health inequities. The post-Dobbs legal landscape has intensified these pressures, and some states have restricted, or are considering restricting, access to emergency contraception or other contraceptives, creating additional uncertainty for both patients and providers. ACEP has submitted amicus briefs in United States v. State of Idaho and Texas v. Becerra to defend emergency physicians' obligations under EMTALA and their ability to provide appropriate care to pregnant patients without fear of legal consequences.

Patient interest in receiving contraceptive services in the ED is well documented. A cross-sectional survey published in the Western Journal of Emergency Medicine (Alexander et al., 2021) found that over 55% of women of childbearing age indicated a desire to access contraception services in the ED setting. Despite this demand, contraceptive provision in the ED remains rare. A multicenter study of adolescents in pediatric EDs found an unintended pregnancy risk of nearly 8% per year, yet only 5.6% of those eligible for emergency contraception actually received it (Canter et al., JAMA Network Open, 2024). Similarly, a 2025 study in the Western Journal of Emergency Medicine found that women with suicidal ideation, substance use disorders, or intimate partner violence, populations with unintended pregnancy rates as high as 90%, had minimal contraceptive documentation in the ED despite disproportionately relying on emergency care (Ruch et al., 2025).

The clinical feasibility of ED-initiated contraception has been established in the peer-reviewed literature. Multidisciplinary frameworks such as "ContraceptED" have demonstrated that emergency clinicians can be successfully trained in contraception counseling, hormonal contraception prescribing, and long-acting reversible contraception (LARC) insertion, and can integrate these skills into routine ED workflow (Liang et al., *Annals of Emergency Medicine*, 2023). A 2026 article in the *Journal of Emergency Medicine* by Cline, Downey, Rashid, Vora, and Fine further argues the imperative of contraception initiation in the ED, noting that the ED is the only setting where patients can receive a prescription 24/7 for the most effective form of oral emergency contraceptive (ulipristal acetate, ella), yet that medication is not routinely stocked in EDs or nearby pharmacies, limiting its practical utility.

ACEP's policy statement "Access to Reproductive Healthcare in the Emergency Department" encourages hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based reproductive healthcare practices. However, as the resolution notes, ACEP does not currently have a policy statement affirmatively declaring that contraception provision, including counseling, prescribing, and initiation, is within the scope of practice of emergency medicine.

Other major medical organizations have taken more affirmative positions. The American College of Obstetricians and Gynecologists (ACOG) recommends that payers, hospitals, and health care systems include all FDA-approved contraceptive methods on formulary and ensure access without cost sharing or copays (ACOG Committee Statement No. 21, 2025). The American Academy of Pediatrics (AAP) has issued updated guidance encouraging routine contraception counseling and advance prescription of emergency contraception as a public health strategy. The Emergency Medicine Residents' Association (EMRA) has existing policy supporting access to women's health care, including reproductive health care. These positions from peer organizations provide a supportive context although none specifically addresses the scope-of-practice question for emergency physicians.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards,

Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.

Objective 7: Encourage and facilitate training and education in emergency medicine for all medical students.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 4: Develop educational and other resources to prepare emergency physicians for roles in evolving and emerging administrative, clinical, and educational settings.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require resources to convene a task force or working group to develop an educational resource and model residency curriculum. Estimated 200 – 400 staff hours ($15,000 – $40,000); potential vendor or subject matter expert costs of $15,000 – $40,000), and conduct ongoing federal and state advocacy to address formulary, insurance, reimbursement, and regulatory barriers, estimated 100 – 200 staff hours annually ($10,000 – $20,000). Total estimated cost is $40,000 – $100,000 in year one. Additional costs of approximately $20,000 – $30,000 if an in-person task force or work group meeting is held. Ongoing annual advocacy costs could potentially require 1.0 FTE, approximately $150,000.

Prior Council Action

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted. The resolution directed ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide and to advocate for universal access to emergency contraception in the ED.

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement "Management of the Patient with the Complaint of Sexual Assault" accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly.

Prior Board Action

January 2026, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed February 2020, April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted.

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
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Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 45(26)

SUBMITTED BY: Emily Ager, MD, MPH; Michael Bresler, MD, FACEP; Jacqueline Dziedzic, DO, FACEP; Lauren Fine, MD, FACEP; Alicia Gonzalez, MD, FACEP; Laura Melville, MD; Carl Preiksaitis, MD, MEd; Kelly Quinley, MD; Monica Saxena MD, JD; California Chapter

SUBJECT: Medical Management of Early Pregnancy Loss in the Emergency Department

PURPOSE: Update ACEP's existing policy "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" to include specific medication management regimens, and develop a curriculum for emergency medicine clinicians on the diagnosis and treatment of early pregnancy loss in the emergency department, in collaboration with CORD and other relevant groups.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated $15,000 – $30,000 for committee and staff resources to update the policy statement. Working with CORD and others to develop a curriculum would require additional funds, estimated at $30,000 for staff time and resources.

WHEREAS, Early pregnancy loss (EPL – aka first trimester miscarriage) occurs in approximately 10–20% of clinically recognized pregnancies and is one of the most common conditions encountered in emergency departments;[1] and

WHEREAS, The ACEP policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" recognizes early pregnancy loss as a common and potentially life-threatening emergency department diagnosis, and does not specifically outline medication treatment regimens nor provide guidance for treating first trimester miscarriage; and

WHEREAS, The ACEP policy statement "Access to Reproductive Health Care in the Emergency Department" encourages hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications including miscarriage; and

WHEREAS, ACEP's strategic priorities call for fostering innovation in emergency medicine practice and equipping emergency physicians with the resources and education necessary to meet the evolving needs of the populations they serve; and

WHEREAS, Emergency departments are increasingly experiencing overcrowding, and treating patients with miscarriage in the emergency department with medication or procedural management decreases ED repeat visits (aka bouncebacks")[2-4]; and

WHEREAS, The addition of mifepristone to misoprostol, compared to misoprostol alone, greatly increases the efficacy of medication treatment of miscarriage, resulting in less patients later needing repeat medication treatment and less patients needing uterine aspiration to fully treat their miscarriage[5]; and

WHEREAS, Clinical guidelines from the American College of Obstetricians and Gynecologists (ACOG) recommend that mifepristone, when available, be used in conjunction with misoprostol for the treatment of miscarriage[6]; and

WHEREAS, Despite these ACOG recommendations, less than 20% of emergency medicine clinicians consistently offer EPL treatment, and mifepristone and misoprostol are being underutilized in EDs[2,4,7]; and

WHEREAS, Emergency medicine residents, physicians, nurses and administrators report many barriers to providing miscarriage care, including lack of training and gaps in clinician knowledge, and patients report high levels of dissatisfaction with their care and lack of timely follow-up for miscarriage addressed in the ED[8-13]; and

WHEREAS, Patients seeking care for EPL in the ED are more likely to be socioeconomically and psychosocially vulnerable than those cared for in the ambulatory setting[12,14]; and

WHEREAS, The U.S. widely is experiencing continued closures of Labor and Delivery Units in hospitals across the country, with over 500 hospitals having closed their Labor and Delivery Units since 2021, increasing the likelihood that emergency physicians will be caring for patients with a miscarriage in an ED without a 24-hour in-house OBGYN consultant, and leaving emergency clinicians to expect more delays in consults and reproductive health follow-up care[12]; and

WHEREAS, Following the Dobbs v Jackson Women's Health Organization Supreme Court decision, states implementing trigger abortion bans experienced decreased prescribing of medication management for miscarriage, and emergency clinicians concern about the overlap between abortion care and miscarriage care may contribute to confusion and hesitation in providing legally permissible miscarriage treatment[16,17]; and

WHEREAS, A 2026 study of emergency residencies in Texas found that approximately one quarter of respondents did not recognize mifepristone or misoprostol as legal treatment for confirmed early pregnancy loss[18]; and

WHEREAS, ACEP has a longstanding history of collaborating with the Council of Residency Directors (CORD) in Emergency Medicine to improve emergency medicine education and curricula; and

WHEREAS, Emergency physicians would benefit having more explicit support from ACEP in using medication management of early pregnancy loss across all ED settings; therefore be it

RESOLVED, That ACEP, supporting clinical practice in line with the American College of Obstetricians and Gynecologists Practice Bulletin and clinical guidelines for medication management of early pregnancy loss, update the existing policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" to include the medication management regimens that can be offered to patients with early pregnancy loss in the ED; and be it further

RESOLVED, That ACEP expand on the miscarriage management resources available on the website by collaborating with Council of Residency Directors in Emergency Medicine and other relevant groups to develop a curriculum for emergency medicine clinicians for diagnosis and treatment of early pregnancy loss in the emergency department, highlighting medication management regimens, as standard in emergency medicine.

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Background

This resolution directs ACEP to update its existing policy statement on the emergency physician's role in the medication and procedural management of early pregnancy loss to include specific medication management regimens, and to develop a curriculum for emergency medicine clinicians on the diagnosis and treatment of early pregnancy loss in the emergency department, in collaboration with the Council of Residency Directors in Emergency Medicine (CORD) and other relevant groups.

Early pregnancy loss (EPL), also known as first-trimester miscarriage, occurs in up to 20% of clinically recognized pregnancies and is a common condition encountered in emergency departments. Each year, over 900,000 patients present to the emergency department with early pregnancy loss, accounting for 2.7% of all ED visits for women ages 15-44 years. Compared with other ED patients, patients presenting with early pregnancy loss are more likely to be younger, Black or Hispanic, or publicly insured. Pregnancy complications are the fifth most common reason women between ages 15-64 visit EDs in the United States. An estimated quarter of all women will experience early pregnancy loss in their lifetime, and 20% of these losses will require some form of intervention to completely clear the uterus of retained tissue.

ACEP's policy statement, "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" recognizes early pregnancy loss as a common and potentially life-threatening emergency department diagnosis and acknowledges the emergency physician's role in its management, but does not specifically outline medication treatment regimens. ACEP maintains a resource page on early pregnancy loss management, and additional emergency reproductive health information and resources on the website. ACEP is also actively working with ACOG to develop additional resources for emergency physicians treating patients with early pregnancy loss.

Three management approaches exist for early pregnancy loss: expectant management, medication management, and procedural management. Expectant management is approximately 61% effective by 14 days, with 28% of patients ultimately requiring a procedure and resolution potentially taking up to 8 weeks. Medication management with mifepristone and misoprostol is 84-93% effective by 8 days, offers quicker resolution than expectant management, and results in fewer return visits to the ED. Uterine aspiration is nearly 100% effective on the same day but is more time-intensive, requires procedural space, and carries a risk of procedural complications. Clinical guidelines from the American College of Obstetricians and Gynecologists (ACOG) recommend that mifepristone, when available, be used in conjunction with misoprostol for the treatment of miscarriage, as the combination is significantly more effective than misoprostol alone, resulting in fewer patients requiring repeat medication treatment or uterine aspiration. Over 70% of obstetricians provide either procedural or medication interventions for miscarriage management. Despite these

recommendations, fewer than 20% of emergency medicine clinicians consistently offer early pregnancy loss treatment, and mifepristone and misoprostol are underutilized in emergency departments. Emergency medicine residents, physicians, nurses, and administrators report barriers including lack of training and gaps in clinician knowledge. A 2026 study of emergency residencies in Texas found that approximately one quarter of respondents did not recognize mifepristone or misoprostol as legal treatment for confirmed early pregnancy loss.

The post-Dobbs legal environment has compounded these challenges. States implementing trigger abortion bans experienced decreased prescribing of medication management for miscarriage following the Dobbs v. Jackson Women's Health Organization decision, and emergency clinicians' concern about the overlap between abortion care and miscarriage care may contribute to confusion and hesitation in providing legally permissible miscarriage treatment. Separately, the ongoing closure of obstetric services across the country is increasing the frequency with which emergency physicians must manage early pregnancy loss without specialist backup. An August 2023 report from the March of Dimes demonstrates that almost one in ten counties in the United States do not have an obstetrics unit in their hospitals, leaving 5.6 million women in counties with limited maternity care, including EPL management. The resolution notes that more than 500 hospitals have closed their Labor and Delivery Units since 2021, a figure that has grown substantially since the 217 closures documented as of a February 2023 report cited in prior Council background materials. Legal changes in the United States resulting in reduced access to family planning and abortion services will likely lead to increasing numbers of patients experiencing early pregnancy loss seeking care in an emergency department. These converging trends, underutilization of evidence-based medication regimens, clinician knowledge gaps, post-Dobbs confusion, and the erosion of in-house obstetric support, underscore the need for clinical guidance and a formal training curriculum for emergency physicians managing early pregnancy loss across all practice settings.

ACEP Strategic Plan Reference

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

> Objective 4: Develop educational and other resources to prepare emergency physicians for roles in evolving and emerging administrative, clinical, and educational settings.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated costs of $15,000 – $30,000 for committee and staff resources to update the policy statement. Working with CORD and others to develop a curriculum would require additional funds, estimated at $30,000 for staff time and resources.

Prior Council Action

Amended Resolution 48(25) Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA adopted. Directed ACEP to: 1) update the policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' unwavering ethical and legal obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; 2) affirm that

federal EMTALA obligations should supersede conflicting state laws or mandates that would prevent emergency physicians and all members of the medical staff from providing medically necessary stabilizing treatment for emergency medical conditions; 3) advocate for clear federal protections for emergency physicians and all members of the medical staff providing care in accordance with EMTALA requirements, particularly when such care conflicts with state laws; 4) work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and 5) provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors. The resolution requested the Board to have the Clinical Policies Committee issue recommendations on two clinical questions regarding medication management and procedural management of early pregnancy loss initiated in the emergency department.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Prior Board Action

March 2026, discussed the updated "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" and referred it back to the Clinical Policies Committee for additional revisions.

Amended Resolution 48(25) Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA adopted.

September 2024, approved the policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss."

April 2024, affirmed the Clinical Policies Committee's recommendation that a clinical policy on early pregnancy loss management not be pursued due to insufficient quality literature specific to emergency medicine, and that a policy statement be developed instead, consistent with the direction of Amended Resolution 45(23).

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy."

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 46(26)

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Emergency Ultrasound Section
Social Emergency Medicine Section

SUBJECT: Strengthening ACEP Educational Resources and Guidelines on the Ultrasonographic Diagnosis of Early Pregnancy Loss

PURPOSE: Request the Emergency Ultrasound Section to explore incorporating early pregnancy loss into the evaluation of first-trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines, and assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant committees and sections to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the ED.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Estimated costs include 0.25 – 0.5 FTE, approximately $15,000 – $30,000, to coordinate the guideline revision process and to support the working group tasked with developing the clinical resource. Additional costs of approximately $20,000 – $30,000 if an in-person meeting is held.

WHEREAS, Early pregnancy loss (miscarriage) occurs in approximately 10–20% of clinically recognized pregnancies and is one of the most common conditions encountered in emergency departments; and

WHEREAS, The ACEP policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" recognizes early pregnancy loss as a common and potentially life-threatening emergency department diagnosis; and

WHEREAS, Emergency physicians are frequently the first clinicians to evaluate patients presenting with first-trimester vaginal bleeding and/or abdominal pain, and must distinguish early pregnancy loss from ectopic pregnancy, molar pregnancy, and viable intrauterine pregnancy; and

WHEREAS, The ACEP policy statement "Access to Reproductive Health Care in the Emergency Department" encourages hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications including miscarriage; and

WHEREAS, ACEP's Strategic Priorities call for fostering innovation in emergency medicine practice and equipping emergency physicians with the resources and education necessary to meet the evolving needs of the populations they serve; and

WHEREAS, The current ACEP "Clinical Policy on Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" focuses primarily on the evaluation of

ectopic pregnancy and the use of β-hCG discriminatory thresholds, and does not comprehensively address the ultrasonographic criteria for the definitive diagnosis of early pregnancy loss; and

WHEREAS, The ACEP "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine" recognizes the importance of emergency ultrasound as a core clinical bedside skill for practicing emergency physicians; and

WHEREAS, The ACEP "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine" identify pregnancy ultrasound as clinically valuable in the first trimester pregnant patient for the diagnosis of an intrauterine pregnancy, indeterminate location of pregnancy, ectopic pregnancy, molar pregnancy or fetal demise; and

WHEREAS, The diagnostic criteria for early pregnancy loss have undergone significant revision in recent years, with the Society of Radiologists in Ultrasound, the American College of Obstetricians and Gynecologists, and international consensus groups adopting more conservative thresholds — including a crown-rump length (CRL) ≥7 mm without cardiac activity and a mean gestational sac diameter (MSD) ≥25 mm without a visible embryo to achieve near-100% specificity and prevent the misdiagnosis of viable pregnancies; and

WHEREAS, There is significant variation among providers and institutions in the diagnostic algorithms used to evaluate early pregnancy complications, and a lack of emergency medicine-specific educational resources on the sonographic diagnosis of pregnancy failure contributes to this variability; and

WHEREAS, Misdiagnosis of early pregnancy loss can have serious consequences including unnecessary surgical or medical intervention on a viable pregnancy, delayed diagnosis of ectopic pregnancy including severe morbidity and mortality, and significant psychological harm to patients; and

WHEREAS, Emergency physicians would benefit from a comprehensive, evidence-based clinical policy resource and education paper that synthesizes current ultrasonographic criteria, integrates POCUS applications, and provides clear diagnostic algorithms for early pregnancy loss tailored to the emergency department setting; therefore be it

RESOLVED, That the Board of Directors request the Emergency Ultrasound Section to explore including early pregnancy loss into the evaluation of first trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant committees and sections as needed to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the emergency department.

Resolution References

1. Coomarasamy A, Gallos ID, Papadopoulou A, et al. Sporadic miscarriage: evidence to provide effective care. *Lancet.* 2021;397(10285):1668–1674. DOI: 10.1016/S0140-6736(21)00683-8
2. Barnhart KT. Ectopic pregnancy. *N Engl J Med.* 2009;361(4):379–387. DOI: 10.1056/NEJMcp0810384
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4. American College of Emergency Physicians. Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine. Irving, TX: ACEP; 2023.
5. Doubilet PM, Benson CB, Bourne T, et al. Diagnostic criteria for nonviable pregnancy early in the first trimester. *N Engl J Med.* 2013;369(15):1443–1451. DOI: 10.1056/NEJMra1302417
6. Committee on Practice Bulletins—Gynecology. ACOG Practice Bulletin No. 200: Early Pregnancy Loss. *Obstet Gynecol.* 2018;132(5):e197–e207. DOI: 10.1097/AOG.0000000000002899
7. Rodgers SK, Horrow MM, Doubilet PM, et al. A Lexicon for First-Trimester US: Society of Radiologists in Ultrasound Consensus Conference Recommendations. Radiology. 2024 Aug;312(2):e240122. doi: 10.1148/radiol.240122

Background

This resolution asks the College to request the Emergency Ultrasound Section to explore incorporating early pregnancy loss into the evaluation of first-trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines, and to assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant bodies to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the ED.

Early pregnancy loss, defined as a nonviable intrauterine pregnancy identified before 13 weeks gestation, is one of the most common conditions encountered in EDs. Early pregnancy loss, or loss of an intrauterine pregnancy within the first trimester, is encountered commonly in clinical practice. It occurs in approximately 10-20% of clinically recognized pregnancies. Emergency physicians are frequently the first clinicians to evaluate patients presenting with first-trimester vaginal bleeding and/or abdominal pain, and must distinguish early pregnancy loss from ectopic pregnancy, molar pregnancy, and viable intrauterine pregnancy. Use of emergency ultrasound in pelvic disorders centers on the detection of intrauterine pregnancy, detection of ectopic pregnancy, detection of fetal heart rate in all stages of pregnancy, dating of the pregnancy, and detection of significant free fluid. Bedside pelvic ultrasound during the first trimester of pregnancy can be used to exclude ectopic pregnancy by demonstrating an intrauterine pregnancy. Emergency physician-performed pelvic ultrasound has been shown to save lives, expedite patient care, and improve patient satisfaction. ACEP's "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine" define pelvic ultrasound as a core application for the assessment of the first-trimester patient presenting with vaginal bleeding or abdominal pain.

The diagnostic criteria for early pregnancy loss have undergone significant revision in recent years. ACOG states that ultrasound is the "preferred modality to verify the presence of a viable intrauterine gestation." The 2012 Society of Radiologists in Ultrasound (SRU) Multispecialty Panel established more conservative diagnostic thresholds to achieve near-100% specificity and prevent the misdiagnosis of viable pregnancies. These include: a crown-rump length (CRL) of ≥7 mm without cardiac activity; a mean gestational sac diameter (MSD) of ≥25 mm without a visible embryo; absence of an embryo with heartbeat two weeks or more after a scan showing a gestational sac without a yolk sac; and absence of an embryo with heartbeat 11 or more days after a scan showing a gestational sac with a yolk sac. Findings that are suggestive but not diagnostic, such as a CRL less than 7 mm without cardiac activity or an MSD of 16-24 mm without an embryo, require follow-up imaging at 7-10 days before a definitive diagnosis of pregnancy loss can be made. Obstetricians and gynecologists should understand the use of various diagnostic tools to differentiate between viable and nonviable pregnancies and offer the full range of therapeutic options to patients, including expectant, medical, and surgical management. The SRU published an updated first-trimester ultrasound lexicon in 2024 (Rodgers et al, Radiology, August 2024), further refining terminology and diagnostic standards. These evolving criteria have not yet been incorporated into ACEP's emergency ultrasound or clinical policy guidance.

ACEP's policy statements "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" and "Access to Reproductive Healthcare in the Emergency Department" do not address the specific ultrasonographic diagnostic criteria for early pregnancy loss. This resolution is not duplicative of prior Council action and addresses a distinct and currently unmet need for emergency medicine-specific educational resources and updated ultrasound guideline content on the sonographic diagnosis of pregnancy failure. The concern about misdiagnosis is clinically significant and applying older or less conservative thresholds risks intervention on a viable pregnancy, delayed diagnosis of ectopic pregnancy, and significant psychological harm to patients.

ACEP's current "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" is structured around two critical questions focused on ectopic pregnancy evaluation and the diagnostic utility of β-hCG: (1) Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β-hCG level below a discriminatory threshold?; and (2) In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy? The clinical policy does not comprehensively address the ultrasonographic criteria for the definitive diagnosis of early pregnancy loss.

ACEP's policy statement, "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine" recognizes pregnancy ultrasound as clinically valuable in the first-trimester patient for the diagnosis of intrauterine pregnancy, indeterminate location of pregnancy, ectopic pregnancy, molar pregnancy, or fetal demise, but do not specifically address the updated sonographic criteria for early pregnancy loss diagnosis.

When the Clinical Policies Committee reviewed Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss, which called for clinical policy recommendations on the management of early pregnancy loss, it found that there is little literature (and no quality literature) on early pregnancy loss management in the ED. The remaining literature is written from the perspective of obstetrics and, even then, is poor quality. Based on the lack of sufficient quality literature to inform a clinical policy recommendation, the Clinical Policies Committee recommended that development of a clinical policy not be pursued and that a policy statement be developed regarding the role of emergency physicians in treating and evaluating patients presenting with early pregnancy loss. This finding underscores the absence of emergency medicine-specific educational resources and updated ultrasound guideline content on the sonographic diagnosis of pregnancy failure.

ACEP Strategic Plan Reference

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 6: Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.

Priority 3: Practice Innovation - ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

> Objective 4: Develop educational and other resources to prepare emergency physicians for roles in evolving and emerging administrative, clinical, and educational settings.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Implementation would require diverting current budgeted resources from other work or including funds in the next fiscal year budget. Estimated costs include 0.25 – 0.5 FTE, approximately $15,000 – $30,000, to coordinate the guideline revision process and to support the cross-committee and section working group tasked with developing the clinical resource. Additional costs of approximately $20,000 – $30,000 if an in-person meeting is held.

Prior Council Action

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted. Directed ACEP to work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Amended Resolution 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss referred to the Board of Directors. The resolution requested the Board to have the Clinical Policies Committee issue recommendations on two clinical questions regarding medication management and procedural management of early pregnancy loss initiated in the ED.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals. Directed ACEP to support an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Resolution 47(96) Ultrasound Imaging adopted. Directed ACEP to create a new policy on emergency ultrasonography affirming that limited bedside ultrasound imaging is within the scope of practice of emergency physicians, and to work with other interested organizations to examine curriculum, training, and credentialing issues in the use of limited ultrasound imaging by emergency physicians.

Prior Board Action

March 2026, discussed the updated "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" and referred it back to the Clinical Policies Committee for additional revisions.

September 2024, approved the policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss."

Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss adopted.

June 2023, approved the policy statement "Access to Reproductive Healthcare in the Emergency Department."

April 2023, approved the revised policy statement "Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine;" revised and approved June 2016 with the current title; revised and approved October 2008; originally approved June 2001 title "Emergency Ultrasound Guidelines."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy."

Resolution 47(96) Ultrasound Imaging adopted.

Background Information Prepared by: Julie Rispoli
Manager, Clinical Ultrasound Accreditation Program

Sandy Schneider, MD, FACEP
Chief Medical Officer

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 47(26)

SUBMITTED BY: Tom Benzoni, MD, FACEP
Virgil Smaltz, MD, FACEP
Peter Viccellio, MD, FACEP

SUBJECT: ED of the Future

PURPOSE: Appoint a task force to define the ED of the present and near future, including scope of practice, structural and functional needs, and anticipated changes in medicine, to ensure patients receive the best care possible.

FISCAL IMPACT This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Depending on the final scope of the project, the estimated cost is $30,000 – $75,000 in staff resources, task force meeting expenses, and report development. Additional costs of approximately $20,000 – $30,000 if an in-person task force meeting is held.

WHEREAS, As we evolved from an under-resourced, understaffed, and under-appreciated "emergency room;" and

WHEREAS, ED design has not kept up with change in emergency medicine; and

WHEREAS, We have evolved in ways similar to the frog with the water slowly brought to a boil; and

WHEREAS, Other specialties have no difficulty whatsoever demanding appropriate space, staff, and resources; and

WHEREAS, Other specialties do not see patients in tents, bathrooms, hallways, or with other patients in the same room; and

WHEREAS, The specialty has evolved, providing much more complex care and much more prolonged care in the ED; and

WHEREAS, Patients deserve proper care, staff, resources, and privacy during their most challenging moments; and

WHEREAS, There is immense pressure on us to provide the best and timely care; and

WHEREAS, The degree of current dysfunction would not be tolerated by any other specialty; and

WHEREAS, Our specialty might benefit from a sharp reset of what our environment should be; and

WHEREAS, There is a need to describe how the ED of the present/future should function and what the patient's experience should be, so that appropriate design and resources can be driven by a vision of what a modern ED should be; therefore be it

RESOLVED, That ACEP appoint a task force to define the ED of the present and near future, including scope of practice, structural and functional needs, anticipating future changes in medicine, such that patients are assured the best care possible.

Background

This resolution directs the College to appoint a task force to define the emergency department of the present and near future, encompassing scope of practice, structural and functional requirements, and anticipated changes in medicine, with the goal of ensuring patients receive the best care possible.

There are several parts to this resolution request – physical plant, equipment, scope of practice/personnel and changes in workflow. This resolution takes a different approach and rather than addressing the symptoms of a dysfunctional environment, it asks the College to define what the environment itself should be. No current ACEP initiative specifically charges a body with articulating a comprehensive, forward-looking vision of what the modern ED should look like in terms of scope, structure, function, and patient experience. A framework developed by a task force could inform advocacy, accreditation criteria, facility planning, and institutional-level negotiations by emergency physicians seeking appropriate space, staffing, and resources.

Emergency medicine has evolved substantially since the era of the understaffed and under-resourced "emergency room." The specialty now routinely provides complex, prolonged care for patients with serious and multi-system illness, yet the physical design and resource allocation of many emergency departments have not kept pace with that evolution. The first consideration of the actual physical space for the ED and its configuration, allotting for space needed for current and future equipment. The future ED should not have ultrasounds and other equipment 'parked' in the hallways. Today, many emergency departments experience critical overcrowding and heavy resource demand, which hampers the delivery of high-quality medical care and compromises patient safety. Most EDs are running at or above perceived maximum capacity daily, and many simply do not have the resources to surge beyond their already overtaxed environment. Patients are frequently evaluated in hallways, tents, bathrooms, or shared spaces and these conditions would not be accepted in other specialty settings.

The primary driver of this dysfunction is boarding, which is the practice of holding admitted patients in the emergency department because no inpatient beds are available. Boarding results in ambulance refusals, prolonged patient waiting times, and increased suffering for those who wait on gurneys in emergency department corridors for hours, and even days, affecting not only their care and comfort but also the primary work of the emergency department staff caring for emergency patients. As treatment times increase, and boarding is unlikely to be eliminated any time soon, there is the need for greater patient comfort measures, such as more comfortable beds particularly for the elderly and boarding patients, more amenities such as private bathrooms, televisions, Wi-Fi/technology, and chargers. It should be noted that cell phones are often blocked in many emergency departments, a situation that cannot exist in the near future.

The resolution also calls for consideration of scope of emergency medicine practice. The mismatch between the modern scope of emergency medicine and the physical and operational environment in which it is practiced is not new, but it has grown more acute. As our scope evolves, so will our requirements. Already we are seeing the impact of artificial intelligence as scribes. As an example, the future is self-registration for a large percentage of patients, requiring the need for private kiosks..

The Facility Guidelines Institute, in its 2018 report "Reimagining the ED: Ideas for Shaping the Emergency Department of the Future," developed with input from ACEP, identified a range of structural and operational challenges facing patients and clinicians in ED clinical spaces, including inadequate space for behavioral health patients, poor arrival and front-end operations, and environments that do not support patient privacy or dignity. That report used a human-centered design process to generate ideas for improving ED design, but it did not produce a binding, specialty-endorsed framework for what the modern ED should look like. No such framework currently exists under ACEP's authority.

Throughout its history, ACEP has engaged with the downstream consequences of inadequate ED environments. Our ED Accreditation Program (EDAc) combines policies of the College to create an accreditation for those departments that reach that standard. The newly approved Blue Ribbon Recognition Program does the same for groups to be recognized who have met the policies of the College.

There have been decades of work by ACEP on ED crowding and boarding through Council resolutions, policy statements, advocacy to Congress and the Administration, and a September 2023 multi-stakeholder summit that brought together the Agency for Healthcare Research and Quality, the American Hospital Association, the American Nurses Association, and others to discuss collaborative solutions. (A full report of the Summit's proceedings was published on October 20, 2023.) In November 2022, ACEP led a coalition letter to President Biden characterizing the ED boarding crisis as a public health emergency. Federal legislative and regulatory advocacy efforts continue, including work with CMS and The Joint Commission. Despite this sustained effort, health policy makers at the federal level have been slow to act, and the structural and design conditions that contribute to the crisis remain largely unaddressed.

Emergency Department Boarding and Crowding resources are available on the ACEP website, including Policy Solutions to Emergency Department Boarding. These policy solutions point to some of these financial drivers and potential ways to realign financial incentives, such as establishing reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding, tying additional financial incentives and penalties to measures of crowding and boarding, developing incentives to enable skilled nursing facilities and long-term care facilities to expand capacity and accept patients from the ED outside of core business hours, as well as possible penalties for refusing patients without documentation of legitimate reasons for doing so, among others.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 2: Expand ACEP's accreditation programs to further recognize excellence in the delivery of emergency care.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

> Objective 1: Identify and support the practice models for emergency physicians that expand the field of acute, unscheduled care.
>
> Objective 2: Support the creation of innovative practice models by anticipating emerging trends in clinical and business practices.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Depending on the final scope of the project, the estimated cost is $30,000 – $75,000 in staff resources, task force meeting expenses, and report development. Additional costs of approximately $20,000 – $30,000 if an in-person task force meeting is held.

Prior Council Action

The Council has discussed and adopted multiple resolutions pertaining to boarding, on-call services, scope of practice, and other system problems affecting emergency department patient care; however, there have not been prior resolutions related to defining the ED of the present and near future.

Prior Board Action

February 2023, approved establishing an ED Accreditation Program based on the business plan and preliminary criteria and tiers for the accreditation program.

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

Background Information Prepared by: Sandy Schneider, MD, FACEP
Chief Medical Officer

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 48(26)

SUBMITTED BY: Tom Benzoni, MD, FACEP
Chirag Shah, MD, FACEP
Peter Viccellio, MD, FACEP

SUBJECT: No-Cost Solutions to ED Boarding

PURPOSE: Promote a focused message on proven, no-cost or low-cost solutions to ED boarding and crowding, specifically elective admission smoothing, early patient discharge, enhanced weekend discharges, and expanded ancillary service hours – and to communicate these interventions to hospitals, members, and stakeholders as strategies that can be implemented immediately to improve patient safety, staff satisfaction, and hospital finances.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated 0.10 – 0.25 FTE staff time, approximately $10,000 – $25,000 to develop and disseminate a focused messaging framework and supporting materials.

WHEREAS, ED crowding and boarding is dangerous to patients and stressful on staff; and

WHEREAS, The request for more funding by ACEP is specific neither in amount nor how it would be spent nor framed in any way which demonstrates improvement in boarding; and

WHEREAS, Hospitals have not implemented known solutions to address boarding; and

WHEREAS, Hospitals function like they did decades ago with little interest in systems engineering to improve flow; and

WHEREAS, A document listing multiple pages of solutions distracts from a shorter list of practical, proven interventions to improve boarding that can be implemented now; and

WHEREAS, There are proven methods to improve hospital flow and improve ED boarding without significant cost; and

WHEREAS, These solutions should be highlighted as currently available solutions which decrease boarding, improve patient safety, improve staff satisfaction, and improve hospital finances; therefore be it

RESOLVED, That ACEP have a focused message on crowding and boarding solutions including:

1. Practical solutions to boarding and capacity exist at little or no cost that are not being implemented.
2. Smoothing of elective admissions have been shown to improve capacity to the benefit of patients, staff, physicians, and hospital finances.
3. Early discharge of patients to a sufficient degree has shown to decrease length of stay and increase capacity to the benefit of the patient, staff, physicians, and hospital finances.
4. Enhanced weekend discharges has been shown to decrease length of stay and increase capacity to the benefit of the patient, staff, physicians, and hospital finances.
5. Expanded hours for ancillary services on evenings and weekends improves flow, increases capacity, and shortens length of stay.

Background

This resolution directs the College to promote a focused message on proven, no-cost or low-cost solutions to emergency department boarding and crowding, specifically elective admission smoothing, early patient discharge, enhanced weekend discharges, and expanded ancillary service hours, and to communicate these interventions to hospitals, members, and stakeholders as strategies that can be implemented immediately to improve patient safety, staff satisfaction, and hospital finances.

ACEP is currently performing an IRB-approved qualitative study of hospital/EDs that have low boarding time and/or short lengths of stay. Interviews are underway on this initiative and should be completed by ACEP26. These will become a toolkit, emphasizing those that are low cost but also highlighting real-life evidence of financial return (decreased attrition of physicians, nurses and ancillary personnel, decrease length of stay for inpatients, etc.) In the second phase of this current program, ACEP will be conducting a point in time study, asking emergency physicians to answer a short survey on what attempt have been made by their institution to reduce boarding. Specific options will include those from prior task forces and those compiled from the qualitative study. Then, on a specific date that will be announced at the Council meeting, emergency physicians will be asked to provide a deidentified census of their ED, including patients in hall beds, waiting room, and boarding with their lengths of stay. This data will be used for advocacy over the coming months. Councillors will be provided with a brief synopsis of this study and a QR code inviting them to sign up during our deliberations. There will also be information regarding this point-in-time study at ACEP Central in the exhibit hall or available directly by contacting Sandy Schneider, MD, FACEP, sschneider@acep.org.

ED boarding and crowding is a well-documented, decades-long patient safety crisis. Boarding is the practice of keeping admitted patients in the emergency department while awaiting an inpatient bed and it is now a nationwide phenomenon affecting nearly all U.S. hospitals. At its root, boarding is a consequence of hospital-wide capacity constraints, not an ED-specific problem. Between 1975 and today, the United States lost roughly 600,000 inpatient hospital beds, from 1.5 million beds in 1975 to approximately 900,000 today, even as the total population grew by more than 50%. On a per-person basis, there is currently one inpatient bed for every 390 people, compared with one per 143 people in 1975. Over the same period, the population has aged, obesity prevalence in adults has nearly tripled to 42%, and the rate of diabetes has quintupled to 12%, which means a sicker, older population is competing for a sharply reduced inpatient supply. ACEP's policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department" affirms that ED crowding is a direct result of diminished bed and resource capacity created by boarding, and that hospitals bear the responsibility to ensure prompt transfer of admitted patients to inpatient units.

The consequences of boarding are serious and well-established. Crowding is associated with increased patient mortality, longer lengths of stay, higher rates of medical errors, increased patient elopements, ambulance diversions, and diminished staff satisfaction. An informal ACEP member survey conducted in July 2021 found that 70% of respondents reported crowding conditions worse than pre-pandemic levels. The COVID-19 pandemic accelerated an already deteriorating trend, with some EDs forced to see patients in hallways, waiting rooms, tents, and converted conference rooms. Despite the severity of the problem, a set of proven, low- or no-cost operational interventions has been identified in the literature and in ACEP's resources that can meaningfully reduce boarding without requiring new capital investment. ACEP's information paper "Emergency Department Crowding: High Impact Solutions" identifies a range of output strategies that address the hospital-wide causes of crowding. Among the most evidence-supported are: 1) smoothing of elective surgical admissions – boarding in the ED is greatest on Monday through Thursday, with one study reporting that 42% of elective surgeries are performed on Mondays and Tuesdays alone; redistributing elective OR block time across the week has been shown to reduce peak census and hospital overload; 2) early patient discharge – moving discharge processes earlier in the day frees inpatient beds before the afternoon peak of ED admissions, reducing boarding time; 3) enhanced weekend discharges – expanding discharge activity on weekends addresses the well-documented "weekend effect," in which reduced weekend staffing and discharge activity contributes to bed unavailability on Monday and Tuesday; and 4) expanded ancillary service hours – limiting laboratory, imaging, and therapy services to weekday business hours creates bottlenecks that delay both inpatient discharges and ED throughput; extending these services to evenings and weekends improves flow and shortens length of stay. The Emergency Medicine Practice Committee has completed a toolkit emphasizing many potential solutions.

A persistent challenge is that, despite the evidence base for these interventions, few hospitals have implemented or sustained them. Solutions such as full capacity protocols, or schedule smoothing, discharges by noon, and seven-day-a-week hospital programs exist, but few hospitals are willing to entertain or sustain them over time. A key reason is misaligned financial incentives. Hospitals may perceive that boarding ED patients is financially neutral or even advantageous, as it allows inpatient beds to be reserved for higher-reimbursing elective or surgical patients.

ACEP's current messaging encompasses a broad range of solutions. Emergency Department Boarding and Crowding resources are available on the ACEP website, including Policy Solutions to Emergency Department Boarding. Policy solutions point to some of these financial drivers and potential ways to realign financial incentives, such as establishing reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding, tying additional financial incentives and penalties to measures of crowding and boarding, developing incentives to enable skilled nursing facilities and long-term care facilities to expand capacity, and accept patients from the ED outside of core business hours (as well as possible penalties for refusing patients without documentation of legitimate reasons for doing so), among others.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.
>
> Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Estimated 0.10 – 0.25 FTE staff time, approximately $10,000 – $25,000 to develop and disseminate a focused messaging framework and supporting materials.

Prior Council Action

Amended Resolution 80(25) Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding adopted. Directed ACEP to collaborate with relevant stakeholders, including the American College of Surgeons and the American Hospital Association, to develop and disseminate a comprehensive elective surgery scheduling toolkit aimed at guiding hospitals in implementing effective scheduling practices to mitigate ED crowding.

Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events adopted. Directed the College to work with accrediting bodies and patient safety organizations to ensure that ED boarding and crowding are considered as contributing factors when conducting root cause analyses and developing corrective action plans in response to medical errors and adverse patient safety events.

Resolution 25(24) Boarding – Follow the Money adopted. Directed ACEP to Collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the ED to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the ED.

Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments adopted. Directed the College to advocate for increased resources and systemic changes to address the boarding of pediatric mental health patients in emergency departments.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. Directed the College to use legislative and regulatory venues to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve emergency department capacity; and define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted. Directed the College to study financial and other incentives that might be used to reduce boarding of admitted patients in the emergency department.

Amended Resolution 24(16) Mental Health Boarding Solutions adopted. Directed ACEP to partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, the National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; develop and share ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and work with the Agency for Healthcare Research and Quality and other appropriate stakeholders to develop community and hospital based benchmark performance metrics for ED mental health flow and psychiatric facilities acceptance of patients.

Amended Resolution 13(16) ED Boarding and Overcrowding is a Public Health Emergency adopted. Directed the College to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Amended Resolution 19(09) Defining Boarding Time in the Nation’s Emergency Departments adopted. Directed ACEP to work with stakeholders to establish a standardized definition of boarding time for use in data collection and reporting.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, and identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Called for ACEP to 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 for it to include 7 specific elements,

including smoothing of elective surgery scheduling and diagnostic/therapeutic procedures.

Amended Resolution 26(07) Hallway Beds adopted. Directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. Directed ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department."

Prior Board Action

January 2026, approved the revised policy statement "Definition of Boarded Patient;" revised and approved September 2018, reaffirmed October 2017, originally approved January 2011.

Amended Resolution 80(25) Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding adopted.

Resolution 26(24) Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events adopted.

Resolution 25(24) Boarding – Follow the Money adopted.

June 2024, approved the revised policy statement "Boarding of Pediatric Patients in the Emergency Department;" revised and approved September 2018; originally approved January 2012.

Resolution 29(23) Addressing Pediatric Mental Health Boarding in Emergency Departments adopted.

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department" revised and approved June 2017, April 2011, April 2008, January 2007; originally approved October 2000.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

June 2023, filed the report of the ED Boarding Summit Task Force and approved convening an ED Boarding Summit within the next 12 months.

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted.

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

Amended Resolution 24(16) Mental Health Boarding Solutions adopted.

Amended Resolution 13(16) ED Boarding and Overcrowding is a Public Health Emergency adopted.

May 2016, reviewed the revised report, "Emergency Department Crowding: High Impact Solutions;" originally developed April 2008.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Amended Resolution 19(09) Defining Boarding Time in the Nation's Emergency Departments adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

January 2008, reviewed the information paper "Optimizing ED Front End Operations."

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

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Reviewed by: Michael J. McCrea, MD, FACEP
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PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 49(26)

SUBMITTED BY: Oregon Chapter

SUBJECT: Ensuring Transparency and Accountability in Emergency Department Staffing Proposals

PURPOSE: Develop and disseminate best practice guidelines for emergency department RFP processes that promote transparency in workforce disclosures, implementation plans, and evaluation criteria; advocate for objective and transparent proposal evaluation; and support post-transition outcome reporting.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated cost: $15,000 – $40,000 for guideline development and dissemination. External subject matter consultants and legal resources are needed to address applicable law and contractual obligation considerations with an estimated cost range of $10,000 – $20,000.

WHEREAS, Patients, physicians, hospitals, and organizations participating in emergency department Request for Proposal (RFP) processes all benefit from access to clear, objective, and transparent information regarding proposals under consideration; and

WHEREAS, Hospitals and health systems use RFP processes to select organizations to provide emergency department clinical services; and

WHEREAS, Organizations responding to RFPs may differ in their existing workforce, implementation strategies, recruitment plans, and operational capabilities; and

WHEREAS, Clear, objective, and transparent information regarding these proposals supports informed decision-making by hospitals, physicians, and other stakeholders; and

WHEREAS, Transparency and accountability in emergency department RFP processes promote confidence in contract award decisions and help facilitate successful transitions of patient care; and

WHEREAS, There are currently no widely recognized best practices promoting transparency in emergency department RFP processes; therefore be it

RESOLVED, That ACEP develop and disseminate best practice guidelines for emergency department Request for Proposal (RFP) processes that promote transparency by encouraging:

- objective disclosure of the clinician workforce and operational resources available to support implementation of the proposed contract at the time of award;
- clear distinction between existing resources and projected future recruitment or expansion;
- transparent description of implementation plans, assumptions, and anticipated timelines; and
- disclosure, upon request by interested parties and consistent with applicable law and contractual obligations, of the evaluation criteria and materials used during the contract selection process, including scoring methodologies and other documentation supporting the award decision; and be it further

RESOLVED, That ACEP advocate for emergency department Request for Proposal (RFP) processes that promote objective evaluation of proposals using transparent criteria and accurate representations of organizational capabilities, while recognizing the diversity of emergency medicine practice structures and employment models; and be it further

RESOLVED, That ACEP support transparency regarding implementation outcomes following emergency department contract transitions by encouraging reporting, upon request by interested stakeholders and consistent with applicable law and contractual obligations, comparing key elements of proposed implementation plans with actual implementation one year following transition.

Background

This resolution asks the College to develop and disseminate best practice guidelines for emergency department Request for Proposal (RFP) processes, advocate for transparent and objective evaluation of proposals, and support post-transition outcome reporting.

Hospitals and health systems routinely use competitive RFP processes to select organizations to provide emergency department clinical services. Organizations responding to these RFPs may differ substantially in their existing physician workforce, operational infrastructure, recruitment pipelines, and implementation timelines. There are currently no widely recognized best practices governing transparency in ED RFP processes, including how organizations disclose their existing workforce, implementation plans, or the criteria used to award contracts. Without standardized disclosure expectations, hospitals and other stakeholders may lack the objective information needed to make fully informed contract award decisions, and physicians may face abrupt transitions that affect patient care continuity.

This issue is heightened by accelerating consolidation in emergency medicine. A 2025 analysis published in *Annals of Emergency Medicine*, covering 3,998 hospital-based emergency departments and 109.7 million visits, found that fewer than half of emergency visits are staffed by majority physician-owned employers. Health system-owned groups staffed approximately one-third of all emergency visits, while nearly one in four visits were staffed by physicians in private equity-owned groups. Within the private equity ownership category, 93 percent of all ED visits were seen by physicians under just three employers, and 84 percent of hospital referral regions qualified as highly concentrated. The study also noted that a lack of transparency in practice ownership has impaired the ability to understand market dynamics. This concentration of market power among a small number of large staffing organizations makes the RFP process, which is the primary mechanism by which hospitals select and transition between ED staffing partners, an increasingly consequential decision point for physicians, patients, and communities.

Federal policymakers and researchers have raised parallel concerns. The U.S. Government Accountability Office released a report in 2025 finding that consolidation among hospitals, insurers, and private equity firms is associated with higher costs for patients and Medicare without clear evidence of better quality, while also raising concerns about competition and access. The FTC and DOJ jointly launched a cross-government public inquiry into private equity and corporate control of health care in March 2024. At the state level, legislatures in New York, Pennsylvania, and Massachusetts have enacted or proposed laws requiring advance notice and review of material health care transactions. Congressional scrutiny has also focused specifically on emergency medicine: Senator Gary Peters sought information from private equity firms and physician staffing companies about business operations, staffing decisions, and patient care at emergency departments, citing concerns that cost-saving measures may be occurring at the expense of patient safety.

ACEP has documented the effects of consolidation on emergency physicians through its own member surveys and advocacy. In 2022, ACEP collected member stories for submission to the FTC and DOJ, with responses indicating that consolidation in emergency medicine detrimentally affects physicians' interests and well-being, including reduced wages, infringement of due process rights, interference with physician autonomy, and a shift toward use of a health care workforce with less skills. ACEP has also engaged directly with the FTC and DOJ on merger guidelines and filed an amicus brief in the AAEMPG v. Envision case upholding the sanctity of a physician's duty to patients.

The RFP and contract transition process itself carries significant risks when not managed transparently. ACEP's information paper "Emergency Department Physician Group Staffing Contract Transition" acknowledges that while some contract transitions are smooth and amicable, others are contentious, difficult, or confusing and require the College and its members to consider the interests of all involved and understand ethical obligations. Transitions involving residency training programs carry additional complexity, as ACGME requirements impose obligations on sponsoring institutions and program directors that must be carefully managed during any staffing change.

A recent real-world example illustrates the policy gap this resolution seeks to address. In early 2026, PeaceHealth in Lane County, OR conducted an RFP process to transition emergency physician services. The transition drew scrutiny from the Governor's office and the public, with PeaceHealth's CEO acknowledging in a March 2026 letter to Governor Tina Kotek that he should have communicated more clearly about the rationale for the change, the criteria used to select a new partner, and what the decision would mean for day-to-day operations. PeaceHealth subsequently proposed publishing community-facing transition dashboards tracking key indicators of emergency department performance, including mortality, diversion, door-to-doctor times, and recruitment statistics, as a transparency measure. This episode illustrates both the community trust implications of opaque RFP processes and the emerging recognition that proactive transparency and outcome reporting can serve as a meaningful accountability mechanism. ACEP worked closely with the Oregon Chapter as well as local and state leaders to help ensure that physicians' voices were heard, important questions were raised, and advocacy remained focused on supporting both the emergency physicians and patients of Eugene, OR.

ACEP has existing policy relevant to ED staffing and physician rights in contractual arrangements. The policy statement "Emergency Physician Rights and Responsibilities" affirms that high-quality emergency care is best provided when emergency physicians practice in a fair and equitable environment, and that emergency physicians and their patients have a right to adequate staffing, resources, and equipment to meet the acuity and volume needs of patients. The policy statement "Emergency Physician Contractual Relationships" includes provisions that emergency physicians employed or contracted should be informed of any provisions in the contracting vendor's contract with the hospital concerning termination of a physician's ability to practice at that site, including any knowledge by the contracting vendor of substantial risk of hospital contract instability. No current ACEP policy or guideline specifically addresses transparency standards for the RFP and contract selection process itself.

Resources regarding employment contracts are available on the ACEP website.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.
>
> Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

> Objective 4: Increase transparency in the emergency medicine job market by sharing data on various employment settings and developing employer accountability initiatives.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated cost range: $15,000 – $40,000 for guideline development and dissemination. External subject matter consultants and legal resources are needed to address applicable law and contractual obligation considerations with an estimated cost range of $10,000 – $20,000.

Prior Council Action

None specific to addressing transparency or best practice standards for emergency department RFP or contract selection processes.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted. Directed ACEP to advocate for stricter enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with The Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting.

Prior Board Action

None specific to addressing transparency or best practice standards for emergency department RFP or contract selection processes.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities," which addresses the contractual environment in which emergency physicians practice and affirms that high-quality emergency care is best provided when emergency physicians practice in a fair and equitable environment.

July 2018, reviewed the Policy Resource and Education Paper "Emergency Physician Contractual Relationships."

May 2018, reviewed the information paper "Emergency Department Physician Group Staffing Contract Transition."

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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

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Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 50(26)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Law Enforcement Presence in the Emergency Department

PURPOSE: 1) recognize the deterrent effect of federal law enforcement, including U.S. Immigration and Customs Enforcement (ICE), on vulnerable patients seeking emergency care; 2) affirm that EDs are spaces for unbiased, nondiscriminatory care regardless of immigration status; 3) reaffirm that no law enforcement process should interfere with patient care absent immediate safety threats or specific applicable laws; 4) encourage hospitals to adopt clear policies guiding staff in navigating immigration agent presence; 5) discourage routine documentation of immigration status in clinical records unless clinically relevant or legally required; and 6) reaffirm that medical screening examinations do not constitute fitness-for-confinement determinations and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.

FISCAL IMPACT: Budgeted resources for current and ongoing work. No additional funding is required for ACEP to reaffirm current policy statements. Revisions to current policy statements would require diverting budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated $15,000 – $30,000 for committee and staff resources to update each policy statement.

WHEREAS, As of January 20, 2025, the Department of Homeland Security rescinded internal policy which previously directed U.S. Immigration and Customs Enforcement (ICE) officers to avoid conducting enforcement activities (such as arrests, interviews, searches, and surveillance) at protected areas, including hospitals, churches, and schools[1]; and

WHEREAS, Fear of racialized immigration enforcement activities by agencies such as ICE deters patients from seeking emergency medical care, leading to delayed presentation, increased morbidity and mortality, and preventable public health harms[2] and further exacerbates existing health disparities among vulnerable populations; and

WHEREAS, Existing policies governing law enforcement presence in the emergency department are often unclear or inconsistent, leading to confusion among emergency medicine physicians, particularly given the differing roles and motivations of law enforcement and health care professionals, which may increase the risk of patient privacy breaches and contribute to inequitable care;[3] and

WHEREAS, The lack of clear policies and boundaries may further contribute to physicians feeling uncomfortable and inadequately prepared to navigate interactions with federal agents in the emergency department[4]; and

WHEREAS, The absence of clear, consistent institutional guidelines and training may further discourage patients from presenting to the emergency department, as uncertainty regarding existing patient protections can heighten fear and erode trust in the safety of the healthcare environment[5]; and

WHEREAS, ACEP believes that no legal or law enforcement process should interfere with patient care in the ED absent immediate safety threats or specific applicable laws[6]; and

WHEREAS, ACEP believes that law enforcement activities within or immediately surrounding an ED should first coordinate with hospital staff and security to prevent worsening healthcare disparities and erosion of trust in the healthcare system[6]; and

WHEREAS, ACEP has reinforced that the emergency physician's role is to perform medical screening exams

and to stabilize and treat any emergency medical conditions identified as mandated under EMTALA for any person brought to or presenting to the ED[7]; and

WHEREAS, ACEP collaborates with other interested organizations to create easily accessible transparent toolkits that outline state-specific policies and laws regarding law enforcement presence in the hospital environment, including but not limited to the ED[8], therefore be it:

RESOLVED, That ACEP recognize the impact of federal law enforcement in hospital spaces and how it may deter vulnerable populations, regardless of immigration status, from seeking care, or providing pertinent health information during visits due to fear of confidentially breaches, in emergency departments leading to worsening disparities in health outcomes of an already marginalized population; and be it further

RESOLVED, That ACEP affirm that emergency departments are spaces dedicated to unbiased, nondiscriminatory emergency medical care, and supports policies that protect safe access to emergency care regardless of immigration status; and be it further

RESOLVED, That ACEP reaffirm that no legal or law enforcement process, including immigration enforcement, should interfere with patient care in the ED absent immediate safety threats or specific applicable laws; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt or develop clear hospital policies to guide medical staff in navigating the presence of immigration agents, thereby reducing confusion and uncertainty and promoting accessible, equitable, patient-centered care, consistent with ACEP's existing policy encouraging hospital partnerships with community groups and law enforcement agencies to develop clear ED access policies; and be it further

RESOLVED, That ACEP discourage the routine inclusion of immigration status in clinical documentation, including EMS records, unless clinically relevant or required by law; and be it further

RESOLVED, That ACEP reaffirm that a medical screening examination and any resulting documentation reflect emergency medical evaluation only, do not constitute a fitness-for-confinement determination, and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.

Resolution References

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Background

This resolution asks the College to recognize the deterrent effect of federal law enforcement, including U.S. Immigration and Customs Enforcement (ICE), on vulnerable patients seeking emergency care; affirm that EDs are spaces for unbiased, nondiscriminatory care regardless of immigration status; reaffirm that no law enforcement process should interfere with patient care absent immediate safety threats or specific applicable laws; encourage hospitals to adopt clear policies guiding staff in navigating immigration agent presence; discourage routine documentation of immigration status in clinical records unless clinically relevant or legally required; and reaffirm that medical screening examinations do not constitute fitness-for-confinement determinations and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.

ACEP's policy statement "Understanding the Effects of Law Enforcement Presence in the Emergency Department" addresses the deterrent effect of law enforcement presence on vulnerable populations and supports hospital partnerships with community groups and law enforcement agencies to develop clear ED access policies. The policy states specifically:

- No legal or law enforcement process should interfere with patient care in the ED absent immediate safety threats or specific applicable laws.

The State Legislative/Regulatory Committee, in collaboration with the Diversity, Equity, & Inclusion Committee (now Access, Belonging, & Community Committee) developed the toolkit "Law Enforcement Presence in the Emergency Department" to assist with navigating encounters with law enforcement personnel beyond ICE.

ACEP's policy statement "The Role of Emergency Physicians in Medical Screening of Patients Brought in By Law Enforcement," approved by the Board in June 2026, affirms the emergency physician's EMTALA obligations and the limits of the medical screening examination. The smart phrase "Fitness for Confinement," can be used by emergency physicians when documenting the results of a medical screening exam performed on a patient in law enforcement custody. It is intended to accurately reflect the scope and limitations of the emergency physician's role.

Last year the Council and the Board adopted Resolution 58(25) Role of EDs in Interactions with U.S. Immigration and Customs Enforcement. The resolution directed ACEP to continue current advocacy initiatives and work with the American Hospital Association and the Federation of American Hospitals to investigate developing guidance and/or policy to address hospital-level protocols for immigration enforcement interactions. Work on this resolution is still in progress.

Emergency departments have traditionally been considered places of refuge, providing medical care to all individuals regardless of immigration status. Research has documented that the threat of immigration enforcement deters patients from seeking necessary medical care due to fear of deportation, thereby compromising public health and patient safety. A 2021 study published in Health Affairs (Friedman and Venkataramani) found that U.S. immigration enforcement activities were associated with reduced health care-seeking behavior among Hispanic adults, with chilling effects extending beyond undocumented individuals to mixed-status families and communities. The deterrence effect is not limited to immigration enforcement: broader research on law enforcement presence in health care settings has documented that visible enforcement activity, including the presence of officers in or near EDs, can heighten fear, erode trust, and discourage patients from disclosing clinically relevant information, all of which can worsen health outcomes and exacerbate existing disparities among already-marginalized populations. A 2018 survey published in *Annals of Emergency Medicine* (Palter et al.) found that emergency physicians reported feeling uncomfortable and inadequately prepared to navigate interactions with law enforcement in the ED, underscoring the need for clear institutional guidance and training.

The policy landscape shifted materially on January 20, 2025, when the Department of Homeland Security rescinded the longstanding internal ICE policy that directed officers to generally avoid conducting enforcement activities at protected areas, including hospitals, churches, and schools. Following that rescission, there have been increased instances of ICE officials entering hospitals to conduct enforcement actions, including the detention of patients. ACEP responded promptly by developing the resource "Navigating Immigration Enforcement in the Emergency

Department," which clarifies the legal framework governing ICE access to hospital spaces, HIPAA protections, and the rights of patients and providers. That resource notes that health care providers have no affirmative legal obligation under federal law to inquire into or report on a patient's immigration status, and that HIPAA prohibits disclosure of patient information to ICE officers absent a valid court order, judicial warrant, or patient authorization. The resource also notes that ICE officials may enter public areas of a health care facility without a warrant but must have either a warrant or consent from an authorized hospital staff person to enter private areas. ACEP has heard reports of hospitals that either lack clear policies on these interactions or have not trained ED staff on existing policies, leaving physicians uncertain about their rights and obligations.

An additional complication is state-level variation. Florida and Texas currently require hospitals to ask patients about their immigration status for aggregate reporting of uncompensated care provided to undocumented patients, which means national-level guidance must be appropriately caveated and may be limited in specificity.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 4: Evaluate the social and economic aspects of emergency medical care to inform advocacy positions and policy recommendations.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Fiscal Impact

Budgeted resources for current and ongoing work. No additional funding is required for ACEP to reaffirm current policy statements. Revisions to current policy statements would require diverting budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated $15,000 – $30,000 for committee and staff resources to update each policy statement.

Prior Council Action

Resolution 58(25) Role of EDs in Interactions with U.S. Immigration and Customs Enforcement adopted. Directed ACEP to: 1) Acknowledge it's prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the ED and recognize the continuing potential impact of ICE enforcement actions within EDs on patient care and public health. 2) Advocate for development and dissemination of guidelines and training programs for ED staff to manage interactions with ICE officials, ensuring the protection of patient rights and the provision of uncompromised medical care. 3) Support collaboration with legal experts, hospital administrations, and community organizations to establish policies delineating the role of EDs in relation to ICE activities, emphasizing the importance of patient trust, safety, and confidentiality.

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presence in the Emergency Department adopted. Directed ACEP to support research, development, and adoption of best practices regarding law enforcement and security personnel presence in the hospital environment, including but not limited to the ED and collaborate with other interested organizations to create easily accessible transparent toolkits outlining state-specific policies and laws regarding law enforcement presence in the hospital environment, including but not limited to the ED.

Resolution 53(22) Law Enforcement and Intoxicated Patients in the ED referred to the Board of Directors. Called for ACEP to investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and to encourage law enforcement to remain with patients they bring to the ED who are intoxicated, altered, agitated, or otherwise pose a safety risk until a disposition has been determined or the physician determines their assistance is no longer needed.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted. Required revisions to the existing policy statement on "Law Enforcement Information Gathering in the Emergency Department" to reflect the recent relevant court decisions regarding consent for searches with or without a warrant to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

Resolution 35(18) ACEP Policy Related to Immigration referred to the Board of Directors. The resolution sought for ACEP to affirm the right for all patients to receive emergency medical care; encourage establishment of policies of non-collaboration between hospital staff and immigration authorities, unless required by warrant; and oppose modifications to U.S. public charge policies, referred.

Resolution 33(17) Immigrant and Non-Citizen Access to Care referred to the Board of Directors. The resolution requested that ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy statement for physicians to access and present to their hospital systems for implementation and make available online for public use, in multiple languages, a "Safe Zone" statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physician can ensure the policy is communicated in the language most relevant to their patient populations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Directed ACEP to develop a paper addressing the impact of foreign nationals on the American health care safety net and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in U.S. emergency departments.

Prior Board Action

June 2026, approved the policy statement "The Role of Emergency Physicians in Medical Screening of Patients Brought in By Law Enforcement." The Board also reviewed the smart phrase "Fitness for Confinement." The smart phrase can be used by emergency physicians when documenting the results of a medical screening exam performed on a patient in law enforcement custody. It is intended to accurately reflect the scope and limitations of the emergency physician's role.

Resolution 58(25) Role of EDs in Interactions with U.S. Immigration and Customs Enforcement adopted.

September 2024, reaffirmed the policy statement "Delivery of Care to Undocumented Persons;" revised and approved June 2018; reaffirmed February 2018, April 2012, October 2005, July 2000; originally approved January 1995.

September 2024, approved the policy statement "Understanding the Effects of Law Enforcement Presence in the Emergency Department."

June 2023, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved June 2017 and April 2010; originally approved September 2003.

February 2022, Reviewed the Policy Resource & Education Paper (PREP) "Law Enforcement Information Gathering in the Emergency Department: Legal and Ethical Background and Practical Approaches."

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presence in the Emergency Department adopted.

June 2019, approved the Medical-Legal Committee's recommendation to take no further action on Resolution 35(18) ACEP Policy Related to Immigration. The committee noted that policies already exist throughout the health care

community to protect patient information, unless disclosure is required by law, and creating additional policy specific to providing information to immigration authorities would essentially be superfluous. Further, the committee noted the Fourth Amendment provides patients with a reasonable expectation of privacy and protects against unreasonable search and HIPAA requires patient information to be protected unless by a court order or in special circumstances not relevant to this issue. The U.S. Immigration and Customs Enforcement Agency also has policy stating that hospitals are included in the definition of "sensitive zones" where access by immigration officials is severely limited except in extraordinary circumstances.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

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American College of Emergency Physicians®
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RESOLUTION: 51(26)

SUBMITTED BY: Kentucky Chapter

SUBJECT: Physician Staffing Requirements for Pediatric Ready Designation

PURPOSE: Advocate for amending the joint ACEP/AAP pediatric readiness policy to require continuous on-site physician presence (24/7/365) as a condition of "pediatric ready" designation; and work collaboratively with national stakeholders on implementation, including resource allocation, workforce development, and rural access considerations.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Implementation would be a multi-year process and require committee and staff resources to engage the AAP, ENA, ACS, and other national stakeholders, including federal agencies. Estimated costs for staff resources could range $10,000 – $25,000 annually (.10 – .25 FTE). Alternatively, an outside consultant could be utilized to assist with the work and estimated costs could range $25,000 – $50,000 annually.

WHEREAS, The American Academy of Pediatrics (AAP) and ACEP, in their joint policy statement on pediatric readiness, published in *Annals of Emergency Medicine* in February 2026, emphasize that all emergency departments must be prepared to provide timely, high-quality emergency care to children; and

WHEREAS, The joint AAP/ACEP pediatric readiness policy highlights the importance of appropriate staffing, training, and physician-led care to improve outcomes in pediatric emergencies; and

WHEREAS, Critically ill and injured children may present at any time, and delays in physician evaluation and intervention are associated with increased morbidity and mortality; and

WHEREAS, Variability currently exists across emergency departments in the United States regarding continuous on-site physician coverage, particularly in rural and resource-limited settings; and

WHEREAS, The presence of a physician in the emergency department 24 hours a day, 7 days a week, 365 days a year ensures immediate medical decision-making, advanced resuscitation capability, and appropriate escalation of care for pediatric patients; and

WHEREAS, National efforts to standardize pediatric readiness have demonstrated improved outcomes when emergency departments meet higher readiness criteria, including physician-led care models; and

WHEREAS, Aligning pediatric readiness designation with continuous physician presence would establish a clear, patient-centered standard that prioritizes safety, equity, and quality of care for children; therefore be it

RESOLVED, That ACEP advocate for amendment of the current "Pediatric Readiness in the Emergency Department" policy statement, developed in collaboration with the American Academy of Pediatrics, to require that any hospital designated as "pediatric ready" maintain continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year; and be it further

RESOLVED, That ACEP work collaboratively with national stakeholders to support implementation of the standard to require continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year, including consideration of resource allocation, workforce development, and rural access to care.

Background

This resolution asks the College to advocate for amending the current joint "Pediatric Readiness in the Emergency Department" policy statement to require continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year as a condition of "pediatric ready" designation, and to work collaboratively with national stakeholders on implementation, including resource allocation, workforce development, and rural access considerations.

Children have unique physical and psychosocial needs that are heightened in the setting of serious or life-threatening emergencies, and most ill and injured children, including those with mental health emergencies, are brought to community hospital emergency departments by virtue of proximity rather than to specialized pediatric centers. More than 80% of children who seek emergency care present to general EDs rather than specialized pediatric EDs. Emerging data demonstrate that high pediatric readiness in the ED is associated with reductions in mortality for children with critical illness and injury and reductions in health care disparities. Improving pediatric readiness among emergency physicians and all community EDs improves outcomes, including mortality, for pediatric patients.

ACEP has a long history of working with AAP on pediatric related policy statements, which can be a multi-year process. The 2025 joint policy statement "Pediatric Readiness in the Emergency Department," developed by ACEP, the American Academy of Pediatrics (AAP), the Emergency Nurses Association (ENA), and the American College of Surgeons (ACS), outlines the resources necessary for EDs to stand ready to care for children of all ages and provides details of the foundational infrastructure needed to ensure immediate high-quality care for critically ill or injured children. The policy addresses staffing competencies, pediatric emergency care coordinator roles, quality improvement, equipment, and protocols across seven domains, but does not currently require continuous on-site physician presence as a condition of designation.

The National Pediatric Readiness Project (NPRP) and the "Pediatric Readiness in the Emergency Department" policy statement are part of a complex, interconnected national pediatric emergency care infrastructure involving federal agencies, national professional organizations, state programs, and hospital and EMS systems. Supported in large part through the Health Resources Administration (HRSA) Emergency Medical Services for Children (EMSC) Program, the initiative brings together organizations including ACEP, AAP, ENA, and ACS to establish national standards for pediatric readiness, assess and improve readiness in EDs, and support implementation through quality-improvement programs, pediatric emergency care coordinators, and emerging verification/recognition efforts. Consequently, the joint policy statement is more than an individual organizational policy since it provides an important foundation for the NPRP and related national, state, and federal pediatric readiness efforts, meaning substantive changes to the policy can have broader implications for national standards, assessment tools, implementation strategies, federal partnerships, and pediatric emergency care system. Advocating for changing the policy statement, which would likely be a multi-year process, is particularly challenging since it informs the NPRP assessment and broader pediatric readiness infrastructure supported by the federal EMSC program. Any changes in the policy statement also have downstream implications for the NPRP assessment, implementation tools, quality-improvement initiatives, and emerging verification standards.

This resolution is connected directly to a broader, active ACEP advocacy effort on physician staffing in emergency departments. ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "…the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in emergency medicine or pediatric emergency medicine or an equivalent international certifying body recognized by ABEM or AOBEM in emergency medicine or pediatric emergency medicine."

ACEP released a Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023, which has been instrumental in helping states pass legislation requiring a physician in the ED at all times. In the 2024-25 legislative session, South Carolina joined Indiana (2023) and Virginia (2024) in passing such a law. The AMA

adopted resolution 204 in June 2024 compelling the AMA to seek federal legislation or regulation that would require physician presence in EDs.

The resolution's specific focus on pediatric readiness designation adds a new dimension to this ongoing effort and would tie the "pediatric ready" designation, which is a nationally recognized quality marker, to the same continuous physician presence standard ACEP has been advancing in the general ED staffing context. Significant variability currently exists across emergency departments in the United States regarding continuous on-site physician coverage, particularly in rural and resource-limited settings.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 1: Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Objective 2: Expand ACEP's accreditation programs to further recognize excellence in the delivery of emergency care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting budgeted committee and staff resources from other work or including funds in the next fiscal year budget. Implementation would be a multi-year process and require committee and staff resources to engage the AAP, ENA, ACS, and other national stakeholders, including federal agencies. Estimated costs for staff resources could range $10,000 – $25,000 annually (.10 – .25 FTE). Alternatively, an outside consultant could be utilized to assist with the work and estimated costs could range $25,000 – $50,000 annually.

Prior Council Action

Amended Resolution 51(25) Supporting Board Certified Physicians in Every Emergency Department adopted. Directed ACEP to reaffirm current policy that the gold standard for emergency department care is provided by an emergency physician, and support state and federal legislative and regulatory efforts to require that a physician be present and available in every emergency department.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted. The resolution directed ACEP to advocate for stricter enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with The Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted. Directed ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all EDs and continue to promote the gold standard for physicians working in an ED is a board-certified/board-eligible emergency physician certified by the ABEM, AOBEM, or certified by the ABP in pediatric

emergency medicine.

Resolution 68(21) Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Asked ACEP to support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

Substitute Resolution 66(21) ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76) adopted. Directed that ACEP publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician and support the standard that board certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

Resolution 27(16) Pediatric Surgery Centers adopted. Directed ACEP to collaborate with appropriate stakeholders to amend the Pediatric Surgery Center Guidelines and reaffirm the "Guidelines for the Care of Children in the ED" as the standard for pediatric emergency care.

Resolution 19(12) Pediatric Emergency Preparedness Recognition - not adopted. Sought to support a regional approach to stratify pediatric emergency care, support state autonomy in establishing pediatric designation guidelines, and establish a clearinghouse of information for states wishing to develop their own systems of pediatric designation.

Prior Board Action

January 2026, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved October 2024, June 2023, March 2022, and June 2020 with the current title; revised and approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" and replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department.

Amended Resolution 51(25) Supporting Board Certified Physicians in Every Emergency Department adopted.

Amended Resolution 50(25) Emergency Department Staffing Transparency adopted.

April 2025, approved revised policy statement "Pediatric Readiness in the Emergency Department;" revised and approved June 2018 and April 2009; originally approved December 2000 titled "Guidelines for Care of Children in the Emergency Department."

January 2025, approved the revised policy statement "The Role of Emergency Physicians in the Care of Children;" revised and approved October 2019; reaffirmed June 2013 and October 2007; revised and approved June 2001; approved January 1996; rescinded June 1995; originally approved September 1989.

Amended Resolution 42(23) On-site Physician Staffing in Emergency Departments adopted.

Substitute Resolution 66(21) ACEP Promotion of Emergency Physician Led Teams (as substituted in lieu of Resolutions 66, 67, and 76) adopted.

Resolution 27(16) Pediatric Surgery Centers adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

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Council Secretary and Executive Director

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RESOLUTION: 52(26)

SUBMITTED BY: Amy Costigan, MD, MBA, FACEP
Joseph Tennyson, MD, MHCM, FACEP, FAEMS
Massachusetts College of Emergency Physicians

SUBJECT: Prioritizing Inpatient Medical Admission for Geriatric Psychiatric Patients When Psychiatric Beds Are Unavailable

PURPOSE: Develop a policy statement and engage in advocacy, education, and external partnerships to establish admission to an inpatient medical unit, with appropriate psychiatric consultation and geriatric-focused care, as the preferred alternative to prolonged ED boarding for geriatric psychiatric patients who require inpatient-level mental health care when a psychiatric bed cannot be secured within 24 hours. Also work with accrediting and regulatory bodies to remove barriers and evaluate incorporating explicit guidance into the Geriatric Emergency Department Accreditation Program.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff and GEDA resources across multiple workstreams: 1) developing a new policy statement (estimated 200-300 staff hours with estimated costs of $15,000 – $30,000; 2) advocacy and external partnership engagement with accrediting bodies, hospital associations, and health systems (ongoing estimated 0.25 – 0.5 FTE annually, $35,000 – $75,000); and 3) evaluation and potential revision of GEDA program standards (estimated $15,000 – $25,000). Total estimated cost range $65,000 – $130,000, with ongoing annual advocacy costs of approximately $35,000 – $75,000.

WHEREAS, Emergency department boarding has been recognized by the American College of Emergency Physicians (ACEP) as a significant patient safety and public health crisis, and older adults are particularly vulnerable to the adverse effects of prolonged emergency department stays; and

WHEREAS, Prolonged emergency department boarding among geriatric psychiatric patients is associated with increased risks of delirium, falls, aspiration, pressure injury, functional decline, sleep disruption, and loss of mobility, while also contributing to emergency department crowding and reduced access to care for other patients; and

WHEREAS, Inpatient medical units generally provide a safer and more therapeutic environment for older adults through enhanced nursing support, multidisciplinary care, mobility programs, delirium prevention strategies, and access to psychiatric consultation services; and

WHEREAS, ACEP's Geriatric Emergency Department Accreditation (GEDA) program recognizes prolonged boarding as an important quality issue and currently recommends that accredited emergency departments implement care processes that minimize geriatric boarding and provide access to geriatric psychiatry consultation; however, GEDA does not explicitly address disposition pathways for geriatric psychiatric patients who are unable to obtain timely psychiatric placement, nor does it specifically encourage admission to inpatient medical units as an alternative to prolonged emergency department boarding; therefore be it

RESOLVED, That ACEP develop a policy statement supporting admission to an inpatient medical unit, with appropriate psychiatric consultation and geriatric-focused care, as the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients who require inpatient-level mental health care when an appropriate psychiatric bed cannot be secured within 24 hours; and be it further

RESOLVED, That ACEP advocate, through policy, education, and external partnerships, that admission to an

inpatient medical unit with appropriate psychiatric consultation and geriatric-focused care should be the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients who require inpatient-level mental health care when an appropriate psychiatric bed cannot be secured within 24 hours; and be it further

RESOLVED, That ACEP work with accrediting and regulatory bodies, hospital leaders, and health systems to remove barriers and clarify that admission to inpatient medical services for such patients is an acceptable and preferred safety practice when psychiatric beds are unavailable; and be it further

RESOLVED, That ACEP advocate for national quality standards that discourage prolonged emergency department boarding of geriatric psychiatric patients and support timely admission to inpatient medical settings when psychiatric placement is unavailable; and be it further

RESOLVED, That ACEP evaluate incorporation of more explicit guidance into the Geriatric Emergency Department Accreditation (GEDA) Program encouraging accredited emergency departments to establish policies that prioritize inpatient admission for geriatric psychiatric patients when psychiatric placement is unavailable and prolonged emergency department boarding would otherwise occur.

Background

This resolution asks the College to develop a policy statement and engage in advocacy, education, and external partnerships to establish admission to an inpatient medical unit, with appropriate psychiatric consultation and geriatric-focused care, as the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients when a psychiatric bed cannot be secured within 24 hours. It further directs ACEP to work with accrediting and regulatory bodies to remove barriers to this practice and to evaluate incorporating more explicit guidance into the Geriatric Emergency Department Accreditation (GEDA) Program.

ACEP has long recognized ED boarding as a hospital-wide patient safety problem and has stated that the most effective care of admitted patients is provided in an inpatient unit. ACEP's existing policy on boarding holds that hospitals have the responsibility to ensure the prompt transfer of admitted patients to inpatient units, and that hospital regulatory and accrediting bodies should mandate standards for prompt transfer. Despite this longstanding position, no ACEP policy specifically addresses the disposition pathway for geriatric psychiatric patients who cannot obtain timely psychiatric placement, leaving a gap between ACEP's general boarding policy and the specific clinical and safety needs of this population. This resolution seeks to fill that gap by establishing inpatient medical unit admission, with psychiatric consultation and geriatric-focused care, as the preferred alternative to prolonged ED boarding when a psychiatric bed cannot be secured within 24 hours, and by directing ACEP to advocate for the removal of regulatory and accreditation barriers to this practice. In addition, ACEP's Geriatric ED Accreditation Program now requires Level 1 sites to record and report on boarding hours among their geriatric patients.

Psychiatric boarding in emergency departments, the practice of holding behavioral health patients in the ED while awaiting an inpatient psychiatric bed, has become a pervasive and worsening patient safety crisis. The Agency for Healthcare Research and Quality (AHRQ) estimates that approximately one in every eight ED visits is related to psychiatric care or substance use disorder, and studies have shown that patients with a psychiatric condition have increased odds of being in the ED for more than 24 hours and consistently wait longer than non-psychiatric patients. A 2016 survey of emergency physicians conducted by ACEP found that nearly half (48%) reported psychiatric patients boarded in their ED waiting for an inpatient bed one or more times a day, and more than 10% reported having six to ten patients waiting for an inpatient psychiatric bed on their last shift. Average boarding times for psychiatric patients range between 15 and 30 hours. Preliminary results of a 2022 Emergency Department Benchmarking Alliance (EDBA) performance measures survey found a significant deterioration in patient processing due to inpatient boarding.

The root cause of this is a decades-long collapse in psychiatric inpatient capacity. The National Association of State Mental Health Program Directors has documented a decline of 77.4% in inpatient psychiatric beds since 1970; the Agency for Healthcare Research and Quality reports that public psychiatric hospital beds dropped from 207 to 21 per 100,000 persons between 1970 and 2000. Nationally, there was an average of only 26.1 psychiatric beds per 100,000

people a decade ago, according to ACEP's 2014 Report Card. Community mental health cuts have compounded the shortage: from 2009 to 2012, states cut $1.6 billion in mental health funding, a decrease of 10%. With fewer community resources available, patients in need of mental health services are increasingly presenting to emergency departments. Many psychiatric facilities do not fall under EMTALA and can legally refuse admission; most are already at capacity. Insurance authorization for psychiatric admission from the ED can take extensive amounts of time, further prolonging boarding. A 2016 HHS/HRSA report projected a shortage of behavioral health workers by 2025 alongside increasing national demand, and only 16.9% of emergency physicians in the 2016 ACEP survey reported having a psychiatrist available to respond to psychiatric emergencies in their ED.

Older adults are a particularly vulnerable population within this broader crisis. Behavioral health disorders are common among older adults, and due to limited access to community mental health resources, emergency department providers are frequently on the front lines of mental health crises in this population. Older adults with complicated illnesses such as Alzheimer's disease and other neurocognitive disorders often require specialized treatment in geriatric psychiatric facilities when inpatient psychiatric hospitalization is needed; however, there is a shortage of these specialized inpatient facilities. A 2018 study published in the Primary Care Companion for CNS Disorders reviewed records for patients aged 60-89 years who received a psychiatric consultation in the ED over a two-year period and found that the mean time in the ED was over a day for patients with a recommendation for admission, compared to only 13 hours for patients recommended for discharge. Dementia and neurocognitive disorders were the most common diagnoses leading to geriatric psychiatry referral, and admission to a medical unit was the least common disposition recommendation, suggesting that inpatient medical admission as an alternative to prolonged boarding is underutilized even when psychiatric placement is unavailable.

The harms of prolonged ED boarding fall disproportionately on older adults. The ED environment, with its noise, bright lighting, disrupted sleep, physical restraint, limited mobility, and absence of structured therapeutic activity, is poorly suited to the care of geriatric patients with psychiatric needs. Prolonged ED stays in this population are associated with increased risk of delirium, falls, aspiration, pressure injury, functional decline, and loss of mobility. These harms are compounded by the fact that many psychiatric facilities lack the ability to provide basic medical care for patients with complex comorbidities such as insulin-dependent diabetes, dialysis-dependent renal failure, or other conditions common in older adults, making psychiatric placement even more difficult to secure. The Geriatric Emergency Department Collaborative (GEDC) has recognized prolonged ED boarding as particularly dangerous for vulnerable older patients, noting that the results of insufficient inpatient capacity are "problematic and dangerous from many angles, perhaps most acutely evident in the horrors, especially for vulnerable patients, of prolonged ED Boarding."

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 2: Clinical Excellence, Research and Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Objective 2: Expand ACEP's accreditation programs to further recognize excellence in the delivery of emergency care.

Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require staff and GEDA resources across multiple workstreams: 1) developing a new policy statement (estimated 200-300 staff hours with estimated costs of $15,000 – $30,000; 2) advocacy and external partnership engagement with accrediting bodies, hospital associations, and health systems (ongoing estimated 0.25 – 0.5 FTE annually, $35,000 – $75,000); and 3) evaluation and potential revision of GEDA program standards (estimated $15,000 – $25,000). Total estimated cost range $65,000 – $130,000, with ongoing annual advocacy costs of approximately $35,000 – $75,000.

Prior Council Action

Amended Resolution 46(19) Mental Health Care for Vulnerable Populations adopted. Directed ACEP to support increasing the capacity of current conventional mental health facilities to provide care for patients.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted. The resolution directed ACEP to develop a psychiatric boarding toolkit.

Amended Resolution 24(16) Mental Health Boarding Solutions adopted. Directed ACEP to partner with stakeholders including the American Psychiatric Association, SAMHSA, and the National Alliance on Mental Illness to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and to develop and share ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in EDs.

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted. Directed ACEP to convene a work group of appropriate stakeholders to explore and identify additional resources, technologies, and best practices that promote quality patient care for timely evaluation and disposition of behavioral health patients.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted. Directed ACEP to meet with the American Psychiatric Association and other stakeholders to create a standard for the medical stability of psychiatric patients that includes the conclusions from the 2006 ACEP "Clinical Policy: Clinical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department."

Substitute Resolution 28(06) Psychiatric Bed Availability adopted. Directed that ACEP work with appropriate organizations to study the impact of psychiatric bed availability on emergency departments and EMS, seek solutions to problems identified, and bring the issue to the AMA House of Delegates at the 2007 annual meeting.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. This resolution called on ACEP to develop talking points to respond to issues related to psychiatric and substance use patients in the ED.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. This resolution called on ACEP to support legislation around psychiatric involuntary transfers.

Prior Board Action

April 2023, approved the revised policy statement on "Adult Psychiatric Emergencies;" originally approved October 2020.

Amended Resolution 46(19) Mental Health Care for Vulnerable Populations adopted.

October 2019, Board reviewed a compiled list of resources on psychiatric boarding assembled by the Emergency Medicine Practice Committee in response to Amended Resolution 39(18).

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted.

June 2017, approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in emergency departments.

January 2017, approved the revised "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," replacing the 2006 clinical policy with the same title.

Amended Resolution 24(16) Mental Health Boarding Solutions adopted.

November 2015, reviewed the information paper "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department."

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted.

Substitute Resolution 28(06) Psychiatric Bed Availability adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. patients in the ED.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted

Background Information Prepared by: Sandy Schneider, MD, FACEP
Chief Medical Officer

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Senior Manager, Accreditation Programs

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PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 53(26)

SUBMITTED BY: Government Services Chapter

SUBJECT: Protecting Emergency Physician Privacy in Hospital Identification and Directories

PURPOSE: Develop a policy statement supporting emergency physicians' discretion over the extent of personally identifying information displayed on hospital identification badges, attire, and public-facing directories.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Developing a policy, related resources, and appropriate promotion requires multiple staff from various areas of the College. Estimated cost range $30,000 – $50,000 depending on additional resources developed and scope of promotional efforts.

WHEREAS, A January 2024 national poll of ACEP members found that 91% of emergency physicians reported that they or a colleague had been a victim of violence in the prior year; and

WHEREAS, The risk to emergency physicians increasingly extends beyond the emergency department, as a 2023 poll of more than 2,000 physicians found that 85% are concerned that a patient could find their personal information online and 35% reported this had already occurred, with emergency physicians among the most concerned; and

WHEREAS, A 2025 study found that the majority of physicians had exposure of personal information online; and

WHEREAS, We recognize that patients have a legitimate interest in identifying the physicians involved in their care, and identification requirements arising from accreditation standards and any physician information privacy efforts must be balanced with state health care practitioner transparency laws; and

WHEREAS, Physician identity is readily observable via identification badges, attire, and online hospital directories, which often display full legal names; this information, when combined with readily available data from third-party brokers and social media, enables not only patients but also members of the public to identify and locate physicians outside the workplace, creating significant privacy and safety risks; and

WHEREAS, ACEP's policy "Protection from Violence and the Threat of Violence in the Emergency Department" and ACEP's general violence prevention advocacy efforts so far address physical security within the emergency department but do not address physician personal information exposure or identification practices; therefore be it

RESOLVED, That ACEP develop a policy statement supporting emergency physicians' discretion over the extent of personally identifying information displayed on hospital identification badges, attire, and public-facing directories.

Background

This resolution asks the College to develop a policy statement supporting emergency physicians' discretion over the extent of personally identifying information displayed on hospital identification badges, attire, and public-facing directories.

Emergency physicians face escalating safety risks that extend well beyond the walls of the emergency department. Violence in the ED has been a documented and growing concern: a January 2024 national poll of ACEP members found that 91% of emergency physicians reported that they or a colleague had been a victim of violence in the prior year. A 2022 ACEP survey found that 85% of emergency physicians believe the rate of violence experienced in emergency departments has increased over the past five years. In response to this trend, ACEP has collected more than 800 personal accounts from emergency physicians detailing workplace violence and has advocated for improved local reporting mechanisms, findings that highlight the prevalence of workplace violence in emergency settings.

The threat to emergency physicians increasingly extends outside the clinical environment through the exposure of personal information online. A 2023 poll of more than 2,000 physicians found that 85% are concerned that a patient could find their personal information online, and 35% reported this had already occurred, with emergency physicians among the most concerned. A 2025 study found that the majority of physicians had exposure of personal information online. The mechanism connecting in-hospital identification to out-of-hospital risk is the combination of full legal names displayed on identification badges, attire, and public-facing hospital directories with data readily available from third-party data brokers and social media. This combination enables not only patients but also members of the general public to identify and locate physicians outside the workplace, creating significant privacy and safety risks.

ACEP's existing policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" addresses physical security within the emergency department but does not address physician personal information exposure or identification practices. ACEP's prior Council and Board actions on workplace violence have similarly focused on in-facility security measures, criminal penalties, and reporting mechanisms rather than on the upstream privacy risk created by physician identification practices. No current ACEP policy statement specifically addresses physician discretion over identifying information on badges, attire, or public-facing directories.

Patients have a legitimate interest in identifying the physicians involved in their care, however, physician information and privacy efforts must be balanced with state health care practitioner transparency laws and accreditation standards. Some states have enacted or are considering physician address confidentiality or data-broker opt-out protections. Many of the institutional policies and procedures are hospital-wide and not specific to the emergency department. Enlisting support from across emergency care and medical systems, including organizations such as the Emergency Nurses Association and the American Medical Association, may be needed.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

> Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.
>
> Objective 5: Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

> Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.
>
> Objective 3: Expand wellness, peer support, and burnout prevention resources to promote the well-being, health, and resilience needs of emergency physicians.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget.

Developing a policy, related resources, and appropriate promotion requires multiple staff from various areas of the College. Estimated cost range $30,000 – $50,000 depending on additional resources developed and scope of promotional efforts.

Prior Council Action

The Council has discussed and adopted many resolutions pertaining to workplace violence; however, none have specifically addressed emergency physician privacy with respect to identification badges, attire, or public-facing hospital directories.

Prior Board Action

None that specifically addresses emergency physician privacy regarding identification badges, attire, or public-facing hospital directories.

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" with the current title; revised and approved April 2016 titled "Protection from Violence in the Emergency Department; revised and approved June 2011 and April 2008 titled "Protection from Physical Violence in the Emergency Department Environment;" reaffirmed October 2001 and October 1997; originally approved January 1993.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
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Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
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Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 54(26)

SUBMITTED BY: Thomas Benzoni, MD, FACEP
Fred Dennis, MD, FACEP
Nicholas Jouriles, MD, FACEP
James Mitchiner, MD, FACEP
Chirag Shah, MD, FACEP
Peter Viccellio, MD, FACEP

SUBJECT: Radiology Turn-Around Time in the ED

PURPOSE: Promote a standard that radiology turn-around time for plain films and CT scans in the ED, from the time the patient is ready for imaging to the time the test is completed and definitively interpreted should be no more than 60 minutes; and include ED radiology turn-around time as a metric in the Clinical Emergency Data Registry.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require two distinct workstreams: 1) committee and staff resources for development and promotion of the 60-minute radiology TAT standard, potentially including outreach to the American College of Radiology and other stakeholders; and 2) integration of radiology TAT as a metric in CEDR requiring technology and data infrastructure work by the CEDR team. Estimated cost is $15,000 – $30,000 in staff time and committee resources, adding a new metric to CEDR estimated $150,000 – $200,000 plus ongoing staff resources for metric maintenance and reporting. Total estimated range is $165,000 – $230,000 plus ongoing staff resources.

WHEREAS, ED crowding and boarding is dangerous to patients and stressful on staff; and

WHEREAS, The large majority of ED patients are ultimately discharged; and

WHEREAS, Decreasing the turn-around time (TAT) of all ED patients will improve bed availability; and

WHEREAS, There is pressure on the ED to see patients as quickly as possible; and

WHEREAS, There is pressure on the provider to minimize the time to provider; and

WHEREAS, There is no defined standard for radiology TAT for the ED and prolonged radiology TAT have a profound impact on overall ED TAT; and

WHEREAS, Although there is no specific time performance requirement for any step of the patient's care in the ED, establishing standards for performance influences a movement to achieve those standards; therefore be it

RESOLVED, That ACEP promote the following standard: from the time the patient is ready for a plain film or CT to the time the test is completed and definitively interpreted should be no more than 60 minutes; and be it further

RESOLVED, That emergency department radiology turn-around time should be included in ACEP's Clinical Emergency Data Registry.

Background

This resolution asks the College to promote a standard that radiology turn-around time (TAT) for plain films and CT scans in the ED, from the time the patient is ready for imaging to the time the test is completed and definitively

interpreted, should be no more than 60 minutes, and to include ED radiology TAT as a metric in ACEP's Clinical Emergency Data Registry (CEDR).

ED crowding and boarding are well-documented patient safety concerns, and prolonged radiology TAT can significantly contribute to overall ED length of stay. Imaging results frequently gate disposition decisions for the majority of ED patients who are ultimately discharged, meaning that delays in completing and interpreting studies directly impact the time patients occupy ED beds. Research confirms the magnitude of this bottleneck: one analysis found that each CT scan can add up to 150 minutes of ED time for patients, and ED overcrowding is frequently attributable to patients waiting for CT scan results. A 2018 study published in the American Medical Informatics Association Annual Symposium Proceedings (Perotte et al., NewYork-Presbyterian/Columbia University) found that CT TAT was a significant driver of ED flow and that targeted process interventions, including dedicated transport and workflow redesign, produced measurable reductions in TAT and downstream length of stay. A quality improvement initiative at the University of Colorado Health (UCH) similarly found that nearly half of ED visits require imaging, and that because decision-making in the ED rests heavily on image interpretation, delays can have serious consequences; the UCH team reduced CT TAT by 25 minutes through operational changes, a result estimated to have saved the ED millions of dollars annually while improving patient satisfaction.

Despite the recognized impact of radiology TAT on ED throughput, no nationally uniform numeric standard currently defines an acceptable TAT for plain film or CT imaging in the ED setting. Benchmarking data in use across institutions varies. One hospital quality improvement project identified a national benchmark of 77 minutes from imaging order to final read, while a separate academic medical center used a target of a finalized report within four hours of an order, and found that only 64 percent of CTs met even that more permissive goal. The 60-minute standard proposed in this resolution uses a different definition of the time interval that focuses on a starting poit as when the patient is ready versus when the study is ordered. Using this definition of the window from patient readiness for imaging through completed interpretation is a narrower and more operationally precise definition. However, this starting point may be harder to capture and measure as it may require an additional time stamp in the electronic record that may have to be entered manually. The proposed 60-minute standard is not currently in use as a published national benchmark, and the evidence base for a specific numeric threshold is drawn from institutional quality improvement literature rather than prospective clinical trials. More research would be required to support this as a validated measure.

ACEP's policy statement "Interpretation of Imaging Diagnostic Studies" states that "the communication of diagnostic study results is critical to the evaluation and management of emergency department (ED) patients. Such communication should be performed contemporaneously with the ED visit to guide ongoing treatment decisions." Additionally, the policy states "interpretations should be available immediately to the ordering emergency physician or their designee" and "if the emergency physician believes that an urgent consultation with a radiologist is needed for the interpretation of a diagnostic study, that consultant must be immediately available for discussion and/or consultation with the treating physician." However, the policy does not specify a specific turnaround time. The policy statement "Availability of Diagnostic Resources on a 24-7 Basis to Support Emergency Care" states that ACEP "strongly advocates for hospitals to provide continuous, 24/7 access to critical diagnostic modalities, including computed tomography, magnetic resonance imaging, X-ray, and ultrasound to support timely and effective delivery of emergency care." A Policy Resource & Education Paper "Availability of Diagnostic Resources on a 24-7 Basis to Support Emergency Care" was also developed as an adjunct to the policy statement and provides additional guidance.

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states that radiological, imaging, and other diagnostic services should be available within a reasonable period of time for individuals who require those services and CT should be readily available 24 hours a day for emergency patients." Neither policy statement specifies a numeric time standard. The American College of Radiology's (ACR) Practice Parameter for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments similarly calls for "timely consultative services" including interpretation, reporting, and consultation with referring physicians, but defers to state and federal statutes to define "timely coverage" and does not set a numeric threshold. The absence of a defined numeric standard across both ACEP and ACR policy is the core gap this resolution seeks to address.

The second RESOLVED asks that ED radiology TAT be included in ACEP's Clinical Emergency Data Registry (CEDR). CEDR is ACEP's qualified clinical data registry, which collects and reports emergency medicine quality

measures. Adding radiology TAT as a tracked metric would enable benchmarking across participating EDs and support quality improvement efforts aligned with the proposed standard. ACEP has previously developed imaging-related measures for emergency medicine in conjunction with the CEDR program, establishing an existing infrastructure on which this metric could build. The building and validating of a measure is a staff- and data-intensive effort that requires extensive testing and validation.

ACEP Strategic Plan Reference

Priority 2: Clinical Excellence, Research & Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

> Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.
>
> Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

> Objective 1: Identify and support the practice models for emergency physicians that expand the field of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Implementation would require two distinct workstreams: 1) committee and staff resources for development and promotion of the 60-minute radiology TAT standard, potentially including outreach to the American College of Radiology and other stakeholders; and 2) integration of radiology TAT as a metric in CEDR requiring technology and data infrastructure work by the CEDR team. Estimated cost is $15,000 – $30,000 in staff time and committee resources, adding a new metric to CEDR estimated $150,000 – $200,000 plus ongoing staff resources for metric maintenance and reporting. Total estimated range is $165,000 – $230,000 plus ongoing staff resources.

Prior Council Action

Amended Resolution 32(15) Critical Communications for ED Radiology Findings adopted. Directed ACEP to work with the American College of Radiology to develop a joint best practice guideline regarding imaging findings that should be communicated in real-time and in a closed-loop manner by the radiologist to the emergency provider.

Amended Substitute Resolution 47(05) Contemporaneous Interpretation of CT Scans adopted. Directed that when emergency physicians request urgent interpretation of CT scans, such interpretation be made contemporaneously by a health care facility credentialed residency-trained and/or board-certified radiologist, and that both the written preliminary and final reports be documented in the patient's medical record.

Substitute Resolution 45(05) Availability of Hospital Diagnostic and Therapeutic Services adopted. Directed ACEP promote policies that endorse consistent 7-days a week availability of hospital diagnostic and therapeutic services to facilitate timely disposition of ED patients and minimize hospital crowding.

Prior Board Action

April 2025, approved the policy statement "Availability of Diagnostic Resources on a 24-7 Basis to Support Emergency Care."

April 2025, reviewed the Policy Resource & Education Paper "Availability of Diagnostic Resources on a 24-7 Basis to Support Emergency Care."

June 2024, approved the revised policy statement "Interpretation of Imaging Diagnostic Studies;" revised and approved June 2018 with the current title; revised and approved February 2013 and June 2006 titled "Interpretation of Imaging Diagnostic Studies;" reaffirmed October 2000; revised and approved September 1996; originally approved March 1990 titled "Interpretation of Diagnostic Studies."

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

Amended Resolution 32(15) Critical Communications for ED Radiology Findings adopted.

Amended Substitute Resolution 47(05) Contemporaneous Interpretation of CT Scans adopted.

Substitute Resolution 45(05) Availability of Hospital Diagnostic and Therapeutic Services adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
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Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 55(26)

SUBMITTED BY: Washington Chapter

SUBJECT: Responsible Use of AI in Emergency Medicine Documentation

PURPOSE: Affirm ACEP's support for responsible use of AI-enabled documentation tools in emergency medicine; to affirm that the treating emergency physician remains responsible for the accuracy, clinical reasoning, and narrative integrity of the medical record; develop educational resources and practical guidance for the safe, effective, and responsible use of AI-enabled documentation tools in emergency medicine.

FISCAL IMPACT: Ongoing committee and staff resources. Estimated $15,000 – $40,000 for educational resource development, requiring staff (0.25 – 0.5 FTE) and potential vendor resources.

WHEREAS, Artificial intelligence (AI) tools, including ambient listening and automated documentation systems, are rapidly expanding within the practice of medicine and are likely to become an integral component of emergency department clinical workflows; and

WHEREAS, Clinical documentation in emergency medicine is a core component of patient care that reflects physician clinical reasoning and medical decision-making and represents the official medical and legal record; and

WHEREAS, AI-enabled documentation tools may provide meaningful benefits, including improved efficiency, reduced administrative burden, and enhanced completeness and organization of clinical notes; and

WHEREAS, AI-generated documentation may produce complete clinical narratives that do not fully reflect the physician's clinical reasoning, uncertainty, or decision-making process if not actively validated; and

WHEREAS, The emergency physician remains responsible for the accuracy and narrative integrity of the medical record, consistent with prior emergency medicine consensus principles supporting physician-led and human-centered implementation of AI tools; and

WHEREAS, As AI-enabled documentation becomes more prevalent, there is a need for guidance and education to support appropriate physician engagement and adaptation; therefore be it

RESOLVED, That ACEP support the use of responsible AI-enabled documentation tools in emergency medicine while recognizing clinical documentation as a core component of the emergency physician's practice and affirming that such tools should augment, not replace, physician work; and be it further

RESOLVED, That ACEP affirm that the treating emergency physician remains responsible for the accuracy, clinical reasoning, and narrative integrity of the medical record and must ensure that the documentation reflects their clinical judgment; and be it further

RESOLVED, That ACEP support development of educational resources and practical guidance for the safe, effective, and responsible use of AI-enabled documentation tools in emergency medicine, while recognizing variation in documentation workflows and physician practice styles.

Background

This resolution asks the College to affirm support for responsible AI-enabled documentation tools in emergency medicine, affirm that the treating emergency physician remains responsible for the accuracy, clinical reasoning, and

narrative integrity of the medical record, and direct development of educational resources and practical guidance for the safe, effective, and responsible use of AI-enabled documentation tools.

AI-enabled documentation tools, most prominently ambient listening systems that use voice recognition technology to listen to provider-patient conversations in real time, interpret the dialogue, and create medically relevant clinical documentation, are expanding rapidly across health care settings, including emergency departments. Ambient listening is gaining attention as health care organizations adopt AI-powered technology, and approximately 30% of physician practices already use ambient listening AI, according to the Medical Group Management Association. Health systems including the University of Chicago Medicine have deployed these tools at scale: ambient clinical documentation is now used by more than 550 clinicians across that health system, allowing doctors to focus more completely on each patient and spend less time looking at the computer.

The primary driver of adoption is documentation burden and its relationship to physician burnout. By automatically capturing and transcribing patient-physician interactions, ambient listening technology can potentially alleviate the burden of manual documentation, a problem that is more than just a thorn in the side for clinicians in this age of burnout and physicians have experienced staggering rates of burnout for the past several years. A 2025 quality improvement study published in *JAMA Network Open* evaluating an ambient AI documentation platform at Sutter Health found that ambient AI was associated with decreased time in notes per appointment and improved clinician satisfaction at work and decreased cognitive load.

The emergency department presents a distinct and more complex environment for ambient AI documentation than ambulatory settings. A 2026 scoping review of ambient documentation systems in emergency medicine published in *Cureus Journal of Medical Science*, the first systematic review focused specifically on ED applications, found that growing ED-specific evidence, with three studies examining ambient AI adoption, documentation time, and note quality in ED settings, suggests that ambient systems may shift rather than eliminate documentation effort, particularly in emergency settings characterized by interruptions, multitasking, and evolving clinical narratives. The same review identified additional concerns specific to the ED context, including algorithmic equity, safety and governance, and financial and quality outcomes as areas requiring further examination. Computer science literature cited in that review has also identified significant racial and dialect-based disparities in automatic speech recognition accuracy, raising equity concerns for diverse patient populations commonly seen in emergency departments.

Clinical documentation in emergency medicine serves as the official medical and legal record and is a core expression of physician clinical reasoning. The emergency physician's responsibility for the accuracy and integrity of that record is well established in existing professional and legal standards. As AI-generated notes become more prevalent, there is a recognized risk that physicians may accept AI-generated narratives without adequate review, potentially producing documentation that does not fully reflect their clinical reasoning, uncertainty, or decision-making.

ACEP appointed an AI Task Force in June 2024 to determine the current landscape of utilization of AI in emergency medicine practice, to include an assessment of prevalence, practice type, and purpose as well as other objectives to help prepare emergency physicians and their teams for the provision of care using AI. The task force scope of work evolved and a new Artificial Intelligence Committee was appointed in 2025. The committee was assigned objectives for identifying relevant opportunities and risks in the application of AI in the practice of emergency medicine, including activities related to clinical practice such as documentation of care.

ACEP convened an "All Emergency Medicine AI Summit" in October 2025, bringing together members from AACEM, AAEM, ABEM, ACOEP, AOBEM, CORD, EMRA, and SAEM to prepare for how AI will transform emergency medicine education, research, and clinical practice. A consensus "Statement of Principles" was developed that affirmed a shared commitment to advocate for the deployment of AI safely, ethically, and equitably. The organizations committed to working collaboratively to establish standards that protect patients and support clinicians and endorsed the following principles:

1. AI integration must be human-centered, in which emergency physicians retain authority for patient care decisions (Human-in-the-loop). AI must enhance, not replace, clinical judgment, and must preserve the physician-patient relationship.

2. AI implementation must occur under a physician-led governance framework, ensuring emergency physicians maintain primary input in the selection, design, validation, and use of AI tools in emergency care.
3. AI adoption must prioritize patient safety, care quality, and clinical outcomes.
4. Standards for AI transparency must promote equitable and safe clinical use. We further endorse shared accountability among clinicians, vendors, and institutions for patient outcomes influenced by AI.
5. Competency-based educational frameworks for AI encourage that emergency medicine trainees first demonstrate clinical reasoning and clinical skills with progressive, supervised integration of AI tools into their practice as their clinical competency develops.
6. When AI is used to support scholarly activity advancing the specialty of emergency medicine, its use must be clearly disclosed to maintain transparency and academic integrity.
7. Training emergency physicians on the safe and effective use of AI is a prerequisite to deployment and is essential to responsible use of AI in practice.
8. There must be proactive design, deployment, and monitoring of AI applications across diverse patient populations and practice settings to mitigate bias and ensure equitable patient care outcomes.
9. Policies, regulations, and organizational practices must ensure data privacy, obtain consent for data use, and promote the responsible utilization of acquired data by AI systems linking this transparency to informed consent, disclosure, and shared decision-making for patients and clinicians.
10. AI tools must be developed and validated for emergency medicine's unique environment, such as time-critical workflows, diagnostic challenges, and patient complexity. Emergency medicine organizations believe that evidence-based deployment of AI requires independent validation, real-world performance monitoring, and continuous quality improvement.

In the 2026-27 committee year, the AI Committee will operate as a subcommittee of the Health Information Technology Committee (HITC). The HITC has multiple objectives that encompass the use of AI, including:

- Lead the creation and dissemination of AI education needs assessment for resident/fellow and post-training physicians to measure AI competency gaps and work toward integrating foundational AI competencies. Collaborate with Academic Affairs Committee, EMRA, Informatics Section, and other relevant stakeholders
- Partner with relevant stakeholders to disseminate practical education on AI, clinical informatics, decision support, and digital health for emergency physicians. Deliverables may include webinars, *ACEP Now* articles, conference programming proposals, website materials, or member-facing toolkits translating HIT/AI Committee work into actionable guidance for members.
- Develop a comprehensive strategy on how to leverage the All-EM Consensus Statement on AI (the 10 Principles of AI) to guide ACEP's governance, evaluation, and response to AI tools affecting clinical practice. Create a prioritization roadmap for future ACEP policy updates, new policy statements, and/or PREP papers. Initial efforts will focus on operationalizing Principle #10, ensuring that AI tools are specifically developed, independently validated, and continuously monitored for emergency medicine's unique, time-critical workflows and diagnostic challenges.

ACEP Strategic Plan Reference

Priority 2: Clinical Excellence, Research and Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Priority 3: Practice Innovation – ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objective 3: Monitor and evaluate the impact of artificial intelligence, telehealth, and other emerging technologies on emergency care delivery and physician practice.

Objective 4: Develop educational and other resources to prepare emergency physicians for roles in evolving and emerging administrative, clinical, and educational settings.

Fiscal Impact

Ongoing committee and staff resources. Estimated $15,000 – $40,000 for educational resource development, requiring staff (0.25 – 0.5 FTE) and potential vendor resources.

Prior Council Action

Amended Resolution 56(25) Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions adopted. The resolution directed ACEP to advocate for state and federal legislation requiring that AI-assisted reimbursement or coverage decisions be reviewed and approved by qualified human personnel, to support prohibiting health insurers from relying solely on AI-based algorithms to deny, delay, or downcode claims, and to collaborate with stakeholders to ensure AI algorithms used in health care decision-making are transparent, accountable, and subject to oversight by qualified health care professionals.

Resolution 42(19) Augmented Intelligence in Emergency Medicine referred to the Board of Directors. The resolution requested ACEP to convene an Emergency Medicine Augmented Intelligence (EMAI) Summit and/or a task force to produce an information paper on the issues and concerns surrounding augmented intelligence and make recommendations for the College. Advised the Board of Directors to consider updating the College's Strategic Plan to include augmented intelligence and include a presentation/session on augmented intelligence in emergency medicine at LAC20 or ACEP20.

Prior Board Action

October 2025, hosted an All-Emergency Medicine AI Summit.

Amended Resolution 56(25) Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions adopted.

April 2021, approved the revised policy statement "Health Information Technology for Emergency Care" with the current title; revised and approved June 2015 and August 2008 titled "Health Information Technology;" revised and approved February 2003; originally approved October 1998 titled "Internet Access."

April 2020, reviewed a report from the Health Information Technology Committee regarding implementation of Resolution 42(19) Augmented Intelligence in Emergency Medicine.

July 2019, hosted the "HIT SUMMIT: *Evolving Emergency Care with Technology*" in Dallas, TX, attended by 100 participants from a broad spectrum of Health Information Technology stakeholders, with a breakout session dedicated to Artificial (Augmented) Intelligence (AI) and Clinical Decision Support. The event proceedings resulted in a comprehensive Vision Paper, including a section on AI with seven related detailed recommendations.

Background Information Prepared by: Dhruv Sharma, MS
Lead Data Scientist

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2026 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 56(26)

SUBMITTED BY: Virginia College of Emergency Physicians

SUBJECT: Strengthening ACEP Policy on the Appropriate Use of ED Patient Experience Surveys

PURPOSE: Strengthen ACEP policy on the appropriate use of ED patient experience surveys by: 1) reaffirming opposition to the use of survey results for physician compensation, credentialing, or employment decisions; 2) opposing the use of survey results when the survey population excludes admitted, observation, transferred, or other ED patients and therefore does not represent the physician's full practice; 3) opposing the use of survey results unless the survey is administered and analyzed in accordance with its validated methodology; and 4) advocating that physician performance assessment prioritize evidence-based clinical quality measures and other scientifically valid metrics.

FISCAL IMPACT: Ongoing advocacy initiatives. Potential revisions to the policy statement would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated costs $15,000 – $30,000 in staff time and committee resources. Potential development of evidence-based clinical quality metrics requiring new research or external partnerships could range $50,000 – $150,000.

WHEREAS, The mission of ACEP is to promote the highest quality emergency care and advocate for emergency physicians and their patients; and

WHEREAS, ACEP's "Patient Experience of Care Surveys" policy statement, revised and approved by the Board of Directors in September 2025, recognizes the limitations of patient experience surveys as physician performance measures, opposing their inappropriate use in physician reimbursement and employment decisions, and supporting scientifically valid approaches to measuring the patient experience; and

WHEREAS, Emergency physicians provide care to all patients presenting to the emergency department regardless of insurance status, acuity, diagnosis, or disposition, including patients who are discharged, admitted, transferred, placed in observation, or who die in the emergency department; and

WHEREAS, Many hospital systems evaluate emergency physician performance using patient experience surveys collected only from patients discharged from the emergency department, thereby excluding admitted, observation, transferred, psychiatric, critically ill, and other patients who comprise a substantial portion of an emergency physician's clinical practice; and

WHEREAS, Performance evaluations based solely on surveys of discharged emergency department patients do not accurately represent the full scope of an emergency physician's practice and may introduce systematic bias into physician assessment; and

WHEREAS, Nationally recognized patient experience instruments, including the Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS), were scientifically validated using standardized methodologies that include specific requirements for patient sampling, survey administration, response weighting, and statistical analysis; and

WHEREAS, Many hospitals and third-party vendors modify these validated methodologies through selective survey distribution, altered sampling strategies, proprietary analytic methods, customized reporting, or nonvalidated scoring systems, thereby reducing the scientific validity and comparability of survey results; and

WHEREAS, Physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, and employment decisions should be based upon reliable, valid, and scientifically sound performance measures; therefore be it

RESOLVED, That ACEP reaffirm its existing policy opposing the inappropriate use of patient experience survey results for physician reimbursement, compensation, credentialing, or employment decisions; and be it further

RESOLVED, That ACEP advocate that patient experience survey results should not be used for physician performance evaluation, physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or other contractual determinations when the survey population excludes admitted, observation, transferred, or other emergency department patients and therefore does not represent the physician's overall emergency medicine practice; and be it further

RESOLVED, That ACEP oppose the use of patient experience survey results for physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or physician performance evaluation unless the survey is administered, sampled, analyzed, scored, and reported in accordance with the scientifically validated methodology established for that survey instrument; and be it further

RESOLVED, That ACEP advocate that physician performance assessment in emergency medicine prioritize evidence-based clinical quality measures, patient safety outcomes, operational performance measures, and other scientifically valid metrics that accurately reflect the delivery of emergency care.

Resolution References

1. American College of Emergency Physicians. *ACEP Council Resolution Compendium. September 2025.* (Patient Experience Survey Policy; Amended Resolution 51(23).)
2. American College of Emergency Physicians. Policy Statement: Patient Experience Surveys. Adopted by the ACEP Board of Directors following action of the September 2025 Council.
3. Centers for Medicare & Medicaid Services. *Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS).*
4. Agency for Healthcare Research and Quality. *CAHPS® Emergency Department Surveys.*
5. Centers for Medicare & Medicaid Services. *CMS Quality Strategy: Person-Centered Care.*
6. National Quality Forum. *Patient Experience and Patient-Reported Outcome Measurement Principles.*

Background

This resolution directs the College to reaffirm its existing policy opposing the inappropriate use of patient experience survey results in physician reimbursement, compensation, credentialing, and employment decisions; to advocate that survey results not be used for such purposes when the survey population excludes admitted, observation, transferred, or other ED patients and therefore does not represent the physician's overall emergency medicine practice; to oppose the use of survey results for physician evaluation unless the survey is administered, sampled, analyzed, scored, and reported in accordance with the scientifically validated methodology established for that instrument; and to advocate that physician performance assessment in emergency medicine prioritize evidence-based clinical quality measures, patient safety outcomes, and other scientifically valid metrics.

In September 2025, the ACEP Board of Directors approved the revised policy statement "Patient Experience of Care Surveys." The policy statement addresses the validity and appropriate use of patient experience surveys in emergency medicine and specifically states that patient experience of care survey scores should not be used for credentialing, contract renewal, or incentive bonus programs, and that rank-ordered percentiles should be abandoned. This resolution seeks to build on the policy by adding two specific protections: 1) an explicit prohibition on using survey results for physician evaluation when the survey population is limited to discharged patients and therefore excludes a substantial portion of the physician's practice; and 2) an explicit requirement that any survey used for physician evaluation must be administered, sampled, analyzed, scored, and reported in strict accordance with the validated methodology of the original instrument.

Emergency physicians provide care to all patients presenting to the emergency department regardless of disposition. Admitted, observation, transferred, psychiatric, trauma, and critically ill patients frequently represent the most complex and resource-intensive aspects of emergency medicine practice. Many hospital systems evaluate emergency physician performance using patient experience surveys collected only from patients discharged from the emergency department, thereby excluding a substantial portion of the physician's clinical practice. ACEP's own information paper on statistically valid patient satisfaction surveys notes that many emergency department surveys exclude patients who are admitted to the hospital, who instead receive a survey about their inpatient care, and that admitted patients may have a different, possibly more positive, experience of care. Evaluating physicians solely on surveys of discharged patients therefore fails to capture the breadth of emergency medicine practice and may introduce systematic bias into physician assessment.

Survey methodology and sample size present additional, well-established validity concerns. ACEP's information paper on statistically valid patient satisfaction surveys establishes that a provider seeing approximately 4,000 patients per year needs roughly 350 surveys per year, or approximately 30 surveys per month, for a reliable evaluation of individual performance. In practice, sample sizes routinely fall far short of this threshold. ACEP has cautioned CMS that most current vendors that would administer ED CAHPS do not survey a large enough sample size to allow for statistically valid individual physician attribution, and Press Ganey has reported a response rate of only 16.5%. CMS states the minimum number of surveys is 30 and recommends 50, but that standard is not applied uniformly by physician groups and hospitals when they act on these scores. When sample sizes are inadequate, confidence intervals are wide and overlapping, meaning that apparent differences in scores between physicians may reflect statistical noise rather than genuine differences in performance or care quality.

Beyond sample size, several other sources of bias undermine the reliability of ED patient experience surveys as physician performance measures. Respondents who reply to surveys may hold stronger opinions, positive or negative, than those who do not respond, and longer delays between the ED visit and survey administration increase this response bias. Language barriers may lead to underrepresentation of minority populations. The method of survey distribution (telephone, mail, email, or in-person) affects which patients respond and how. Many factors that lead to poor patient experience scores, such as wait times and boarding, are beyond the control of the individual emergency physician. During the pandemic and in the post-pandemic era, with massive boarding and workplace stress, many emergency physicians have been deeply affected by low scores on patient experience surveys or quality metrics, contributing to burnout and moral distress.

Nationally recognized patient experience instruments, including the Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS), were developed and validated using rigorous scientific methodologies specifying standardized patient sampling, survey administration, response weighting, statistical analysis, and reporting procedures. CMS worked with the RAND Corporation beginning in 2010 on what was initially called the ED PEC survey and later renamed the ED CAHPS survey, with ACEP members serving on the Technical Expert Panel that modified the original instrument. CMS has decided not to make the ED CAHPS survey mandatory. Many hospitals and third-party vendors employ modified survey methodologies, including selective survey distribution, customized sampling, proprietary scoring algorithms, and non-validated analytic techniques, that no longer reflect the validated methodology of the original instrument and therefore should not be considered scientifically reliable measures of physician performance.

A 2025 peer-reviewed study published in Cureus (Kuhn et al., Indiana University School of Medicine, May 2025; doi: 10.7759/cureus.83429) surveyed emergency physician alumni of a large Midwestern residency program and found that physicians held relatively neutral positions on whether the current use of experience data was reasonable, but had numerous concerns regarding data quality. Physicians raised concerns in free-response comments about gender and racial bias, sample size and distribution of surveys, and the relevance of factors outside of physician control. Female physicians had lower odds of perceiving the use of ratings as fair. The study found that financial incentives tied to patient experience data were more common at the group level than at the individual level, and that the most common uses of data were publication of group performance and individual emails to physicians regarding patient feedback. This recent evidence reinforces the longstanding concerns ACEP has raised about the fairness and scientific validity of using patient experience survey results for physician performance evaluation and compensation decisions.

ACEP Strategic Plan Reference

Priority 1: Advocacy – ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objective 2: Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.

Objective 3: Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.

Priority 2: Clinical Excellence, Research and Scholarship – ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objective 1: Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards.

Objective 3: Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.

Priority 4: Career Fulfillment – ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objective 1: Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.

Objective 4: Increase transparency in the emergency medicine job market by sharing data on various employment settings and developing employer accountability initiatives.

Fiscal Impact

Ongoing advocacy initiatives. Potential revisions to the policy statement would require diverting current budgeted committee and staff resources from other work to support this effort or including funds in the next fiscal year budget. Estimated costs $15,000 – $30,000 in staff time and committee resources. Potential development of evidence-based clinical quality metrics requiring new research or external partnerships could range $50,000 – $150,000.

Prior Council Action

Resolution 54(25) Reassessment and Potential Restructuring of the HCAHPS Survey and Its Role in Medicare Reimbursement not adopted. The resolution requested that ACEP Study the feasibility and potential impact of a complete restructuring or replacement of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to develop recommendations that focus on patient-centered care, physician autonomy, and sustainable health system payment.

Resolution 55(24) Patient Experience Reporting not adopted. Directed the College to work with relevant stakeholders to change reporting for ED patient experience scores to be based on mean score rather than percentile score and revise ACEP's "Patient Experience of Care" policy statement to advocate for mean score rather than percentile scores.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted. Directed ACEP to advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

Amended Resolution 55(21) Patient Experience Scores adopted. Directed ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy; define standardized inclusion and exclusion criteria for patient experience survey populations; define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

September 2025, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved February 2023, June 2016 with the current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

January 2025, March 2024, February 2023, and January 2022 – Approved legislative and regulatory priorities that included advocating for patient experience validity and working with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

Amended Resolution 51(23) Quality Measures and Patient Experience Scores adopted.

Amended Resolution 55(21) Patient Experience Scores adopted.

November 2017, reviewed the information paper "Statistically Valid Patient Satisfaction Surveys."

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015, April 2002, June 1997; reaffirmed October 2008, April 1992; originally approved June 1988.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Associate Executive Director, Clinical Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
Vice Speaker

Michael Fraser, PhD, MS, CAE
Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 57(26)

SUBMITTED BY: Michael Gerardi, MD, FACEP
Jay Kaplan, MD, FACEP
David McKenzie
Arizona Chapter
New Jersey Chapter

SUBJECT: In Memory of Peter L. Sawchuk, MD, JD, MBA

WHEREAS, Peter L. Sawchuk, MD, JD, MBA, was a longstanding ACEP member and served at the state and national levels for decades, including as president of the New Jersey Chapter; and

WHEREAS, He was one of the original founders and president of one of the first emergency physician owned groups in the United States, Emergency Medical Associates, in New Jersey; and

WHEREAS, He was one of the few emergency physicians who obtained a Juris Doctor degree to equip himself to advocate for his colleagues in his group and ACEP with hospitals, CMS, and insurance companies; and

WHEREAS, He served with distinction as a councillor or alternate councillor for New Jersey for 25 years and as an alternate councillor for Arizona for 10 years and was an invaluable bylaws guru for both chapters; and

WHEREAS, He served on the Council Steering Committee and was recognized with the Council Meritorious Service Award, the Council's highest honor, in 1994 and the Council Curmudgeon Award in 2010; and

WHEREAS, He was honored with the James D. Mills Outstanding Contribution to Emergency Medicine Award in 2007, one of the College's highest honors; and

WHEREAS, He was active on several committees, including the Bylaws Committee, Education Committee, Reimbursement Committee, Coding & Nomenclature Advisory Committee (CNAC), Federal Government Affairs Committee, and the Medical Legal Committee, serving as chair of both Bylaws and CNAC, and additionally served on numerous task forces including the EMTALA Task Force and Medicare Documentation Guidelines Reform Task Force; and

WHEREAS, He was active for many years in ACEP educational offerings, serving as faculty for the Reimbursement & Coding Conferences; and

WHEREAS, He served as one of ACEP's representative to both the AMA Relative Value Update Committee (RUC) and the AMA CPT Editorial Panel for 10 years, helping to significantly increase emergency physician reimbursement; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Peter L. Sawchuk, MD, JD, MBA, for his contributions to the College in governance, health policy, and education; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife, Kathleen McCartney-Sawchuk, family, and friends of Peter L. Sawchuk, MD, JD, MBA, our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of Arizona, New Jersey, and the United States.

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American College of Emergency Physicians®
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Late Resolution

RESOLUTION: 58(26)

SUBMITTED BY: Florida College of Emergency Physicians
Minnesota Chapter
New Jersey Chapter

SUBJECT: In Memory of Annalee Morgan Baker, MD, FACEP

WHEREAS, The American College of Emergency Physicians mourns the passing of Annalee Morgan Baker, MD, FACEP, a distinguished emergency physician, educator, mentor, advocate, colleague, and friend, who passed away on March 17, 2026, at the age of 44; and

WHEREAS, Dr. Baker dedicated her professional life to the practice and advancement of emergency medicine, bringing compassion, intellectual curiosity, energy, and an unwavering commitment to the care of her patients and the communities she served; and

WHEREAS, Dr. Baker's journey in medicine was grounded in a life-long passion for education and science, beginning with her studies in biochemistry at the University of Wisconsin-Madison, followed by her work in cancer research at Memorial Sloan Kettering Cancer Center, and her subsequent medical education at Penn State; and

WHEREAS, Following medical school, Dr. Baker completed her emergency medicine residency at NYU/Bellevue, where she developed a deep commitment to public health and to caring for vulnerable communities with dignity, compassion, and respect; and

WHEREAS, Dr. Baker's career in emergency medicine included practicing and teaching at Aventura Hospital and Jackson Memorial Hospital in Miami, serving as Director of the Emergency Medicine Residency Program at NYU/Bellevue, and most recently serving as an attending physician and faculty member in emergency medicine at Rutgers University Hospital; and

WHEREAS, Throughout her career, Dr. Baker distinguished herself as a dedicated physician, educator, mentor, and leader who was deeply committed to teaching and mentoring the next generation of emergency physicians and to improving the lives of her patients and their families; and

WHEREAS, Dr. Baker was a tireless advocate for her patients and their families and embodied the highest ideals of emergency medicine through her dedication to compassionate care, education, mentorship, public health, and service to vulnerable populations; and

WHEREAS, Dr. Baker's commitment to social justice extended beyond the walls of the hospital, including work with FemInEM and multiple media interviews and written contributions, reflecting her fierce determination to make the world a better place and her belief in treating every individual with dignity and compassion; and

WHEREAS, Beyond her remarkable professional accomplishments, Dr. Baker possessed a vibrant spirit and an endless capacity for creativity, adventure, humor, and fun, with passions that included art, music, science, education, and family; and

WHEREAS, The life and career of Annalee Morgan Baker, MD, FACEP, stand as a testament to the ideals of compassion, service, education, mentorship, advocacy, creativity, and dedication that define the very best of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians expresses its profound sorrow at the loss of Annalee Morgan Baker, MD, FACEP, and its deepest gratitude for her extraordinary contributions to emergency medicine, medical education, patient care, and the communities she served; and be it further

RESOLVED, That ACEP honors and celebrates Dr. Baker's enduring legacy as a physician, educator, mentor, advocate, and colleague, recognizing the lasting impact of her dedication to her patients, learners, colleagues, and the specialty of emergency medicine; and be it further

RESOLVED, That this memorial resolution serve as a lasting tribute to the life, achievements, character, and service of Annalee Morgan Baker, MD, FACEP, whose legacy of compassionate patient care, teaching, mentorship, advocacy, and love for her family and community will endure within emergency medicine and among all those whose lives she touched.

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American College of Emergency Physicians®
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Late Resolution

RESOLUTION: 59(26)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Fran Kennel Kratz, MD, FACEP

WHEREAS, The specialty of emergency medicine lost an exceptional physician when Fran Kennel Kratz, MD, FACEP, passed away on June 28, 2026, at the age of 51, after a courageous journey with cancer; and

WHEREAS, Dr. Kratz was born in Lancaster, PA, and grew up in Mount Joy, PA; and

WHEREAS, She graduated from Lancaster Mennonite High School and then Elizabethtown College; and

WHEREAS, She graduated from the University of Pittsburgh School of Medicine in 2001; and

WHEREAS, She completed her emergency medicine residency training at the University of Pittsburgh in 2004; and

WHEREAS, Dr. Kratz returned to her home community after training to begin her career at York Memorial Hospital and Lancaster General Hospital; and

WHEREAS, She worked for many years as an emergency physician at Lancaster General Hospital, in Lancaster, PA, and was active in the EMS community; and

WHEREAS, She advocated selflessly for patients, prehospital clinicians, and her community; and

WHEREAS, While Dr. Kratz was an accomplished emergency physician who valued her profession deeply and her family remained her greatest joy; and

WHEREAS, She took great pleasure supporting her children in their interests of horseback riding and soccer; and

WHEREAS, She enjoyed bringing her extended family together at the family cabin and enjoyed various outdoor activities, visiting greenhouses, drawing and painting, sporting events, and vacationing with family; and

WHEREAS, Dr. Kratz's compassion and skill as an emergency physician extended outside the emergency department, assisting loved family members and friends when in need of medical attention; and

WHEREAS, Her faith guided her in all aspects of her life, demonstrating compassion and service both in and outside the emergency department; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Fran Kennel Kratz, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to her husband of 30 years, Steve, her children Lily, Logan, and Lucas, her parents Larry and Marilyn Kennel, her brother Nathan Kennel, her parents-in-law Ray and Mary Kratz, her numerous nieces, nephews, and extended family members, as well as her friends, colleagues, and patients gratitude for her service as an emergency physician as well as for her dedication and commitment to the specialty of emergency medicine.

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American College of Emergency Physicians®
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Late Resolution

RESOLUTION: 60(26)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Paul W. Sokoloski, MD, FACEP

WHEREAS, The specialty of emergency medicine lost an exceptional physician when Paul William Sokoloski, MD, FACEP, tragically passed away on August 19, 2026, at the age of 57, from an in-air collision while flying his Cessna aircraft; and

WHEREAS, Dr. Sokoloski was born in Bay City, MI, and grew up in Shamokin, PA with his mother, grandmother, and numerous extended family members and friends; and

WHEREAS, He attended Shamokin Area High School, graduating in 1987, where he found his initial passion for medicine serving as a firefighter and EMT; and

WHEREAS, He attended and graduated from Penn State University in 1991; and

WHEREAS, He attended Jefferson Medical College, graduating in 1996; and

WHEREAS, Dr. Sokoloski completed his emergency medicine residency training at Jefferson in 1999; and

WHEREAS, He enlisted in the Pennsylvania Air National Guard in 1989, serving during both college and medical school, ultimately earning the rank of Staff Sargent; and

WHEREAS, Dr. Sokoloski spent nearly 30 years practicing emergency medicine across Maryland, West Virginia, and Pennsylvania, most recently working with Penn State Health; and

WHEREAS, He frequently chose to serve communities in rural and underserved areas, similar to the rural Pennsylvania community in which he grew up; and

WHEREAS, Dr. Sokoloski was known for his intellect, his ability to lead care amidst chaos, and was a strong advocate for his patients, learners working under him, and his staff; and

WHEREAS, He had many passions outside of medicine, including building his own house and barn and raising numerous farm animals, snowboarding, and was a lover of craft beer, gastropubs, and live music; and

WHEREAS, He was a licensed pilot for over 15 years and a member of several aviation communities; and

WHEREAS, Dr. Sokoloski took great pride in and spoke lovingly of his four children; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Paul William Sokoloski, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his children Madeline, Amelia, Lily Claire, and Mathias, and his father Joseph Jasper, Sr., as well as his friends, colleagues, and patients gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 61(26)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of David L. Morgan, MS, MD, FACEP

WHEREAS, The American College of Emergency Physicians (ACEP) and Texas College of Emergency Physicians (TCEP) recognizes with deep respect and gratitude the life, service, and legacy of David L. Morgan, MD, MS, FACEP, who passed away on October 9, 2025; and

WHEREAS, Dr. Morgan devoted more than four decades to the practice, education, and advancement of emergency medicine, exemplifying excellence, humility, and compassion throughout his distinguished career; and

WHEREAS, Dr. Morgan earned his medical degree from the University of Miami, completed his internship at the University of Texas Medical Branch in Galveston, and his emergency medicine residency at the University of Oklahoma, becoming board certified by the American Board of Emergency Medicine in 1987; and

WHEREAS, Dr. Morgan served as a respected educator and academic leader, including his tenure as Professor in the Department of Emergency Medicine at Texas A&M Health Science Center College of Medicine, and through academic appointments at institutions such as UT Southwestern and the University of Texas at Austin; and

WHEREAS, Dr. Morgan provided exemplary clinical leadership at Scott & White Hospital in Temple, Texas, serving as Senior Staff Physician and Research Director, and previously as an attending physician at Parkland Memorial Hospital in Dallas, where he mentored generations of emergency physicians many of whom credit him with their decision to pursue emergency medicine as a career; and

WHEREAS, Dr. Morgan was a trusted leader in emergency medical services across Texas, serving as Medical Director for multiple EMS agencies, chairing quality committees, and advising regional EMS councils, thereby strengthening pre-hospital care and patient safety statewide; and

WHEREAS, Dr. Morgan was a long-time and dedicated member of both the Texas College of Emergency Physicians (TCEP) and the American College of Emergency Physicians (ACEP), and served with distinction as President of TCEP from 2004-05, providing visionary leadership and steadfast advocacy for emergency physicians; and

WHEREAS, Dr. Morgan was omnipresent at formal and informal meetings of ACEP and TCEP; and

WHEREAS, Dr. Morgan's professional service extended to numerous organizations, including the American Medical Association, the Texas Medical Association, and national efforts in toxicology, poison control, and bioterrorism preparedness; and

WHEREAS, Dr. Morgan will be remembered not only for his clinical expertise and academic accomplishments, but for his warmth, wit, integrity, mentorship, and unwavering dedication to his family, colleagues, students, and patients; therefore be it

RESOLVED, That the American College of Emergency Physicians honors the life and enduring legacy of David L. Morgan, MS, MD, FACEP, for his extraordinary contributions to emergency medicine, medical education, organized medicine, and emergency medical services; and be it further

RESOLVED, That ACEP extends its deepest sympathies to Dr. Morgan's wife, Vicky Trompler, MD, JD, his daughter, Jerri Morgan, his grandchildren, and his extended family, colleagues, and friends, recognizing that his influence will live on through the countless lives he touched and the physicians and other health care professionals he mentored.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 62(26)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: In Memory of Robert K Anzinger, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a pioneering physician when Robert K Anzinger, MD, FACEP, passed away on December 9, 2025; and

WHEREAS, Dr. Anzinger led the Illinois College of Emergency Physicians as President in 1976 and worked to improve the emergency care of patients in the State of Illinois; and

WHEREAS, He served on the national ACEP Board of Directors 1978-81 and 1986-91 and served as President 1989-90; and

WHEREAS, He maintained quintessential standards of the practice of our specialty; and

WHEREAS, He was a decorated member of the United States Armed forces, having served in Vietnam; and

WHEREAS, He exhibited a marvelous bonhomie that earned the respect and love of his peers; and

WHEREAS, He never forgot his roots as the son of a physician, and took pride in being a doctor above all else; and

WHEREAS, He remained dedicated to his family through thick and through thin; therefore be it

RESOLVED, That the American College of Emergency Physicians and the Illinois College of Emergency Physicians recognize the love for and contributions to emergency medicine of Robert K Anzinger, MD, FACEP, to the specialty of emergency medicine and be it further

RESOLVED, That the American College of Emergency Physicians and the Illinois College of Emergency Physicians extends condolences to the family of Robert K Anzinger, MD, FACEP.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2026 Council

From: Sonja Montgomery
Governance Operations Director

Date: August 26, 2026

Subj: ACEP Composition Annual Report

The 2019 Council adopted Amended Resolution 12 ACEP Composition Annual Report:

> RESOLVED, That ACEP provide the Council with an annual report on the demographics of its councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, career stage, and employment environment.

The attached report contains the demographic information requested in the resolution.

Although ACEP's membership system has the ability to capture the information, the data is limited to the extent that members provide the information in their membership profile and how often the information is updated.

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EXECUTIVE DIRECTOR
Michael Fraser, PhD, MS, CAE

Gender

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Female	12,144	*30.70%*	259	*37.76%*	264	*35.11%*	8	*32.00%*	98	*41.88%*	4	*14.29%*	7	*41.18%*
Gender Nonconforming	11	*0.03%*												
I Prefer Not to Answer	86	*0.22%*	11	*1.60%*	2	*0.27%*			1	*0.43%*				
Male	20,238	*51.17%*	393	*57.29%*	471	*62.63%*	17	*68.00%*	128	*54.70%*	24	*85.71%*	10	*58.82%*
Non-binary	23	*0.06%*												
Other/Not Listed	18	*0.05%*												
Trans Man	9	*0.02%*												
Trans Woman	8	*0.02%*	2	*0.29%*										
Unanswered	7,017	*17.74%*	21	*3.06%*	15	*1.99%*			7	*2.99%*				

Sexual Orientation

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Asexual	12	*0.03%*	1	*0.15%*										
Bisexual	191	*0.48%*	3	*0.44%*	1	*0.13%*			2	*0.85%*				
Gay/Lesbian	323	*0.82%*	13	*1.90%*	5	*0.67%*			7	*2.99%*				
I Don't Know	11	*0.03%*	1	*0.15%*										
I Prefer Not to Answer	523	*1.32%*	42	*6.12%*	14	*1.86%*			10	*4.27%*			2	*11.76%*
Pansexual	30	*0.08%*												
Something Else	19	*0.05%*			2	*0.27%*								
Straight	4,938	*12.48%*	192	*27.99%*	100	*13.32%*	3	*12.00%*	40	*17.09%*	7	*25.00%*	11	*64.71%*
Unanswered	33,507	*84.71%*	434	*63.27%*	629	*83.75%*	22	*88.00%*	175	*74.79%*	21	*75.00%*	4	*23.53%*

Race / Ethnicity

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Asian	2,260	*5.71%*	43	*6.27%*	54	*7.18%*	1	*4.00%*	19	*8.12%*	1	*3.57%*	2	*11.76%*
Black or African American	1,052	*2.66%*	30	*4.37%*	33	*4.39%*			7	*2.99%*	1	*3.57%*		
Hispanic or Latino	1,479	*3.74%*	21	*3.06%*	23	*3.06%*	2	*8.00%*	6	*2.56%*				
I Prefer Not to Answer	353	*0.89%*	18	*2.62%*	7	*0.93%*			4	*1.71%*	1	*3.57%*	2	*11.76%*
Middle Eastern/North African	264	*0.67%*	4	*0.58%*	1	*0.13%*								
More Than One/Multiracial	569	*1.44%*	9	*1.31%*	19	*2.53%*			9	*3.85%*			1	*5.88%*
Native American or Alaska Native	63	*0.16%*	2	*0.29%*										
Native Hawaiian or Other Pacific Islander	27	*0.07%*			1	*0.13%*			1	*0.43%*				
Other/Not Listed	5,207	*13.16%*	91	*13.27%*	149	*19.81%*	13	*52.00%*	38	*16.24%*	1	*3.57%*		
Unanswered	14,817	*37.46%*	104	*15.16%*	146	*19.41%*	2	*8.00%*	51	*21.79%*				
White	13,463	*34.04%*	364	*53.06%*	319	*42.42%*	7	*28.00%*	99	*42.31%*	24	*85.71%*	12	*70.59%*

Disability

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Ambulatory	84	0.21%	6	0.87%	1	0.13%								
Cognitive	9	0.02%												
Hearing	36	0.09%	2	0.29%	5	0.66%			3	1.28%			2	11.76%
I Prefer Not to Answer	245	0.62%	18	2.62%	6	0.80%			4	1.71%	1	3.57%	1	5.88%
Independent Living	10	0.03%	1	0.15%										
Mental Health	23	0.06%			1	0.13%			1	0.43%				
Not Applicable	3,190	8.06%	169	24.64%	81	10.77%	3	12.00%	31	13.25%	5	17.86%	7	41.18%
Other/Not Listed	61	0.15%	4	0.58%	3	0.40%			2	0.85%				
Self-care	4	0.01%	2	0.29%										
Unanswered	35,872	90.69%	482	70.26%	654	86.97%	22	88.00%	191	81.62%	22	78.57%	6	35.29%
Vision	20	0.05%	2	0.29%	1	0.13%			2	0.85%			1	5.88%

Practice Geography

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
I Prefer Not to Answer	217	0.55%	7	1.02%	4	0.53%			1	0.43%				
Not Applicable	1,256	3.18%	13	1.90%	11	1.46%			4	1.71%	1	3.57%	1	5.88%
Other/Not Listed	226	0.57%	9	1.31%	4	0.53%			4	1.71%				
Rural	1,736	4.39%	53	7.73%	26	3.46%	1	4.00%	9	3.85%	2	7.14%	2	11.76%
Suburban	4,475	11.31%	134	19.53%	78	10.37%	2	8.00%	30	12.82%	4	14.29%	6	35.29%
Unanswered	23,795	60.16%	195	28.43%	295	39.23%	13	52.00%	67	28.63%	12	42.86%	1	5.88%
Urban	7,849	19.84%	275	40.09%	334	44.41%	9	36.00%	119	50.85%	9	32.14%	7	41.18%

Practice Setting

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Academic Medical Center	3,880	9.81%	181	26.38%	190	25.27%	4	16.00%	67	28.63%	3	10.71%	5	29.41%
Community Hospital	4,560	11.53%	160	23.32%	57	7.58%	4	16.00%	34	14.53%	2	7.14%	9	52.94%
Critical Care	107	0.27%	2	0.29%	2	0.27%			2	0.85%				
EMS	158	0.40%	3	0.44%	7	0.93%			2	0.85%	1	3.57%		
Freestanding Emergency Department (ED)	198	0.50%	7	1.02%	3	0.40%			2	0.85%	1	3.57%	1	5.88%
Government	186	0.47%	6	0.87%	6	0.80%			1	0.43%			1	5.88%
I Prefer Not to Answer	139	0.35%	5	0.73%	3	0.40%			1	0.43%				
Military	313	0.79%	6	0.87%	5	0.66%			1	0.43%				
Not Applicable	1,159	2.93%	13	1.90%	11	1.46%			3	1.28%				
Other/Not Listed	267	0.68%	8	1.17%	5	0.66%			7	2.99%	1	3.57%		
Unanswered	28,437	71.89%	290	42.27%	459	61.04%	17	68.00%	113	48.29%	20	71.43%	1	5.88%
Urgent Care	150	0.38%	5	0.73%	4	0.53%			1	0.43%				

Age

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
20s	5,392	13.63%	16	2.33%	21	2.79%			1	0.43%				
30s	12,602	31.86%	169	24.64%	176	23.40%	3	12.00%	66	28.21%				
40s	7,539	19.06%	237	34.55%	245	32.58%	11	44.00%	86	36.75%	3	10.71%	7	41.18%
50s	4,756	12.02%	133	19.39%	182	24.20%	10	40.00%	47	20.09%	1	3.57%	8	47.06%
60s	2,550	6.45%	61	8.89%	70	9.31%	1	4.00%	22	9.40%	5	17.86%	2	11.76%
70+	1,630	4.12%	63	9.18%	54	7.18%			11	4.70%	19	67.86%		
Unanswered	5,085	12.86%	7	1.02%	4	0.53%			1	0.43%				

Career Stage

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Fellow	583	1.47%	7	1.02%	12	1.60%			3	1.29%				
Intern	3,183	8.05%	1	0.15%	7	0.93%								
Medical Student	2,467	6.24%			5	0.66%								
New To Practice	5,617	14.20%	67	9.81%	57	7.58%			24	10.30%				
Practicing Physician	18,716	47.32%	547	80.09%	611	81.25%	24	96.00%	202	86.70%	24	85.71%	17	100.00%
Resident	6,910	17.47%	38	5.56%	24	3.19%			1	0.43%				
Retired	88	0.22%			2	0.27%			2	0.86%	1	3.57%		

Semi-retired	1,058	*2.67%*	23	*3.37%*	28	*3.72%*	1	*4.00%*	1	*0.43%*	3	*10.71%*		
Unknown	932	*2.36%*			6	*0.80%*								

Medical School Specialty

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
Allopathic	25,554	*64.61%*	543	*79.15%*	647	*86.04%*	24	*96.00%*	192	*82.05%*	25	*89.29%*	14	*82.35%*
Osteopathic	8,223	*20.79%*	113	*16.47%*	65	*8.64%*	1	*4.00%*	32	*13.68%*	1	*3.57%*	2	*11.76%*
Unanswered	5,777	*14.61%*	30	*4.37%*	40	*5.32%*			10	*4.27%*	2	*7.14%*	1	*5.88%*

Board Certifications

	All Members	%	Council	%	Committee Members	%	Committee Chairs	%	Section Leadership	%	Past Leadership	%	ACEP Board of Directors	%
ABEM	14,139	*34.22%*	501	*69.58%*	476	*59.72%*	21	*77.78%*	155	*61.75%*	10	*33.33%*	16	*80.00%*
ABOEM	222	*0.54%*	9	*1.25%*	3	*0.38%*			4	*1.59%*				
None	25,943	*62.79%*	163	*22.64%*	260	*32.62%*	4	*14.81%*	70	*27.89%*	17	*56.67%*	1	*5.00%*
Other	1,012	*2.45%*	47	*6.53%*	58	*7.28%*	2	*7.41%*	22	*8.76%*	3	*10.00%*	3	*15.00%*

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2026 Council

From: Sonja Montgomery
Governance Operations Director

Date: September 1, 2026

Subj: Compensation Committee Report

The Compensation Committee's primary objective is to establish stipends for Board members, Board officers, and Council officers. The basis for the Compensation Committee resides in the ACEP Bylaws, Article XI – Committees, Section 7 – Compensation Committee:

"College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board's proposed compensation, the Compensation Committee's recommendation will then take effect."

The committee recommended a 1% increase for Board member and officer terms effective November 1, 2026, through October 30, 2027, and removing the $10,000 supplemental compensation pool that was approved last year for Board members or officers undertaking additional work beyond their typical responsibilities. The Board discussed the challenges of developing and administering a process to assign and track additional tasks and requested the committee to reconsider the supplemental stipend pool. The Board approved the Compensation Committee's recommendations on June 11, 2026. The global stipend pool decreased from $565,771 to $561,329. The stipends approved for the Board member and officer terms effective November 1, 2026, through October 30, 2027, are:

President	$149,624
President-Elect	$108,869
Chair	$36,289
Vice President (2)	$30,707
Secretary-Treasurer	$30,321
Immediate Past President	$28,925
Speaker	$35,625
Vice Speaker	$20,936
Non-Officer Board Members (8)	$11,166

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Memorandum

To: 2026 Council

From: Sonja Montgomery
Governance Operations Director

Date: September 14, 2026

Subj: Action on 2025 Resolutions

The 2025 Council considered 91 resolutions: 67 were adopted, 14 were not adopted, 1 was withdrawn, 7 were referred to the Board of Directors, and 1 was referred to the Council Steering Committee. There were 2 Bylaws amendments, 1 Council Standing Rules amendment, 7 commendation resolutions, and 22 memorial resolutions.

Note: Amended Resolution 45 Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies was adopted in lieu of Resolutions 45 and 46.

The attached report summarizes the actions taken on the 2025 resolutions adopted by the Council and those that were referred to the Board of Directors and the Council Steering Committee.

The updated actions are also available on the ACEP website. *Reminder:* Scroll to the end of each resolution to see amended or substituted language and review the implementation action.

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Summary of 2025 Council Resolutions

Resolutions Not Adopted (NA) or Withdrawn (W)

28 Establish a College-Wide Mentorship Program (NA)
29 Promote Equal Access in Leadership (NA)
30 Development of Research Grant Funding Opportunities Exclusively for ACEP Members as a Membership Benefit (NA)
31 Evaluate the Quality and Member Support for ACEP's Association with an Open Access Journal (NA)
33 Emergency Medicine Public Education (NA)
35 Appropriate Representation in the Review Committee for Combined EM Residency Programs (NA)
39 Support Board Certification as an Exemption for State Mandated CME Topics (NA)
42 Occurrence-Based Malpractice Coverage for All Emergency Physicians (W)
52 Investigation of State Licensure Requirement for Hospital Administrators (NA)
54 Reassessment and Potential Restructuring of the HCAHPS Survey and Its Role in Medicare Reimbursement (NA)
60 Tele-Emergency Medicine Oversight of Non-Board-Certified/Board-Eligible Emergency Medicine EDs (NA)
63 Addressing Bullying in the ED – Role of Emergency Physicians in Identification and Intervention (NA)
69 Investigating Best Practices and Policy Solutions for Direct Communication When Referring Patients to the ED (NA)
70 Mandated Reporting of ED Violence (NA)
78 Standardized Emergency Medicine Post-Graduate Training for Advanced Practice Providers (NA)

Referred Resolutions – to the Council Steering Committee

23 Councillor Allocations for Sections of Membership – Council Standing Rules Amendment

Referred Resolutions – to the Board of Directors

26 Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in EM
27 Upholding Equal Access to Care in EM Amidst Political Challenges
32 Transparency in Vendor and Speaker Communication Restrictions at Scientific Assembly (as amended)
37 Support for Funding Resident Training Away from Home Institutions
40 Support Ongoing Education on Implicit Bias and Structural Inequity
75 Protecting the Term "Emergency Department" in Critical Access Hospitals
77 Investigating Practice Patterns of NPs and PAs Following Independent Practice Legislation

Bylaws Resolutions

21 Distinguished ACEP Fellow Recognition – Bylaws Amendment (as amended)
22 International ACEP Fellow Recognition – Bylaws Amendment (as amended)

College Manual Resolution

24 Procedures for Addressing Charges of Ethical Violations & Other Misconduct – College Manual Amendment

Non-Bylaws Resolutions – Commendations

1 Commendation for Melissa W. Costello, MD, FACEP
2 Commendation for Terry Fulmer, PhD, RN, FAAN, and the John A. Hartford Foundation
3 Commendation for Gene Scruggs
4 Commendation for Michael Lemanski, MD, FACEP
5 Commendation for Shelly Lyford and West Health
6 Commendation for Aisha T. Terry, MD, MPH, FACEP
7 Commendation for Richard E. Wolfe, MD, FACEP

Non-Bylaws Resolutions – Memorials

8 In Memory of James B. Broselow, MD
9 In Memory of Vinod K. Chettur, MD
10 In Memory of Conklin, MD, FACEP
11 In Memory of Gregory L. Henry, MD, FACEP
12 In Memory of Richard T. Hostelley, MD, FACEP
13 In Memory of Frank J. Jehle, Jr, MD, MPH, FACEP, FAAP
14 In Memory of Roger B. Lim, MD
15 In Memory of Lidio W. Medina, MD
16 In Memory of Joseph Moellman, MD

17 In Memory of Frank S. Orth, DO, FACEP
18 In Memory of Janice E. Reisinger, MBA, CAE
19 In Memory of Ronald D. Stewart, MD, FACEP, FAEMS
20 In Memory of Todd Thomas, CPC, CCS-P
81 In Memory of Joshua Alinger, MD
82 In Memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired)
83 In Memory of Elizabeth B. Jones, MD, FACEP
84 In Memory of Brian Wai Lin, MD
85 In Memory of Forest Daniel McCoig, MD
86 In Memory of Jack Henriquez, MD, FACEP
87 In Memory of Carl S. Werne, MD
88 In Memory of Jamie Shandro, MD, MPH
91 In Memory of Frank Zwemer, Jr., MD, FACEP

Non-Bylaws Resolutions

25 Protecting Section Integrity and Member Engagement in ACEP
34 Recognition of Public Media as a Public Health Necessity
36 Reaffirming Support for 3-Year and 4-Year Emergency Medicine Residency Program Accreditation (as amended)
38 Inclusion of ACEP Leadership Roles as Approved Practice Improvement Activities for ABEM Certification
41 Advocate for No-Fault Medical Liability Reform and Redefinition of Negligence in Health Care (as amended)
43 Support for Eliminating Physician Non-Compete Clauses in Contracts
44 Advocating for National Leadership on Workplace Violence in Health Care through the AMA (as amended)
45 Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies (as amended and adopted in lieu of Resolutions 45 and 46)
47 Protecting Medicaid Disproportionate Share Hospital (DSH) Payments to Preserve Emergency Care Access (as amended)
48 Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA (as amended)
49 Support for EMTALA Reform to Ensure Timely Access to Definitive Care (as amended)
50 Emergency Department Staffing Transparency (as amended)
51 Supporting Board Certified Physicians in Every Emergency Department (as amended)
53 Prior Authorization Reform to Reduce Delays in Care and Emergency Department Burden (as amended)
55 Reduce Non-Beneficial Regulation by The Joint Commission and other Health Care Regulatory Bodies (as amended)
56 Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions (as amended)
57 Repeal Certificate of Need Laws to Expand Access and Improve Patient Care (as amended)
58 Role of EDs in Interactions with U.S. Immigration and Customs Enforcement
59 Support Interstate Telemedicine Practice for Physicians with Permanent Licensure (as amended)
61 Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers (as amended)
62 Promoting Environmental Sustainability and Waste Reduction in the ED (as amended)
64 Endorsement of Electronic Discharge Instructions for Patients with Electronic Medical Records (as amended)
65 Emergency Physicians and Collaborative Practice Agreements (as substituted)
66 Endorsing a Realistic Door-to-Doctor Standard (as amended)
67 Forensic Programs in Trauma Centers (as amended)
68 Integrating Firearm Safety Counseling into Emergency Medicine Education and Practice (as amended)
71 Member Resources for Best Practices in Employment Negotiations (as amended)
72 Naloxone Access and Education in Public Schools
73 Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation (as amended)
74 Necessary Facility-Provided Medications from Emergency Departments (as substituted)
76 Protection and National Standardization of Transgender Care in Emergency Medicine
79 Standards for the Safe and Appropriate Transport of Patients to Psychiatric Facilities (as amended)
80 Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding (as amended)
89 Support for Scientific Integrity in Medicine and Public Health (as amended)
90 Support and Endorsement of Current Vaccine Guidelines by Fellow Medical Professional Organizations (as amended)

Action on 2025 Council Resolutions

Resolution 1 Commendation for Melissa W. Costello, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Melissa Wysong Costello, MD, FACEP, for her service as Council Vice Speaker and Council Speaker and for her enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Dr. Costello.

Resolution 2 Commendation for Terry Fulmer, PhD, RN, FAAN, and the John A. Hartford Foundation

RESOLVED, That the American College of Emergency Physicians commends and expresses its deepest appreciation to the John A. Hartford Foundation and its President, Terry Fulmer, PhD, RN, FAAN, who is stepping down after 10 years of dedicated service to the foundation, for their exceptional leadership, dedication, and support of geriatric emergency care on behalf of the College.

Action: A framed resolution was sent to Dr. Fulmer.

Resolution 3 Commendation for Gene Scruggs

RESOLVED, That the American College of Emergency Physicians commends Gene Scruggs for his outstanding service and commitment to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for his extraordinary contributions.

Action: A framed resolution was sent to Mr. Scruggs.

Resolution 4 Commendation for Michael Lemanski, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Michael J. Lemanski, MD, FACEP, for his outstanding dedication and contributions on behalf of the specialty of emergency medicine and to the CPT Editorial Panel.

Action: A framed resolution was sent to Dr. Lemanski.

Resolution 5 Commendation for Shelly Lyford and West Health

RESOLVED, That the American College of Emergency Physicians commends and expresses its deepest appreciation to West Health and its CEO Shelley Lyford for their exceptional leadership, dedication, and support of geriatric emergency care on behalf of the College.

Action: A framed resolution was sent to Ms. Lyford.

Resolution 6 Commendation for Aisha T. Terry, MD, MPH, FACEP

RESOLVED, That the American College of Emergency Physicians commends Aisha T. Terry, MD, MPH, FACEP, for her exceptional leadership, enduring contributions to the specialty of emergency medicine, and her unwavering dedication to the mission and values of ACEP and the patients we serve.

Action: A framed resolution was presented to Dr. Terry.

Resolution 7 Commendation for Richard E. Wolfe, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Richard E. Wolfe, MD, FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Wolfe.

Resolution 8 In Memory of James B. Broselow, MD

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by James B. Broselow, MD, as one of the leaders in advancing pediatric emergency care, pediatric readiness, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of James B. Broselow, MD, his wife Millie, his family, and his friends our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of North Carolina and the United States.

Action: A framed resolution was sent to Dr. Broselow's family.

Resolution 9 In Memory of Vinod K. Chettur, MD

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Vinod K. Chettur, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his mother Jayanthi Menon, his father Govindan Chettur, his sister Rema Makhija, and his nephew Aran our heartfelt gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Chettur's family.

Resolution 10 In Memory of Conklin, MD, FACEP

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognizes the outstanding dedication and contribution of Terry A. Conklin, MD, FACEP, to the specialty of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further

RESOLVED, That the American College of Emergency Physicians and the Alaska Chapter extends to the family of Terry A. Conklin, MD, FACEP, his colleagues, partners, former residents, and all friends our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Alaska, where his impact will be felt for generations to come.

Action: A framed resolution was sent to Dr. Conklin's family.

Resolution 11 In Memory of Gregory L. Henry, MD, FACEP

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the lifetime of service that Gregory L. Henry, MD, FACEP gave to the specialty of emergency medicine, generations of emergency physicians, and the patients we serve as a clinician, educator, leader, orator, advocate, and scholar; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Henry, MD, FACEP, especially his wife Margene, his three children, and his two grandchildren, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, the United States, and the world, where his impact will be felt for generations to come.

Action: A framed resolution was sent to Dr. Henry's family.

Resolution 12 In Memory of Richard T. Hostelley, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Richard T. Hostelley, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Linda of 49 years, his sister Bissie Miller, and numerous nieces and nephews gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Hostelley's family.

Resolution 13 In Memory of Frank J. Jehle, Jr, MD, MPH, FACEP, FAAP

RESOLVED, That the American College of Emergency Physicians extends its deepest sympathy to the family, friends, and colleagues of Frank J. Jehle, Jr., MD, MPH, FACEP, FAAP; and be it further

RESOLVED, That ACEP gratefully acknowledges and honors the legacy of Frank J. Jehle, Jr., MD, MPH, FACEP, FAAP, a physician of extraordinary compassion, wisdom, and integrity that touched innumerable live, whose wisdom will be

passed down for generations and made lasting contributions to the field of pediatric emergency medicine.

Action: A framed resolution was sent to Dr. Jehele's family.

Resolution 14 In Memory of Roger B. Lim, MD

RESOLVED, That the American College of Emergency Physicians honors the legacy of Roger B. Lim, MD, and recognizes his extraordinary contributions to emergency medicine, his dedication to the countless lives he saved, and the compassion that defined his practice; and be it further

RESOLVED, That the American College of Emergency Physicians extends our deepest sympathies to the family, friends, and colleagues and remembers the profound impact Roger B. Lim, MD, made and that his memory will continue to inspire all who follow in his footsteps.

Action: A framed resolution was sent to Dr. Lim's family.

Resolution 15 In Memory of Lidio W. Medina, MD

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Lidio W. Medina, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Patricia of 53 years, his son Jim (wife Stacie), and daughter Michelle Medina-Smuck (husband Darryl), as well as his numerous grandchildren, gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Medina's family.

Resolution 16 In Memory of Joseph Moellman, MD

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Joesph Moellman, MD, who dedicated himself to his patients, his trainees, his profession, and his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Ohio College of Emergency Physicians extends to his wife Kim, his sons Josh Moellman and Jordan Moellman, gratitude for his tremendous service as an emergency physician at the University of Cincinnati, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Moellman's family.

Resolution 17 In Memory of Frank S. Orth, DO, FACEP

RESOLVED, That the American College of Emergency Physicians extends to the family of Frank S. Orth DO, FACEP, his friends, and his colleagues our condolences and gratitude for his service to his community and the countless patients that benefited from his care.

Action: A framed resolution was sent to Dr. Orth's family.

Resolution 18 In Memory of Janice E. Reisinger, MBA, CAE

RESOLVED, That the American College of Emergency Physicians honors the memory of Jan Reisinger, MBA, CAE; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to her husband Greg, her mother Maxine, her sister Ann, and her extended family, as well as countless professional colleagues and personal friends, gratitude for her service to the specialty of emergency medicine.

Action: A framed resolution was sent to Ms. Reisinger's family.

Resolution 19 In Memory of Ronald D. Stewart, MD, FACEP, FAEMS

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Ronald D. Stewart, MD, FACEP, FAEMS; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his sister Donalda (James) Davis, and his countless friends, colleagues, and students gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Stewart's family.

Resolution 20 In Memory of Todd Thomas, CPC, CCS-P

RESOLVED, That the American College of Emergency Physicians honors the memory of Todd Thomas, CPC, CCS-P, and extends its deepest sympathies to his family, friends, and colleagues, and gratitude for his commitment and contributions to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Stewart's family.

Resolution 21 Distinguished ACEP Fellow Recognition – Bylaws Amendment (as amended)

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility and Section 2 – Fellow Status be amended to establish a "Distinguished Fellow of ACEP" [FACEP(D)] that is based on objective, points-based criteria and awarded to members who have held FACEP status for a minimum of 12 years and demonstrated continued commitment to ACEP and the specialty of emergency medicine:

ARTICLE V — ACEP FELLOWS
Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, regular, or international members for three continuous years immediately prior to election.
2. Be 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.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria 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.

Distinguished Fellows of the College shall meet the following criteria:

1. **Have held FACEP status for at least 12 years.**
2. **Maintained certification:**
   - **A. in emergency medicine by the American Board of Emergency Medicine~~,~~ or the American Osteopathic Board of Emergency Medicine, or**
   - **B. in pediatric emergency medicine by the American Board of Pediatrics, or**
   - **C. have achieved FACEP through the ACEP Legacy track.**
3. **Meet a minimum number of points within the following requirements demonstrating evidence of commitment to emergency medicine:**
   - **A. Research and scholarship, as evidenced by grant awards, peer-reviewed publication, or review or authorship of books or other professional resources.**
   - **B. Teaching and mentorship, as evidenced by teaching history, faculty status, student or resident advisement, or residency/fellowship/clerkship leadership.**

C. **Service and leadership, as evidenced by leadership within their emergency department, hospital, staffing group, state or local medical societies, community health planning, or other roles which have advanced the field.**
D. **Clinical excellence, as evidenced by clinical or industry awards, letters of support from their chair or medical director, or participation in quality, safety, or wellness activities.**

4. **Meet a minimum number of points within the following requirements demonstrating evidence of commitment to ACEP.**
   A. **Leadership activities, including participation or leadership within ACEP sections, committees, chapters, delegations, advocacy groups, task forces, Member Interest Groups, Board of Directors, or Council.**
   B. **Education activities, including participation as faculty or course directors in ACEP in-person or virtual educational offerings.**
   C. **Public awareness activities, including active involvement in ACEP's online communities, media relations or spokesperson network, or promotion of College wins and activities on social media.**
   D. **Recognitions, including individual receipt of ACEP awards or hospital/employer receipt of ACEP accreditation status.**

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.

Section 2 – Fellow Status

Fellows shall be authorized to use the letters FACEP **or FACEP(D)** in conjunction with professional activities. Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status. Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

Action: The Bylaws were updated and are available on the ACEP website. Assigned to the Membership Committee to develop the "points" system for approval by the Board of Directors. Assigned to Membership staff to update the FACEP application form as needed to incorporate the revised criteria and points system after approval by the Board and to work with communications staff to develop promotional materials and communications.

Resolution 22 International ACEP Fellow Recognition – Bylaws Amendment (as amended)

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility and Section 2 – Fellow Status be amended to establish an "International Fellow of ACEP" [**(i)**FACEP~~(I)~~] and awarded to members who live and practice outside of the United States:

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician**, or** regular~~, or international~~ member**s** for three continuous years immediately prior to election.
2. Be 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.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria 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.

International Fellows of the College shall meet the following criteria:

1. **Be an international member of ACEP for at least three years immediately prior to election.**
2. **Be certified in emergency medicine by an internationally recognized certifying body, or have completed the minimum training standards to practice emergency medicine within their country (if certification is not available).**
3. **Provide a letter of support from an established authority such as their institution medical director, training program director, or emergency medicine society.**
4. **Satisfy at least three of the following individual requirements demonstrating commitment to emergency medicine:**
   - A. **Active involvement in organized medicine, as evidenced by three years of membership or leadership within any local, national, or regional society dedicated to advancing emergency medicine.**
   - B. **Active involvement in local hospital affairs, such as medical staff committees.**
   - C. **Active involvement in the formal training of future emergency medicine physicians.**
   - D. **Active involvement in departmental or governmental administration or affairs.**
   - E. **Active involvement in EMS systems or disaster preparedness planning activities.**
   - F. **Research or scholarly publication in emergency medicine.**
5. **Satisfy at least one of the following individual requirements demonstrating involvement with ACEP:**
   - A. **Active participation in ACEP sections, committees, or other leadership bodies.**
   - B. **Participation in the development, delivery, or promotion of ACEP educational offerings and resources within home country.**
   - C. **Participation in ACEP educational or research activities (such as in-person attendance at ACEP Scientific Assembly meeting(s), scholarly publication in emergency medicine in *Annals of Emergency Medicine* or *JACEP Open*, etc.).**
   - D. **Other contributions to 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.

Section 2 – Fellow Status

Fellows shall be authorized to use the letters FACEP **or (i)FACEP~~(I)~~** in conjunction with professional activities. Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status. Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

Action: The Bylaws were updated and are available on the ACEP website. Assigned to Membership staff to develop an International Fellow application form and to work with the International Emergency Medicine Committee, the International Emergency Medicine Section, and communications staff to develop promotional materials and communications.

Resolution 24 Procedures for Addressing Charges of Ethical Violations and Other Misconduct – College Manual Amendment

RESOLVED, That the College Manual be amended by substitution of the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to read:

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. Definitions

1. ACEP means the American College of Emergency Physicians.
2. *Code of Ethics* means the *Code of Ethics for Emergency Physicians.*
3. *Procedures* means the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct.*
4. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee **with no conflicts of interest in each pending matter** – in matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee.
5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.
6. Board Hearing Panel conducts all hearings and consists of ~~the~~ **an** ACEP Vice President, Chair of the Board, and Board Liaison to the Ethics Committee.
7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

B. 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;
2. Must specify in reasonable detail an alleged violation by an ACEP member of an ACEP policy as it existed at the time of the alleged violation, including ACEP Bylaws, ACEP *Code of Ethics,* other ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within ten (10) years prior to the submission of the complaint, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating 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~~ **any protected health information** or any identifying information related to members of the patient's family;
5. Must state that the complainant is willing to have ~~his or her~~ **their** name disclosed to the ACEP Executive Director~~,~~ **and** any additional ACEP review body listed in these *Procedures,* ~~and the respondent~~ should the complaint be forwarded to the respondent; and
6. Must be submitted to the ACEP Executive Director.

C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.
   b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming complainant's intent to file a complaint. Includes a copy of ACEP's *Procedures* providing guidelines and timetables that will be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the *Procedures*.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the *Procedures.*
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. **Determines, in consultation with the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, along with other committee designee(s) as appropriate given the subject matter of the complaint, that:**
   a. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, the Bylaws Committee, or other committee designee, that t~~**T**he **charges and conduct set forth in the** complaint**, as alleged by the complainant,** ~~is frivolous, inconsequential, or~~ do~~es~~ not allege an actionable violation of a policy or principle included in the *Code of Ethics* or 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. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, or other committee designee, that t~~**T**he complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics*, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics Complaint Review Panel **after membership on the Ethics Complaint Review Panel has been confirmed;** or
   c. ~~Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee, or other committee designee, that t~~**T**he complaint alleges conduct that may constitute a violation of ACEP

Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, after both are received, to each member of the 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 **and that has been screened for conflicts of interest;** 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. T~~**t**he Ethics Complaint Review Panel or the Bylaws Committee**, as appropriate,** will review the President's ~~action~~ **recommendation to reject the complaint**. The President's action can be overturned by a majority vote of the applicable ACEP review body **or adopted by the body**.

5. Within ten (10) business days after the determination specified in Section C.4.b. or Section C.4.c. of these *Procedures*, forwards the complaint to the respondent by USPS Certified Mail with a copy of these *Procedures* 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 complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the applicable ACEP review body decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant 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 applicable ACEP review body, including 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–Complaint Review Panel or the Bylaws Committee appointed to review the complaint, as appropriate.

D. Ethics Complaint Review Process. ~~w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Ethics Complaint Review Panel:

1. Reviews the written record of any complaint that alleges a violation of the ACEP *Code of Ethics* or other ACEP ethics policies as they existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference **or web conference** call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of the applicable version of the ACEP *Code of Ethics* or other ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Decides to:
   a. Dismiss the complaint; or
   b. ~~Ethics Complaint Review Panel r~~**R**enders a decision to impose disciplinary action, based on the written record.
6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:
   a. A hearing; or
   b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.
7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

E. Bylaws Complaint Review Process ~~w~~Within sixty (60) days of the forwarding of the complaint /response specified in Section C.4.b. above, the Bylaws Committee:

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws as it existed at the time of the alleged violation and the accompanying response.
2. Discusses the complaint and response by telephone conference **or web conference** call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:

a. Applicable version of the ACEP Bylaws apply.
b. Alleged behavior constitutes a violation of the applicable version of the ACEP Bylaws.
c. Alleged conduct warrants censure, suspension, or expulsion.

5. Decides to:
   a. Dismiss the complaint; or
   b. ~~Bylaws Committee r~~**R**enders a decision to impose disciplinary action, based solely on the written record.
6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.
7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

F. Right of Respondent to Request a Hearing

If the Ethics Complaint Review Panel or Bylaws Committee chooses to impose disciplinary action, the Executive Director will send to the respondent a written notice by USPS Certified Mail of the right to request a hearing. ~~This~~ **The respondent may request a hearing to appeal the disciplinary decision or the sanction imposed. 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 Executive Director within thirty (30) days of receipt of the notice of right to a hearing. In the event of no response, the applicable ACEP review body will implement its final decision.

G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail 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.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel ~~or any other person of their 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, audio~~tape~~, **recording,** or video~~tape~~ **recording** at the expense of the requesting party. **A copy of any such record must be provided to the Executive Director.**
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is ~~impossible or commercially~~ ~~impracticable~~ **impractical** for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.
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. **Any documents or materials to be provided or presented during the hearing not already in the record, including written documents, handouts, or slide presentations, must be provided to the presiding officer 14 days prior to the hearing to assess if the material and information contained therein are relevant to the proceedings.** 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. The Board Hearing Panel 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.
9. The decision of the Board Hearing Panel 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 Hearing Panel's decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board Hearing Panel's decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the applicable ACEP review body in its review of the complaint. The Board shall review the *Procedures* used in the complaint review process but will not review the facts or merits of the case. Should the Board decide these *Procedures* were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. Possible Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Action
   a. Censure
      i. Private Censure: a private letter of censure informs a member that his or her conduct does not conform with the College's ethical standards; it may detail the manner in which ACEP expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. Upon written request by a member of ACEP, ACEP may confirm the censure; however, contents of the letter will not be provided.
      Private censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards but appears to be a minor isolated incident. The member's actions are not egregious in nature but fall outside of acceptable conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for single ethical violations in the course of a single legal case.
      ii. 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 set forth in Section B.2. above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**.
      Public censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and demonstrates a pattern of unethical behavior or a single example of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for multiple ethical violations in the course of a single legal case.
   b. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the-ACEP President. At the end of the twelve (12) month period of suspension, the suspended member may request 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). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to the Board 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.
      Suspension is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or multiple examples of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations across more than one legal case.
   c. Expulsion from ACEP membership shall be for a period of five (5) 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. The expulsion announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by and shall inform ACEP members that they may request further information about the disciplinary action**, disclosure of which shall be subject to the discretion of the Executive Director**. 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.
      Expulsion is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and the member has either received prior disciplinary action by the College, demonstrates a pattern of serious unethical behavior, or demonstrates a single example or

multiple examples of egregious conduct to a degree warranting discipline beyond the suspension available under I.1.b. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action should be considered for multiple ethical violations over multiple legal cases.

2. Scope and Manner of Disclosure
   a. Disclosure to ACEP Members: Any ACEP member may transmit a request for information to the Executive Director regarding disciplinary actions taken by the College. ~~Such~~ **The** letter shall specify the name of the member or former member who is the subject of the request. The Executive Director ~~shall~~ **may** disclose, in writing, the relevant information as described in Section I.1.
   b. Disclosure to Non-Members: If a non-member makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication. No further information shall be provided. **If a non-member makes a request for information about disciplinary actions against a member who has received private censure, the Executive Director shall inform the individual that no published announcement of disciplinary action is available but shall not indicate or confirm that a private censure has been imposed.**

J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the applicable ACEP review body, at which time the decision will be available upon request by ACEP members, to the extent specified in Section I. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel, 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 ACEP review body's overall time to complete its task.
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel) 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 person shall recuse himself or herself from the process except as a complaining party or respondent, at which time the ACEP President will appoint a replacement.
6. Once the Ethics Complaint Review Panel or the Bylaws Committee has made a decision on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The Ethics Complaint Review Panel or the Bylaws Committee's decision to impose ~~an adverse~~ **a disciplinary** 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~~ **review** process.
8. If a respondent fails to respond to a complaint, to a notice of the right to request a hearing, or to a request for information, the Ethics Complaint Review Panel, the Bylaws Committee, or the Board Hearing Panel may make a decision on the complaint solely on the basis of the information it has received.
9. If a respondent seeks to voluntarily resign ~~his/her~~ **their** ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

Action: The College Manual was updated and is available on the ACEP website. The revised procedures will be used for future ethics complaints.

Resolution 25 Protecting Section Integrity and Member Engagement in ACEP

RESOLVED, That the Board of Directors amend the "Policy on Sections of Membership" to require that a charter for any section of membership may only be suspended or revoked by a two-thirds vote of the Board of Directors.

Action: The "Policy on Sections of Membership" was revised and approved by the Board of Directors on September 4, 2025. The policy has been updated on the website and in the Sections Manual.

Resolution 34 Recognition of Public Media as a Public Health Necessity

RESOLVED, That ACEP recognize public media as a public health necessity, which is a vital component of a well-informed public and public health infrastructure; and be it further

RESOLVED, That ACEP support the use and protection of public media as a tool for improving health outcomes and enhancing emergency preparedness.

Action: Assigned to Public Relations staff to develop messaging for posting on the website and utilizing for public health advocacy. Assigned to Advocacy & Practice Affairs staff for advocacy initiatives and messaging as appropriate.

Resolution 36 Reaffirming Support for 3-Year and 4-Year Emergency Medicine Residency Program Accreditation (as amended)

RESOLVED, That ACEP reaffirm the policy statement "Length of Residency in Training in Emergency Medicine," established by Council Resolution 22(23) recognizing the value of and supporting continued accreditation of both three- and four-year emergency medicine residency programs; and be it further

RESOLVED, That the Board of Directors reaffirm their commitment to represent ACEP policy statements when making public statements on behalf of the College.

Action: The policy statement was updated to reflect it was reaffirmed by the Board in September 2025. The ACGME released a statement on February 10, 2026, announcing their determination to defer a decision regarding the proposed Program Requirements for Graduate Medicine in Emergency Medicine, including consideration of the move to a four-year program format. The ACGME is developing a process to collect additional information and continue the review. A timeline has not yet been established. ACEP and EMRA released a statement on February 11, 2026, regarding the ACGME's action. ACEP and EMRA sent a letter to the ACGME on June 4, 2026, urging them to seek more input from the full emergency medicine community regarding any changes to EM residency training requirements. ACEP and EMRA want to see engagement across EM on these major decisions, including an outline of a clear process for stakeholder input, and a timeline for decisions and implementation, the letter asserts. The ACGME announced on June 10, 2026, that more information is needed before it makes any changes to the length of current EM residency programs and has paused further action on a proposal to change from the current three-or four-year program format to a standard four-year format. A pilot program is being developed to gather perspectives across emergency medicine. Details are forthcoming.

Resolution 38 Inclusion of ACEP Leadership Roles as Approved Practice Improvement Activities for ABEM Certification

RESOLVED, That ACEP advocate for the American Board of Emergency Medicine to acknowledge participation in ACEP leadership positions as approved practice improvement activities that meet certification requirements; and be it further

RESOLVED, That ACEP collaborate with the American Board of Emergency Medicine to develop a framework outlining the specific criteria and processes by which participation in leadership roles within ACEP can be deemed as fulfilling practice improvement requirements for maintenance of certification; and be it further

RESOLVED, That ACEP and the American Board of Emergency Medicine work toward implementing the criteria and process while informing ACEP members of new opportunities for fulfilling practice improvement obligations through leadership involvement.

Action: ACEP discussed the resolution with ABEM leadership and explore how leadership activities could potentially be structured to align with the core principles of practice improvement that focus on measurable patient outcomes.

ABEM's president and executive director participated in a webinar open to all ACEP members, hosted by the Locum Tenens Section, to answer questions about maintaining board certification while practicing as a locum physician and to share insights about certification requirements and updates relevant to locums work.

ABEM sent a letter to ACEP on February 18, 2026, reporting their decision against recognizing participation in ACEP leadership roles as meeting the IMP requirement at this time. ABEM requires that IMP activities follow a specific four-step quality improvement framework that: 1) measures a clinical care process or outcome; 2) compares performance to a standard or benchmark; 3) implements an intervention to address an identified gap; and 4) re-measures to evaluate the impact of that intervention. This framework documents a continuous, data-informed cycle of improvement that reflects changes in individual or team practice and patient care outcomes. ABEM's assessment determined that general participation in leadership roles does not document the specific cycle of measuring and improving practice or patient outcomes. Blanket approval of all ACEP leadership positions as meeting the requirements does not align with the standards applied to other IMP activities and could introduce inequity across diplomates whose activities must explicitly demonstrate the four-step improvement cycle.

Resolution 41 Advocate for No-Fault Medical Liability Reform and Redefinition of Negligence in Health Care (as amended)

RESOLVED, That ACEP support the development and implementation of a no-fault medical liability system that prioritizes patient compensation and systemic health care improvements over physician punishment; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders and legal experts to identify models that shift medical liability from a fault-based system to a no-fault compensation model; and be it further

RESOLVED, That ACEP advocate for a legal standard that recognizes systemic contributions to medical errors, encourages root cause analysis over individual blame, and better reflects modern health care practice and patient safety goals.

RESOLVED, That ACEP promote and advocate for an elevation of the civil tort burden of proof for EMTALA-related care from a preponderance of evidence to clear and convincing evidence.

Action: Assigned to the Medical-Legal Committee to develop a plan for potential strategies and resources to address the resolution.

Resolution 43 Support for Eliminating Physician Non-Compete Clauses in Contracts

RESOLVED, That ACEP develop and make available publicly a generic support letter that emergency physicians may use during contract negotiations to advocate for the removal of non-compete clauses that prohibit clinical practice within a defined region; and be it further

RESOLVED, That ACEP clearly state in a generic support letter that emergency physicians can use during contract negotiations that non-compete clauses restricting the clinical practice of medicine, as opposed to limiting contractual competition for hospital coverage, are fundamentally unfair, ethically problematic, and harmful to public health and physician well-being; and be it further

RESOLVED, That ACEP continue monitoring and updating members on state and federal developments regarding non-compete reform and support physician advocacy efforts on this issue.

Action: Assigned to Clinical Affairs staff to draft a general support letter for approval by the president. ACEP's policy statement "Emergency Physician Contractual Relationships" supports this resolution. ACEP released a public statement on September 10, 2025, reaffirming support for banning non-compete agreements in health care.

Assign to Advocacy & Practice Affairs staff to continue current advocacy initiatives and topical updates on the website and other communications to reflect current actions. (see resolution background information and provide as implementation action)

Resolution 44 Advocating for National Leadership on Workplace Violence in Health Care through the AMA (as amended)

RESOLVED, That ACEP encourage its delegates to the American Medical Association to introduce and support AMA policy that prioritizes addressing workplace violence in health care as a top national advocacy issue; and be it further

RESOLVED, That ACEP encourage its delegates to the American Medical Association to advocate for mandatory, standardized reporting of workplace violence incidents across all health care settings and support the aggregation and public dissemination of this data to inform research, benchmarking, and national policy development; and be it further

RESOLVED, That ACEP encourage its delegates to the American Medical Association to advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce.

Action: The resolution was provided to the AMA Section Council on Emergency Medicine for review and consideration in developing or supporting resolutions for the AMA House of Delegates.

The AMA has fairly extensive policy, directives, and activity around workplace violence in health care, such as the following, several of which touch on supporting mandatory reporting of violence incidents and use of evidence-based strategies to protect the health care workforce:

- Directive: Affirmatively Protecting the Safety and Dignity of Physicians and Trainees as Workers D-515.977 · Directive: Preventing Violent Acts Against Health Care Providers D-515.983
- Policy: Violence and Abuse Prevention in the Health Care Workplace H-515.966
- Policy: Protecting Physicians and Other Healthcare Workers in Society H-515.950
- Policy: Workplace Violence Prevention H-215.978
- Policy: Violent Acts Against Physicians H-515.982
- Policy: Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997

Resolution 45 Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies (as amended and adopted in lieu of Resolutions 45 and 46)

RESOLVED, That ACEP continue to advocate for the full preservation and expansion of the Medicaid program as an essential component of equitable access to emergency care; and be it further

RESOLVED, That ACEP create a unified policy statement that recognizes Medicaid's importance as a safety net insurance to emergency medicine, and include within it the concepts of the current policy statements "Work Requirements for Medicaid Beneficiaries," "Medicaid Expansion," and "Opposition to Copays for Medicaid Beneficiaries" to create a single, robust policy statement on Medicaid; and be it further

RESOLVED, That ACEP policy affirm ACEP's opposition to administrative or financial barriers, including third-party administrator interference, that reduce timely access to emergency care for Medicaid beneficiaries and promotes emergency physicians' roles as key stakeholders in Medicaid policy development and reform.

RESOLVED, That ACEP advocate for adequate federal and state Medicaid funding levels for patients.

Action: Assigned to Advocacy & Practice Affairs staff to continue current federal and state advocacy initiatives.

Assigned second resolved to the State Legislative/ Regulatory Committee. The committee developed the unified policy statement "Medicaid" and it was approved by the Board on April 29, 2026.

Protecting and improving Medicaid has been and remains a legislative and regulatory priority for the College. The Legislative and Regulatory Priorities for the First Session of the 119th Congress, as approved by the ACEP Federal Government Affairs (FGA) Committee and the Board of Directors, included:

- Ensure Prudent Layperson Standard extends to Medicaid FFS and compliance measures are in place for other health plans.
- Monitor efforts to establish block grants, per-capita allotments for federal share of Medicaid funding, establishment of Medicaid work requirements, or other proposals regarding Medicaid eligibility requirements/restrictions.
- Seek permanent repeal of Medicaid IMD exclusion.
- Monitor efforts to establish/change Medicaid work requirements.
- Monitor legislative efforts to voluntarily expand Medicare or Medicaid to additional patient populations.

ACEP federal advocacy has prioritized the preservation of Medicaid in light of the substantial changes to the program that were being considered by Congress and were ultimately included in H.R. 1, the "One Big Beautiful Bill Act," (P.L. 119-21) that was signed into law on July 4, 2025. Among the major Medicaid provisions included in the law are:

- **"Community Engagement" Requirements**: Establishment of work requirements for eligible adults that are part of the Affordable Care Act's Medicaid expansion population. The law requires that able-bodied individuals must work at least 80 hours per month or complete volunteer, community service, or other eligible educational programs, with limited exceptions. 40 states and the District of Columbia have expanded Medicaid to cover most adults under 138% of the federal poverty level (FPL). According to the Kaiser Family Foundation (KFF), "As of June 2024, over 20 million people were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states."
- **State provider tax freeze and reduction**: Freezes the current Medicaid provider tax thresholds for all states for two years, and reduces the maximum allowable provider tax for expansion states from 6 percent to 3.5 percent by 2032 (in 0.5 percent increments annually).
    - Context: Medicaid is jointly financed by the federal government and the states, and states are permitted to finance their non-federal share through multiple sources, including state general funds, taxes on providers (most commonly hospitals and/or nursing facilities), and local government funds. All states except for Alaska finance some of their state costs with taxes on these health care providers. These revenues are used to boost Medicaid provider payments, thereby increasing the state's Medicaid costs that in turn increase the Federal Matching Assistance Percentage (FMAP) rate provided by the federal government.
    - Federal law requires a provider tax to be uniform and broad-based, meaning it must be applied at the same level and to all Managed Care Organizations (MCOs) in the state, not just Medicaid MCOs. A state can apply to the Centers for Medicare & Medicaid Services (CMS) to waive the broad-based and uniform requirements if the net impact of the tax is generally redistributive and the tax amount is not directly correlated to Medicaid payments. States must conduct a statistical test to demonstrate that the tax is generally redistributive.
- **State directed payment limits**: Sets the limit for state directed payments (SDPs) to 110 percent of Medicare rates for non-expansion states, and 100 percent of Medicare for expansion states. For states that newly expand Medicaid, all SDPs will be subject to this provision, even if previously approved.
    - Context: SDPs allow states to direct MCOs to pay providers according to specific rates or methods, and can be used to establish minimum or maximum fee schedules for certain types of providers, to require

participation in value-based payment arrangements, or to make uniform payment rate increases. States have had significant discretion in developing SDPs (including determining which providers receive SDPs and the amounts of the payments). The Biden administration's managed care rule capped the SDP ceiling for certain services at the average commercial rate.

- **Medicaid cost-sharing & copays**: Requires states to impose cost-sharing/copays on certain services for Medicaid expansion adults with incomes above 100 percent of the federal poverty level (FPL). Cost-sharing will be at a rate determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5 percent of the family income. Certain types of services are exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers.
    - Context: Under existing federal law, such cost-sharing requirements by a state Medicaid program were already permitted with the above limitations, but now will be required. States with existing Medicaid copay policies for non-emergent ED use include Florida, Kentucky, Minnesota, Montana, Ohio, Pennsylvania, South Carolina, and Washington.

ACEP created a summary of the emergency medicine-specific provisions of the law detailing these and other relevant provisions and associated implementation timelines and deadlines.

ACEP's existing policies have served and continue to serve as the foundation of the College's ongoing advocacy work, supplemented by the April 2025 RAND report, "Strategies for Sustaining Emergency Care in the United States," other ACEP resources, and coalition efforts among other physician and provider specialties.

ACEP continues monitoring legislative activity in the wake of the passage and enactment of the "Big Beautiful Bill," as some Republican legislators have indicated they are seeking changes to some of the Medicaid provisions of the law. ACEP will continue the ongoing work to fight for the preservation and expansion of Medicaid to the fullest extent possible.

Resolution 47 Protecting Medicaid Disproportionate Share Hospital (DSH) Payments to Preserve Emergency Care Access (as amended)

RESOLVED, That ACEP recognize the Disproportionate Share Hospital cuts are of specific concern to emergency physicians as they have been shown to increase the amount of rural hospital closures; and be it further

RESOLVED, That ACEP partner with relevant organizations such as America's Essential Hospitals to further the cause of protecting Disproportionate Share Hospital payments; and be it further

RESOLVED, That ACEP advocate for existing and future legislation to repeal or delay the Medicaid Disproportionate Share Hospital cuts scheduled for fiscal years 2026 through 2028.

Action: Assigned to Advocacy & Public Affairs staff for advocacy initiatives and to pursue potential collaboration with America's Essential Hospitals, American Hospital Association, and Federation of American Hospitals.

The FY26 Appropriations & Health Care Package was signed into law on February 3, 2026. One of the provisions prevents Medicaid Disproportionate Share Hospital (DSH) cuts for the remainder of FY2026 and throughout FY2027.

Resolution 48 Affirming Emergency Physicians' Ethical and Legal Obligations Under EMTALA (as amended)

RESOLVED, That ACEP update its policy statement "Access to Reproductive Health Care in the Emergency Department" to include language that explicitly affirms emergency physicians' unwavering ethical and legal obligations under EMTALA to provide necessary stabilizing care for all patients presenting with emergency medical conditions, including pregnant patients when stabilizing treatment may require pregnancy termination; and be it further

RESOLVED, That ACEP affirm that federal EMTALA obligations should supersede conflicting state laws or mandates that would prevent emergency physicians and all members of the medical staff from providing medically necessary stabilizing treatment for emergency medical conditions; and be it further

RESOLVED, That ACEP advocate for clear federal protections for emergency physicians and all members of the medical staff providing care in accordance with EMTALA requirements, particularly when such care conflicts with state laws; and be it further

RESOLVED, That ACEP work with relevant federal agencies, medical societies, and stakeholders to ensure consistent interpretation and enforcement of EMTALA requirements that protect both patients and physicians; and be it further

RESOLVED, That ACEP provide educational resources and support to emergency physicians navigating complex legal landscapes while maintaining their professional and ethical obligations to provide emergency medical care.

Action: Assigned first resolved to the Medical-Legal Committee (lead) and the Public Health Committee to update the "Access to Reproductive Health Care in the Emergency Department" policy statement and to review in conjunction with the

current committee objective to develop a policy statement as directed in Resolution 37(24) Reinforcing EMTALA in Pregnancy Related Emergency Medical Care. The Medical-Legal Committee was also assigned to conduct a webinar and prepare a 2-page summary document on key concepts emergency physicians need to know regarding ethical and legal obligations under EMTALA.

Assigned to Advocacy & Practice Affairs to continue current federal advocacy initiatives.

Resolution 49 Support for EMTALA Reform to Ensure Timely Access to Definitive Care (as amended)

RESOLVED, That ACEP support legislative, regulatory, and policy reforms to strengthen the EMTALA mandate regarding transfers and advocate to reduce barriers that create delays in transferring patients to a higher level of care.

Action: Assigned to Advocacy & Public Affairs staff to develop advocacy strategy regarding EMTALA and the need for improved systems to coordinate the safe and appropriate transfer of patients. The State Legislative/Regulatory Committee has an objective to collaborate with the Arizona and Connecticut Chapters and others as directed in Substitute Resolution 36(24) Reform to Improve Patient Access to Necessary Care:

> RESOLVED, That ACEP collaborate with the Arizona and Connecticut Chapters and others to develop model state policy, regulation, and legislation, that requires reporting of ED/hospital crowding and interhospital transfer data to a relevant state entity (e.g. State Department of Health) and develop a state-wide system to facilitate interfacility transfers.

ACEP's policy statement "Appropriate Interfacility Patient Transfer" outlines principles regarding patient transfer for patients requiring transfer from the ED to another facility. Among these principles is that "[a]greement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer."

Resolution 50 Emergency Department Staffing Transparency (as amended)

RESOLVED, That ACEP advocate for stricter enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting.

Action: Assigned to Advocacy & Public Affairs staff to continue current advocacy initiatives and meet with CMS to discuss enforcement of federal regulations requiring hospitals without 24/7 on-site physician coverage to clearly post such notices and ways to improve transparency.

ACEP released the Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit in 2023 that includes key considerations when crafting and lobbying for a bill or regulation related to the topic. This toolkit, along with support from ACEP's advocacy team, was instrumental in helping states pass legislation that requires a physician in the ED at all times.

Resolution 51 Supporting Board Certified Physicians in Every Emergency Department (as amended)

RESOLVED, That ACEP reaffirm current policy that the gold standard for emergency department care is provided by an emergency physician, and support state and federal legislative and regulatory efforts to require that a physician be present and available in every emergency department.

Action: Several ACEP policy statements support the gold standard that emergency department care is provided by an emergency physician. ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" most recently updated in January 2026 states:

> "Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

The Physician Staff Requirement in Emergency Departments Model Legislation and Toolkit includes key considerations when crafting and lobbying for a bill or regulation related to physician staffing in EDs.

Assigned to Advocacy & Public Affairs staff to continue current federal and state advocacy initiatives. ACEP has continually promoted and advocated the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians and for physician-led care teams in the emergency department at both the national and state level. ACEP's Advocacy and Practice Affairs staff have advocated for this standard to the Centers for Medicare and Medicaid Services as well as Health and Human Services and the U.S. Congress.

ACEP's Legislative and Regulatory Priorities for the First Session of the 119th Congress included:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs. (Legislative)
- Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas. (Legislative)
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities. (Legislative)
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option. (Regulatory)

Resolution 53 Prior Authorization Reform to Reduce Delays in Care and Emergency Department Burden (as amended)

RESOLVED, That ACEP support federal and state legislative and regulatory efforts to reform prior authorization processes, with the goal of reducing care delays that result in avoidable emergency department visits or hospitalizations; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders to advocate for real-time transparency, standardization, and accountability in prior authorization practices to promote timely, equitable, and efficient patient care across all health care settings.

Action: Assigned to Advocacy & Public Affairs staff to continue current federal and state advocacy initiatives. ACEP's legislative and regulatory priorities for the First Session of the 119th Congress included:

- Oppose efforts by insurers to create unnecessary barriers to care, including through use of prior authorization, etc.
- Monitor regulatory changes in Medicare that promote Medicare Advantage and potential increased patient burdens via prior authorization requirements, narrow networks, increased cost-sharing, step therapy, and others.

Resolution 55 Reduce Non-Beneficial Regulation by The Joint Commission and other Health Care Regulatory Bodies (as amended)

RESOLVED, That ACEP collaborate with Joint Commission and other health care regulatory bodies to review and advocate for the elimination or modification of requirements that do not demonstrably improve the care of Emergency Department patients.

Action: Assigned to Advocacy & Public Affairs staff to continue ongoing discussions with Joint Commission, CMS, and other health care regulatory bodies.

Resolution 56 Regulate Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions (as amended)

RESOLVED, That ACEP advocate for legislation at the state and federal levels requiring that reimbursement denials or negative coverage decisions by insurers be reviewed and approved by qualified human personnel who are board-certified physicians in the relevant specialty or sub-specialty with an unrestricted and active license, and are not incentivized to deny payment for care; and be it further

RESOLVED, That ACEP support prohibiting health insurers from relying solely on artificial intelligence-based algorithms to deny, delay, or downcode health care claims or services and urge both CMS and state regulatory agencies to establish policies requiring human oversight in these decisions; and be it further

RESOLVED, That ACEP collaborate with relevant stakeholders, including insurers, technology providers, and regulators, to ensure that artificial intelligence algorithms used in health care decision-making and the datasets they are trained on are transparent, accountable, based on accurate and up-to-date clinical criteria derived from national medical

specialty society guidelines and peer reviewed clinical literature, and subject to oversight by qualified health care professionals.

Action: Assigned to Advocacy & Public Affairs staff for federal and state advocacy initiatives. Assigned to the State Legislative/ Regulatory Committee to develop model state legislation.

Assigned second and third resolveds to the Reimbursement Committee (lead) and the Artificial Intelligence Committee to provide a recommendation to develop policy language for approval by the Board of Directors regarding federal and state regulatory agencies to require insurers to have human oversight reimbursement decisions.

Resolution 57 Repeal Certificate of Need Laws to Expand Access and Improve Patient Care (as amended)

RESOLVED, That ACEP collaborate with other health care organizations to raise public awareness and educate state policymakers on the impacts of Certificate of Need (CON) laws on patient access to emergency care, including overcrowding, boarding, and limited capacity, and advocate for the removal of these regulatory barriers to improve patient flow and health care access.

Action: Assigned to Advocacy & Public Affairs staff for advocacy initiatives. Assigned to the State Legislative/Regulatory Committee to develop a 2-page summary document.

Resolution 58 Role of EDs in Interactions with U.S. Immigration and Customs Enforcement

RESOLVED, That ACEP acknowledge its prior guidance on U.S. Immigration and Customs Enforcement (ICE) in the emergency department as a valuable foundation, and recognize the continuing potential impact of ICE enforcement actions within emergency departments on patient care and public health; and be it further

RESOLVED, That ACEP advocate for the development and dissemination of clear guidelines and training programs for emergency department staff to manage interactions with U.S. Immigration and Customs Enforcement officials, ensuring the protection of patient rights and the provision of uncompromised medical care; and be it further

RESOLVED, That ACEP support collaboration with legal experts, hospital administrations, and community organizations to establish policies that delineate the role of emergency departments in relation to U.S. Immigration and Customs Enforcement activities, emphasizing the importance of patient trust, safety, and confidentiality.

Action: Assigned to Advocacy & Practice Affairs staff to continue current advocacy initiatives and work with the American Hospital Association and the Federation of American Hospitals to investigate developing guidance and/or policy to address the third resolved. Continue to monitor and update guidance on the ACEP website as necessary.

Resolution 59 Support Interstate Telemedicine Practice for Physicians with Permanent Licensure (as amended)

RESOLVED, That ACEP work with relevant stakeholders to advocate for states to establish a special purpose telehealth registry or license; and be it further

RESOLVED, That ACEP advocate to expand access to emergency telemedicine services with licensure recognition across state lines while ensuring patient safety and physician accountability.

Action: Assigned to the State Legislative/Regulatory Committee to develop strategies to address the resolution and to obtain input from the Emergency Telehealth Section.

Assigned to the Emergency Medicine Practice Committee to review the "Emergency Medicine Telehealth" policy statement to ensure it does not conflict with the tenets of the resolution in conjunction with their current objective pertaining to Referred Amended Resolution 40(24).

Resolution 61 Acknowledging and Mitigating the Environmental Impact of Metered-Dose Inhalers (as amended)

RESOLVED, That ACEP acknowledge the environmental impact of metered-dose inhalers and supports efforts to reduce their carbon footprint through sustainable practices.

Action: Assigned to the Public Health Committee to review and incorporate in their work on Amended Resolution 58(24) Reducing Waste in Our Emergency Departments and Resolution 59(24) Tap Water is Sufficient. The committee developed the policy statement "Reducing Waste in the Emergency Department" and it was approved by the Board June 11, 2026.

Resolution 62 Promoting Environmental Sustainability and Waste Reduction in the ED (as amended)

RESOLVED, That ACEP encourage hospitals to implement environmentally responsible practices, including but not limited to proper waste segregation, development of recycling programs, reduction of low-value medical interventions, and the use of sustainable alternatives when clinically appropriate.

Action: Assigned to the Public Health Committee to review and incorporate in their work on Amended Resolution 58(24) Reducing Waste in Our Emergency Departments and Resolution 59(24) Tab Water is Sufficient. The committee developed the policy statement "Reducing Waste in the Emergency Department" and it was approved by the Board June 11, 2026.

Resolution 64 Endorsement of Electronic Discharge Instructions for Patients with Electronic Medical Records (as amended)

RESOLVED, That ACEP endorse the use of electronic discharge instructions for patients with access to electronic medical records and electronic communication capabilities; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt policies and technologies that support patient-centered, secure, timely, and environmentally responsible electronic delivery of discharge instructions in compliance with HIPAA regulations.

Action: The resolution as written is a policy statement. Assigned to the Health Innovation Technology Committee to determine if additional language is needed for the policy statement and provide a recommendation to the Board of Directors. The Health Innovation Technology Committee was also assigned to develop talking points for members to use in advocating for adoption of policies and techniques with their hospital leadership.

Resolution 65 Emergency Physicians and Collaborative Practice Agreements (as substituted)

RESOLVED, That ACEP develop a policy statement opposing the establishment of collaborative practice agreements without the specific and informed authorization of the supervising physician; and be it further

RESOLVED, that ACEP oppose the execution of collaborative practice agreements by employers, hospitals, or contract groups on behalf of emergency physicians; and be it further

RESOLVED, that ACEP support the prior disclosure of collaborative practice agreements when required for employment of emergency physicians.

Action: Assigned to the Emergency Medicine Practice Committee to develop a policy statement.

Resolution 66 Endorsing a Realistic Door-to-Doctor Standard (as amended)

RESOLVED, That ACEP oppose practices that encourage unsafe or unsustainable door-to-doctor expectations.

Action: The Quality & Patient Safety Committee was assigned an objective to review the "Standards for Measuring and Reporting Emergency Department Wait Times" policy statement as part of the policy sunset review process and to include the tenets of the resolution in the revised policy statement. The committee submitted a revised policy statement to the Board in January 2026 and it was referred back to the committee for additional revisions. The Board approved the revised policy statement "Standards for Measuring and Reporting Emergency Department Wait Times" on June 24, 2026.

Resolution 67 Forensic Programs in Trauma Centers (as amended)

RESOLVED, That ACEP work with relevant stakeholders to implement a collaborative standard of forensic programs at all Level 1 and Level 2 trauma centers.

Action: ACEP contacted ACS-COT leadership to make them aware of the resolution and requested collaboration. Assigned to the Public Health Committee (lead) to work with the Forensic Medicine Section to develop an advocacy program/toolkit to assist members with implementing a forensic program at their hospital. The committee developed the policy statement "Dedicated Forensic Programs in Trauma Centers" with input from the Forensic Medicine Section and the Emergency Nurses Association and it was approved by the Board on June 11, 2026. The committee continues working on developing the toolkit.

Resolution 68 Integrating Firearm Safety Counseling into Emergency Medicine Education and Practice (as amended)

RESOLVED, That ACEP amend its policy statement "Firearm Safety and Injury Prevention" to include integration of firearm injury prevention, safe storage, and counseling education into emergency medicine residency training and continuing medical education; and be it further

RESOLVED, That ACEP develop or identify easily accessible-member-facing clinical information to support emergency physicians in conducting brief, trauma-informed firearm safety counseling, particularly for high-risk patients consistent with ACEP's firearm safety policies.

Action: Assigned to the Public Health Committee to revise the policy statement "Firearm Safety and Injury Prevention" as directed in the resolution and develop resources to address the second resolved, such as a 2-page summary or infographic for members.

Resolution 71 Member Resources for Best Practices in Employment Negotiations (as amended)

RESOLVED, That ACEP curate existing and future educational materials and webinars focused on best practices in employment negotiation into a centralized member-accessible resource that is easily identifiable on the ACEP website.

Action: This work is in progress by staff and members of the Employee Protections Workgroup. Assigned to the Emergency Medicine Practice Committee to continue monitoring and updating information for members.

Resolution 72 Naloxone Access and Education in Public Schools

RESOLVED, That ACEP endorse efforts to assure naloxone is in public schools and incorporate education on overdose and substance use disorder into health education.

Action: There are organizations working to support naloxone-related initiatives in educational settings. Assigned to the Public Health Committee and staff to review the National School Overdose Preparedness Campaign and submit a recommendation regarding endorsement. The campaign is seeking alliances and endorsements from multiple organizations (i.e., school nurses, PTAs, school boards, student councils, etc.). The committee's recommendation to endorse the campaign was approved by the Board of Directors at their January 2026 Board meeting.

ACEP has supported the Helping Educators Respond to Overdoses (HERO) Act (H.R. 7994) which would establish a competitive grant program to provide schools with opioid overdose reversal drugs. The HERO Act would help save lives by expanding access to opioid overdose reversal medications, such as Narcan, in schools while providing educators with critical training and equipping students and communities with educational resources to combat the opioid and fentanyl epidemic.

Resolution 73 Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation (as amended)

RESOLVED, That ACEP develop a plan to promote and facilitate the initiation of nationwide emergency department programs to improve substance use disorder treatment including, but not limited to, staff training, dispensing harm reduction materials, initiating evidence-based medication where applicable, and rapid clinical referrals to outpatient treatment where available; and be it further

RESOLVED, That ACEP work with relevant stakeholder organizations to obtain funding for substance use disorder programs; and be it further

RESOLVED, That ACEP report back to the Council in a timely manner on the development of a plan to promote and facilitate the initiation of nationwide emergency department programs to improve substance use disorder treatment and any progress made on the goals of the plan.

Action: Assigned to the Public Health Committee (lead) to work with the Pain Management & Addiction Medicine Section to develop a plan and strategies to address the resolution as well as identify appropriate stakeholder organizations.

Resolution 74 Necessary Facility-Provided Medications from Emergency Departments (as substituted)

RESOLVED, That ACEP develop strategies to address barriers preventing the dispensation of essential medications in sufficient quantity upon discharge from the emergency department during off hours and when pharmacies are not available.

Action: Assigned to the State Legislative/Regulatory Committee. The committee has a current objective to investigate developing state model legislation to allow emergency physicians to give the remaining doses of multiuse prescriptions to patients at the time of discharge from the emergency department.

Resolution 76 Protection and National Standardization of Transgender Care in Emergency Medicine

RESOLVED, That ACEP support the development and publication of nationally recognized guidelines for transgender care in emergency medicine; and be it further

RESOLVED, That ACEP advocate for the protection of transgender patients and the ability of emergency physicians to provide evidence-based care to patients of all gender identities.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

ACEP has a policy statement "Caring for Transgender and Gender Diverse Patients in the Emergency Department" and a Policy Resource & Education Paper (PREP) "A Guide to Caring for Patients Who Identify as Transgender and Gender Diverse in the Emergency Department."

Resolution 79 Standards for the Safe and Appropriate Transport of Patients to Psychiatric Facilities (as amended)

RESOLVED, That ACEP work collaboratively with relevant stakeholders to develop consensus recommendations and best practices regarding transport requirements for patients being transferred to psychiatric facilities, with specific attention to the transferring facility determining clinical stability, restraint use, and acceptable means of transportation.

Action: Assigned to the Emergency Medicine Practice Committee (lead) to work with the EMS Committee to develop strategies to address the resolution and to seek input from the Emergency Behavioral Health Workgroup and the Coalition on Psychiatric Emergencies as needed.

Resolution 80 Toolkit for Elective Surgery Scheduling to Mitigate ED Crowding (as amended)

RESOLVED, That ACEP collaborate with relevant stakeholders, including the American College of Surgeons and the American Hospital Association, to develop and disseminate a comprehensive elective surgery scheduling toolkit aimed at guiding hospitals in implementing effective scheduling practices to mitigate ED crowding.

Action: Assigned to the Emergency Medicine Practice Committee to work with representatives from stakeholder organizations to develop a toolkit.

Resolution 81 In Memory of Joshua Alinger, MD

RESOLVED, That the American College of Emergency Physicians mourns the loss and expresses its deep sorrow at the passing of Joshua Alinger, MD, and extends heartfelt condolences to his family, friends, colleagues, and the Northwestern University Emergency Medicine community.

Action: A framed resolution was sent to Dr. Alinger's family.

Resolution 82 In Memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired)

RESOLVED, That the American College of Emergency Physicians honors the memory of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), and his extraordinary contributions to emergency medicine, education, and community service; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Donald J. Gordon, MD, PhD, FACEP, Lieutenant Colonel, US Army (Retired), acknowledging that though he may be gone, his remarkable achievements and enduring impact will be remembered with gratitude and admiration.

Action: A framed resolution was sent to Dr. Gordon's family.

Resolution 83 In Memory of Elizabeth B. Jones, MD, FACEP

RESOLVED, That the American College of Emergency Physicians honors the memory of Elizabeth B. Jones, MD, FACEP, and her extraordinary contributions to emergency medicine, patient advocacy, academic excellence, and integrity in research and clinical care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Elizabeth B. Jones, MD, FACEP, acknowledging that though she may be gone, her remarkable achievements and enduring impact will be remembered with gratitude and admiration.

Action: A framed resolution was sent to Dr. Jones' family.

Resolution 84 In Memory of Brian Wai Lin, MD

RESOLVED, That the American College of Emergency Physicians and the California Chapter recognizes the extraordinary contributions of Brian Wai Lin, MD, to the specialty of emergency medicine as a physician, educator, innovator, and mentor; and be it further

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Brian Wai Lin, MD, especially his beloved children Isaiah, Elliot, and Daphne, along with his loved ones, friends, students, residents, and colleagues our heartfelt condolences and deepest appreciation for his lasting impact on the specialty of emergency medicine and the lives of those he touched with generosity and grace.

Action: A framed resolution was sent to Dr. Lin's family.

Resolution 85 In Memory of Forest Daniel McCoig, MD

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Forrest Daniel McCoig, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Virginia College of Emergency Physicians extends to his devoted wife Katharine (married in 1958) of 23 years, and mother to their children James, Amy, and Laura, and his wife Janet (married in 1991) of 34 years, and mother to Kelly, gratitude for his service as an emergency physician, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. McCoig's family.

Resolution 86 In Memory of Jack Henriquez, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jack A. Henriquez, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his sons Eric W. Henriquez, Ryan S. Henriquez, his wife, and four grandchildren gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Henriquez's family.

Resolution 87 In Memory of Carl S. Werne, MD

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Carl S. Werne, MD; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his daughters Joanna Werne and Emily Kennerley, his sister Dr. Joellen Werne, his partner Dr. Amy Zimet, and his first wife Patricia Daly Vance and extended family gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Werne's family.

Resolution 88 In Memory of Jamie Shandro, MD, MPH

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jamie Shandro, MD, MPH; and be it further

RESOLVED, That the American College of Emergency Physicians and the Washington Chapter extends to her children Nina and Kai, husband Hans, mother Cathy, brother Tim, extended family, friends, and colleagues our heartfelt gratitude for her service as an emergency physician as well as for her dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Shandro's family.

Resolution 89 Support for Scientific Integrity in Medicine and Public Health (as amended)

RESOLVED, That ACEP strongly recognize and commend Debra Houry, MD, FACEP; Demetre Daskalakis, MD; Jennifer Layden, MD, PhD; and Daniel Jernigan, MD, MPH, for their principled stand in defense of science-based medical practice and patient safety; and be it further

RESOLVED, That ACEP strongly oppose interference in the leadership, operations, and recommendations of critical public health agencies such as the CDC, thus affirming the definitional roles of scientific independence and adherence to known facts and evidence-based medicine guidance in safeguarding the practice of medicine and public health.

Action: ACEP released a public statement on August 28, 2025, regarding the CDC leadership departures. The Council and the Board of Directors recognized the contributions of the other individuals with the adoption of this resolution.

Assigned second resolved to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. Assigned to the Public Health Committee to develop a policy statement. The Board of Directors approved the policy statement "Support for Scientific Integrity in Medicine and Public Health Policy" in March 2026.

Resolution 90 Support and Endorsement of Current Vaccine Guidelines by Fellow Medical Professional Organizations (as amended)

RESOLVED, That ACEP promptly create a policy statement endorsing the use of high-quality evidence-based vaccine schedules as outlined in and based upon the most current recommendations and vaccine schedules as published by the American Academy of Pediatrics, the American College of Cardiology, and the American College of Obstetrics and Gynecology.

Action: ACEP released a public statement on September 19, 2025, endorsing evidence-based vaccine schedules. Assigned to

the Public Health Committee to develop a policy statement in conjunction with their current objective to "develop a policy statement addressing ACEP's support of evidence-based vaccine science and the timely development of vaccines in advance of anticipated disease spread" and in their review of the current policy statement "Immunization of Adults and Children in the Emergency Department" as part of the Policy Sunset Review process.

ACEP released a public statement on November 20, 2025, reiterating vaccine effectiveness and safety in response to news that the CDC updated its vaccine information page that the CDC updated its vaccine information page to suggest a link between vaccines and autism. ACEP joined with several other medical, health, and patient advocacy groups and released a statement on December 5, 2025, expressing concern about the actions of the CDC's Advisory Committee on Immunization Practices (ACIP) regarding pediatric vaccines and specifically scaling back universal newborn Hepatitis B vaccines.

ACEP issued a public statement on January 5, 2026, in response to the Centers for Disease Control and Prevention (CDC) reducing the number of vaccines from the recommended immunization schedule.

Resolution 91 In Memory of Frank Zwemer, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians honors and remembers the profound impact made by Frank L. Zwemer, Jr., MD, MBA, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Laura Brewer; his children, Dr. Catherine Zwemer and Jonathan Zwemer, his mother Ann, sisters Mimi Freeman and Kim McCart, and his Aunt Joan our heartfelt condolences and gratitude for sharing him with us all of these years and acknowledges his impact and care will ripple through generations of emergency physicians.

Action: A framed resolution was sent to Dr. Zwemer's family.

Resolution Referred to the Council Steering Committee

Resolution 23 Councillor Allocations for Sections of Membership – Council Standing Rules Amendment

RESOLVED, That the Council Standing Rules – Councillor Allocation for Sections of Membership be amended to read:

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, ~~or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting~~ **as defined in the Bylaws**. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Action: The Council Steering Committee discussed the referred resolution at their January 29, 2026, meeting. A subcommittee was assigned to review the resolution and provide a recommendation to the Steering Committee for consideration at their April 27, 2026, meeting.

Resolutions Referred to the Board of Directors

Resolution 26 Affirmation of ACEP's Support for Diversity, Equity, and Inclusion in Emergency Medicine

RESOLVED, That ACEP reaffirm its commitment to the core principles of diversity, equity, and inclusion, recognizing their fundamental role in promoting patient-centered care, health equity, and a thriving, representative workforce by reaffirming its previous policy statement supporting diversity, equity, and inclusion as essential to the College's mission and the practice of emergency medicine.

Action: A message was distributed to the Access, Belonging, & Community Committee and the Access, Belonging, & Community Section on September 6, 2025, acknowledging that the Board of Directors has not made changes to the College's current values or policy statement on diversity, equity, and inclusion in emergency medicine and remains committed to equal access for all physicians, residents, trainees, and medical students, and the patients and communities that we serve. ACEP continues to look for ways to preserve and improve opportunities for all and will work to engage members in a variety of ways, including through sections and committees, to help achieve our shared values.

Resolution 27 Upholding Equal Access to Care in EM Amidst Political Challenges

RESOLVED, That ACEP reaffirm its commitment to promoting and maintaining equal access to care in the emergency department, ensuring that all patients and staff are treated with respect, dignity, and fairness; and be it further

RESOLVED, That ACEP advocate for the implementation of policies and practices in the ED that address unconscious bias and cultural competence, and support equitable health care delivery for all, regardless of the political environment; and be it further

RESOLVED, That ACEP support the continued development and integration of implicit bias training into emergency medicine residency programs, continuing medical education courses, and ongoing professional development to equip emergency providers with the tools necessary to maintain inclusive and equitable care for all regardless of political and societal challenges; and be it further

RESOLVED, That ACEP support efforts to incorporate education on culturally and religiously sensitive care into emergency medicine training and continuing education programs, including awareness of variations in patient preferences and beliefs regarding gender concordance in care, expressions of pain, and attitudes toward different medical systems; and be it further

RESOLVED, That ACEP call for active collaboration with other health care organizations, advocacy groups, and community leaders to ensure that culturally sensitive equal access to care for all remains a central focus in emergency medicine practice and policy, particularly in the context of current political dynamics.

Action: A message was distributed to the Access, Belonging, & Community Committee and the Access, Belonging, & Community Section on September 6, 2025, acknowledging that the Board of Directors has not made changes to the College's current values or policy statement on diversity, equity, and inclusion in emergency medicine and remains committed to equal access for all physicians, residents, trainees, and medical students, and the patients and communities that we serve. ACEP continues to look for ways to preserve and improve opportunities for all and will work to engage members in a variety of ways, including through sections and committees, to help achieve our shared values.

Resolution 32 Transparency in Vendor and Speaker Communication Restrictions at Scientific Assembly (as amended)

RESOLVED, That ACEP publicly release its current guidelines on restricted or censored topics; and be it further

RESOLVED, That ACEP refrain from restricting or censoring vendors or speakers at Scientific Assembly unless such restriction is necessary to uphold legal or safety standards; and be it further

RESOLVED**,** That any restriction of vendors or speakers at Scientific Assembly be subject to review ~~and approval~~ by the Council to ensure transparency and accountability.

Action: The Scientific Assembly Rules and Regulations for exhibitors were reviewed and revised with guidance from ACEP's General Counsel. The revisions were non-substantive. In addition to a formal revision to the exhibitor rules and regulations regarding surveys, ACEP included in the same rules an exhibitor code of conduct that mirrors the code of conduct for ACEP attendees, staff, and volunteers. Additionally, a mechanism was created for attendees to easily communicate concerns about exhibitor behaviors and activity so staff can respond to issues more immediately.

The updated exhibitor guidelines are available on the ACEP website. The products or services to be exhibited must be of professional or educational interest or benefit to the registrants and are, in the opinion of ACEP, related to the field of emergency medicine or the physician's practice. Exhibiting at Scientific Assembly does not imply ACEP's endorsement of products or services. The only exception to the guidelines (as delineated in the guidelines) pertains to companies that are considered to be of "consumer interest." These companies may include, but are not limited to, automobile manufacturers, credit card companies, banking institutions, etc. Companies selling items such as tens units, red light therapy, copper bracelets, massage guns, skin care, etc., will not be permitted to exhibit.

ACEP's Education Committee Scientific Assembly Planning Subcommittee ensures all content is consistent with ACEP's Board approved policies. All CME-accredited content is governed by the Accreditation Council for Continuing Medical Education (ACCME) Standards for Integrity and Independence in Accredited Continuing Education, which require faculty to present fair, balanced, and scientifically valid content, free from commercial influence. ACEP does not have guidelines restricting or censoring topics. Presentations complying with ACCME standards and appropriate for our professional audience are not limited in the scope of discussion or content areas other than to ensure they do not contradict ACEP's approved policies. Faculty must uphold standards of professionalism, inclusion, and appropriate language, as outlined in the "Presentation Policy for ACEP Faculty." This policy is provided before the faculty agreement is signed and it reinforces ACEP's commitment to educational excellence and respect for a diverse audience.

Resolution 37 Support for Funding Resident Training Away from Home Institutions

RESOLVED, That ACEP advocate for changes in Centers for Medicare & Medicaid Services policy to allow funding of resident physicians during educational rotations outside their primary institution, including international and rural placements, to enhance cultural competence and patient care.

Action: Assigned to Assign to Advocacy & Practice Affairs staff and Clinical Affairs staff to provide a recommendation to the Board on the advisability of implementing the resolution and potential strategies to address it.

Resolution 40 Support Ongoing Education on Implicit Bias and Structural Inequity

RESOLVED, That ACEP provide and encourage ongoing education for members on implicit bias, systemic inequities, culturally responsive, and equal access to care for all as part of its life-long learning commitment.

Action: ACEP currently offers a wide range of educational content and resources to address implicit bias. There are several educational sessions available in ACEP Anytime.

Resolution 75 Protecting the Term "Emergency Department" in Critical Access Hospitals

RESOLVED, That ACEP develop a policy to ensure that the term "Emergency Department" ~~is used exclusively to describe facilities where a physician is physically present on-site at all times during operational hours~~ **ensuring it accurately reflects that the level of care provided aligns with both federal expectations and public understanding, and to exclusively describe facilities where a physician is physically present at all times**; and be it further

RESOLVED, That ACEP request that regulatory and accrediting bodies, such as CMS and Joint Commission enforce appropriate use of facility titles such as "Emergency Department" or "Urgent Care", ensuring that such designations are consistent with the services and staffing requirements as described in the Code of Federal Regulations, in accordance with services provided, particularly with regard to the availability of physician-on-site emergency care; and be it further

RESOLVED, That in the interest of public transparency, ACEP develop and promote policy and regulation that when Critical Access Hospitals do not have a physician physically present in the emergency department while it is open, the facility should adopt alternative terminology to clearly inform the public that physician-level medical care is not continuously available on-site.

Action: Assigned to the Federal Government Affairs Committee to provide a recommendation to the Board on the advisability of developing strategies to address the referred resolution. *Note*: The amended language was submitted for consideration by the Council prior to the motion to refer. The resolution was referred without specific action on the amended language. This referred resolution will be reviewed in context with Amended Resolution 50(25) Emergency Department Staffing Transparency that was adopted:

> RESOLVED, That ACEP advocate for stricter enforcement of the federal regulation requiring hospitals without 24/7 on-site physician coverage to clearly post such notices, including an explanation of how emergency medical needs will be addressed when a physician is not present, and that ACEP work with Joint Commission and other regulatory bodies to advance educational and regulatory initiatives that improve transparency for patients in the emergency setting.

Amended Resolution 50(25) is assigned to Advocacy & Public Affairs staff to continue current advocacy initiatives and discuss with CMS enforcement of federal regulations requiring hospitals without 24/7 on-site physician coverage to clearly post such notices and ways to improve transparency.

Resolution 77 Investigating Practice Patterns of NPs and PAs Following Independent Practice Legislation

RESOLVED That ACEP support and, if feasible, conduct or commission a study to investigate the geographic and clinical practice patterns of nurse practitioners and physician assistants in states with independent practice authority and use the findings of that study to inform ACEP policy positions and advocacy efforts regarding team-based care and scope of practice.

Action: Assigned to the State Legislative/Regulatory Committee to provide a recommendation to the Board on the advisability of implementing the resolution or potential strategies to address the referred resolution.

Note: The American Medical Association Advocacy Resource Center is studying each of the states that granted independent practice authority to nurse practitioners, although this is not a formal academic study and does not include physician assistants. The study is tracking metrics for quality and patient safety and watching for information demonstrating why a physician-led team would have potentially had a better outcome.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2026 Council

From: Sonja Montgomery
Governance Operations Director

Date: September 14, 2026

Subj: Action on 2024 Resolutions

The 2024 Council considered 70 resolutions: 55 adopted, 6 were not adopted, 1 was withdrawn, and 9 were referred to the Board of Directors. There were 4 Bylaws amendments, 1 Council Standing Rules amendment, 7 commendation resolutions, and 11 memorial resolutions.

Note: The first resolved of Resolution 22 was adopted and the second resolved was not adopted. Amended Resolution 41 was adopted in lieu of Resolution 41 and Resolution 42. Resolveds 2,3, and 4 of Resolution 43 were adopted and resolveds 1, 5, 6, and 7 were referred to the Board of Directors.

The attached report summarizes the actions taken on the 2024 resolutions adopted by the Council and those that were referred to the Board of Directors.

The updated actions are also available on the ACEP website. *Reminder:* Scroll to the end of each resolution to see amended or substituted language and review the implementation action.

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Michael J. McCrea, MD, FACEP
Speaker
Larisa M. Traill, MD, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Michael Fraser, PhD, MS, CAE

Action on 2024 Council Resolutions

Resolution 1 Commendation for Stephen V. Cantrill, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Stephen V. Cantrill, MD, FACEP, for his outstanding dedication and contributions on behalf of the College and the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Cantrill.

Resolution 2 Commendation for J.T. Finnell, II, MD, MSc, FACMI, FACEP

RESOLVED, That the American College of Emergency Physicians commends and thanks J.T. Finnell, II, MD, MSc, FACMI, FACEP, for his exemplary service, leadership, and commitment to the College and the specialty of emergency medicine.

Action: A framed resolution was presented to Dr. Finnell.

Resolution 3 Commendation for Mary Ellen Fletcher, CPC, CEDC, CAE

RESOLVED, That the American College of Emergency Physicians commends Mary Ellen Fletcher, CPC, CEDC, CAE, for her outstanding service and dedication to the College and the specialty of emergency medicine and extends heartfelt gratitude and appreciation for her extraordinary contributions.

Action: A framed resolution was presented to Ms. Fletcher.

Resolution 4 Commendation for Christopher S. Kang, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Christopher S. Kang, MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

Action: A framed resolution was presented to Dr. Kang.

Resolution 5 Commendation for Rami R. Khoury, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Rami R. Khoury, MD, FACEP, for his outstanding service, leadership, and commitment to the College, the specialty of emergency medicine, and the patients we serve.

Action: A framed resolution was presented to Dr. Khoury.

Resolution 6 Commendation for Shari Purpura

RESOLVED, That the American College of Emergency Physicians commends Shari Purpura for her outstanding service and commitment to the College, its chapters, and the specialty of emergency medicine.

Action: A framed resolution was sent to Ms. Purpura.

Resolution 7 In Memory of Neal F. Aulick, II, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Neal Aulick, II, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians, the Ohio Chapter, the Pennsylvania College of Emergency Physicians, and the West Virginia College of Emergency Physicians extends to his wife Ginger of 33 years, and his daughters Afton and Harper Aulick, gratitude for his service as an emergency physician at multiple hospitals in Ohio, Pennsylvania, and West Virginia, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Aulick's family.

Resolution 8 In Memory of Marilyn J. Gifford, MD

RESOLVED, That the American College of Emergency Physicians and the Colorado Chapter extend to Marilyn J. Gifford, MD's son, Eric Caplan, MD, and his wife Melissa Ewer, MD, son Brian Caplan, JD, and his wife Christina, brother Steve Gifford, and his wife Mimi, her five grandchildren Connor, Carson, Alaina, Piper, and Relic, other family members, friends and colleagues, condolences and profound gratitude for her advocacy to Emergency Medical Services and her commitment to the specialty of emergency medicine

Action: A framed resolution was presented to Dr. Gifford's family.

Resolution 9 In Memory of Veronica Greer, MD

RESOLVED, That the American College of Emergency Physicians hereby honors the memory of Veronica Greer, MD, for her exceptional contributions to the field of emergency medicine, her inspiring leadership, and her unwavering dedication to education and patient care; and be it further

RESOLVED, That ACEP extends its deepest sympathies to the family, friends, and colleagues of Veronica Greer, MD, acknowledging that though she may be gone, her legacy as a friend, mentor, and role model will live on in perpetuity.

Action: A framed resolution was sent to Dr. Greer's family.

Resolution 10 In Memory of Christopher H. Linden, MD, FACEP

RESOLVED, That the American College of Emergency Physicians honors the life and legacy of Christopher H. Linden, MD, FACEP, expressing our deepest condolences to his family and all who loved him and acknowledging his remarkable achievements and the profound impact he had on the fields of emergency medicine and medical toxicology and the lives of those fortunate enough to have known him

Action: A framed resolution was sent to Dr. Linden's family.

Resolution 11 In Memory of Gregory L. Walker, MD, FACEP

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians recognize the outstanding dedication and contribution of Gregory L. Walker, MD, FACEP, to the specialty of emergency medicine as a clinician, partner, educator, leader, and advocator; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extend to the family of Gregory L. Walker, MD, FACEP, especially his sons Andy and Sam, his colleagues, partners, former residents, and all friends, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of emergency medicine in Michigan, where his impact will be felt for generations to come.

Action: A framed resolution was sent to Dr. Walker's family.

Resolution 12 In Memory Jesse A. Weigel, MD, FACEP

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Jesse A. Weigel, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his children Karen Weigel, Kevin Weigel, and Jennifer Hudson gratitude for his service as an emergency physician as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Weigel's family.

Resolution 13 Allocation of Councillors – Bylaws Amendment (as amended)

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

Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the **average** membership roll~~s~~ of the College ~~on December 31~~ **of the preceding** ~~**during the**~~ **calendar year**. **The average will be calculated by using the count of primary members in each chapter** ~~**at midnight**~~ **on the first day of the month then adding together each month's total and dividing by 12.** However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies.

Action: The Bylaws were updated and are available on the ACEP website. Membership staff were informed of the new procedure to use when calculating councillor allocations beginning in 2025. Chapters were notified that the new procedure will be implemented beginning in January 2025. The councillor allocations for 2025 were determined using the prescribed calculation procedure. The total councillor allocation for the 2025 Council meeting is 436 based on the average total membership as of December 31, 2024. This is 14 additional councillors than were allocated for the 2024 meeting. The following chapters gained one councillor for 2025: Arkansas, California, Colorado, Florida, Government Services, Kansas, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Virginia, and West Virginia. No chapter lost any councillors based on the average membership calculation. Under the prior allocation method, based on the total membership of the chapter as of December 31, the total councillor allocation would have been 430. The following chapters would have gained one councillor: Alaska, Arkansas, California, Florida, Kansas, New Jersey, North Carolina, Ohio, Oklahoma, and West Virginia. The Government Services Chapter would have gained 2 councillors. The following chapters would have lost one councillor: Connecticut, Idaho, Illinois, and Maryland.

Resolution 14 College Parliamentary Authority - Bylaws Amendment (as amended)

RESOLVED, That the ACEP Bylaws, Article XIV –Miscellaneous, Section 3 – Parliamentary Authority, be amended to read:

The parliamentary authority for meetings of the College shall be **the ~~most recent~~ current edition** of ~~***The Standard Code of Parliamentary Procedure (Sturgis)***~~ ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure***, except when in conflict with the Bylaws of the College or the Council Standing Rules.

Action: The Bylaws were updated and are available on the ACEP website.

Resolution 16 International Members Serving as Section Officers - Bylaws Amendment

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

Any physician interested in emergency medicine who is not a resident of the United States or a possession thereof, and who is licensed to practice medicine by the government within whose jurisdiction such physician resides and practices, shall be eligible for international membership. All international members will be assigned by the Board of Directors to either active or inactive status. Members who qualify will additionally be assigned to life status.

International members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

Any international member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain life status.

~~International members may not hold office and may not serve on the Council. International members, with the exception of those in inactive status, may vote in committees on which they serve.~~

International members may not seek election to or serve on the national Board of Directors, may not seek election to or serve as Council Speaker or Council Vice Speaker, may not serve as a councillor or alternate councillor, and may not serve on a Council committee. With the exception of those in inactive status, international members may serve as voting members of College committees to which they are appointed but may not serve as committee chairs, may participate as voting members in sections of membership, and may serve as a section officer except for the positions of councillor and alternate councillor.

Action: The Bylaws were updated and are available on the ACEP website. Committee and section staff liaisons were informed of the Bylaws change.

Resolution 17 Removing Gendered Pronouns from ACEP's Bylaws – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 3 – Qualifications be amended to read:

The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter's jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to a new chapter, dues for the new chapter shall not be required until the member's next anniversary date.

A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who

retires from medical practice regardless of membership class and changes ~~his/her~~ state of residence may retain membership in a chapter of prior professional practice/residence.; and be it further

RESOLVED, That the ACEP Bylaws Article IX – Board of Directors, Section 2 – Composition and Election be amended to read:

Election of Directors shall be by majority vote of the Councillors present and voting at the annual meeting of the Council.

The Board shall consist of 12 elected directors, plus the president, president-elect, immediate past president, and chair if any of these officers is serving following the conclusion of ~~his or her~~ **an** elected term as director. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council. In no instance may a member of the Board of Directors sit as a member of the Council.; and be it further

RESOLVED, That the ACEP Bylaws Article X– Officers/Executive Director, Section 7 – Vice President be amended to read:

"The vice president shall be a member of the Board of Directors. A director shall be eligible for election to the position of vice president if ~~he or she has~~ at least one year ~~remaining~~ **remains** as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The vice president's term of office shall begin at the conclusion of the meeting at which the election as vice president occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected"; and be it further

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 9 – Secretary-Treasurer be amended to read:

A director shall be eligible for election to the position of secretary-treasurer if ~~he or she has~~ at least one year ~~remaining~~ **remains** on the Board as an elected director and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The secretary-treasurer's term of office shall begin at the conclusion of the meeting at which the election as secretary-treasurer occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No secretary-treasurer may serve more than two consecutive terms.; and be it further

RESOLVED That the ACEP Bylaws Article XI – Committees, Section 5 – Finance Committee be amended to read:

The Finance Committee shall be appointed by the president. The committee shall be composed of the president-elect, secretary-treasurer, speaker of the Council or ~~his/her~~ **the speaker's** designee, and at least eight members at large. The chair shall be one of the members at large. The Finance Committee is charged with an audit oversight function and a policy advisory function and may be assigned additional objectives by the president. As audit overseers, the committee performs detailed analysis of the College budget and other financial reports ensuring due diligence and proper accounting principles are followed. In addition, expenses incurred in attending official meetings of the Board, shall be reimbursed consistent with amounts fixed by the Finance Committee and with the policies approved by the Board.; and be it further

RESOLVED, That the ACEP Bylaws Article XV – Mandatory Indemnification, Section 3 – Non-Exclusive; Continuation) be amended to read:

The indemnification provided by this Article XV shall not be deemed exclusive of any other rights to which the person claiming indemnification may be entitled under any agreement or otherwise both as to any action in ~~his or her~~ **the individual's** official capacity and as to any action in another capacity while holding such office, and shall continue as to a person who shall have ceased to be a Director, Officer, or Employee of the College engaged in any other enterprise at the request of the College and shall inure to the benefit of the heirs, executors and administrators of such person.

Action: The Bylaws were updated and are available on the ACEP website.

Resolution 22 Support for the "Well Workplace" Policy Statement – *first resolved*

RESOLVED, That ACEP promote, advertise, and support the best practices as defined in the "Well Workplace" policy statement.

Action: Assigned to communications staff to promote the policy statement. The policy statement was featured on the front page of the ACEP website and highlighted in multiple issues of the *EM Today* email newsletter distributed to members.

The Well-Being Committee was assigned an objective to create a process for recognizing organizations that adhere to the ACEP "Well Workplace" policy statement. The nomination form for the Emergency Medicine Center of Wellness award was updated to include a link to the "Well Workplace policy statement" and for nominators to indicate the components of the policy statement utilized by the institution.

Many components of the policy statement are incorporated in the ED Accreditation criteria. Assigned the ED Accreditation Board of Governors to review the policy statement to ensure the components are included as the accreditation criteria continue to be developed.

Resolution 24Address ED Boarding and the Medicare Three-Midnight Rule for Post-Acute Rehabilitation

RESOLVED, That the American College of Emergency Physicians prioritize advocacy to have the Medicare three-midnight rule for skilled nursing placement removed.

Action: Assigned to Advocacy & Practice Affairs staff to continue federal advocacy initiatives. Elimination of the three-midnight rule has been a priority on ACEP's legislative and regulatory agenda for the past 20 years and continues to be a priority for ACEP's advocacy initiatives. ACEP has supported every Congressional proposal and related regulatory action or proposal to rescind or ameliorate the rule's effects by at least counting time in observation toward the three-day requirement. ACEP currently supports the Improving Access to Medicare Coverage Act (H.R. 5138/S. 4137) to count time spent under observation status towards the three-day hospital stay for coverage of skilled nursing care, and establish a 90-day appeal period following passage for those that have a qualifying hospital stay and have been denied skilled nursing care after January 1, 2024. This bipartisan, bicameral legislation was introduced in the current 118th Congress by U.S. Representatives Joe Courtney (D-CT), Glenn Thompson (R-PA), and others, and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), and Sheldon Whitehouse (D-RI). The legislation remains a priority for ACEP's federal advocacy. ACEP is also a member of a larger coalition solely focused on addressing this issue. While there is significant industry and stakeholder support for changing this policy, Congress has not yet acted on this legislation. However, as there is now a greater body of evidence from the pandemic experience that revising the three-day stay rule leads to better outcomes for patients without increasing costs, ACEP and coalition advocates have renewed the push for Congress to take up and pass this legislation. ACEP also identified removal of the three-midnight rule as a key policy solution for addressing ED boarding in the Policy Solutions to ED Boarding document, a document that guides ACEP advocacy strategies.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress included "Encourage the use of waivers to restrictive payment policies such as telehealth and the 3-day SNF rule, as appropriate, based on experience from waivers granted during the COVID-19 public health emergency."

Elimination of the three-day rule continues to be a priority for ACEP for the past 20 years. ACEP has supported every congressional proposal and related regulatory action to rescind or ameliorate the rule's effects, including the bipartisan Improving Access to Medicare Coverage Act (H.R. 3954/S. 4641), which would count time spent under observation status toward the three-day requirement. Although there is significant industry and stakeholder support for changing this policy, Congress has not yet acted on this legislation. Legislators and advocates had hoped that CMS would make the COVID-19 public health emergency waiver permanent, but CMS indicated it did not have the authority to do so, and the waiver expired with the end of the public health emergency declaration in May 2023. As there is now a greater body of evidence from the pandemic experience that revising the three-day stay rule leads to better outcomes for patients without increasing costs, ACEP and coalition advocates have renewed the push for Congress to act.

Another resolution pertaining to the three-day rule was submitted to the 2026 Council for consideration.

Resolution 25 Boarding – Follow the Money

RESOLVED, That ACEP collaborate with relevant stakeholders including the AMA, hospital associations, nursing associations, patient groups, and others to propose legislation that would adequately fund health care from the emergency department to hospital discharge and chronic care facility placement if necessary for all patients admitted to observation and inpatient status from the emergency department.

Action: Assigned to Advocacy & Practice Affairs staff to initiative discussions with relevant stakeholders, as directed in the resolution, to pursue proposing federal legislation.

The Emergency Medicine Policy Institute (EMPI) Board of Directors commissioned RAND to conduct a new study of emergency medicine to focus on the value of emergency care, evaluate impediments to ED resources and capacity, trends in emergency medicine reimbursement, and propose new innovative funding strategies for emergency care. The report, "Strategies for Sustaining Emergency Care in the United States," was released in April 2025.

In the 119th Congress, ACEP secured introduction of new ACEP-developed bipartisan legislation based upon the output of the boarding summit and AHRQ roundtable, introduced by Reps. John Joyce (R-PA) and Debbie Dingell (D-MI) and Senators Chris Coons (D-DE), Dave McCormick (R-PA), and Angus King (I-ME). The bill, the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act," utilizes existing an existing federal health data

modernization grant to support development and implementation of real-time hospital bed tracking and hospital capacity management systems with a focus on ED boarding, supports innovative care models through Medicare pilot programs focused on improving geriatric emergency care and psychiatric emergency care and transfers, and commissions a GAO study to identify best practices for hospital capacity tracking and its effect on boarding, wait times, and EMS offload delays.

The Centers for Medicare & Medicaid Services (CMS) finalized the new *Emergency Care Access and Timeliness* quality measure in the Calendar Year 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule. This measure represents a critical step toward confronting the dangerous and pervasive problem of hospital patients boarding in emergency departments (EDs).

Addressing boarding continues to be a priority for ACEP. Two additional resolutions pertaining to boarding were submitted to the 2026 Council for consideration.

Resolution 26 Ensuring Hospitals Consider Contributions of Boarding and Crowding to Safety Events (as amended)

RESOLVED, That ACEP advocate for and support the development of policies that will ensure appropriate consideration of context of contemporaneous boarding and overcrowding during Root Cause Analysis and related patient safety processes in hospitals; and be it further

RESOLVED, That ACEP commit resources for establishing best practices and assisting hospitals with considering relevant corrective actions for medical errors committed as a result of ED overcrowding; and be it further

RESOLVED, That ACEP provide a written proposal to The Joint Commission and other relevant accrediting organizations suggesting a revision to the framework for Root Cause Analysis and corrective actions that includes emergency department and hospital capacity constraints and overcrowding as a "Root Cause Type" and "Causal Factor" as part of the root cause analysis.

Action: Assigned to the Quality Improvement & Patient Safety Committee (QIPSC) to develop a policy statement and other resources to address the first and second resolveds. Assigned third resolved to Advocacy & Practice Affairs staff to work with the Quality Improvement & Patient Safety Committee to develop the proposal to submit to The Joint Commission and other relevant accrediting organizations.

The QIPSC developed a policy statement to address the first and second resolveds. The policy statement highlights the negative effects of hospital crowding on both caregivers and patients, emphasizes the importance of root cause analysis (RCA) in identifying systemic factors that lead to safety events, and advocates for boarding and crowding to be included in every RCA and related findings incorporated into corrective action plans. The Board of Directors approved the policy statement "Hospital Boarding and Crowding Must Be Included in Formal Event Reviews and Quality Improvement Processes" at their January 2026, meeting.

Resolution 29 Minimum Standards for Freestanding Emergency Departments (as substituted)

RESOLVED, That ACEP promote the maintenance of more specific minimum standards for freestanding emergency departments (FSEDs) pertaining to appropriate staffing, lab, security, service availability, and imaging capabilities, and update the FSED policy statement accordingly.

Action: ACEP's "Freestanding Emergency Departments" policy statement addresses some of the standards requested, including staffing by appropriately qualified emergency physicians, adequate medical and nursing personnel, and provision of stabilizing treatment by any FSED that presents itself as an ED. ACEP has resources available on FECs on the web site, including an information paper and the Freestanding Emergency Centers Section newsroom.

Assigned to the Emergency Medicine Practice Committee to collaborate with the Freestanding Emergency Centers Section to review the policy statement and provide recommendations to the Board of Directors regarding potential revisions.

Assigned to the State Legislative/Regulatory Committee to review state laws and regulations related to FSEDs.

Resolution 30 Hospital Network Requirements for Emergency Physicians

RESOLVED, That ACEP formally request that appropriate federal government agencies investigate whether health insurers and hospitals violate antitrust or other laws by requiring emergency physicians to be in-network as a condition for an emergency professional service contract.

Action: Assigned to Advocacy & Practice Affairs staff.

Resolution 32 Preventing Harmful Health Care Deals (as amended)

RESOLVED, That ACEP advocate for legislation that would require health systems to file notice with regulatory agencies before completing critical transactions – including but not limited to sale-leaseback agreements, purchases or sales of health system facilities or real estate, dividend recapitalization, private practice rollups, and changes in majority owner equity stakes – to protect the integrity of health systems and maintain competitive markets.

Action: Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives. Assigned to the State Legislative/Regulatory Committee to develop a policy statement addressing competitive markets and health systems.

Resolution 33 Promotion of Nursing in Emergency Medicine (as amended)

RESOLVED, That ACEP collaborate with relevant organizations and stakeholders to look at models including, but not limited to incentivized pay structures, to recruit and maintain nursing staff in emergency medicine, in alignment with our organization's beliefs and policies, to maintain a safe standard of care for our patients.

Action: Assigned to Advocacy & Practice Affairs staff to discuss strategies and collaboration with the Emergency Nurses Association.

Resolution 34 Reimbursement for Emergency Physician Services Provided Out-of-Hospital

RESOLVED, That ACEP collaborate with other stakeholders to investigate ways to establish EMS physician reimbursement pathways.

Action: Assigned to the Reimbursement Committee to collaborate with the EMS Committee and develop strategies to address the resolution.

Resolution 35 Sharing of Protected Health Information

RESOLVED, That ACEP provide guidance to members on legally and operationally sound practices for sharing of protected health information; and be it further

RESOLVED, That ACEP encourage hospital systems to improve the education of relevant employees regarding the legality and appropriateness of accessing and/or sharing protected health information with emergency physicians actively engaged in patient care.

Action: Assigned to the Medical-Legal Committee to develop a policy statement.

Resolution 36 Reform to Improve Patient Access to Necessary Care (as substituted)

RESOLVED, That ACEP collaborate with the Arizona and Connecticut Chapters and others to develop model state policy, regulation, and legislation, that requires reporting of ED/hospital crowding and interhospital transfer data to a relevant state entity (e.g. State Department of Health) and develop a state-wide system to facilitate interfacility transfers.

Action: Assigned to the State Legislative/Regulatory Committee.

Resolution 37 Reinforcing EMTALA in Pregnancy Related Emergency Medical Care

RESOLVED, That ACEP develop a policy statement that delineates:

- EMTALA applies to all emergency medical conditions and there should be no exceptions to EMTALA for any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a patient.
- ACEP supports that the decision to provide any procedure in the course of patient care to satisfy EMTALA requirements, including, but not limited to, abortion care and/or pregnancy termination, be made between the patient and the emergency clinician, and that laws and regulations should not inhibit or obstruct the patient-physician relationship.
- ACEP reinforces the need for emergency physicians to be able to provide care at the standard required by medical best practices and that no procedure or treatment be removed from those treatment options in the care of emergency patients served under federal EMTALA protections.

Action: Assigned to the Medical-Legal Committee.

Resolution 38 Termination of Pregnancy (as substituted)

RESOLVED, That ACEP will work with the federal government and support chapters in working with their state government entities, along with other relevant stakeholders, to ensure all patients have access to the full spectrum of

evidence-based prenatal, peripartum, and postpartum physical and mental health care, including but not limited to termination of pregnancy of a non-living fetus, a fetus with no hope of survival, or to protect the health or life of a pregnant person.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. ACEP's legislative and regulatory priorities for the first session of the 119th Congress include: "Enact liability immunity for physicians providing EMTALA-mandated services, with considerations for reproductive health and patient safety related emergencies." (legislative strategy) and "Monitor new guidance and proposed regulations released by the Administration on reproductive health and patient safety related emergencies." (regulatory strategy)

Assigned to the State Legislative/Regulatory Committee to compile resources for chapters to use in advocating for access to reproductive health care in alignment with existing ACEP policy.

Resolution 39 Urgent Care Transparency on Available Resources and Credentials

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing what resources are or are not available at a given time; and be it further

RESOLVED, That ACEP advocate for legislation requiring signage visible to patients prior to entering urgent care centers, listing the credentials of care providers on site (i.e., physician, physician assistant, nurse practitioner, with or without physician on site).

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Assigned the Urgent Care Task Force to review ACEP's "Urgent Care Centers" policy statement and determine if any revisions are needed. The task force submitted its final report to the Board in September 2025 and did not recommend any changes to the policy statement. The Board filed the task force report and will determine the disposition of the recommendations in the final report.

Resolution 41 Workplace Violence (in lieu of Resolutions 41 and 42) (as amended)

RESOLVED, That ACEP advocate for all emergency departments to preserve and protect the accurate reporting of each workplace violence incident while preserving employee confidentiality without repercussion or recrimination for employment purposes; and be it further

RESOLVED, That ACEP officially work with the Occupational Safety and Health Administration, the Department of Justice, and other relevant stakeholders to advocate for national legislation that standardizes the prevention and the response to harmful acts of violence on health care workers in emergency departments.

Action: This tenets of this resolution are addressed in the proposed "Safety from Violence for Healthcare Employees (SAVE) Act" legislation. Assigned to Advocacy & Practice Affairs staff to continue advocacy initiatives in support of the SAVE Act and/or other legislation and continue working with OSHA. ACEP's legislative and regulatory priorities for the first session of the 119th Congress include: "Advocate for passage of bills to address violence against health care workforce and for increased safety measures in the ED and secure new congressional champions." (legislative strategy) and "Continue to follow-up with OSHA regarding the development of standards for workplace violence in health care that appropriately take into account the unique factors of dealing with violent episodes in the emergency department." (regulatory strategy)

In January 2026, ACEP and a coalition of health care organizations sent a letter urging the Centers for Medicare & Medicaid Services (CMS) to issue guidance that facilitates the posting of signage in emergency departments (EDs) discouraging violence.

ACEP created a Workplace Violence in the Emergency Department toolkit that can help chapters in advocating for legislation addressing violence against health care workers. The toolkit includes state-level solutions that can be helpful in the emergency department and to EMS professionals.

Resolution 43 Addressing Challenges Related to the New ABEM Oral Board Exam Format (as substituted) – *resolveds 2,3, and 4*

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to explore additional testing sites to reduce travel costs and minimize time zone impacts for candidates; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to implement a fee structure for the new oral board examination to improve affordability and accessibility for all candidates, including differentiating between early career attendings and fellows; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to ensure oral board candidates will not bear undue financial burdens related to the newly proposed ABEM Oral Boards Update for 2026.

Action: Continue dialogue with ABEM for potential solutions to address the resolution. ABEM submitted a response to the resolution and it was discussed by the ACEP Board of Directors during the March 19, 2025, meeting.

- ABEM acknowledges the travel costs associated with the new Continuing Examination (CE) and currently uses the AIME Center in Raleigh, which is equipped for high-stakes testing with expert staff, trained standardized patients, and simulation capabilities. No regional alternative yet matches this standard, but ABEM is open to considering any site that can., ABEM is developing a system to improve scheduling flexibility that will randomly assign candidates to an exam administration that allow them to select their specific day and session (morning or afternoon) on a first-come, first-served basis once registration opens. ABEM is considering giving West Coast candidates earlier access to session selection based on their registered address, possibly using a time zone-based system where those farthest from Raleigh register first. ABEM continues to explore ways to enhance fairness, flexibility, and accessibility.
- ABEM will continue to maintain their philosophy of keeping certification fees for both primary EM and subspecialties low. These fees have remained low for over 10 years. ABEM will continue its commitment to keeping fees low for early career attendings and fellows.
- The fee for the Oral Certification Examination is $1,255. This fee will not be increased for the last three administrations of the Oral Certification Exam in 2025. Moreover, ABEM has committed to not raising initial certification fees for the first three years of the Certifying Exam. Currently, of the 14 ABMS specialties that require an oral examination for certification, the ABEM oral examination is the third least expensive. Travel to the testing center is variable depending on the cost of airfare. Affordable lodging is conveniently near the testing center. ABEM will negotiate with local hotels to offer candidates reasonable hotel costs.

The ACEP Board will continue discussions with ABEM regarding the concerns from members.

Resolution 44 Building the Rural Emergency Medicine Workforce by Expanding Access to Rural Resident Rotations (as amended)

RESOLVED, That ACEP continue to advocate for additional critical access hospital funding to cover the salary, housing, and travel costs of emergency medicine resident rotations at rural Critical Access Hospitals; and be it further

RESOLVED, That ACEP support the Rural Emergency Medicine Section in maintaining a central "Rural Rotation List" to be managed by the ACEP Rural Emergency Medicine Section and shared with the Council of Residency Directors in Emergency Medicine; and be it further

RESOLVED, That ACEP request that the Accreditation Council for Graduate Medical Education encourage all emergency medicine residencies to offer at least one rural emergency medicine clinical elective.

Action: Assigned first resolved to Advocacy & Practice Affairs staff for federal advocacy initiatives. ACEP's legislative and regulatory priorities for the first session of the 119th Congress included: "Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs." (legislative strategy)

Assigned second and third resolveds to the Academic Affairs Committee to work with the Rural Emergency Medicine Section and integrate into ACEP's response to the ACGME requirements.

Resolution 45 Climate Change Research and Education in Emergency Medicine (as amended)

RESOLVED, That ACEP encourage and support comprehensive research efforts on the health effects of climate change and the pivotal role of emergency medicine in mitigating and responding to these effects; and be it further

RESOLVED, That ACEP call for and promote initiatives to facilitate data collection on climate-related health emergencies, such as heat-related illnesses, vector-borne diseases, and extreme weather events, to inform evidence-based interventions, strengthen disaster preparedness, and enhance the capacity to respond effectively to climate change-induced health challenges; and be it further

RESOLVED, That ACEP support the introduction of curricula that address climate change in medical schools and residency programs.

Action: ACEP's policy statement "Impact of Climate Change on Public Health and Implications for Emergency Medicine" partially addresses the resolution. The Public Health Committee reviewed the policy statement and determined that no changes were needed to support the resolution. The committee is working on developing a Policy Resource & Education Paper (PREP), in collaboration with the Ethics Committee, as an adjunct to the policy statement and will include information about the ethical issue and duty of emergency physicians to respond as stewards of the environment that supports the health of patients.

The Academic Affairs Committee provided information to the American Board of Emergency Medicine regarding climate change information to include in the next update of "The Model of the Clinical Practice of Emergency Medicine."

Resolution 46 Human Trafficking Training for All Emergency Medicine Residents (as amended)

RESOLVED, That ACEP develop training presentations and resources for identification of human trafficking that can be used at all institutions and included at Scientific Assembly.

Action: Assigned to the Public Health Committee to develop the training materials and work with ACEP's Education staff on courses and materials to include at Scientific Assembly. Utilize ACEP Anytime to disseminate courses and training materials.

Resolution 47 Human Trafficking is a Public Health Crisis (as amended)

RESOLVED, That ACEP declare human trafficking a public health crisis in the United States and revise ACEP's policy statement on human trafficking.

Action: Assigned to the Public Health Committee to revise the "Human Trafficking" policy statement. The Board of Directors approved the revised policy statement at their September 4, 2025, meeting.

Resolution 48 Alarm Fatigue (as amended)

RESOLVED, That ACEP collaborate with stakeholders to identify evidence-based solutions to address alarm fatigue in the emergency department setting, with topics including indications for clinical monitoring devices in the emergency department and appropriate silencing of clinical alarms including when latching (silencing the alarm after the initial alert) is appropriate.

Action: Assigned to the Quality & Patient Safety Committee develop a strategy to address the resolution, such as an information paper or best practice reference document or guideline.

Resolution 49 Centralized Repository of Credentialing Data (as amended)

RESOLVED, That ACEP advocate for the establishment of a centralized repository of verified primary source documents, work history, case logs, certificates of insurance, and other materials; and be it further

RESOLVED, That ACEP work with the American Medical Association, the American Osteopathic Association, the Federation of State Medical Boards, The Joint Commission, American Hospital Association, state agencies, and other interested parties to establish a recognized centralized repository of verified credentialing documents that can be used by all hospitals in the process of credentialing and privileging physicians at their facility that requires a minimum amount of additional submissions by physicians applying for privileges.

Action: Assigned first resolved to Advocacy & Practice Affairs staff for advocacy initiatives. Assigned to the AMA Section Council on Emergency Medicine to review and consider submitting a resolution to the AMA.

Resolution 50 Communication to Established Patients Being Referred to the Emergency Department (as amended)

RESOLVED, That ACEP work with other stakeholders to develop a strategy to address the problem of patients with terminal or end stage diseases being referred to the ED for education and disposition of expected prognosis and disease progression of which they and their families were not educated by the physicians responsible for doing so.

Action: Assigned to the Emergency Medicine Practice Committee to work with the Palliative Care Section to develop a strategy to address the resolution.

Resolution 54 Mandated Public Health Screening (as amended)

RESOLVED, That ACEP work with relevant stakeholders, including but not limited to departments of health, accreditation bodies, and hospital systems, to prioritize the acute care and evaluation of emergent patients and not require routine unrelated screenings in the emergency department without adequate resources, funding and supports; and be it further

RESOLVED, That ACEP develop a policy statement noting that mandating the emergency department to offer public health disease screening and behavioral health screening outside of the reason for the acute visit in the emergency department, without adequate resources, funding and supports, has unintended consequences on workflow and care of emergency department patients.

Action: Assigned first resolved to Advocacy & Practice Affairs staff for advocacy initiatives.

Assigned second resolved to the Public Health Committee to review the "Screening for Disease Factors in the ED" policy statement and determine if revisions are needed or if a new policy statement should be developed. The Board approved the revised policy statement at their September 4, 2025, meeting.

Resolution 56 Patient and Visitor Code of Conduct (as substituted)

RESOLVED, That ACEP create and implement a concise, universal code of patient and visitor conduct for emergency departments, featuring prominently displayed signage that clearly defines acceptable behavior and states that non-medical aggression may result in immediate removal.

Action: Assigned to the Public Health Committee (lead) to work with the Emergency Medicine Practice Committee and the Medical-Legal Committee. The Board of Directors approved a patient-facing poster "Emergency Department Patient & Visitor Code of Conduct" at their September 4, 2025, meting.

Resolution 57 Rationalizing Communication of Imaging Hazards to Improve Care (as amended)

RESOLVED, That ACEP work with the American College of Radiology and other stakeholders, to develop a policy statement or other resource information on the rational communication of imaging hazards to emergency patients.

Action: Assigned to the Quality & Patient Safety Committee to develop a policy statement or other resource information as directed in the resolution.

Resolution 58 Reducing Waste in Our Emergency Departments (as amended)

RESOLVED, That ACEP encourage and support comprehensive research efforts to facilitate data collection of the measurements of emergency department waste and energy consumption; and be it further

RESOLVED, That ACEP work with stakeholders, such as hospital administrations, to decrease energy consumption and decrease the amount of hospital waste such as general trash, unused disposables, true plastics, micro plastics, and non-recycled glass, as well as biohazard/medical waste.

Action: Assigned to the Public Health Committee to review existing resources and develop a policy statement with input from other stakeholders as identified in second resolved. The committee developed the policy statement "Reducing Waste in the Emergency Department" and it was approved by the Board June 11, 2026.

Resolution 59 Tap Water is Sufficient Treatment

RESOLVED, That ACEP advocate to transition to hospital tap water in the United States for wound irrigation to decrease the carbon footprint of emergency departments contributing to global efforts to combat climate change; and be further

RESOLVED, That ACEP emphasize the importance of research and education within the emergency medicine community, and to raise awareness of the financial and environmental benefits of tap water for wound irrigation in the United States highlighting its safety, efficacy, and potential for cost savings; and it further

RESOLVED, That ACEP urge policymakers and health care administrators to support initiatives that promote sustainable health care practices and to advocate for the adoption of tap water for wound irrigation in U.S. emergency settings, aligning with broader efforts to enhance environmental sustainability in health care.

Action: Assigned first and second resolveds to the Public Health Committee to review existing resources and consider developing a policy statement. The committee developed the policy statement "Reducing Waste in the Emergency Department" and it was approved by the Board June 11, 2026.

Assigned third resolved to Advocacy & Practice Affairs staff for advocacy initiatives.

Resolution 60 Lethal Means Firearm Counseling (as amended)

RESOLVED, That ACEP develop resources for ACEP members to provide evidence-based lethal means safety counseling to at risk youth; and be it further

RESOLVED, That ACEP work with other organizations to develop training for health care providers in lethal means safety training.

Action: Assigned to the Pediatric Emergency Medicine Committee to investigate available resources and enhance their availability to ACEP members. Seek input from other committees and sections as needed. The committee developed the information paper "Safety Planning for Youth in the Emergency Department Who Have Suicide Risk." The paper includes information about safety planning, including lethal means such as firearms. The committee continues to work on additional resources for members in the 2025-26 committee year .

Resolution 61 Safe Storage of Firearms (as amended)

RESOLVED, That ACEP create education to raise awareness that secure gun storage, (storing guns locked, unloaded and separate from ammunition) can save lives, can prevent theft, and can prevent access by unauthorized users who may pose a danger to themselves or others; and be it further

RESOLVED, That ACEP encourage emergency physicians and/or departments to function as messengers to patients about safe gun storage.

Action: Assigned to the Public Health Committee to develop strategies to address the resolution. Seek input from other committees and sections as needed.

Resolution 62 Stop the Bleed Education (as substituted)

RESOLVED, That ACEP promote activities that foster education and awareness of bleeding control techniques within high-risk communities including at risk youth.

Action: Assigned to the EMS Committee to develop strategies to address the resolution. The EMS Committee developed resource documents on: Stop the Bleed, Chest Compression-Only CPR, and use of Naloxone in suspected overdose for use in ACEP's advocacy with other stakeholder organizations with interest in these topics.

Resolution 63 Commendation for Todd B. Taylor, MD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Todd B. Taylor, MD, FACEP, to the advancement of emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians commends Todd B. Taylor, MD, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

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

Resolution 64 In Memory of Amy H. Kaji, MD, PhD, MPH

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Amy H. Kaji MD, PhD, MPH, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Amy H. Kaji, MD, PhD, MPH, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine, and to the patients and physicians of California and the United States.

Action: A framed resolution was sent to Dr. Kaji's family.

Resolution 65 In Memory of Joseph Sabato, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians honors the memory of Joseph Sabato, Jr., MD, FACEP, and extends its deepest sympathies to his family, friends, and colleagues and acknowledges that his legacy will continue to inspire and guide the emergency medicine community.

Action: A framed resolution was sent to Sabato's family.

Resolution 66 In Memory of Christopher J. Karns, DO

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Christopher J. Karns, DO;

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Dawn E. Beemer Karns, their three children Nathan Christopher, Carter Alexander, and Alaina Grace, his parents John and Cynthia Karns, and the rest of his family gratitude for his service as an emergency physician as well as his commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Karns' family.

Resolution 67 In Memory of Madeline Giegold, MD

RESOLVED, That the American College of Emergency Physicians and the California Chapter extend their heartfelt gratitude to the family of Madeline "Maddie" Giegold, MD, for sharing her extraordinary life with us; and be it further

RESOLVED, That the memory of Madeline "Maddie" Giegold, MD, will be cherished and her impact on emergency medicine will be felt for years to come

Action: A framed resolution was sent to Dr. Giegold's family.

Resolution 68 In Memory of Jeffery Scott Shafer, MD, FACEP

RESOLVED, That the American College of Emergency Physicians honors the memory of Jeffery Scott Shafer, MD, FACEP; and be it further

RESOLVED, That the American College of Emergency Physicians and the Illinois College of Emergency Medicine extends to his wife of 19 years Jamie, their two children Seth and Allison, his mother, Bonnie (John) Howard, his father Clyde (Trish) Shafer, his father-in-law and mother-in-law, Gary and Vicki Elis, his brother Jeremy (Staci) Shafer, step-brothers, Patrick (Tana) Howard and Steve (Angela) Benard, brother-in-law Jeremy Ellis, maternal grandmother Dorothy Farris and cherished family members gratitude for his service to the pre-hospital community and his dedication to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Shafer's family.

70(24) Reaffirming EMRA's Vital Relationship with ACEP

RESOLVED, That our American College of Emergency Physicians formally recognize the Emergency Medicine Residents' Association as our official partner representing the voice of emergency medicine physicians-in-training.

Action: ACEP has recognized EMRA and is committed to remaining in partnership with EMRA. Negotiations with EMRA are ongoing regarding various partnership initiatives. A strategic partnership agreement was signed in February 2025. ACEP and EMRA leaders continue to meet regularly.

Council Standing Rules Resolution

(Does not require action by the Board of Directors.)

Resolution 15 College Parliamentary Authority - Council Standing Rules Amendment (as amended)

RESOLVED, That the ACEP Council Standing Rules, Parliamentary Procedure (paragraph one) be amended to read as follows with the proviso that the changes will become effective after the 2024 Council meeting and only upon adoption of the companion resolution College Parliamentary Authority – Bylaws Amendment:

Parliamentary Procedure

The ~~**most recent**~~ **current** edition of ~~*Sturgis, Standard Code of Parliamentary Procedure*~~ ***The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*** will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Limiting Debate and Voting Immediately***.

Action: The Council Standing Rules were updated and are available on the ACEP Website.

Resolutions Referred to the Board of Directors

Resolution 18 ACEP Council and Scientific Assembly Meeting Location

RESOLVED, That ACEP survey the membership to obtain robust, direct member feedback on Scientific Assembly locations, including whether they would prefer a rotating or semi-permanent site, preferred and non-preferred cities, and provide input on the other factors that the College should consider when designating a conference location.

Action: Assigned to Education and Membership staff to develop a strategy for the best approach to obtain input from members regarding the location of Scientific Assembly. Staff continue to survey meeting attendees about preferred locations for Scientific Assembly. The Board of Directors will have a comprehensive, strategic discussion about future Scientific Assembly meetings during their October 2, 2026, meeting.

Resolution 21 Printable Volunteer Recognition Certificate

RESOLVED, That ACEP develop a volunteer recognition certificate for ACEP physician volunteers and leaders that can be printed and proudly displayed for interested parties.

Action: Assigned to Member Engagement and Governance Operations staff to continue to develop strategies to recognize member volunteers in their leadership roles. Volunteer leadership recognition is a priority in the new AMS that will be operational by 2027. The AMS will have the capability to create a volunteer profile that tracks volunteer activities for each member.

Resolution 27 Continuous Physician Staffing for Rural Emergency Departments (as amended)

RESOLVED, That ACEP collaborate with the American Medical Association to advocate that the Centers for Medicare and Medicaid Services (CMS) modify the "Staff and Staffing Responsibilities" Conditions of Participation for critical access and rural emergency hospitals such that a qualified, state-licensed (MD/DO/MBBS) physician be ~~required to be~~ **immediately available for** on-site ~~and available for~~ care of emergency department patients at all times.

Action: Assigned to the AMA Section Council on Emergency Medicine to review and provide a recommendation to the Board of Directors on the advisability of submitting a resolution to the AMA.

Resolution 28 Data Gathering on Freestanding EDs: Examining Regulations, Services Offered, and Staffing Policies

RESOLVED, That ACEP collect data on free standing emergency department-type facilities (FSEDs) nationally, and any state regulations specifically pertaining to them, and this may include a survey of current services and equipment offered at FSEDs in each state as well as staffing and other pertinent policies that might be helpful to ACEP chapters who may be addressing issues with these facilities.

Action: Assigned to Advocacy & Practice Affairs staff to review and provide a recommendation to the Board with a cost analysis and the advisability of implementing the referred resolution. Share the analysis with the State Legislative/ Regulatory Committee for their work in analyzing state laws and regulations related to FSEDs in response to Substitute Resolution 29(24) Minimum Standards for Freestanding Emergency Departments.

Resolution 40 Telehealth Emergency Physician Standards (as amended)

RESOLVED, That ACEP affirm that physicians providing telehealth emergency medicine be board certified or board eligible in emergency medicine, in congruence with existing ACEP policy on telehealth.

Action: Assigned to the Emergency Medicine Practice Committee to work with the Emergency Telehealth Section to review the "Emergency Medicine Telehealth" policy statement and provide a recommendation to the Board on the advisability of revising the policy statement to address the referred amended resolution. The committee submitted a revised policy statement for the Board to consider at their January 27-28, 2026, meeting. It was referred back to the committee to ensure consistency with the updated "Guidelines Regarding the Role of NPs and Pas in the Emergency Department" policy statement.

Resolution 43 Addressing Challenges Related to the New ABEM Oral Board Exam Format (as substituted) – *resolveds 1,5,6, and 7*

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to explore delaying implementation of the new oral board examination format to allow for adequate preparation by emergency medicine residency programs and graduating residents; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to provide a 5-year period after implementation during which the cost of retaking the new oral boards will be waived for those who do not pass; and be further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to develop and implement a comprehensive, candidate facing, evaluation process for the new oral board examination format to ensure that it equitably assesses communication, procedural skills, patient management, high-stakes communication, difficult conversations, patient communications beyond diagnosis, procedural skills, clinical decision making/shared decision making, team management, leadership, troubleshooting, task switching, prioritization, and continues to bring value to the public and diplomates; and be it further

RESOLVED, That ACEP continue their engagement with the American Board of Emergency Medicine to establish accommodations and alternative arrangements for candidates with health, safety, or legal concerns, who may face risks or challenges in traveling to the examination site.

Action: Continue dialogue with ABEM for potential solutions to address the resolution. ABEM submitted a response to the resolution and it was discussed by the ACEP Board of Directors during the March 19, 2025, meeting.

- Delaying the launch of the new CE is not an option. ABEM continues to promote and publish material to help inform the community, including residency programs, that may be helpful to prepare for the CE. This material includes dedicated visits to residency programs, case summaries, case video summaries, reference material, informational webinars, and scoring information. ABEM will continue to post information to help support the training community during this transition to the CE.
- In general, ABEM has been concerned about offering a waiver for retaking any exam after a candidate fails it, because it could give the appearance of rewarding failure. However, ABEM will continue to review candidate costs. If there are opportunities to mitigate financial impacts to candidates, ABEM will certainly evaluate them.
- ABEM always has been and always will be committed to criterion-based certification examinations; the examinations are not "graded on a curve." ABEM uses standard-setting to determine its criteria for passing based on a recommendation to the ABEM Board by clinically active, ABEM certified physicians. ABEM will use standard settings for the new Certifying Exam. ABEM evaluates current certification examinations. ABEM will also develop an ongoing evaluation process that will evaluate the validity, fairness, and reliability of the Certifying Examination. This internal process includes the use of equating to ensure that the difficulty of the Certifying Examination is consistent between administrations. This evaluation will also help ABEM assess the opportunities to enhance cases and eventually add new case types, such as leadership and team management. Work is underway to publish information about content and construct validity.
- ABEM appreciated learning of the concerns of some candidates about the location of the CE in the event of a medical emergency while at the exam. ABEM has established a partnership with Wake Emergency Physicians PA (WEPPA) in Raleigh. WEPPA serves 5 hospital systems in the state including WakeMed hospital sites near the AIME center. WEPPAs physicians are ABEM-certified and committed to providing high-quality emergency care to any candidate or examiner attending the CE in Raleigh. Candidates and examiners from other Boards who have administered their examination at the AIME Center have not had any issues receiving care when needed.

The ACEP Board will continue discussions with ABEM regarding the concerns from members.

Resolution 52 Delegation of Critical Care to Non-Physician Practitioners

RESOLVED, That ACEP revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department"[6] policy statement to include that:

1. Emergency physicians should retain primary responsibility for performing critical care activities within emergency departments to ensure that practitioners possess the requisite knowledge, skills, and experience to manage critical care scenarios effectively; and
2. Credentialing processes must prioritize patient safety and quality of care, ensuring that physicians and non-physician practitioners are granted privileges to manage patients commensurate with their training; and
3. The scope of practice for nurse practitioners and physician assistants in emergency departments should be clearly defined, focusing on roles where their training and expertise can complement but not substitute for the specialized skills of emergency physicians in critical care.

Action: Assigned to the Emergency Medicine Practice Committee to review the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement and provide a recommendation to the Board on the advisability of revising the policy statement to address the referred resolution. The committee revised the policy statement to include language regarding critical care supervision and procedural interventions for physician assistants and nurse practitioners to be tailored to the skills and education of the individual. The revised policy statement was approved by the Board of Directors at their January 27-28, 2026, meeting.

Resolution 53 Emergency Nursing and Emergency Department Accreditation

RESOLVED, That ACEP collaborate with relevant organizations to amend and include requirements for emergency nursing within the tiered levels of the ACEP ED accreditation pathway.

Action: Assigned to the Emergency Department Accreditation Program Board of Governors to review and provide a recommendation on the advisability of implementing the referred resolution.

Resolution 69 Updating ACEP's Position on PA and NP Supervision in the ED

RESOLVED, That ACEP amend by deletion its "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to read:

~~"ACEP Acknowledges that there are currently workforce limitations in specific CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means as follows:~~

- ~~Critical Access Hospitals (CAHs)~~
- ~~Rural Emergency Hospitals (REHs)~~

Action: The Board of Directors discussed the referred resolution on October 28, 2024, and approved removing the language from the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department."

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2026 Council

From: Sonja Montgomery
Governance Operations Director

Date: September 14, 2026

Subj: Action on 2023 Resolutions

The 2023 Council considered 62 resolutions: 46 adopted, 10 were not adopted, and 7 were referred to the Board of Directors. There were 2 Bylaws resolutions, 7 commendation resolutions, and 12 memorial resolutions.

Note: The first resolved of Amended Resolution 39 was adopted and the second resolved was referred to the Board of Directors.

The attached report summarizes the actions taken on the 2023 resolutions adopted by the Council and those that were referred to the Board of Directors.

The updated actions are also available on the ACEP website.

Reminder: Scroll to the end of each resolution to see amended or substituted language and to see the implementation action.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Action on 2023 Council Resolutions

Resolution 1 Commendation for Patrick Elmes, EMT-P

RESOLVED, That the American College of Emergency Physicians commends Patrick Elmes, EMT-P, for his outstanding service and commitment to the College and the specialty of emergency medicine.

Action: A framed resolution was presented to Mr. Elmes.

Resolution 2 Commendation for Kelly Gray-Eurom, MD, MMM, FACEP

RESOLVED, That the American College of Emergency Physicians commends Kelly Gray-Eurom, MD, MMM, FACEP, for her service as Council Speaker, Council Vice Speaker, and for her enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Dr. Gray-Eurom.

Resolution 3 Commendation for Russell H. Harris, MD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Russell H. Harris, MD, FACEP, to the advancement of emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians commends Russell H. Harris, MD, FACEP for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

Action: A framed resolution was presented to Dr. Harris.

Resolution 4 Commendation for Rick Murray, EMT-P, FAEMS

RESOLVED, That the American College of Emergency Physicians commends Rick Murray, EMT-P, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, and the subspecialty of emergency medical services.

Action: A framed resolution was presented to Mr. Murray.

Resolution 5 Commendation for Gillian R. Schmitz, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Gillian R. Schmitz, MD, FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the patients and communities we serve.

Action: A framed resolution was presented to Dr. Schmitz.

Resolution 6 Commendation for JoAnne Tarantelli

RESOLVED, That the American College of Emergency Physicians commends and thanks JoAnne Tarantelli for her outstanding career and decades of dedicated service, leadership, commitment to the College, the emergency physicians of New York, the specialty of emergency medicine, and the patients that we serve.

Action: A framed resolution was sent to Ms. Tarantelli.

Resolution 7 In Memory of Clifford Findeiss, MD

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the contributions of a trailblazing pioneer, visionary leader, invaluable mentor, and outstanding emergency physician, J. Clifford “Cliff” Findeiss, MD, and his selfless contributions to emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians extends condolences and appreciation to his wife Jean; his four sisters Marcia, Joan, Pat, and Michele; as well as his four children and his granddaughter in whom his legacy lives on: Dr. Laura Findeiss, Craig Findeiss, Amanda (Findeiss) Rosillo, Allison Findeiss, granddaughter Elizabeth

(Lily) Rosillo; and to his family, friends, and colleagues for his remarkable service to the specialty of emergency medicine, patient care, and the communities he served.

Action: A framed resolution was sent to Dr. Findeiss's family.

Resolution 8 In Memory of Scott A. Hall, MD

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments of Scott A. Hall, MD, and offer our heartfelt condolence to his wife, daughter, and the entire Hall family.

Action: A framed resolution was sent to Dr. Hall's family.

Resolution 9 In Memory of Gene W. Kallsen, MD

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to the family of Gene W. Kallsen, MD, gratitude for his tremendous service to emergency medicine.

Action: A framed resolution was sent to Dr. Kallsen's family.

Resolution 10 In Memory of Michael Kleinman, DO

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Michael Kleinman, DO, who dedicated himself to his patients, his trainees, his profession, and his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his wife Jacklyn, his sons Dr. Steve Kleinman and David Kleinman, gratitude for his tremendous service as an emergency physician at the WellSpan York Hospital, as well as for his dedication and commitment to the specialty of emergency medicine.

Action: A framed resolution was sent to Dr. Kleinman's family.

Resolution 11 In Memory of Gloria J. Kuhn, DO, PhD

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians hereby expresses their enduring appreciation to Gloria J. Kuhn, DO, PhD, as a champion for emergency medicine; and be it further

RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency Physicians extends to the family of Gloria J. Kuhn, DO, PhD, her colleagues, and former residents, our condolences along with our profound gratitude for her lifetime of service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States of America and likely beyond.

Action: A framed resolution was sent to Dr. Kuhn's family.

Resolution 12 In Memory of Richard M. Nowak, MD, MBA, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Richard M. Nowak, MD, MBA, FACEP, to the specialty of emergency medicine as a clinician, educator, researcher, scholar, and leader; and be it further

RESOLVED, That the College extends condolences to his wife, Deborah, and children, Michael and Kathryn, and he will forever endure in the minds of all who had the great opportunity to interact with him.

Action: A framed resolution was sent to Dr. Nowak's family.

Resolution 13 In Memory of Barbara W. Trainor

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her daughter Karyn Trainor and son William Trainor and his partner Patrice Pineda, her brothers David Wallace and Doug Wallace, and sisters Carolyn Wallace Dee and Melanie Wallace, and the many others she impacted, gratitude for her tremendous service to emergency medicine.

Action: A framed resolution was sent to Ms. Trainor's family.

Resolution 14 In Memory of Lori Weichenthal, MD, FACEP

RESOLVED, That the American College of Emergency Physicians, the California Chapter, and the Wellness and Wilderness Medicine Sections hereby acknowledge the many contributions made by Lori Weichenthal, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her family gratitude for her tremendous service to emergency medicine.

Action: A framed resolution was sent to Dr. Weichenthal's family.

Resolution 15 Additional Vice President Position on the ACEP Board of Directors (as amended)

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 1 – Officers, Section 2 – Election of Officers, and Section 7 – Vice President, and Article XI – Committees, Section 2 – Executive Committee, be revised to read:

ARTICLE X – OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice president**s**, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of Directors may appoint other officers as described in these Bylaws.

Section 2- Election of Officers

The chair, vice-president**s**, and secretary-treasurer shall be elected by a majority vote at the Board meeting immediately following the annual meeting. The president-elect shall be elected each year and the speaker and vice speaker elected every other year by a majority vote of the councillors present and voting at the annual meeting.

Section 7 – Vice President**s**

There shall be two vice president positions. The vice president**s** shall be ~~a~~ member**s** of the Board of Directors. A director shall be eligible for election to ~~the~~ **a** position of vice president if he or she has at least one year remaining as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. ~~The~~ **A** vice president's term of office shall begin at the conclusion of the meeting at which the election as **a** vice president occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected.

ARTICLE XI – COMMITTEES

Section 2 – Executive Committee

The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice president**s**, secretary-treasurer, immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board**,** subject to ratification by the Board at its next meeting.

Meetings of the Executive Committee shall be held at the call of the chair or president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.**; and be it further**

RESOLVED, That the additional vice president position on the ACEP Board of Directors be implemented in a budget neutral manner.

Action: The Bylaws were updated. The Board elected both vice president positions on October 12, 2023. The Compensation Committee presented their recommendation to the Board on October 12, 2023, to retain the Global Stipend Pool at the current budgeted amount. The stipends for all officer and non-officer positions were adjusted to accommodate the second vice president officer position.

Resolution 16 Council Quorum – Defining "Present" – Housekeeping Bylaws Amendment

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 4 – Quorum, of the ACEP Bylaws be amended to read:

Article VIII - COUNCIL

Section 4 — Quorum

A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or these Bylaws.

Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to councillor voting, "present" is defined as either in person or participating by approved remote communication technology.

Action: The Bylaws were updated.

Resolution 19 Scientific Assembly Vendor Transparency (as amended)

RESOLVED, For transparency as part of the vendor contract, vendors recruiting emergency physicians for employment be encouraged to bring a current contract for physicians to review during Scientific Assembly exhibits and the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on transparency in billing/collections.

Action: Assigned to Corporate Development staff to update the exhibitor contract and communicate to vendors.

Resolution 20 Emergency Medicine Research Mentorship Network (as substituted)

RESOLVED, That ACEP foster collaborations with Society for Academic Emergency Medicine, Council of Residency Directors in Emergency Medicine, and Emergency Medicine Foundation, and other stakeholders to support robust research mentorship opportunities.

Action: Assigned to the Research Committee to work with CORD, SAEM, EMF, EMRA, and other stakeholders to enhance the research scholar pipeline within emergency medicine and support robust research mentorship opportunities.

Resolution 21 Mitigation of Competition for Procedures Between Emergency Medicine Resident Physicians and Other Learners

RESOLVED, That ACEP support emergency medicine resident physicians' right of first refusal over non-physicians, such as physician assistants and nurse practitioners, in performing ACGME-required procedures that are deemed medically necessary in emergency medicine.

Action: Assigned to the Academic Affairs Committee to develop a policy statement. The committee developed the policy statement "Prioritization of Resident Education in Procedures" and it was approved by the Board of Directors on March 2024. The Board also directed the AMA Section Council on Emergency Medicine to advocate for and promote the prioritization of residents for procedures needed for education over non physician practitioners at the AMA including submitting a resolution as appropriate. The Physician Extenders H-310.913 AMA policy was reaffirmed at AMA Interim Meeting 2023. The policy reads: In academic environments, our American Medical Association will only support payment models for non-physician practitioners that do not interfere with graduate medical training. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures."

Resolution 22 Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation

RESOLVED, That ACEP recognizes the value of choice in emergency medicine residency training formats and supports the continued accreditation of both three-year and four-year emergency medicine residency programs.

Action: Assigned to the Academic Affairs Committee to develop a policy statement. The committee developed the policy statement "Length of Residency Training in Emergency Medicine" and it was approved by the Board of Directors in April 2023. The Council and the Board of Directors adopted Amended Resolution 36(25) directing the College to reaffirm the policy statement. The policy statement was updated to reflect it was reaffirmed by the Board in September 2025.

Resolution 24 Addressing the Growing Epidemic of Pediatric Cannabis Exposure

RESOLVED That ACEP advocate for changes in product packaging so as not to resemble non-cannabis containing products, i.e., candy commonly marketed towards children; and be it further

RESOLVED, That ACEP appeal to regulatory bodies and public health agencies for labeling regulations to reduce the likelihood of accidental ingestion by young children and clearly communicate dosing information as well as the potential risks to children associated with cannabis products.

Action: Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

Resolution 28 Facilitating EMTALA Interhospital Transfers

RESOLVED, That ACEP work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA; and be it further

RESOLVED, That ACEP support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In November 2024, the Centers for Medicare and Medicaid Services (CMS) finalized changes to the Emergency Services Condition of Participation (CoP), which includes new requirements for transfer protocols: Facilities must have written policies and procedures for transferring patients under their care; and Facilities must provide training to the relevant staff regarding the hospital policies and procedures for transferring patients under its care. Though (as of July 2025) CMS interpretive guidance has not been released, ACEP worked with the American College of Obstetricians and Gynecologists (ACOG) to create a guidance document for members to ensure that their hospitals meet the protocols described in the CoP.

Resolution 29 Addressing Pediatric Mental Health Boarding in Emergency Departments (as amended)

RESOLVED, That ACEP advocate for federal support to decrease ED boarding of pediatric mental health patients; and be it further

RESOLVED, That ACEP advocate for increased, adequate reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

Action: Assigned to Advocacy & Practice Affairs staff for federal advocacy initiatives.

ACEP's legislative and regulatory priorities for the First Session of the 119th Congress included:

1) Develop and promote legislative efforts to address ED boarding and crowding crisis, including increased, adequate reimbursement for pediatric mental health admissions and payment for boarding of children for whom there is no other medical necessity for hospital care.
2) Seek opportunities to address increase in pediatric ED visits and improve coordination of acute mental health care services for children and young adults.

ACEP helped develop several federal bills, including the "Improving Mental Health Access from the Emergency Department Act," that will help address various aspects of the ED boarding crisis. ACEP also endorsed the "Helping Kids Cope Act" (H.R. 2412), bipartisan legislation to fund necessary staffing, capacity increases, and infrastructure adjustments needed to alleviate pediatric boarding, maintaining initiatives to allow more children to access care outside EDs, and addressing gaps in the continuum of care for children. ACEP continues working to get this legislation reintroduced.

ACEP secured introduction of new ACEP-developed bipartisan legislation based upon the output of the boarding summit and AHRQ roundtable, introduced by Reps. John Joyce (R-PA) and Debbie Dingell (D-MI) and Senators Chris Coons (D-DE), Dave McCormick (R-PA), and Angus King (I-ME). The bill, the "Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act," utilizes existing an existing federal health data modernization grant to support development and implementation of real-time hospital bed tracking and hospital capacity management systems with a focus on ED boarding, supports innovative care models through Medicare pilot programs focused on improving geriatric emergency care and psychiatric emergency care and transfers, and commissions a GAO study to identify best practices for hospital capacity tracking and its effect on boarding, wait times, and EMS offload delays.

Resolution 31 Combating Mental Health Stigma in Insurance Policies (as amended)

RESOLVED, That ACEP advocate and commit resources for the elimination of discrimination against emergency physicians with treated mental health conditions in life, health, disability, and/or professional liability (malpractice) insurance policies; and be it further

RESOLVED, That ACEP work with other organizations to promote equitable access to life, health, disability, and/or professional liability (malpractice) insurance for all emergency physicians.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Resolution 35 Declaring Firearm Violence a Public Health Crisis

RESOLVED, That ACEP declare firearm violence to be a public health crisis in the United States.

Action: Assigned to the Public Health Committee to include in the revision of the "Firearm Safety and Injury Prevention" policy statement (as directed in the 3rd resolved of Resolution 36). The revised policy statement was approved by the Board in June 2024. The U.S. Surgeon General issued an advisory on June 25, 2024, declaring firearms violence a public health crisis. ACEP provided a brief quote from ACEP's President Aisha Terry, MD, FACEP, to be included in the press release on this issue: "By raising awareness of this public health crisis, the Surgeon General's Advisory on Firearm Violence Prevention speaks to the gun violence that emergency physicians observe all too often, as well as the repercussions on the communities they serve."

Resolution 36 Mandatory Waiting Period for Firearm Purchases

RESOLVED, That ACEP advocate for a mandatory federal waiting period prior to firearm purchases; and be it further

RESOLVED, That ACEP assist state chapters in promoting legislation on mandatory waiting periods at the state level; and be it further

RESOLVED, That ACEP add language to its "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

Action: Assigned first and second resolveds to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. Assigned third resolved to the Public Health Committee. The revised policy statement "Firearm Safety and Injury Prevention" was approved by the Board in June 2024.

ACEP's legislative and regulatory priorities continue to include working with Members of Congress to promote efforts that may prevent firearm-related injuries/deaths and support continued and increased funding for firearms injury research.

Resolution 37 Support for Child-Protective Safety Firearm Safety and Storage Systems (as amended)

RESOLVED, That ACEP support efforts to improve firearm safety in the United States, including effective emerging safety technology, while respecting responsible firearm ownership; and be it further

RESOLVED, That ACEP promote child-protective firearm safety and storage systems.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. ACEP's legislative and regulatory priorities continue to include working with Members of Congress to promote efforts that may prevent firearm-related injuries/deaths and support continued and increased funding for firearms injury research.

Assigned to Communications staff to develop messaging.

Resolution 38 Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals (as amended)

RESOLVED, That ACEP advocate for sufficient reimbursement for emergency physician services in Critical Access Hospitals and Rural Emergency Hospitals, and other rural hospitals, to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives. ACEP's legislative and regulatory priorities for the First Session of the 119th Congress included:

1) Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals and develop policy suggestions that would make this a more attractive option.
2) Identify innovative staffing, payment, and reimbursement models, such as potential global budgeting for emergency physician professional services to maintain viability of ED coverage in rural and underserved areas.

3) Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
4) Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.

Resolution 39 Medicaid Reimbursement for Emergency Services (as amended) – *first resolved*

RESOLVED, That ACEP advocate at the federal level and support chapters in advocating at the state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates; and be it further

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Resolution 40 Support for Reimbursement of Geriatric ED Care Processes (as amended)

RESOLVED, That ACEP advocate for and support the development of policies that will allow for appropriate reimbursement, outside of the CPT and RUC processes, for high-value Geriatric Emergency Department Accreditation program-defined care processes that have been shown to improve both health system focused and patient centered outcomes.

Action: Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

In the FY 2025 Inpatient Prospective Payment System (IPPS) final rule, CMS incorporated the mandatory Age-Friendly Hospital Measure, which incorporates concepts and standards included in the Geriatric Emergency Department Accreditation program, into the Inpatient Quality Reporting (IQR) Program. Hospitals that participate in Medicare's IQR Program will be required to report on whether hospitals have protocols in place to: 1) elicit patient health care goals, 2) responsibly manage medications, 3) implement frailty screening and intervention (including for cognition and mobility), 4) assess social vulnerability (e.g. social isolation, caregiver stress, elder abuse) and 5) designate age-friendly leadership. Hospitals that choose not to participate in the IQR program face a significant reduction in their annual Medicare payment update.

Resolution 42 On-site Physician Staffing in Emergency Departments (as amended)

RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further

RESOLVED, That ACEP continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician certified by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, or certified by the American Board of Pediatrics in pediatric emergency medicine.

Action: Assigned first resolved to State Legislative/Regulatory Committee. The committee developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation (HOUSE BILL No. 1199) along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider. The toolkit was distributed to chapters in time for the 2023-24 state legislative season.

Assigned second resolved to Communications staff to include in ongoing communications. ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP."

The Board of Directors revised the policy statement on January 27, 2026, to clarify and formally state that offsite supervision by an emergency physician of a PA or NP who is the sole practitioner physically present in the emergency department is not adequate for optimal patient care and is not considered appropriate supervision. This policy change was prompted by recent events in which portions of the policy were being misinterpreted or misrepresented, including in official testimony before state legislatures and by other specialty societies.

Resolution 43 Adopt Terminology "Unsupervised Practice of Medicine"

RESOLVED, That ACEP adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on-site supervision of non-physician practitioners.

Action: Assigned to Emergency Medicine Practice Committee to develop a policy statement. The committee developed two policy statements to address the resolution, one for residents and one for attendings. The policy statements "Resident Moonlighting in the Emergency Department" and "Unsupervised Practice of Emergency Medicine by Non-Physician Practitioners" were approved by the Board of Directors in April 2025.

Resolution 45 Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss (as amended)

RESOLVED, That ACEP work with other relevant stakeholders to determine the best approaches for preparing emergency medicine trainees in the management of early pregnancy loss; and be it further

RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and be it further

RESOLVED, That ACEP develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Action: Assigned first resolved to the Academic Affairs Committee.

Assigned second and third resolveds to the Public Health Committee to develop a policy statement. The Public Health Committee developed the policy statement "Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss" and it was approved by the Board of Directors on September 26, 2024.

Resolution 46 Policy Statement on the Care of Pregnant Individuals with Substance Use Disorder (as substituted)

RESOLVED, That ACEP create a policy statement on the care of pregnant individuals with substance use disorder, based upon the concepts of the "American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist."

Action: Assigned to the Public Health Committee to develop a policy statement. The policy statement "Care of Pregnant Individuals with Substance Use Disorder" was approved by the Board of Directors in June 2024.

Resolution 47 Clarification of and Taking a Position Against Use of Excited Delirium Syndrome (as amended)

RESOLVED, That ACEP develop a statement to clarify that the 2009 White Paper Report on Excited Delirium is no longer current with the College's position based on new science and understanding of the entity; and be it further

RESOLVED, That ACEP clarify its position in writing, that the 2009 white paper is inaccurate and outdated, and that while the ACEP Board of Directors had previously approved the 2009 White Paper Report on Excited Delirium, it has withdrawn such approval; and be it further

RESOLVED, That ACEP disseminate their position that they no longer endorse or approve the 2009 White Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations, and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation.

Action: Assigned to ACEP's communications staff. A statement was issued on October 12, 2023, reaffirming several ACEP positions regarding the use of the terms "excited delirium" and "hyperactive delirium with severe agitation." The statement emphasized "ACEP's 2009 White Paper Report on Excited Delirium Syndrome is outdated and does not align with the College's position based on the most recent science and better understanding of the issues surrounding hyperactive delirium. ACEP has withdrawn its approval of this paper." The results of ACEP's communications efforts were:

- 1,047 articles mentioned ACEP
- Coverage included: Associated Press, Becker's Hospital Review, CNN, CNN International, Daily Mail, HealthLeaders, Kaiser Family Foundation, MSN, MedPage Today, Medscape, NBC News, NBC News – Boston, NBC News – Bay Area, NBC News – New York, Newsday, Politico, Los Angeles Times, New York Post, Washington Post, US News & World Report.
  - 68 articles quoted designated subject matter expert, Dr. Jeff Goodloe.
  - 406 articles resulted from the Associated Press article: A doctors group calls its 'excited delirium' paper outdated and withdraws its approval (October 13, 2023)
  - 78 articles resulted from two Kaiser Family Foundation articles Police Blame Some Deaths on 'Excited Delirium.' ER Docs Consider Pulling the Plug on the Term (October 2, 2023) Doctors Abandon a Diagnosis Used to Justify Police Custody Deaths. It Might Live On, Anyway. (October 16, 2023)

- 72 articles resulted from the HealthDay article: Doctor's Group Pulls Paper on 'Excited Delirium,' Often Cited in Cases Involving Excessive Force by Police (October 13, 2023)
- 56 broadcast mentions in local media markets, including Buffalo, Chicago, Denver, Los Angeles, Minneapolis, Reno, Sacramento, San Diego, and San Francisco.

The Clinical Policies Committee developed the "Clinical Policy: Critical Issues in the Evaluation and Management of Adult Prehospital or Emergency Department Patients Presenting with Severe Agitation" and it was approved by the Board in October 2023. This clinical policy is intended for the initial treatment of undifferentiated agitation in which the underlying etiology is unknown, and attempts to summarize the current body of literature surrounding the safety and efficacy of agents used for treatment of severe agitation in the emergency department by addressing the following critical question: "Is there a superior parenteral medication or combination of medications for the acute management of adult prehospital or emergency department patients with severe agitation?"

In June 2021, the Board of Directors approved the document titled *ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings*. In August 2021, the task force report was submitted to *Annals of Emergency Medicine* for publication consideration and it was not accepted based on the length of the paper. *Annals* recommended that the report be edited down to comply with the maximum word limit for acceptance, but the suggestion was rejected by the authors since all content presented in the report was considered necessary to inform the paper's intended audience of EMS professionals, emergency physicians, and ED medical staff (e.g., nurses, technicians, etc.). The report was also submitted to *JACEP Open*, which resulted in the same outcome. Shortly after the discussions with *Annals* and *JACEP Open*, work began to draft an executive summary of the 2021 task force report that would be submitted to *Annals*. Work on the paper was suspended following the submission of Resolution 47(23) Clarification of and Taking a Position Against the Use of Excited Delirium Syndrome" to the ACEP Council. Work on the paper resumed after the amended resolution was adopted by the Council and the Board of Directors. The paper includes information about the action taken by the Council and the Board. The Board of Directors reviewed the final paper "Hyperactive Delirium with Severe Agitation – Evolving Recognition and Evidence-Based Recommendations" in April 2024 and it was submitted to *JACEP Open* for publication consideration.

Resolution 48 Medical Malpractice Certificate of Merit (as amended)

RESOLVED, That ACEP recommends an affidavit of merit must be from an emergency physician who is board certified per ACEP policy in the same specialty of emergency medicine, as well as licensed and currently practicing in the same state.

Action: Assigned to the Medical-Legal Committee to review ACEP's policy statement "Anonymous Affidavits of Merit" and determine if revisions should be made or whether a new policy statement should be developed. The committee developed a revised policy statement and it was approved by the Board of Directors in January 2025.

Resolution 51 Quality Measures and Patient Experience Scores (as amended)

RESOLVED, That ACEP advocate for alignment with current ACEP policy and previous recommendations that patient experience surveys be extended to all appropriate categories of emergency department patients to attempt to improve validity; and be it further

RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient experience surveys; and be it further

RESOLVED, That ACEP work with relevant stakeholders to decrease or eliminate the role of patient experience surveys in reimbursement decisions.

Action: Assigned to Advocacy & Practice Affairs staff for federal, state, and professional advocacy initiatives.

Assigned to the Emergency Medicine Practice Committee to revise ACEP's policy statement "Patient Experience of Care Surveys" to address the intent of the resolution. The Board approved the revised policy statement on September 4, 2025.

Patient experience metrics like the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) continue to be optional for reporting and reimbursement programs. In various Medicare and Medicaid responses to regulations and requests for information, ACEP repeatedly states our opposition to using patient experience scores in reimbursement mechanisms and requests that these remain optional or removed in future rulemaking.

ACEP will continue to oppose the inappropriate use of patient experience survey results in physician reimbursement, compensation, credentialing, and employment decisions. Another resolution pertaining to the use of patient experience of care surveys was submitted to the 2026 Council.

Resolution 53 Treating Physician Determines Patient Stability (as amended)

RESOLVED, That ACEP enact policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and be it further

RESOLVED, That ACEP develop an additional policy statement that speaks to the implications of coercion or threats of financial penalties to the emergency physician who has not personally evaluated the patient to coerce or threaten financial penalties to force the treating emergency physician to transfer a patient when the treating physician believes that the patient is unstable and such a transfer may compromise patient safety.

Action: Assigned to the Emergency Medicine Practice Committee to develop policy statements as directed in the resolution. The policy statements "Treating Physician Determines Patient Stability" (addresses first resolve) and "Protection of Emergency Physicians from Coercion in Patient Transfers" (addresses second resolved) were approved by the Board of Directors in April 2025.

Resolution 54 Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions

RESOLVED, That ACEP engage with The Joint Commission to oppose credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

Action: Assigned to Advocacy & Practice Affairs staff and Clinical Affairs staff to continue dialoguing with The Joint Commission and working with the Coalition of Board Certified Emergency Physicians (formerly known as the Coalition Opposing Medical Merit Badges) to oppose credentialing requirements for individual emergency conditions by engaging in efforts to educate hospitals and medical staff credentialing entities on the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated by board certification through ABEM, AOBEM, or ABP and ABEM partner boards for dual/subspecialties.

In April 2025, ACEP leadership and staff met with The Joint Commission to raise concerns regarding current credentialing requirements for individual emergency conditions given the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated by board certification and asked for simplification and clarifying guidance on credentialing.

Assigned to the Emergency Medicine Practice Committee to create talking points to assist physicians in lobbying hospital administrators to use board certifications such as ABEM to validate training, core competencies, and scope of care.

Resolution 55 Uncompensated Required Training (as amended)

RESOLVED, That ACEP convene a working group to evaluate fair market compensation for required training, accurate estimates of the time to completion, and appropriate protected time allowances for training without requiring completion during off hours; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

Action: Assigned to the Emergency Medicine Practice Committee to develop an information paper or other resources.

The AMA Section Council on Emergency Medicine developed a resolution to submit for the June 2025 AMA annual House of Delegates meeting.

Resolution 56 In Memory of William A. Nice, MD

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of William A. Nice, MD, to emergency medicine and extends the College's condolences to his family and his life-long medical group partners.

Action: A framed resolution was sent to Dr. Nice's family.

Resolution 57 Commendation for Raymond L. Fowler MD, FACEP, FAEMS

RESOLVED, That the American College of Emergency Physicians commends Raymond Logan Fowler, MD, FACEP, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, the subspecialty of EMS medicine, and his patients

Action: A framed resolution was sent to Dr. Fowler.

Resolution 58 In Memory of Bradley Middleton, MD

RESOLVED, That the American College of Emergency Physicians cherishes the memory of Bradley Middleton, MD, whose short career touched many lives; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Liz, their daughters Penelope (3) and Mae (2), and son Vander (2 months), as well as the extended Middleton and West families, gratitude for his tremendous service to emergency medicine.

Action: A framed resolution was sent to Dr. Middleton's family.

Resolution 59 In Memory of Ann L. Harwood-Nuss, MD

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Ann Harwood-Nuss, MD, and extends condolences and gratitude to her husband, Robert C. Nuss, MD; her step-daughters Jennifer Nuss, and Robin Gefin; her brothers George, John, David, and Donald Harwood; family; friends; and colleagues for her remarkable service to the specialty of emergency medicine, patient care, and the communities she served so well.

Action: A framed resolution was sent to Dr. Harwood-Nuss's family.

Resolution 60 In Memory of Frank S. Pettyjohn, MD

RESOLVED, That the American College of Emergency Physicians honors and commends Frank S. Pettyjohn, MD, who dedicated his life to emergency medicine and was critical in its inception, and offers our sincerest condolences to his beloved family, both at home and in the emergency department.

Action: A framed resolution was sent to Dr. Pettyjohn's family.

Resolution 61 ACEP Financial Decision Transparency (as amended)

RESOLVED, That ACEP suspend passing on credit processing fees pending an open comment period from member chapters; and be it further

RESOLVED, That ACEP provide a substantial notice period to chapters and/or sections before passing on costs to allow for budgeting; and be it further

RESOLVED, That ACEP evaluate mechanisms for improved communication between ACEP and chapter leaders and representatives to increase transparency to the membership regarding dues related fees.

Action: The Executive Committee met on October 8, 2023, and adopted a motion to suspend the decision to require chapters to pay the credit card processing fees for their chapter membership dues. This decision was ratified by the Board of Directors on October 12, 2023. The following message was distributed to chapters on October 18, 2023: "The ACEP Board respects the Council resolution and has suspended the implementation of asking chapters to cover their own credit card fees beginning January 1, 2024. Discussions on this will continue and additional chapter leader and executive feedback will be included prior to any new decisions being made. In addition, the Board and staff will continue to investigate the feasibility of providing alternative payment options with lower fees to help reduce this burden on ACEP and its chapters."

A new payment option for membership dues was implemented effective February 5, 2024, to allow ACH transfers, also known as electronic bank drafts. ACH transfers are electronic, bank-to-bank money transfers processed through the Automated Clearing House (ACH) Network. This new payment option is now available on the membership application for new and renewing members. Staff are working on adding this option to My Account so that members using installments and auto-renew can easily update their payment information. Work is also underway to incentivize members to choose ACH payments instead of credit card payments.

The Board discussed chapter credit card fees on April 17, 2024, and approved giving chapters notice of the plan to withhold their portion of the credit card fees related to membership and state PAC transactions starting July 1, 2025. Chapters were notified of this intent and provided a comment period through May 31, 2024, to submit feedback, ask questions, and offer ideas on how national ACEP and chapters can work together to incentivize use of ACH payments, increase membership, or reduce costs.

The Board discussed chapter relations and next steps that could be taken to improve relations based on feedback received from several large chapters and the need for effective, bidirectional, consistent, and active communications to help achieve trust between chapters and national ACEP during the June 26-27, 2024, Board meeting. The Board also discussed the possibility of deferring or eliminating the pass through of credit card fees and the possibility of reinvesting the recovered fees into support for the chapters such as through staff time, new services, scalable technologies, better reporting, or accelerating the AMS project. It was acknowledged that recent budget constraints, staff turnover, and

technology challenges have impacted ACEP's ability to consistently meet chapter expectations. Staff continued working to prioritize chapter needs, finding the best ways to communicate, promoting the use of ACH to reduce the credit card fees, and continuing to investigate the possibility of charging a processing fee or the ability for members to pay the credit card processing fee at the time of any transactions. Discussions with individual chapters continued and additional feedback sought to assess possible improvements for two-way communication throughout the year.

During the fall of 2024, staff implemented verbiage on the checkout for membership, meeting registration, and group billing that actively explains to members why choosing payment by bank account (ACH) helps more of their dollars go towards ACEP's mission. Promotion of ACH is also included in ACEP's series of emails sent to members during their membership renewal cycle. Chapter Leaders were notified and provided with suggested similar language to include in their member communications to encourage use of ACH. Legal and technical research into the feasibility of three different ways to pass through the credit card fees directly to members was conducted, as well as the approximate percentage of members that would need to move to ACH to reduce fees significantly enough to cover the chapters' portion. Current system limitations and the difficulty of keeping up with 50 different state laws would require a significant amount of overhead effort. ACEP will continue to investigate options for members to voluntarily pay the fees.

Despite efforts by ACEP to offer and publicize the ACH option, uptake has been limited. Members have expressed security concerns and many prefer to use their credit card to receive points or miles. Staff modeled out the possible impact of implementing a cash discount (legally preferable over service charge/convenience fee), which showed a high threshold of over 50% uptake to save the $150,000 that would otherwise be passed through to chapters.

In January and February 2025, chapter executives and chapter leaders were separately presented with the results of staff research regarding the legal and technical options. No additional feedback or concerns were raised during or after those calls. Chapters were encouraged to help incentivize or communicate ACH as a payment method.

Chapters were notified on May 7, 2025, of the Board's April 30, 2025, decision that beginning July 1, 2026, chapters will be responsible for paying the credit card processing fees (3%) for transactions associated with their own portion of membership dues (chapter dues) and chapter PAC contributions (if ACEP collects the dues on behalf of the chapter). ACEP will continue to pay for the credit card processing fees (3%) associated with its own portion of membership dues (National dues) and NEMPAC contributions. ACEP will continue encouraging members to opt in for ACH/bank payment as they renew their membership, through timely automated messaging and on-screen reminders during checkout. As of April 1, 2025, ACH/bank payment is the default payment option instead of credit card. Chapters received in June 2025 their actual dues and PAC contribution amounts collected by credit card during the 18-month period between July 1, 2023, and December 30, 2024, to assist chapters with budgeting. The fees will be deducted from chapter monthly direct deposits starting in August 2026 for July transactions and itemized on their monthly statements.

Chapters were also notified on May 7, 2025, of the Board's decision to implement a 3% national dues increase for regular members effective July 1, 2025. No changes were made to candidate or international member dues.

Chapters were notified on February 4, 2026, of the Board's decision to implement a 3% dues increase limited to Regular ACEP membership dues effective July 1, 2026. The new attending subscription bundle (RegYR123) will remain at $25/month and dues for Candidate (Resident, Fellow-in-training and Medical Student) members will not increase. Chapters were also notified that effective July 1, 2026, interest payments on passed through chapter dues held temporarily by ACEP will be discontinued. This change was discussed multiple times with the chapters throughout 2025. As of September 2025, only seven chapters maintained funds with ACEP. These chapters will continue to receive interest payments for equity held by ACEP for more than 30 days post month-end.

National ACEP staff have ongoing dialogue with chapters to share information and obtain feedback. ACEP will continue to investigate options for members to voluntarily pay credit fees as implementation of the new membership and financial systems begin.

Resolutions Referred to the Board of Directors

Resolution 23 Opposing Sale-Leaseback Transactions by Health Systems

RESOLVED, That ACEP advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

Action: Assigned to Advocacy & Practice Affairs staff to review the referred resolution and provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution or potential initiatives to address the resolution.

Resolution 27 Addressing Interhospital Transfer Challenges for Rural EDs (as amended)

RESOLVED, That ACEP work with state and federal agencies to ~~create~~ **advocate for** state and regional transfer

coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems and to report their activities publicly; and be it further

RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not available at the referring hospital, ~~even when capacity is limited at the tertiary center~~; and be it further

RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined as patient catchment areas rather than jurisdictional boundaries; and be it further

RESOLVED, That ACEP support research to strengthen the evidence base regarding rural hospital transfer processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes and experience and include investigation of common challenges experienced by all small, non-networked hospitals~~; and be it further~~

~~RESOLVED, That ACEP create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts regarding interhospital transfer challenges for rural EDs and the task force should:~~

- ~~Examine existing and theoretical transfer models to identify best practices, including coordination of transfers across state borders.~~
- ~~Enumerate and endorse effective mechanisms to facilitate tertiary care hospitals' acceptance of patients in transfer with time-sensitive conditions who are initially treated at EDs without needed services.~~
- ~~Identify key capacity measures for public reporting of hospital capacity limitations, and propose mechanisms to create and sustain appropriate state/regional dashboards.~~

Action: Assigned to the Federal Government Affairs Committee and the State Legislative/Regulatory Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. A recommendation to implement the referred resolution with additional edits was submitted to the Board of Directors for consideration at their September 26, 2024, meeting. The Board approved the committee's recommendation to amend the referred resolution to read:

> RESOLVED, That ACEP work with state and federal agencies to advocate for state and regional transfer coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and ED capacity problems; and be it further
>
> RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional process for rapidly accepting patients from hospitals when the patient needs an emergency intervention not available at the referring hospital; and be it further
>
> RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis, STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease); and be it further
>
> RESOLVED, That ACEP support research to strengthen the evidence base regarding hospital transfer processes including delays, administrative burden on sending hospitals, and association with patient outcomes and experience.

Implementation of the resolution was assigned to Advocacy & Practice Affairs staff for federal and state advocacy work and creating a workgroup consisting of subject matter experts from the Federal Government Affairs Committee, State Legislative/Regulatory Committee, and the Medical-Legal Committee to develop the guidance or best practices to establish appropriate procedures to avoid EMTALA violations. An objective was assigned to the committees.

Resolution 39 Medicaid Reimbursement for Emergency Services (as amended) – *second resolved*

RESOLVED, That ACEP work with the AMA to assist states with model legislation and regulatory language to require that all publicly funded insurance plans be reimbursed at a minimum of 100% of the prevailing Medicare rate.

Action: Assigned to the AMA Section Council on Emergency Medicine to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

Resolution 44 Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss (as amended)

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management initiated in the

emergency department by an emergency physician safe and effective compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management in the emergency department by an emergency physician safe and effective compared to expectant management?

Action: Assigned to the Clinical Policies Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. ACEP's current "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" is based on two critical questions:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β-hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy?

This clinical policy was approved in 2016 and is currently in the process of being updated. The writing group has decided to proceed with updating the clinical policy to include a single critical question regarding the safety of imaging modalities in suspected pulmonary embolism. In accordance with the Clinical Policies Committee procedures, the critical questions called for in this resolution would require development of two new single-question clinical policies.

The Clinical Policies Committee and the Writing Committee on Early Pregnancy reviewed the resolution, conducted a review of the current literature on the topic in emergency medicine, and discussed the possibility of creating a robust clinical policy regarding the management of early pregnancy loss in the emergency department. In the literature review process, we identified the most current reaffirmed policy statement on early pregnancy loss management from the American College of Obstetricians and Gynecologists (ACOG) from 2018. ACOG does not have guidelines or policies regarding this topic. A Cochrane review on the topic was identified, but the included studies were not specific to emergency medicine and were critically appraised (graded) as low quality by their reviewers, and was last updated in 2012. It was also noted there is little literature (and no quality literature) on early pregnancy loss management in the emergency department. The remaining literature is written from the perspective of obstetrics and, even then, is poor quality. Based on the lack of sufficient quality literature to inform a clinical policy recommendation, the Clinical Policies Committee recommended that development of a clinical policy not be pursued and that a policy statement be developed regarding the role of emergency physicians in treating and evaluating patients presenting with early pregnancy loss as directed in Amended Resolution 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss. The Board of Directors affirmed the findings of the Clinical Policies Committee in April 2024.

Resolution 49 Patients Leaving the ED Prior to Completion of Care Against Medical Advice (as amended)

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, and all indicated consults; and be it further

RESOLVED, That ACEP ~~create a document acknowledging that physicians and hospitals/systems share a joint responsibility to notify patients who have left prior to the completion of care regarding testing requiring intervention that results after their departure and develop reasonable systems to help communicate these results~~ **work with relevant stakeholders such as the American Hospital Association to create a document or tool outlining responsibilities and systems of communication for the conveyance of information about testing and follow up of patients who leave the emergency department prior to the completion of care**; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of ~~care~~ **evaluation and treatment bear ~~some~~ responsibility for ongoing care and** may not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

Action: Assigned to the Emergency Medicine Practice Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution. The committee developed the policy statement "Patients Leaving the ED Prior to Completion of Care" and it was approved by the Board of Directors at their September 4, 2025, meeting.

Resolution 50 Metric Shaming (as amended)

RESOLVED, That ACEP develop practices and policies to prevent the ~~publishing~~ **public or external publication**, ~~transmitting~~ **transmission**, and/or ~~releasing~~ **release** of unblinded metric-related **productivity** information about individual emergency physician performance to safeguard the welfare of our membership.

Action: Assigned to the Emergency Medicine Practice Committee to provide a recommendation to the Board of Directors regarding the advisability of implementing the resolution and potential initiatives to address the resolution.

Note: ABEM provided the following information to ACEP:

> ABEM publicly reports physician certification status, which is a physician-specific metric. This practice is a service to hospital systems, crendentialers, and the certified physicians themselves. ABEM does not publicly report the names of any physicians who are not certified, nor does ABEM publicly provide any information about the specific level of performance on any ABEM assessment. We believe that most physicians take personal and professional pride in the accomplishment of ABEM certification. Moreover, ABEM posts the names of all physicians who have been ABEM-certified for at least 30 years.

The Board approved the policy statement "Addressing Public Reporting of Individual Physician Metrics" at their September 4, 2025, meeting. The Emergency Medicine Practice Committee suggested additional options to address the intent of Referred Amended Resolution 50(23) Metric Shaming:

- Refer the "Addressing Public Reporting of Individual Physician Metrics" policy statement to the AMA Section Council on Emergency Medicine for discussion.
- Request the Clinical Emergency Data Registry to explore how performance measures are reported to CMS to shift from the individual level (less ideal) or the group level (more perfect). If reported at the personal level, ACEP should ensure that the individual physicians are made aware of their metrics.
- Actively engage CMS and other regulatory bodies to advocate for more equitable and statistically valid performance reporting methods and propose adjustments to CMS reporting rules to ensure that individual physician performance is not reported publicly without adequate risk adjustment.

Resolution 62 Cooperation Between National ACEP and State Chapters

RESOLVED, That ACEP staff revise the membership payment process to allow members to voluntarily pay for any credit card fees that are permitted to be passed on to the member and then require each state chapter to pay for any fees not paid.

Action: Assigned to membership, legal, technology, and accounting staff to provide an update and recommendation to the Board of Directors regarding the implementation of initiatives to address the resolution. Staff have researched the feasibility of such an option and various state laws make implementation of this resolution of questionable legality, and if legal, complicated to implement. The flexibility of ACEP's current membership system is significantly limited. Any changes to the checkout process and/or dynamic logic regarding pricing require several sprints of IT development. Chapter executives have been involved in the requirements gathering process for the new membership system, which will be implemented in the next few years.

A new payment option for membership dues was implemented effective February 5, 2024, to allow ACH transfers, also known as electronic bank drafts. ACH transfers are electronic, bank-to-bank money transfers processed through the Automated Clearing House (ACH) Network. This new payment option is now available on the membership application for new and renewing members. Staff are working on adding this option to My Account so that members using installments and auto-renew can easily update their payment information. Work is also underway to incentivize members to choose ACH payments instead of credit card payments.

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The Board discussed the possibility of deferring or eliminating the pass through of credit card fees and the possibility of reinvesting the recovered fees into support for the chapters such as through staff time, new services, scalable technologies, better reporting, or accelerating the AMS project during the June 26-27, 2024, Board meeting. It was acknowledged that recent budget constraints, staff turnover, and technology challenges have impacted ACEP's ability to consistently meet chapter expectations. Staff continued working to prioritize chapter needs, finding the best ways to communicate, promoting the use of ACH to reduce the credit card fees, and continuing to investigate the possibility of charging a processing fee or the ability for members to pay the credit card processing fee at the time of any transactions.

During the fall of 2024, staff implemented verbiage on the checkout for membership, meeting registration, and group billing that actively explains to members why choosing payment by bank account (ACH) helps more of their dollars go towards ACEP's mission. Promotion of ACH is also included in ACEP's series of emails sent to members during their

membership renewal cycle. Chapter Leaders were notified and provided with suggested similar language to include in their member communications to encourage use of ACH. Legal and technical research into the feasibility of three different ways to pass through the credit card fees directly to members was conducted, as well as the approximate percentage of members that would need to move to ACH to reduce fees significantly enough to cover the chapters' portion. Current system limitations and the difficulty of keeping up with 50 different state laws would require a significant amount of overhead effort. ACEP will continue to investigate options for members to voluntarily pay the fees.

Despite efforts by ACEP to offer and publicize the ACH option, uptake has been limited. Members have expressed security concerns and many prefer to use their credit card to receive points or miles. Staff modeled out the possible impact of implementing a cash discount (legally preferable over service charge/convenience fee), which showed a high threshold of over 50% uptake to save the $150,000 that would otherwise be passed through to chapters.

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Chapters were notified on May 7, 2025, of the Board's April 30, 2025, decision that beginning July 1, 2026, chapters will be responsible for paying the credit card processing fees (3%) for transactions associated with their own portion of membership dues (chapter dues) and chapter PAC contributions (if ACEP collects the dues on behalf of the chapter). ACEP will continue to pay for the credit card processing fees (3%) associated with its own portion of membership dues (National dues) and NEMPAC contributions. ACEP will continue encouraging members to opt in for ACH/bank payment as they renew their membership, through timely automated messaging and on-screen reminders during checkout. As of April 1, 2025, ACH/bank payment is the default payment option instead of credit card. Chapters received in June 2025 their actual dues and PAC contribution amounts collected by credit card during the 18-month period between July 1, 2023, and December 30, 2024, to assist chapters with budgeting. The fees will be deducted from chapter monthly direct deposits starting in August 2026 for July transactions and itemized on their monthly statements.

National ACEP staff have ongoing dialogue with chapters to share information and obtain feedback. ACEP will continue to investigate options for members to voluntarily pay credit fees as implementation of the new membership and financial systems begin.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

President-Elect Candidates

Scientific Assembly CHICAGO 26

Scientific Assembly CHICAGO 26

2026 President-Elect Candidates



Heidi C. Knowles, MS, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Kristin B. McCabe-Kline, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



James L. Shoemaker, Jr., MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV

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2026 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Heidi C. Knowles, MS, MD, FACEP

Question #1: **How do you suggest ACEP navigate policy issues in a highly partisan political environment?**

In the emergency department, I have never once asked patients who they voted for before I treated them. The person having a stroke, a heart attack, or a traumatic injury does not care whether the solution comes from the right or the left. They care about the outcome, and so should we.

That is why emergency medicine cannot afford to be a partisan specialty. We care for everyone who comes through our doors, regardless of politics, insurance status, geography, or circumstance. That gives us credibility that few others in healthcare can claim: our advocacy is grounded in patients, not ideology. It lets us say things others cannot and still be believed.
I would apply one test to every position ACEP takes: not whether it pleases a party, but whether it protects patients and the physicians caring for them. Emergency physicians are often the first to see the consequences of policy decisions and the last line of defense when those decisions fall short. That perspective should guide our advocacy.

Whether the issue is patient access, physician safety, reimbursement, or the sustainability of our specialty, ACEP should remain focused on solving problems rather than choosing sides. On issues like these, I would build coalitions with anyone willing to help solve them, as I have throughout my career working to reduce boarding, improve consultant responsiveness, and strengthen the voice of emergency physicians.

But nonpartisan does not mean passive. When the stakes are real, ACEP must speak clearly, advocate forcefully, and lead without apology. As President, I will ensure this College remains principled, focused, and unafraid, protecting our patients, supporting our physicians, and strengthening the specialty they both depend on, because emergency medicine is a profession worth fighting for, and our physicians are counting on us to do it.

Question #2: **How would you allocate your time as president to advance ACEP's strategic priorities given the competing demands on finite resources?**

As medical director of a large, complex emergency department, I learned that clarity under pressure is not optional. It is how teams survive, how decisions get made, and how trust is built. I also learned that not every problem can be the top priority. Organizations fail when everything becomes urgent.

I would start the way every shift starts: by understanding what is actually in front of us. The needs of a rural physician in Montana are not those of an academic physician in Boston or a community physician in Texas, and my job is not to assume I have the answers. It is to listen, and then to act.

As President, I would lead ACEP with disciplined focus, clear advocacy, and a constant test: does this make emergency medicine safer, more sustainable, and more professionally meaningful for our members? If it does, it earns our resources and my attention. If it does not, it should not crowd out the work that does, no matter how loud the demand or how long we have done it out of habit. Finite resources demand clear choices, and those choices should be guided by impact rather than tradition.
Leadership is often the discipline of deciding what not to do. That focus is not mine to invent. The Board built our strategic plan with input from across the College, and its priorities, from advocacy to career fulfillment to practice innovation, define where we have agreed to put our weight. My responsibility is to execute on them with consistency, and to protect that focus from the urgent distractions that pull every organization off course.

Above all, I would measure success the way our members do: not by how many initiatives ACEP launches, but by whether an emergency physician can see and feel the difference in their own practice. That is the difference that matters most, and it is the one I would never lose sight of.

Question #3: **What existential problems in emergency medicine keep you awake at night?**

What keeps me awake at night is not any single crisis. It is the slow, steady transfer of risk, responsibility, and burden onto emergency physicians. We have become the default solution to every problem the rest of the healthcare system has failed to solve. We board patients for hours, sometimes days, because there are no inpatient beds. We manage behavioral health crises because there is nowhere else for those patients to go. We absorb the reimbursement cuts, rising violence, workforce shortages, unfunded mandates, and growing administrative load. And through all of it, the expectation somehow remains that we will simply be more resilient.

Resilience is not a strategy. Every system eventually reaches the limit of what one group of professionals can be asked to carry, and we are nearing that limit now. If we keep absorbing the failures no one else will fix, without the authority, the support, or the resources to meet them, *we risk turning emergency medicine from a profession into just a job.* That distinction may sound small, but it is the difference between the physicians who stay and the ones who walk away. People endure hard times for a profession they believe in. A job that has become this hard is one they leave.

This is where ACEP must lead, and we are not starting from zero. ACEP has already fought hard for workplace protections and payment reform, and that work matters. But progress is not the same as relief, and my job as President is to drive it until physicians feel the difference on shift. Our role is not to ask physicians to carry more. It is to stop normalizing this burden and start forcing the conversations that match the scale of the problem: pressing for the inpatient capacity and behavioral health resources that sit upstream of so much of the rest, and turning the protections and payment reform already underway into real weight lifted off our physicians' backs. Naming the crisis is not enough. ACEP's role is to make the rest of the system own its share of it.

Emergency medicine has always adapted, innovated, and answered the call, and I have no doubt it will keep doing so. But we cannot keep asking physicians to absorb every failure that lands at our doors and still expect the workforce to hold.
And that should concern *all* of us.

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CANDIDATE DATA SHEET

Heidi C. Knowles, MS, MD, FACEP

Contact Information

11901 Ridge Road
Forney, Texas 75126
Phone: 903-681-3762
E-Mail: hknowles@acep.org

Current and Past Professional Position(s)

Vice Chair, Chief of Operations & Medical Director 1/2023-Present
Integrative Emergency Services - John Peter Smith Hospital, Fort Worth, Texas
Level I Trauma Center · Emergency Medicine Residency · ~135,000 visits/yr
Previously held leadership roles within the department:
Associate Medical Director August 2020-December 2022
Assistant Medical Director, July 2019-July 2020
Director-Leadership and Advocacy, July 2015-June 2019
Core Faculty, Emergency Medicine Residency, July 2015-Present

Interim Medical Director 8/2025-5/2026
Integrative Emergency Services - St. Francis Hospital - Tulsa, Oklahoma
Level I Trauma Center · EM Residency Program · ~75,000 patients/year

Southlake Emergicare
Texas Health Southlake ED, December 2016-Present
Trinity Valley Community College
EMS Program Medical Director, April 2011-Present
Palestine Regional Medical Center
EmCare 2012-2017
Emergency Service Partners 2006-2012
Rural ED, 32,000 volume, Level III Trauma Center
University of Texas Health Science Center - Houston
Memorial Hermann Hospital, October 2011 to August 2015
Level I Trauma Center, EM Residency, Staff Physician
Pegasus
Metroplex Hospital-Killeen August 2012-December 2012
Staff physician (temporary position for new contract start-up)

Education (include internships and residency information)

Emergency Medicine Residency 07/03–06/06
University of Texas Health Science Center at Houston
Memorial Hermann Hospital, Houston, Texas

University of Texas at Houston, Medical School 08/99–06/03
Houston, Texas
Doctor of Medicine

Southwest Texas State University
San Marcos, Texas
Master of Science-Microbiology 01/96–08/98
Bachelor of Science-Biology/Chemistry minor 08/90–05/94

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM – initial certification 12/2007; Recertification 12/2017-2027

Professional Societies

American College of Emergency Physicians
Texas College of Emergency Physicians
Texas Medical Association

National ACEP Activities – List your most significant accomplishments

Vice President, Membership, 2025-Present
Secretary-Treasurer, 2024-2025
Board of Directors, 2021-Present
ACEP Representative- Federation of State Medical Boards, 2020-2025
ACEP Representative, Society of Critical Care Medicine Committee to develop Guidelines to Identify Critical Patients Outside the Emergency Department 2020-2023

Board Liaison to multiple ACEP committees and sections, including Medical-Legal, Academic Affairs, Chapter Relations, Ultrasound, Freestanding Emergency Centers, AAWEP, Cruise Ship Medicine, Early Career Physicians, EMRA, and Membership

ACEP Chapter Activities – List your most significant accomplishments

Texas College of Emergency Physicians (TCEP)

President 2017-2018
President-elect 2016-2017
Immediate Past President 2018-2019
Treasurer 2015-2016
Young Physician Representative 2012-2013
Board of Directors, 2013-2016
Residency Visit Lecture Program 2010-2019
Coordinator 2014-2018
Leadership and Advocacy Program Fellow 2010

Practice Profile

Total hours devoted to emergency medicine practice per year: **1,776** Total Hours/Year

Direct Patient Care **35** % Research **1** % Teaching **15** % Administration **49** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am an employed emergency physician with Integrative Emergency Services, a physician-owned, multi-hospital staffing group (no private equity, no debt). My primary clinical practice is at a high-volume Level I Trauma Center and county safety-net emergency department, where I also serve in departmental leadership as Medical Director/Vice Chair and Chief of Operations, with responsibilities for ED operations, staffing, throughput, quality, and physician leadership.

In addition to this role, I have served as Interim Medical Director for a Level I Trauma Center in Tulsa, Oklahoma, a role that concludes this summer. I also work as an independent contractor physician on an "as-needed" basis for Southlake Emergicare, a physician-owned group at a small surgical hospital emergency department.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

John Peter Smith Hospital: Medical Director, Vice Chair, Chief of Operations, Core Faculty
Saint Francis Health System: Interim Medical Director
THR Southlake: Staff Physician

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases Plaintiff Expert 0 Cases

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Heidi C. Knowles, MS, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Integrative Emergency Services (IES)
Address: Heritage Square One 4835 LBJ Freeway, Suite 900
Dallas, Texas 75244
Position Held: Medical Director, Vice Chair, John Peter Smith Hospital
Type of Organization: County Hospital, Level 1 Trauma Center, EM Residency Program

Employer: Integrative Emergency Services (IES)
Address: Heritage Square One 4835 LBJ Freeway, Suite 900
Dallas, Texas 75244
Position Held: Interim Medical Director, Saint Francis Health System
Type of Organization: Level 1 Trauma Center

Employer: Southlake Emergicare – Texas Health Southlake
Address: 1545 E. Southlake Blvd
Southlake, Texas 76092
Position Held: Staff Physician (PRN)
Type of Organization: Surgical Hospital Emergency Department

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Texas College of Emergency Physicians
Address: PO Box 26164
Austin, Texas 78755
Type of Organization: ACEP State Chapter
Leadership Position: Board of Directors (Young Physician Representative, Secretary, Treasurer, President Elect, President, Past President)
Term of Service: 2011-2019

Organization: Trinity Valley Community College

Address: 1200 I-20

Terrell, Texas 75160

Type of Organization: Community College

Leadership Position: Medical Director EMS Program

Term of Service: 2011-current

Organization: Texas Medical Association

Address: 401 W 15th Street

Austin, Texas 78701

Type of Organization: Organized Medicine / Physician Advocacy Organization

Leadership Position: Representative for Texas ACEP chapter on the Interspecialty Society Committee

Term of Service: 2014-current

Organization: EMPACT (Emergency Medicine Political Action Committee of Texas)

Address: 401 W 15th Street

Austin, Texas 78701

Type of Organization: Emergency Medicine Political Action Committee

Leadership Position: Executive Board / Controlling Member

Term of Service: 2018-current

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE

☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☐ NONE
☒ If YES, Please Describe: My spouse is a chiropractor in private practice.

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ N/A
☒ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☒ NO
☐ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☒ NO
☐ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☒ NO
☐ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Heidi Knowles, MD Date May 26, 2026

2026-2027
Board of Directors

Bryan Dunn, MD, FACEP
President

Marcus Sims, II, DO, FACEP
President Elect

Angela Cornelius, MD, FACEP
Treasurer

Ben Leeson, MD, FACEP
Secretary

AJ Kirk, MD, FACEP
Immediate Past President

Directors
Sara Andrabi, MD, FACEP

Chinwe Anyanwu, DO

Jemma Killingworth
(Medical Student Representative)

Kimberly Leeson, MD, FACEP

Michael Parsa, MD, FACEP

Abbey Pastorelle, DO
(Candidate/Resident Director)

Jeff Pinnow, MD, FACEP

J. Robert Rosillo, MD, FACEP, MBA

Michael Rozum, MD
(Young Physician Director)

Kristopher Sutherly, MD, FACEP

Executive Director
Jill Sutton, CMP

TCEP
TEXAS COLLEGE of EMERGENCY PHYSICIANS

June 23, 2026

Dear ACEP Councilors,

On behalf of the Texas College of Emergency Physicians (TCEP), it is my distinct pleasure to endorse Heidi Knowles, MD, FACEP for President-Elect of the ACEP Board of Directors.

Dr. Knowles has been a dedicated member of ACEP since 2002 and brings extensive experience from both rural and community emergency medicine practice, along with significant leadership at both the national and chapter levels. Her depth of experience and steady leadership make her exceptionally well-suited to help guide emergency medicine through the challenges facing our specialty today.

Throughout her service to ACEP, Dr. Knowles has held numerous leadership roles, including Vice President of Membership, Secretary-Treasurer, Board Member and Councilor. She has also contributed extensively through committee service, including participation on the Ethics Committee and the 911 Network.

Within TCEP, Dr. Knowles' contributions further demonstrate the leadership, commitment, and vision she will bring to ACEP. Her CV reflects longstanding involvement across numerous committees, as well as participation in our yearlong TCEP Leadership and Advocacy Fellowship (TLAF) program. She continues to serve on the EMPACT Board, Bylaws Committee, and Nominating Committee. In addition, she first co-directed and later directed TCEP's highly successful Residency Visit Program, which now includes 18 emergency medicine residency programs across Texas.

Dr. Knowles has served in every officer position on the TCEP Board, culminating in her presidency in 2018. During her term as President, TCEP faced a particularly difficult period when the organization operated without staff for more than a year. Following the Board's decision to temporarily relocate the office to ACEP headquarters, Dr. Knowles demonstrated extraordinary dedication by personally managing day-to-day association operations, often working in the office four to five days per week after completing clinical shifts. Her leadership and tireless commitment were instrumental in maintaining stability and continuity of the organization during that transition. Through this experience, she developed a deep understanding of the complexities and operational needs of a state chapter. Today, she remains actively involved in TCEP leadership and continues to represent emergency physicians through service on several Texas Medical Association committees and in their House of Delegates.

The Texas Chapter is proud to offer Dr. Knowles our highest endorsement for President-Elect of the ACEP Board of Directors.

Thank you for your consideration. Please feel free to contact me or our Executive Director, Jill Sutton, at jill@texacep.org, with any questions.

Sincerely,



Bryan Dunn, MD, FACEP
President
Texas College of Emergency Physicians

Mission Statement:
The Texas College of Emergency Physicians exists to promote quality emergency care for all patients and to represent the professional interests of our members.

Heidi C. Knowles, MS, MD, FACEP

Almost thirty years ago, I started as a volunteer in the emergency department at Parkland, the county hospital in Dallas, and I fell in love with it: the chaos, the challenge, and the team that showed up for every patient. At the time, people warned me away from emergency medicine. I took a chance and have never regretted it. Some of the struggles I witnessed are still with us today, like boarding and overcrowding. Others we fixed, like the prudent layperson standard that stops insurers from denying emergency care based on the final diagnosis, proof that what feels immovable can move when we fight for it. I am running for President-Elect because our specialty is worth that fight, and because I want the physicians who come after us to know the same joys I have found.

I am a thoughtful, collaborative leader who listens to understand what members want, need, and struggle with, then I don't back down. I hold every decision to one test: does it make emergency medicine safer, our careers more sustainable, and our members feel better supported? ***Safe. Sustainable. Supported.*** If it does, we act. If not, we say so and explain why. When the stakes are real, we should speak clearly and lead with purpose.

I will meet these pressures with action, not slogans. On boarding, the crisis behind so much harm and burnout, we recently won a victory: CMS finalized the Emergency Care Access and Timeliness (ECAT) measure, which will require hospitals to report boarding and access delays. I would turn that transparency into accountability and arm our chapters to win state-level solutions: more psychiatric beds, more nurses, and greater inpatient discharge capacity. On violence, many of us have been threatened or attacked on shift. I will push for protections with teeth: reporting that counts and penalties that mean something. No one should be threatened while providing care. On payment, I will fight the cuts and denials that erode every career. These are failures to fix, not burdens to endure. ***Resilience is not a strategy.***

Most of all, ACEP's value cannot be a mystery. You should be able to name what the College has done for you this year, clearly and easily. That support should follow you throughout your entire career: from the day you choose emergency medicine, hand-in-hand with EMRA, through the early years that decide whether you stay, to later chapters that let you wind down, still relevant and grounded in the specialty you helped build. I will measure success not by the initiatives we launch, but by whether members feel that difference at the bedside.

A President must weigh every corner of our specialty, and I have practiced across it: nine years in rural emergency medicine plus academics and urban Level I trauma. Today, I am the medical director at John Peter Smith Hospital in Fort Worth, Texas, one of the busiest emergency departments in the country, where operations under pressure are my daily work. I have taught in EMS and residency education, worked locums, and advocated in our state legislature. All the while, I continued my share of nights, weekends, and holiday shifts. ***I lead from inside our specialty, not above it.***

I am here for you. I am here for our specialty. In every role, I have given my best, and will bring that same commitment, clarity, and determination to serving as your President-Elect. I respectfully ask for your vote and the opportunity to continue serving the specialty I love.

Please call, text, or email me anytime with questions: (903) 681-3762, hknowles@acep.org.

★ ★ ★

HEIDI KNOWLES

for

ACEP PRESIDENT-ELECT

Principled. Focused. Unafraid.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS



ONE STANDARD FOR EVERY DECISION

*Every choice ACEP makes should meet a single test: does it make emergency medicine **safer**, more **sustainable**, and our members feel better **supported**?*

Safe

Workplace protections, security, and the resources physicians need to care for patients, and themselves, without absorbing every system failure.

Sustainable

Payment reform, boarding solutions, and protecting emergency physicians' scope of practice, so a career in emergency medicine can last a lifetime.

Supported

Relief from the crushing administrative load, and the institutional backing physicians deserve, so emergency medicine stays a profession worth choosing, not a job to endure.

LEADERSHIP & INVOLVEMENT

STATE

- **Past President,** Texas College of Emergency Physicians (TCEP)
- **TCEP Leadership & Advocacy Fellow**
- **Past Director,** TCEP Residency Visit Program
- **Executive Board Member,** EMPACT (TCEP Political Action Committee)
- **TCEP Representative** to the Texas Medical Association Interspecialty Society & House of Delegates

ACADEMIC

- **Core Faculty,** JPS Emergency Medicine Residency
- **Assistant Professor,** TCU Burnett School of Medicine

NATIONAL

- **Vice President of Membership,** ACEP Board of Directors
- **Board Liaison:** Cruise Ship Medicine, EMRA, and Early Career Physician sections, plus many past liaison roles
- **Committee Service:** Ethics, Membership, Steering, Reference, and Tellers & Credentials
- **Past Secretary-Treasurer,** ACEP Board of Directors
- **Past Representative** to the Federation of State Medical Boards (FSMB) and the Society of Critical Care Medicine (SCCM)
- **ACEP member** since 2002

ADVOCACY

A fixture at ACEP's **Leadership & Advocacy Conference annually since 2010**, and an active voice in **Texas legislative advocacy** with TCEP and the Texas Medical Association, showing up *year after year* where policy is made.

For more than 20 years, I have practiced, taught, and led where the pressure is highest: in EMS education, rural and community emergency departments, and one of the busiest Level I trauma centers in the country. Serving as Medical Director and Core Faculty for our Emergency Medicine Residency Program, and as Assistant Professor at the TCU Burnett School of Medicine, I proudly still work all clinical shifts, including mid-shifts, nights, weekends, and holidays. On every shift, I care for whoever comes through our doors, regardless of politics or circumstance, and ACEP's advocacy should work the same way: emergency medicine cannot afford to be a partisan specialty. I build coalitions with anyone willing to solve the problem, nonpartisan but never passive. That is how I would lead ACEP.

The practice of emergency medicine should be **safe, sustainable, and supported**.

★ ★ ★

OFFICIAL CHAPTER ENDORSEMENT

TEXAS COLLEGE OF EMERGENCY PHYSICIANS

Endorses Heidi Knowles, MS, MD, FACEP · for ACEP President-Elect

*"The Texas Chapter is proud to offer Dr. Knowles our **highest endorsement** for President-Elect."*

Dear ACEP Councillors,

On behalf of the Texas College of Emergency Physicians, it is my distinct pleasure to endorse **Heidi Knowles, MS, MD, FACEP**, for President-Elect of the ACEP Board of Directors.

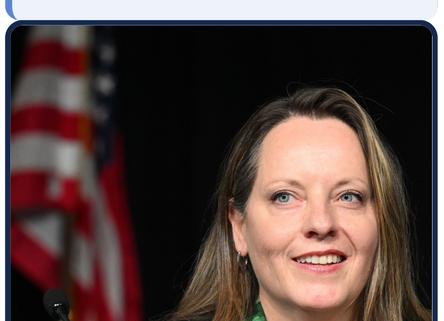
Dr. Knowles has been a dedicated member of ACEP since 2002 and brings extensive experience from both rural and community emergency medicine, along with significant leadership at the national and chapter levels. Her depth of experience and steady leadership make her exceptionally well-suited to guide emergency medicine through the challenges facing our specialty today.

Throughout her service to ACEP she has held numerous leadership roles, including Vice President of Membership, Secretary-Treasurer, Board Member, and Councillor, and contributed through the Ethics Committee and the 911 Network.

Within TCEP, she has served in every officer position, culminating in her presidency in 2018. When the chapter operated without staff for more than a year, she personally managed daily operations, often in the office four to five days a week after completing clinical shifts, keeping the organization stable through that transition. She directed TCEP's Residency Visit Program, now spanning 18 residency programs across Texas, and continues to represent physicians on Texas Medical Association committees and in its House of Delegates.

Sincerely,
Bryan Dunn, MD, FACEP
President, Texas College of Emergency Physicians

> *Her depth of experience and steady leadership make her exceptionally well-suited to guide emergency medicine through the challenges facing our specialty.*
>
> TEXAS COLLEGE OF EMERGENCY PHYSICIANS



Heidi Knowles, MS, MD, FACEP
Candidate for ACEP President-Elect
PRINCIPLED · FOCUSED · UNAFRAID

Here for you. Here for our specialty.

I respectfully ask for your vote for ACEP President-Elect.

(903) 681-3762 · hknowles@acep.org

PROVEN LEADERSHIP · DEDICATED SERVICE · TRUSTED ADVOCATE

HEIDI C. KNOWLES, MD, FACEP

Emergency Physician · ED Operations Leader · National Emergency Medicine Leader and Advocate

Fort Worth, Texas · (903)681-3762 · **hknowles@acep.org**

EXECUTIVE LEADERSHIP

Vice Chair and Chief of Operations
Medical Director, Department of Emergency Medicine

John Peter Smith (JPS) Health Network − Fort Worth, Texas
Level 1 Trauma Center ~135,000 visits annually

Interim Medical Director

Department of Emergency Medicine, St Francis Hospital − Tulsa, Oklahoma
Level 1 Trauma Center ~75,000 visits annually

NATIONAL LEADERSHIP

American College of Emergency Physicians
Vice President, Membership, 2025-Present
Secretary-Treasurer, 2024-2025
Board of Directors, 2021-Present

ACEP Representative
Federation of State Medical Boards, 2020-2025

Board Liaison to multiple ACEP committees and sections, including Medical-Legal, Academic Affairs, Chapter Relations, Ultrasound, Freestanding Emergency Centers, AAWEP, Cruise Ship Medicine, Early Career Physicians, EMRA, and Membership

STATE LEADERSHIP

Texas College of Emergency Physicians
President, 2017-2018
Immediate Past President, 2018-2019
Treasurer, 2015-2016
Board of Directors, 2012-2019

Emergency Medicine Political Action Committee of Texas (EMPACT)
Executive Board / Controlling Member

PROFESSIONAL EXPERIENCE

Vice Chair, Chief of Operations & Medical Director 1/2023-Present
Integrative Emergency Services - John Peter Smith Hospital, Fort Worth, Texas
Level 1 Trauma Center · Emergency Medicine Residency · ~135,000 visits/yr

Previously held leadership roles within the department:
Associate Medical Director August 2020-December 2022
Assistant Medical Director, July 2019-July 2020
Director-Leadership and Advocacy, July 2015-June 2019
Core Faculty, Emergency Medicine Residency, July 2015-Present

Interim Medical Director 8/2025-5/2026
Integrative Emergency Services - St. Francis Hospital - Tulsa, Oklahoma
Level 1 Trauma Center · EM Residency Program · ~75,000 patients/year

Southlake Emergicare
Texas Health Southlake ED, December 2016-Present
Trinity Valley Community College
EMS Program Medical Director, April 2011-Present
Palestine Regional Medical Center
EmCare 2012-2017
Emergency Service Partners 2006-2012
Rural ED, 32,000 volume, Level 3 Trauma Center
University of Texas Health Science Center - Houston
Memorial Hermann Hospital, October 2011 to August 2015
Level 1 Trauma Center, EM Residency, Staff Physician
Pegasus
Metroplex Hospital-Killeen August 2012-December 2012
Staff physician (temporary position for new contract start-up)

LEADERSHIP AND GOVERNANCE

American College of Emergency Physicians (ACEP) 2002-Present
Vice President, Membership 2025-Present
Secretary-Treasurer − 2024-2025
Board of Directors − 2021-Present

ACEP Committees
Ethics Committee (2015-2019)
Reference Committee (2010, 2016)
Tellers and Credentials Committee (2011-2013)
Steering Committee (2014, 2015)
Membership Committee 2010-2016

Representative Roles

ACEP Representative to the Federation of State Medical Boards (2020-2025)
ACEP Representative, Society of Critical Care Medicine Committee to develop Guidelines to Identify Critical Patients Outside the Emergency Department 2020-2023

Texas College of Emergency Physicians (TCEP)
President 2017-2018
President-elect 2016-2017
Immediate Past President 2018-2019
Treasurer 2015-2016
Young Physician Representative 2012-2013
Board of Directors, 2013-2016
Residency Visit Lecture Program
Coordinator 2014-2018
Leadership and Advocacy Program Fellow 2010

Emergency Medicine Political Action Committee of Texas (EMPACT)
Executive Board / Controlling Member 2018-Present

Texas Medical Association
Young Physician Section Delegate 2012-2014
Young Physician Section Steering Committee 2012-2014
TexPAC Vice Chair, Region 2012
Inter-specialty Society Committee - TCEP Representative
Delegate 2014-Present
Anderson-Leon County Medical Society Member 2006-2019
Tarrant County Medical Society Member 2019-Present

Society of Academic Emergency Medicine
Faculty Development Committee 2016-2018
Speed Mentoring Faculty 2017-2018

TEACHING AND EDUCATIONAL LEADERSHIP

Core Faculty, Emergency Medicine Residency Program - JPS Health Network
Residency mentorship and didactics, including airway management, acute coronary syndromes, orthopedic emergencies, HEENT procedures, obstetric emergencies, emotional intelligence, and physician leadership

Course Director
ABCD (Airway, Breathing, Circulation & Difficult Delivery) Simulation Course, 2017-2019

EMS Program Medical Director
Trinity Valley Community College
Classroom lectures and clinical teaching for paramedic and EMT students

Department of Pharmacy Lecture

Burnout Identification and Prevention
JPS Health Network-June 2019

Residency Visit Coordinator - Texas College of Emergency Physicians

Career development lecture for residents on topics including Leadership / Advocacy / Life After Residency / Myths of EM / Hot Topics of EM / Importance of Getting Involved / Maximizing Efficiency in the ED / Motivation

INVITED PRESENTATIONS AND NATIONAL LECTURES

National and Organizational Leadership Presentations

American College of Emergency Physicians Leadership and Advocacy Conference

Succession Planning February 2018
Contract Management Groups: Historical Perspectives May 2022

American Association of Women Emergency Physicians (AAWEP)

Why Lead Now - Discussion Panel May 2023
Women in EM January 2025
When Doing Nothing Is More Dangerous March 2026

Academic Grand Rounds

UT Southwestern Department of Emergency Medicine − Grand Rounds

Decision Making When the Margin of Error is Zero March 2026

UT Health San Antonio Department of Emergency Medicine − Grand Rounds

Emerging Infectious Diseases April 2015

Regional Educational Lectures

Texas College of Emergency Physicians Annual Meeting

LLSA Review − 2019, 2020, 2022, 2023

RESEARCH AND SCHOLARSHIP

Research contributions focused on physician well-being, empathy in emergency medicine, and the relationship between physician culture and patient experience

Peer-Reviewed Publications

1. **Knowles HC**, Swoboda TK, Sandlin D, et al. The association between electronic health information usage and patient-centered communication. *BMC Health Services Research*. 2023.
2. Holmes CT, Huggins C, **Knowles H**, et al. The association of name recognition, empathy perception, and satisfaction with resident physicians' care. *J Clin Med Res*. 2023.
3. Kirby R, **Knowles HC**, Patel A, et al. Physician empathy and patient satisfaction. *Health Science Reports*. 2021.
4. Byrd J, **Knowles H**, et al. Synergistic effects of emergency physician empathy and burnout on patient satisfaction. *Emergency Medicine Journal*. 2021.

5. Jyothindran R, et al., **Knowles HC**. Burnout and wellness culture among emergency medicine providers. *Clin Exp Emerg Med*. 2021.
6. Jyothindran R, et al., **Knowles H**. Fulfillment, burnout and resilience in emergency medicine. *PLOS One*. 2020.
7. Wolfshohl JA, et al., **Knowles H**. Empathy and burnout among emergency medicine physicians. *J Clin Med Res*. 2019.
8. **Knowles H**, Huggins C, Robinson R, et al. Seventy-two-hour ED return visits among homeless patients. *J Clin Med Res*. 2019.
9. Huggins C, **Knowles H**, Wang H. Predicting emergency department return visits. *Clin Exp Emerg Med*. 2019.
10. Marco CA, et al., **Knowles H**. Prescription drug monitoring programs: ethical issues in the ED. *Annals of Emergency Medicine*. 2016.
11. Morgan D, Wainscott M, **Knowles H**. EMS liability litigation in the United States. *Prehospital Disaster Medicine*. 1994.

Book Chapters

- Holmes M, Stanzer M, Schrader C, **Knowles H**. *Emergency Medicine Advocacy Handbook*.
- Mazur B, Jennings A, **Knowles H**. *Reichman's Emergency Medicine Procedures.*

Educational Clinical Reviews

- Freeman L, Carvajal M, **Knowles H**. Treating hypertension in the emergency department—Part 1. *Emergency Medicine Reports.* 2005;26(7):1-12.
- Freeman L, Carvajal M, **Knowles H**. Treating hypertension in the emergency department—Part 2. *Emergency Medicine Reports.* 2005;26(8):1-12.

Grants and Research Support

Site Principal Investigator
BrainBox Inc. – HeadSMART2 Trial
Serum Biomarkers and Multimodal Assessment of Traumatic Brain Injury
JPS Health Network

Sub-Investigator
Calcimedica – CARPO Trial
Auxora for Acute Pancreatitis with Systemic Inflammatory Response Syndrome
JPS Health Network

Sub-Investigator
Comprehensive Research Associates – PLATINUM Trial
Patiromer for Hyperkalemia in Emergency Department Patients
JPS Health Network

EDUCATION

Emergency Medicine Residency

University of Texas Health Science Center at Houston
Memorial Hermann Hospital, Houston, Texas 07/03–06/06

University of Texas at Houston, Medical School
Houston, Texas
Doctor of Medicine 08/99–06/03

Southwest Texas State University
San Marcos, Texas
Master of Science-Microbiology 01/96–08/98
Bachelor of Science-Biology/Chemistry minor 08/90–05/94

LICENSURE

Texas Medical License
Oklahoma Medical License

BOARD CERTIFICATION

American Board of Emergency Medicine 12/17–12/27

ACADEMIC APPOINTMENT

Assistant Professor, Burnett School of Medicine at TCU

AWARDS

John Peter Smith Hospital Physician of the Year 2021
Texas Health Resources Southlake Physician of the Quarter 6/2017
James E. Hayes Award for Outstanding Contributions to TX Emergency Medicine 2019
Outstanding Emergency Medicine Resident- UT Houston 2006

VOLUNTEER ACTIVITIES

Henderson County United Way Board of Directors, 2009-2013
Hurricane Katrina Disaster Relief, Astrodome Physician Services, 09/05
Kiwanis Club of Athens, Sponsored Youth Director 2009-2013
Trinity Habitat for Humanity Cowtown Brushup 2017, 2018, 2025
North Texas Alliance for Clinical Resilience 2018-2019

PERSONAL

Born in McKinney, Texas
Married to Michael Ely, DC
Hobbies/interests include travel, scuba diving, gardening, and beekeeping

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Kristin B. McCabe-Kline, MD, FACEP

Question #1: **How do you suggest ACEP navigate policy issues in a highly partisan political environment?**

We currently find ourselves in a very polarized and highly partisan environment. I believe strongly that the key to moving forward successfully requires ACEP to focus on issues, not parties or alignments that are in conflict with the consensus view reflective of the many perspectives of our diverse members. We need to focus on the areas where we opine, support, or oppose a policy based on the issue at hand. ACEP members fall on both sides of the aisle, as do our consensus positions on issues.

It is essential that we work to set aside our many differences recognizing there are more issues on which we are solidly aligned. These are the spaces where we need to lean in and speak with a definitive collective voice. In order to execute properly, ACEP needs to listen to our members and leaders to ensure we are stepping forward on behalf of emergency medicine physicians as well as our care teams, patients, and communities. This requires a strong moral compass and servant leadership which I am well prepared to provide on behalf of ACEP.

As the current landscape is highly polarized, a collaborative and team building strategy is imperative. We will need to work with difficult organizations and individuals to properly position ourselves for the best possible outcomes. Emergency physicians do not fear dumpster fires or back away from crucial conversations- our specialty emerged because we have been doing this work locally and globally on a regular basis. I am committed to representing our collective voice with persistence and patience when we face complex issues (tack hammer approach) and a firm stance (sledge hammer approach) when considering proposed policy.

Question #2: **How would you allocate your time as president to advance ACEP's strategic priorities given the competing demands on finite resources?**

ACEP needs to work strategically and with strong direction to stay aligned with the goals of our members which are the lifeblood of of our organization. There are times when we need to allocate substantial effort toward our objectives and other times when we are working in a silo without collaborating appropriately to capitalize on our strong relationships with other organizations and their work products.

Governance plays a strong role in how we should be working. ACEP needs to lean on our dedicated members and the work of our committees and sections who have many relationships and tentacles into pockets of experts across the health care landscape. We cannot dedicate resources to a conflicted initiative that will not support the future of our specialty or a position of strength within the house of medicine and policy making communities. Working closely with our Executive Director and staff as well as the Council and Board of Directors is essential.

At the end of the day, there will always be things we should do more of, things we should continue doing, and things we should abandon. A high degree of discernment and active listening are core skills that are needed to move forward to ensure we are working smarter, not harder. I am committed to bringing these skills to the table on behalf of ACEP.

Question #3: **What existential problems in emergency medicine keep you awake at night?**

The single item that keeps me awake more than any other is the internal conflicts we have allowed into our house as emergency medicine physicians. We are more aligned than we think, but there are always personal experiences and perspectives that have sometimes resulted in us finding fault with one another. Emergency medicine physicians have far too many external threats and divisive forces to create more of our own.

Laser focus on the key issues and areas were we are strongly aligned will help to resolve some of the fracture lines that currently exist within ACEP. We are a tribe, family, and share a collective experience known by no other humans. We need each other personally and professionally. I am committed to perpetuating a sense of belonging and family to ACEP members. We stand on the shoulders of those who came before us and we are stronger, better, and healthier together.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Kristin B. McCabe-Kline, MD, FACEP

Contact Information

91 Island Estates Pkwy.
Palm Coast, FL 32137
Phone: (386) 283-2326
E-Mail: kmccabemd@gmail.com

Current and Past Professional Position(s)

CMIO AdventHealth Growth & Acquisitions, Divisional CMIO East Florida
EMS Medical Director, Flager County/City of Palm Coast/City of Flager Beach/AllCare
CMO WaterSafe

Education (include internships and residency information)

Advocate Christ Medical Center Emergency Medicine Residency Program
Program Director: Robert Harwood, M.D.
Oak Lawn, Illinois, June 2002 – June 2005

M.D. University of Texas Medical School, San Antonio, Texas, 1998-2002
Top 20% of Graduating Class

B.A. Rice University, Houston, Texas, 1994-96 (Major: English)
Rice University President's Honor Roll

University of Michigan, Ann Arbor, Michigan, 1992-94, 1996
University of Michigan Class Honors

Harvard University, Cambridge, Massachusetts, Summer 1993

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM Subspecialty Certified in EMS 2021
ABEM Specialty Certified in 2007 and recertified in 2017

Professional Societies

ACEP
AAEM
AMA
FCEP
FMA
FLAAEM
ACHE

National ACEP Activities – List your most significant accomplishments

VP Membership, American College of Emergency Physicians, 2024-25
Treasurer, American College of Emergency Physicians, 2023-2024
Board Member, American College of Emergency Physicians, 2022-present
Board Liaison, ED Accreditation Program Board of Governors, 2022-present
Board Liaison, EMS Committee, 2022-present
Board Liaison, Quality&Patient Safety Committee, 2022-2023
Faculty, Indy Master Class, American College of Emergency Physicians, 2021-present
Councillor, American College of Emergency Physicians, 2013-2022
Council Steering Committee, American College of Emergency Physicians, 2020-2022
Candidate Forum Subcommittee of the Council Steering Committee, American College of Emergency Physicians,
Annual Meeting Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physi
Chair, Council Reference Committee B 2018, American College of Emergency Physicians
Council Reference Committee B 2015, American College of Emergency Physicians
Quality&Patient Safety Committee, 2020-2022, American College of Emergency Physicians
Measure Lifecycle Subcommittee of the Quality & Patient Safety Committee, 2020-2022, American College of Emergency Physicians
Reimbursement Committee, 2019-present, American College of Emergency Physicians
Surprise Medical Billing (SMB)/Independent Dispute Resolution (IDR) Implementation Joint Task Force, 2021-2 American College of Emergency Physicians and EDPMA
Emergency Medicine Practice Committee, 2017-2022, American College of Emergency Physicians
Best Practices for Incidental Findings in the Emergency Department National Working Group, 2021-2024, Selecte representative of the ACEP Emergency Practice Committee for this Joint Venture Project with the American C of Radiology
Chair, Policy Statement Supporting Safer Working Conditions for Emergency Care
Workers Subcommittee of the EM Practice Committee, 2020-2021, American College of Emergency Physicians
Award Selection Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
Disaster Preparedness Joint Subcommittee of the EM Practice Committee and the Disaster Management Section, American College of Emergency Physicians
Chair, EM Subspecialty Board Certification Subcommittee of the Emergency Medicine Practice Committee, 2019 American College of Emergency Physicians
Disaster Preparation Standards Related to Personal Protection Equipment in the ED, Subcommittee of the EM Pra Committee, 2021, American College of Emergency Physicians
EMS Committee, 2017-2022, American College of Emergency Physicians
Democratic Group Practice Section, 2016- present, American College of Emergency Physicians
Emergency Medical Services-Prehospital Care Section, 2016-present, American College of Emergency Physicians
Freestanding Emergency Centers Section, 2016-present, American College of Emergency Physicians
Well Being Committee, 2016-2017, American College of Emergency Physicians
Physician Representative, 2013 Rand Corporation Study US Value of Emergency Medicine

ACEP Chapter Activities – List your most significant accomplishments

Immediate Past President, Florida College of Emergency Physicians, 2021-22
President, Florida College of Emergency Physicians, 2019-2021
- Served Two Consecutive Terms (1 of 3 people to have done so over 50 years)
- Completed Executive Search/Transitioned CEO and Organizational Restructure
- Revised Bylaws
- Established Women in Medicine Committee
- Established Florida EM Physician Owned Corporation Consortium

President Elect, Florida College of Emergency Physicians, 2018-2019
Vice President, Florida College of Emergency Physicians, 2017-2018
Treasurer, Florida College of Emergency Physicians, 2016-2017
Bylaws Task Force, Florida College of Emergency Physicians 2020
Executive Committee, Florida College of Emergency Physicians, 2016-present
Finance Committee, Florida College of Emergency Physicians, 2016-present
Board of Directors, Florida College of Emergency Physicians, 2013-present

Women in Emergency Medicine Committee, Florida College of Emergency Physicians, 2019-present
Florida EM Physician Owned Corporation Consortium, Florida College of Emergency Physicians, 2019-present
Government Affairs Committee, Florida College of Emergency Physicians, 2013-present
Medical Economics Committee, Florida College of Emergency Physicians, 2013-present
Pediatrics Committee, Florida College of Emergency Physicians, 2013-present
EMS Committee, Florida College of Emergency Physicians, 2013-present
Readmissions Stakeholder Summit Panelist, 2017, Florida Hospital Association
Florida Office of Insurance Regulation and Insurance Consumer Advocate, Emergency Medical Transportation Work Group, 2016-2017
Faculty/Panel Moderator, FCEP Emergency Medicine Payment Reform Summit, 2017-2019

Practice Profile

Total hours devoted to emergency medicine practice per year: **3000** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **10** % Research **10** % Teaching **40** % Administration **40** %
Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Employed as a CMIO for a national health care system that is the largest health care provider in my community.
Contracted with all EMS agencies in the county where I reside.
Volunteer for non-profit WaterSafe to prevent childhood drowning.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Vice President and CMIO, AdventHealth
Medical Director, all EMS agencies within Flagler County
CMO, WaterSafe

Expert Witness Experience

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Defense Expert	**Cases**	**Plaintiff Expert**	**Cases**

I previously contracted with a consulting firm to opine regarding Florida State Medical Board cases. I am no longer serving in that role (and have not done so for as long as I have been on the ACEP BOD). I have never provided expert witness testimony in any case other than those I was asked to review for the Florida State Medical Board.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Kristin B. McCabe-Kline, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: AdventHealth

Address: 900 Hope Way

Altamonte Springs, FL 32714

Position Held: Chief Medical Information Officer

Type of Organization: Health Care System

Employer: EMS Agencies within Flagler County (Flagler County/City of Palm Coast/City of Flagler Beach/AllCare)

Address: multiple

Position Held: Medical Director

Type of Organization: EMS agencies

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: WaterSafe

Address: Virtual – no physical address

Type of Organization: Non-profit providing free swim lessons and water safety awareness

Leadership Position: CMO

Term of Service: 2016-present

Organization: AdventHealth

Address: 900 Hope Way

Altamonte Springs, FL 32714

Type of Organization: Health Care System

Leadership Position: Clinical Care Committee

Term of Service: currently serving second term

Organization: Florida College of Emergency Physicians

Address: 3717 S. Conway Road

Orlando, FL 32812

Type of Organization: Florida State Chapter of ACEP

Leadership Position: Immediate Past President

Term of Service: August 2021- August 2022

Organization: Flagler County EMS Advisory Board

Address: 1769 E. Moody Blvd, Building 3

Bunnell, FL 321102

Type of Organization: Advisory Board to the County Commissioner

Leadership Position: Chair

Term of Service: 2014-25

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

Not applicable

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Kristin McCabe-Kline May 26, 2026

FCEP | Florida College of Emergency Physicians

A CHAPTER OF THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
400 N Wymore Rd • Winter Park, FL 32789
(407) 281-7396 • FAX (407) 281-4407
www.fcep.org

Officers:

Saundra, Jackson MD, FACEP
President

Blake Buchanan, MD, FACEP
President-Elect

Shayne Gue, MD, FACEP, FAAEM
Vice-President

Eliot Goldner, MD, FACEP
Secretary-Treasurer

Todd L. Slesinger, MD, FACEP, FCCM, FCCP
Immediate Past President

Melissa Keahey
Executive Director

Board of Directors:

Rajiv Bahl, MD, MBA, MS, FACEP
Tom Bentley, MD, FACEP
Stuart Bumgarner, MD
Kylie Caouette, DO
Latha Ganti, MD, FACEP
Kyle Gerakopoulos, MD, MBA, FACEP
Anton Gomez, DO, FACEP
Steven B. Kailes, MD, FACEP
Joseph King, MD
Sara Kirby, MD
Kristin McCabe-Kline, MD, FACEP, FAAEM, FACHT
Brandy Milstead-Hollingsworth, MD
Vincent Roddy, MD, MBA, FACEP
Jeremy Selley, DO, FACOEP
Zach Terwilliger, MD
Josef Thundiyil, MD, MPH, FACEP
Christine Van Dillen, MD, FACEP
Stephen Viel, MD, MBA, FACEP
Cristina Zeretzke, MD, FACEP

Dr. McCabe-Kline's candidacy reflects the very best of our specialty—experienced leadership, strong governance, and an unwavering commitment to emergency physicians and the patients we serve. Now serving her second term on the ACEP Board of Directors and having served as Secretary-Treasurer as well as Vice President of Membership, she has demonstrated a clear ability to navigate complex organizational, clinical, and policy challenges with sound judgment and strategic perspective.

Her leadership journey has been grounded in meaningful service and sustained impact. Within FCEP, she has served in numerous leadership roles, including President, where she led for two consecutive terms in that role with clarity and purpose during a period of transition. She continues to contribute as a trusted advisor and mentor while remaining actively engaged with our chapter and its members. FCEP has worked closely with Dr. McCabe-Kline for many years and has seen firsthand the results of her leadership at both the state and national levels.

Dr. McCabe-Kline brings a comprehensive understanding of ACEP's governance and priorities. Her work across key committees including Council Steering, Reimbursement, EMS, Emergency Medicine Practice, and Quality and Patient Safety reflects both the breadth of her experience and her commitment to advancing practical solutions for emergency physicians. Just as importantly, she is a collaborative and steady leader who builds trust and works effectively across diverse perspectives. She approaches challenges with a pragmatic, solutions-oriented mindset grounded in real-world experience.

Emergency medicine is at a defining moment. Issues related to reimbursement, workforce sustainability, practice environment, and patient access continue to shape the future of our specialty. ACEP requires leaders who not only understand these challenges but are prepared to move meaningful work forward on behalf of its members.

Kristin McCabe-Kline is that leader.

The Florida College of Emergency Physicians offers its strong and unequivocal support for Kristin B. McCabe-Kline, MD, FACEP, FAAEM, FACHT, as President-Elect of the American College of Emergency Physicians. We are confident in her ability to lead with purpose, represent emergency physicians nationwide, and advance the priorities critical to our specialty.

KRISTIN MCCABE-KLINE



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Kristin Bond McCabe-Kline, MD, FACEP, FAAEM

91 Island Estates Pkwy
Palm Coast, FL
32137
Cell (386) 283-2326
kmccabemd@gmail.com

EMERGENCY MEDICINE RESIDENCY TRAINING

Advocate Christ Medical Center Emergency Medicine Residency Program
Program Director: Robert Harwood, M.D.
Oak Lawn, Illinois, June 2002 – June 2005

EDUCATION

M.D. **University of Texas Medical School**, San Antonio, Texas, 1998-2002
Top 20% of Graduating Class

B.A. **Rice University**, Houston, Texas, 1994-96 (Major: **English**)
Rice University President's Honor Roll

University of Michigan, Ann Arbor, Michigan, 1992-94, 1996
University of Michigan Class Honors

Harvard University, Cambridge, Massachusetts, Summer 1993

PROFESSIONAL WORK EXPERIENCE

Vice President/Chief Medical Information Officer, Growth & Acquisitions
Divisional Chief Medical Information Officer, East Florida Division
AdventHealth

Altamonte Springs, Florida (7/24-present)
Chief Medical Information Officer of AdventHealth Growth and Acquisitions responsible for working with greenfield projects as well as acquisitions across the organization to understand and execute upon change management needs while adhering to AdventHealth governance and standards. This includes incorporation of the AdventHealth single platform of Epic, integration with local third party applications, consideration of local bylaws/rules and regulations, and medical staff cultures. Reports directly to the AdventHealth Corporate Chief Medical Information Officer. Equivalent responsibilities to both AdventHealth Clinical and AdventHealth Information Technology. Collaborates with senior leadership to meet market needs while ensuring that systems development is enterprise applicable. Works with Epic, EI Agfa, and other vendors to develop and mature their products, particularly as clinical practice evolves and complex needs of service lines are accommodated. Evaluates a variety of clinical pathways working closely with the AdventHealth Evidence Based Medicine team. Also responsible for overseeing difficult service lines requiring integration of multiple vendor products to execute on deliverables including Cardiology, Pediatric Cardiology, Medical Oncology, and Radiation Oncology in close coordination with the corresponding AdventHealth

Institutes. Regular participation in meetings and strong alignment/collaboration with the AdventHealth Legal, Risk, and Compliance experts along with Corporate Responsibility leadership.

Vice President/Chief Medical Information Officer, AdventHealth Central Florida Division

Altamonte Springs, Florida (10/21-6/24)

Chief Medical Information Officer of the AdventHealth Central Florida Division responsible for more than 50% of the corporation and reports directly to the AdventHealth Corporate Chief Medical Information Officer. Equivalent responsibilities to both AdventHealth Clinical and AdventHealth Information Technology. Works to collaborate with CEOs, COOs, CMOs, CNOs, and CFOs to meet market needs while adhering to corporate governance ensuring that systems development is applicable across the enterprise. Works with Epic and other vendors to develop and mature their products, particularly as clinical practice evolves and complex needs of service lines are accommodated. Evaluates a variety of clinical pathways working closely with the AdventHealth Evidence Based Medicine team. Transitioned quickly into this role while AdventHealth was leveraging Cerner and on the eve of transitioning to Epic. Took the Central Florida Division East Region live on Epic in March 2022, followed by the Central Florida Division South Region live on Epic in July 2022. Subsequently assisted with change management and operational planning for all Go Lives including the West Florida Division in December 2022, Multi-State Division in March 2023, Great Lakes Region in October 2023, and Rocky Mountain Region January 2024.

Flagler County Fire Rescue Emergency Medicine Services Medical Director,

Bunnell, Florida (8/14-present)

City of Palm Coast Emergency Medicine Services Medical Director,

Palm Coast, Florida (8/14-present)

Flagler County Sheriff's Department Medical Director,

Bunnell Florida (8/14-present)

City of Flagler Beach Emergency Medical Services Medical Director,

Flagler Beach, Florida (10/14-present)

Providing medical direction for all EMS agencies in Flagler County including ongoing work group of Field Training Officers to continually keep guidelines up to date. Oversight of Flagler County Fire Rescue Fire Flight program. Initiated monthly QA meetings utilizing technology to achieve 100% participation of all medics. Work with Flagler County Emergency Manager, Chiefs of all First Responder agencies as well as AdventHealth Palm Coast administration to perform periodic disaster drills. Oversight of SWAT Medic program in coordination with the Sheriff's Department. ***Developed a Community Paramedicine program for Flagler County Fire Rescue incorporating close communication with AdventHealth Care Management, community providers, and local agencies to improve access to care and promote health equity. Empowered all first responders to initiate treatment with intranasal Narcan when appropriate. Coordinated "Leave Behind Narcan" program for first responders.***

Flagler Technical College EMT Training Program Medical Director

Palm Coast, Florida (7/18-present)

Providing medical direction for all EMT program instructors and oversight of all EMT students. Responsible for adherence of the program to state statute and coordination of field training with local EMS agencies as well as in hospital clinical training at AdventHealth Palm Coast. Proctor of final clearing exam upon completion of the classroom and clinical training assuring proficiency to graduate the EMT course.

AllCare Medical Transport Medical Director

Flagler County, Florida (4/21-present)

Assisted this medical transport company in becoming a BLS transport entity and an ALS entity throughout 2021 including adherence of the program to state statute and coordination of certification and clearing processes to provide community standards for medical transport and competencies beyond state requirements. Providing medical direction and oversight of quality assurance programming.

Vice President/Regional Operations Coordinator, Emergency Medicine Professionals

Volusia/Flagler Counties, Florida (5/17-12/21)

Regional Operations Coordinator specifically works with the Emergency Medicine Professionals Executive Committee and Board of Directors to support corporate operations and development as well as corporate management and Emergency Department/Hospital throughput. The Regional Operations Coordinator serves to provide high level communication to the AdventCare Health System Central Florida Region North Division Administrations as well as working on health care process improvement and care delivery innovation with AdventHealth Corporate Administration.

Chief of Staff, Florida Hospital Flagler (Now AdventHealth Palm Coast)

Palm Coast, Florida (1/16-12/18)

Participating in expansion of capacity from 99 to 150 patients including observation unit following new construction, sole hospital in Flagler County, with thriving Interventional Cardiology program, Orthopedic Center of Excellence, Cancer Center, and Robotic Surgery program. Initiating improved hospital wide throughput utilizing LEAN methodologies. Rolling out hospital wide Just Culture education and responsible for ensuring medical staff compliance. Completed Bylaws revision. ***Awarded the "2016 Florida Hospital Mission Award" while serving as Chief of Staff.***

Daytona International Speedway

Daytona Beach, Florida (1/15-5/18)

Attending Physician serving as "99" or trackside physician as well as providing physician services at the Infield Care Center for participants, crew members, employees, and fans. ***Provided pre-hospital care on scene and during transport for Kyle Busch post crash February 21, 2015.***

Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)

Palm Coast, Florida (1/16)

Assistant Medical Director, Served in this role to help transition the new Medical Director into his position as well as launching two projects that had been in process for the past year: Emergency Department Improvement Team (ongoing LEAN team to continually address reduction of waste in ED processes) and introduction of Tele-Neurology including Stroke LEAN event.

Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)

Palm Coast, Florida (4/14-12/15)

Medical Director 30+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Transitioned this new contract as an employee of **Emergency Medicine Professionals**. ***Decrease in LWBS from 14% to 1% with Press Ganey scores improved from 70th %tile to 90th %tile.***

Bert Fish Medical Center Emergency Department (Now Advent Health New Smyrna)

New Smyrna Beach, Florida (1/12-3/14)

Medical Director 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**. BFMC ED awarded "***Innovation of the Year in Patient Care***" by the Florida Hospital Association in 2012 for implementation of multiple initiatives to improve patient focused care with an emphasis on quality and safety.

Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)

New Smyrna Beach, Florida (4/11-12/11)

Attending Physician 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

Florida Hospital Fish Memorial Emergency Department (Now AdventHealth Fish)

Orange City, Florida (1/11-3/11)

Attending Physician 30+ Bed ED with Cardiology, Pulmonology, Surgery, Gastroenterology, Orthopedic, Gyn, ENT, Psychiatry, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**. ***VOTED INTO PARTNERSHIP IN APRIL 2011 AFTER MINIMUM PREREQUISITE 18 MONTH PERIOD.***

Florida Hospital DeLand Emergency Department (Now AdventHealth DeLand)

DeLand, Florida (10/10-12/10)

Attending Physician 25+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Ob/Gyn, Psychiatric, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)

New Smyrna Beach, Florida (8/09-7/10)

Attending Physician 20+ Bed ED with Cardiology, Cardiac Cath Lab, Surgery, Gastroenterology, Orthopedic, GYN, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

Carolina Emergency Medicine Physician Association, Partner, Director ED Operations

Greenville, South Carolina (7/05-6/07 and 1/08-6/10)

Attending Physician rotating in four facilities of the Greenville Hospital System.
Greenville Memorial Hospital (*Greenville*): Level I Trauma Center with 90,000 ED visits annually. 50+ Bed ED including Critical Care, Intermediate Care, Pediatric, Cardiac Care, and Fast Track Areas.
Allen Bennett Memorial Hospital (*Greer*): 30,000 ED visits annually in this 25+ Bed ED with Ob/Gyn, Cardiology, Orthopedic, Gastroenterology, and General Surgery specialty service availability on site.
Hillcrest Memorial Hospital (*Simpsonville*): 25,000 ED visits annually in this 20+ Bed ED with Orthopedic and General Surgery specialty service availability on site.
North Greenville Hospital (*Travelers Rest*): 10,000 ED visits annually in this 10+ Bed ED with no specialty services on site.
VOTED INTO PARTNERSHIP IN 2007 AFTER MINIMUM PREREQUISITE 2 YEAR PERIOD.
DIRECTOR OF ED OPERATIONS- Including patient experience, Press Ganey orientation and ongoing coaching of physicians, all patient complaints/concerns, facilitating transitions of care.
MEDICAL DIRECTOR, GREENVILLE MEMORIAL HOSPITAL BEHAVIORAL ANNEX- Provided clinical policy oversight, process improvement, and coordination with hospital employed Advanced Practice Clinicians for care of patients awaiting placement at inpatient psychiatric facilities.

Bert Fish Medical Center Emergency Department (Now AdventHealth New Smyrna)

New Smyrna Beach, Florida (1/07-2/08)

Attending Physician 20+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Gynecology, and Nephrology specialty service availability on site. Employed by **Emergency Medicine Professionals**.

Stuart F. Meyer Hospice House

Palm Coast, Florida (8/07-12/07)

Associate Medical Director 8 Bed inpatient Hospice unit providing patient care and facilitating the Interdisciplinary Team involving administration, nursing and patient care staff, social workers, and clergy. Responsible for developing plans of care for terminally ill patients facing imminent expiration, as well as providing inpatient care for those enrolled in the Home Hospice program requiring symptom management or respite care.

Florida Hospital Flagler Emergency Department (Now AdventHealth Palm Coast)

Palm Coast, Florida (5/07-11/07)

Attending Physician Level II Facility with 50,000 visits annually. 20+ Bed ED with Cardiology, Surgery, Gastroenterology, Orthopedic, Gynecology, Pediatric, and Nephrology specialty service availability on site.

Advocate Christ Medical Center, Emergency Department

Oak Lawn, Illinois (6/02-6/05)

Resident Physician in Level I Trauma Center with 82,000 ED visits annually. 50+ Bed ED including Critical Care, General Care, Pediatric, Cardiac Care, and Fast Track Areas. Rotations outside of the Emergency Department include Ultrasound, MICU, PICU, Trauma Surgery, General Surgery, Pediatrics, Orthopedics, Obstetrics/Gynecology, Oral Surgery, EMS, and Radiology.

Henry Ford Health System, Center for Clinical Effectiveness

Detroit, Michigan (10/97-6/98)

Administrative Assistant and **Data Analyst** working on several outcomes-based research projects and grant applications (including NIH). Worked under the Director of Cardiovascular Informatics to coordinate computer programmers and outside consultants to develop a new computer-based cardiovascular information system for electronic charting in the hospital/clinic as well as formation of a queryable database.

St. Joseph Mercy Health System, McPherson Hospital, Emergency Department

Ann Arbor/Howell, Michigan (8/96-10/97)

Unit Clerk in the Emergency Department coordinating inter-departmental services and patient care including hospitalizations and transfers to outlying facilities.

LICENSURE

State of Florida	April 11, 2007 - present
State of South Carolina	March 4, 2005 - present
State of Illinois	June 24, 2002 – July 31, 2005

CERTIFICATIONS

Healthcare Leadership, Administration, and Management Subspecialty Board Eligible
Exam Completed November 19, 2024 (results pending)
EMS Initial Subspecialty Board Certification November 19, 2021
Emergency Medicine Board Recertification January 1, 2018
Emergency Medicine ConCert Exam Pass September 15, 2016

ACEP Directors Academy Graduate

Phase I	November 2011
Phase II	May 2012
Phase III	November 2012
Phase IV	August 2015

FCEP Leadership Academy June 2012 - July 2013

Emergency Medicine Initial Board Certification December 6, 2007

Written Examination	Pass	November 8, 2006	10
Oral Examination	Pass	October 22, 2007	

Diplomate of the National Board of Medical Examiners

USMLE Step 1	Pass	May 26, 2000
USMLE Step 2	Pass	July 2, 2001
USMLE Step 3	Pass	April 14, 2004

PROFESSIONAL ACTIVITIES

Vice President of Membership, American College of Emergency Physicians, 2024-2025
BOD Liaison to the EMRA BOD, American College of Emergency Physicians, 2024-2025
Secretary/Treasurer, American College of Emergency Physicians, 2023-2024
Board of Directors, American College of Emergency Physicians, 2022-present
Executive Committee, American College of Emergency Physicians, 2023-2025
Nominating Committee, American College of Emergency Physicians, 2023-2025
ACEP Liaison to the American College of Surgeons Committee on Trauma, 2023-present
Liaison to the ACEP EMS and Disaster Medicine Committees, 2022-present
Liaison to the ACEP Emergency Department Accreditation Board of Governors, 2023-present
Executive Director Search Firm Selection Committee, American College of Emergency Physicians, 2024
ACEP BOD Liaison to ACEP Council Reference Committee B, 2024
Liaison to the ACEP Finance Committee, 2023-2024
Liaison to the ACEP Health Information Technology Committees & Sections, 2022-2023
AdventHealth Artificial Advisory Council, 2022-present
AdventHealth Epic Steering Committee, 2022-present
AdventHealth Corporate Clinical Informatics Governance Committee, 2022-present
AdventHealth Best Practices Committee, 2022-present
AdventHealth Best Practices Subcommittee, 2022-present
AdventHealth Evidence Based Medicine Order Set Review Committee, 2022-present
AdventHealth Epic Provider Enhancement Request Committee, 2022-present
AdventHealth Corporate CMO Consortium, 2021-present
AdventHealth Legal, Risk, and Compliance Advisory Committee, 2022-present
AdventHealth Population Health Advisory Committee, 2022-present
AdventHealth Referral Governance Committee, 2022-present

AdventHealth Radiology Stewardship Committee, 2022-present
AdventHealth Clinical Excellence Steering Committee, 2023-present
Liaison to the AdventHealth Oncology Institute, 2023-present
Liaison to the AdventHealth Medical Oncology Council, 2023-present
Liaison to the AdventHealth Radiation Oncology Council, 2023-present
Liaison to the AdventHealth Heart, Lung, and Vascular Institute, 2023-present
Liaison to the AdventHealth Cardiology and Pediatric Cardiology Council, 2023-present
Advisor, AdventHealth Emergency Medicine Council, 2022-present
Advisor, AdventHealth Behavioral Health Council, 2022-present
Advisor, AdventHealth Care Management Council, 2022-present
Vice President, Emergency Medicine Professionals, 2017-2021
Executive Committee Member, Emergency Medicine Professionals, 2011-2021
Board of Directors, Emergency Medicine Professionals, 2011-2021
Partner/Shareholder, Emergency Medicine Professionals, 2010-2021
President, Florida College of Emergency Physicians, 2019-2021
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Vice President, Florida College of Emergency Physicians, 2017-2018
Treasurer, Florida College of Emergency Physicians, 2016-2017
Bylaws Task Force, Florida College of Emergency Physicians 2020
Executive Committee, **Florida College of Emergency Physicians,** 2016-2022
Finance Committee, **Florida College of Emergency Physicians,** 2016-2021
Board of Directors, **Florida College of Emergency Physicians,** 2013-2022
Flagler Technical College EMT Advisory Board of Directors, 2018-present
AdventHealth Corporate Emergency Department Reimagine Design Group, 2021-2023
AdventHealth Central Florida Division Clinically Integrated Network Board of Managers, 2021-present
AdventHealth Corporate Transitions of Care Steering Committee, 2020-present
AdventHealth Corporate Transitions of Care Clinical Workstream Committee, 2020-present
AdventHealth Corporate Change Coalition Steering Committee, 2021-2023
AdventHealth Corporate Cross Clinical Advisory Council, 2020-2022
Co-Chair, AdventHealth Cross Clinical Advisory Council Emergency Medicine Rapid Decision Group, 2020-2022
Co-Chair AdventHealth ED/Imaging Subject Matter Expert Working Group, 2020-2022
AdventHealth Corporate Formulary & Therapeutics Critical Care and Emergency Medicine Clinical Advisory Committee, 2020-present
AdventHealth Corporate Care Management Steering Committee, 2021-present
AdventHealth Corporate Epic Advanced Care Planning Working Group, 2020-present

AdventHealth Corporate Epic Opioid Working Group, 2020-present
AdventHealth Corporate COVID-19 Vaccination Planning Taskforce, 2020-2022
AdventHealth Corporate COVID-19 Open Door Task Force, Emergency Medicine, 2020
AdventHealth Corporate Clinical Response to COVID-19 Contributing Author, Emergency Medicine, 2020
AdventHealth Central Florida Division COVID-19 Workstream Task Force, 2020-2022
Co-Chair, AdventHealth Corporate ED Clinical Reliability Council, 2019-2023
AdventHealth Corporate Protecting Access to Medicare Act (PAMA) / Radiology Appropriate Use Criteria (AUC) Clinical Advisory Task Force, 2020-2023
AdventHealth Corporate PAMA/CDSM Committee, 2019-present
AdventHealth Central Florida Division Cardiovascular Institute Heart Failure Steering Committee, 2021-present
Co-Chair, AdventHealth Central Florida Division North Region ED Governance Council, 2019-2021
Co-Chair, AdventHealth Central Florida Division North Region ED/Hospitalist Governance Council, 2018-2021
AdventHealth Central Florida Division North Physician Champion Orthopedics, 2020-2021
AdventHealth Central Florida Division North Physician Champion Neurosciences, 2020-2021
AdventHealth Central Florida Division North Readmissions Committee, 2018-2021
AdventHealth Central Florida Division North Region Transfer Committee, 2018-2021
AdventHealth Central Florida Division North Opioid Stewardship Committee, 2018-2021
AdventHealth Central Florida Division North Region ED/Radiology Council, 2017-2021
AdventHealth Central Florida Division North Region CHF Committee, 2017-2021
AdventHealth Central Florida Division North Region Stroke Committee, 2017-2021
AdventHealth Central Florida Division North Region Pediatric Quality Committee, 2017-2021
Flagler County Open Arm Recovery Services (OARS) Committee, 2020-present
Chief Medical Officer, WaterSafe (501C3), 2019-present
Executive Committee Member, WaterSafe (501C3), 2019-present
Board of Directors, WaterSafe (501C3), 2019-present
Co-Founder, WaterSafe, 2016-present
ED Throughput Council, AdventHealth Daytona Beach, 2017-2021
ED Throughput Council, AdventHealth Fish Memorial, 2017-2021
ED Throughput Council, AdventHealth Deland, 2017-2021
ED Throughput Council, AdventHealth Palm Coast, 2014-present
ED Throughput Council, AdventHealth New Smyrna Beach, 2012-2014, 2017-2021
Board of Directors, Florida Hospital Flagler 1/16-12/18
Chief of Staff, Florida Hospital Flagler 1/16-12/18
Revised Bylaws
EMPros Physician Leader Representative to the Emergency Department Practice Management Association (EDPMA), 2018-2021

Councillor, American College of Emergency Physicians, 2013-2022
Council Steering Committee, 2020-2022, American College of Emergency Physicians
Candidate Forum Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physicians
Annual Meeting Subcommittee of the Council Steering Committee, 2021, American College of Emergency Physicians
Chair, Council Reference Committee B 2018, American College of Emergency Physicians
Council Reference Committee B 2015, American College of Emergency Physicians
Quality&Patient Safety Committee, 2020-2023, American College of Emergency Physicians
Measure Lifecycle Subcommittee of the Quality & Patient Safety Committee, 2020-2023, American College of Emergency Physicians
Reimbursement Committee, 2019-2022, American College of Emergency Physicians
Chair, Reimbursement Committee Working Group 1, 2021-present, American College of Emergency Physicians
Surprise Medical Billing (SMB)/Independent Dispute Resolution (IDR) Implementation Joint Task Force, 2021, American College of Emergency Physicians and Emergency Department Practice Management Association
Emergency Medicine Practice Committee, 2017-2022 American College of Emergency Physicians
Best Practices for Incidental Findings in the Emergency Department National Working Group, 2021-2022, Selected representative of the ACEP Emergency Practice Committee for this Joint Venture Project with the American College of Radiology
Chair, Policy Statement Supporting Safer Working Conditions for Emergency Care Workers Subcommittee of the Emergency Medicine Practice Committee, 2020-2021, American College of Emergency Physicians
Award Selection Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
Disaster Preparedness Joint Subcommittee of the EM Practice Committee and the Disaster Management Section, 2021, American College of Emergency Physicians
Chair, EM Subspecialty Board Certification Subcommittee of the Emergency Medicine Practice Committee, 2019-2020, American College of Emergency Physicians
Disaster Preparation Standards Related to Personal Protection Equipment in the ED, Subcommittee of the EM Practice Committee, 2021, American College of Emergency Physicians
EMS Committee, 2017-present, American College of Emergency Physicians
Democratic Group Practice Section, 2016- present, American College of Emergency Physicians
Emergency Medical Services-Prehospital Care Section, 2016-present, American College of Emergency Physicians
Freestanding Emergency Centers Section, 2016-present, American College of Emergency Physicians
Well Being Committee, 2016-2017, American College of Emergency Physicians
Women in Emergency Medicine Committee, Florida College of Emergency Physicians,

2019-2021
Florida EM Physician Owned Corporation Consortium, Florida College of Emergency Physicians, 2019-2021
Government Affairs Committee, Florida College of Emergency Physicians, 2013-2022
Medical Economics Committee, Florida College of Emergency Physicians, 2013-2022
Pediatrics Committee, Florida College of Emergency Physicians, 2013-2022
EMS Committee, Florida College of Emergency Physicians, 2013-2022
Chair, American Heart Association Go Red for Women Luncheon, 2018
Readmissions Stakeholder Summit Panelist, 2017, Florida Hospital Association
Florida Office of Insurance Regulation and Insurance Consumer Advocate, Emergency Medical Transportation Work Group, 2016-2017
Faculty/Panel Moderator, FCEP Emergency Medicine Payment Reform Summit, 2017-2019
AHS Florida Regional Strategic Physician Leadership Development Program, 2013-2014
Baker Act Interagency Committee, 2012-2016 Volusia and Flagler Counties
Physician Representative, 2013 Rand Corporation Study US Value of Emergency Medicine
Chief of Staff Elect, Florida Hospital Flagler 2015
Interim Chair Department of Medicine, Florida Hospital Flagler 2015
Vice Chief of Staff, Florida Hospital Flagler 2014
Hospital/Physician Strategy Committee, 2014-2016, Florida Hospital Flagler
Medical Executive Committee Member, 2014-2019, Florida Hospital Flagler
Medical Director, 2014-2016, Florida Hospital Flagler Emergency Department
Performance Improvement Committee, 2014-2019, Florida Hospital Flagler
Peer Review Committee, 2014-2019, Florida Hospital Flagler
Biomedical Ethics Committee, 2014-2019, Florida Hospital Flagler
Patient Safety Committee, 2014-2019, Florida Hospital Flagler
Medical Records and Utilization Review Committee, 2014-2018, Florida Hospital Flagler
Emergency Management Committee, 2014-2018, Florida Hospital Flagler
Readmissions Committee, 2014-2018, Florida Hospital Flagler
Care Transitions Committee, 2014-2018, Florida Hospital Flagler
Cardiology Committee, 2016-2018, Florida Hospital Flagler
Stroke Committee, 2014-present, Florida Hospital Flagler
Critical Care Committee, 2016-2018, Florida Hospital Flagler
Pharmacy and Therapeutics Committee, 2016-2018, Florida Hospital Flagler
Community Relations Committee, 2014-2018, Florida Hospital Flagler
Medical Executive Committee Member, 2013, Bert Fish Medical Center
Chair, Peer Review Committee, 2013, Bert Fish Medical Center
Medical Director, 2011-2014, Bert Fish Medical Center Emergency Department
Physician Director, 2010-2014, Stroke Program, Bert Fish Medical Center
Expert Witness, 2010-2020, Abbason & Associates contracted with Florida DOH
Judge, Florida College of Emergency Physicians Annual Case Presentation Competition
Judge, Florida College of Emergency Physicians Annual Simulation Wars Competition
Director of Emergency Department Operations, Carolina Emergency Medicine
Associate Director, Greenville Memorial Hospital Emergency Department Behavioral Annex

(Psychiatric care holding facility within ED for patients awaiting inpatient psychiatric placement.)
Candidate Selection Committee Member, Carolina Emergency Medicine, 2005-2009
Board of Directors, Carolina Emergency Medicine Physicians Association, 2007-2009
Member, Advocate Christ Emergency Medicine Department Journal Club, 2002-2005
Mentor, Advocate Christ Emergency Medicine Residency Mentorship Program, 2003-2005
Member, Advocate Christ Emergency Medicine Residency Selection Committee, 2003-2005

PROFESSIONAL ORGANIZATIONS

Fellow of the American College of Emergency Physicians
Fellow of the American Academy of Emergency Medicine
Founding Fellow of the American College of Healthcare Trustees
Member of the American College of Health Care Executives
Member of the American College of Health Care Executives Physician Forum
Member of the National Association of EMS Physicians
Member of the Florida College of Emergency Physicians
Member of the Florida Association of EMS Medical Directors
Member of the American Medical Association
Member of the Florida Medical Association

AWARDS

ACEP Speaker's Award for Outstanding Service, 2021-2023
AdventHealth Information Technology Clairvoyant Award, 2022
ACEP Speaker's Award for Outstanding Service, 2019-2021
Humanitarian of the Year, AdventHealth Palm Coast Foundation, 2019
ACEP President's Award for Outstanding Service, 2018-2019
Physician of the Quarter, Florida Hospital Flagler, 2017
"Top Doctor" Award, Daytona Beach News Journal, 2016
Mission Leadership Award, Florida Hospital Flagler, 2016
Dedication to Community Service Award, WaterSafe 2016
Health Professional of the Year, Flagler County 2015

PUBLICATIONS

Christopher L. Moore, MD, Andrew Baskin, MD, Anna Marie Change, MD, MSCE, Dickson Cheung, MD, MBA, MPH, Melissa A. Davis, MD, MBA, Baruch S. Fertel, MD, MPA, Kristen Hans, RN, MS, Stella K. Kang, MD, MSc, David M. Larson, MD, Ryan K. Lee, MD, MBA, **Kristin B. McCabe-Kline, MD**, Angela M. Mills, MD, Gregory N. Nicola, MD, Lauren P. Nicola, MD. **White Paper: Best Practices in the Communication and Management of Actionable Incidental Findings in Emergency Department Imaging**. Journal of the American College of Radiology. Volume 20, Issue 4, p422-430, April 2023. Published online March 13, 2023, DOI: https://doi.org/10.1016/j.jacr.2023.01.001

Dr. Kristin McCabe-Kline, MD. FCEP President's Last Message: FCEP's 50th Anniversary Reflections. *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 6, Summer 2021 issue, page 6.

Dr. Kristin McCabe-Kline, MD. FCEP President's Message: Emergency Medicine Workforce: Emergency Medicine is an Essential Voice in the House of Medicine. *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 5, Spring 2021 issue, page 6.

Dr. Kristin McCabe-Kline, MD. FCEP President's Message: Beyond the Pandemic: Stop Surviving and Start Thriving. *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 4, Winter 2021 issue, page 6.

Dr. Kristin McCabe-Kline, MD. FCEP President's Message: Rise Up. *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 27, Number 2, Summer 2020 issue, pages 6-7.

Dr. Kristin McCabe-Kline. Emerging from COVID-19 crisis calls for coming together. Daytona Beach News-Journal May 3, 2020.

Kristin McCabe-Kline: In COVID-19 pandemic, It's time to get to work 'doing right'. *floridapolitics.com* April 30, 2020.

Kristin McCabe-Kline, MD. FCEP President's Message: Finding Peace in the Emergency Department. *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 26, Number 4, Winter 2020 issue, page 6.

Kristin McCabe-Kline, MD. FCEP President's Message: Strategic Goal Updates. *EmPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 26, Number 3, Fall 2019 issue, pages 4-5.

Dr. Kristin McCabe-Kline and Dr. Charles Duva. PHYSICIANS: Medical billing law is rebounding on Volusia, Flagler emergency medical staff. Daytona Beach News-Journal August 21, 2019.

Kristin McCabe-Kline, M.D. Tackling Florida's Opioid Crisis Requires Clinical Collaboration. *Tampa Bay Times*. May 2, 2019.

Kristin McCabe-Kline. Communication Across the Continuum of Care: Emergency Department information exchange (EDie). *EMPulse.* Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 25, Number 2, Summer 2018 issue, page 19.

Kristin McCabe-Kline. Resilience in the Emergency Department. *EMPulse*. Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 23, Number 4, Winter 2016-2017 issue, pages 24-25.

Kristin McCabe, M.D. Don't Tear Safety Net. *Daytona Beach News-Journal*. Community Voices, March 2, 2016.

Kristin McCabe-Kline. End Game in the Emergency Department: The Tip of the Spear. *EMPulse*. Official Publication of the Florida College of Emergency Physicians, a Chapter of the American College of Emergency Physicians. Volume 18, Number 2, Spring 2013 issue, pages 14-15.

Kristin B. McCabe. **Fix-It-Man.** *Preach: Enlivening the Pastoral Art*. Copyright © World Library Publications, A division of J.S. Paluch Company, Inc., Schiller Park, IL. March-April 2005 issue. (This was a commissioned work linking the practice of Emergency Medicine with pastoral avocations for the "Intersections" feature column.)

Shalin S. Shah, Glenn F. Tokarski, James K. McCord, Nabil E. Khoury, **Kristin B. McCabe**, Robert J. Morlock, Husam Noor, Peter A. McCullough. **Acute Coronary Syndromes in the Emergency Room: Impact of an Emergency Department Cardiac Clinical Decision Unit on a Population of Patients with Episodic Chest Discomfort.** *Supplement to Journal of the American College of Cardiology*, February 2000. Volume 35. Supplement A, page 380. Abstract 1127-138.

PRESENTATIONS

Business Ethics: Tying Mission to Financial Success. February 2026
American College of Emergency Physicians Master Class. Dallas, Texas.

EM Town Hall: The ED is the Opportunity. August 2023
Florida College of Emergency Physicians Annual Meeting. Bonita Springs, Florida.

What to Do: Before Day 1 of a New Contract. May 2023
American College of Emergency Physicians Indy Class. Dallas, Texas.

Negotiating Employee Contracts. August 2022
American College of Emergency Physicians Indy Class. Dallas, Texas.

New Contract Change Management. August 2022
American College of Emergency Physicians Indy Class. Dallas, Texas.

One Voice for Volusia. December 2020
Volusia County Florida, Virtual Event.

Flagler Cares Coalition: Opioid Use Disorders. November 2020
Flagler County Florida, Virtual Event.

Emergency Medicine Vision 2030. October 2020
AdventHealth Corporate Clinical Excellence Conference, Altamonte Springs, Florida.

Protecting Access to Medicare Act / Appropriate Use Criteria. October 2020
AdventHealth Central Florida Division North Region CMO Roundtable. Virtual Event.
AdventHealth Central Florida Division North Region CEO Roundtable. Virtual Event.

Regional AdventHealth Opioid Initiatives Presentation. September 2020
Leadership Daytona Class XL Program /Daytona Regional Chamber of Commerce, Virtual Event.

Preparing for the Next Pandemic: Information Flow. September 2020
American College of Emergency Physicians Webinar Series, Virtual Event.

Florida Emergency Medicine Town Hall. August 2020
Symposium by the Sea, Florida College of Emergency Physicians Conference, Virtual Event.

Statewide Effort to Prepare for the COVID-19 Surge in Florida. April 2020
FMDA Quality Advocacy Coalition Stakeholders Virtual Meeting.

Opioid Epidemic Impact and Solutions. August 2019
Keeping Hope: Overdose Awareness & Remembrance Day, Daytona Beach, Florida.

Florida Emergency Medicine Town Hall. August 2019
Symposium by the Sea, Florida College of Emergency Physicians Annual Conference, Boca Raton, Florida.

Fearless and Focused. February 2019
Flagler Professional Women's Council Luncheon Presentation, Palm Coast, Florida.

Emergency Medicine Innovators Summit Panelist Moderator. February 2019
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

Statewide Effort to Avoid Hospital Readmissions Panelist. October 2018
FMDA Quality Advocacy Coalition Stakeholders Workshop, Orlando, Florida.

Emergency Medicine Payment Reform Summit Panelist Moderator. February 2018

FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

EMS Wellness: Where are we? December 2017
FCEP/Emergency Medicine Learning Resource Center Webinar.

Emergency Medicine Innovators Summit Panelist Moderator. February 2017
FCEP Conference, Emergency Medicine Learning and Resource Center, Orlando, Florida.

Work Life Balance. September 2016
FCEP Life after Residency Conference Faculty, Gainesville, Florida.

Optimizing Transitioning of Patients from the Emergency Department. April 2014
Flagler County Emergency Nurses Association Meeting, Palm Coast, Florida.

Pre-Hospital Education for Stroke Alert and STEMI Alert. December 2013
Volusia County EMS and Fire/Rescue CE, BFMC, New Smyrna Beach, Florida.

Juggling Personal and Professional Life. September 2013
FCEP Life after Residency Conference Faculty, Orlando, Florida.

Trauma in Pregnancy Case Presentation and Follow-Up. April 2004
Joint ACMC Trauma Surgery/Emergency Department Conference, Oak Lawn, Illinois**.**

Pediatric Head Trauma. November 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

Pulmonary Embolism Case Presentation and Follow-Up. July 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

Testicular Cancer Case Presentation and Follow-Up. July 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

Caring for Caregivers. May 2003
ACMC Emergency Department Conference, Oak Lawn, Illinois.

PROFESSIONAL REFERENCES

Available Upon Request.

PERSONAL ACTIVITIES

Member, Santa Maria del Mar Catholic Church
Member, Father Lopez Catholic High School Parent Teacher Organization
Member, Father Lopez Catholic High School Greenwave Athletic Association
Certified Judge and Coach, USA Artistic Swimming Association
Sustaining Member, Junior League of Daytona Beach, Florida
Former Member, Junior League of Greenville, South Carolina

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

James L. Shoemaker, Jr., MD, FACEP

Question #1: **How do you suggest ACEP navigate policy issues in a highly partisan political environment?**

ACEP stands at a difficult intersection where medicine, policy and politics increasingly collide. In a highly partisan environment, the path forward is not to retreat from advocacy or be drawn into ideological extremes, but to remain anchored in what has always defined emergency medicine: commitment to our patients, our colleagues and doing what is right when it matters most.

At its core, ACEP's strength is its clarity of purpose. Emergency physicians care for everyone, 24/7/365, under any circumstance. That mission is inherently nonpartisan. We do not ask about political affiliation before delivering care, and the College should not be shaped by political winds in developing policy. Its advocacy must remain grounded in access, quality, safety, and sustainability - values that are not partisan, but are fundamental to both our patients and our profession.

In a polarized climate, organizations often are tempted to engage on every issue, respond to every external pressure, or align with broader political movements. That approach risks diluting the College's voice and fragmenting its membership. ACEP must remain disciplined. Being mindful of potential political wedge issues, especially those that do not directly affect emergency physicians or the patients they serve, is not avoidance; it is a deliberate strategy to preserve unity, focus and credibility. When ACEP speaks, it must do so with clarity, cohesion, and purpose.

This does not mean silence in the face of meaningful challenges. On issues central to emergency medicine – reimbursement, workforce stability, ED safety, and patient access – ACEP must be decisive and unambiguous. Positions should be rooted in evidence, clinical experience and real-world impact, not political ideology. Advocacy should be framed through the lens of frontline care: what improves outcomes, protects physicians, and sustains the system our communities depend on. Equally important is the well-being of our colleagues. Emergency physicians face growing strain from burnout, moral injury, workplace violence, and financial constraints. Advocacy must prioritize solutions that strengthen the workforce: fair reimbursement, safe practice environments, and a sustainable pipeline of expert physicians.

Listening is also essential. ACEP is strongest when it reflects the diversity of its membership across geography, practice settings, and perspectives. Unity does not require uniformity, but it does require respect and a shared commitment to mission. Finally, credibility must remain paramount. In a time of fragile institutional trust, ACEP's voice must be measured, consistent and grounded in expertise. Policymakers should look to the College not for political alignment, but for reliable insight. Emergency physicians navigate complexity and uncertainty every day; ACEP must approach policy the same way — steady, principled, and focused. By keeping patients and physicians at the center, avoiding unnecessary political entanglement and standing firm when it matters most, the College will not only protect the specialty — it will strengthen our collective future.

Question #2: **How would you allocate your time as president to advance ACEP's strategic priorities given the competing demands on finite resources?**

The presidency track of the American College of Emergency Physicians is fundamentally an exercise in disciplined focus. The challenge is not identifying worthy priorities, but managing the constant competition for limited time, resources, and attention. Without structure, the role can quickly become reactive. To lead effectively, time must be deliberately organized around a clear framework. My "Four Corners" of reimbursement, membership, workforce, and emergency department safety bring clarity and focus to the navigation of many complex issues. These "four corner" priorities provide both direction and filter. Reimbursement sustains the financial viability of the specialty and requires ongoing advocacy. The workforce defines the future of emergency medicine and demands long-term solutions. ED safety is immediate and deeply tied to physician well-being and patient care. Membership is the force multiplier, because without an engaged base, progress in every other domain is limited. Intentionally allocating time across these areas ensures balance and prevents drift toward only the most immediate, short-term issue. Structure is essential. Establishing a consistent rhythm with regular touchpoints for each Corner, periodic deep dives and quarterly re-assessments creates accountability and forward momentum. Just as important, is leveraging and elevating others. The president's

impact is multiplied by aligning board members, committees, sections, colleagues, and staff around each priority, empowering them to execute while maintaining strategic oversight. The greatest efficiency comes from integration. These priorities overlap: improving reimbursement supports workforce stability; advancing ED safety reduces burnout; strengthening membership amplifies advocacy. Focusing on initiatives that advance multiple "Corners" at once maximizes the return on limited resources. Equally critical is protecting time to listen. Engaging with members and frontline physicians ensures that leadership remains grounded and responsive. Closing that feedback loop strengthens trust and reinforces the value of membership. Ultimately, the risk is not lack of effort, but diffusion of effort. By consistently filtering decisions through the "Four Corners" and aligning time with those priorities, my presidency term will convert finite resources into meaningful, lasting progress for ACEP, its members and the patients we serve.

Question #3: **What existential problems in emergency medicine keep you awake at night?**

What keeps me awake at night is not a single crisis in emergency medicine, but the convergence of several slow-moving forces that together threaten the foundation and thus, the stability of emergency medicine while leading to morale injury, burnout, and endless frustration of our colleagues. Our specialty risks fracturing from within. Competing specialty organizations and internal divisions can at times feel like a circular firing squad, with energy spent on ideological differences rather than shared purpose. In that fragmentation, we weaken our collective voice; while external stakeholders are more than willing to chip away at emergency medicine, our physicians and access to care for the patients who depend on us. A core area of my concern is the steady erosion of physician reimbursement that I view as a house of cards in a windstorm. Payment models increasingly decouple effort, complexity, and risk from fair compensation, while insurers downcode, deny and delay payments, placing financial strain on physician groups. At the same time, emergency departments face rising acuity, prolonged boarding, and system-wide dysfunction, yet reimbursement continues to stagnate or decline in real dollars. As margins tighten, hospitals respond with staffing reductions, consolidation and productivity demands that may not align with safe, sustainable care. The concern is not only financial but structural: at what point does the economic model no longer support the work we are asked to do? Closely tied to this is the fragility of the emergency department safety net. Emergency medicine has become the default access point for gaps in primary care, behavioral health, and social support. This was highlighted in the recent Emergency Medicine RAND study. While essential, this role is increasingly unfunded and operationally strained. Boarding, crowding, and throughput failures are no longer episodic; they are defining features of our specialty. The risk is not sudden collapse, but gradual erosion, where declining access and quality become normalized. Burnout compounds these challenges. It is not simply individual exhaustion, but the predictable result of sustained misalignment between mission and environment. Clinicians are asked to absorb systemic failure at the bedside while navigating rising cognitive load, administrative burden and medicolegal risk. Over time, this erodes morale, retention, and the pipeline into the specialty. Liability pressures and the tort environment remain a persistent undercurrent. Even where reforms exist, the perception of risk drives defensive medicine, inefficiency, and anxiety in clinical decision-making. Taken together, these forces raise a fundamental question of sustainability: can emergency medicine remain both a profession and a public good under current trajectories? The answer depends on whether we can restore alignment between value, compensation, autonomy, and the realities of caring for an increasingly complex patient population within a strained system — and whether we can remain united around our core mission of caring for emergency physicians and the patients we serve. These are not small challenges. But there is reassurance in the collective resolve of those committed to moving the specialty forward and our shared mission: caring for anyone, at any time, under any circumstance.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

James L. Shoemaker Jr., MD, FACEP

Contact Information

14302 Southold Drive
Granger, IN 46530
Phone: cell/home (269) 267-3953
E-Mail: jshoemakermd@gmail.com

Current and Past Professional Position(s)

1 – Partner and Attending Emergency Physician with Elite Emergency Physicians, Inc. (EEPI) (2007-2025)
2 – Director of Quality for EEPI (2016-present)
3 – Director of Compliance for EEPI (2016-present)
4 – Indiana University School of Medicine, South Bend Volunteer EM Clerkship Faculty (2011-present)
5 – Member of National ACEP Board of Directors – served as Secretary/Treasurer and Vice President of Membership (2020-present)
6 – Partner, Attending Physician and Midwest Advocacy Lead, Vituity (June 2025-present)
7 – Emergency Medicine Strategic Advisor, Ventra Health (July 2024-present)

Education (include internships and residency information)

1 – Edinboro University of PA, Edinboro, PA (1993-94) attended Freshman year and transferred
2 – Dickinson College, Carlisle, PA (1994-97), B.S. Biology *cum laude*
3 – Indiana University Bloomington/Medical Sciences Program (1998-2000), M.A. Physiology with thesis
4 – Indiana University School of Medicine, Indianapolis, IN — (2000-2004), M.D. in 2004
5 – MSU/KCMS Kalamazoo, MI (2004-2007) — Emergency Medicine Residency Training Program

Specialty Board Certifications (e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM Board certified — certificate expires December 31, 2028

Professional Societies

1 – ACEP Member (2004-present)
2 – ACEP Fellow (2010-present)
3 – Indiana ACEP Member (2007-present)
4 – AMA Member (2018-present)
5 – Indiana State Medical Association (2007-present)
6 – EDPMA Group Member (2017-2025)
7 – Member of the Emergency Medicine Business Coalition (EMBC) (2020-2025)

National ACEP Activities – List your most significant accomplishments

1 – National ACEP Board of Directors (2020-present)
2 – Secretary/Treasurer ACEP Board of Directors (2022-2023) | Vice President of Membership (2024-2025)
3 – Innovator, creator, and course co-director of ACEP Independent EM Group Master Class conference
4 – ACEP Reimbursement Leadership and Development Program Fellow (2018-2020)
5 – Board Liaison to Small Democratic Group, Toxicology and Observation Sections.
6 – Member of Council Steering Committee (2019-2020)
7 – ACEP Alternate Delegate for AMA/Specialty RVS Update Committee (RUC) (2019-present)
8 – Reimbursement Committee (2015-present) – Board Liaison 2020-2025
9 – Reimbursement Committee Workgroup 2 (2018-present)
10 – Chairman, National Chapter Relations Committee (2020)
11 – Member of National Chapter Relations Committee (2013-2020)

12 – Coding and Nomenclature Advisory Committee Member (2018-present) – Board Liaison 2020-2025
12 – ACEP Council Reference Committee 'A' Member (2018 Council)
13 – ACEP Clinical Resources Review Committee Member (2018-2020)
14 – Board Liaison to EMPC, Bylaws and Quality Measure Development Committees (2025-present)
15 – Served on the search committee for the appointment of the new ACEP Executive Director
16 – Provide reimbursement, ED violence, ACEP updates and SDG lectures to state chapters including IN, OH, KY, GA, FL, NM, TN as well as at the Emerald Coast and Coastal combined chapter conferences

ACEP Chapter Activities – List your most significant accomplishments

1 – President of Indiana Chapter of ACEP (2015-2016)
2 – Vice-President of Indiana Chapter of ACEP (2014-2015)
3 – Secretary/Treasurer of Indiana Chapter of ACEP (2013-2014)
4 – Indiana State Chapter Councilor (2015-2020); Alternate Councilor (2013-2015)
5 – Indiana Chapter of ACEP Board of Directors Member (2011-2016)
6 – *Ex officio* Board of Directors Member of the Indiana Chapter of ACEP (2016-present)
7 – Part of annual Indiana ACEP delegation at Leadership and Advocacy Conference (2014-present)
8 – State advocacy with the Indiana Legislature on scope of practice, reimbursement and other issues
9 – Helped to develop, advocate for and pass model State legislation requiring a physician in every Indiana Emergency department.

Practice Profile

Total hours devoted to emergency medicine practice per year: **1800** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **90** % Research **0** % Teaching **0** % Administration **10** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

From 2007 to 2025, I practiced emergency medicine with Elite Emergency Physicians, Inc. (EEPI), a private, democratic physician group rooted in local control, clinical excellence, and physician leadership at the bedside. As hospital consolidation reshaped the emergency medicine landscape, our group made the deliberate decision to join Vituity, a wholly physician-owned, national multispecialty practice that preserves the values of autonomy, transparency, and fairness while providing the scale and infrastructure needed to thrive in a consolidating environment. Vituity is defined by physician governance, an unwavering commitment to patient-centered care, and reinvestment in physicians and communities rather than external shareholders. I currently practice at a community hospital in Elkhart, Indiana, and serve as Vituity's Midwest Advocacy Lead, where I actively fight for fair reimbursement, meaningful limitations on scope creep and model state legislation that ensures a physician in every emergency department.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Vituity positions:
1 – Midwest Advocacy Lead for Vitutiy

EEPI positions:
1 - EEPI Director of Quality (2016-2025)
2 - Management Team Member of EEPI (2012-2025)
3 - EEPI Compensation Committee Member (2010-2025)
4 – EEPI Compliance Committee Chair (2016-2025)
5 – Volunteer Clinical Faculty for IUSM EM Clinical Clerkship (2011-present)
6 – Member of the IUSM Interview Admissions Team (2017-present)

Elkhart General Hospital (EGH) Positions:
1 – Chairman and Medical Director of EGH Emergency Department (2012-2016)
2 – Chairman and member of EGH ED Quality Assurance Committee (2012-2016)

3 – Medical Co-Director EGH Chest Pain Center (2014-2017)
4 – Medical Co-Director for EGH EMS Program (2010-2012)
5 – Member of EGH Medical Executive Committee (2012-16, 2018-2022)
6 – Member of EGH Trauma and Trauma QI committees (2012-present)
7 – Member of EGH Cardiovascular Services and Cardiovascular Services QI Committees (2012-2024)
8 – Member of EGH Stroke and Stroke QI Committees (2016-present)

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert **0 Cases** **Plaintiff Expert** **0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

James L. Shoemaker Jr., MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Vituity
Address: 600 E. Blvd
Elkhart, IN 46514
Position Held: Indiana and Midwest Advocacy Lead | Full Partner
Type of Organization: Physician-owned multispecialty group

Employer: Ventra Health
Address: 5001 LBJ Freeway, Suite 320
Dallas, TX 75244
Position Held: Emergency Medicine Strategic Advisor
Type of Organization: Revenue cycle management company

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: National ACEP Board of Directors
Address: 4950 W. Royal Ln
Irving, TX 75063
Type of Organization: National Emergency Medicine Professional Organization
Leadership Position: Board of Directors | VP of Membership | Secretary/Treasurer
Term of Service: October 2000-present

Organization: Indiana Chapter of ACEP
Address: PO Box 17136
Indianapolis, IN 46217
Type of Organization: State chapter of National ACEP - EM Professional Organization
Leadership Position: Past-President | VP | Secretary/Treasurer | *ex officio* Board member
Term of Service: July 2011-Present

Organization: St. Joseph County, Indiana Board of Health

Address: 227 W. Jefferson Avenue

South Bend, IN 46601

Type of Organization: Board of Health

Leadership Position: Appointed Board Member

Term of Service: January 2020-August 2022

Organization: AMA RBRVS Committee

Address: 330 N. Wabash Ave, Suite 39300

Chicago, IL 60601

Type of Organization: House of Medicine Membership Organization

Leadership Position: Alternate RUC Member representing ACEP and all EM physicians

Term of Service: July 2020-May 2026

Organization: Elite Emergency Physicians, Inc.

Address: 600 E. Blvd

Elkhart, IN 46514

Type of Organization: Independent EM group

Leadership Position: ED Chairman | Director of Quality | Compliance Committee Chair

Term of Service: Chair 2012-16 | Director of Quality and Compliance 2016-2025

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

I am a paid Emergency Medicine Strategic Advisor with Ventra Health and provide insights and expertise in revenue cycle management and EM reimbursement to the company, clients and prospects.

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE

☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE

☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO

☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO

☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO

☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO

☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

James L. Shoemaker Jr., MD FACEP Date May 1, 2026

Joint Endorsement of James L. Shoemaker, MD, FACEP
Candidate for President Elect, American College of Emergency Physicians

On behalf of the Indiana Chapter of the American College of Emergency Physicians and the Democratic Group Practice Section, we are proud to offer our joint endorsement of Dr. James L. Shoemaker for President Elect of the American College of Emergency Physicians.

Dr. Shoemaker's candidacy represents the very best of ACEP leadership: deeply experienced, forward-looking, and firmly grounded in the real-world practice of Emergency Medicine. We have known and worked closely with Dr. Shoemaker for over a decade, collaborating at the local, state, and national levels, and have witnessed firsthand the substantial and lasting impact of his leadership on our specialty.

As a past President of Indiana ACEP and a long-standing leader within a small democratic Emergency Medicine group, Dr. Shoemaker has consistently demonstrated a clear understanding of the challenges facing frontline Emergency Physicians. His leadership has always been informed by active clinical practice, ensuring that advocacy and policy efforts remain connected to the realities of patient care, workforce sustainability, and Emergency department operations.

Dr. Shoemaker has also been a tireless and effective advocate for Emergency Medicine beyond the bedside. His work lobbying on Capitol Hill with ACEP has helped advance critical legislative priorities, and just as importantly, he has inspired and recruited others to engage in advocacy, strengthening the voice of Emergency Physicians at every level. His ability to bring new leaders into the work of ACEP reflects both his commitment to the organization and his belief in the power of collective action.

Through his service in ACEP governance and national leadership roles, Dr. Shoemaker has earned a reputation for principled decision-making, fiscal responsibility, and thoughtful collaboration. He approaches complex issues with preparation, integrity, and a focus on solutions that benefit both Physicians and the patients we serve. His experience navigating reimbursement challenges, workforce pressures, and the evolving healthcare landscape uniquely positions him to lead ACEP during a critical time for our specialty.

Equally important, Dr. Shoemaker understands the value of independent and democratic practice models and has consistently advocated for preserving physician autonomy, professional fulfillment, and sustainable practice environments. His leadership reflects a balanced perspective that respects diversity of practice settings while uniting Emergency Physicians around shared goals.

Indiana ACEP and the Democratic Group Practice Section believe that Dr. Shoemaker's experience, judgment, and dedication make him exceptionally well qualified to serve as President Elect of the American College of Emergency Physicians. We are confident that his leadership will strengthen ACEP, advance effective advocacy, and help secure a vibrant future for Emergency Medicine.

We strongly and enthusiastically endorse Dr. James L. Shoemaker for President Elect of the American College of Emergency Physicians.



Kyle English, MD, FACEP
President, Indiana Chapter
American College of Emergency Physicians



Eric Yazel, MD, FACEP
Vice President, Indiana Chapter
American College of Emergency Physicians



Chris Ross, MD, FACEP
Chair, Democratic Group Practice Section
American College of Emergency Physicians

James L. Shoemaker, Jr., MD, FACEP

I am honored to announce my candidacy for President-Elect of the American College of Emergency Physicians.

Emergency medicine stands at a pivotal moment. Our specialty faces workforce instability, threats to the ED safety net, escalating workplace violence and, most concerning, a coordinated erosion of emergency physician reimbursement. Each of these challenges affects you and demands experienced, focused and determined leadership.

I am ready to fight – for you and for our specialty.

Emergency physicians are worth every penny we earn. We provide 24/7 access to care, stabilize the critically ill, lead disaster response and uphold the EMTALA-mandated safety net in every community. We are the best value in the House of Medicine. Yet insurers continue an egregious pattern of downcoding, delays, denials, and technology-driven payment suppression designed to undervalue our work. This is not sustainable. As your President-Elect, I will aggressively advocate to curb these practices and defend fair reimbursement.

My campaign is grounded in what I call ACEP's "Four Corners": reimbursement, workforce, membership, and ED safety. These priorities are inseparable. Reimbursement drives workforce stability. Workforce stability protects the ED safety net. A strong safety net strengthens membership. Together, they define our future. My leadership will ensure ACEP remains focused, forceful, and aligned in advancing these priorities.

Reimbursement advocacy is where I bring particular expertise. As an inaugural David McKenzie Reimbursement Fellow, I developed a deep understanding of payer tactics, revenue cycle vulnerabilities, and opportunities to modernize reimbursement. I will leverage the objective findings of the Emergency Medicine RAND study to identify new revenue opportunities, strengthen our negotiating position, and protect the financial viability of emergency departments nationwide. Data-driven advocacy must remain central to preserving the ED safety net.

I am equally committed to empowering emergency physicians with the business knowledge needed to thrive. I pioneered the ACEP Independent Emergency Medicine Group Master Class. This course empowers physicians with the business and financial knowledge to build their own groups and determine their own destiny, strengthening the resilience and influence of our specialty through self-empowerment and a deeper understanding of the business of medicine.

My candidacy is built on a long-standing commitment to ACEP. Before my six years on the Board of Directors, I served in multiple committee roles shaping policy, strategy, and advocacy. I later had the privilege of serving as Treasurer and VP of Membership. These experiences provide a comprehensive understanding of ACEP governance, finances, and member engagement.

My advocacy also extends to the state level. As a proud Past President of Indiana ACEP, we secured meaningful legislative victories, including landmark legislation requiring physician coverage in every emergency department 24/7/365. More recently, we successfully pushed back against harmful insurer practices, advancing protections that prevent hospitals from being penalized for utilizing out-of-network physicians. These wins required sustained engagement, coalition-building and disciplined execution – an approach I will bring as your President-Elect.

Finally, and most importantly, I continue to practice clinical emergency medicine. I face the same boarding crises, staffing shortages, payer frustrations, and workplace safety concerns you confront every day. I understand these challenges because I live them, and that perspective will guide my leadership.

This is my opportunity to run for President-Elect, and I approach it with urgency, humility, and resolve. The headwinds are significant – but so is our collective strength.

With focused advocacy, data-driven strategy, and unwavering commitment to our members, we can protect reimbursement, stabilize the workforce, defend EMTALA, and secure the future of our specialty.

I would be honored to earn your support. A vote for me is a vote for strong advocacy, fair reimbursement, and a resilient future for emergency medicine.

Respectfully,

Jamie

Jamie Shoemaker, MD, FACEP | jshoemaker@acep.org | (269) 267-3953

2026

JAMIE SHOEMAKER

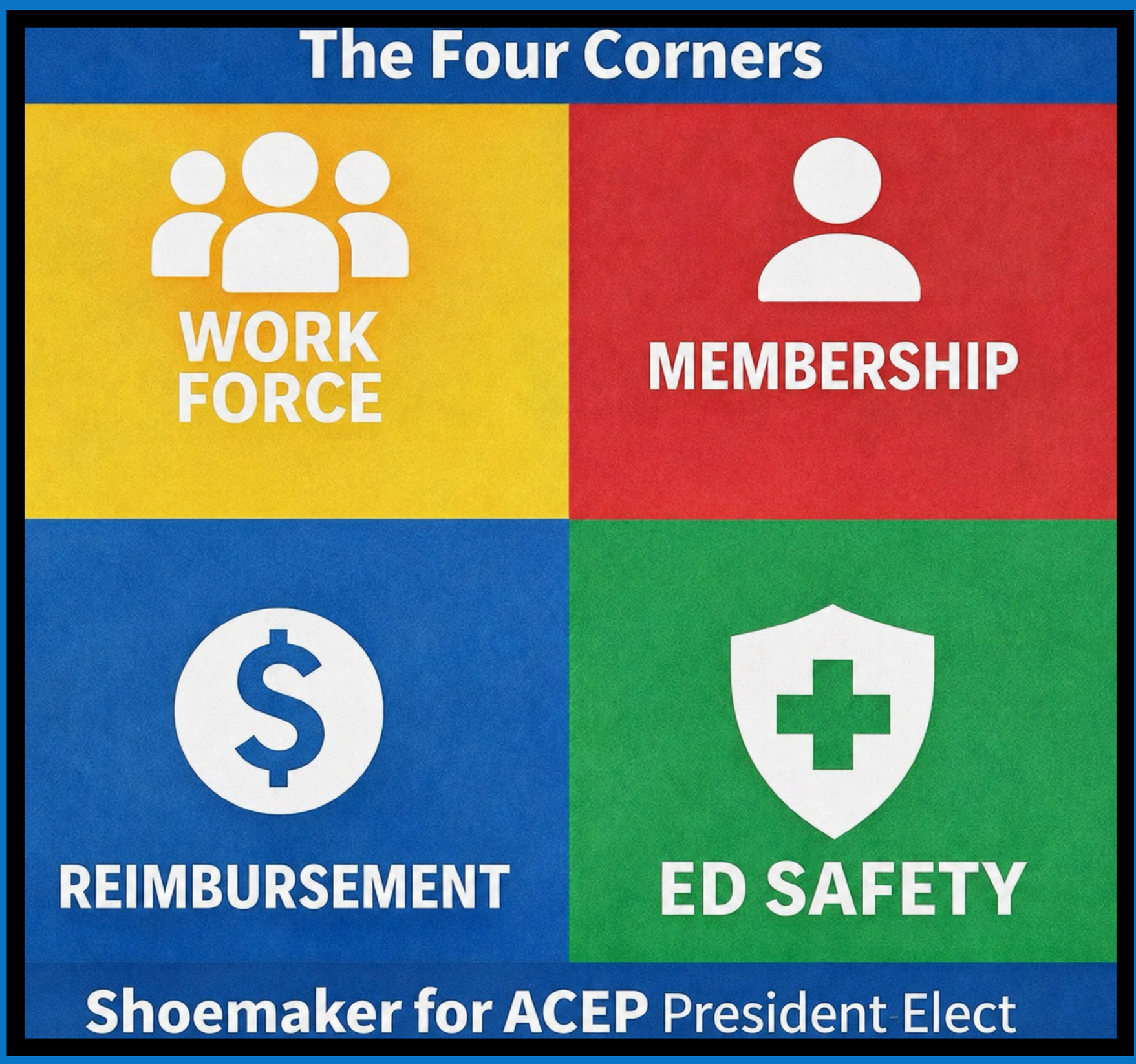
FOR ACEP PRESIDENT-ELECT



- TESTED & PROVEN ACEP LEADER
- RELENTLESS ADVOCATE FOR EM
- DEFENDING OUR VALUE

★ THE FOUR CORNERS ★

LEADING ACEP FORWARD



PROUDLY ENDORSED BY THE
INDIANA STATE CHAPTER OF ACEP AND DEMOCRATIC GROUP PRACTICE SECTION

TESTED LEADERSHIP.
REIMBURSEMENT EXPERTISE.
PROVEN RESULTS.

EMAIL: JSHOEMAKER@ACEP.ORG
DIRECT CELL: (269)-267-3953

JAMES L. SHOEMAKER JR., MD FACEP
14302 Southold Drive, Granger, IN 46530 | 269-267-3953 (cell) | jshoemakermd@gmail.com

EDUCATION

Western Michigan University (formerly MSU/KCMS) – Kalamazoo, MI
Emergency Medicine Residency Training **2004-2007**

Indiana University School of Medicine – Indianapolis, IN
M.D. Allopathic Medicine **2000-2004**

Indiana University – Bloomington, IN
M.A. Physiology **1998-2000**
Thesis: "Oxygen-dependent binding of chloride to hemoglobin: The importance of the chloride shift in acid-base physiology." Advisor: Henry Prange, Ph.D.

Dickinson College – Carlisle, PA
B.S. Biology **1994-1997**
Graduated *cum laude*
Transferred to Dickinson from Edinboro University of PA after Freshman year with full scholarship

WORK EXPERIENCE

Vituity - Emergency Medicine
Full partner and Indiana Advocacy Lead for Vituity. **July 2025-present**

Elite Emergency Physicians, Inc. (EEPI)
Partner and Attending Emergency Medicine Physician
ABEM Board Certified in Emergency Medicine (renewal December 31, 2028) **2007-June 2015**
Attending physician at Elkhart General and St. Joseph Hospital Emergency Departments in a small, democratic group of Emergency medicine physicians

Board Member of the American College of Emergency Physicians (ACEP) Board of Directors **2020-present**

Secretary/Treasurer for American College of Emergency Physicians (ACEP) Board of Directors **2022-2023**

VP of Membership for American College of Emergency Physicians (ACEP) Board of Directors **2024-2025**

Practice Essentials of Emergency Medicine **2024-present**
Contributing author and editor for this asynchronous curriculum and platform designed to teach the Business of Emergency Medicine to colleagues.

Emergency Medicine Strategic Advisor, Ventra Health **2024-present**
Concentrate strategically on advocacy at the local, state, and national legislative levels to advocate for equitable physician reimbursement and safeguard patient access to healthcare. Address egregious healthcare insurer behaviors, such as denials, downcoding, and other tactics aimed at reducing reimbursement. Collaborate closely with emergency medicine (EM) colleagues and clients at both the macro and micro levels of physician reimbursement to enhance their comprehension of how a patient encounter directly impacts their financial compensation. This engagement encompasses various activities, including speaking engagements, blog posts, white papers, podcasts and other media.

Chairman, Elkhart General Hospital Emergency Department **2012-2016**
Work to streamline ED processes including direct bedding, decreasing LWBS, patient throughput, departmental representation on committees, handling all QA concerns and complaints, maximizing Press-Ganey performance and many other tasks to allow for smooth ED operations. Served as Vice-Chairman of the ED throughout 2011.

Chairman, Elkhart General Hospital ED Quality Assurance Committee **2012-2016**
Review all ED deaths, 72-hour returns and any quality or behavioral concerns brought to the committee or hospital's attention. Review charts to ensure the standard of care is met and provide

feedback to providers and/or patients. Served on the committee from 2008-2011 before becoming Chairman.

Co-innovator and Co-Course Director, ACEP/EMBC Independent EM Group Masterclass **2021-present**
Developed a comprehensive, 2.5-day curriculum designed to equip Emergency Medicine (EM) colleagues with the knowledge and skills necessary to establish, manage, or enhance their own independent EM groups or excel within their current work environment. Collaborated with other my colleague to develop all course curricula and content, selected faculty members, and coordinated the participation of sponsors and attendees.

Committee Member, Elkhart General Hospital ED Quality Assurance Committee **2008-present**

Medical Co-Director, Elkhart General Hospital Chest Pain Center **2014-2017**
Streamline emergency medical services (EMS), emergency department (ED), and hospital processes for all patients presenting with typical and atypical chest pain. Standardize processes for patients requiring urgent percutaneous intervention and cardiac rule-outs for acute coronary syndrome. Implement best practices for all aspects of coronary care, from arrival to discharge, including aftercare.

Management Team Member of EEPI **2012-2016**
Meet to discuss and act on the day-to-day operations of our multi-million-dollar Corporation. All facets of our dynamic group are discussed and acted upon by the Management Team for presentation to the Board of Directors by this Corporate Leadership group.

Member of EEPI Compensation and Compliance Committees **2010-present**
This Corporate group meets to discuss Corporate compliance, chart audits, rules and regulations as well as pay structure and distribution. Address reimbursement issues and charting compliance.

Member of Elkhart General Hospital Medical Executive Committee **2011-2016, 2019-present**
Represent the Emergency Department as Chairman on this vital committee that facilitates and manages the daily operations of the Hospital and Medical Staff.

Trauma Committee and Trauma Quality Assurance Committee Member **2008-present**
Serve on this hospital committee to review all trauma deaths, transfers and procedures. Intimately involved with Elkhart General Hospital's roll-out of planning to become an ACS designated Level III Trauma Center. Review Trauma cases for Quality of Care under peer review processes. Serve as Trauma Liaison in ED. Serve as ED liaison for our Level III trauma center.

Cardiovascular Services and Cardiovascular Services Quality Assurance Committee **2008-2013; 2015-present**
Serve on this hospital committee to review all Cardiovascular service line issues including, but not limited to, STEMI door-to-wire time, ECG interpretations, and CVS QI issues.

ED Delegate for the EGH Cardiovascular Services Committee **2018-present**
Serve on this hospital committee to review all stroke patients presenting to the hospital for timely administration of thrombolytics or mechanical thrombectomy.

President (2015-2016) and *Ex Officio* Board Member, Indiana ACEP Board of Directors **2010-present**
Serve on the Board for Indiana's chapter of the American College of Emergency Physicians**.** Intimately involved with State Chapter on issues germane to the practice of Emergency Medicine in IN and the Nation. Served as *Secretary Treasurer 2013-2014, Vice-President 2014-2015 and President 2015-2016*. Actively engage with state Legislator's to advocate on behalf of the specialty and the House of Medicine in Indiana.

Councilor for Indiana ACEP at ACEP Scientific Assembly **2015-present**
Selected as one of allotted Councilors to represent IN ACEP at the National ACEP meetings. Councilors are responsible for synthesis, discussion and passage of ACEP's clinical guidelines, standing on issues of national importance and representing the interests of their state as voting members at Scientific Assembly.

ACEP Council Reference Committee 'A' Member **2018**
Selected as one of the Reference committee members for ACEP SA 2018 Council meeting. Actively engaged in listening to Councilor testimony and discussing Resolutions as a committee for recommendations to the Council Speaker for council voting and Resolution outcomes. Selection is for one year only.

National ACEP Reimbursement Committee Member **2015-present**
Committee members actively participate in discussions with state Medicaid, HMO and PPO as well as National payors such as CMS and Medicare with billing and payment issues regarding emergency medicine and access to care. Assigned to WG6 (Medicaid issues) and actively participate on the WG2 calls and initiatives.

National ACEP Coding and Nomenclature Advisory Committee **2019-present**
Committee actively involved in analyzing Medicare, Medicaid and 3rd party payor processing policies for Deviations from CPT principles; Track payor issues that impact reimbursement; monitor ICD-10 Implementation; advocate for EM issues via the AMA CPT construct; develop FAQs to support EM colleagues with up-to-date information; explore Alternative Payment Model constructs and other tasks.

National ACEP Chapter Relations Committee **2015-present**
Committee members actively participate in discussions state ACEP chapters and act as liaisons to National ACEP. Coordinate and responsible for the disbursement of grant funding to Chapters.

Chairman, National ACEP Chapter Relations Committee **2020**
Rotated off of committee and as Chairman when elected to the ACEP Board of Directors

National ACEP Clinical Resources Review Committee **2019-2020**
Committee reviews and makes recommendations to ACEP President or its representative concerning externally funded ACEP products. Define processes for product oversight and review. Review and comment on draft ACEP informational papers and topics. Review potential products and resources for organizations requesting ACEP comments.

National ACEP Steering Committee **2019-2020**
Steering Committee members provide counsel to the speaker and vice speaker, provide leadership to councilors, coordinate the activities of the Council meetings, and develop policies, procedures, and resolutions as requested.

Medical Co-Director, Elkhart County EMS Medical Co-Director **2010-2012**
Provided physician medical control and oversight of EMS Providers. Undertook complete revisions to EMS field protocols, provided QA feedback and educational opportunities.

EEPI Director of Quality and Compliance **2016-present**
Director of Quality initiatives, peer review, evidence-based practice and performance metrics. Align group practice with ACEP Clinical Policies and Evidence-based practice. Compliance audits of charts. Representation for EM Legislative issues at the State and National level. Chair the EEPI QA Committee.

Indiana University School of Medicine Admissions Committee **2018-present**
Appointed to the IUSM Medical school Admissions Committee to interview and rank prospective students for admission to the IUSM.

Indiana University School of Medicine Clinical Faculty **2013-present**
Actively engaged in the Emergency Medicine clerkship education for the MS-IV IUSM students through direct patient contact, didactics and lectures. Help teach procedural skills to the medical students (intubation, suturing, ultrasound, cardioversion, ACLS and many others)

ACEP David McKenzie Reimbursement and Leadership Development (RLDP) Fellow **2018-2020**
Selected from a pool of over seventy highly-qualified candidates, I am honored to be one of five RLDP Fellows. This exceptional opportunity, led by ACEP's Reimbursement Director, David McKenzie, CAE, provides an immersive experience to enhance our skills in essential reimbursement roles within CMS, commercial payors, Medicaid, RVS Committee, and various other committees and arenas. The curriculum covers pertinent topics such as balance billing, physician fee schedules, RVS committee, CPT, ERISA, and more. Additionally, I am pleased to serve on the ACEP/EDPMA joint task force.

ACEP Alternate Representative for AMA/Specialty RVS Update Committee (RUC) **2019-present**
Selected as the Alternate Delegate for ACEP at the AMA Resource-Based Relative Value Scale (RBRVS) Update committee to serve the specialty of Emergency medicine and the House of Medicine as a whole in assignment and updates to the model used to pay physicians for services rendered for CMS. I also serve on multiple committees within the RUC structure.

PUBLICATIONS, PRESENTATIONS, LECTURES AND PAPERS

Multiple peer-reviewed publications, presentations, podcasts, editorials and lectures available upon request. National lecturer on reimbursement issues impacting Emergency Medicine. Central focus to help colleagues understand how their patient encounter becomes their pay check, Advocate at the state and federal level for reimbursement issues impacting Emergency medicine. Have presented at EDPMA and to multiple ACEP state chapters and conferences including IN, TN, KY, FL, OH, MI, CA, NE and AL.

MEMBERSHIPS

Fellow, American College of Emergency Physicians (ACEP)
Ex Officio Board of Directors Member and Past President of Indian ACEP Chapter
Member, American Medical Association
Member, EDPMA
Member, Indiana State Medical Association

REFERENCES

Available upon request

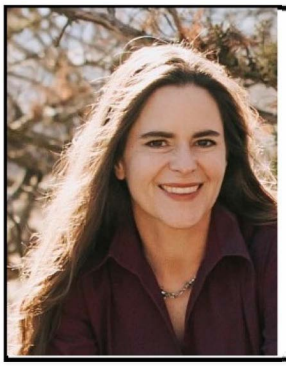
American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Board of Directors Candidates



2026 Board of Directors Candidates



Torree M. McGowan, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Abhi Mehrotra, MD, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer
- CV



Heather S. Owen, MD, MPH, FACEP

- Written Questions
- Candidate Data Sheet
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Scientific Assembly CHICAGO 26

2026 Board of Directors Candidates



Henry Z. Pitzele, MD, FACEP

- Written Questions
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Alexandra Nicole Thran, MD, FACEP

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Torree M. McGowan, MD, FACEP

Question #1: **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

Emergency medicine is worth fighting for. Not just as a specialty, but as the last open door in American healthcare, the place where no one is turned away regardless of ability to pay, insurance status, or how sick they are. I've spent my career defending those who can't fight for themselves, and I'm running for the ACEP Board because I believe the skills I've built doing that will make this Board stronger.

Long before medical school, I was a military officer. I entered the Air Force Academy three weeks after high school graduation, an institution built to produce leaders of character for the nation's military. I could have spent my military years working shifts and waiting to return to civilian life. Instead, I chose optional Professional Military Education alongside my CME, studying leadership and strategy starting in basic training and continuing through Air War College, the graduate-level course for national-level strategic decisions. Understanding how great thinkers approach leadership, collaborating across political and cultural divides to find common values, and approaching complex problems with genuine curiosity are skills I refined in combat hospitals and as commander of a CBRNE response unit during COVID. My best work as a leader isn't having the answer. It's creating the conditions where the team builds a better answer than any of us could have reached alone.

The military also teaches you to follow rules. Salute smartly, stand here, check this box. There is power in understanding process and procedure, because if you want a different outcome from a system, you have to change the system. American healthcare isn't broken. It is perfectly designed to produce exactly what it produces: crowded EDs, burned-out physicians, and patients dying while waiting for prior authorizations as insurers post record profits. Changing that requires the slow, unglamorous work of legislation, coalition building, and advocacy. It doesn't make for social media clickbait, but it's how systems actually change. My career has been training for exactly this kind of work.

I bring to the Board perspective from my work across the full spectrum of emergency medicine: deployed combat trauma, Level 1 centers, community hospitals, and rural critical access, combined with over 20 years at ACEP Council and formal leadership training that most physicians never pursue.

There is no single answer that will solve what emergency medicine faces. There are thousands of answers. I'll inspire teams to find them.

Question #2: **What is your perspective on ACEP's role in the 3-year versus 4-year emergency medicine training program discussion?**

The emergency medicine residency duration is a wicked problem, partly because we were presented a solution before anyone knew there was a problem to be solved. Because of that order of operations, instead of defining what we value as physicians about our training, so now we are left with arguing about issues of how to implement a solution no one knew needed to happen.

The ACGME process began by asking residency directors what skills emergency physicians should have at graduation. That's the right question, but asked in the wrong context. One of EM's great strengths is our diversity of experience and passion, but that expanse is part of our current problem. Ask 100 emergency physicians what matters most at graduation and you'll get 342 answers. Every physician has their area of passion that we all think students should learn more about. I would love all EM residents to understand human factors analysis and be trained in how to run a MASCAL. If you ask me whether those passions should extend training by a year, however, my answer is very different.

Data driven people point out equivalence between 3 and 4-year programs on board pass rates and practice readiness. Finance thinkers note that an extra year saves hospital systems millions while locking physicians into low wages longer. Workforce advocates warn of seismic disruption if the 80% of programs that are 3-year must convert at once. Those watching scope of

practice issues remind us that longer training may drive talented students toward other specialties, a particularly dangerous outcome when non-physician providers are entering our EDs with online coursework and 500 hours of shadowing.

The most important voice in this conversation may be our trainees themselves. Medical students and residents are watching their futures held hostage to an unresolved tangle. They deserve clarity of the process, the purpose, and a timely resolution so they can step into and lead this specialty with confidence.

As the quote from *Necessary Turbulence* puts it: *"Once we named what mattered most, our priorities were no longer abstract ideals but daily decisions about our focus."*

That's ACEP's role here. Not to pick a side, but to bring every stakeholder including AAEM, SAEM, CORD, ACGME, and especially our trainees to the table, and lead the hard work of naming what we actually value as a specialty. Reconciling those priorities into operational guidance requires dissenting voices to surface unintended consequences. That step appears to have been missing from the original process. ACEP is uniquely positioned to ensure it isn't missing from the next one.

Question #3: **What is the most effective strategy you would use to recruit and retain members considering generational differences?**

Emergency medicine is a team sport, more than almost anywhere else in medicine. That's one of the reasons I love EM, the sense of purpose and shared commitment to being there for patients when they need us most. The purpose transcends generations, whether you trained in the first residency programs in the late 1970s or you're graduating next year.

The pressures we face don't discriminate by generation either. Our healthcare system keeps asking us to do more with less while cutting payments, putting us at risk of violence, and allowing our contracts to be taken over by profit-driven entities who slash physician coverage. Being an ACEP member means that no matter what PGY you are, none of us face those challenges alone.

Connection depends on meeting people where they already are. Younger physicians expect on-demand digital access, with education, advocacy updates, and community available at their fingertips. Experienced physicians often find their deepest value in face-to-face connection through regional meetings, leadership engagement, and mentorship. An effective strategy builds pathways between those two worlds rather than choosing one over the other. Most physicians do not go from stranger to champion overnight. They start small by following a social channel, reading a newsletter, or attending one virtual event, and they deepen their engagement over time when ACEP consistently delivers tangible value at every step.

The most powerful retention tool ACEP has is not a digital platform or a dues discount. It is a meaningful personal connection. A resident who finds a mentor at a regional chapter meeting, a mid-career physician who feels genuinely heard in a committee discussion, and a veteran emergency physician who sees their advocacy work translate into real policy change are exactly the kinds of experiences that create lifelong members. Small, intentional interactions in chapter meetings, section communities, and mentorship relationships drive engagement far more reliably than broad outreach ever will. Lifelong members are made one meaningful interaction at a time.

ACEP's ability to recruit and retain members across generations requires investment in both the infrastructure of connection and the culture of belonging. That means funding digital platforms that meet younger physicians where they are, supporting chapter engagement that creates in-person community, and empowering mentorship that ties generations together around our shared values. As a Board member, I am committed to building an organization where every emergency physician, at every stage of their career, finds a reason to stay.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Torree M. McGowan, MD, FACEP

Contact Information

8728 SW Bear Drive
Culver, OR 87734
Phone: 503-449-4477
E-Mail: torreemcg@me.com

Current and Past Professional Position(s)

2017 – current Emergency Physician, St Charles Medical Group
2017 – 2023 Emergency Physician, Oregon Air National Guard
2005 – 2017 Emergency Physician, Lieutenant Colonel (ret), US Air Force
- David Grant Medical Center, Travis Air Force Base
- Craig Joint Theater Hospital, Bagram, Afghanistan
- Air Force Theater Hospital, Balad, Iraq
- Mat-Su Regional Hospital (moonlighting), Palmer, AK

Elmendorf Hospital, Elmendorf Air Force Base, AK

Education (include internships and residency information)

2005-2008 San Antonio Uniformed Services Health Education Consortium Emergency Medicine Residency
2005 Medical Doctorate, Oregon Health and Science University

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
2009 – current American Board of Emergency Medicine (recertified 2018)
2025 – current American Board of Obesity Medicine

Professional Societies

American College of Emergency Physicians
American Medical Association
Government Services Chapter, American College of Emergency Physicians
Physician Women Equestrians
Physicians for Patient Protection
US Air Force Academy Association of Graduates
Academy Women

National ACEP Activities – List your most significant accomplishments

2015-Present ACEP Communications Committee, Chair 2023 – 2025
2015-Present ACEP Online Education Subcommittee
2015-Present ACEP Disaster Medicine Committee
2023-25 Council Reference Committee Member
2024 Council Reference Committee B Chair

ACEP Chapter Activities – List your most significant accomplishments

2014 President, Government Services Chapter
2023-Present Government Services Chapter Secretary Treasurer
2018 History of Military Emergency Medicine Project Lead
2001-Present Government Services Chapter
2005-08 GSACEP Board of Directors, Resident Representative

Practice Profile

Total hours devoted to emergency medicine practice per year: **1250** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **85** % Research **0** % Teaching **5** % Administration **10** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Staff emergency physician in a group that staffs one community emergency department and two critical access hospitals in central Oregon. We work in all three hospitals. Our group is a part of a 350 person hospital owned multi-specialty group owned by St Charles Health System, a non profit hospital.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Emergency Department Site Lead, St Charles Madras

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Torree M. McGowan, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: St. Charles Medical Group

Address: 2500 NE Neff Road

Bend, OR 97701

Position Held: Staff Emergency Physician

Type of Organization: non-profit owned multi-specialty group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: ACEP Government Services Chapter

Address:

Type of Organization: ACEP Chapter

Leadership Position: Secretary-Treasurer

Term of Service: 2023-current

Organization: ACEP Government Service Chapter

Address:

Type of Organization: ACEP Chapter

Leadership Position: Councillor

Term of Service: 2005-current (with a few years off)

Organization: ACEP Government Service Chapter

Address:

Type of Organization: ACEP Chapter

Leadership Position: President

Term of Service: 2014-15

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

I am a cadaver lab instructor for Teleflex. I have also served on their Medical Advisory Board for Trauma.

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Torree McGowan Date 19 May 2026

GSACEP
GOVERNMENT SERVICES CHAPTER
American College of Emergency Physicians

GOVERNMENT SERVICES CHAPTER
1506 Frontier Drive
Arlington, TX 76012
Direct: 817-683-7007
www.GSACEP.org

BOARD OF DIRECTORS
Christine DeForest, DO, FACEP
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Sean Stuart, DO, FAWM, FACEP
Councillor
Evan Miller, DO
Resident Representative

EXECUTIVE DIRECTOR
Michele Byers, CAE, CMP Fellow

August 3, 2026

To the esteemed ACEP Council members,

On behalf of the Government Services Chapter of the American College of Emergency Physicians (GSACEP), I am honored to offer our unequivocal and enthusiastic support for Dr. Torree McGowan in her candidacy for the ACEP Board of Directors.

Dr. McGowan is a long-standing and deeply valued member of our chapter. She has served as Chapter President, Councillor, Board member, and currently as Secretary-Treasurer. Her leadership within GSACEP has been steady, strategic, and mission-driven. She helped establish our Public Relations and Advocacy Committee—an initiative that grew and evolved into two distinct and impactful entities within our chapter. That structural vision alone reflects her ability to anticipate growth, build infrastructure, and position organizations for long-term success.

Torree's leadership is defined by action. Her career spans operational military medicine, disaster response, academic contribution, and civilian emergency medicine leadership. As Commander, she has led complex, multidisciplinary teams in high-stakes environments with clarity and composure. She understands systems, readiness, and mission execution at a level few can claim.

At the national level, Dr. McGowan has been a consistent and visible contributor to ACEP. She recently served as Chair of the Communications Committee and has long-standing involvement with the Public Affairs Committee, Disaster Medicine Committee, and Online Education Subcommittee. She is a frequent and sought-after presenter at Scientific Assembly and other national meetings, speaking on disaster response, human factors, burnout, trauma systems, aviation safety principles in medicine, and physician wellness. Her scholarship includes academic publication in disaster medicine and wilderness burn care, further demonstrating her depth of expertise.

What distinguishes Dr. McGowan most, however, is her ability to translate experience into mentorship and momentum. Personally, she encouraged my own initial involvement in GSACEP and has done the same for many others. She invests in people. She identifies future leaders and creates pathways for them to contribute. Her leadership is not performative—it is generative.

She brings a rare combination of operational credibility, policy fluency, educational engagement, and organizational governance experience. She understands emergency medicine from the bedside to the boardroom, from deployed environments to critical access hospitals, from local chapters to national committees. Just as importantly, she understands the importance of communication—of connecting members to mission and ensuring physicians feel heard and represented.

GSACEP supports her candidacy without reservation. We believe she will bring to the ACEP Board thoughtful judgment, disciplined leadership, strategic insight, and an unwavering commitment to emergency physicians across all practice environments—including those in federal and military systems whose perspectives are essential to the College's strength.

Dr. McGowan has dedicated her career to service—service to patients, to colleagues, to the military, and to the profession of emergency medicine. She has already contributed enormously to ACEP. We are confident she will continue to elevate the organization at the highest level.

It is with great pride that we endorse Dr. Torree McGowan for the ACEP Board of Directors.

Respectfully,

Justine Stremick

Justine Stremick, MD, MPH&TM, FACEP
Government Services Chapter
American College of Emergency Physicians
jstremic@gmail.com

Torree M. McGowan, MD, FACEP

We didn't choose emergency medicine because it was easy. We don't go to work for the URIs or the ankle sprains. We are the experts for when things are at their worst: the codes, the bad traumas, the truly life and death moments. Those are the same reasons we choose ACEP, because we need an organization that doesn't back down from the toughest problems. I have been an ACEP member since I was an intern in 2005, and over the past 21 years have watched this specialty define our space in the house of medicine, defend access to care for millions of Americans, and elevate emergency medicine through research and innovation.

We are facing real challenges in emergency medicine, but that is nothing new. We've already solved the easy problems, so what remains are the wicked ones, the kind without simple answers. Those problems require serious people willing to do the hard work of curiosity, collaboration, and deep investment in our values, to craft solutions that serve as many people as possible. ACEP's commitment to physician autonomy and to high quality emergency care in small towns as well as major cities means we have to meet fair reimbursement and rural access head on. It means calling out the dangerous impact of private equity on patient safety, and insisting physicians, not corporate interests, decide what is best for our patients. It means using the collected wisdom of 40,000 emergency physicians to build sustainable places to work so more of us can practice past 47, the average age emergency physicians leave the specialty.

My journey in emergency medicine has taken me from residency training in Level 1 trauma centers to two combat deployments in the busiest trauma bays in the world. I have worked in rural Alaska, suburban California, and finally settled in critical access hospitals in a frontier community in Oregon. I have led emergency departments in five states and two countries, and commanded a National Guard all hazards disaster response team during COVID, the largest activation of Guardsmen since World War II. I have spoken at Scientific Assembly for over a decade, sharing military lessons learned and new ways to look at patient safety. My work with the Disaster Committee opened doors to journal and textbook authorship that is rare for a small rural EM physician. ACEP is the reason a small town physician has had a seat at the table on national committees, in journals, and at the podium at Scientific Assembly.

My leadership training began at the Air Force Academy and continued through the graduate level Air War College. That through line has held from guiding cadets in basic military training, through combat medical operations, to leading a statewide pandemic response. I learned that as a leader I should never be the smartest person in the room, except in one thing: empowering others to bring their best to a problem. On your Board, I will do the same: listen first, ask hard questions, and put the collective expertise of this College to work on the problems in front of us. I am asking for your vote because I believe ACEP is at its best when we are challenged, and I am ready to do that work alongside you.

TORREE M. McGOWAN, MD, FACEP

Candidate, ACEP Board of Directors | Government Services Chapter



We didn't choose emergency medicine because it was easy. We chose it for the codes, the bad traumas, the truly life-and-death moments, and we chose ACEP for the same reason: because our specialty needs an organization that doesn't back down from the hardest problems.

"Airplane wings are built to create lift from a headwind. I think emergency physicians are the same. We do our best work when it's someone else's worst day. Let's turn into those headwinds together."

WHERE I STAND

Protect the Physician-Patient Relationship

Private equity and corporate interference put profits ahead of patients, pushing clinicians with less training into single coverage EDs without the strength of a physician led team. Physicians should decide what is best for the patient in front of them, and should be fairly compensated for that care.

Defend Rural & Underserved Access

Patients in rural areas face higher disease burden and mortality, and rural hospitals continue to close. Access to care continues to erode as physicians are not prepared or incentivized to practice in rural communities. As a critical access physician myself, I know firsthand what's at stake when rural emergency care disappears.

Lead Through Proven Crisis Experience

Burnout, boarding, and workplace violence are the wicked problems left after the easy ones are solved. My background in military command, disaster response, and human factors analysis gives ACEP battle proven leadership for future challenges.

TWENTY-ONE YEARS PREPARING FOR THIS

ACEP member since 2005, when I attended Council as an intern in New Orleans just after Katrina. Since then I've watched, and helped, this specialty define its place in the house of medicine.

- Professional military leadership training up through graduate level Air War College
- Site Lead, St. Charles Medical Group — two critical access hospitals, Central Oregon, since 2014
- Retired Lieutenant Colonel, Oregon Air National Guard; Commander, all-hazards CBRNE disaster response unit
- Flight Commander, busiest trauma hospital in the world, Bagram, Afghanistan — 99.5% survival rate for war casualties
- Commanded Oregon's COVID vaccination response: 800,000+ vaccinations across 5 hospital systems and 6 counties
- ACEP Communications Committee Chair (2023–2025); Council Reference Committee B Chair (2024)
- ACEP Disaster Medicine, Online Education, and Public Affairs Committees, 2015–present
- Scientific Assembly faculty for over a decade: fatigue management, human factors, disaster response, trauma
- President (2014–15) and Secretary-Treasurer (2022–present), Government Services Chapter

I'm not smart enough to have all the answers, but my job on your Board is to bring the brilliance of 40,000 emergency physicians to bear on the problems in front of us.

TorreeMcG@me.com | 503-449-4477 | Government Services Chapter

Torree M. McGowan, MD, FACEP
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Culver, OR 97734
503-449-4477
TorreeMcG@me.com

WORK EXPERIENCE

Jan 2021 - April 2021

Officer In Charge, Vaccination Administration Teams 2&4

Oregon Convention Center, Deschutes County Expo

Officer in Charge of 92 Air/Army Guard members at OCC site, 30 Guard members at DC providing support to civilian agencies administering COVID19 Vaccinations. Ensured adequate training, staffing, administrative support for dual service team resulting in over 800k vaccinations administered by Oregon Guard members.

Mar 2022 - Present

Teleflex Medical Advisory Board, Clinical Advisor

Represent rural and general emergency physicians to the Medical Advisory Board for hemorrhage control and vascular access for Teleflex product evaluation and development. Teach cadaver procedure labs reinforcing critical life saving resuscitation skills for physicians, nurses, emergency medical technicians, paramedics.

Jul 2014 - Present

St Charles Medical Group Site Lead, St Charles Madras Central OR

Emergency Physician

Lead emergency physician for two critical access hospitals, focusing on patient safety, process improvement, trauma system coordination, disaster preparedness.

Vice Chair, Medical Governance Board Dec 2020 - Dec 2021

Represent over 300 physicians and non physician providers to provide strategic guidance to St Charles Medical Group

Jul 2017 - 2023

Oregon Air National Guard 142 MDG/Det1 (CBRNE Enhanced Force Response Package)

Portland Air National Guard Base, Portland, OR

Commander Jun 2019 - Dec 2021

Command 47 member medical element of all hazards disaster response unit with specialized CBRNE capability. Responsible for strategic vision, readiness, training, manning, and discipline.

Officer In Charge, All4Oregon and Deschutes County COVID Vaccination Sites Jan-Mar 2021

Commanded 92 member Army/Air Force vaccination team for COVID mass vaccination effort. Coordinated across 5 hospital systems, 6 counties, and multiple National Guard units to ensure 7 day a week manning, logistics, personnel issues, and quality of care concerns.

Emergency Physician Jul 2017 - Dec 2021

Created new training regimen to enhance patient stabilization capabilities for CERFP operations. Subject matter expert on critical care considerations for all hazards response transition that is setting standard for CERFP units nationally.

SGH, 142 MDG Nov 2017-Jan 2019

Chief of Medical Staff for 142 MDG, ensure appropriate credentialing, oversight of immunizations, deployment and military readiness for Portland Air National Guard base population.

Aug 2011 - 2017

David Grant Medical Center Emergency Department

Travis Air Force Base, Fairfield, CA

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Culver, OR 97734
503-449-4477
TorreeMcG@me.com

Medical Director, Staff Emergency Physician
Coordinated initial interview, hiring, training, and credentialing process for 12 new physicians. Conducted three formal standard of care reviews. Analyzed 6 hour stay data for root causes, resulting in best door to floor time in Air Force hospitals. Created point of care ultrasound course that trained 34 physicians in latest techniques, award 396 hours of CME. Authored hospital wide point of care ultrasound program. Medical director for David Grant training site supporting largest US physician assistant education program.

Apr - Oct 2013
CRAIG JOINT THEATER HOSPITAL
Bagram, Afghanistan
Flight Commander, Staff Emergency Physician
Led 25 member team staffing busiest trauma hospital in world during Operation Enduring Freedom. Responsible for staffing, logistics, education, training, discipline of team that boasted a 99.5% survival rate for war casualties. MASCAL Immediate Team Chief, responded to 3 real world MASCAL events.

2008 - 2011
ELMENDORF AIR FORCE BASE EMERGENCY DEPARTMENT
Anchorage, AK
Staff Emergency Physician

2008 - 2011
MAT-SU REGIONAL MEDICAL CENTER
Palmer, AK
Locums Emergency Physician

2009 - 2010
AIR FORCE THEATER HOSPITAL
Balad, Iraq
Medical Director, Staff Emergency Physician

EDUCATION

AIR WAR COLLEGE
Correspondence. Completed February 2021. Senior-level professional education program of the U.S. Air Force focused on strategic leadership, national security, and joint military operations. The curriculum emphasizes critical thinking, policy analysis, and decision-making in complex global environments.

AIR COMMAND AND STAFF COLLEGE
Correspondence. Completed April 2010. Intermediate-level professional education program of the U.S. Air Force that develops leaders in operational art, joint planning, and organizational leadership. The program emphasizes critical thinking and the application of military power within complex, multi-domain environments.

SAN ANTONIO UNIFORMED SERVICES HEALTH EDUCATION CONSORTIUM
San Antonio, Texas
Emergency Medicine Residency, June 30, 2008

OREGON HEALTH & SCIENCE UNIVERSITY
Portland, Oregon
Medical Doctorate
June 1, 2005

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Culver, OR 97734
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TorreeMcG@me.com

UNITED STATES AIR FORCE ACADEMY
Colorado Springs, Colorado
Bachelor of Science, Biology
May 31, 2001
Distinguished Graduate

HONORS AND AWARDS

2017 EXCELLENCE IN MILITARY EMERGENCY MEDICINE AWARD, GOVERNMENT SERVICES CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Awarded to active GSACEP member recognized as a leader with a record of significant contributions to military emergency medicine, resulting in noteworthy impact on the profession.

2015 MILITARY HEALTH SYSTEM AIR FORCE JUNIOR FEMALE PHYSICIAN OF THE YEAR
Selected as the top junior female physician (below the rank of Colonel) in the U.S. Air Force by the Military Health System in recognition of outstanding clinical excellence, leadership, operational support, and contributions to military medicine.

2014 TRAVIS AIR FORCE BASE MEDICAL OPERATIONS SQUADRON FIELD GRADE OFFICER OF THE YEAR

2012 OUTSTANDING PRECEPTOR, DAVID GRANT MEDICAL CENTER, INTERSERVICE PHYSICIAN ASSISTANT PROGRAM
Selected by students as outstanding clinical preceptor for the Physician Assistant training program at David Grant Medical Center

2011 FELLOW OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

2008 LEADERSHIP IN EMERGENCY MEDICINE AWARD
San Antonio Uniformed Services Health Education Consortium

2001 UNITED STATES AIR FORCE ACADEMY DISTINGUISHED GRADUATE
Graduation Order of Merit Rank of 46 out of 847 Cadets based upon academic and military performance. Top 5% of Class

SELECTED MILITARY DECORATIONS

Meritorious Service Medal, Second Award
Air Force Commendation Medal, Second Award
Army Commendation Medal
Air Force Meritorious Unit Award
Iraqi Campaign Medal
Afghanistan Service Medal
Nato Service Medal
Global War On Terror Ribbon
National Defense Medal
Global War On Terrorism Service Medal
Air Force Expert Marksmanship Ribbon, Second Award

LEADERSHIP ACTIVITIES

SECRETARY TREASURER, GOVERNMENT SERVICES CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2022 - Present

CHAIR, COMMUNICATIONS COMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2023-2025

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CHAIR, COUNCIL REFERENCE COMMITTEE B, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2024
COUNCIL REFERENCE COMMITTEE MEMBER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2023-2025
2024 CERFP DETACHMENT COMMANDER, OREGON AIR NATIONAL GUARD
142 MEDICAL GROUP, PORTLAND AIR NATIONAL GUARD
Jun 2019 - Jan 2022
CHAIR, ST CHARLES MEDICAL GROUP LEADERSHIP DEVELOPMENT TASK FORCE
Aug 2020 - Dec 2021
PUBLIC AFFAIRS COMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2015 - Present
ONLINE EDUCATION SUBCOMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2015 - Present
DISASTER MEDICINE COMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2015 - Present
COUNCILLOR, GOVERNMENT SERVICES CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2015 - Apr 2022
PRESIDENT, GOVERNMENT SERVICES CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2014 - 2015
FLIGHT COMMANDER, CRAIG JOINT THEATER HOSPITAL
BAGRAM, AFGHANISTAN
April 2013 – October 2013
COMMUNICATIONS COMMITTEE CHAIR, GOVERNMENT SERVICES CHAPTER OF AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
2008 - Present
CHIEF RESIDENT, SAN ANTONIO UNIFORMED SERVICES HEALTH EDUCATION CONSORTIUM EMERGENCY MEDICINE RESIDENCY
2007 - 2008

PRESENTATIONS

"Make It Stop! Persistent Crying in the Newborn."
Presented at the Joint Services Symposium, Lake Tahoe, CA, Mar 2012

"Talk Nerdy to Me: How to Have Great Consultant Interactions."
Presented at Balboa Naval Medical Center Emergency Medicine Residency. San Diego, CA, July 2015.

"Burns: To the Nth Degree."
American College of Emergency Physicians Scientific Assembly, Las Vegas, NV, Oct 2016.

"MASCAL Every Day: Wartime Lessons for Successful Disaster Response."
American College of Emergency Physicians Scientific Assembly, Las Vegas, NV, Oct 2016.
American College of Emergency Physicians Scientific Assembly, Washington DC, Oct 2017.
American College of Emergency Physicians Scientific Assembly, San Diego, CA, Oct 2018.

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"Redefining Reality in PTSD."
American College of Emergency Physicians Scientific Assembly, Washington DC, Oct 2017.
Government Services Symposium, Nashville, TN, Mar 2019

"Battle Forged: How the Military Has Shaped Emergency Medicine."
American College of Emergency Physicians Scientific Assembly, Washington DC, Oct 2017.
American College of Emergency Physicians Scientific Assembly, San Diego, CA, Oct 2018.

"Break Glass in Case of Disaster: How the Single Coverage Emergency Physician Can Cope in the First 30 Minutes"
American College of Emergency Physicians Scientific Assembly, San Diego, CA, Oct 2018.

"Crash and Burn: What Emergency Medicine Is Missing from Aviation Safety"
Coastal Emergency Medicine Conference, Jun 2019
American College of Emergency Physicians Scientific Assembly, Denver, CO, Oct 2019.

"Disaster Response Playbook"
American College of Emergency Physicians Scientific Assembly, Denver, CO, Oct 2019.
Northwest Trauma Conference, Virtual, May 2020.

"Dead Tired: The Impact of Fatigue on Physician Wellness and Patient Safety."
American College of Emergency Physicians Scientific Assembly, Virtual, Oct 2020
American College of Emergency Physicians Scientific Assembly, Boston, MA, Oct 2021
American College of Emergency Physicians Scientific Assembly, San Francisco, CA Oct 2022
American College of Emergency Physicians Scientific Assembly, Philadelphia, PA Oct 2023

"Trauma Mythbusters."
American College of Emergency Physicians Scientific Assembly, Virtual, Oct 2020

"Trauma At Your Doorstep."
American College of Emergency Physicians Scientific Assembly, Virtual, Oct 2020
American College of Emergency Physicians Scientific Assembly, Boson, MA Oct 2022
American College of Emergency Physicians Scientific Assembly, San Francisco, CA Oct 2022

"Burned Beyond Recognition: Burnout's Cost and Its Solutions."
American College of Emergency Physicians Scientific Assembly, Philadelphia, PA Oct 2023

"Designed to Fail: How Human Factors Put Patients and Physicians at Risk"
Coastal Emergency Medicine Conference, 2024
American College of Emergency Physicians Scientific Assembly, Las Vegas, NV Oct 2023
Government Services Symposium, Norfolk, VA 2026

"Night Shift Like A Pro"
Coastal Emergency Medicine Conference, 2024
Government Services Symposium, Norfolk, VA 2026

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"From Aviation To Achievement"
American College of Emergency Physicians Scientific Assembly, Salt Lake City, UT Sep 2025

ACADEMIC PUBLICATIONS

Bitter, C. C., Storkan, M., Overmiller, A., Respicio, J. A., McGowan, T., Park, A., & Culhane, J. T. (2025). Wilderness Medical Society clinical practice guideline on care of burns in the wilderness. Wilderness & Environmental Medicine, 36(4), 549 – 558. https://doi.org/10.1177/10806032251345768

Mace, S., Pettit, A., McGowan, T. Information Technology in Disaster Medicine. Chapter 27. In: Koenig KL, Schultz CH, eds. *Koenig and Schultz's Disaster Medicine*. 3rd ed. Cambridge University Press. Manuscript completed; in preparation.

PROFESSIONAL ORGANIZATIONS

American College of Emergency Physicians
2015 - Present ACEP Communications Committee
Chair 2023 - 2025
2015 - Present ACEP Online Education Subcommittee
2015 - Present ACEP Disaster Medicine Committee
2014 - President, Government Services Chapter
2023 - Present Government Services Chapter Secretary Treasurer
2001 - Present
Government Services Chapter
2005 – 2008
Board of Directors, Resident Representative

Physicians for Patient Protection
2019 - Present

Beta Beta Beta Biological Honor Society
1999 - Present
Air Force Academy Chapter President 1999

US Air Force Academy Association of Graduates
1997 - Present

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Abhi Mehrotra, MD, MBA, FACEP

Question #1: **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

Emergency medicine faces an inflection point. The pressures reshaping our specialty (e.g., workforce disruption, private equity consolidation, AI-driven clinical documentation, alternative payment models, and the rapid commoditization of care delivery) are fundamentally business and innovation challenges as much as they are clinical ones. Navigating them effectively requires more than policy experience or advocacy instincts. It requires fluency in the language and frameworks of business strategy, entrepreneurship, and organizational design. That is what I bring.

My MBA from Kenan-Flagler Business School has shaped how I approach governance: with attention to organizational incentives, financial sustainability, and competitive positioning. It informs how I analyze the economic forces bearing down on our members — from independent group viability to the downstream effects of consolidation on physician autonomy — and how I help translate those dynamics into Board-level strategy.

Beyond formal training, I bring direct entrepreneurial experience to this Board. I co-founded a medical scribe company, which required recruiting talent, constructing operations from scratch, and managing the tension between clinical quality and business viability. My involvement with Bivarus, a patient experience analytics platform, further deepened my exposure to healthcare technology commercialization, data-driven quality improvement, and the intersection of venture-backed innovation with care delivery. These are spaces where ACEP increasingly needs strategic credibility as we engage with health systems, technology vendors, payers, and policymakers.

My academic position at UNC also grounds me in the long-term health of our specialty's pipeline. I take that responsibility seriously and have acted on it structurally: I developed and launched an Administration and Leadership Fellowship within the UNC Department of Emergency Medicine, creating a formal pathway for emerging physicians to build organizational and strategic competencies beyond traditional residency training. Cultivating the next generation of emergency medicine leaders is fundamental for me. That commitment to younger members extends beyond the training environment. My experience as a former EMRA leader gave me an early and enduring appreciation for the concerns, ambitions, and vulnerabilities of residents and early-career physicians.

ACEP needs a Board that can execute on our strategic priorities to champion individual emergency physicians. My blend of clinical experience, business acumen, entrepreneurial background, and investment in physician development gives the Board a perspective that is otherwise underrepresented. I would welcome the opportunity to continue bringing that perspective as your representative on the ACEP Board of Directors.

Question #2: **What is your perspective on ACEP's role in the 3-year versus 4-year emergency medicine training program discussion?**

This is one of the most consequential workforce debates our specialty has faced in a generation, and ACEP's role must be to lead it with both rigor and principle: defending an evidence-based position even when external pressures push in a different direction.

ACEP's current policy is clear: we support both 3-year and 4-year training models, grounded in evidence that outcomes between them are equivalent. Studies comparing ABEM board performance and clinical practice patterns have found no meaningful difference between graduates of either format. ACEP's formal position reinforces this: any changes to physician education must be evidence-based.

The ACGME's 2025 proposal to mandate a 4-year model for all programs deserves scrutiny on both educational and economic grounds. Roughly 80% of programs currently use the 3-year pathway. Critics have rightly noted that a mandate of this scale would impose substantial financial burden on future residents — through delayed income, compounding debt, and lost investment runway — while simultaneously generating significant increases in subsidized resident labor for health systems.

ACEP and EMRA have taken a clear joint position: training standards can be raised without mandating increased training time, and any new review process must be transparent, evidence-based, and inclusive of broad stakeholder involvement. I fully support that stance.

Where I would focus ACEP's energy going forward is on the affirmative case: championing curriculum innovation within existing training structures. Declining board pass rates and reduced patient encounter volumes are real concerns that deserve real solutions. But the answer lies in educational quality, not simply adding time. ACEP is uniquely positioned, through its Clinical Excellence and Practice Innovation strategic priorities, to lead that work. Our credibility in this debate depends on being the organization that prioritizes what the evidence actually shows over what is administratively convenient for health systems.

Question #3: **What is the most effective strategy you would use to recruit and retain members considering generational differences?**

Recruitment and retention are not the same problem, and the generational dimension makes that distinction even more important. Effective strategy requires understanding what each cohort actually needs from a professional organization and being honest about where ACEP has historically underdelivered.

For residents and early-career physicians, the barrier to joining is not awareness; it is skepticism about relevance. This mobile-first generation expects membership value to be demonstrated digitally and in real time. What resonates is tangible impact: visible wins on workplace safety, debt burden, schedule sustainability, and the integrity of independent practice in a consolidating market. ACEP's strategic priority on Career Fulfillment (championing well-being, professional satisfaction, and a transparent job market) speaks directly to these concerns and should be front and center in how we recruit younger members. The proposed objective to proactively showcase emergency medicine as a rewarding and sustainable career to medical students and residents is exactly right.

Retaining mid-career and senior members requires a different lens. These physicians often disengage not from lack of interest but from a sense that the organization has moved on without them; that reimbursement erosion, administrative burden, and scope of practice encroachment receive less attention than emerging priorities. ACEP's Advocacy priority, fighting for emergency physicians from the workplace to Washington, must demonstrably deliver for this cohort. Transparent reporting of wins (as called for in the Member Engagement and Trust priority) matters enormously here. Retention follows demonstrated value, not promises of it.

The strategy I would advocate is segmented communication anchored to a unified value proposition — and our new association management system will give us the infrastructure to finally execute it with precision. By leveraging member data across career stage, practice setting, and engagement history, we can move beyond broad messaging to targeted outreach that speaks to what individual members actually care about. Early-career physicians can receive communications centered on financial wellness, career development, and leadership pathways; mid-career members can be engaged around advocacy wins, practice management resources, and peer networks; senior members can be recognized and activated as mentors and institutional voices. The EMRA-to-ACEP transition remains a critical leverage point within this framework: residents who feel genuinely engaged during training are far more likely to remain members long-term.

Ultimately, the goal is not simply to grow membership numbers; it is to build a community where every emergency physician, at every stage of their career, finds something worth staying for. That is the promise embedded in our new vision, and the new AMS gives us the tools to deliver on it with the specificity and intentionality it deserves.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Abhi Mehrotra, MD, MBA, FACEP

Contact Information

117 Sagerview Way
Durham, NC. 27713
Phone: 919-672-3096
E-Mail: Abhi@med.unc.edu

Current and Past Professional Position(s)

University of North Carolina	Assistant Prof. of Emergency Medicine	2003 – 2013
University of North Carolina	Assistant Residency Director	2005 – 2007
University of North Carolina	Associate Residency Director	2007 – 2010
University of North Carolina	Assistant Medical Director	2004 – 2020
University of North Carolina	Associate Prof. of Emergency Medicine	2013 – 2019
University of North Carolina	Medical Director, Hillsborough Campus	2015 – 2020
University of North Carolina	Dept. of EM, Vice Chair - Operations	2015 – Present
University of North Carolina	System Emergency Service Lead	2018 – Present
University of North Carolina	Professor of Emergency Medicine	2019 – Present
University of North Carolina	Adjunct Professor, Kenan Flagler Business School	2021 – Present

Education (include internships and residency information)

M.B.A.	University of North Carolina	2014 – 2015
Emergency Medicine Residency	University of North Carolina	2000 – 2003
M.D.	The Ohio State University	1996 – 2000
B.A. (Chemistry)	The Ohio State University	1992 – 1996

M.D. - 2000

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)
Diplomate, American Board of Emergency Medicine – 2004, Renewal 2014, 2024

Professional Societies

American College of Emergency Physicians
North Carolina College of Emergency Physicians
Society for Academic Emergency Medicine
Emergency Medicine Residents' Association
American Medical Association
North Carolina Medical Society

National ACEP Activities – List your most significant accomplishments

ACEP Board of Directors	Secretary / Treasurer	2025 – Present
ACEP Board of Directors	Member	2023 – Present
Finance Committee	Member	2002 – 2003, 2022 – 2023
CEDR Committee	Member (Chair)	2017 – 2023 (2018-2020)
HIT Committee	Member	2019 – 2023
Quality and Performance Committee	Member	2010 – 2021
Council Steering Committee	Member	2000 – 2002, 2008 – 2010
Reference Committee	Member (Chair)	2001, 2008, 2010, 2021, 2022 (2010, 2021, 2022)

EM Practice Management & Health Policy Section	Member (Chair)	2007 – 2023 (2012-2014)
Young Physicians Section	Member (Chair)	2005 – 2023 (2008)
ED Categorization Task Force	Chair	2008 – 2010

ACEP Chapter Activities – List your most significant accomplishments

NCCEP Education Committee	Member (Chair)	2006 – 2008 (2007)
NCCEP Board	Member	2010 – 2016
NCCEP Board	Secretary-Treasurer	2012 – 2013
NCCEP Board	President-Elect	2013 – 2014
NCCEP Board	President	2014 – 2015
NCCEP Board	Past-President	2015 – 2016
NCCEP	Councillor	2010 – 2023

Practice Profile

Total hours devoted to emergency medicine practice per year: **2000** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **35** % Research **5** % Teaching **10** % Administration **50** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Academic emergency physician seeing patients primarily and with residents at two facilities – a regional teaching referral center and a community facility. University employee, member of a faculty practice plan.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Vice Chair, Strategic Initiatives & Operations, UNC Department of Emergency Medicine

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 1 Cases Plaintiff Expert 1 Cases

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Abhi Mehrotra, MD, MBA, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: University of North Carolina at Chapel Hill
Address: 103 South Building, Campus Box 9100
Chapel Hill, NC 27599
Position Held: Attending Physician
Type of Organization: University

Employer: MedScribes, Inc.
Address: 6409 Fayetteville Rd., Suite 120-346
Durham, NC 27713
Position Held: CEO
Type of Organization: Medical scribe services

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: North Carolina College of Emergency Physicians
Address: PO Box 1038
Wake Forest, NC 27588
Type of Organization: State Chapter of ACEP
Leadership Position: Board of Directors
Term of Service: 2010 – 2016

Organization: Emergency Medicine Residents Association (EMRA)
Address: 1601 Utica Avenue South
Minneapolis, Minnesota 55416
Type of Organization: Not-for-profit organization representing Emergency Medicine Residents and Medical Students with a career interest in Emergency Medicine
Leadership Position: Board of Directors
Term of Service: 2000 - 2002

Organization: University of North Carolina Faculty Physicians

Address: 145 Medical Drive, Suite 400

Chapel Hill, NC 27599

Type of Organization: Faculty group practice plan

Leadership Position: Board of Directors

Term of Service: 2017 – 2020

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe: Co-founder and CEO of a medical scribe company

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Abhishek Mehrotra Date May 29, 2026

NCCEP
North Carolina College of Emergency Physicians

August 3, 2026

ACEP Council

Re: Abhi Mehrotra, MD, MBA, FACEP

Dear ACEP Council:

On behalf of the North Carolina Chapter, it is with great enthusiasm and conviction that I endorse Abhi Mehrotra, MD, MBA, FACEP as a candidate for a second term on the ACEP Board of Directors. His unwavering dedication to advancing emergency medicine and his exceptional leadership qualities make him a standout candidate who will continue to contribute significantly to ACEP's mission.

Dr. Mehrotra's exceptional track record of leadership and service within the North Carolina College of Emergency Physicians (NCCEP) is a testament to his passion for our specialty. As a pivotal figure in our chapter, he has consistently demonstrated a keen understanding of the challenges and opportunities that emergency physicians encounter. His commitment to nurturing a collaborative environment and fostering innovation has left a lasting impact on our community.

During his first term on the Board, Dr. Mehrotra translated his unique ability to bridge local and national perspectives into actionable results. Recognizing the pressing challenges facing our specialty, he helped organize the AHRQ Boarding Summit, highlighting potential solutions across the spectrum of care to address the severe capacity issues affecting emergency physicians nationwide.

Drawing on his expertise at the intersection of emergency medicine and informatics, Dr. Mehrotra played a vital role in stabilizing our data infrastructure. He successfully transitioned the Clinical Emergency Data Registry (CEDR) into the broader Emergency Medicine Data Institute (EMDI) to improve clinical research, quality measure reporting, and federal registry support. This crucial effort has resulted in a positive, measurable contribution to the financial equity of the organization over the past two years.

His broader financial stewardship this past year as Secretary/Treasurer has further secured an incredibly stable future for the College. In this executive role, Dr. Mehrotra successfully

Officers

Christopher Griggs, MD, MPH, FACEP
President

Smeet Bhimani, DO, MBA, FACEP
President-Elect

Laura Murphy, MD
Secretary/Treasurer

Melanie Artho, MD, FACEP
Immediate Past President

Board of Directors

Carrie Fales, MD, FACEP
Jeremiah Gaddy, MD, FACEP
Sierra Gilder, MD
Matthew Heuton, MD
Richard Jean-Louis, MD, MA
Eric LeFebvre, MD, FACEP
Michael Merrill, MD
Chelsea Rushnell, MD
Benjamin Wiles, DO

Resident Members
Alex Beam, MD (Voting Resident Member)
Michael Collins, MD
Jennifer Evans, MD
Rachael Hamm, MD
Lyndsay Oakeson, MD

Councillors

Melanie Artho, MD, FACEP
Jill Benson, MD, FACEP
Smeet Bhimani, DO, MBA, FACEP
Scott Brown, MD, FACEP
Jeremiah Gaddy, MD, FACEP
Matthew Heuton, MD
Christopher Griggs, MD, MPH, FACEP
Eric Maur, MD, FACEP
Laura Murphy, MD
Bret Nicks, MD, FACEP
Stephen Small, MD, FACEP
Benjamin Wiles, DO

Executive Director

Colleen Kochanek
colleen@kochaneklawgroup.com
P.O. Box 1038
Wake Forest, NC 27588
(919) 809-5618
http://www.nccep.org

A chapter of the
American College of Emergency Physicians

onboarded a new Finance Committee Chair and a new CFO. He facilitated and executed the complete payoff of the mortgage on the ACEP headquarters building, spearheaded the passage of a new cash balance policy, and passed a balanced budget with directed investment in growth.

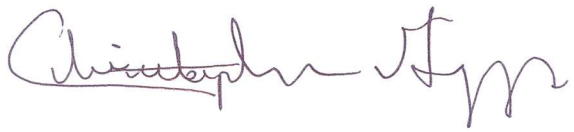
Dr. Mehrotra's professional accomplishments also highlight his dedication to innovation and patient care. As an advocate for evidence-based practice, he has actively contributed to advancements that benefit both patients and emergency physicians. His expertise in technology and his commitment to staying at the forefront of healthcare trends are valuable assets that ACEP continues to leverage for the betterment of our specialty.

Moreover, Dr. Mehrotra's commitment to inclusivity and diversity is evident in his professional activities. His involvement in initiatives promoting equity in healthcare delivery reflects his dedication to addressing disparities within our specialty. By prioritizing inclusivity, Dr. Mehrotra not only embodies the values that ACEP stands for but also ensures that all voices within emergency medicine are heard and represented.

In conclusion, Dr. Abhi Mehrotra's exceptional leadership, profound dedication to our specialty, and track record of concrete results make him an outstanding candidate for a second term on the ACEP Board of Directors. His ability to inspire collaboration, advocate for evidence-based practice, and champion diversity and inclusivity are precisely the attributes that our organization needs to thrive in an ever-evolving healthcare landscape.

I am honored to extend my heartfelt endorsement for Dr. Abhi Mehrotra for the national ACEP Board of Directors. His vision and capabilities align seamlessly with ACEP's mission to represent and advocate for all emergency physicians, ensuring a prosperous future for our specialty.

Sincerely,



Christopher Griggs, MD, MPH, FACEP
President, North Carolina Chapter American College of Emergency Physicians

Abhi Mehrotra, MD, MBA, FACEP

Dear Esteemed Councillors and ACEP Family,

Emergency medicine stands at an inflection point. The forces reshaping our specialty (private equity consolidation, AI-driven documentation, alternative payment models, workforce uncertainty, and the rapid commoditization of care delivery) are as much business and innovation challenges as they are clinical ones. Navigating them requires a Board with the breadth and sophistication to match what we are up against.

I am writing to ask for your support and vote for my re-election to the ACEP Board of Directors.

Over the past year as your Secretary-Treasurer, I have had the privilege of serving at the intersection of ACEP's governance and financial stewardship during a period of significant change for our organization and our specialty. That experience has deepened my conviction that the work ahead demands continuity of leadership, institutional knowledge, and a willingness to engage the hard questions — on workforce sustainability, member engagement, and the economic forces bearing down on individual emergency physicians.

My background is uncommon for a physician-leader. My MBA from Kenan-Flagler Business School shapes how I approach governance: with attention to organizational incentives, financial sustainability, and competitive positioning. As co-founder of a medical scribe company and involved in the start-up of Bivarus, a patient experience analytics platform, I have built organizations from scratch, managed the tension between clinical quality and business viability, and navigated the realities of healthcare technology commercialization. These are experiences that translate directly to the strategic challenges ACEP faces.

As Executive Vice Chair at UNC and Director of our Administration and Leadership Fellowship, I have invested concretely in building the next generation of emergency medicine leaders — creating formal pathways for emerging physicians to develop the organizational and strategic competencies that clinical training alone does not provide. My earlier service on the EMRA Board of Directors gave me an enduring appreciation for the concerns of residents and early-career physicians. Their voices must be more than acknowledged — they must be structurally represented.

On member engagement, I am committed to a strategy that is segmented and data-driven. Residents and early-career physicians need to see ACEP winning fights that matter in their daily lives: on workplace safety, debt burden, and independent practice. Mid-career and senior members need to know their concerns around reimbursement erosion, administrative burden, and scope of practice are front and center. Our new association management system gives us the infrastructure to move beyond broad messaging and deliver targeted, meaningful engagement at every career stage. Retention follows demonstrated value, not promises of it.

ACEP is our collective voice, and our new strategic framework — anchored in advocacy, clinical excellence, practice innovation, career fulfillment, and member engagement — gives us the right foundation for the years ahead. I am committed to helping execute those priorities with the rigor and urgency they deserve.

I am honored to ask for your continued confidence and your vote. If re-elected, I pledge to bring the same energy, accountability, and commitment to the advancement of our specialty that I have tried to demonstrate in this first term.

Thank you for your leadership, your time, and your trust.

Abhi Mehrotra, MD, MBA, FACEP

Endorsed by the North Carolina College of Emergency Physicians
Incumbent Candidate for Re-Election, ACEP Board of Directors

National Leadership

- Secretary-Treasurer, ACEP Board of Directors
- YPS Section Chair
- EMP & HP Section Chair
- CEDR Committee Chair
- Finance Committee
- HIT Committee
- EM Practice Committee
- ED Categorization TF
- Diversity & Inclusion TF
- EMRA Board of Directors

Council Service & Awards

- Steering Committee, 2000
- Steering Committee, 2008
- Reference Committees
  – Chair, 2010, 2021, 2022
- Councillor 2010 - Present
- EMRA 45 Under 45
- Council Horizon Award
- Hero of Emergency Medicine Award

Chapter Leadership

- President
- Secretary-Treasurer
- Board Member
- Councillor
- Education Committee Chair

Experience

- Executive Vice Chair
- EM System Co-lead
- Medical Director
- Admin Fellowship Director
- Co-founder & CEO

VOTE



Abhi Mehrotra, MD, MBA, FACEP

Secretary-Treasurer, ACEP Board of Directors

Incumbent Candidate for Re-Election, ACEP Board of Directors

ABHISHEK MEHROTRA, MD, MBA, FACEP
CURRICULUM VITAE

OFFICE ADDRESS:
170 Manning Drive, CB# 7594
Chapel Hill, NC 27599-7594
Tel (919) 843-8896
Fax (919) 966-3049
Email: Abhi@med.unc.edu

HOME ADDRESS:
117 Sagerview Way
Durham, NC 27713
Tel (919) 493-1538

CURRENT POSITION:
Clinical Professor
Vice Chair, Strategic Initiatives & Operations
Department of Emergency Medicine
University of North Carolina

EDUCATION:

Professional Development

Professional Development Foundation Series	University of North Carolina SOM Chapel Hill, NC	2018
Chair Development Program	Association of Academic Chairs of Emergency Medicine	2017
Six Sigma Blue Belt	University of North Carolina Hospitals Chapel Hill, NC	2010
Six Sigma Yellow Belt	University of North Carolina Hospitals Chapel Hill, NC	2009
Team STEPPS Coach	University of North Carolina Hospitals Chapel Hill, NC	2009
ACEP Medical Director's Academy Phase I, II, III	American College of Emergency Physicians Dallas, TX	2005, 2007, 2008
EMF/ACEP Research Skills Course	American College of Emergency Physicians Dallas, TX	2007

EMF/ACEP Teaching Fellowship	American College of Emergency Physicians Dallas, TX	2005

Postgraduate

Emergency Medicine Residency	University of North Carolina Hospitals Chapel Hill, NC	2000 – 2003

Graduate

M.B.A.	The University of North Carolina Kenan-Flagler Business School Chapel Hill, NC	2014 – 2015
M.D.	The Ohio State University College of Medicine and Public Health Columbus, OH	1996 – 2000

Undergraduate

B.A. (Chemistry) Honors in the Liberal Arts	The Ohio State University Columbus, OH	1992 – 1996

MEDICAL LICENSURE: North Carolina #2003-00383

BOARD CERTIFICATION: Diplomate, American Board of Emergency Medicine
2004, Renewal 2014, Renewal 2024

ACADEMIC & RESEARCH POSITIONS:

Adjunct Professor, Kenan-Flagler Business School University of North Carolina Chapel Hill, NC	2021 – Present
Clinical Professor, Department of Emergency Medicine University of North Carolina Chapel Hill, NC	2019 – Present
Clinical Associate Professor, Department of Emergency Medicine University of North Carolina Chapel Hill, NC	2013 – 2019
Vice Chair, Strategic Operations, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC	2015 – Present
Medical Director, Hillsborough Campus, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC	2015 – 2020
Assistant Medical Director, Medical Center, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC	2004 – 2020
Chief, Division of Quality & Performance, Dept. of Emergency Medicine University of North Carolina Chapel Hill, NC	2010 – 2015
Associate Residency Director, Department of Emergency Medicine University of North Carolina Chapel Hill, NC	2007 – 2010
Assistant Residency Director, Department of Emergency Medicine University of North Carolina Chapel Hill, NC	2005 – 2007
Clinical Assistant Professor, Department of Emergency Medicine University of North Carolina Chapel Hill, NC	2003 – 2013
Chief Resident, Department of Emergency Medicine University of North Carolina, Chapel Hill, NC	2002 – 2003

Research Assistant, Quality & Operations Improvement Department 1999 – 2000
The Ohio State University Medical Center
Columbus, OH

Research Assistant, NHLBI 1994, 1995, 1997
National Institutes of Health, NHLBI
Bethesda, MD

HONORS AND AWARDS:

Emergency Medicine Resident's Association 45 Under 45 2019
Awarded to recognize influencers in the field of Emergency Medicine

UNC School of Medicine Academy of Educators Fellow 2017 – Present
Awarded in recognition of excellence in teaching

UNC School of Medicine ACCLAIM Fellow 2015 – 2016
Leadership development program

Beta Gamma Sigma 2015
International Honor Society for Collegiate Schools of Business

Poets & Quants for Executives 2015
Class of 2015 – The Best Executive MBAs
Awarded by Poets & Quants based upon nominations from across the country

Council Horizon Award 2010
American College of Emergency Physicians (ACEP)
Awarded by the ACEP Council to a member who displays leadership potential

Hero of Emergency Medicine 2009
ACEP
Awarded by ACEP in recognition of contribution to the specialty

Renaissance Award 2006, 2008
UNC Department of Emergency Medicine
Awarded by the EM Residents to an attending exemplifying balance of professional & personal life

Fellow, American College of Emergency Physicians 2006
ACEP

Distinguished Fellow, EMF / ACEP Teaching Fellowship 2004
ACEP

Robert J. Doherty EMF / ACEP Teaching Fellowship Scholarship 2004
ACEP

Most Helpful Resident Award 2003
UNC Hospitals' Nursing Staff

Chief Resident 2002
UNC Department of Emergency Medicine

Sphinx Senior Class Honorary 1995
The Ohio State University

Bucket & Dipper Junior Class Honorary 1994
The Ohio State University

PUBLICATIONS:

A) **Book Chapters**

1) **Mehrotra A.** Behavioral Health in Emergency Care, in Strauss R, Mayer T (editors), ED Management, 2nd Edition, (American College of Emergency Physicians) 50, 2021.

2) Glickman S, **Mehrotra A.** Using Data on Patient Experience to Improve Clinical Care, in Wiler J, Pines J, Ward M (editors), Value and Quality Innovations in Acute and Emergency Care, (Cambridge University Press) 178, 2017.

3) Goodman G, **Mehrotra A.** Ethical / Legal Issues, in Blok B, Cheung D, Platts-Mills T (editors), First Aid for the Emergency Medicine Boards, (McGraw Hill) 1059, 2016.

4) Waller N, **Mehrotra A.** Pericarditis, Myocarditis, and Endocarditis, in Mattu A, et al. (editors), Cardiovascular Emergencies, (American College of Emergency Physicians), 2014.

5) **Mehrotra A,** Hobgood C. Disclosure of Medical Error and Truth Telling, in Jesus J, et al. (editors), Ethical Problems in Emergency Medicine: A Discussion Based Review, (Wiley-Blackwell), 27, 2012.

6) **Mehrotra A**. Hematologic Emergencies, in Rivers CS (editor), Preparing for the Written Board Exam in Emergency Medicine (5th edition) (EMEE) 2006.

7) **Mehrotra A**, Harmondy M. Headache, in Schaider J, et al. (editors), Rosen and Barkin's 5 Minute Emergency Medicine Consult (2nd edition) (Philadelphia; Lippincott Williams & Wilkins) 468, 2003.

B) **Peer-Reviewed Manuscripts**

1) Lin P, Argon NT, Cheng Q, Evans CS, Linthicum B, Liu Y, **Mehrotra A**, Murphy L, Patel MD, Ziya S. Identifying Patient Subpopulations with Significant Race-Sex Differences in Emergency Department Disposition Decisions. Health Services Insights, 17, 2024.

2) Cheng Q, Argon NT, Evans CS, Lin P, Linthicum B, Liu Y, **Mehrotra A**, Patel MD, Ziya S. An Investigation into Demographic Disparities in Emergency Department Disposition Decisions. *Production and Operations Management*, online, 2024.

3) Lin MP, Sharma D, Venkatesh A, Epstein SK, Janke A, Genes N, **Mehrotra A**, Augustine J, Malcolm B, Goyal P, & Griffey RT (2024). The Clinical Emergency Data Registry: Structure, Use, and Limitations for Research. *Annals of Emergency Medicine*, online, 2024.

4) Patel MD, Lin P, Cheng Q, Argon NT, Evans CS, Linthicum B, Liu Y, **Mehrotra A**, Murphy L, Ziya S. Patient sex, racial and ethnic disparities in emergency department triage: A multi-site retrospective study. *The American Journal of Emergency Medicine*. Volume 76, pp 29-35, 2024.

5) Lin P, Argon NT, Cheng Q, Evans C, Linthicum, B, Liu Yufeng, Mehrotra A, Patel M, Ziya S. Disparities in Emergency Department Prioritization and Rooming of Patients with Similar Triage Acuity Score. *Academic Emergency Medicine*, 29:11, pp 1320-1328, 2022.

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16) Kalich BA, Maguire JM, Campbell-Bright SL, **Mehrotra A**, Caffey T, Tulu Z, Lin FC, Carson SS. Impact of an Antibiotic-specific Sepsis Bundle on Appropriate and Timely Antibiotic Administration for Severe Sepsis in the Emergency Department. *J Emerg Med;* 50(1):79-88.e1, 2016.

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Patients Presenting to the Emergency Department with Acute Blunt Abdominal Trauma. *Annals of Emergency Medicine*. 57:387-404, 2011.

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C) **Non Peer-Reviewed Articles**

1) **Mehrotra A**, Buff TD, Hatfield LM, Kessler CS. Oral anticoagulation reversal. *Emergency Medicine Reports.* 37: 197-208, 2016.

D) **Abstracts**

1) Galske J, Venkatesh A, Makutonin M, Barthell E, **Mehrotra A**, Epstein S, Aldeen A, Dalsey W, Richardson L, Ravi S, Lin M, Sabbatini A, Cirillo A, Tinloy B, Goyal P, Augustine J, Gettel CJ. QCDR Measure Reporting Among Emergency Medicine Physicians: Trends in MIPS from 2017 to 2022. Society for Academic Emergency Medicine, Philadelphia, May 2025.

2) Mendoza C, Lucke A, Barletson P, **Mehrotra A**, Bohrmann T, Patel M, Seaman C. Implementation of an Influenza Vaccination Program is a Feasible and Effective Public Health Tool in the Emergency Department. *Annals of Emergency Medicine*; 78 (4), p. S125; 2021.

3) Myers JG, Sackmann R, Cai A, Meyer M, **Mehrotra A**. Eliminating Routine Use of Oral Contrast in Diagnostic Abdominopelvic Computed Tomography Imaging: Implications for Patient Care and Efficiency in the Emergency Department. *Academic Emergency Medicine*, 25 (S1), p. S234, 2018.

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5) **Mehrotra A**, Travers D, Chen W, Lopiano K, Bohrmann T, Argon N, Ziya S, Strickler J, Ring J, Linthicum B. Starting with a Clear Endpoint: Development of a Tool to Predict Admissions at Triage. *Academic Emergency Medicine.* 24:S1:S13-4, 2017.

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8) Jones C, Culbreath K, **Mehrotra A**, Gilligan P, Shofer S. Urinalysis Reflex Testing in the Emergency Department. *Academic Emergency Medicine*. 18:4:S197-8, 2011.

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10) Biese K, **Mehrotra A**, Page B, Cook J, Merck L. ED Crowding Increases Acquisition Time of Brain CT and ECG. *Academic Emergency Medicine*. 15:5:S199-200, 2008.

TEACHING RECORD:

COURSE DIRECTOR

Emergency Medicine Administration and Leadership Fellowship
UNC Department of Emergency Medicine
Ongoing Audience: 2
Chapel Hill, NC

Administration Rotation
UNC Emergency Medicine Residency Curriculum
Ongoing Audience: 12
Chapel Hill, NC

LECTURES / GRAND ROUNDS

"ACEP Update 2025"
Duke Emergency Medicine Grand Rounds
December 2025 Audience: 50
Durham, NC

"GI Foreign Bodies"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"Novel Agents for Sedation"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"ALTO: Alternatives to Opioids"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"Sepsis Updates - 2025"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"ED Boarders: Managing the Challenge"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"Aviation Applications: Optimizing Safety Strategies in EM"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"Anticoagulation Reversal"
Topics in Emergency Medicine
August 2025 Audience: 120
Paris, France

"Unlocking Revenue Potential: ED Obs Billing Essentials"
Coastal Emergency Medicine Conference
June 2025 Audience: 300
Kiawah Island, SC

"ACEP Update 2025"
Coastal Emergency Medicine Conference
June 2025 Audience: 300
Kiawah Island, SC

"ACEP National Focus 2025"
North Carolina College of Emergency Physicians' Medical Director's Summit
March 2025 Audience: 60
Greensboro, NC

"Operational Challenges in Managing an ED"
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
February 2025 Audience: 70
Chapel Hill, NC

MASH to ER to The Pitt: The Transformation and State of Emergency Medicine in 2025 and Beyond
UNC Department of Emergency Medicine Grand Rounds
January 2025 Audience: 60
Chapel Hill, North Carolina

2025 Quality Reporting Solutions: MIPS, MVPs, and Potential Data Opportunities
ACEP Reimbursement and Coding Conference
January 2025 Audience: 120
Orlando, Florida

"ALTO: Alternatives to Opioids"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"GI Foreign Bodies"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"Sepsis Updates - 2024"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"Novel Agents for Sedation"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"Psychiatric Boarding in the ED"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"Update on Stroke 2024"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"Anticoagulation Reversal"
Topics in Emergency Medicine
October 2024 Audience: 70
New York, New York

"Aviation Applications: Optimizing Safety Strategies in EM"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"Novel Agents for Sedation"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"Managing Sepsis: 2024 Updates"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"ALTO: Alternatives to Opioids"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"Psychiatric Observation in the ED"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"ED Boarders: Managing the Challenge"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"Anticoagulation Reversal"
Topics in Emergency Medicine
October 2024 Audience: 70
Jackson Hole, Wyoming

"Beautiful Data for Real People"
American College of Emergency Physicians Scientific Assembly
September 2024 Audience: 100
Las Vegas, NV

"Waiting Room Medicine and Risk Mitigation"
Summit to Sound 2024
June 2024 Audience: 100
Cle Elum, WA

"Entrepreneurship Lessons"
MBA 956 – New Ventures – Discovery; UNC Kenan-Flagler Business School
April 2024 Audience: 90
Chapel Hill, NC

"AI: What Does It Mean for Emergency Medicine"
American College of Emergency Physicians' Leadership and Advocacy Conference
April 2024 Audience: 500
Washington, DC

"ACEP National Focus 2024"
North Carolina College of Emergency Physicians' Medical Director's Summit
March 2024 Audience: 60
Greensboro, NC

"Case Study – MedScribes"
MBA 835 – Introduction to Entrepreneurship; UNC Kenan-Flagler Business School
February 2024 Audience: 90
Chapel Hill, NC

"AI in the ED"
$traight Talk XXXII: Today's Reimbursement Issues
November 2023 Audience: 70
Troy, MI

"The Land of Obs: Psych Observation Billing Across EDs"
Emergency Department Practice Management Association Solutions Summit
April 2023 Audience: 75
Las Vegas, NV

"Entrepreneurship Lessons"
MBA 956 – New Ventures – Discovery; UNC Kenan-Flagler Business School
April 2023 Audience: 90
Chapel Hill, NC

"Stroke Update"
Topics in Emergency Medicine
March 2023 Audience: 60
Banff, Alberta [Canada]

"Anticoagulation Reversal"
Topics in Emergency Medicine
March 2023 Audience: 60
Banff, Alberta [Canada]

"Psychiatric Boarding Solutions"
Topics in Emergency Medicine
March 2023 Audience: 60
Banff, Alberta [Canada]

"Quality Measures in the ED"
Topics in Emergency Medicine
March 2023 Audience: 60
Banff, Alberta [Canada]

"Alternatives to Opioids"
Topics in Emergency Medicine
March 2023 Audience: 60
Banff, Alberta [Canada]

"Novel Agents for Sedation"
Topics in Emergency Medicine
March 2023 Audience: 60
Banff, Alberta [Canada]

"ACEP National Focus 2023"
North Carolina College of Emergency Physicians' Medical Director's Summit
March 2023 Audience: 60
Greensboro, NC

"Operational Challenges in Managing an ED"
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
December 2022 Audience: 40
Chapel Hill, NC

"Operational Challenges in Managing an ED"
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
August 2022 Audience: 40
Chapel Hill, NC

"Entrepreneurship Lessons"
MBA 956 – New Ventures – Discovery; UNC Kenan-Flagler Business School
March 2022 Audience: 50
Chapel Hill, NC

"Boarding – Solutions?"
North Carolina College of Emergency Physicians' Medical Director's Summit
March 2022 Audience: 60
Greensboro, NC

"Quality Measures in the ED"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"Alternatives to Opioids"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"Anticoagulation Reversal"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"Stroke Update"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"Psychiatric Boarding Solutions"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"Novel Agents for Sedation"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"GI Foreign Bodies"
Topics in Emergency Medicine
September 2021 Audience: 40
Las Vegas, NV

"Operational Challenges in Managing an ED"
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
July 2021 Audience: 40
Chapel Hill, NC

"Operational Challenges in Managing an ED"
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
January 2021 Audience: 40
Chapel Hill, NC

"Quality Measures in the ED"
Topics in Emergency Medicine
December 2020 Audience: 80
Virtual

"Alternatives to Opioids"
Topics in Emergency Medicine
December 2020 Audience: 80
Virtual

"Anticoagulation Reversal"
Topics in Emergency Medicine
December 2020 Audience: 80
Virtual

"Stroke Update"
Topics in Emergency Medicine
December 2020 Audience: 80
Virtual

"Psychiatric Boarding Solutions"
Topics in Emergency Medicine
December 2020 Audience: 80
Virtual

"Sepsis Quality Measures Update"
Topics in Emergency Medicine
December 2020 Audience: 80
Virtual

"Design and Delivery of Healthcare Systems"
MBA 898 – UNC Kenan-Flagler Business School – Healthcare Operations
July 2020 Audience: 40
Chapel Hill, NC

"Metrics in Managing the ED"
North Carolina College of Emergency Physicians' Medical Director's Summit
March 2020 Audience: 60
Greensboro, NC

"GI Foreign Bodies"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"Anticoagulation Reversal"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"Novel Agents for Sedation"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"Quality Measures in the ED"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"What's New With Sepsis?"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"ED Quality in the Eyes of the Patient: Does the Internet Lie?"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"Psychiatric Boarding Solutions"
Topics in Emergency Medicine
November 2019 Audience: 130
Key West, FL

"ED Quality in the Eyes of the Patient: Does the Internet Lie?"
American College of Emergency Physicians Scientific Assembly
October 2019 Audience: 110
Denver, CO

"ACEP Connect: Split Flow Success – Avoiding Pitfalls and Getting Up to Speed"
American College of Emergency Physicians Scientific Assembly
October 2019 Audience: 200
Denver, CO

"How to Sleep Soundly After Discharging Suicidal Patients From Your ED"
American College of Emergency Physicians Scientific Assembly
October 2019 Audience: 200
Denver, CO

"Sepsis Core Measures – Where Are We Now?"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
October 2019 Audience: 70
Asheville, NC

"Approach to Low Risk Chest Pain"
UNC Department of Medicine Grand Rounds
September 2019 Audience: 200
Chapel Hill, NC

"ACS Risk Stratification"
UNC Department of Emergency Medicine Residency Conference
August 2019 Audience: 40
Chapel Hill, NC

"Operational Challenges in Managing an ED"
MBA 898 – UNC Kenan-Flagler MBA Class – Healthcare Operations
July 2019 Audience: 40
Chapel Hill, NC

"Shark Tank"
PUBH 755 – Translating Evidence into Practice for Population Health; UNC School of Public Health
April 2019 Audience: 35
Chapel Hill, NC

"Chest Pain Pathway"
UNC Department of Emergency Medicine Faculty Education Session
April 2019 Audience: 25
Chapel Hill, NC

"Entrepreneurship Lessons"
MBA 956 – New Ventures – Discovery; UNC Kenan-Flagler Business School
March 2019 Audience: 90
Chapel Hill, NC

"Case Study – MedScribes"
MBA 835 – Introduction to Entrepreneurship; UNC Kenan-Flagler Business School
March 2019 Audience: 60
Chapel Hill, NC

"Metrics in Managing the ED"
North Carolina College of Emergency Physicians' Medical Director's Summit
March 2019 Audience: 60
Greensboro, NC

"Physician Executives in the Hospital Environment"
HPM 713 – Hospital Operations; UNC School of Public Health
January 2019 Audience: 35
Chapel Hill, NC

"Sepsis Core Measures – Where Are We Now?"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2018 Audience: 70
Asheville, NC

"Thrombolysis or No Thrombolysis – Update in Acute Stroke Care"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2018 Audience: 70
Asheville, NC

"ED Quality in the Eyes of the Patient: Does the Internet Lie?"
American College of Emergency Physicians Scientific Assembly
October 2018 Audience: 110
San Diego, CA

"ACEP Connect: Split Flow Success – Avoiding Pitfalls and Getting Up to Speed"
American College of Emergency Physicians Scientific Assembly
October 2018 Audience: 200
San Diego, CA

"Working with a Scribe: Tips and Tricks for Success!"
UNC Emergency Medicine Resident Conference
July 2018 Audience: 25
Chapel Hill, NC

"Operational Challenges in Managing an ED"
UNC Kenan-Flagler MBA Class – Healthcare Operations
July 2018 Audience: 40
Chapel Hill, NC

"One Organization's Journey Through the Psychpocalypse"
EDPMA Solutions Summit
April 2018
Ft. Lauderdale, FL Audience: 130

"GI Foreign Bodies"
Topics in Emergency Medicine
April 2018 Audience: 70
Singer Island, FL

"Anticoagulation Reversal"
Topics in Emergency Medicine
April 2018 Audience: 70
Singer Island, FL

"Novel Agents for Sedation"
Topics in Emergency Medicine
April 2018 Audience: 70
Singer Island, FL

"Quality Measures in the ED"
Topics in Emergency Medicine
April 2018 Audience: 70
Singer Island, FL

"Thrombolysis or No Thrombolysis: Update on Stroke Management"
Topics in Emergency Medicine
April 2018 Audience: 70
Singer Island, FL

"Case Study – MedScribes"
MBA 835 – Introduction to Entrepreneurship; UNC Kenan-Flagler Business School
March 2018 Audience: 60
Chapel Hill, NC

"Optimizing Psychiatric Care – Beyond Boarding"
North Carolina College of Emergency Physicians Medical Director Summit
March 2018 Audience: 45
Greensboro, NC

"Operational Challenges in Managing an ED"
UNC Kenan-Flagler MBA Class – Healthcare Operations
February 2018 Audience: 40
Chapel Hill, NC

"Innovations in the Healthcare Arena"
UNC Kenan-Flagler MBA Class – Health Economics
February 2018 Audience: 40
Chapel Hill, NC

"Physician Executives in the Hospital Environment"
HPM 713 – Hospital Operations; UNC School of Public Health
January 2018 Audience: 35
Chapel Hill, NC

"This Boarding is Crazy: What To Do With Mental Health Boarders in Your Department"
American College of Emergency Physicians Scientific Assembly
October 2017 Audience: 220
Washington, D.C.

"ED Quality in the Eyes of the Patient: Does the Internet Lie?"
American College of Emergency Physicians Scientific Assembly
October 2017 Audience: 150
Washington, D.C.

"ACEP Connect: Mental Health Patients in Your Department"
American College of Emergency Physicians Scientific Assembly
October 2017 Audience: 300
Washington, D.C.

"Sepsis Core Measures – Where Are We Now?"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
October 2017 Audience: 70
Asheville, NC

"Novel Agents for Sedation"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
October 2017 Audience: 70
Asheville, NC

"VTE – A Critical Unmet Need"
Portola Preceptorship
August 2017 Audience: 35
Chapel Hill, NC

"Managing Major Bleeds on NOACs"
Portola Preceptorship
August 2017 Audience: 35
Chapel Hill, NC

"Anticoagulation Reversal"
Hot Topics in Emergency Care 2017
June 2017 Audience: 75
Porto, Portugal

"Operational Challenges in Managing an ED"
UNC Kenan-Flagler MBA Class – Healthcare Operations
April 2017 Audience: 35
Chapel Hill, NC

"GI Foreign Bodies"
Emergency Medicine Update
March 2017 Audience: 120
Kauai, HI

"Anticoagulation Reversal"
Emergency Medicine Update
March 2017 Audience: 120
Kauai, HI

"Novel Agents for Sedation"
Emergency Medicine Update
March 2017 Audience: 120
Kauai, HI

"Quality Measures in the ED"
Emergency Medicine Update
March 2017 Audience: 120
Kauai, HI

"Panel Discussion: Moving Forward as an Emergency Care Community"
Turn the Tide NC – A US Surgeon General Initiative
March 2017 Audience: 110
Durham, NC

"Behavioral Health Challenges – An Update for North Carolina"
North Carolina Medical Director's Summit
March 2017 Audience: 65
Greensboro, NC

"Physician Executives in the Hospital Environment"
HPM 713 – Hospital Operations; UNC School of Public Health
January 2017 Audience: 35
Chapel Hill, NC

"LLSA Literature Review"
Coastal Emergency Medicine Conference
June 2016 Audience: 45
Kiawah Island, SC

"Focused Reassessment of Where We Stand: Sepsis Core Measures are Here"
Coastal Emergency Medicine Conference
June 2016 Audience: 90
Kiawah Island, SC

"Reversing the Irreversible (NOACs and Their Reversal Agents)"
Coastal Emergency Medicine Conference
June 2016 Audience: 90
Kiawah Island, SC

"Leading Transformational Change: The Physician-Executive Partnership"
5th Annual Triangle Healthcare Executive Forum Leadership Summit
June 2016 Audience: 120
Cary, NC

"GI Foreign Bodies"
Emergency Medicine Update
May 2016 Audience: 75
Destin, FL

"Anticoagulation Reversal"
Emergency Medicine Update
May 2016 Audience: 75
Destin, FL

"Novel Agents for Sedation"
Emergency Medicine Update
May 2016 Audience: 75
Destin, FL

"Quality Measures in the ED"
Emergency Medicine Update
May 2016 Audience: 75
Destin, FL

"Operational Challenges in Managing an ED"
UNC Kenan-Flagler MBA Class – Healthcare Operations
April 2016 Audience: 35
Chapel Hill, NC

"Physician Executives in the Hospital Environment"
HPM 713 – Hospital Operations; UNC School of Public Health
January 2016 Audience: 35
Chapel Hill, NC

"LLSA Literature Review"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2015 Audience: 40
Asheville, NC

"Anticoagulation Reversal"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2015 Audience: 40
Asheville, NC

"Psychiatric Boarding: Three State Perspective on a National Problem"
American College of Emergency Physicians Scientific Assembly
October 2015 Audience: 60
Boston, MA

"Emergency Physician Career Transitions"
American College of Emergency Physicians Scientific Assembly
October 2015 Audience: 100
Boston, MA

"Maintaining Your ABEM Certification: Review of 2015 LLSA Articles: Part 1"
American College of Emergency Physicians Scientific Assembly
October 2015 Audience: 250
Boston, MA

"Maintaining Your ABEM Certification: Review of 2015 LLSA Articles: Part 2"
American College of Emergency Physicians Scientific Assembly
October 2015 Audience: 250
Boston, MA

"LLSA Literature Review"
Coastal Emergency Medicine Conference
June 2015 Audience: 45
Kiawah Island, SC

"Anticoagulation Reversal"
Emergency Medicine Update
March 2015 Audience: 50
Punta Cana, Dominican Republic

"GI Foreign Bodies"
Emergency Medicine Update
March 2015 Audience: 50
Punta Cana, Dominican Republic

"Quality & Performance Measures"
Emergency Medicine Update
March 2015 Audience: 50
Punta Cana, Dominican Republic

"LLSA Literature Review"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2014 Audience: 40
Asheville, NC

"Quality and Performance Measures – Why You Should Care"
Risk Management Emergency Medicine Seminar 2014
October 2014 Audience: 30
Jekyll Island, GA

"High Risk Coagulation Problems – Anticoagulation Reversal"
Risk Management Emergency Medicine Seminar 2014
October 2014 Audience: 30
Jekyll Island, GA

"Quality Measures"
APS Orientation
September 2014 Audience: 25
Chapel Hill, NC

"LLSA Literature Review"
Coastal Emergency Medicine Conference
June 2014 Audience: 45
Kiawah Island, SC

"Quality Measures in EM – Why You Should Care"
University of California, San Francisco Residency in Emergency Medicine Grand Rounds
March 2014 Audience: 70
San Francisco, CA

"LLSA Literature Review"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2013 Audience: 35
Asheville, NC

"Innovations and Best Practices – Patient Satisfaction at UNC"
ACEP and Urgent Matters Present: Emergency Care Quality Improvement in the Era of Public Accountability
October 2013 Audience: 150
Seattle, WA

"LLSA Literature Review"
Coastal Emergency Medicine Conference
June 2013 Audience: 45
Kiawah Island, SC

"Anticoagulation Reversal"
24th Annual May Day Trauma Conference
May 2013 Audience: 20
Chapel Hill, NC

"Innovative Transfer Center Strategies and Successful ED Patient Flow Management"
Patient Flow Management Congress
January 2013 Audience: 60
Las Vegas, NV

"LLSA Literature Review"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2012 Audience: 20
Asheville, NC

"Quality Measures Update"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2012 Audience: 30
Asheville, NC

"Quality Measures Update"
University of California, Davis Residency in Emergency Medicine
Grand Rounds, August 2012 Audience: 60
Sacramento, CA

"LLSA Literature Review"
North Carolina College of Emergency Physicians
June 2012 Audience: 25
Myrtle Beach, SC

"Complications of Conscious Sedation"
University of North Carolina Department of Internal Medicine
Grand Rounds, January 2012 Audience: 100
Chapel Hill, NC

"Quality Measures in EM – Why You Should Care"
University of California, Davis Residency in Emergency Medicine
Grand Rounds, November 2011 Audience: 60
Sacramento, CA

"Quality Assessment in Emergency Medicine"
7th Annual Indo-US Emergency Medicine Summit; INDUS-EM
September 2011 Audience: 150
New Delhi, India

"Quality Measures in EM – Why You Should Care"
University of North Carolina Residency in Emergency Medicine
Grand Rounds, July 2010 Audience: 40
Chapel Hill, NC

"Quality Measures in EM – Why You Should Care"
East Carolina University Residency in Emergency Medicine
Grand Rounds, July 2010 Audience: 50
Greenville, NC

"Quality Measures in EM – Why You Should Care"
Carillion Clinic Residency in Emergency Medicine
Grand Rounds, May 2010 Audience: 50
Roanoke, VA

"Quality Measures in EM – Why You Should Care"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
November 2010 Audience: 40
Asheville, NC

"Update on Acute Stroke Management"
North Carolina College of Emergency Physicians
June 2009 Audience: 50
Myrtle Beach, SC

"EM Gastrointestinal Foreign Body Management"
Resident Lecture Series, 2009 Audience: 30
UNC Residency in Emergency Medicine
Chapel Hill, NC

"Financial Planning for EM Physicians"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
September 2008 Audience: 25
Asheville, NC

"LLSA Literature Review"
North Carolina College of Emergency Physicians
June 2007 Audience: 25
Myrtle Beach, SC

"Dog Days of Summer"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
September 2006 Audience: 30
Asheville, NC

"Clinical Decision Rules"
Excellence in Emergency Medicine: Update in Emergency and Trauma Care
September 2006 Audience: 30
Asheville, NC

"Overview of the 2005 AHA ECC Guidelines"
Resident Lecture Series, 2006 Audience: 25
UNC Residency in Emergency Medicine
Chapel Hill, NC

"Basic Airway Instruction"
Intern Orientation Lecture Series, 2005 – 2011
UNC Residency in Emergency Medicine
Chapel Hill, NC Audience: 15

"Basic Laryngoscopy"
Intern Orientation Lecture Series, 2005 – 2011
UNC Residency in Emergency Medicine
Chapel Hill, NC Audience: 15

"Introduction to Wound Management"
Resident Lecture Series, 2005 - 2011
UNC Residency in Emergency Medicine
Chapel Hill, NC Audience: 15

"Suturing Techniques for Primary Care Physicians"
North Carolina State University Student Health Service
April 2004 Audience: 15
Raleigh, NC

"Fiberoptic Scope – Airway Management"
American College of Emergency Physicians Scientific Assembly
October 2002 Audience: 30
Seattle, WA

"Introduction to Pediatric Wound Management"
Resident Lecture Series, 2002, 2003, 2008
UNC Residency in Pediatrics Audience: 25
Chapel Hill, NC

RESEARCH GRANTS:

Carolinas Collaborative Mehrotra (Site PI) 2016 – 2017
The HEART Pathway" a learning health system project, translating evidence to practice across the Carolinas.
Role: Site PI (0% Effort – NC TRACS Grant)

UNC Innovations Center Mehrotra, Travers (Co-PI) 2015 – 2016
Improving Throughput Time for High Complexity Patients in the Emergency Department
Role: Co-PI

Roche Mehrotra (Site PI) 2014 – 2016
Clinical Performance of Elecsys Troponin T Gen 5 in Subjects with Symptoms of Acute Coronary Syndrome (ACS): ACS Collection Study for Serum Claim.
Role: Site PI (0% Effort – Industry Sponsored)

BTG International, Inc. Quackenbush (Site PI) 2014 – 2015
A Randomized, Double-Blind, Placebo-Controlled Study comparing CroFab® versus Placebo with Rescue Treatment for Copperhead Snake Envenomation
Role: Site Sub-Investigator

Roche Mehrotra (Site PI) 2011 – Jan 2013
Clinical Performance of Elecsys High Sensitive Troponin T in Subjects with Symptoms Suggestive of Acute Coronary Syndrome (ACS) Study # CIM RD001088
Role: Site PI (0% Effort – Industry Sponsored)

Bayer Sen (Site PI) 2003 – 2004
A Randomized, Double-Blind, Placebo-Controlled Trial to Evaluate the Efficacy, Safety, Tolerability, and Pharmacokinetic/Pharmacodynamic Effects of a Targeted Exposure of Intravenous Repinotan HCL in Patients with Acute Ischemic Stroke (Modified RECT)
Role: Site Sub-Investigator

Concentric Medical Solander (Site PI) 2003 – 2004
Mechanical Embolus Removal in Cerebral Ischemia Trial to Study Safety and Efficacy of the MERCI Retriever in the Treatment of Thrombotic Occlusion Originating in the Internal Carotid, Middle Cerebral (M1 & M2 segments), Basilar or Vertebral Arteries
Role: Site Sub-Investigator

Ono Pharma Sen (Site PI) 2003 – 2005
A Randomized, Double-blind, Placebo-controlled, Multi Center Study of the Effects of ONO-2506 Intravenous Infusion on the Amelioration of Neurological Damage and Improvement of Stroke Assessment Scale Scores in Patients with Acute Ischemic Stroke" (RREACT Study)
Role: Site Sub-Investigator

Centers for Disease Control Roseman (Site PI) 2003 – 2010
The North Carolina Collaborative Stroke Registry
Role: Site Sub-Investigator

Genentech Sen (Site PI) 2004 – 2007
IV vs. IA tPA (Activase) in Acute Ischemic Stroke with CTA Evidence of Major Vessel Occlusion
Role: Site Sub-Investigator

Astrazeneca Felix (Site PI) 2004 – 2006
A double-blind, randomized, placebo-controlled, parallel-group, multicenter, phase llb/lll study to assess the efficacy and safety of intravenous NXY-059 in acute ischemic stroke (SA-NXY-0007)
Role: Site Sub-Investigator

CoAxia Sen (Site PI) 2005 – 2010
SENTIS Stroke Trial: Safety and Efficacy of NeuroFlo Technology in Ischemic Stroke with SCION: A Study of Care Intensity and outcomes of NeuroFlo
Role: Site Sub-Investigator

National Institutes of Health Sen (Site PI) 2005 – 2010
IMS-lll: Interventional Management of Stroke (IMS-lll) Trial" (randomized, open-label multi-center study examining whether a combined intravenous (IV) and intra-arterial (IA) approach to recanalization is superior to standard IV t-PA)
Role: Site Sub-Investigator

Taisho Pharmaceutical Sen (Site PI) 2005 – 2007
A Multi-Center, Randomized, Double-Blind, Placebo-controlled, Ascending-Dose Study of the Safety, Pharmacokinetics, and Pharmacodynamics of a Single, l-Hour Infusion of TS-011 in Acute Ischemic Stroke (AIS) Patients
Role: Site Sub-Investigator

NovoNordisk Huang (Site PI) 2005 – 2006
Randomised, Double-Blind, Placebo Controlled, Multi-Centre, Parallel Groups Confirmatory Efficacy and Safety Trial of Activated Recombinant Factor VII (NovoSeven ®/Niastase®) in Acute Intracerebral Haemorrhage
Role: Site Sub-Investigator

NINDS U01 NS40406-04
National Institutes of Health Sen (Site PI) 2006 – 2010
Albumin in Acute Stroke (ALIAS) Trial: A Phase III Randomized Multi-center Clinical Trial of High-Dose Human Albumin Therapy for Neuroprotection in Acute Ischemic Stroke
Role: Site Sub-Investigator

University Research Council Mehrotra, Biese (Co-PI) 2007
ED Overcrowding affecting time to diagnostic studies
Role: Co-PI

PhotoThera, Inc. Huang (Site PI) 2007 – 2008
NeuroThera® Effectiveness and Safety Trial - 2 (NEST-2) A double blind, randomized, controlled, parallel group, multicenter, pivotal study to assess the safety and effectiveness of the treatment of acute ischemic stroke with the NeuroThera® Laser System within 24 hours from stroke onset
Role: Site Sub-Investigator

CoAxia Sen (Site PI) 2007 – 2008
Safety and Efficacy of NeuroFlo in 8-24 Hour Stroke Patients (FlO 24)
Role: Site Sub-Investigator

NATIONAL COMMITTEE SERVICE:

American College of Emergency Physicians (ACEP):

Board of Directors, Member	2023 – Present
Secretary / Treasurer	*2025 – 2026*
Quality and Patient Safety Committee	2022 – 2023
Finance Committee	2022 – 2023
Representative to American Society of Hematology TEP	2022 – 2023
Implementing Clinical Pretest Probability Tools into Practice	
Data Registry Source Selection Task Force	2020 – 2021
Health Innovation Technology Committee	2019 – 2023
Clinical Resources Review Committee	2019 – 2023
Clinical Data Registry Committee	2017 – 2023
Chair	*2018 – 2020*
ACEP Councillor	2010 – 2024
Quality and Performance Committee	2010 – 2021
Quality Improvement and Patient Safety Section	2008 – Present
EM Practice Management and Health Policy Section	2007 – Present
Chair	*2012 – 2014*
Chair-Elect	*2010 – 2012*
Secretary	*2008 – 2010*
Young Physicians Section	2005 – 2023
Immediate Past Chair, Chair, Chair-Elect	*2006 – 2009*
Diversity and Inclusion Task Force	2016 – 2018
Council Steering Committee	2008 – 2010
Annual Meeting & Communications Subcommittee	*2008 – 2009*
Chair	*2009 – 2010*
Election Reform Subcommittee	*2008 – 2009*
Strategic Issues Forum	*2009*
Transitions of Care Task Force	2011 – 2012
ED Categorization Task Force	2008 – 2010
Chair	*2008 – 2010*
Integration Model Task Force	2009 – 2010
ACEP Alternate Councillor	2008 – 2010
ACEP Council Reference Committee	2001, 2008, 2010, 2021, 2022
Chair	*2010, 2021, 2022*
Clinical Policies Committee – Blunt Abdominal Trauma Subcommittee Member	2007 – 2011
Emergency Medicine Practice Committee – Subcommittee Chair	2004 – 2009
Finance Committee	2002 – 2003
Council Steering Committee	2000 – 2002

Society for Academic Emergency Medicine (SAEM):

Finance Committee	2016 – 2020
Membership Committee	2016 – 2020

Clinical Director's Interest Group	2008 – Present
Faculty Development Committee	2016 – 2017
Regionalization Task Force	2009 – 2010

American Board of Emergency Medicine (ABEM):

Certification Exam Examiner	2026 - Present
Senior Oral Examiner	2024 – 2025
Health Care Administration, Leadership, and Management Advisory (HALM) Committee	2023 – Present
Item Writer	2015 – 2025
Oral Examiner	2012 – 2024

National Quality Forum:

Chief Complaint-Based Quality of Emergency Care Committee	2018 – 2020

Emergency Medicine Residents' Association (EMRA):

Program Committee	2001 – 2003
Chair	*2001 – 2002*
ACEP Board Liaison	2000 – 2002
Program Representative	2000 – 2002

American Medical Association (AMA):

Medical Student Section (MSS) Reference Committee	1998 – 1999
Chair	*1999*
Committee on Recruitment	1998 – 1999
Computer Projects Committee	1997 – 1998

REGIONAL COMMITTEE SERVICE:

North Carolina Institute of Medicine:

Task Force on the Future of the Nursing Workforce	2023 – 2025

North Carolina Department of Health & Human Services:

Behavioral Health Crisis Referral System Advisory Committee	2017 – 2022

North Carolina Division of Health Service Regulation:

Trauma Designation Site Reviewer	2009

North Carolina College of Emergency Physicians (NCCEP):

Immediate Past President	2015 – 2016
President	2014 – 2015
President-Elect	2013 – 2014
Secretary-Treasurer	2012 – 2013
Board Member	2010 – 2016

Councillor to ACEP Council	2010 – 2024
Alternate Councillor to ACEP Council	2008 – 2010
Educational Committee	2006 – 2008
Chair	*2007*

Ohio State Medical Association (OSMA):

Committee on Emergency and Disaster Medical Care	1998 – 1999
Reference Committee	1998
Medical Student Section	1996 – 2000
Chair	*1999 – 2000*
Vice-Chair	*1998 – 1999*

LOCAL COMMITTEE SERVICE:

UNC Healthcare System:

One UNC Clinical Research Pharmacy Design Committee	2023 – 2025
System Emergency Services Leadership Council	2018 – Present
Chair	*2023 – Present*
Co-Chair	*2018 – 2023*
System Pharmacy & Therapeutics Committee	2016 – Present
Chair	*2016 – Present*

UNC Faculty Physicians:

Board Member	2017 – 2020
Benefits Committee	*2018 – 2020*
Exceptions Committee	*2018 – 2020*

UNC School of Medicine:

Representative to University Faculty Council	2021 – 2024
Fixed Term Faculty Promotions Committee	2017 – 2020
Physician Service Line Leader	2009 – 2021
Chair Review Committee	2017
Member, Department of Ophthalmology Review	
Physician's Performance Improvement Leadership Group	2005 – 2008
Problem Based Learning curriculum development committee	2003 – 2004

UNC Hospitals:

Patient Flow & Transitions of Care Committee	2020 – 2024
Hillsborough Campus Executive Steering Committee	2017 – 2020
Outpatient Care Services Executive Council	2013 – 2019
UNC Medical Center Improvement Council	2013 – 2024
Standing Orders Committee	2013 – 2020
Utilization Management Committee	2012 – 2023
Credentials Committee	2011 – 2025
Acute Myocardial Infarction Process Improvement Team	2005 – 2024
Pharmacy & Therapeutics Committee	2004 – Present

Chair	2010 – 2018
Adult Sedation Committee	2008 – 2011
Chair	2008 – 2010
Transfusion Committee	2007 – 2017
Medical Staff Executive Committee	2005 – 2007
Quality Council	2005 – 2013
Pneumonia Clinical Process Improvement Team	2004 – 2005

UNC Department of Emergency Medicine:

Finance Committee	2017 – Present
Leadership Council	2015 – Present
Peer Review Committee	2013 – 2024
Chair	2013 – 2016
Clinical Operations Group	2004 – Present
Co-Chair	2004 – Present
Throughput Committee	2008 – 2013
Chair	2008 – 2013
Residency Selection Committee	2005 – 2010
Residency Education Steering Committee	2002 – 2003
	2005 – 2010
Patient Safety Board	2004 – 2006
Chair	*2004 – 2005*
Electronic T-System Implementation Committee	2003 – 2004

OSU College of Medicine & Public Health:

Pre-Clinical Task Force	1999 – 2000
Medical Student Council	1997 – 2000
Vice-President	*1998 – 1999*
Problem Based Learning Program Evaluation Committee	1997 – 1998
Problem Based Learning Program Computer Resources Committee	1997 – 1998

Columbus Medical Association:

Governing Council	1997 – 1998
Education and Program Committee	1997 – 1998

PROFESSIONAL SOCIETIES:

American College of Healthcare Executives	2016 – Present
American College of Emergency Physicians	2000 – Present
Society for Academic Emergency Medicine	2000 – Present
North Carolina College of Emergency Physicians	2000 – Present
Emergency Medicine Resident's Association	2000 – Present
American Medical Association	1996 – Present
North Carolina Medical Society	2000 – 2007
Ohio State Medical Association	1996 – 2000

MODERATOR / REVIEWER SERVICES:

Member, Technical Expert Panel — 2023
Diagnostic Quality & Safety Measurement / Quality Measure
Remote

Moderator, Careers with Impact Forum — 2021
UNC Kenan Flagler Business School, Reimaging Healthcare
Chapel Hill, NC

Reviewer, ACEP17 Research Forum — 2017
ACEP17 Annual Meeting
Washington, D.C.

Moderator, Small & Medium Chapter Breakfast Discussion — 2016
ACEP Leadership & Advocacy Meeting
Washington, D.C.

Moderator, Strategic Issues Forum — 2009
ACEP Annual Council
Boston, Massachusetts

BOARD SERVICE:

Board Member — 2023 – Present
American College of Emergency Physicians
Dallas, TX

Advisory Board — 2020 – Present
Excelerate Health Ventures
Durham, NC

Board Member — 2017 – 2020
UNC Faculty Physicians Practice
Chapel Hill, NC

Board Member — 2015 – Present
MedScribes, Inc.
Durham, NC

Board Member 2010 – 2016
North Carolina College of Emergency Physicians
Raleigh, NC

Advisory Board 2008
King Pharmaceuticals
Philadelphia, PA

Board Member 2000 – 2002
Emergency Medicine Resident's Association
Dallas, TX

EDITORIAL SERVICE:

Manuscript Consultant / Reviewer 2007 – Present
Journal of Emergency Medicine

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2026 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Heather S. Owen, MD, FACEP

Question #1: **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?*)***

Emergency medicine is one of the most complex and rapidly evolving fields in healthcare. The challenges facing our specialty require thoughtful leadership from a Board with diverse experiences, varied perspectives, and complementary strengths. ACEP's Board must reflect the breadth of emergency medicine itself, bringing together leaders with different backgrounds and expertise who can adapt to an increasingly complex healthcare landscape and help guide our specialty through continued change.

My experience across multiple emergency medicine practice settings, combined with my background in patient safety and clinical quality, allows me to bring a unique and valuable perspective to the Board. I began my career in a small community emergency department with limited specialist support, where I frequently managed critically ill patients independently until transfer to a higher level of care. I spent the first half of my career practicing in this environment and now work in a Level I Trauma Center where I help train the next generation of emergency physicians.

These varied experiences have given me a broad understanding of the clinical, operational, and cultural challenges facing physicians across our specialty. They have also reinforced the importance of adaptable, practical solutions that can succeed in very different practice environments.

In addition to frontline clinical experience, I bring extensive leadership experience in patient safety, clinical quality, and systems improvement. As the Patient Safety and Clinical Quality Officer for a multi-hospital physician-owned group, I led initiatives focused on improving risk profiles surrounding high-risk encounters and strengthening quality of care. Currently serving as the Executive Director of a Patient Safety Organization has provided me with the experience to identify our greatest opportunities for improvement and then successfully improve emergency practice in those vulnerable areas. Identifying a problem, then creating scalable solutions that improve both physician practice environments and patient outcomes is a valuable skillset I have honed in the past years.

As healthcare continues to evolve, malpractice pressures rise, and administrative burdens intensify, supporting and protecting physicians at the bedside remains imperative. Identifying vulnerabilities within our systems, developing measurable improvement strategies, and helping physicians deliver safe, high-quality care despite increasing demands on their time and attention is where my strengths lie.

I believe this combination of frontline emergency medicine experience, patient safety expertise, and collaborative problem-solving would add an important and complementary perspective to the ACEP Board at a time when innovative, adaptable leadership is more important than ever.

Question #2: **What is your perspective on ACEP's role in the 3-year versus 4-year emergency medicine training program discussion?**

The debate over three-year versus four-year emergency medicine residencies is a significant conversation that will shape the future of our specialty, and ACEP plays a pivotal, though distinct, role in the discussion. While the ACGME governs the standards and duration of training, ACEP is the leading voice for emergency physicians and should ensure that any changes to residency reflect the needs of the specialty and the physicians it serves. ACEP's role in this discussion is largely one of advocacy, guidance and facilitating meaningful discussion.

ACEP does not set or enforce residency lengths, but it ensures that all voices of emergency physicians are heard. Whether representing physicians practicing in community settings, academic centers, or diverse geographic areas, ACEP has been intentional about maintaining a balanced perspective on highly debated topics. When the ACGME proposed a universal four-year model, ACEP engaged in the public comment process, gathering feedback from practicing physicians, residents, and

program leaders. By facilitating this meaningful dialogue, ACEP was able to collect comments and concerns from practicing physicians. Many physicians expressed a clear message: a one-size-fits-all approach risks alienating early-career physicians, delaying their financial independence, and potentially increasing burnout. ACEP is then able to provide guidance and advocate for flexibility, arguing that any decision should be evidence-based and should protect diversity in practice and geography.
In February 2026, ACEP and EMRA reaffirmed support for both three and four year residency formats, noting the historical success of three-year residencies while also remaining open to data that may support a four-year model.
In summary, ACEP's role is to provide a forum for discussion, collect data, and advocate for physicians. By doing this, ACEP helps ensure that both three- and four-year pathways remain viable, so that emergency medicine continues to attract, train, and retain the best physicians.

Question #3: **What is the most effective strategy you would use to recruit and retain members considering generational differences?**

Recruiting and retaining members across generations is one of ACEP's most important opportunities and challenges. Today's emergency physicians seek different forms of value from professional organizations, often shaped by generational experiences and expectations. To remain relevant and impactful, ACEP must evolve from a traditional membership organization into a trusted professional partner that meets physicians where they are, addresses the issues that matter most to them, and creates value that resonates across generations while reinforcing our shared commitment to emergency medicine.

Developing an effective recruitment and retention strategy begins with understanding what motivates each generation and how ACEP can best support those priorities. Many senior emergency physicians joined ACEP because membership was viewed as an extension of professional responsibility. Organized medicine was the primary vehicle for protecting the specialty, influencing policy, and advancing patient care. Participation in advocacy, governance, and committee work was considered an important part of a physician's professional identity. Today, many of these physicians are looking for opportunities to share their experience, mentor future leaders, and leave a lasting legacy within the specialty.

In contrast, younger physicians, residents and medical students often evaluate organizations through the lens of impact, flexibility, authenticity, and practical value. They are seeking resources that help them navigate early career decisions, access educational opportunities, achieve work-life integration, and address the challenges they face every day in the emergency department. They want to understand how membership improves their professional lives. As ACEP provides meaningful solutions to those challenges, membership becomes more than a professional obligation; it becomes an essential career resource. Advocacy remains one of ACEP's most important functions, but younger generations want to see a clear connection between advocacy efforts and improvements in their daily practice. Meeting these expectations allows ACEP to deliver tangible value and then communicate that value effectively which also requires an intentional, strategic approach as each generation relies on different methods to attain information.

Generational differences also influence how members choose to engage. While some physicians are comfortable with traditional committee structures and long leadership pathways, others seek opportunities for immediate impact, project-based work, virtual participation, and more accessible leadership roles. ACEP can strengthen recruitment and retention by creating flexible engagement opportunities that allow members to contribute meaningfully in multiple ways and variable platforms.
At the same time, ACEP should capitalize on one of its greatest strengths: a diverse, multigenerational membership. Senior physicians bring invaluable institutional knowledge, advocacy experience, and mentorship capabilities, while younger physicians contribute fresh perspectives, innovation, and new approaches to longstanding challenges. Creating intentional opportunities for mentorship, collaboration, and bidirectional learning strengthens both groups and enriches the organization as a whole.

Importantly, retirement should not represent the end of engagement with ACEP. Many retired and late-career physicians remain deeply committed to emergency medicine and eager to contribute. Meaningful roles as mentors, educators, leadership advisors, and advocates allow ACEP to preserve institutional knowledge while providing valuable guidance to future generations.
Ultimately, the key to recruitment and retention is not treating all members the same. ACEP's greatest opportunity lies in recognizing the unique expectations of each generation while fostering a shared sense of purpose around advancing our specialty. Organizations that successfully bridge generational differences, demonstrate meaningful value, and create impactful opportunities for engagement will be best positioned to attract, retain, and inspire emergency physicians for years to come.

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CANDIDATE DATA SHEET

Heather S. Owen, MD, FACEP

Contact Information

7830 Purdue Avenue
Dallas, Texas 75225
Phone: 214.497.8242
E-Mail: hsowen@gmail.com

Current and Past Professional Position(s)

Emergency Medicine Physician: Texas Health Presbyterian Dallas;
Chief Clinical Officer, TeamHealth (2020 – current);
Executive Director, Patient Safety Organization (2020 – current)
Chief Patient Safety and Quality Officer of Emergency Medicine Consultants (2015 – 2020)

Education (include internships and residency information)

Emergency Medicine Residency, University of Texas Southwestern/Parkland Memorial Hospital
MD, University of Texas Medical Branch School of Medicine; Doctor of Medicine, 2005

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM Board Certification: 2009, recertification: 2019

Professional Societies

American College of Emergency Physicians
Texas College of Emergency Physicians
Dallas County Medical Society
Texas Medical Association
American Medical Association

National ACEP Activities – List your most significant accomplishments

Emergency Care Quality Metric Consortium Board of Governors, Chair (2025 – current)
Board of Governors, Vice Chair (2022 – 2024)
Board of Governors, Secretary/Treasurer (2020 – 2022)
ED Accreditation Task Force (2022 – 2024)
ED Directors Academy Phase II Faculty (2023 – current)
Emergency Medicine Practice Committee (2024 – current)
Quality and Patient Safety Committee (2016 – 2018)
Public Health, Policy Review Subcommittee Chair (2012 – 2014)
Public Health and Injury Prevention Committee Member (2007 – 2016)
Delegate to ACEP Council (2010 – current)

ACEP Chapter Activities – List your most significant accomplishments

Texas College of Emergency Physicians:
Past President, 2016 – 2017
Board of Directors, Executive Committee, 2014 – 2018
Board of Directors, 2006 – 2018
Legislative Affairs Committee, 2006 – 2018; 2025 – current
Medical Education Committee, 2008 – 2018
Membership and Public Relations Committee, 2008 – 2019

Practice Profile

Total hours devoted to emergency medicine practice per year: **2000 hrs** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **25** % Research **5** % Teaching **30** % Administration **40** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Upon completion of residency, I joined Emergency Medicine Consultants as an independent contractor. I worked in several small community hospitals, mostly Texas Health Allen and Texas Health Rockwall. In my 10 years at Texas Health Allen, I served in many leadership positions eventually serving as the Chief of Medical Staff. In 2015, I accepted the role of Chief Patient Safety and Clinical Quality Officer for EMC. EMC was acquired by TeamHealth in 2018, and I have served as Chief Clinical Officer of Emergency Medicine since 2020.
I have practiced clinically consistently since residency and continue to practice emergency medicine at Texas Health Dallas, a Level I Trauma center, approximately 45 hours a month.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Chief Clinical Officer, TeamHealth
Executive Director, Patient Safety Organization

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert Yes Cases 40 Plaintiff Expert No Cases 0

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Heather S. Owen, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: TeamHealth

Address: 265 Brookview Centre Way, Suite 400

Knoxville, TN 37919

Position Held: Chief Clinical Officer of Emergency Medicine

Type of Organization: National Management Group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: TeamHealth

Address: 265 Brookview Centre Way, Suite 400

Knoxville, TN 37919

Type of Organization: National Management Grouptem

Leadership Position: Chief Clinical Officer

Term of Service: 2020 – current

Organization: TeamHealth Patient Safety Organization

Address: 265 Brookview Centre Way, Suite 400

Knoxville, TN 37919

Type of Organization: PSO

Leadership Position: Executive Director

Term of Service: 2020 - current

Organization: ACEP Emergency Care Quality Metric Consortium

Address: 4950 W. Royal Lane

Irving, Texas 75063-2524

Type of Organization: Consortium

Leadership Position: Board of Governors, Chair

Term of Service: 2025 – current

Organization: Texas College of Emergency Physicians

Address: PO Box 26164

Austin, TX 78755

Type of Organization: Professional membership organization – ACEP Chapter

Leadership Position: Past President, Executive Committee, Board of Directors

Term of Service: 2016 – 2017; 2014 – 2018; 2006 - 2018

Organization: Texas Health Dallas

Address: 8196 Walnut Hill Lane

Dallas,Texas

Type of Organization: Hospital

Leadership Position: Credential Committee Chair

Term of Service: 2015 – 2016

Organization: Texas Health Allen

Address: 8196 Walnut Hill Lane

Dallas,Texas

Type of Organization: Hospital

Leadership Position: President of the Medical Staff; Medical Executive Committee

Term of Service: 2013 – 2015; 2011 - 2016

Organization: Texas Health Resources

Address: 8196 Walnut Hill Lane

Dallas,Texas

Type of Organization: Hospital System

Leadership Position: Physician Leadership Council

Term of Service: 2013 - 2017

Organization: Emergency Medicine Consultants

Address: 6451 Brentwood Stair Road, Suite 200

Fort Worth, TX 76112

Type of Organization: Physician Owned EM Group

Leadership Position: Chief Patient Safety and Clinical Quality Officer

Term of Service: 2015 – 2020

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Heather S. Owen, MD, FACEP Date 5.15.2026

2026 – 2027
Board of Directors

Bryan Dunn, MD, FACEP
President

Marcus Sims, II, DO, FACEP
President Elect

Angela Cornelius, MD, FACEP, FAEMS
Treasurer

Ben Leeson, MD, FACEP
Secretary

A.J. Kirk, MD, FACEP
Immediate Past President

Directors
Sara Andrabi, MD, FACEP

Chinwe Anyanwu, DO

Jemma Killingworth
(Medical Student Representative)

Kimberly Leeson, MD, FACEP

Michael Parsa, MD, FACEP

Abbey Pastorelle, DO
(Candidate/Resident Director)

Jeff Pinnow, MD, FACEP

J. Robert Rosillo, MD, FACEP

Michael Rozum, MD
(Young Physician Director)

Kristopher Sutherly, MD, FACEP

Jill Sutton, CMP
Executive Director

Mission Statement:
The Texas College of Emergency Physicians exists to promote quality emergency care for all patients and to represent the professional interests of our members.

TCEP
TEXAS COLLEGE of EMERGENCY PHYSICIANS

August 3, 2026

Dear ACEP Councillors,

On behalf of the Texas College of Emergency Physicians (TCEP), it is my privilege to offer our strongest endorsement of Heather Owen, MD, FACEP, as a candidate for the ACEP Board of Directors.

Dr. Owen brings to this election an exceptional combination of clinical experience, organizational leadership, advocacy, and expertise in quality and patient safety. She has spent her career not only caring for patients in the emergency department but also working to improve the systems in which emergency physicians practice. She understands the challenges facing our specialty and that breadth of perspective is precisely what she would bring to the ACEP Board.

Dr. Owen has demonstrated sustained leadership within organized emergency medicine at both the state and national levels. She has been a dedicated member of ACEP since 2005 with exceptional service and leadership during that time. She has served as a Texas Councillor since 2010 and currently chairs a Texas Delegation Reference Committee, where she is recognized as a thoughtful consensus builder and effective advocate. She serves on the ACEP Emergency Medicine Practice Committee, the Quality Improvement and Practice Patient Safety Committee, the ED Accreditation Task Force, and as faculty for the ACEP Emergency Department Directors Academy Phase II, mentoring the next generation of emergency medicine leaders. As Chair of the ACEP Emergency Care Quality Metric Consortium, she plays an important role in developing meaningful quality measures that will influence the future of emergency care nationwide.

Her commitment to TCEP has been equally significant. Dr. Owen has been a dedicated volunteer and leader, serving on the Board of Directors and Executive Committee for many years before serving as TCEP President from 2016–2017. Her service has included leadership in Legislative Affairs, Membership and Public Relations, Medical Education, and other chapter initiatives. Dr. Owen has testified at legislative hearings defending tort reform and Texas' willful-and-wanton standard. She has helped shape TCEP's strategic direction and advocacy efforts on behalf of emergency physicians across Texas.

Dr. Owen also brings a unique depth of expertise in clinical quality and patient safety. She currently serves as Chief Clinical Officer for Emergency Medicine at TeamHealth and previously served as Chief Patient Safety and Quality Officer for Emergency Medicine Consultants. As Executive Director of the TeamHealth Patient Safety

Organization, she leads efforts to advance patient safety and quality across emergency departments nationwide. Her ability to transform complex quality initiatives into meaningful improvements has earned her the respect of colleagues throughout emergency medicine.

Dr. Owen embodies the qualities essential for service on the ACEP Board of Directors. She is a respected clinician, innovative leader, collaborative problem solver, and passionate advocate for emergency medicine. Dr. Owen is the kind of leader who brings people together, tackles difficult problems directly and turns ideas into action. Her expertise in patient safety and quality improvement, combined with decades of service to TCEP and ACEP, provides the perspective and leadership needed as our specialty continues to face evolving challenges.

The Texas College of Emergency Physicians is proud to offer Dr. Heather Owen our enthusiastic and unequivocal endorsement for election to the ACEP Board of Directors. We are confident she will serve ACEP and its members with distinction while advancing the mission of improving emergency care for physicians and the patients they serve.

Thank you for your thoughtful consideration of her candidacy. Should you have any questions, please do not hesitate to contact me or our Executive Director, Jill Sutton, at jill@texacep.org.

Sincerely,



Bryan Dunn, MD, FACEP
President
Texas College of Emergency Physicians

Heather S. Owen, MD, FACEP

Councillors, Colleagues and Friends,

I am honored to be a candidate for the ACEP Board of Directors and grateful for the opportunity to address the Council. My experiences in advocacy, clinical quality & patient safety, and physician leadership have given me a broad perspective on our incredible past, our present challenges and the opportunities we have to shape our future, making me a strong candidate for the ACEP Board of Directors.

I have been an advocate for emergency medicine at the state and national levels for more than two decades. I have had the privilege of serving ACEP in many capacities and working alongside our colleagues to advance projects and policies that protect our patients, our profession, and our ability to practice emergency medicine.

As a practicing emergency physician, I continue to experience firsthand the challenges facing our specialty. I see how healthcare policy, decreasing reimbursement, workforce pressures, and the changing practice environment affect physicians and our ability to care for patients. That experience keeps me grounded in the realities our members face and informs how I approach leadership and advocacy at the state and national level.

My leadership experience has taught me the importance of being willing to step forward when our profession needs it most. Challenging times require strong leadership, collaboration, adaptability, and trust. Working closely with our physician leaders, we can successfully navigate the challenges of emergency medicine and emerged stronger. Leadership is not about having all the answers; it is about bringing people together, listening, solving problems collaboratively, and moving forward with action and purpose.

As a Board member, my priorities would center on three pillars:

Protecting Our Practice. We must continue to advocate fiercely for fair reimbursement, appropriate physician payment, sustainable practice environments, and policies that recognize the value and complexity of emergency care. We must protect physician autonomy and ensure that emergency physicians have a strong voice in the decisions shaping our profession.

Empowering Our Physicians. ACEP must deliver value to physicians at every stage of their careers. We need to support physicians facing workplace challenges, strengthen leadership opportunities, provide practical resources, and ensure that the voices of our state chapters, young physicians, academic physicians, community physicians, and experienced physicians are heard.

Defining Our Future. Emergency medicine is changing rapidly. Artificial intelligence, emerging technologies, evolving models of care, and workforce challenges will all shape what our specialty looks like tomorrow. ACEP should be the organization that anticipates what is coming and helps define our future, with the physician perspective at the center. We need to ensure that innovation strengthens emergency medicine and that physicians remain at the center of emergency care.

I believe we are **stronger together.** As one united voice, when we can protect our practice, empower our physicians, and define our future.

I respectfully ask for your vote for the ACEP Board of Directors. I would be honored to work on behalf of every emergency physician we represent.

Sincerely,



Heather S. Owen, MD, FACEP

ELECT

Heather S. Owen, MD, FACEP

Candidate for ACEP Board of Directors



Active, Frontline Physician:
Practicing ED clinician experiencing the same workforce, policy, and reimbursement realities you face.

20+ Years of Fierce Advocacy:
Proven legislative champion fighting for emergency medicine, actively defending critical state and national protections like tort reform.

Quality and Safety Expertise:
Physician leader driving systemic quality improvement initiatives that protect patients and safeguard our clinical environment.

Forward-Looking Vision for Technology:
Committed to ensuring physicians dictate the integration of AI and emerging technologies, keeping ACEP ahead of industry disruption.

PROTECTING OUR PRACTICE

Protecting what we've built

- Advocacy that delivers results
- Fair and sustainable compensation
- Risk mitigation and liability awareness

EMPOWERING OUR PHYSICIANS

Investing in our members

- Physician-led teams
- Professional growth
- Clinical excellence
- Support and well-being

DEFINING OUR FUTURE

Shaping what comes next

- Leading innovation
- Embracing technology integration
- Strengthening accreditation

ADVANCING EMERGENCY MEDICINE, TOGETHER



HEATHER S. OWEN, M.D., FACEP

214-497-8242

hsowen@gmail.com

EDUCATION

University of Texas Medical Branch
School of Medicine; Galveston, TX
Doctor of Medicine, May 2005

Emory University; Atlanta, GA
Bachelor of Science, Neuroscience and Behavioral Biology, May 1999

RESIDENCY

University of Texas Southwestern at Dallas/Parkland; Dallas, TX
Emergency Medicine Residency, completed June 2008

BOARD CERTIFICATION

Emergency Medicine,
American Board of Emergency Medicine
2009 - current

PROFESSIONAL EXPERIENCE

Chief Clinical Officer of Emergency Medicine, TeamHealth	2020 – current
Executive Director, TH Patient Safety Organization	2020 – current
Chief Patient Safety and Quality Officer, EMC	2016 – 2020
Director, Scribe Services	2021 – 2026
Co-Chair TeamHealth Clinical Resiliency Committee	2019 – 2024
Director, EMC CME Safety & Quality Conference	2018 – 2020
Fellow of the American College of Emergency Physicians	2013 – current
Expert Witness Case Review	

HOSPITAL AFFILIATIONS

Texas Health Presbyterian Hospital of Dallas	2008 – current
Texas Health Presbyterian Hospital of Allen	2008 – 2020
Texas Health Presbyterian Hospital of Plano	2008 – 2020
Texas Health Presbyterian Hospital of Rockwall	2008 – 2020
Parkland Memorial Hospital, Associate Faculty	2011 – 2016

TEXAS COLLEGE OF EMERGENCY PHYSICIANS

TCEP Board of Directors	2006 – 2018
Executive Committee	2014 – 2018
TCEP, President	2016 – 2017
President- Elect	2015 – 2016
Treasurer/Secretary	2014 – 2015
Past President	2017 – 2018
ABCD Simulation Course Director	2014 – 2017
Membership and Public Relations Committee	2008 – 2019
Medical Education Committee	2006 – 2018
Legislative Affairs Committee	2006 – 2018, 2024 – current

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Emergency Care Quality Metric Consortium	2020 – current
• Board of Governors, Chair	2024 – current
• Board of Governors, Vice Chair	2022 – 2024
• Board of Governors, Secretary/Treasurer	2020 – 2022
Emergency Medicine Practice Committee	2024 – current
ED Directors Academy Phase II Faculty	2023 – current
ED Accreditation Task Force	2022 – 2024
Quality Improvement and Patient Safety Committee	2016 – 2018
Public Health, Policy Review Subcommittee Chair	2012 – 2014
Delegate to ACEP Council	2010 – current
Texas Delegation Reference Committee Chair	
Public Health Committee Member	2007 – 2016
Medical Director Academy Course	2012

TEXAS HEALTH PRESBYTERIAN HOSPITAL OF ALLEN

President of the Medical Staff	2013 – 2015
Medical Executive Committee, Chair	2013 – 2015
Texas Health Resources Physician Leadership Council	2013 – 2017
Vice President of the Medical Staff	2012 – 2013
Board of Trustees	2012 – 2016
Medical Executive Committee, Member	2011 – 2016
Member-at-Large of the Medical Staff	2011 – 2012
Credentials Committee	2010 – 2011
Code Blue Committee	2009 – 2013

TEXAS HEALTH PRESBYTERIAN HOSPITAL OF DALLAS

Advanced Practice Provider Credentials Committee, Chair	2015 – 2016
Credentials Committee	2015 – 2016

DALLAS COUNTY MEDICAL SOCIETY

Public Health Committee	2011 – 2013

PUBLICATIONS

Gregory Kutsen, MD, Kurt Kleinschmidt, MD, **Heather S. Owen, MD**. Chest Pain*, Emergency Medicine Handbook: Critical Concepts for Clinical Practice*. Mosby Elseveir, Philadelphia, 2007; pp 279 – 302.

Isabel A. Barata, MD, MBA; Jamie R. Shandro ,MD, MPH; Margaret Montgomery, RN; Robin Polansky, MD, MPH; Carolyn J. Sachs MD, Montgomery, RN; Robin Polansky, MD, MPH; Carolyn J. Sachs MD, MPH; Herbert C. Duber, MD, MPH; Lindsay M. Weaver, MD; Alan Heins, MD; **Heather S. Owen, MD**; Elaine B. Josephson; Wendy Macias-Konstantopoulos, MD, MPH. Effectiveness of SBIRT for Alcohol Use Disorders in the Emergency Department: A Systematic Review. *Western J Emerg Med*. 2017;18(6):1143-1152.

PROFESSIONAL ORGANIZATIONS

American College of Emergency Physicians
Texas College of Emergency Physicians
Dallas County Medical Society
Emergency Medicine Resident Association
American Medical Association
Texas Medical Association

PRESENTATIONS

National Medical Leadership Conference, Emergency Medicine Breakout Session; 5.2026
Clinical Risk Avoidance and Mitigation: Bilateral Eye Swelling; 4.2026
High Risk ED Diagnoses; 3.2026
"You've Been Served"; TN ACEP Chapter Meeting; 3.2026
APEX: Connecting with Purpose; 3.2026
Clinical Risk Avoidance and Mitigation: Spinal Epidural Abscess; 10.2025

EM Best Practices for Opiate Use Disorder; 5.2025
Disastrous Cases in Electrocardiography with Amal Mattu, MD; 4.2025
Clinical Risk Avoidance and Mitigation: Intracranial Hemorrhage; 4.2025
Wide Complex Tachycardias with Amal Mattu, MD; 11.2024
National Medical Leadership Conference, Emergency Medicine Breakout Session; 9.2024
Memorial Healthcare System EM Medical Legal Ground Rounds; 7.2024
STEMI without the STE: Non traditional predictors of Acute Coronary Occlusion with Amal Mattu, MD; 4.2024
Clinical Risk Avoidance and Mitigation: EM Bouncebacks; 4.2024
Clinical Risk Avoidance and Mitigation: Anatomy of a Lawsuit; 4.2024
Partners in Performance: Advance Solutions for Complex Client Challenges; 1.2024
Clinical Risk Avoidance and Mitigation: Young at Heart; 1.2024
PSO Case Files: Aortic Dissection; 10.2023
Bouncebacks: Achieving Excellence in Stroke Care with Dr. Michael Weinstock; 8.2023
Clinical Risk Avoidance and Mitigation: Chest Pain; 5.2023
National Medical Leadership Conference, Emergency Medicine Breakout Session; 4.2023
EDDA EDPA II: "Creating a Quality Program"; 8.2021
White Paper: Coronavirus Update; 1.2021
"Tales from the Association" Monthly Newletter, 2018 – 2020
"EMC Association: Navigating the Minefield"; Quarterly Leadership Conference, 2018 – 2020
"A Tale of Two Emergency Departments"; EMC CME Conference, 1.2017
"Anatomy of a Medical Error"; EMC CME Conference 1.2016

HONORS AND AWARDS

ACGME's CME Impact of the Year Award Nominee, 2025
Emergency Medicine Consultants: Big Gun Award, 2019
AMA Foundation "Excellence in Medicine" Leadership Award, 2004
Galveston County ImmunizationCoalition Award of Recognition, 2002

CERTIFICATIONS

Advanced Trauma Life Support
Basic Life Support
Advance Cardiac Life Support
Pediatric Advance Life Support

HOBBIES

Spending time with family and friends
Skiing
Scuba Diving
Traveling

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ADVANCING EMERGENCY CARE

2026 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Henry Z. Pitzele, MD, FACEP

Question #1: **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

There's little that's more important to me in College operations than communications. No matter how many amazing, EM-centric things ACEP accomplishes on the daily to make the working lives of emergency physicians better, we can't sustain a specialty organization if the membership never hears about them.

I've worked hard, especially this past year as Vice President of Communications, to build those bridges, and I've been lucky to work with our Leadership and the highly talented and superb new Comms arm of the College on large projects like Built on Results, on our video interviews, on increasing our social media presence, and on our many public position statements that gave frontline docs the support and backing they needed when facing their difficult local environments throughout this tumultuous year. It's been an ongoing effort to meet emergency physicians where they live and work, not only to demonstrate value, but also to show our members the world of possibilities and practice environments beyond the brick and mortar walls of a typical community or academic ED. We must continue to use ACEP's power and strength, through technology and social media, to bring members closer together, whether they are parts of Chapters, Sections, or just individual working emergency physicians; it is one of our most deeply held strategic values to have the College make emergency physicians feel connected, valued, and empowered to shape our specialty's future.

One thing that hasn't gone away is my singular focus that everything the College does is strictly for the improvement of the lives of individual, working emergency physicians – never corporations, universities, or any other institutions, and that business interests never supersede the interests of frontline docs. That means that wherever you work (and by now, most of us are employees), the College is looking out for *you*, not for the entities who employ you. This sentiment informs everything we do, from reimbursement to education, and I take it very seriously – my Board colleagues are probably sick of hearing me repeat it.

Lastly, as an incumbent, I bring the past three years of experience; learning the ropes of Board membership and gaining a deep understanding of the College and the way we do business takes significant time, and is no easy feat. Retaining that institutional knowledge is more important this year than most; it's a tool I want to use to move us forward together.

Question #2: **What is your perspective on ACEP's role in the 3-year versus 4-year emergency medicine training program discussion?**

ACEP has many roles in the discussion, although none of them is the role of the decider; the decision is entirely in the hands of the ACGME. ACEP still has plenty of work to do, though, in this highly controversial space, and the first role is that of a convener. As the largest and most influential organization in emergency medicine, ACEP is the place where the debate itself happens. When ACGME officials (former ACEP Committee members, lecturers, and active members of the College) come to hear comments from the emergency medicine public at large in a townhall format, they do so at ACEP Scientific Assembly. When communications come from the ACGME, they are published in *ACEP Now* and *Annals of Emergency Medicine*, as are the pro/con debates.

The second role the College has in this discussion is to help both sides understand each other. The reasons that ACGME is making its recommendations are not always easy to understand, and it is helpful to have the multiple modalities at our disposal to convey the concepts of raising the bar for emergency medicine education and its implications to trainees, to funding, and to the larger emergency medicine workforce. ACEP journalism, in print and online, allowed for massive reach in translating those concepts; President-Elect Stanton's Frontline podcast with members of the ACGME RCEM was probably the best explanation I have ever heard of the motivations and particulars of the ACGME recommendations. Conversely, making the strong case against the ACGME recommendations, especially on the untested nature of the structure, and on the extremely limited and sample-biased methods of survey data that led to the recommendations, was clearly synthesized and transmitted to ACGME through those same ACEP channels.

The third role ACEP has will cut in once the decision is officially made. Community is one of the pillars of the College, and if a decision comes down to move to a four-year training requirement, we will need to make sure that every emergency physician understands the decision, and that every trainee, academic faculty member, and institutional leader understands the short-term and downstream subtleties that this decision will bring, and that no emergency physician, especially no trainee, is left fending for themselves. While such a decision would create uncertainty, it is something we will tackle together, with the strongest and most dedicated operational minds in Emergency Medicine (I'm looking at you, ACEP Clinical Affairs) guiding us through.

Question #3: **What is the most effective strategy you would use to recruit and retain members considering generational differences?**

Our most rich and plentiful resource for recruiting and retention is our membership itself. Right now, there is an epic cratering of belief and trust in institutions—this is true across generations. Even more potent is the across-the-board increase in people's ability to sniff out inauthenticity. Emergency physicians are desperate for personal connections with individuals they trust, whose motivations are clear and aligned with their own. We have exactly that. We have thousands of amazing emergency physicians, leading in large and small ways, and all working to advance emergency care. Whatever our perceived differences are (and they are likely smaller than we think), we are all here because we care deeply about emergency medicine – about our patients, and about our jobs. Showing our members (and potential members) the real lives of emergency docs – not just the physicians in busy Level I's, but the ones lobbying their state houses, the ones blazing new trails in teleEM, the ones writing our new sepsis guidelines, the ones doing Street Med – all of them! Showing these docs walking the walk to make EM a sustainable, high-longevity career is how we cut through the noise to recruit and retain.

The time of physicians joining their specialty society out of sheer professional obligation has completely passed. With the rise of non-academic employment and the decline of academic stipends, every single emergency physician is calculating the direct ROI of their membership. ACEP must always be auditioning for a spot in every emergency physician's next yearly budget. We can never rest on our previous achievements. We have to show exactly what we're doing, and why that matters to each emergency physician. And we have so much to show! It's going to be our exemplary membership who does the showing, in concert with the amazing ACEP staff—as dedicated to our mission as our docs are—and show every day, every month, every year what we in Council already know; that ACEP dues are the highest yield dollars spent on our professional lives.

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CANDIDATE DATA SHEET

Henry Z. Pitzele, MD, FACEP

Contact Information

617 S. Loomis
Chicago, IL 60607
Phone: (312) 523-6080
E-Mail: pitzele@gmail.com

Current and Past Professional Position(s)

Attending Physician (full time), Jesse Brown VA Medical Center, Chicago (2007-present)
Deputy Section Chief of Emergency Medicine 2007-2012
Section Chief of Emergency Medicine 2012-2015
Chief Health Informatics Officer 2023-present
Attending Physician (part time) Advocate Illinois Masonic Medical Center, Chicago (2010-present)
Attending Physician (part time) Mesa View Regional Medical Center, Mesquite NV (2011-present)
Attending Physician, Mercy Hospital, Chicago (full time 2003-2007, part time 2007-2010)

Education (include internships and residency information)

Univ. of Illinois at Chicago, Emergency Medicine residency 2000-2003
Univ. of Illinois at Chicago College of Medicine: MD 2000

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

ABEM 2004, 2014, 2025
Clinical Informatics 2022

Professional Societies

ACEP, AAEM, ICEP (Illinois Chapter)

National ACEP Activities – List your most significant accomplishments

Board of Directors 2023-present
VP Communications 2025-present (and liaison to Communications Committee, ACEPNow)
Board liaison to Education Committee 2024-present
Board liaison to Health Innovations and Tech Cmte 2023-25
Board liaison to Coding/Nomenclature Cmte 2023-24
Board liaison to multiple sections (Cruise Ship Medicine, Workforce, Democratic Practice, Informatics, Social EM, Palliative, Dual Training, Critical Care)
State Legislative/Regulatory Committee 2021-23—led several subcommittees in designing roundtable webinar discussions on scope of practice and leveraging strength in small/medium chapters, and in creating a dashboard to display state advocacy work on a number of common issues.
Communications Committee 2022-present—worked on a rapid-action response team for social media issues
ACEP Partner Collaborative Summit 2023-present

ACEP Chapter Activities – List your most significant accomplishments

ICEP president 2020-21
ICEP Board of Directors 2015-2022
ICEP EMBRi Written Board Review Course, course and committee chair 2012-2019

Practice Profile

Total hours devoted to emergency medicine practice per year: **2200** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **15** % Research ____ % Teaching ____ % Administration **0** %

Other: **Health Informatics** **85** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Full time in tertiary VA teaching hospital—detailed as Chief Health Informatics Officer during deployment of new EHR, which goes live March 2027; will return to full time nocturnist clinical practice late 2027. Moonlighting at an urban Level I trauma center (also an EM residency program site).

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Chief of Health Informatics since March 2023

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Henry Z. Pitzele, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: US Dept of Veterans Affairs—Jesse Brown VAMC
Address: 820 S. Damen
Chicago, IL 60612
Position Held: Attending Physician, Chief Health Informatics Officer
Type of Organization: VA Hospital

Employer: Advocate Medical Group—Advocate Illinois Masonic Hospital
Address: 836 W. Wellington
Chicago, IL 60657
Position Held: Attending Physician—part-time/moonlighting
Type of Organization: Regional medical group

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Illinois College of Emergency Physicians
Address: 2001 Butterfield Rd, Esplanade 1, Suite 320
Downer's Grove, IL 60515
Type of Organization: State Chapter of ACEP
Leadership Position: Board member, various officer positions including president
Term of Service: 7 years (2015-2022)

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Henry Pitzele Date 5/10/2026

Illinois College of Emergency Physicians

ADVANCING EMERGENCY CARE ICEP.org

2001 Butterfield Road, Esplanade I, Suite 320,Downers Grove, IL 60515 phone: 630.495.6400 toll-free: 888.495.ICEP

August 3, 2026

Dear Council:

The Illinois College of Emergency Physicians proudly endorses Dr. Henry Pitzele for re-election to the board of directors of the American College of Emergency Physicians.

Dr. Pitzele has been a vital and active member of the Illinois College for two decades. His service began as an educator lecturing in (and eventually leading) our oral board review course. Dr. Pitzele moved into leadership of the Chapter, starting on the Board of Directors in 2015, just in time to face significant challenges to the financial health of the organization. With an eye on the long-term health of the College, but without fear of significant changes to the organization's structure and physical presence, Dr. Pitzele and the leadership team heralded ICEP through those times towards the much more stable fiscal foundation on which it now rests.

Dr. Pitzele served as ICEP president from 2020-21, which provided a different set of challenges. In concert with the courageous and tireless efforts of ICEP staff, Henry was able to lead the organization through that tumultuous year, pivoting to an online position for most activities, bringing in new engagement with Social EM. Most importantly, he was able to stand up for individual EM physicians in Illinois who, as independent contractors, were not given COVID protections by their hospital systems.

We at ICEP have been proud to see Henry continue that focus on the front-line physician as he turned his efforts to the national organization. Through the past three years on the Board, through his efforts as Committee and Section liaison, and even more with the Communications Committee during his time as Vice President of Communications, Dr. Pitzele has been one of the leaders who has continued to center ACEP as an organization with the singular goal of representing the working interests of the individual Emergency Physician. We know that the clear voice he has used in the boardroom, online, and in person to keep those interests in the forefront as the College continues to face challenges from government, corporations, and payors has allowed the College to continue to prosper, even in times of significant financial challenges.

BOARD OF DIRECTORS

Kristen Donaldson, MD, MBA, FACEP
President

Nicholas Cozzi, MD, MBA
President-Elect

Monika Pitzele, MD, PhD, FACEP
Secretary-Treasurer

Monika Pitzele, MD, PhD, FACEP
Member-at-Large

Amit Arwindekar, MD, MBA, FACEP
Past President

Halleh Akbarnia, MD, MPH, FACEP
Elisabeth Giblin, MD
Samantha Hay, MD

Adnan Hussain, MD, FACEP
Jason Kegg, MD, FACEP
Joshua Miksanek, MD, FACEP
Joseph Palter, MD

Gregory Podolej, MD, MPHE, FACEP
Thomas Sugarman, MD, FACEP
Kelly Geldmacher, MD, FACEP

Erin Berg, MS, DO
Resident Member

EXECUTIVE DIRECTOR
Maggie Gruennert, CAE, CMP

The Illinois Chapter of the American College of Emergency Physicians

Illlinois College of Emergency Physicians

ADVANCING EMERGENCY CARE ICEP.org

2001 Butterfield Road, Esplanade I, Suite 320,Downers Grove, IL 60515 phone: 630.495.6400 toll-free: 888.495.ICEP

Throughout his time on the ACEP Board, Henry has continued to be an active member of ICEP, teaching our gold standard board review course, and participating in our successful legislative advocacy campaigns. He truly cares about improving the working lives of physicians in Emergency Medicine, and we would like to see him do even more for the specialty in a second term on the ACEP Board.

Sincerely,



Kristen Donaldson, MD, MPH, FACEP
President
Illinois College of Emergency Physicians

BOARD OF DIRECTORS

Kristen Donaldson, MD, MBA, FACEP
President

Nicholas Cozzi, MD, MBA
President-Elect

Monika Pitzele, MD, PhD, FACEP
Secretary-Treasurer

Monika Pitzele, MD, PhD, FACEP
Member-at-Large

Amit Arwindekar, MD, MBA, FACEP
Past President

Halleh Akbarnia, MD, MPH, FACEP
Elisabeth Giblin, MD
Samantha Hay, MD

Adnan Hussain, MD, FACEP
Jason Kegg, MD, FACEP
Joshua Miksanek, MD, FACEP
Joseph Palter, MD

Gregory Podolej, MD, MPHE, FACEP
Thomas Sugarman, MD, FACEP
Kelly Geldmacher, MD, FACEP

Erin Berg, MS, DO
Resident Member

EXECUTIVE DIRECTOR
Maggie Gruennert, CAE, CMP

The Illinois Chapter of the American College of Emergency Physicians

Henry Z. Pitzele, MD, FACEP

We get to write several pieces as part of our campaign, but I like this one the best – it's the least formal. I want to tell you a bit about how I see the Board, and how I see the part I want to play in the next three years.

Firstly, I want to say that I feel extremely lucky to be a part of the Board we've got. Everyone is unified in a common goal, and when we disagree, we do so passionately but professionally, and once we decide, we all commit. The unification is glorious, but so is the disagreement! When we do disagree, and bring multiple viewpoints to bear on each issue, I think we are truly doing our best work representing the College. I love arguing with my friends when it's done in good faith, and continuing to bring this kind of discourse at the Board level is one of the things I hope to continue in a second term.

This concept of making sure all voices are heard is a piece of something larger which I also view as one of my central goals – communication. Communication inside the board, certainly, but I also think endlessly about ways that the College can communicate more effectively with members, with potential members, with Chapters, and with the public at large. One of our strongest communicators is becoming president in October, and we need other people on the team to keep their attention strongly trained on that area – I want to do that.

I also want to continue to support the evolution of the College in the next decade; as the speed of our world's change accelerates, we need to change with it. I want us to represent EM physicians in 2035 and 2045, and to do that, we will need to focus on experiences and interactions, with as much concentration on the digital space as the physical one. We need to be at the top of the stack for the design and implementation of clinical AI. And we have to do all that and still remain the most trusted voice in Emergency Medicine, in academics, in advocacy, and in working to make our specialty a better place to spend our waking lives.

I have learned a ton in my first term on the Board. Not just about the College and about EM, but about leadership, and about myself as well. I've learned about the ways to get things accomplished within the College, and I've learned so much about our history and about they key players, past and present, who make the wheels of the College turn. I only say this because I think that the first term on the Board involves a great deal of learning, and at the end of the second day of Council, I truly hope you'll bring back the incumbents for a second term; there's so much great work for us to do in the next few years, and we're ready to go.



Henry Pitzele, MD, FACEP

Candidate for ACEP Board of Directors

Focus: The Individual, Working Emergency Physician

Who I Am

- **Frontline Clinician:** Full-time attending physician at Jesse Brown VA Medical Center and moonlighter at an urban Level I trauma center.
- **Informatics Leader:** Currently serving as Chief Health Informatics Officer; expert in leveraging technology and AI to improve the practice of emergency medicine.

Leadership That Delivers

- **Incumbent ACEP Board Member (2023–Present):** Bringing three years of institutional knowledge and a deep understanding of College operations.
- **VP of Communications (2025–Present):** Leading efforts to meet EPs where they work through social media, the College's Communications overhaul, and rapid-action responses.
- **ACEP BOD Employed Physician Protection Workgroup 2024-2025**: Led efforts to support, prepare, and empower employed EPs around fallout of corporate collapse
- **Broad Board Liaison Experience:** Serving as a bridge to committees such as Education, Communications, HIT, and Coding, as well as diverse sections including Workforce, Democratic Practice, Cruise Ship med, and Social EM.

My Vision & Priorities

- **Member-Centric Focus:** My singular goal is to ensure ACEP activities strictly improve the lives of **individual, working EPs**—never corporations or institutions.
- **Closing the Communication Gap:** I am committed to building bridges so every member understands the ROI of their dues and feels connected to the College's advocacy wins.
- **The Future of EM (2035 & Beyond):** I will push for ACEP to lead the design and implementation of clinical AI and both digital and physical interactions to ensure we remain the most trusted voice in the next decade.
- **Authentic Advocacy:** I believe in cutting through the noise by showing the real, diverse lives of emergency docs—from those lobbying state houses to those doing Street Med—to recruit and retain the next generation of leaders.

I have spent my first term learning the ropes and building the team. I am ready to hit the ground running on day one of my second term to move our specialty forward.

HENRY ZOLTAN PITZELE, MD

Work Experience

2/23-present	Chief Health Informatics Officer 2/23-present, Jesse Brown VA Medical Center, Chicago (50% clinical EM, 50% CHIO)
6/07-present	Attending Physician, Emergency Medicine Service, Jesse Brown VA Medical Center, Chicago (Deputy Chief 6/2007-9/2012, Section Chief 9/2012-9/2015)
11/11-present	Attending physician, Department of Emergency Medicine, Mesa View Regional Hospital, Mesquite NV (part-time/moonlighting)
8/10-present	Attending physician, Department of Emergency Medicine, Advocate Illinois Masonic Medical Center, Chicago (Level I Trauma Center—part-time/moonlighting)
3/16-12/18	Attending physician, Department of Emergency Medicine, Advocate Trinity Hospital, Chicago (Part-time/moonlighting)
6/03-7/10	Attending physician, Department of Emergency Medicine, Mercy Hospital and Medical Center, Chicago (Full-time 2003-2007, part-time 2007-2010)
11/02-6/03	Attending physician at UIC O'Hare Medical Clinic, part-time

Educational Experience

2000-2003	University of Illinois at Chicago Emergency Medicine Residency Chief Resident at Mercy Hospital and Medical Center
1996-2000	University of Illinois at Chicago College of Medicine Graduated top quartile of class
1992-1996	University of Chicago BA in Economics with General Honors

Publications

Pitzele HZ. Scapular Winging (Chapter 62) and Maisonneuve Fracture (Chapter 37) in Atlas of Clinical Emergency Medicine. Edited by Sherman SC, et al, Lippincott 2015.

Pitzele HZ, Kessler CS. Life-threatening Dermatoses. Chapter 96 in Clinical Emergency Medicine, Edited by Sherman SC and Weber JM, Mcgraw-Hill 2013.

Garcia C, Pitzele HZ. Man with Shoulder Pain After a Fall. *Annals of Emergency Medicine.* 2011 58(6) p. 574, 578.

Pitzele HZ, Tolia V. Twenty per Hour: Altered Mental State due to Ethanol Abuse and Withdrawal. *Emergency Medicine Clinics of North America.* 2010 28(3) p. 683.

Unterman S, Kessler CS, Pitzele HZ. Staffing of the Emergency Department by non-Emergency Medicine-trained Personnel: The VA Experience. *American Journal of Emergency Medicine.* 2010 28(5) p. 622.

Pitzele HZ. Acquired Lateral Rectus Palsy: A Case Report. *The Internet Journal of Emergency Medicine.* 2009 Volume 6 Number 1

Aks S, Erickson TB, Paloucek F, Pitzele HZ. Famous Chicago Poisonings. Oral Presentation at North American Congress of Clinical Toxicology Annual Meeting, Chicago, IL, Aug 2003. Published as an article in *Mithridata: Newsletter of the Toxicological History Society* 2004 14(2) p. 6-10.

Pitzele HZ, Eilbert WP. Abdominal CT Scan and Diagnostic Delay in Men and Women Undergoing Appendectomy. Oral Presentation at AAEM Scientific Assembly, New Orleans, LA, Feb 2003. Abstract published in *J Emerg Med* 2003 24(4) p. 479

Awards

Award of Teaching Excellence, UIC Internal Medicine Residency, 2011-2012

Oral Presentations
Lecturer, UIC Internal Medicine Residency Noon Conference 2007-2024
Lecturer, Illinois College of Emergency Physicians Written Board Review Course, "EMBRi" 2004-2019
Lecturer, American Academy of Emergency Medicine Scientific Assembly, San Diego 2012
Lecturer, Third Dutch North Sea Emergency Medicine Conference, Netherlands, June 2009
Lecturer, American College of Emergency Physicians Scientific Assembly, Chicago 2008
Lecturer, American College of Emergency Physicians Spring Congress (New Speaker's Forum), Las Vegas 2006

Leadership Experience
American College of Emergency Physicians
Vice President of Communications (2025-2026)
Board of Directors (2023-present)
Illinois College of Emergency Physicians (Illinois Chapter of ACEP)
President, 2020-2021
Secretary/Treasurer 2019-2020
Board of Directors, 2015-2021
Chair, Written Board Review Course committee, Illinois College of Emergency Physicians 2012-2019
Medical Director (Section Chief) Emergency Medicine, Jesse Brown VAMC 2012-2015
VA National Emergency Medicine Field Advisory Committee, 2013-2016
Lead Physician for Emergency Medicine, VA Great Lakes Health Care System 2012-2015
Jesse Brown VAMC LEAN Steering Committee 2014-2015
Chair, ED Committee at Jesse Brown VAMC 2012-2015
Site Director, Medical Student Rotation in EM at Jesse Brown VAMC, 2007-2013

Hospital Committees
Peer Review (2014-present)
Inpatient Flow (2012-2015)
Utilization Management (2012-2015)
Emergency Management (2012-2015)
Medical Executive Council (2012-2015)
CPR (2012-2015)
Clinical Products and Resources (2012-2015)
Ebola Preparedness (2014-2015)

Certifications
BLS, ACLS, ATLS
LEAN Green Belt
AMIA 10x10

Professional Organizations
Clinical Assistant Professor, Department of Emergency Medicine, University of Illinois at Chicago, 2013-present
Fellow, American College of Emergency Physicians, 2006-present
Examiner, Illinois College of Emergency Physicians, Oral Board Review Course 2004-present
Board Certified in Emergency Medicine, American Board of Emergency Medicine, 2004, 2014, 2024
Board Certified in Clinical Informatics 2022

pitzele@gmail.com
617 S. Loomis, Chicago IL 60607
cell (312) 523-6080

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2026 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Alexandra Nicole Thran, MD, FACEP

Question #1: **What skills, background, knowledge, or unique abilities will you bring to the Board that may be currently missing?**

My experience is the most valuable contribution I can bring to the ACEP Board of Directors.
I am a locums physician. I work in a wide variety of EDs and have over 30 years in the pit. This gives me a broad perspective. I work in different hospital settings, with different staffing models, with a variety of EMS systems, with different state laws. I know we share many challenges unique to our practice.

Boarding and overcrowding, lack of adequate beds and staffing, increasing amounts of societal violence, lack of primary care, lack of specialty care, especially in rural settings, lack of social service, and decreasing reimbursement; all these issues harm our patients and cause us moral injury and burnout.

I understand differing operational structures, resource limitations, workplace cultures, and patient care demands.

If elected, I will make ACEP stronger and help shape policies and initiatives that benefit you, our members, against the challenges that we all share.

Practicing locums has additional benefits. I have become more flexible, adaptable, and a better communicator. I am a better listener and collaborator. I can work with others toward a common cause, even when they hold different perspectives and priorities.

I believe these are essential qualities for effective board leadership, particularly during a time when emergency medicine continues to face significant workforce, operational, and advocacy challenges.

Participation in sections has given me insight into issues related to inclusion, professional development, physician wellness, career sustainability, and the evolving nature of emergency medicine practice.

I am actively involved in multiple ACEP sections; AAWEP changed my life. Those members taught me leadership skills, gave me speaking opportunities, and gave me confidence and camaraderie. AAWEP remains a professional “safe space” and resource for leadership development and personal and professional satisfaction.

My committee service has further broadened my understanding of operational work inside our College.

Through my work on the ACEP National/Chapter Relations Committee, I gained appreciation for the important relationship between national ACEP leadership and state chapters, as well as the challenges and opportunities faced at the chapter level. My service on the Access, Belonging, & Community Committee reinforced the importance of fostering an organization where all members feel valued, heard, and supported. Participation on the Professional Well-Being Committee deepened my understanding of the systemic and personal factors contributing to physician burnout and professional fulfillment, issues that remain critically important to the future of our specialty.

Collectively, these experiences have given me a broad perspective on the needs of ACEP members across career stages, practice settings, and backgrounds. I believe I can contribute thoughtful, balanced leadership grounded in practical frontline experience, active organizational engagement, and a commitment to collaborative problem-solving.

Most importantly, I strive to approach discussions with respect, openness, and a willingness to work constructively with colleagues with divergent viewpoints, to move our organization and specialty forward together.

Question #2: **What is your perspective on ACEP’s role in the 3-year versus 4-year emergency medicine training program discussion?**

As a candidate for the ACEP Board of Directors, I believe the 3-year versus 4-year debate fundamentally misses the point. The primary measure of an exceptional emergency medicine residency is not the calendar duration, but the quality and depth of the training.

My perspective is shaped directly by my own journey. I trained in a 3-year program at the University of Massachusetts in Worcester, MA. Thanks to the exceptional teachers, mentors, and rigorous clinical environment there, I graduated fully prepared to handle the highest-acuity environments independently. My experience is proof that an efficient, high-yield curriculum can produce elite, capable attendings without requiring an extra year of training.

Arbitrarily forcing a 48-month mandate across the board does not automatically create a superior physician. True educational excellence is driven by clinical diversity, procedural volume, robust simulation, and constructive mentorship—not hours spent on a clock. Simply extending a program's duration without overhauling its educational substance risks transforming an additional year into low-cost service labor. This adds an unjustified financial debt burden and delays career progression for our trainees without a shred of data proving it improves patient outcomes.

ACEP's role must be one of unwavering, evidence-based advocacy that protects the flexibility and autonomy of our training institutions. ACEP must firmly stand by its established policy supporting the value and validity of both 3-year and 4-year formats. Rather than allowing a one-size-fits-all timeline to be dictated from the top down, ACEP must serve as the primary shield protecting our programs from unsubstantiated educational inflation.

On the Board, I will advocate for ACEP to lead a hard pivot toward objective, competency-based education. We must partner closely with EMRA and CORD to push the ACGME to evaluate graduate readiness through verifiable clinical milestones and high-impact instructional design. We can protect the future pipeline of our specialty, elevate clinical standards, and defend trainee well-being by demanding that our training infrastructure prioritizes actual learning outcomes over arbitrary time frames.

Question #3: **What is the most effective strategy you would use to recruit and retain members considering generational differences?**

Recruitment and retention aren't two problems. They're the same problem, viewed from opposite ends of a career.

A significant part of my career has been as a locums physician, staffing rural critical access EDs, academic trauma centers, and everything in between. That vantage point taught me something the membership survey data can't: the reason a 29-year-old joins ACEP is almost never the reason a 61-year-old renews. When we run one recruitment strategy for everyone, we lose people on both ends and wonder why.

I also happen to live this generational range outside of work. My closest circle spans people in their twenties through their eighties, a mix of physicians, nurses, engineers, teachers, musicians and artists. I hear, unfiltered and off the record, why someone in their twenties is disillusioned by traditional institutions and how they weigh a membership dollar against investing in their families and retirement. I understand why a physician in their fifties can feel like ACEP is no longer relevant to their day to day practice. We need to listen closely and communicate effectively. I will listen across generations and use my position as a board member to advocate for the College.

Here's how I'd translate it into strategy. Early-career members and residents want proof of return before they want belonging. They're debt-burdened, mobile, and skeptical of institutions that ask for buy-in before showing value. The fix is frictionless, low-stakes entry: discounted first-year chapter dual-membership, a genuinely useful digital community, and structured mentorship built into section onboarding rather than left to chance — the model I've pushed for within the ABC, Wellness and Locums Section.

Mid-career physicians, roughly ten to twenty-five years out, are the group we're likely bleeding fastest. They're absorbing the worst of boarding, contract instability, and corporate practice pressure while raising families and running households. They don't need another CME credit; they need to see ACEP's advocacy work land on their specific problem — not "we support EMTALA," but what changed in their state this quarter. Retention here is about relevance and proof of fight, in specific, dated terms.

Senior members want their legacy protected and their expertise used, not shelved. Many step back from committee work not because they're disengaged, but because the pathways assume a full-time, still-working-nights schedule. Governance roles, mentorship leadership, and advocacy work structured for a part-time or semi-retired schedule keep that expertise in the organization instead of losing it.

Underneath all three groups is one connective thread: belonging. This is where the ABC Section and Wellness Section work I've been part of directly overlaps with membership strategy. A member who feels excluded or burned out doesn't renew, regardless of age. A recruitment strategy that ignores that is decorating the outside of a house with a cracked foundation.

If elected, I'd push for three things: a structured, section-anchored mentorship pipeline that deliberately pairs across career stage; state-chapter advocacy reporting written in plain terms members can use in their own workplace conversations; and membership pathways built for how emergency physicians actually work now — locum, part-time, telehealth, hybrid — instead of assuming one full-time, single-site career model.

Generational differences in this specialty are real, but they close quickly once someone actually listens and responds. That's the work I want to bring to the Board.

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CANDIDATE DATA SHEET

Alexandra Nicole Thran, MD, FACEP

Contact Information

16 Dimetro Rd. #8, Warren, VT 05674
Phone: 401-527-8224
E-Mail: nikiermd@gmail.com

Current and Past Professional Position(s)

PROFESSIONAL EXPERIENCE
2023 - present: Emergency Physician (Independent Contractor)

- 12/1/2025 - present: Independent Contractor, CHI St. Alexius Health, Dickinson, ND
- 9/1/2025 - 2/28/2025: Independent Contractor, CHI St. Alexius Health, Devil's Lake Hospital
- 5/1/2025 - present: Independent Contractor, North Country Hospital, Newport, VT
- 5/1/2025 - 7/30/2025: Independent Contractor, McLaren Greater Lansing, Lansing, MI
- 6/1/2024 - 5/30/2025: Independent Contractor, Springfield Hospital, Springfield, VT
- 8/1/2024 - 11/30/2024: Independent Contractor, Kimball Hospital, Putnam, CT
- 6/1/2023 - 9/30/2025: Independent Contractor, Northeastern Vermont Regional Hospital, St. Johnsbury, VT

10/1/2013 - 7/31/2023: Emergency Physician | Gifford Medical Center, Randolph, VT
Clinical Coordinator (ED Director) (2019-2020)
Co-Founder and Past Chair, Energy Committee (2018–2023)
Member of Patient Experience (2017–2023) and Diversity Committees (2020–2023)

Locum Tenens | Various locations

2011- 2013 Locum Tenens
Rutland Regional Medical Center, Rutland, VT
Brattleboro Memorial Hospital, Brattleboro, VT
Chickasaw Nation Medical Center, Ada, OK
Our Lady of Fatima Hospital, North Providence, RI
Roger Williams Medical Center, Providence, RI
2010 - 2012 Emergency Physician, Kent Hospital, Warwick, RI
2003 - 2010 Emergency Physician, The Westerly Hospital, Westerly, RI
2002 - 2003 Emergency Physician, Garden City Treatment Center, Cranston, RI
1998 - 2002 Clinical Instructor of Emergency Medicine
Emergency Physicians of Tidewater, Virginia Beach, VA
1995 - 1998 Emergency Physician, Peninsula Emergency Physicians, Hampton, VA
1994 - 1995 Emergency Physician, Riverside Regional Medical Center, Newport News, VA
1991 Emergency Physician, Hartford Hospital & University of Connecticut, Hartford, CT
Assistant Clinical Professor of Emergency Medicine and Surgery
Assistant Director of Lifestar
Flight Crew Instructor
1991 Emergency Medicine Residency, Elective
Kapi'olani Medical Center, Honolulu, HI
1988 Emergency Medicine Senior Medical School Elective
Royal Perth Hospital, Perth, Australia

Education (include internships and residency information)

7/1/1989 - 6/30/1991 Emergency Medicine Residency,
University of Massachusetts
Worcester, Ma

7/1/1988 - 6/30/1989 Internship, Emergency Medicine,
University of Massachusetts
Worcester, MA

MD: 9/1/1984 - 5/13/1988 Doctor of Medicine,
Vanderbilt University School of Medicine
Nashville, TN

Specialty Board Certifications(e.g., ABEM, AOBEM, AAP, etc.) and dates certified and recertified)

AMERICAN BOARD OF EMERGENCY MEDICINE 1992, 2001, 2011, 2021

Professional Societies

ACEP, VT State Chapter, AMA, Vermont Medical Society

National ACEP Activities – List your most significant accomplishments

Vermont Chapter President, Past Treasurer
ACEP Counsilor
Chair-elect, ACEP Locums Section

ACEP Chapter Activities – List your most significant accomplishments

Established Chapter Committees for Membership, EMS and Legislation

Practice Profile

Total hours devoted to emergency medicine practice per year: **1440#** Total Hours/Year
hrs

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **100** % Research ____% Teaching ____% Administration ____%
Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

100 % Locums in multiple states and multiple types of practice, primarily Critical Access and rural practices.

Provide specific title(s) or position(s) within your group, hospital, department, system (e.g., Medical Director, Regional Director, Director of Quality, Vice President, Chief of Staff, etc.)

Medical Director (but actual title was Clinical Coordinator), Vermont EMS Medical Advisor District 8,

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony. Expert witness testimony is defined as oral or written evidence given by an expert witness under oath, at trial, or in an affidavit or deposition.

Defense Expert **Cases** **Plaintiff Expert** **Cases**

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CANDIDATE CONFLICT OF INTEREST DISCLOSURE STATEMENT

Alexandra Nicole Thran, MD, FACEP

1. Employment – *List current employers with addresses, position held, and type of organization.*

Employer: Warren Emergency Medicine

Address: 16 Dimetro Road, Unit 8

Warren, VT 05674

Position Held: CEO

Type of Organization: PLLC

2. Leadership Positions in Other Organizations, Chapters, Commissions, Groups, Coalitions, Agencies, and/or Entities (e.g., Board of Directors positions, committees, and/or spokesperson roles) – *List all organizations and addresses for which you have served (past and current) – including ACEP chapter Board of Directors.*

Organization: Vermont ACEP

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: ACEP Chapter

Leadership Position: Immediate Past President and Board of Directors

Term of Service:

Organization: ACEP Locums Tenens Section

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: ACEP Section

Leadership Position: Chair-Elect

Term of Service: Current

Organization: Windsor County Democratic Committee

Address: Windsor County, VT

Type of Organization: Political

Leadership Position: Vice Chair

Term of Service: 2019-20

Organization: Hartford Energy Commission

Address: 171 Bridge Street

White River Junction, VT 05001

Type of Organization: Town Commission

Leadership Position: Vice Chair

Term of Service: 2019-20

3. Describe any outside relationships with any person(s) or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, and/or a malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Do you have any family members who are non-physicians providing care to patients, including, but not limited to, nurse practitioners, physician assistants, or certified nurse specialists? Family members include a spouse, domestic partner, parent, child, sibling, grandparent, grandchild, parents, and siblings-in-law, stepparents, stepchildren, guardians, wards, or members of your household.

☒ NONE
☐ If YES, Please Describe:

6. If you answered yes to Question 5, is your family member currently or was formerly employed in an emergency department or in urgent care?

☒ N/A
☐ NO
☐ If YES, Please Describe:

7. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

8. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

9. I have read and agree to abide by the ACEP Business Arrangements policy statement.

☐ NO
☒ YES

10. I have read and agree to abide by the ACEP Conflict of Interest policy statement.

☐ NO
☒ YES

11. I have read and agree to abide by the ACEP Leadership and Volunteers Conduct policy to ensure that ACEP volunteers, consultants, and staff can perform their valuable services to ACEP free of harassment and discrimination.

☐ NO
☒ YES

I certify that the above is true and accurate to the best of my knowledge and belief: Should a possible conflict of interest arise, I recognize that I have the obligation to notify the appropriate individual(s) and to abstain from participation in any business of ACEP that may be affected from such perceived or actual conflict of interest until it is determined whether or not a conflict exists and if so how that conflict may be resolved. If any relevant changes occur in my circumstances that would be reasonably viewed as requiring disclosure, I recognize that I have an obligation to file an amended conflict of interest disclosure statement.

Alexandra Nicole Thran, MD, FACEP Date May 13, 2026

August 3, 2026

Dear Members of Council,

We write jointly, on behalf of the Vermont Chapter and the Access, Belonging, and Community Section, in strong support of Dr. Niki Thran, MD, as a candidate for the American College of Emergency Physicians (ACEP) Board of Directors. Dr. Thran exemplifies the leadership, vision, and dedication this role demands, and we are confident she would be an outstanding addition to the Board.

Dr. Thran brings over thirty years of emergency medicine experience to this nomination, including extensive work in rural and resource-limited emergency departments and service as an EMS district medical advisor. This breadth of experience would make her a particularly powerful voice for rural chapters and locum tenens physicians, constituencies often underrepresented at the national level. Her long history of advocacy within ACEP, at the local, state, and national levels, reflects both her passion for the specialty and her effectiveness as a voice for emergency medicine. Her civic engagement extends beyond medicine, as evidenced by her participation in the 2022 Democratic primary for U.S. Senate in Vermont, underscoring a deep commitment to serving the public good.

During her tenure as President of Vermont ACEP, Dr. Thran demonstrated exceptional organizational leadership. She authored numerous resolutions, grew chapter membership, and created three new subcommittees that expanded the chapter's reach. When the chapter faced a mid-term transition in executive leadership, Dr. Thran worked closely with ACEP national staff to ensure continuity and stability, demonstrating her ability to manage complexity while keeping the mission front and center.

That same follow-through has defined her work with the Access, Belonging, and Community Section, where she has served on committees and stepped up to lead a subcommittee, driving real progress on the Section's strategic goals rather than settling for good intentions.
Emergency medicine serves an enormously diverse patient population, and Dr. Thran's own background shapes how she thinks about access, about who gets left out of a conversation, and about what belonging requires in practice. That perspective isn't abstract for her; it shows up in every discussion, project, and decision she takes on.

Dr. Thran is an effective and collaborative leader who works well across differing perspectives and is known for bringing people together around shared goals. Beyond her professional accomplishments, she is warm, welcoming, and genuinely interested in the people around her. She brings sincerity and integrity to every interaction, and a calm, confident energy balanced with humility. The ability to listen, build trust, and inspire confidence across a room of strong-willed professionals is a gift, and Dr. Thran has it in abundance.

A Board of Directors is stronger when the people at the table have lived, and worked through, different versions of what it means to practice emergency medicine—and different versions of what it means to be seen, or overlooked, within it. Dr. Thran brings that lived perspective, paired with a demonstrated record of turning it into action. We offer this nomination with the fullest confidence and urge the Nominating Committee to give her candidacy the serious consideration it deserves.

Sincerely,

Matthew S. Siket, MD, MHCI, FACEP
President, Vermont Chapter
Christopher Smith, MD, FACEP
Chair, Access, Belonging, and Community Section

Alexendra Nicole (Niki) Thran, MD, FACEP

I am honored to be considered for a position on the ACEP Board of Directors, and I ask for your vote based on a career built on clinical depth, active engagement across the College, and a proven ability to bring people together around shared solutions.

Clinical Experience Across the Spectrum of Emergency Care
Over more than 30 years in emergency medicine, I have practiced as a locums physician across a wide range of settings — from large corporate systems with multiple emergency departments to small, unaffiliated critical access hospitals. I have worked in urban and rural emergency departments, under different state laws and regulatory environments, and with diverse patient populations. This breadth of experience has given me a firsthand understanding of the challenges that unite emergency physicians everywhere, regardless of practice setting: boarding and overcrowding, burnout, and the ongoing need for strong member advocacy. I do not view these issues through the lens of a single hospital system or region; I have lived them in dozens of different emergency departments, and that perspective would inform how I approach decisions at the Board level.

A Record of Active ACEP Involvement
I have served as an ACEP Councillor for many years, during which I have written and defended numerous resolutions on issues that matter to our specialty. That work has given me a deep understanding of how the College's governance functions, and how Council priorities translate into action at the Board and staff level. Beyond the Council floor, I have contributed to ACEP's work through committee service on the National/Chapter Relations Committee, the Access, Belonging and Community Committee, and the Professional Wellness Committee. I am also an active member of multiple ACEP sections, which has kept me connected to the many different communities and subspecialty interests within our College.

Leadership Built on Coalition-Building
Effective board leadership requires the ability to work across differences, and that is where I believe I can offer the most value. I get along well with colleagues from all backgrounds and practice environments, and I have a track record of building coalitions among people with divergent perspectives and priorities. I bring that same approach to public service: in 2022, I ran for United States Senate in Vermont, an experience that sharpened my ability to listen to a wide range of viewpoints, communicate clearly under pressure, and build consensus toward practical, actionable outcomes. I believe these skills translate directly to the strategic and fiduciary responsibilities of the Board, where building consensus among diverse stakeholders is essential to moving the College forward.

Why This Matters for ACEP's Future
Emergency medicine is facing significant challenges, including boarding, workforce burnout, scope of practice pressures, and the need for sustained advocacy at every level. I believe the Board is strongest when its members bring varied, ground-level clinical experience combined with deep institutional knowledge of how the College operates, and a genuine ability to bridge differences among members. My locums career has shown me the full range of what emergency physicians face day to day, and my years of ACEP committee and Council service have prepared me to bring that ground-level perspective into Board-level strategy and decision-making.

I would be honored to earn your support and serve the College in this next capacity.

VOTE

Alexandra "Niki" Thran, MD, FACEP

for ACEP Board of Directors



Immediate Past-President, Vermont Chapter of ACEP

Chair-Elect, ACEP Locums Section

ACEP Council – Vermont Councilor, 12+ years

ACEP

National Chapter Relations Committee
Access, Belonging & Community Committee
Professional Wellness Committee

ACEP Council

Vermont Councilor
Author of multiple Council Resolutions
Reference Committee Member

Civic Engagement

Candidate for U.S. Senate, Vermont (2022)

Clinical Experience

30+ years full-time in Emergency Medicine
Clinical experience in EDs across 9 states
Holds 11 state medical licenses

Priorities

Addressing boarding & overcrowding
Reducing physician burnout
Advancing ACEP's strategic goals: membership & advocacy

ENDORSED BY

ACEP Access, Belonging & Community

American College of Emergency Physicians® Vermont Chapter

EXPERIENCE · LEADERSHIP · ADVOCACY

VOTE — Address boarding & overcrowding

Reduce physician burnout

Advocate for membership & ACEP's strategic goals

Alexandra Nicole (Niki) Thran, MD, FACEP

Emergency Physician | Fellow of the American College of Emergency Physicians
Cell: 401 527 8224
Email: nikiermd@gmail.com
Address: 16 Dimetro Road, Unit 8, Warren, VT 05674

LINKEDIN linkedin.com/in/Alexandra-Nicole-Thran
Facebook facebook.com/Alexandra-Nicole-Thran
X @DrNikiThran
INSTAGRAM @nikiermd

An experienced emergency physician, I am dedicated to advancing health equity and championing the rights of individuals to make autonomous choices about their bodies. I envision a future where every person has access to quality healthcare, free from the burdens of systemic inequities and the impacts of climate change. I am committed to advocating for innovative solutions that reduce mortality and morbidity from firearm violence, ensuring a safer and healthier world for all.

PROFESSIONAL EXPERIENCE

2023 - present: Emergency Physician (Independent Contractor)

- 12/1/2025 - present: Independent Contractor, CHI St. Alexius Health, Dickinson, ND
- 9/1/2025 - 2/28/2025: Independent Contractor, CHI St. Alexius Health, Devil's Lake Hospital
- 5/1/2025 - present: Independent Contractor, North Country Hospital, Newport, VT
- 5/1/2025 - 7/30/2025: Independent Contractor, McLaren Greater Lansing, Lansing, MI
- 6/1/2024 - 5/30/2025: Independent Contractor, Springfield Hospital, Springfield, VT
- 8/1/2024 - 11/30/2024: Independent Contractor, Kimball Hospital, Putnam, CT
- 6/1/2023 - 9/30/2025: Independent Contractor, Northeastern Vermont Regional Hospital, St. Johnsbury, VT

10/1/2013 - 7/31/2023: Emergency Physician | Gifford Medical Center, Randolph, VT
Clinical Coordinator (ED Director) (2019-2020)
Co-Founder and Past Chair, Energy Committee (2018–2023)
Member of Patient Experience (2017–2023) and Diversity Committees (2020–2023)

Locum Tenens | Various locations
2011- 2013 Locum Tenens
Rutland Regional Medical Center, Rutland, VT
Brattleboro Memorial Hospital, Brattleboro, VT
Chickasaw Nation Medical Center, Ada, OK
Our Lady of Fatima Hospital, North Providence, RI
Roger Williams Medical Center, Providence, RI
2010 - 2012 Emergency Physician, Kent Hospital, Warwick, RI
2003 - 2010 Emergency Physician, The Westerly Hospital, Westerly, RI
2002 - 2003 Emergency Physician, Garden City Treatment Center, Cranston, RI
1998 - 2002 Clinical Instructor of Emergency Medicine
Emergency Physicians of Tidewater, Virginia Beach, VA
1995 - 1998 Emergency Physician, Peninsula Emergency Physicians, Hampton, VA
1994 - 1995 Emergency Physician, Riverside Regional Medical Center, Newport News, VA
1991 Emergency Physician, Hartford Hospital & University of Connecticut, Hartford, CT
Assistant Clinical Professor of Emergency Medicine and Surgery
Assistant Director of Lifestar
Flight Crew Instructor
1991 Emergency Medicine Residency, Elective
Kapi'olani Medical Center, Honolulu, HI
1988 Emergency Medicine Senior Medical School Elective
Royal Perth Hospital, Perth, Australia

EDUCATION

7/1/1989 - 6/30/1991 Emergency Medicine Residency,
University of Massachusetts
Worcester, Ma

7/1/1988 - 6/30/1989 Internship, Emergency Medicine,
University of Massachusetts
Worcester, MA

9/1/1984 - 5/13/1988 Doctor of Medicine,
Vanderbilt University School of Medicine
Nashville, TN

5/1984 Bachelor of Science in Biology
Tufts University
Medford, MA

BOARD CERTIFICATIONS AND STATE MEDICAL LICENSES

AMERICAN BOARD OF EMERGENCY MEDICINE 1992, 2001, 2011, 2021
NORTH DAKOTA MEDICAL LICENSE 2025 – PRESENT
MICHIGAN STATE MEDICAL LICENSE 2025 - PRESENT
CONNECTICUT STATE MEDICAL LICENSE 2024-PRESENT
VERMONT STATE MEDICAL LICENSE 2012-PRESENT
MASSACHUSETTS, HAWAII, VIRGINIA, DELAWARE, RHODE ISLAND (EXPIRED)

PROFESSIONAL MEMBERSHIPS

2016 - PRESENT AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP) AMERICAN ASSOCIATION OF WOMEN EMERGENCY PHYSICIANS
1992-PRESENT
2016-PRESENT

Award PROFESSIONAL INVOLVEMENT, CLINICAL GOVERNANCE, AND AWARDS

2018 - American College of Emergency Physicians (ACEP)
2021 - 2025 VT ACEP, Chapter President
- Founded EMS, Legislative, and Member Committees; increased membership.
- Reviewed and approved bylaws; established quarterly board meetings.

2025 - present, Immediate Past-President of VT ACEP Chapter
Chair-elect, ACEP Locums Sections
ACEP Access, Belonging and Community Committee, Member
ACEP Professional Wellness Committee, Member

ACEP Council Resolutions and Leadership

2025: Lead author of a resolution that advocates changes to board certification; passed
2024: Lead author of three climate change resolutions; all passed
2023: Lead author of four assault weapons resolutions; two passed
2021: Drafted and defended a national resolution advocating for weapons bans in emergency departments; passed.

Committees and Sections

2023 - present: Member, Access, Belonging and Community Section (formerly known as Diversity, Inclusion, and Health Equity Committee).
- 2024 : Member; Education Subcommittee

2020 - present: Member of various sections, including EMS, Wilderness Medicine, and International Emergency Medicine
2024 - present: Chair-Elect, Locum Tenens Section
2022: Member; Reference Committee A, summarized member testimony for council debates

ACEP Council Membership and Representation
2018 - present: Council Member representing the Vermont Chapter in voting on national policy and leadership.

Vermont Medical Society
2020 – present: Member, and met with legislators in 2024 to discuss pending bills

Other Affiliations
2024 ACEP Council Teamwork Award
2019 - 2020: Member, Wilderness Medicine Society
2018 - 2023 Vermont EMS District 8 Medical Advisor
Oversaw operations of five EMS services within District 8.
Developed and delivered a unique educational curriculum on treating transgender patients in EMS, pioneering formal education in this area.
Conducted run reviews, managed complaints, and contributed to the development of state EMS protocols.
Coordinated and assisted in Mass Casualty Incident responses.
Medical Student Preceptor | Geisel School of Medicine, Dartmouth College
Clinical teaching of medical students about Emergency Medicine, rural medicine and health

CIVIC ENGAGEMENT AND ACTIVISM
2019 Annual Vermont ACEP Advocate to the Vermont Congressional Delegation, Washington, D.C.
2022 Candidate for the United States Senate (lost to then Rep., now Sen. Welch in the Democratic Primary)
2019 present: Member, Vermont Democratic Party
2019 - 2020 Member Windsor County, VT
Vice Chair of the Windsor Democratic Party, Windsor County, VT
2019 - 2020: Town Chair of the Hartford Democrats
2019 Co-chair of the Women Making a Difference, Award Luncheon, Organizer/Committee Member
2019 - 2020: Vice Chair of the Hartford Energy Commission, Town of Hartford
2018 - 2020: Member of the Energy Commission, Town of Hartford
Ran for State Delegate for Senator Sanders, Washington County, VT
2021 Town Delegate of the Warren Democratic Committee
2020 - present: Member Mad River Democrats
2015 - 2020: Member of the Fitness Committee, Quechee Lakes Landowners Association

CONTINUOUS PROFESSIONAL DEVELOPMENT
BLS/ACLS RECERTIFICATION 2025
ATLS RECERTIFICATION 2025
PALS (expired)
MOAB 2020,2022

LECTURES & REFERENCES ON REQUEST

2026 COUNCIL AWARD RECIPIENTS

The 2026 American College of Emergency Physicians Awards Program honors leadership and excellence.

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the College's award programs.



Council Meritorious Service Award

Doug M. Char, MD, FACEP

Presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.



Council Award in Access, Belonging, & Community

Christopher L. Smith, MD, FACEP

Presented to a member who showcases sustained commitment to fostering involvement and an environment that promotes equal opportunities that directly enhance the work of the council and provides excellence to ACEP.



Council Curmudgeon Award

Gregory J. Cannon, MD, FACEP

To recognize, in a lighthearted way, deserving Council participants that have contributed to the Annual meeting in a unique, eccentric, humorous, or cleverly astute manner.

2026 COUNCIL AWARD RECIPIENTS



Council Teamwork Award

Tanisha Arora, MD, FACEP

Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.



Council Teamwork Award

Jennifer L. Savino, DO, FACEP

Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.



Council Teamwork Award

Nicole A. Veitinger, DO, FACEP

Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

2026 COUNCIL AWARD RECIPIENTS



Council Horizon Award

Jamie Kuo, MD, MHLA, FACEP

Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.



Council Horizon Award

Aaron Snyder, MD

Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.

2026 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2026 American College of Emergency Physicians Awards Program honors leadership and excellence.

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the College's award programs.



John G. Wiegenstein Leadership Award

Alexander M. Rosenau, DO, CPE, FACEP

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.



James D. Mills Outstanding Contribution to Emergency Medicine Award

Michael D. Brown, MD, MSc, FACEP

Presented to an active, life, or honorary member for significant contributions to emergency medicine. The award honors the late James D. Mills Jr., MD, second president of the College.



Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy

Todd Parker, MD, FACEP

Presented to a member who has made a significant contribution to achieving the College's health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP's Executive Director from 1982 to 2003.



Judith E. Tintinalli Award for Outstanding Contribution in Education

Christina L. Shenvi, MD, PhD, MBA, FACEP

Presented to a member who has made a significant contribution to the educational aspects of emergency medicine.

2026 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



John A. Rupke Legacy Award

Marsha D. Ford, MD, FACEP

Presented to a current College member for outstanding lifetime contributions to the College. The award honors John A. Rupke, MD, one of the initial founding members of the College.



Pamela P. Bensen Trailblazer Award

Ralph J. Riviello, MD, MS, FACEP

Presented to a current College member for seminal contributions over time to the growth of the College and to the specialty of emergency medicine. The award is named after Pamela P. Bensen, MD, a charter member of ACEP and the first woman resident in emergency medicine (1971).



Diane K. Bollman Chapter Advocate Award

Holly Dorr, MBA, CAE

Presented to a current or recent (within the past 12 months) ACEP chapter executive or chapter staff member who has made a significant contribution to advancing emergency care and the objectives of an ACEP chapter and the College. The award is named after Diane K. Bollman, who served as the executive director of the Michigan College of Emergency Physicians for 25 years and was an honorary member of ACEP.



Honorary Membership Award

Eileen M. Bulger, MD, FACS

Presented to individuals who have rendered outstanding service to the College or the medical profession.

2026 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



Honorary Membership Award

Greg Hufstetler

Presented to individuals who have rendered outstanding service to the College or the medical profession.



Council Meritorious Service Award

Douglas M. Char, MD, FACEP

Presented to a member who has made consistent contributions to the growth and maturation of the ACEP Council.



Award for Outstanding Contribution in Research

Phillip D. Levy, MD, MPH, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.



Award for Outstanding Contribution in Research

David A. Talan, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

2026 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



Award for Outstanding Contribution in EMS

Brian M. Clemency DO, MBA, FACEP, FAEMS

Presented to an individual who has made an outstanding contribution of national significanceorapplicationinEmergencyMedicalServices.Theawardisnotlimited to ACEP members.



Disaster Medical Sciences Award

Paul D. Biddinger, MD, FACEP

Presented to an individual who has made outstanding contributions of national/ international significance or impact to the field of disaster medicine.



Community Emergency Medicine Excellence Award

Betzaida Gonzales Valentin, MD, FACEP

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.



Innovative Change in Practice Management Award

Michael Yashar, MD, FACEP

Presented to an emergency physician who has developed an innovative process, solution, technology or product to solve a significant problem in the practice of emergency medicine.

ACEP HONORS 2026 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS



Innovation & Excellence in Behavioral Health & Addiction Medicine Award

Kathryn Hawk, MD, MHS, FACEP

Presented to an individual who has made a significant contribution in advancing the emergency department care of patients with behavioral health and substance use disorder.



Public Health Trailblazer Award

Pryanka Relan, MD, MPH

Presented to an individual who has made a significant contribution in advancing public health care and injury prevention measures locally, statewide, or nationally.



Leon L. Haley, Jr. Award for Excellence in Access, Belonging, and Community

Maureen A. Bell, MD, FACEP

In recognition of individuals who have significantly helped to advance diversity, inclusion, and health equity within their community, statewide, or nationally.



Lou Graff Award for Excellence in Observation Medicine

Margarita Pena, MD, FACEP

In recognition of emergency physicians who have made a significant contribution to the field of observation medicine within emergency medicine.

EM Wellness Center of Excellence Award

Mount Sinai Department of Emergency Medicine

Presented to an emergency medicine group, department, or clinical site that incorporates wellness and resilience on an institutional level and to use the information gathered in the nominations process to understand more
about wellness best practices.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

April 2026

VISION STATEMENT

ACEP envisions a future where emergency medicine physicians have an influential voice, a strong community, and fulfilling careers that advance emergency care for all.

MISSION STATEMENT

Founding Mission

ACEP exists to support quality emergency medical care and to promote the interests of emergency physicians.

Purpose Statement

Advancing emergency care as the voice, advocate, and leader for the specialty of emergency medicine and the physicians who practice it.

STRATEGIC PRIORITIES

Priority 1: Advocacy

ACEP advocates for emergency physicians and quality patient care, fighting for the specialty at every level from the workplace to Washington.

Objectives:

1. Expand and strengthen the role, approach, and impact of ACEP's federal and state level advocacy.
2. Use clinical evidence and data to engage with regulatory bodies, payers, and health systems on policies affecting emergency medicine.
3. Empower members to advocate effectively within their states, their own institutions, and in their employment relationships.
4. Evaluate the social and economic aspects of emergency medical care to inform advocacy positions and policy recommendations. (Bylaws #8)
5. Promote policy that advances universally available, cost-effective emergency medical care while preserving the integrity and independence of the practice of emergency medicine. (Bylaws #9, #10)

Priority 2: Clinical Excellence, Research & Scholarship

ACEP leads emergency medicine by setting clinical standards, recognizing excellence through accreditation, and advancing the specialty through quality programs, education, research, and scholarship.

Objectives:

1. Develop, maintain, and disseminate clinical policies and practice guidelines that establish ACEP as the authoritative source for emergency medicine standards. (Bylaws #1)
2. Expand ACEP's accreditation programs to further recognize excellence in the delivery of emergency care.
3. Lead quality improvement and patient safety initiatives that position emergency physicians at the forefront of healthcare quality.
4. Disseminate emergency medicine research and scholarship through peer-reviewed scientific journals (Annals of Emergency Medicine, JACEP Open) and collaborative initiatives with partners in emergency medicine. (Bylaws #11)
5. Partner with the Emergency Medicine Foundation to advance research in emergency medicine. (Bylaws #11)
6. Promote education in emergency care for all physicians and encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.(Bylaws #2, #4)
7. Encourage and facilitate training and education in emergency medicine for all medical students. (Bylaws #3)
8. Promote education about emergency medicine for patients and for the general public. (Bylaws #5)

Priority 3: Practice Innovation

ACEP shapes the future of emergency care by identifying emerging practice models and preparing emergency physicians to lead in evolving healthcare environments.

Objectives:

1. Identify and support the practice models for emergency physicians that expand the field of acute, unscheduled care.
2. Support the creation of innovative practice models by anticipating emerging trends in clinical and business practices.
3. Monitor and evaluate the impact of artificial intelligence, telehealth, and other emerging technologies on emergency care delivery and physician practice.
4. Develop educational and other resources to prepare emergency physicians for roles in evolving and emerging administrative, clinical, and educational settings.
5. Promote the development and coordination of quality emergency medical services and systems and encourage emergency physicians to assume leadership roles in out-of-hospital care and disaster management. (Bylaws #6, #7)

Priority 4: Career Fulfillment

ACEP confronts the issues that frustrate and impact our members and champions the well-being, professional satisfaction, and career fulfillment of emergency physicians.

Objectives:

1. Lead efforts to increase career satisfaction for all emergency physicians and improve emergency medicine workplaces.
2. Address workforce solutions to ensure emergency physicians set the course for the future of the specialty.
3. Expand wellness, peer support, and burnout prevention resources to promote the well-being, health, and resilience needs of emergency physicians.
4. Increase transparency in the emergency medicine job market by sharing data on various employment settings and developing employer accountability initiatives.
5. Proactively showcase emergency medicine as a rewarding and sustainable career to medical students and residents.

Priority 5: Member Engagement and Trust

ACEP is a trusted, strong, and inclusive community where every emergency physician feels connected, valued, and empowered to shape the specialty's future.

Objectives:

1. Build the leadership pipeline within ACEP and encourage emergency physician representation within medical organizations and academic institutions. (Bylaws #12)
2. Leverage personalization and opportunities for issue/interest-based participation to make a member's connection to ACEP more personally meaningful.
3. Re-imagine the EMRA to ACEP pathway to retain more members upon residency completion.
4. Develop recognition and rewards to redefine engagement.
5. Enhance ACEP's brand positioning and communication strategies to proactively communicate ACEP's impact and value proposition through transparent reporting and regular member touchpoints.
6. Modernize the member digital experience to improve access to resources, reduce friction, and enable selfservice.

EMF Emergency Medicine Foundation®
research → education → patient care



COUNCIL REPORT

NOW MORE THAN EVER, YOUR SUPPORT AND YOUR RESEARCH MATTERS TO THE FUTURE OF RESEARCH IN EMERGENCY MEDICINE

2026

In 2026, EMF proudly announced a new milestone of more than $22 million funded supporting more than 350 grant projects since 1972.

COUNCIL CHALLENGE IMPACT

Councillors, members and leaders more than contributed more than $200,000 to EMF. ACEP Council is the largest and longest sustaining supporter of EMF, having contributed $3 million over 30 years.

NEW 2026 GRANTS

In 2026–2027, EMF is investing more than $915,000 in innovative research, funding projects that advance pediatric emergency care, stroke detection, sepsis, respiratory support, emergency department operations, health equity and addiction treatment

UPCOMING RESEARCH PROPOSALS

EMF has released new RFPs for grant projects to begin July 2027. Visit EMF's **website** to learn more. Visit EMF's website to learn more about the grant priorities and due dates.

2026 GRANTEE WORKSHOP

The EMF/SAEMF Grantee Workshop was held in January 2026, providing EMF grantees with training and networking opportunities with that included emergency medicine research leaders.

2026–2027 EMF RESEARCH AWARDEES



Investigator Initiated Research Grant

Pradip Chaudhari, MD

Children's Hospital Los Angeles

Point-of-Care Brain Magnetic Resonance Imaging in Young Children with Head Trauma (BRAINCHILD)

$249,988 two-year grant



Early Career Research Development Grant

Daniel Shapiro, MD, MPH

University of California, San Francisco

As-needed vs. Routinely Scheduled Follow-up Trial in the Emergency Department (AFTER): Evaluating Post-discharge Care for Children with Bronchiolitis

$150,000 two-year grant



Pilot Research Grant

Layne Dylla, MD, PhD

Yale University School of Medicine

Early Stroke Identification Using Natural Language Processing of 9-1-1 Call Audio

$100,000 one-year grant



Pilot Research Grant

Sangil Lee, MD, MS

Weill Cornell Medicine

Multicenter Identification of Incident Delirium in Older Emergency Department Patients

$98,320 one-year grant



Pilot Research Grant

Kristin Rising, MD, MSHP

Thomas Jefferson University

Increasing Cervical Cancer Screening in the Emergency Department through a Shared Decision Making, Patient Preference Study

$100,000 one-year grant



Fisher & Paykel Healthcare Pre-Hospital Noninvasive Respiratory Support Grant

Gregory Peters, MD

Harvard Affiliated Emergency Medicine Residency, Massachusetts General Hospital

Prehospital Management of Respiratory Distress: Current Practices and Opportunities for Noninvasive Approaches

$99,980 one-year grant



US Acute Care Solutions Implementation Research Grant

Michael Light, MD

Rutgers New Jersey Medical School

Evaluating the Effect of Emergency Department In Situ Simulations on Sepsis Outcomes

$25,000 one-year grant



US Acute Care Solutions Implementation Research Grant

Corey Hazekamp, MD

Northwestern University, Feinberg School of Medicine

Harnessing Mixed Methods Data Collection Guided by CFIR to Identify Determinants of Alcohol Use Disorder Treatment in the Emergency Department

$24,995 one-year grant



EMF/EMRA Resident Research Grant

Maximilian Pany, MD, PhD

Massachusetts General Brigham

Examining the Impact of Hospital Mergers and Acquisitions on Emergency Department Operations, Patient Mix, and Patient Outcomes

$10,000 one-year grant



EMF/EMRA Resident Research Grant

Connor Bunch, MD

Henry Ford Hospital

The Auto-Heparinization-In-Trauma Study (A-HIT): Quantifying Endogenous Anticoagulant Activity and Endotheliopathy in Severe Injury

$10,000 one-year grant



EMF/EMRA Resident Research Grant

Kirstin Scott, MD, MPhil, PhD

University of Washington

The Impact of the No Surprises Act on Patient Financial Outcomes After Emergency Department Care

$10,000 one-year grant



EMF/EMRA Resident Research Grant

Terence Hughes, MD

Icahn School of Medicine at Mount Sinai

The Emergency Department as an Entry Point: Expanding Access to Methadone Through an Educational Toolkit

$10,000 one-year grant



EMF/SAEMF Medical Student Research Grant

Drupad Patel

University of Maryland School of Medicine

Prognostic Value of NeurOs Cerebral Oximetry (StO_2) Monitoring on 90-Day Outcomes in Post-Thrombectomy Patients: A Prospective Observational Study

$5,000 one-year grant



EMF/SAEMF Medical Student Research Grant

Daniel Guerra

Icahn School of Medicine at Mount Sinai

Predicting Risk and Investigating Outcomes Using Patient-Reported and Community-Level Social Determinants Data in Vulnerable Populations (PRIORity)

$5,000 one-year grant



EMF/SAEMF Medical Student Research Grant

Sarah Petelinsek

University of Utah

Examining the Exam: Pelvic Pain Workups in the Emergency Department

$5,000 one-year grant



EMF/SAEMF Medical Student Research Grant

Simran Bhutia

University of Maryland Baltimore

Evaluating the Sensitivity and Specificity of Shared Decisions in Long Bone Fracture Detection

$5,000 one-year grant



David E. Wilcox, MD, FACEP Medical Student Research Grant

Aaron Barrera-Alvarez

University of California, Davis

Impact of Point-of-Care Ultrasound on Emergency Department Diagnostic Workflow and Patient Disposition in Critically Ill Patients: A Retrospective Cohort Analysis at a Quaternary Academic Institution

$5,000 one-year grant

SEE THE MISSION IN ACTION AT ACEP26

EMF RESEARCH SHOWCASE

October 5, 3:00 PM
Research Forum, Room 1
See how your donor dollars are spent on practice-changing research by EMF grant recipients.

VIP RECEPTION

October 5, 6:00 PM
MAE District
Donors who give $600 and above annually celebrate EMF at MAE District to unwind and celebrate in the Windy City.

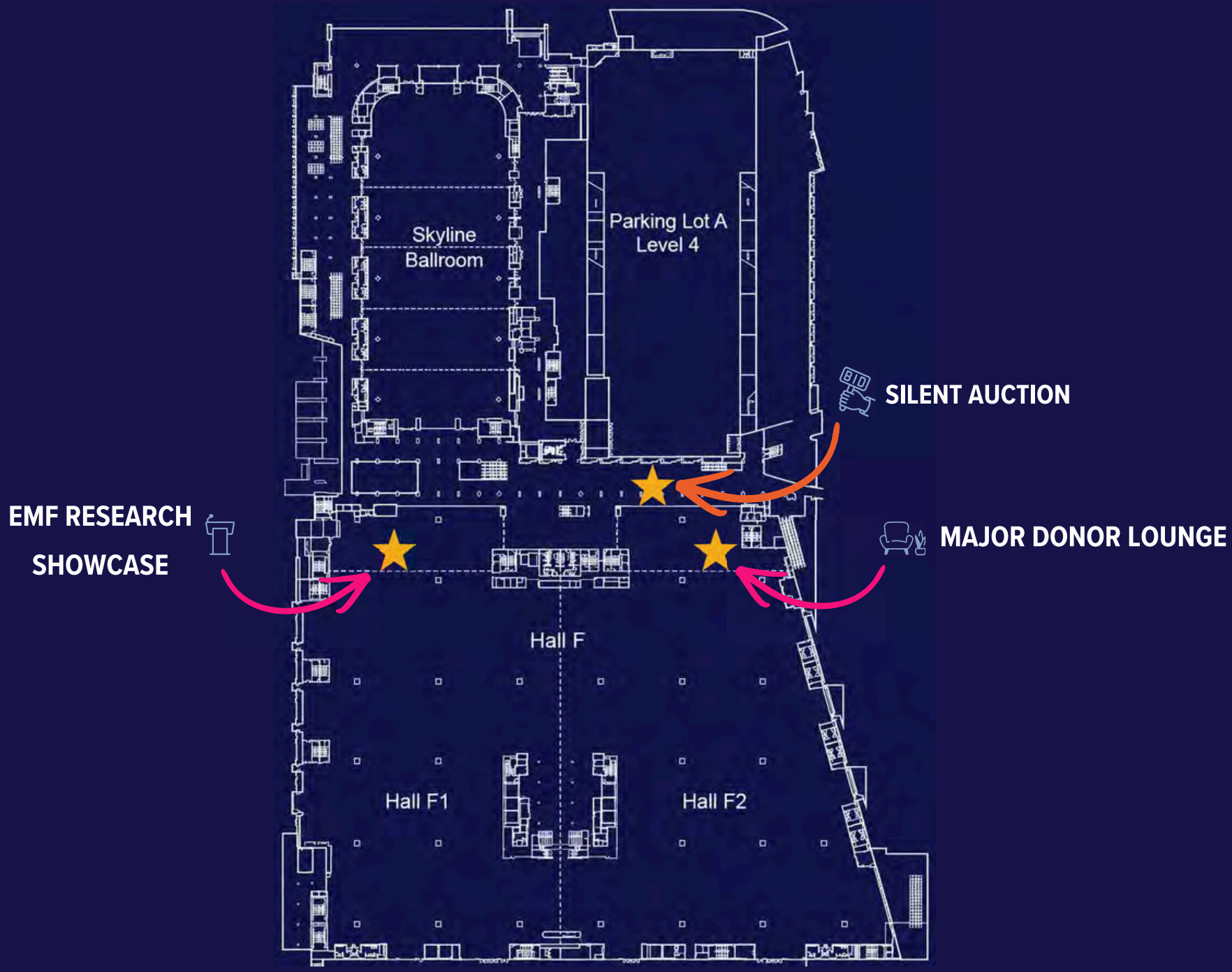
MAJOR DONOR LOUNGE

October 5-7 7:00 AM – 4:00 PM
Exhibit Hall, Convention Center
The donor lounge allows those who give $600 and above annually to relax and enjoy refreshments and breakfast each day.

SILENT AUCTION

October 5-7, 7:00 AM - 6:00 PM
Main Concourse, Convention Center
One-of-a-kind experiences, sports, music, celebrity memorabilia, art, jewelry, and more. Bid, buy, and support EMF!

ACEP26 - MCCORMICK PLACE CONVENTION CENTER - WEST



A SPECIAL THANKS TO OUR PARTNERS & SPONSORS AND LOCATIONS IN EXHIBIT HALL AT ACEP 26

CORNERSTONE PARTNERS

Teleflex™
Empowering the future of healthcare
Visit at Booth #3323

Abbott Point of Care
Visit at Booth #3425

ApolloMD
Visit at Booth #1838

INTEGRATED WEALTHCARE

VAPOTHERM®
Visit at Booth #4215

vituity®
Visit at Booth #40427

IMPACT PARTNERS

Butterfly™
Visit at Booth #2511

Cytovale
Visit at Booth #4020

Fisher & Paykel HEALTHCARE
Visit at Booth #2625

Pfizer

stryker
Visit at Booth #2926

PointClickCare®
Visit at Booth #29260

TEAMHealth®
Visit at Booth #4638

EMF Emergency Medicine Foundation®
research → education → patient care

acep Scientific Assembly CHICAGO 26

30th Annual

David E. Wilcox, MD, FACEP

ACEP Council EMF Challenge

$3 MILLION

ACEP Council has Contributed
more than $3 million in 30 years

Help Us Reach our
$200,000
Goal in 2026



Kristin Rising, MD, MSHP
2026 EMF Grantee

FUNDING RESEARCH
Supporting physician-scientists and innovative emergency medicine research

EDUCATING FUTURE LEADERS
Investing in education and training to build the next generation of EM leaders

IMPROVING PATIENT CARE
Advancing discoveries that lead to better **patient outcomes** and stronger communities

SCAN TO GIVE OR LEARN MORE
donations.emfoundation.org

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THANK YOU FOR LEADING THE WAY.

Report to the ACEP Council

The National Emergency Medicine Political Action Committee (NEMPAC)

September 2026



NEMPAC: Turning Emergency Medicine's Voice into Congressional Influence

For 46 years, NEMPAC has helped ensure that **emergency medicine has a seat at the table in Washington.** NEMPAC is the only national political action committee dedicated exclusively to advancing the bipartisan interests of emergency medicine and its patients in Congress.

In 1980, NEMPAC's founders set a goal of raising $10,000 to help influence the debate over independent contractor status for emergency physicians. **Today, the stakes—and the scale of federal policy affecting emergency medicine—are dramatically larger.**

In 2026, NEMPAC is on track to raise more than $1 million for the **tenth consecutive year**, while expanding its relationships with candidates, congressional leaders, and physician organizations across the political spectrum.

The NEMPAC story at a glance

46 YEARS representing emergency medicine in Washington
$1.7M raised in 2026 Election Cycle*
$1.48M invested in the 2026 cycle
24 physician candidates/incumbents directly supported
180 additional EM-supportive candidates
~600 candidate events attended
53.8% D / 46.2% R bipartisan giving
25+ YEARS of the Council Challenge
$250K average annual Council contributions.

**NEMPAC carried over $230,000 from the 2024 cycle*

These numbers represent more than fundraising. They represent relationships, access, and opportunities to educate Congress about emergency medicine.

Council Makes NEMPAC Possible

For more than 25 years, the **NEMPAC Council Challenge** has demonstrated the commitment of ACEP's elected leaders to political engagement.

Councilors collectively contribute approximately **$250,000 to NEMPAC each year—more than one-quarter of the PAC's annual fundraising.**

That support does more than help fund political contributions. It sends a powerful message to Congress: **emergency medicine is organized, engaged, and prepared to advocate for its patients and physicians.**

This year, NEMPAC is once again challenging the Council to reach 100% participation.

How NEMPAC Is Building Influence for the 2026 Mid-term Elections

NEMPAC's strategy is straightforward: **support the people who can advance emergency medicine, build relationships before we need them, and ensure that emergency medicine has champions on both sides of the aisle.**

In 2026, NEMPAC is:

- **Supporting bipartisan champions** who understand and advance ACEP's legislative priorities.
- **Investing in key committees**—including Ways and Means, Energy and Commerce, Finance and HELP—where decisions affecting emergency medicine are made.
- **Connecting ACEP members with Congress** through fundraisers, meet-and-greets, district events and LAC activities.
- **Building relationships with physician-focused PACs and organizations** to strengthen the physician voice in Congress.
- **Expanding opportunities for ACEP members to engage directly with candidates and elected officials.**

Nearly 600 Opportunities to Advocate for Emergency Medicine

As of September 2, ACEP staff and members have participated in **nearly 600 fundraisers and meet-and-greets** with candidates and incumbents during the 2026 election cycle.

Nearly **15% included ACEP members participating in person**, whether in their home districts, at LAC dine-arounds or through other opportunities in Washington.

And approximately **20% were hosted or co-hosted by NEMPAC** with other medical specialty organizations.

Every one of these events creates an opportunity to do something that a contribution alone cannot accomplish: **We put emergency physicians in the room and talk directly with candidates about the issues affecting our specialty and our patients.**

Strengthening the Physician Voice in Congress

NEMPAC has also expanded its partnerships with organizations working to elect physicians to Congress—on both sides of the political aisle.

- **House Call on the Mall:** NEMPAC co-hosted this event with the NRCC and physician specialty organizations, providing access to party and committee leaders and members of the GOP Doctors Caucus.
- **Democratic Doctors Caucus PAC:** NEMPAC was an inaugural donor to the newly established PAC supporting Democratic physicians running for and serving in Congress.
- **Healthcare Freedom SuperPAC:** NEMPAC is a founding/inaugural donor supporting Republican physician candidates.
- **Physician Voices United:** NEMPAC helped lead the creation and implementation of this effort supporting Democratic physician candidates, including ACEP member **Amish Shah, MD**, in Arizona.
- In 2026, joined and financially supported **Center Forward**, an organization that has been bringing policymakers, business and thought leaders, and administration officials from all sides of the political spectrum together to engage in honest and thoughtful dialogue about the most significant challenges facing our nation.

These partnerships extend NEMPAC's reach beyond individual contributions and help strengthen the overall physician presence in Congress.

How NEMPAC Selects Candidates

NEMPAC evaluates candidates and incumbents based on factors including:

- Support for ACEP's legislative and regulatory priorities
- Sponsorship and support of ACEP-backed legislation
- Congressional committee assignments and leadership positions
- Relationships with ACEP chapters, members, and leaders
- Competitiveness of the election
- The candidate's overall integrity, character, and commitment to democratic governance

NEMPAC-supported candidates are expected to demonstrate behavior consistent with **ACEP's mission, vision, and values**, including respect for science, evidence, and fact.

Support is continually reassessed throughout the election cycle as the congressional landscape and ACEP's priorities evolve.

The Bottom Line

NEMPAC's impact cannot be measured solely by the dollars contributed to candidates.

Its real value is the **relationships those dollars help create and the doors they open for emergency medicine.**

Over 46 years, NEMPAC has helped ACEP:

- Build bipartisan relationships in Congress
- Identify and develop champions for emergency medicine
- Educate new and returning members of Congress
- Put ACEP members directly in front of candidates and policymakers
- Increase the visibility and credibility of emergency medicine on Capitol Hill

And Council has been at the center of that effort for more than 25 years.

One Last Challenge for Council

NEMPAC has grown from a $10,000 fundraising goal in 1980 to raising more than $1 million annually today.

Now let's make 2026 the year Council completes the map.

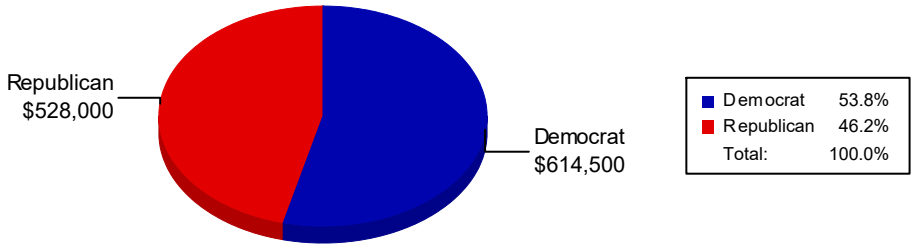
Our goal: **100% participation in the NEMPAC Council Challenge.**

Because every contribution helps ensure that when Congress makes decisions affecting emergency medicine, **our specialty is in the room.**

Federal Expenditures by Election Year By Party

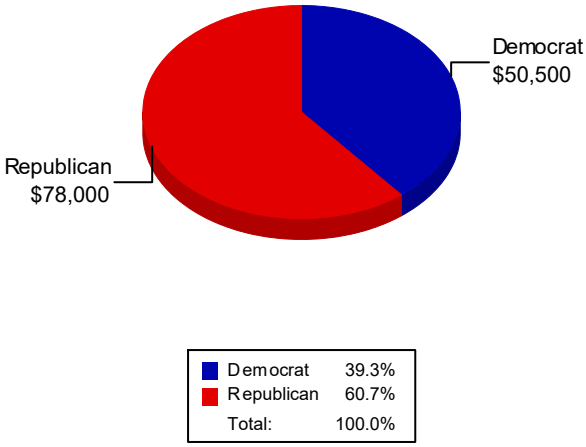
Leadership Committee Expenditures From 1/1/2025 to 9/2/2026
Candidate Committee Expenditures for election year: 2026
PAC: National Emergency Medicine Political Action Committee / American College of Emergency Physicia
Election Year: 2026

Total Expenditures by Party

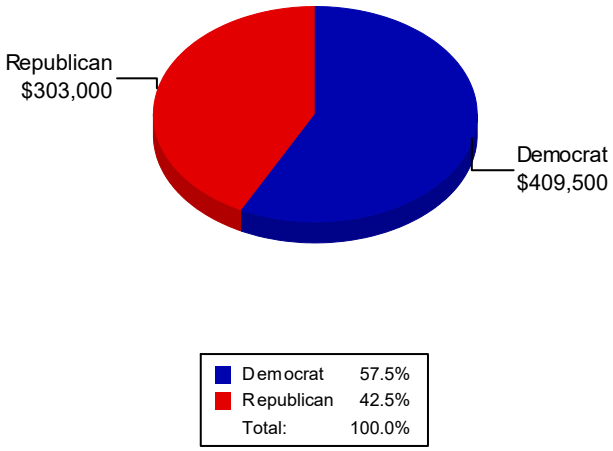


Expenditures by Chamber and Party

Federal Senate

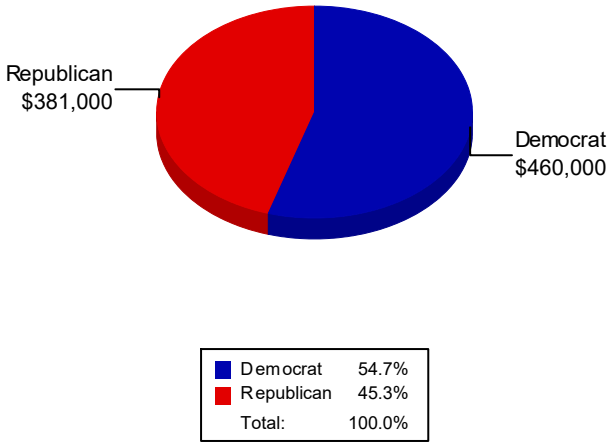


Federal House

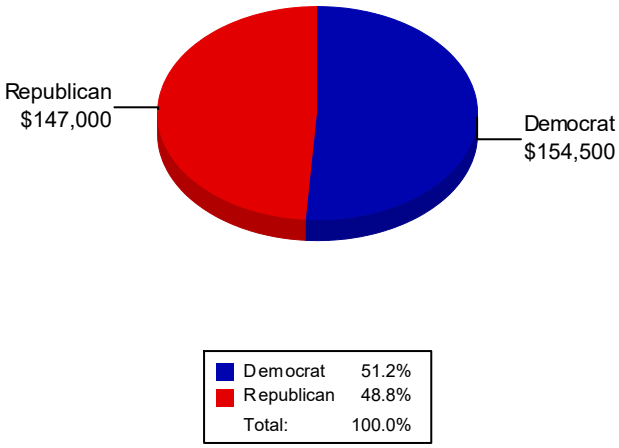


Expenditures by Committee Type and Party

Candidate Committees



Leadership Committees

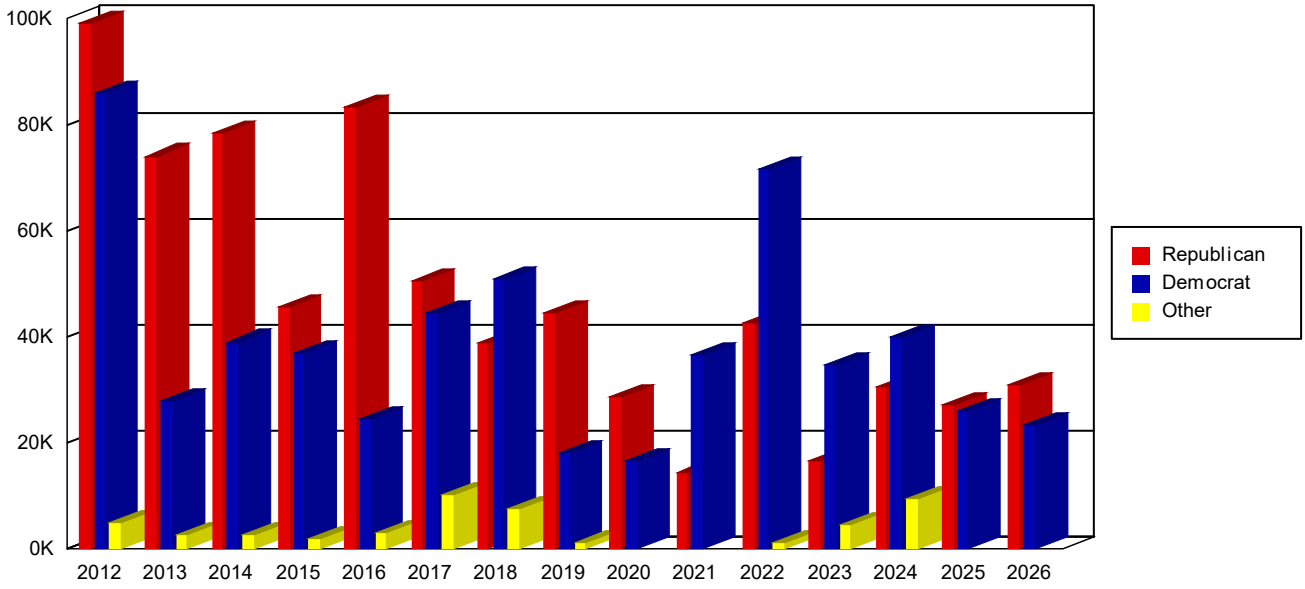


Expenditures by Chamber and Party -Trend

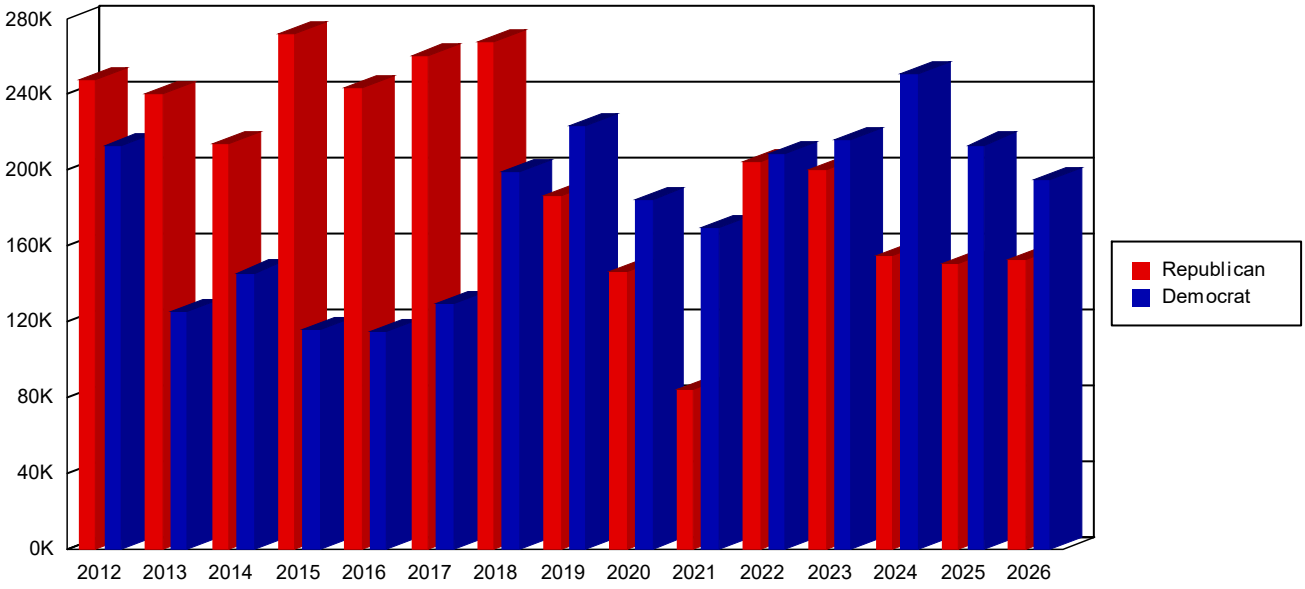
Date Range: 1/1/2012 to 9/2/2026

PAC: National Emergency Medicine Political Action Committee / American College of Emergency

Federal Senate



Federal House

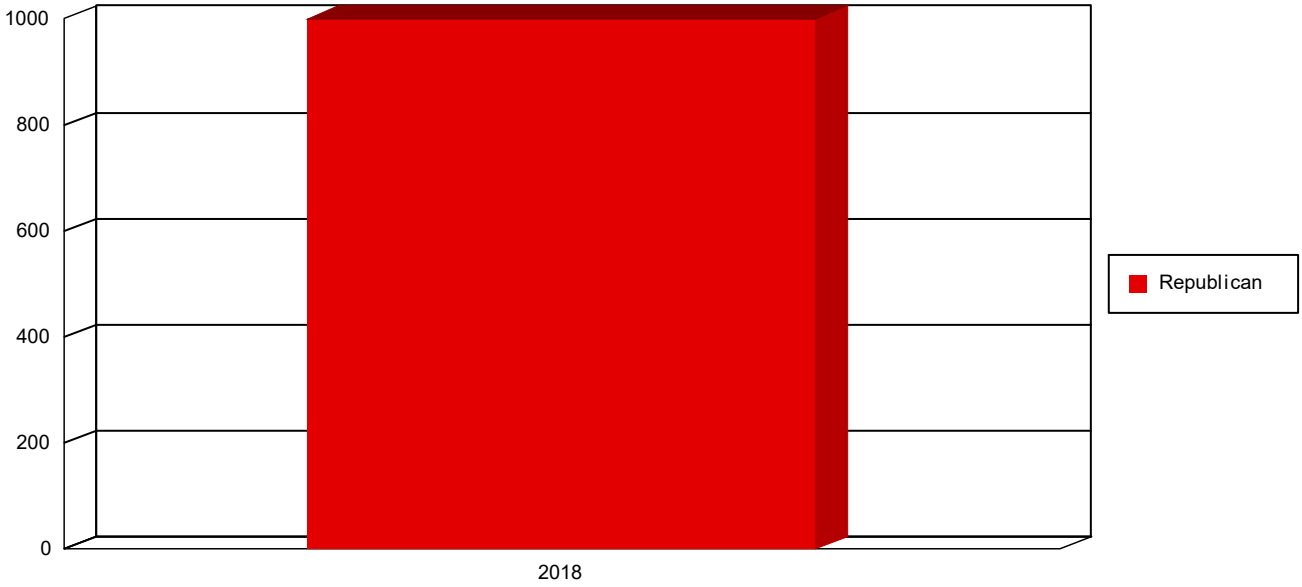


Expenditures by Chamber and Party -Trend

Date Range: 1/1/2012 to 9/2/2026

PAC: National Emergency Medicine Political Action Committee / American College of Emergency

State Senate



NEMPAC at ACEP26

"Give-a-Shift" to the Future of Emergency Medicine

Did You Know?

- Councillors are the foundation of NEMPAC – and the decisions made at Council shape NEMPAC's advocacy priorities.
- NEMPAC supports champions for emergency medicine across the political spectrum.
- NEMPAC supports congressional candidates only - not Presidential races.
- NEMPAC is among the top five medical political action committees in fundraising and candidate support.
- Since NEMPAC's inception nearly five decades ago, the Council has been challenged to reach 100% participation in NEMPAC.

The NEMPAC "Triple M"

The 2026 midterms are just a couple months away, and the future of emergency medicine and your ability to care for your patients is at stake. It is more important than ever that **NEMPAC has the resources to fight for our specialty.**

NEMPAC provides the "Triple M" critical to our advocacy success:

1. **Money** - financial support for congressional candidates and incumbents so we can build a bench of friends and champions to work with on issues such as payment, boarding, and harmful payer reimbursement practices.
2. **Mobility** - opportunities to attend hundreds of events in DC and across the country. Every contribution delivered to a candidate by ACEP members and staff is an opportunity to define and distinguish the specialty.
3. M**essaging** - unifying the voice of emergency medicine to maximize our impact.

All Councillors from Sections and Chapters that reach 100% will be recognized at the NEMPAC table during Council!

NEMPAC VIP Donor Levels

$5,000 CHAIRMAN'S CLUB | **$2,500** PLATINUM
$1,200 GIVE-A-SHIFT
$365 GIVE-A-SHIFT *(Retired physicians and physicians up to three years out of Residency)*
$120 RESIDENT, FELLOW, AND MEDICAL STUDENT GIVE-A-SHIFT

**Monthly and quarterly installment plans are available for all donor levels*



NEMPAC VIP Donor Reception

Invitation-only. This event is open to NEMPAC donors at the **$600** (attending physicians) and **$60** (residents) levels and higher.

Heavy appetizers and drinks will be served. Come enjoy rooftop views of the Windy City and network with other NEMPAC supporters and ACEP leadership!

Each Give-A-Shift donor ($1,200/attending physicians and $120/residents) is welcome to bring a non-member guest.



Sunday, 6:00 – 8:00 pm
VU Rooftop
133 E Cermak Rd
Chicago, IL 60616
Approximately ~3-minute walk from the MPCC.

Please stop by the NEMPAC table at the Council Meeting to get your wristband! This serves as your "ticket" for the event.

Give-a-Shift donors also have access to the **NEMPAC Donor Lounge** Monday – Wednesday from 8am-4pm in the MPCC, Level 3, F1/F1A/F2/F2A.

Complimentary lunch, coffee, soft drinks, and snacks will be available in the lounge, in addition to business center amenities.

How Do I Support NEMPAC?

Visit the NEMPAC table in the MPCC to give via Square, scan this QR code, or go to https://emergencyphysicianspac.org/donate!

Contributions or gifts to NEMPAC are voluntary and are not tax deductible for federal income tax purposes. The amount given or refusal to donate will not benefit or disadvantage you. By law, we may only use your contribution to support federal candidates if your contribution is made using a personal credit card or personal check. We are required to provide your employer's name, your occupation, and to obtain an original signature of the ACEP member if contributing by credit card. NEMPAC encourages personal contributions. All non-personal contributions to NEMPAC will be used to defray costs of educational programs for NEMPAC and other activities permissible under federal law.

FY26 Annual Report

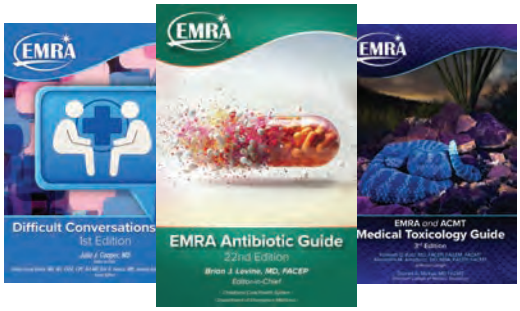
Membership: 20,669

90%+
EM residents are EMRA members

BEST *DOCTOR*

5 new/newly updated clinical resources

36 *books, reference cards, digital, and mobile resources*



295K+
downloads of EMRA*Cast episodes

16K+ *EM Resident* print distribution

EMRA Match

85K+
monthly page visits to EMRA Match

$2.5M+
Annually reinvested into EMRA members

BEST *LEADER*

116 committee leadership roles across 20 committees

33 EMRA Leadership Academy participants

25 EMRA Medical Student Council members

23 *different medical schools throughout the nation represented*

6 EMRA Health Policy Academy fellows



251
EMRAfied residency programs

BEST *SPECIALTY*

7 Drop the Mic speakers at ACEP Leadership & Advocacy Conference

32



days of targeted advocacy for the release of an EM physician detained by ICE

17 resolutions and policy initiatives by the EMRA Representative Council

10+
ongoing collaborations to strengthen EM

EMRA is the voice of emergency medicine physicians-in-training and the future of our specialty.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2026 Council

From: Abhi Mehrotra, MD, MBA, FACEP
Secretary-Treasurer

Date: September 1, 2026

Subj: Fiscal Year 2025-26 Financial Report (Unaudited)

These are preliminary financials for the year ending June 30, 2026. The report is subject to adjustment in preparation for the FY26 audit.

Key Take Aways

- The second payment from the US Treasury for $1,286,563 was received in April 2026 satisfying all outstanding ERTC claims.
- The FY25 Audit & Form 990 were completed and filed in May and June, respectively. A federal single audit was not required in 2025.
- ACEP retired all outstanding mortgage debt in April 2026 following Board approval. Funds were transferred from investments for the payoff. ACEP saved interest of $167K, net of projected investment earnings, and avoids a $1.6MM ballon payment and related costs in November 2028.
- Assets were $38.7MM at year-end, decreasing by ($3.9MM) compared to June 2025 with the largest changes in AR ($2.7MM), cash ($1.1MM) and investments ($1MM), offset by increases in prepaid expenses $1.3MM and fixed assets $300K.
- Liabilities were $18.7MM, decreasing by ($5.2MM) since June 2025, with the biggest changes to deferred revenue ($2.7MM), payroll liability ($1.1MM), mortgage payable ($1.7MM) and Chapter and PAC liabilities ($409K). Members' equity increased by $1.3MM.
- An infusion from investments of $1.5MM (previously approved by the Board to fund the AMS system) was transferred from the investments account in June 2026. The full project cost was estimated at $4.4MM over a 24 month period. The AMS implementation is now in full swing with a go-live date of April 2027.
- The Board approved the FY 2026-27 budget. The rolling cash forecast has been updated to incorporate the approved FY27 budget. Cost cutting resulted in an approved budget for FY27 that is breakeven following the FY26 deficit budget. **Looking ahead, ACEP's must focus on revenue growth and sustainability due to continued resource constraints and cost cuts over several years.**
- Net operating income for FY26 was ($1.2MM), which was ($40K), or (3%) below the budget of ($1,176,917). After inclusion of unrealized investment gains of $2.5MM, the excess revenue over expense was $1.3MM, an improvement over budget of $1.8MM.

Variance Comments

Revenue

Total revenue exceeded budget by $123K, with six of nine operating revenue channels exceeding budget.

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Membership Dues – Membership revenue at $14.7MM was ($106K) below budget and $97K higher than FY25. Membership numbers are improving, and retention and growth rate are up year-over-year.

Meetings and Events – Meetings and events revenue at $9.4K, was ($5001K) below budget, and ($967K) below FY25, all attributable to ACEP25. Impacts were chiefly due to the new location in Salt Lake City and the timing of the event just after Labor Day due to displacement from Dallas, impacting registration revenue.

Business Development, Royalites and Advertising, Product Sales, EMDI, Grants and Association Management all met and exceeded budget.

Emergency Medicine Data Institute (EMDI) Revenue – EMDI revenue at $6.6MM was $737K better than budgeted and $145K more than FY24. There were more customer dashboards and submissions implemented than budgeted.

Grants – Grant Revenue at just under $3MM exceeded budget by $234K. This is a decrease from the prior year of ($1.7MM).

Association Management – Revenue at $703K was just above budget and $542K below FY25. ACEP took over management of International Trauma Life Support in January 2026. EMRA transferred financial services to EWALD as of January 31, 2025.

Accreditation Revenue – The Accreditation Program was ($497K) below budgeted revenue due to the delayed EDAc launch but $224K better than FY25. In addition, there has been slower progress in the international space, but accreditation has been diligent in keeping expenses down.

	ACTUALS	BUDGET COMPARATIVE		PRIOR YEAR COMPARATIVE	
	FY26 06/26 YTD	FY26 06/26 YTD	Fav/(Unfav) Variance	FY25 06/25 YTD	Fav/(Unfav) Year over Year Variance
REVENUES					
Membership Dues	$ 14,669,235	$ 14,775,033	(105,798)	$ 14,571,981	$ 97,254
Meetings and Events	9,422,090	9,923,180	(501,090)	10,388,843	(966,753)
Business Development	736,070	695,000	41,070	703,515	32,555
Royalties and Advertising	2,074,540	2,018,080	56,460	2,026,634	47,906
Product Sales	1,917,658	1,764,848	152,810	1,704,421	213,237
EM Data Institute Revenue	6,637,494	5,900,000	737,494	6,492,764	144,730
Grants	2,981,986	2,748,342	233,644	4,643,235	(1,661,249)
Association Management	703,651	697,597	6,054	1,245,346	(541,695)
Accreditation Revenue	912,405	1,409,750	(497,345)	688,726	223,679
TOTAL REVENUES	40,055,129	39,931,830	123,300	42,465,465	(2,410,336)

Expenses

Total expenses at $41.3M exceeded budget by ($163K), which was less than (1%). Most expense categories were below budget except for Professional Fees, Maintenance and Software, Cost of Products Sold, Cost Reimbursements/Interdepartmental Overhead, Interest Expense and Allowance for Bad Debts.

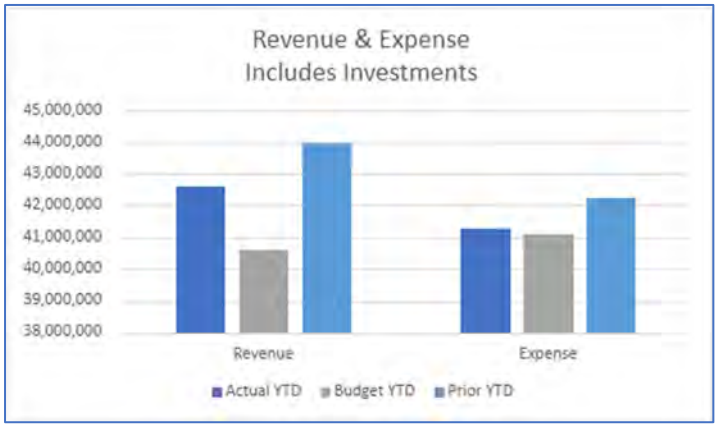
Professional Fees – Professional fees decreased by $722,000 from FY25 and were over budget by $1.2MM in FY25. This is across various areas but includes EMDI costs that are offset by additional revenue, recruitment fees budgeted in FY25, FY24 single audit costs, ACEP25, and Finance due to YPTC only being budgeted until September 2025. Legal fees are over budget by ($260K).

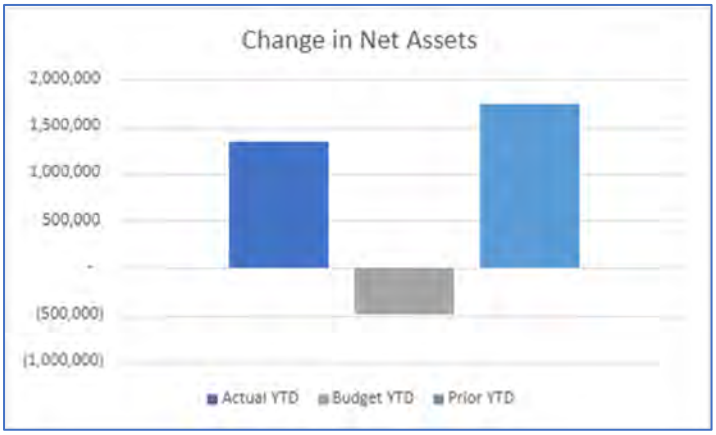
Maintenance and Software – Overbudget by ($123K) primarily due to EMDI software maintenance expenses.

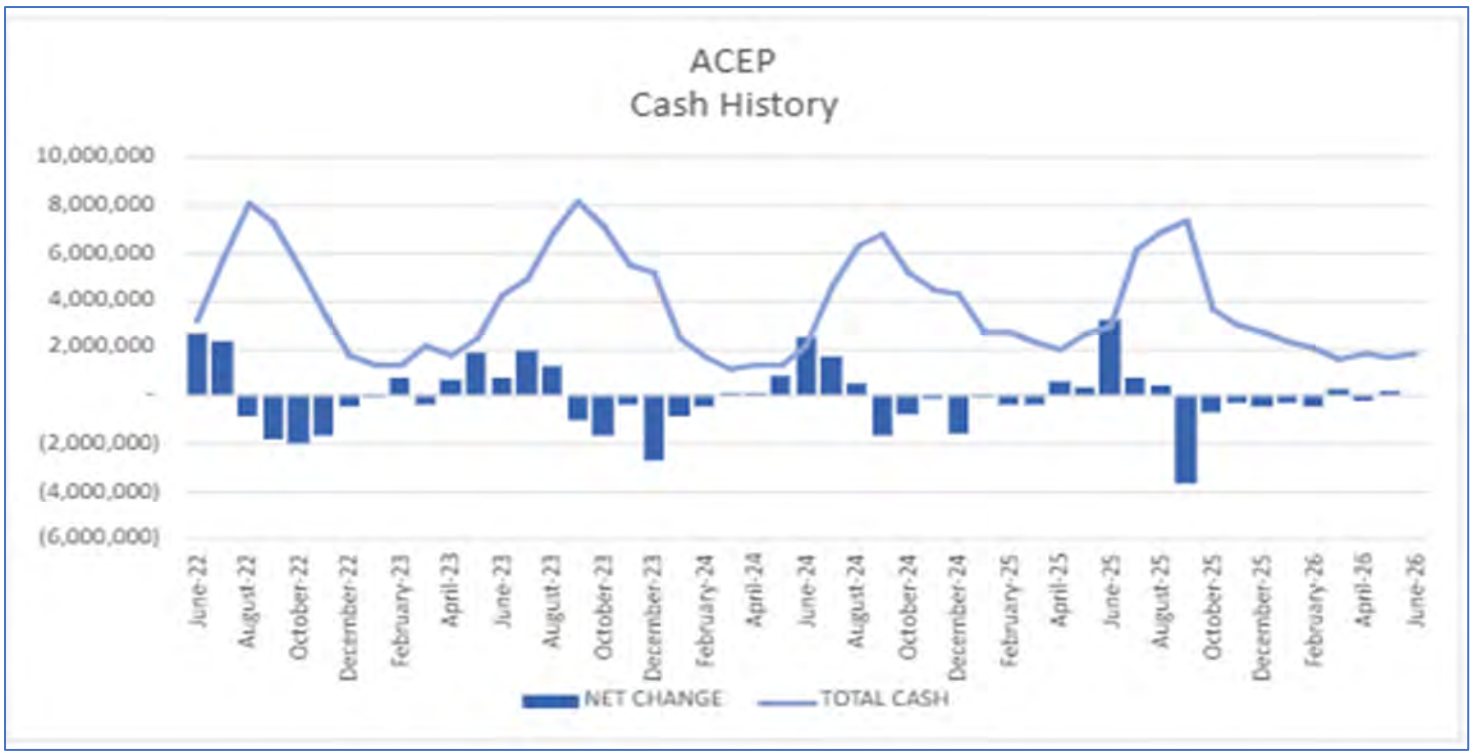
Other Expense – Cost Reimbursement/Interdepartmental Overhead are internal allocations that shift costs between departments and to grants. The allocated amount budgeted was too high. The Interest Expense category was for mortgage interest, with the variance due to a budget error. Allowance for bad debts was for uncollected receivables 12 months or more past due, and unbudgeted cost.

	ACTUALS	BUDGET COMPARATIVE		PRIOR YEAR COMPARATIVE	
	FY26 06/26 YTD	FY26 06/26 YTD	Fav/(Unfav) Variance	FY25 06/25 YTD	Fav/(Unfav) Year over Year Variance
EXPENSE					
Personnel Expense	19,564,307	19,887,766	323,460	19,638,629	74,322
Professional Fees	7,009,995	5,819,776	(1,190,219)	7,732,145	722,150
Facilities	4,667,639	4,707,210	39,572	5,524,707	857,069
Maintenance and Software	2,994,083	2,871,395	(122,688)	2,645,495	(348,588)
Supplies, Shipping and Printing	514,145	721,302	207,157	517,917	3,772
Taxes and Insurance	504,231	513,280	9,049	408,961	(95,270)
Travel	1,855,088	2,204,833	349,746	1,832,471	(22,617)
Fees	1,341,633	1,767,969	426,336	1,437,318	95,686
Stipends	1,001,542	1,120,784	119,242	1,017,958	16,416
Dues & Registration	281,589	351,298	69,709	208,068	(73,521)
Cost of Products Sold	67,579	41,766	(25,812)	123,690	56,111
Contributions and Awards	169,365	155,683	(13,682)	159,957	(9,408)
Cost Reimb. and Interdepartmental OH	(255,070)	(573,597)	(318,527)	(529,055)	(273,985)
Depreciation	1,364,445	1,479,080	114,635	1,248,362	(116,083)
Interest Expense	138,848	40,200	(98,648)	254,889	116,041
Allowance for Bad Debt	52,500	0	(52,500)	7,000	(45,500)
TOTAL EXPENSE	$41,271,918	$41,108,746	($163,172)	$42,228,511	$956,593
NET OPERATING INCOME	($1,216,789)	($1,176,917)	($39,872)	$236,954	($1,453,743)
Gain (Loss) on Investments	$2,554,742	$681,000	$1,873,742	$1,504,140	$1,050,602
NET INCOME	$1,337,952	($495,917)	$1,833,869	$1,741,094	($403,141)

Net Operating Income after inclusion of investment gains of $2.55M was $1.34MM.







July experiences strong cash increases followed by net decreases in late fall/early winter. Cash peaks in September, drops to a low by March or April and stays in the valley until upward momentum begins in early July.