American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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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DEFINITION OF COUNCIL ACTIONS

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 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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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* *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* *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
49	Ensuring Transparency and Accountability in Emergency Department Staffing Proposals *Oregon Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
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*	

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®
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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®
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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®
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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.

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American College of Emergency Physicians®
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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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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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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.

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: 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.

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: 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

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

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

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

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

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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
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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: 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.

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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: 21(26)

SUBMITTED BY: Tim Boardman, MD, FACEP
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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.

Background Information Prepared by: George Solomon, MHS, CAE, FAEMS
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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

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)

SUBMITTED BY: Marc Futernick, MD. FACEP
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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.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Director, EM Clinical Practice and Innovation

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: 23(26)

SUBMITTED BY: 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

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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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

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American College of Emergency Physicians®
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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
Managing Director, Advocacy and Government Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
Speaker

Larisa M. Traill, MD, FACEP
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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."

Background Information Prepared by: Adam Krushinskie
Senior Director, State Legislative & Reimbursement

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: 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
Senior Director, State Legislative & Reimbursement

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: 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
Congressional Lobbyist

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.

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: 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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Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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

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: 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.

Resolution References

1. Ibrahim WH. Recent advances and controversies in adult cardiopulmonary resuscitation. *Postgrad Med J*. Oct 2007;83(984):649-54. doi:10.1136/pgmj.2007.057133
2. American Heart Association. CPR Facts and Stats. Accessed May 1, 2026. https://cpr.heart.org/en/resources/cpr-facts-and-stats
3. Kauvar DS, Lefering R, Wade CE. Impact of hemorrhage on trauma outcome: an overview of epidemiology, clinical presentations, and therapeutic considerations. *J Trauma*. Jun 2006;60(6 Suppl):S3-11. doi:10.1097/01.ta.0000199961.02677.19
4. Levy MJ, Krohmer J, Goralnick E, et al. A framework for the design and implementation of Stop the Bleed and public access trauma equipment programs. *J Am Coll Emerg Physicians Open*. Oct 2022;3(5):e12833. doi:10.1002/emp2.12833
5. Jones AR, Miller J, Brown M. Epidemiology of Trauma-Related Hemorrhage and Time to Definitive Care Across North America: Making the Case for Bleeding Control Education. *Prehosp Disaster Med*. Dec 2023;38(6):780-783. doi:10.1017/S1049023X23006428
6. American College of Surgeons. ACS Stop the Bleed. Accessed May 1, 2026. https://www.stopthebleed.org/
7. Chain of Survival. American Heart Association. Accessed May 1, 2026. https://cpr.heart.org/en/resources/cpr-facts-and-stats/chain-of-survival
8. Good Samaritan Law, §604A.01 Minnesota Statute (2025). https://www.revisor.mn.gov/statutes/cite/604a.01
9. Law Enforcement Officer Acting Within Scope of Office or Employment, 28 U.S.C. § 2671 note United States Code (1998). https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title28-section2671&num=0&edition=prelim
10. Delivery of Health Care by Good Samaritans, H-130.937 American Medical Association (2024). https://policysearch.ama-assn.org/policyfinder/detail/good%20Samaritan?uri=%2FAMADoc%2FHOD.xml-0-237.xml

11. Heffernan S, Meagher T. How ICE and Border Patrol Keep Injuring and Killing People. The Marshall Project. Jan 26, 2026. Accessed May 1, 2026. https://www.themarshallproject.org/2026/01/26/ice-minneapolis-shooting-alex-pretti
12. Barnett S, Nelson S. Fact check: Video, witnesses contradict claims of federal officials in Pretti shooting. *The Minnesota Star Tribune*. Jan 25, 2026. Accessed May 1, 2026. https://www.startribune.com/fact-check-federal-officials-claims-about-fatal-minneapolis-shooting/601570444
13. Devine C, Bordeaux T, Chapman I, Tolan C, Abou-Ghazala Y. Videos and witness statements shed new light on moments leading up to Alex Pretti shooting. *CNN*. Jan 25, 2026. Accessed May 1, 2026. https://www.cnn.com/2026/01/25/us/alex-pretti-shooting-minneapolis-videos-witnesses-invs

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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Reviewed by: Michael J. McCrea, MD, FACEP
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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.

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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®
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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
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Council Secretary and Executive Director

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American College of Emergency Physicians®
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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

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: 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

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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
General Counsel

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

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

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: 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

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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®
ADVANCING EMERGENCY CARE

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

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: 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
Director, EM Clinical Practice and Innovation

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®
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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

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: 44(26)

SUBMITTED BY: 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

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.

Resolution References

1. Emergency Contraception. Nursing for Women's Health. 2012 Oct-Nov;16(5):435-7. doi:10.1111/j.1751-486X.2012.01770.x.
2. When Prevention Is an Emergency: The Imperative of Contraception Initiation in the Emergency Department. Cline L, Downey K, Rashid Y, Vora N, Fine L. The Journal of Emergency Medicine. 2026;85:177-182. doi:10.1016/j.jemermed.2026.02.038.
3. Unintended Pregnancy Risk in an Emergency Department Population. Todd CS, Mountvarner G, Lichenstein R. Contraception. 2005;71(1):35-9. doi:10.1016/j.contraception.2004.08.005.
4. Contraception Use and Pregnancy Risk Among Adolescents in Pediatric Emergency Departments. Canter H, Reed J, Palmer C, et al. JAMA Network Open. 2024;7(6):e2418213. doi:10.1001/jamanetworkopen.2024.18213.
5. Acceptability of Contraceptive Services in the Emergency Department: A Cross-Sectional Survey. Alexander AB, Chernoby K, VanderVinne N, et al. The Western Journal of Emergency Medicine. 2021;22(3):769-774. doi:10.5811/westjem.2021.2.49675.
6. "ContraceptED": A Multidisciplinary Framework for Emergency Department-Initiated Contraception. Liang AC, Sanders NS, Anderson ES, et al. Annals of Emergency Medicine. 2023;81(5):630-636. doi:10.1016/j.annemergmed.2023.01.002.
7. The Evolving Role of Emergency Medicine in Family Planning Services. Preiksaitis C, Henkel A. Current Opinion in Obstetrics & Gynecology. 2023;35(6):484-489. doi:10.1097/GCO.0000000000000908.
8. Practice Bulletin Summary No. 152: Emergency Contraception. Committee on Practice Bulletins—Gynecology. Obstetrics and Gynecology. 2015;126(3):685-686. doi:10.1097/01.AOG.0000471179.25809.d8.
9. Emergency Contraception. Upadhya KK, COMMITTEE ON ADOLESCENCE. Pediatrics. 2019;144(6):e20193149. doi:10.1542/peds.2019-3149.
10. Women With Suicidal Ideation, Substance Use Disorder, or Intimate Partner Violence in the Emergency Department: Retrospective Analysis of Contraceptive Documentation. Ruch A, Henderson A, Rynarzewska AI, Singh H, Jones L. The Western Journal of Emergency Medicine. 2025;27(1):67-77. doi:10.5811/westjem.48357.
11. Reproductive Health Disparities: A focus on family planning and prevention among minority women and adolescents. Haider S, Stoffel C, Donenberg G, Geller S. The Global Advances in Integrative Medicine and Health. 2013;2(5):94-9. doi: 10.7453/gahmj.2013.056.
12. Reproductive Well-Being: A Framework for Expanding Contraceptive Access Axelson SM, Sealy GA, McDonald-Mosley RE. The American Journal of Public Health. 2022; 112(S5):S504-S507. doi: 10.2105/AJPH.2022.306898.
13. Use of Family Planning and Related Medical Services Among Women Aged 15-44 in the United States: National Survey of Family Growth, 2006-2010. Martinex GM, Chandra A, Febo Vazquez I, Mosher WD. *National Health Statistics Reports.* 2013;(68):1-18.
14. Pregnancy Trends in the United States. Guttmacher Institute. 2025. Accessed June 19, 2026.
15. Racial/Ethnic Differences in Unintended Pregnancy: Evidence From a National Sample of US Women Kim TY, Dagher RK, Chen J. American Journal of Preventative Medicine. 2016 Apr;50(4):427-435. doi: 10.1016/j.amepre.2015.09.027.
16. Emergency Department Visit Rates by Selected Characteristics: United States, 2022 Cairns C, Ashman JJ, Kang K. NCHS Data Brief. 2024 Aug;(503):10.15620/cdc/159284. doi: 10.15620/cdc/159284.Associations of Unintended Pregnancy With Maternal and Infant Health Outcomes: A Systematic Review and Meta-analysis. Nelson HD, Darney BG, Ahrens K, Burgess A, Jungbauer RM, Cantor A, Atchison C, Eden KB, Goueth R, Fu R. JAMA. 2022 Nov 1;328(17):1714-1729. doi: 10.1001/jama.2022.19097.

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
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: 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.

Resolution References

1. Benson LS, Magnusson SL, Gray KE, Quinley K, Kessler L, Callegari LS. Early pregnancy loss in the emergency department, 2006-2016. J Am Coll Emerg Physicians Open. 2021 Nov 5;2(6):e12549. doi: 10.1002/emp2.12549. PMID: 34766105.
2. Benson LS, Gunaje N, Holt SK, Gore JL, Dalton VK. Outcomes After Early Pregnancy Loss Management With Mifepristone Plus Misoprostol vs Misoprostol Alone. *JAM A Netw Open*. 2024;7(10):e2435906. doi:10.1001/jamanetworkopen.2024.35906
3. Torre A, Huchon C, Bussieres L, Machevin E, Camus E, Fauconnier A. Immediate versus delayed medical treatment for first-trimester miscarriage: a randomized trial. *Am J Obstet Gynecol*. 2012;206(3):215.e1-6. doi:10.1016/j.ajog.2011.12.009
4. Cline L, Sandfeld E, Brunkal H, et al. Medication Management of Early Pregnancy Loss in an Urban Texas Emergency Department. *Academic Emergency Medicine*. 2026;33(4):e70293. doi:10.1111/acem.70293
5. Schreiber, Courtney A., et al. "Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss." New England Journal of Medicine, vol. 378, no. 23, June 2018, pp. 2161–70. DOI.org (Crossref), https://doi.org/10.1056/NEJMoa1715726.
6. ACOG Practice Bulletin No. 200: Early Pregnancy Loss. *Obstetrics & Gynecology*. 2018;132(5):e197-e207. doi:10.1097/AOG.0000000000002899
7. Lantos, ED, et al. "URGENT, EMERGENT, OR JUST MISSED? GEOPOLITICAL VARIATIONS IN THE MANAGEMENT OF EARLY PREGNANCY LOSS IN US EMERGENCY DEPARTMENTS." Contraception, vol. 139, Nov. 2024, https://doi.org/10.1016/j.contraception.2024.110626.

8. Lantos, E, et al. “Is a Miscarriage an Emergency? A Qualitative Study Assessing Emergency Medicine Physicians ’Views toward Appropriate Care for Early Pregnancy Loss in the Emergency Department.” Contraception, vol. 139, Nov. 2024, p. 110627. DOI.org (Crossref), https://doi.org/10.1016/j.contraception.2024.110627.
9. Yun, Peter Sangeyup, and Monica Saxena. “Caught Unprepared: The Urgent Need for Reproductive Health Training in Emergency Medicine.” Western Journal of Emergency Medicine, vol. 26, no. 3, Mar. 2025. DOI.org (Crossref), https://doi.org/10.5811/WESTJEM.42064.
10. Baird S, Gagnon MD, deFiebre G, Briglia E, Crowder R, Prine L. Women’s experiences with early pregnancy loss in the emergency room: A qualitative study. *Sex Reprod Healthc*. 2018;16:113-117. doi:10.1016/j.srhc.2018.03.001
11. Larivière-Bastien D, deMontigny F, Verdon C. Women’s Experiences of Miscarriage in the Emergency Department. *J Emerg Nurs*. 2019;45(6):670-676. doi:10.1016/j.jen.2019.06.008
12. Miller CA, Roe AH, McAllister A, Meisel ZF, Koelper N, Schreiber CA. Patient Experiences With Miscarriage Management in the Emergency and Ambulatory Settings. *Obstet Gynecol*. 2019;134(6):1285-1292. doi:10.1097/AOG.0000000000003571
13. Tancioco V, Pancholi R, Schechter-Perkins E, Drainoni ML, White K. Emergency department staff perspectives on caring for patients experiencing early pregnancy loss (Boston, Massachusetts 2021). *Contraception*. 2023;125:110091. doi:10.1016/j.contraception.2023.110091
14. Benson LS, Holt SK, Gore JL, et al. Early Pregnancy Loss Management in the Emergency Department vs Outpatient Setting. *JAMA Netw Open*. 2023;6(3):e232639. doi:10.1001/jamanetworkopen.2023.2639
15. Stoneburner A, Lucas R, Fontenot J, Brigance C, Jones E, DeMaria AL. *Nowhere to Go: Maternity Care Deserts Across the US. (Report No 4).* March of Dimes; 2024. Accessed June 30, 2025. 2024. https://www.marchofdimes.org/maternity-care-deserts-report
16. Rodriguez MI, Fuerst M, Schrote K. Management of Spontaneous Abortion Among Commercially Insured Individuals in the United States After Dobbs v Jackson. *JAMA*. Published online May 18, 2026:e266344. doi:10.1001/jama.2026.6344
17. Preiksaitis C, Saxena M, Henkel A. The Impact of Changing Abortion Legislation on Emergency Medicine Residents in a State With Protected Abortion Rights. *Journal of Graduate Medical Education*. 2024;16(4):445-452. doi:10.4300/JGME-D-23-00891.1
18. Fine, L. From Confusion to Confidence: A Medicolegal Education Initiative for Emergency Physicians Managing Early Pregnancy Complications. Poster presentation. *Second Annual TAMU Women’s Health Symposium*. Bryan, TX. April 24, 2026.

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."

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

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: 46(26)

SUBMITTED BY:
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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
3. Hahn SA, Promes SB, Brown MD. Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy. *Ann Emerg Med.* 2017;69(2):241–250.e20. DOI: 10.1016/j.annemergmed.2016.11.002
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.

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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

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®
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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

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: 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.

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

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."

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: 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

1. "Enforcement Actions in or near Protected Areas | Homeland Security." U.S. Department of Homeland Security, 2024, www.dhs.gov/publication/enforcement-actions-or-near-protected-areas.
2. Friedman AS, Venkataramani AS. Chilling Effects: US Immigration Enforcement And Health Care Seeking Among Hispanic Adults. Health Aff (Millwood). 2021 Jul;40(7):1056-1065. doi: 10.1377/hlthaff.2020.02356.
3. Shin H, Baatz M, Butts L, Brugère E, Zapata A, Douglas M. In Trauma Bay, Surgeons Can Protect Patient Rights during Active Criminal Investigations. American College of Surgeons Bulletin. September 10, 2025. Available from: https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2025/september-2025-volume-110-issue-8/in-trauma-bay-surgeons-can-protect-patient-rights-during-active-criminal-investigations/
4. Palter J, Roy C, Aceves J, Moore P. 298 Interactions With Immigration Officers in the Emergency Department: A Needs Assessment Survey. *Annals of Emergency Medicine*. 2018;72(4):S117. doi:10.1016/j.annemergmed.2018.08.303
5. Pillai, D. (2026, January 22). *Health care providers warn of impacts of increased ICE presence at health care facilities*. Kaiser Family Foundation. https://www.kff.org/quick-take/health-care-providers-warn-of-impacts-of-increased-ice-presence-at-health-care-facilities/
6. Understanding the Effects of Law Enforcement Presence in the Emergency Department. *American College of Emergency Physicians Policy Statement*. September 2024. https://www.acep.org/patient-care/policy-statements/understanding-the-effects-of-law-enforcement-presence-in-the-emergency-department
7. The Role of Emergency Physicians in Medical Screening of Patients Brought in by Law Enforcement. *American College of Emergency Physicians Policy Statement*. June 2026. https://www.acep.org/patient-care/policy-statements/the-role-of-emergency-physicians-in-medical-screening-of-patients-brought-in-by-law-enforcement
8. Law Enforcement Presence in the Emergency Department: A Toolkit by the State Legislative & Regulatory Committee Developed in Collaboration with the Diversity, Equity, & Inclusion Committee. Accessed March 4, 2026. https://www.acep.org/state-advocacy/state-advocacy-overview/law-enforcement-toolkit

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.

Background Information Prepared by: Jonathan Fisher, MD, FACEP
Associate Executive Director, Clinical Affairs

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: 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
Director, EM Clinical Practice and Innovation

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: 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

Joya Coffman, MS, CHES, ASQ-CQIA
Senior Manager, Accreditation Programs

Reviewed by: Michael J. McCrea, 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: 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
Associate Executive Director, Clinical Affairs

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®
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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
Associate Executive Director, Clinical Affairs

Reviewed by: Michael J. McCrea, MD, FACEP
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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: 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®
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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

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®
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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.

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®
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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.

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

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.

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

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.