2009 Council Resolution 1: Commendation for Brian F. Keaton, MD, FACEP

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Ohio Chapter ACEP

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

The Council adopted Resolution 1(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 1(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was presented to Dr. Keaton.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 2: In Memory of Carla'nne Dukes, DO, MBA, FACEP, FACOEP

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Michigan College of Emergency Physicians

WHEREAS, Carla'nne Dukes, DO, MBA, FACEP, FACOEP, a long-time member of the American College of Emergency Physicians and the Michigan College of Emergency Physicians (MCEP), succumbed to complications of breast cancer in November of 2007, just short of her 53rd birthday; and

WHEREAS, Dr. Dukes was board certified in Emergency Medicine by both the American Board of Emergency Medicine and the American Osteopathic Board of Emergency Medicine and was a fellow of both ACEP and ACOEP; and

WHEREAS, Dr. Dukes was the founding Residency Director of the Emergency Medicine Residency program at St. Joseph Mercy Hospital, Macomb (now named Henry Ford Macomb Hospital), an institution where she had practiced continually since l990; and

WHEREAS, Dr. Dukes was active with the American Heart Association for over 25 years as a State officer in ECC and ACLS plus teaching dozens of courses as both a course director and ACLS instructor, many on behalf of the Michigan Chapter; and

WHEREAS, Dr. Dukes was one of the first PALS instructors in the State of Michigan, serving as faculty for both APLS courses and PALS courses for nearly 18 years, including courses in India; and

WHEREAS, Dr. Dukes' volunteer activities were well known in the local community, at the state level via the organ donation program "Gift of Life," and extended to medical and educational missionary work at Native American Hospitals in the U.S. as well as overseas in Tanzania; and

WHEREAS, Dr. Dukes was a founding member of the ACEP Pediatric Emergency Medicine Section, past member of the MCEP Board of Directors, and served as a Councillor/Alternate Councillor for MCEP, many of those years at the side of her husband of 30 years, Stephen Knazik, DO, FACEP, who was also a MCEP Board member and Councillor; and

WHEREAS, Dr. Dukes received many awards for service including Service Physician of the Year in 2002 from the Michigan State Medical Society, the Gift of Life Professional Service Award, and the MCEP Outstanding Service Award in 2007; and

WHEREAS, Dr. Dukes was a woman for all seasons for whom a listing of accomplishments is insufficient to reach an understanding of the depth of her commitment to humanity; therefore be it

RESOLVED, That the American College of Emergency Physicians extends heartfelt condolences to the family, colleagues, and friends of Carla'nne Dukes, DO, MBA, FACEP, FACOEP, and acknowledges with gratitude her personal and professional accomplishments and that she is missed by those whose lives she touched.

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

The Council adopted Resolution 2(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 2(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was presented to Dr. Dukes' family.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 3: In Memory of John William “Bill” Jermyn III, DO, FACEP

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Missouri College of Emergency Physicians
Emergency Medical Services-Prehospital Care Section

WHEREAS, Bill Jermyn, DO, FACEP, was an active and contributing member in both the Missouri Chapter of ACEP (MoACEP) and a national leader within the American College of Emergency Physicians until his untimely death on May 15, 2008 in Jefferson City, Missouri; and

WHEREAS, Dr. Jermyn was an Assistant Professor of Clinical Surgery at the University of Missouri, Columbia; an Attending Physician for the Emergency Physicians of Mid-Missouri; and at the time of his death an Instructor in the Division of Emergency Medicine at Washington University School of Medicine, Barnes-Jewish Hospital in St. Louis; and

WHEREAS, Dr. Bill Jermyn served since 2005 as Director of Emergency Medical Services for the Missouri Department of Health and Senior Services after being appointed to this position by the Governor of Missouri; and a few days following his death, Missouri House Bill 1790, a bill he helped create, was passed on the last day of the legislative session. This bill encourages the establishment of a coordinated emergency services system for victims of stroke and acute myocardial infarction in Missouri; and

WHEREAS, Dr. Bill Jermyn was a vital member of ACEP serving as Immediate Past Chair of both the ACEP EMS Committee and the EMS-Prehospital Care Section; a member of the ACEP Awards Committee and Disaster Preparedness Committee; Disaster Preparedness leader on the ACEP Report Card Task Force; and as a Missouri councillor for many years; and

WHEREAS, Dr. Bill Jermyn also served on the Trauma Care/Injury Prevention Committee and the Council Steering Committee, served three terms as the ACEP representative to the Board of Directors for the Commission on Accreditation for Ambulance Services, and co-chaired the National Association of EMS Physicians/ACEP Task Force for Out-of-Hospital Specialty Board Certification; and

WHEREAS, Dr. Bill Jermyn was past president and a member of the Board of Directors of MoCEP, served as Chair of the Missouri State Advisory Council on EMS, member of the EMS Gathering of Eagles Coalition, active member of the American Medical Association, National Association of EMS Physicians, Missouri Association of Osteopathic Physicians and Surgeons, and the Missouri EMS Association; and

WHEREAS, Dr. Bill Jermyn selflessly touched the lives of countless others as a teacher, role model, mentor, friend, and leader working tirelessly with stakeholders in the EMS community to create a seamless emergency medical system for the citizens of Missouri; and

WHEREAS, Dr. Bill Jermyn will be remembered by all those who knew him for his dedication, passion, and commitment to ACEP and MoCEP, as well as the advancement of both Emergency Medicine and Emergency Medical Services; and

WHEREAS, Dr. Bill Jermyn is survived by the love of his life Melinda Ligon, to whom he was to be married on July 19, 2008, his mother Patricia Reese Jermyn; and his sister Deborah Paulson; and

WHEREAS, Dr. Bill Jermyn will be warmly remembered for being a nurturing compassionate friend to many and truly missed by all who knew him; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honor all contributions made by Bill Jermyn, DO, FACEP, as one of the great leaders and mentors in Emergency Medicine; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Dr. Bill Jermyn our deepest sympathy, our great sense of sadness and loss, and our gratitude for having been able to share a part of this remarkable man's life.

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

Council adopted Resolution 3(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 3(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was presented to Dr. Jermyn's family.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 4: In Memory of Neill Oster, MD

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Florida College of Emergency Physicians
New York Chapter ACEP
Disaster Medicine Section

WHEREAS, Neill Oster, MD, was an active and contributing member in both the New York Chapter of ACEP and in the Section of Disaster Medicine since 1993 until his untimely death in July 2008; and

WHEREAS, Dr. Oster selflessly gave of himself to others as a teacher, role model, and leader with a passion for emergency medicine and disaster medicine in the United States and internationally in places such as Israel, the United Arab Emirates, Japan, and Singapore; and

WHEREAS, Dr. Oster believed that one person could make a difference in Disaster Hospital Preparedness and in improving this country's response to disasters and terrorism; and

WHEREAS, Dr. Oster lived his convictions through teaching, writing, lecturing, and showing the way by developing the "Hospital Emergency Analysis Tool" (HEAT) improving hospital and community disaster and terrorism response "one hospital and community at a time," which became the basis for ACEP's grant from the Department of Homeland Security (DHS), "Community Healthcare Disaster Preparedness Assessment, "assessing preparedness in as many as 18 cities and Guam, for which he served as the grant's Medical Director; and

WHEREAS, Dr. Oster contributed not only to ACEP through his participation in the Section of Disaster Medicine, rising to serve as chair (1999-2001), as well as councillor and alternate councillor for many years, but also worked with DHS, the U.S. Department of the Navy, served as Medical Advisor to the U. S. Department of State Antiterrorism Assistance Program, Bureau of Diplomatic Security, and his corporation "Emergency Preparedness Initiatives" while continuing to work as an emergency physician and teach residents, nurses, firefighters, EMS, and law enforcement personnel; and

WHEREAS, Dr. Oster contributed much to the metro New York City's disaster and emergency preparedness through his work on the Mayor's task force and teaching and providing leadership within his own hospital communities, Beth Israel Hospital/Elmhurst Hospital Center in Queens, where he served as academic faculty, as well as academic appointments at New York Methodist Hospital Emergency Medicine Residency Program, Mt. Sinai School of Medicine, and New York Cornell School of Medicine; and

WHEREAS, Dr. Oster will be remembered by all for his dedication, passion, and commitment to emergency and disaster medicine and to improving hospital and community disaster preparedness "one hospital and community at a time"; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the contributions made by Neill Oster, MD, in the pursuit of improving patient, emergency, and disaster medical care for all; and be it further

RESOLVED, That ACEP, the Section of Disaster Medicine, and the New York Chapter of ACEP thanks his

daughter Faith, his fiancé Jean, his father Harry, and his sister Rhonda for sharing that most precious gift of time that he spent with all of us, his colleagues, in making this a safer and better world. One person did make a difference and that was Neill Oster, MD.

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

The Council adopted Resolution 4(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 4(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was presented to Dr. Oster's family.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 5: “Active” Medical Practice – Housekeeping Bylaws Amendment

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Bylaws Committee
ACEP Board of Directors

Purpose:

Deletes the unnecessary term “active’ from the phrase “active medical practice” in the chapter membership qualifications.

Fiscal Impact:

None beyond staff time to update the Bylaws document.

WHEREAS, In Article VI – Chapters, Section 3 – Qualifications, the words “active medical practice” appear in two separate instances; and

WHEREAS, The word “active” is redundant, holds no definition within the Bylaws, and should be deleted for clarity; therefore be it

RESOLVED, That the ACEP Bylaws, Article VI – Chapters, Section 3 – Qualifications, be amended to read:

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

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

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

Background:

The Bylaws Committee has the responsibility to ensure the integrity and clarity of the ACEP Bylaws. The term “active” in this context is redundant and serves no purpose. The recommended change is housekeeping and is intended to clarify these two sentences in the Bylaws. Also, deletion of the term brings this section into

conformity with the usage in Article IV – Membership, Section 2.4 – Life Member.

Stragegic Plan Reference:

None

Prior Council Action:

None

Prior Board Action:

None

Council Action:

Reference Committee A recommended that Resolution 5(08) be adopted.

RESOLVED, That the ACEP Bylaws, Article VI – Chapters, Section 3 – Qualifications, be amended to read:

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

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

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

The Council adopted Resolution 5(08) on October 26, 2008.

Testimony:

Testimony was unanimously in favor of Resolution 5.

Board Action:

The Board adopted Resolution 5(08) on October 30, 2008.

RESOLVED, That the ACEP Bylaws, Article VI – Chapters, Section 3 – Qualifications, be amended to read:

"The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter's jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to

a new chapter, dues for the new chapter shall not be required until the member's next anniversary date.

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

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

References:

Implementation Action:

The Bylaws were updated.

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 6: Authorizing the College Manual in the Bylaws – Bylaws Amendment

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Bylaws Committee
ACEP Board of Directors

Purpose:

Authorizes the College Manual in the Bylaws.

Fiscal Impact:

None beyond staff time to update the Bylaws document.

WHEREAS, The College Manual as it currently exists is referred to in the Bylaws, but is not specifically authorized in the Bylaws; and

WHEREAS, The College Manual is a handbook of guidelines that serve to guide the operations of the College that do not rise to the level of importance of the Bylaws and is meant to be more easily revised than the Bylaws; and

WHEREAS, The amendment process to the College Manual, currently described within the College Manual, is better delineated in the Bylaws; therefore be it

RESOLVED, That the ACEP Bylaws, Article XIV—Miscellaneous, be amended by the addition of a new Section 4 – College Manual, to read:

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

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

Background:

The resolution authorizes the College Manual in the Bylaws. Although the Bylaws refer to the College Manual (Article IV – Membership, Section 3 – Agreement and Section 5 – Disciplinary Action; Article VI – Chapters, Section 1 – Charters; Article VIII – Council, Section 2 – Powers of the Council; and Article XII – Ethics), there is no specific "enabling" section within the Bylaws authorizing the College Manual as a College governing document. This Bylaws amendment resolution provides such authorization. It also includes language describing the process for amending the College Manual, which has been removed from the College Manual in Resolution 7 (08) Amending the College Manual..

Stragegic Plan Reference:

None

Prior Council Action:

Resolution 5(99) *College Manual* adopted. The resolution established the *College Manual* and defined the method for amending it.

Prior Board Action:

June 2008, approved submitting Resolution 6(08) to the 2008 Council.

October 1999, Resolution 5(99) *College Manual* adopted.

Council Action:

Reference Committee A recommended that Resolution 6(08) be adopted.

RESOLVED, That the ACEP Bylaws, Article XIV—Miscellaneous, be amended by the addition of a new Section 4 – College Manual, to read:

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

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

The Council adopted Resolution 6(08) on October 26, 2008.

Testimony:

Testimony was unanimously in favor of Resolution 6.

Board Action:

The Board adopted Resolution 6(08) on October 30, 2008.

RESOLVED, That the ACEP Bylaws, Article XIV—Miscellaneous, be amended by the addition of a new Section 4 – College Manual, to read:

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

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

References:

Implementation Action:

The Bylaws were updated.

Background Information Prepared by: Sonja R Montgomery, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 7: Amending the College Manual – College Manual Amendment

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Bylaws Committee
ACEP Board of Directors

Purpose:

Deletes Section VII – Amendments of the College Manual as redundant if the companion Bylaws resolution authorizing the College Manual is adopted by the Council and the Board.

Fiscal Impact:

None beyond staff time to update the College Manual document.

WHEREAS, The College Manual contains a Section VII – Amendments; and

WHEREAS, The College Manual is a handbook of guidelines that serve to guide certain operations of the College, but is itself subject to the Bylaws; and

WHEREAS, A companion resolution proposes to amend the Bylaws to include an authorization for the College Manual as a governing document of the College and includes the amendment process that is currently in the College Manual, making them redundant; therefore be it

RESOLVED, That the College Manual, Section VII – Amendments, be deleted:

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

~~The Bylaws of the College takes precedence over any provision of the College Manual. Amendment of the College Manual may not bring it into conflict with the Bylaws.~~

Background:

This resolution is a companion to the Bylaws amendment, Resolution 6(08) Authorizing the College Manual in the Bylaws, that codifies the College Manual as a governing document of the College. If Resolution 6(08) is adopted, Section VII of the College Manual, which describes the amendment process for the College Manual, becomes superfluous. Additionally, this resolution eliminates the unnecessary verbiage regarding the precedence of the Bylaws over any provision of the College Manual.

Stragegic Plan Reference:

None

Prior Council Action:

Resolution 5(99) *College Manual* adopted. The resolution established the *College Manual* and defined the method for amending it.

Prior Board Action:

June 2008, approved submitting Resolution 7(08) to the 2008 Council.

October 1999, Resolution 5(99) *College Manual* adopted.

Council Action:

Reference Committee A recommended that Amended Resolution 7(08) be adopted.

RESOLVED, That the College Manual, Section VII – Amendments, be ~~deleted~~ **amended to read**:

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

~~The Bylaws of the College takes precedence over any provision of the College Manual. Amendment of the College Manual may not bring it into conflict with the Bylaws.~~

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

The Council adopted Amended Resolution 7(08) on October 26, 2008.

Testimony:

There was no dissenting testimony regarding Resolution 7.

Board Action:

The Board adopted Amended Resolution 7(08) on October 30, 2008.

RESOLVED, That the College Manual, Section VII – Amendments, be amended to read:

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

References:

Implementation Action:

The College Manual was updated.

Background Information Prepared by: Sonja R Montgomery, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 8: Councillor Class of Membership – Housekeeping Bylaws Amendment

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Bylaws Committee
ACEP Board of Directors
Council Steering Committee

Purpose:

Clarify the councillor class of membership, especially regarding chapters.

Fiscal Impact:

None beyond staff time to update the Bylaws document.

WHEREAS, In recent years the College Bylaws have been amended such that the Council elects the President-Elect of the College in addition to electing the members of the Board of Directors and the Council Officers; and

WHEREAS, Portions of the Bylaws have not been amended to reflect this additional responsibility of the Council; and

WHEREAS, The Model Chapter Bylaws specifies that "Member classifications and privileges in the chapter shall be those designated by the College in its Bylaws." (Article III, Section of the Model Chapter Bylaws); and

WHEREAS, The Bylaws specifies a councillor class of membership in Article IV – Membership, Section 2 – Classes of Membership; and

WHEREAS, Reasonable persons can differ in their opinion as to whether the rights and privileges of the councillor class extend beyond their applicability at the College level to the chapter level; therefore be it

RESOLVED, That the ACEP Bylaws, Article IV – Membership, Section 2.7 – Councillor Members, be amended to read:

"Councillors shall be elected or appointed from active, honorary, life, or candidate physician members. A councillor shall retain all rights and obligations of the class of membership from which the councillor was duly elected or appointed. A councillor may acquire the rights and obligations of a class of membership other than the one from which the councillor was duly elected or appointed, if the councillor satisfactorily documents qualifications for such new class of membership.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the **College** Bylaws, amendment or restatement or repeal of the **College** Articles of Incorporation, and election of **the Council Officers, the President-Elect, and of** members to the **College** Board of Directors are vested exclusively in the councillor class and are specifically denied to all other classes of membership. **These rights are not applicable at the chapter level unless specifically permitted in a chapter's bylaws**."

Background:

This housekeeping Bylaws amendment clarifies the councillor class of membership, especially regarding chapters. The ACEP Bylaws Article XI – Committees, Section 6 – Bylaws Committee, directs the Bylaws Committee to review chapter bylaws. During a review of the Arizona Chapter bylaws, a member questioned the Model Chapter Bylaws requirement that "Member classifications and privileges in the Chapter shall be those designated by the College in its Bylaws" and the implication that chapters must have a councillor class of membership at the chapter level. Councillors are specified as a class of membership in the ACEP Bylaws Article IV – Membership, Section 2 – Classes of Membership: "…Additionally, a member may concurrently belong to the *councillor class...*" (emphasis added). The Model Chapter Bylaws derives its authority from the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws, paragraph 1: "…Chartered chapters must ensure that their bylaws conform to the format of the "Model Chapter Bylaws." During its review of the matter, the ACEP Bylaws Committee identified revisions to address this and other issues as noted in the Whereas clauses.

Stragegic Plan Reference:

None

Prior Council Action:

Resolution 7(95) Councillor Members adopted. This housekeeping resolution clarified that councillors should be physician members from the active, life, candidate, or honorary membership categories.

Prior Board Action:

June 2008, approved submitting Resolution 8(08) to the 2008 Council.

September 1995, Resolution 7(95) Councillor Members adopted.

July 25, 1990, councillor class of membership approved in compliance with the proxy vote of the membership.

Council Action:

Reference Committee A recommended that Resolution 8(08) be adopted.

RESOLVED, That the ACEP Bylaws, Article IV – Membership, Section 2.7 – Councillor Members, be amended to read:

"Councillors shall be elected or appointed from active, honorary, life, or candidate physician members. A councillor shall retain all rights and obligations of the class of membership from which the councillor was duly elected or appointed. A councillor may acquire the rights and obligations of a class of membership other than the one from which the councillor was duly elected or appointed, if the councillor satisfactorily documents qualifications for such new class of membership.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the **College** Bylaws, amendment or restatement or repeal of the **College** Articles of Incorporation, and election of **the Council Officers, the President-Elect, and of** members to the **College** Board of Directors are vested exclusively in the councillor class and are specifically denied to all other classes of membership. **These rights are not applicable at the chapter level unless specifically permitted in a chapter's bylaws.**"

The Council adopted Resolution 8(08) on October 26, 2008.

Testimony:

Testimony was unanimously in favor of Resolution 8.

Board Action:

The Board adopted Resolution 8(08) on October 30, 2008.

RESOLVED, That the ACEP Bylaws, Article IV – Membership, Section 2.7 – Councillor Members, be amended to read:

"Councillors shall be elected or appointed from active, honorary, life, or candidate physician members. A councillor shall retain all rights and obligations of the class of membership from which the councillor was duly elected or appointed. A councillor may acquire the rights and obligations of a class of membership other than the one from which the councillor was duly elected or appointed, if the councillor satisfactorily documents qualifications for such new class of membership.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the College Bylaws, amendment or restatement or repeal of the College Articles of Incorporation, and election of the Council Officers, the President-Elect, and of members to the College Board of Directors are vested exclusively in the councillor class and are specifically denied to all other classes of membership. These rights are not applicable at the chapter level unless specifically permitted in a chapter's bylaws."

References:

Implementation Action:

The Bylaws were updated.

Background Information Prepared by: Sonja R Montgomery, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 9: Fellowship – Bylaws Amendment

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Georgia College of Emergency Physicians

Purpose:

Creates a sunset date for Amended Resolution 11(07) Fellowship closing the date for "legacy" fellowship applications and confirmation.

Fiscal Impact:

None

WHEREAS, The American College of Emergency Physicians amended the fellowship process at the 2007 Council meeting (subsequently approved by the Board); and

WHEREAS, The eligibility criteria for this subset of fellow applicants limits the process to those eligible for membership at the close of business on December 31, 1999; and

WHEREAS, The College has received a large number of applicants, processed and approved many of those applicants for fellowship; and

WHEREAS, There have been unintended consequences to the opening of this pathway toward fellowship; and

WHEREAS, There is a significant concern that the process will continue for many years unless there is a date at which further applications under this pathway will be deemed past due; therefore be it

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

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

1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.

1. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
2. Satisfaction of at least three of the following individual criteria during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;

ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
iv. active involvement in emergency medicine administration or departmental affairs;
v. active involvement in an emergency medical services system;
vi. research in emergency medicine;
vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

3. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. **Candidate must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010.** Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:
4. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
5. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
    iv. active involvement in emergency medicine administration or departmental affairs;
    v. active involvement in an emergency medical services system;
    vi. research in emergency medicine;
    vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
    viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
    ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
    x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

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

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

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

Background:

This Bylaws amendment creates a sunset date for Amended Resolution 11(07) Fellowship specifying December 31, 2009, as the last date upon which applications may be received and December 31, 2010, as the final date of approval or disapproval. As indicated in the Whereas statements, the authors have submitted this resolution in response to unintended consequences of opening this pathway toward fellowship and the significant concern

expressed by some members that the process will continue for many years unless there is a date at which further applications under this pathway will be deemed past due.

Note: The remaining background information for this resolution contains similar information to that written for the other fellowship resolutions submitted to the 2008 Council.

Current requirements are listed in the Bylaws excerpt listed above. Below is a table which summarizes the differences between the two current options for fellow status.

Option 1

Option 2

Board Certification

3 years of active involvement in emergency medicine

Ten years of involvement in emergency medicine

Active member for three continuous years

Active member for six continuous years

Eligible for membership prior to 1/1/2000 (this is a member requirement)

Letter of recommendation by two fellows or chapter

Satisfaction of 3 (min) individual criteria

Satisfaction of 3 (min) individual criteria of which one must be active involvement in ACEP chapter activities attested by chapter president or member of national committee, ACEP Council or national Board of Directors

The 2007 Bylaws amendment also omitted the previous requirement of continuous board certification to retain fellow status.

The attached report summarizes a survey of medical specialty societies completed in June 2008 by the Membership Directors Section of the Council of Medical Special Societies. The survey purpose was to determine whether or not board certification was required by medical specialty societies for membership (as opposed to fellow status). It should be noted that fellow is a membership category with associated privileges for most medical specialty societies. Although board certification is not required for membership in many of these organizations, survey results indicates that board certification is generally required for fellow membership. An alternate survey by the same group completed two years ago indicates that most medical specialty societies require board certification within their specific medical specialty; however, several accept board certification in alternate medical specialties. This previous survey also indicates that, of the four medical specialty societies that have fellow status as a distinction (including ACEP), two require board certification and two do not.

At the end of August 2008, there were 19,204 members in the active and life categories of membership. Approximately 3,700 of these are within the first three years of active membership and not yet eligible for fellow status. 15,011 members (including an estimated 2000 in their first three year of active membership) are currently board certified in emergency medicine by ABEM, AOBEM or ABP in Pediatric Emergency Medicine. There are also 240 members who were at one time board certified by one of these groups but are no longer diplomates. 9,937 of those eligible have chosen to become fellows of the College. There are approximately 1,160 active and life members who may currently be eligible for fellow status through the alternate pathway. This count is based solely on years of membership for those members who are not board certified. As of August 2008, 209 applications have been received using the alternate pathway. 127 have been approved, 62 have been declined and 20 are pending approval.

To date, seven members have cancelled citing the new requirements for board certification as their reason for resigning membership. In addition, two residency programs that previously paid for their residents' member dues have opted not to pay (total residents affected by this decision is 66.)

Stragegic Plan Reference:

None

Prior Council Action:

Amended Resolution 11(07) Fellowship adopted. This resolution created an additional pathway to fellowship, removed the requirement for recertification after election as a fellow, and deleted sections of the Bylaws that became moot upon adoption of the proposed changes.

Resolution 24(05) Fellowship and Its Implications adopted. The resolution directed that a task force be established to study the political, economic, and personal implications of opening ACEP fellowship to all active members of the College and provide a report to the Board and the Council.

Resolution 15(04) Simplification of Requirements to Retain Fellow Status defeated. Called for a Bylaws amendment simplifying the requirements for fellow status by allowing those members who are elected to fellow status to maintain their status whether or not they remain diplomates of their respective Boards as long as they maintain membership in ACEP.

Resolution 1(03) Fellow Reapplication adopted. It called for a Bylaws amendment omitting the requirement that fellows must reapply for fellow status when they recertify with their respective Boards.

Resolution 4(03) ACEP Members with Disabilities adopted. It called for a Bylaws amendment establishing of a mechanism for a member who has attained fellow status within the College to maintain their fellow status indefinitely in the event that member is permanently disabled.

Resolution 1(00) Membership Requirement for Fellowship defeated. Called for a Bylaws amendment eliminating restrictions in the fellow criteria that keep new active members from applying for fellow status until after their third year in the active category of membership.

Resolution 1(99) Fellowship – AOBEM and ABP adopted. It called for a Bylaws amendment allowing board certification by the American Board of Osteopathic Emergency Medicine to be acceptable criteria for fellow status in ACEP.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted. It called for the recognition of the American Board of Osteopathic Emergency Medicine as an emergency medicine certifying body.

Amended Resolution 35(95) Fellow Status Extension adopted. Allowed the Board to grant an extension of fellow status for a period of up to one year past their certification expiration date for fellows who for reasons of illness or other significant personal obstacles are unable to take the board examination.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted. It called for a Bylaws amendment expanding fellowship criteria to include the subspecialty certification in pediatric emergency medicine by either the American Board of Pediatrics or the American Board of Emergency Medicine.

Substitute Resolution 31(94) Fellow Status adopted. It called for the College to establish fellow status eligibility for ACEP members certified in the joint ABEM/AAP subspecialty certification of pediatric emergency medicine.

Resolution 28(94) Fellow Status defeated. It called for a Bylaws amendment expanding fellowship criteria to include BCEM certification.

Resolution 5(92) Fellowship Status adopted. It called for a Bylaws amendment omitting the requirement that candidates for fellow status submit letters from two fellows of the College and allowed the Board of Directors to define the documentation required from a candidate.

Amended Resolution 6(90) Fellow Status adopted. It called for refinement of the requirements for fellow status

including the addition of the requirement for active involvement in emergency medicine as the physician's chief professional activity exclusive of training.

Amended Resolution 7(90) Life Fellow adopted. It called for a Bylaws amendment creating the Life Fellow status.

Resolution 8(89) Fellowship Requirements adopted. It called for the implementation of a notice period of three years before the requirements for fellow status adopted in 1988 took affect.

Resolution 4(89) Fellow Requirements adopted. Instructed the College to review fellow criteria and revise old criteria or add new criteria as deemed appropriate and to report to the 1990 Council.

Amended Resolution 11(88) Fellowship Requirements adopted in lieu of resolutions 10(88) and 12(88). Called for a Bylaws amendment modifying fellow requirements to make them more stringent.

Resolution 6(87) Fellowship Requirements postponed to the 1988 Council meeting. Called for a Bylaws amendment tightening the requirements for fellow status.

Resolution 54(86) Fellow Status adopted. Directed the Board of Directors to augment the qualifications for fellow status and report to the 1987 Council.

Resolution 6(84) Fellow Status postponed to the 1985 Council meeting. Called for additional professional criteria for fellow status eligibility.

Amended Resolution 4(81) Fellow Status adopted. Called for a Bylaws amendment establishing fellow criteria.

Substitute Resolution 17(80) Fellow Status postponed to the 1981 Council meeting. Called for the establishment of criteria for fellow status.

Substitute Resolution 7(74) adopted. It directed the Board of Directors to establish a category of membership to be called fellow and establish its qualifications and requirements.

Prior Board Action:

Amended Resolution 11(07) Fellowship adopted.

Resolution 24(05) Fellowship and Its Implications adopted.

Resolution 1(03) Fellow Reapplication adopted.

Resolution 4(03) ACEP Members with Disabilities adopted.

March 2000 adopted a motion that former fellows who desire to regain membership have their ACEP fellow status immediately reinstated upon initiation of their new membership in ACEP, provided that the new membership in ACEP, provided that their board certification and previous fellow status is current.

Resolution 1(99) Fellowship – AOBEM and ABP adopted.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted the first resolved and contested the second resolve.

Amended Resolution 35(95) Fellow Status Extension adopted.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted.

Substitute Resolution 31(94) Fellow Status adopted and asked the Bylaws Committee to provide language for the 1995 Council.

March 1993 adopted a change to the deadline for reapplication for fellow status to May one of each year and allowed for members to reapply for fellow status as they recertify with ABEM.

January 1993 adopted a change to the deadline for new fellow applications to December 15.

Resolution 5(92) Fellowship Status adopted.

January 1992 adopted key elements of the process for handling recertification of fellows.

Endorsed Amended Resolution 7(90) Fellow Status. The Board did not adopt Bylaws amendments prior to 1993.

Endorsed Amended Resolution 6(90). The Board did not adopt Bylaws amendments prior to 1993.

Council Action:

Reference Committee A recommended that Resolution 9(08) be adopted.

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

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

1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.
2. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
3. Satisfaction of at least three of the following individual criteria during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
    iv. active involvement in emergency medicine administration or departmental affairs;
    v. active involvement in an emergency medical services system;
    vi. research in emergency medicine;
    vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
    viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
    ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
    x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.
4. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. **Candidate must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010.** Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:
5. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
6. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical

students, out-of-hospital care personnel, or the public;
iv. active involvement in emergency medicine administration or departmental affairs;
v. active involvement in an emergency medical services system;
vi. research in emergency medicine;
vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

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

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

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

The Council adopted Resolution 9(08) on October 26, 2008.

Testimony:

The Reference Committee received a significant amount of written testimony opposing Resolution 9. The majority of testimony given during the Reference Committee hearing was in favor of Resolution 9.

Those opposed to Resolution 9 testified that last year's resolution, which created an alternate path to Fellow status, increased participation at the chapter level and promoted unity in the specialty. They also testified that Fellow status is a membership recognition and not an academic credential. Testimony also included commentary that there is a built-in deadline based on membership criteria and the number of "legacy" physicians is limited.

Many in favor of Resolution 9 stated they understood the intent of 11(07) was to recognize members who devoted time and energy to developing the College and the specialty. They testified that these intended recipients have already met the qualifications and will have sufficient time to receive the Fellow recognition if Resolution 9 is adopted. Others in favor of the resolution testified that active involvement in a specialty association should be an inherent aspect of membership and not be undertaken for the sole purpose of receiving the FACEP distinction. Testimony was provided that Fellow status typically implies board certification in other specialties.

Board Action:

The Board adopted Resolution 9(08) on October 30, 2008.

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

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

1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.
2. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;

3. Satisfaction of at least three of the following individual criteria during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
    iv. active involvement in emergency medicine administration or departmental affairs;
    v. active involvement in an emergency medical services system;
    vi. research in emergency medicine;
    vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
    viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
    ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
    x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.
4. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. Candidate must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:
5. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
6. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
    iv. active involvement in emergency medicine administration or departmental affairs;
    v. active involvement in an emergency medical services system;
    vi. research in emergency medicine;
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    viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
    ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
    x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

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

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

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

References:

Implementation Action:

The Bylaws were updated.

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 10: Fellowship Criteria

Council Action: **NOT ADOPTED**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians

Purpose:

Appoint a task force to study modification and implementation of revised fellowship criteria and provide recommendations to the 2009 Council.

Fiscal Impact:

Task force activities relating to conference calls and staffing would be allocated from the committee budget.

WHEREAS, ACEP changed criteria in 2007 for election to fellowship status to no longer require ABEM/AOBEM certification in an effort to honor legacy emergency physicians; and

WHEREAS, This has been misinterpreted by some as devaluing the achievement of fellowship status; and

WHEREAS, There are some who consider current fellowship criteria to be overly inclusive, which may further devalue the achievement of fellowship status; and

WHEREAS, ACEP has matured to the point in which achievement of fellowship status could be limited to those individuals who have provided considerable service to the college and/or advancement of the specialty, rather than any merit badge status or recognition of board certification; and

WHEREAS, Modification of fellowship criteria is a complex process and cannot be adequately achieved on the council floor; therefore be it

RESOLVED, That ACEP appoint a task force to study modification and implementation of revised fellowship criteria that honor true service to the College and/or advancement of the specialty, and be it further

RESOLVED, That the recommendations of the task force be discussed as Council business at the 2009 Council meeting.

Background:

This resolution asks that a task force be appointed to study modification and implementation of revised fellowship criteria and that the recommendations of the task force be presented to the 2009 Council. The authors suggest that the issue is complex and that complete discussion and analysis of fellow status cannot be adequately achieved on the Council floor.

Note: The remaining background information for this resolution contains similar information to that written for the other fellowship resolutions submitted to the 2008 Council.

The 2007 Council adopted Amended Resolution 11(07) Fellowship which created an additional pathway to fellowship, removed the requirement for recertification after election as a fellow, and deleted sections of the Bylaws that became moot upon adoption of the proposed changes.

Below is a table which summarizes the differences between the two current options for fellow status.

Option 1

Option 2

Board Certification

3 years of active involvement in emergency medicine

Ten years of involvement in emergency medicine

Active member for three continuous years

Active member for six continuous years

Eligible for membership prior to 1/1/2000 (this is a member requirement)

Letter of recommendation by two fellows or chapter

Satisfaction of 3 (min) individual criteria

Satisfaction of 3 (min) individual criteria of which one must be active involvement in ACEP chapter activities attested by chapter president or member of national committee, ACEP Council or national Board of Directors

The attached report summarizes a survey of medical specialty societies completed in June 2008 by the Membership Directors Section of the Council of Medical Special Societies. The survey purpose was to determine whether or not board certification was required for membership by medical specialty societies (as opposed to fellow status). It should be noted that fellow is a membership category with associated privileges for most medical specialty societies. Although board certification is not required for membership in many of these organizations, survey results indicates that board certification is generally required for fellow membership. An alternate survey by the same group completed two years ago indicates that most medical specialty societies require board certification within their specific medical specialty; however, several accept board certification in alternate medical specialties. This previous survey also indicates that, of the four medical specialty societies that have fellow status as a distinction (including ACEP), two require board certification and two do not.

At the end of August 2008, there were 19,204 members in the active and life categories of membership. Approximately 3,700 of these are within the first three years of active membership and not yet eligible for fellow status. 15,011 members (including an estimated 2000 in their first three year of active membership) are currently board certified in emergency medicine by ABEM, AOBEM or ABP in Pediatric Emergency Medicine. There are also 240 members who were at one time board certified by one of these groups but are no longer diplomates. 9,937 of those eligible have chosen to become fellows of the College. There are approximately 1,160 active and life members who may currently be eligible for fellow status through the alternate pathway. This count is based solely on years of membership for those members who are not board certified. As of August 2008, 209 applications have been received using the alternate pathway. 127 have been approved, 62 have been declined and 20 are pending approval.

To date, seven members have cancelled citing the new requirements for board certification as their reason for resigning membership. In addition, two residency programs that previously paid for their residents' member dues have opted not to pay (total residents affected by this decision is 66.)

Stragegic Plan Reference:

None

Prior Council Action:

Amended Resolution 11(07) Fellowship adopted. This resolution created an additional pathway to fellowship, removed the requirement for recertification after election as a fellow, and deleted sections of the Bylaws that became moot upon adoption of the proposed changes.

Resolution 24(05) Fellowship and Its Implications adopted. The resolution directed that a task force be established to study the political, economic, and personal implications of opening ACEP fellowship to all active members of the College and provide a report to the Board and the Council.

Resolution 15(04) Simplification of Requirements to Retain Fellow Status defeated. Called for a Bylaws amendment simplifying the requirements for fellow status by allowing those members who are elected to fellow status to maintain their status whether or not they remain diplomates of their respective Boards as long as they maintain membership in ACEP.

Resolution 1(03) Fellow Reapplication adopted. It called for a Bylaws amendment omitting the requirement that fellows must reapply for fellow status when they recertify with their respective Boards.

Resolution 4(03) ACEP Members with Disabilities adopted. It called for a Bylaws amendment establishing of a mechanism for a member who has attained fellow status within the College to maintain their fellow status indefinitely in the event that member is permanently disabled.

Resolution 1(00) Membership Requirement for Fellowship defeated. Called for a Bylaws amendment eliminating restrictions in the fellow criteria that keep new active members from applying for fellow status until after their third year in the active category of membership.

Resolution 1(99) Fellowship – AOBEM and ABP adopted. It called for a Bylaws amendment allowing board certification by the American Board of Osteopathic Emergency Medicine to be acceptable criteria for fellow status in ACEP.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted. It called for the recognition of the American Board of Osteopathic Emergency Medicine as an emergency medicine certifying body.

Amended Resolution 35(95) Fellow Status Extension adopted. Allowed the Board to grant an extension of fellow status for a period of up to one year past their certification expiration date for fellows who for reasons of illness or other significant personal obstacles are unable to take the board examination.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted. It called for a Bylaws amendment expanding fellowship criteria to include the subspecialty certification in pediatric emergency medicine by either the American Board of Pediatrics or the American Board of Emergency Medicine.

Substitute Resolution 31(94) Fellow Status adopted. It called for the College to establish fellow status eligibility for ACEP members certified in the joint ABEM/AAP subspecialty certification of pediatric emergency medicine.

Resolution 28(94) Fellow Status defeated. It called for a Bylaws amendment expanding fellowship criteria to include BCEM certification.

Resolution 5(92) Fellowship Status adopted. It called for a Bylaws amendment omitting the requirement that candidates for fellow status submit letters from two fellows of the College and allowed the Board of Directors to define the documentation required from a candidate.

Amended Resolution 6(90) Fellow Status adopted. It called for refinement of the requirements for fellow status including the addition of the requirement for active involvement in emergency medicine as the physician’s chief professional activity exclusive of training.

Amended Resolution 7(90) Life Fellow adopted. It called for a Bylaws amendment creating the Life Fellow status.

Resolution 8(89) Fellowship Requirements adopted. It called for the implementation of a notice period of three years before the requirements for fellow status adopted in 1988 took affect.

Resolution 4(89) Fellow Requirements adopted. Instructed the College to review fellow criteria and revise old criteria or add new criteria as deemed appropriate and to report to the 1990 Council.

Amended Resolution 11(88) Fellowship Requirements adopted in lieu of resolutions 10(88) and 12(88). Called for a Bylaws amendment modifying fellow requirements to make them more stringent.

Resolution 6(87) Fellowship Requirements postponed to the 1988 Council meeting. Called for a Bylaws amendment tightening the requirements for fellow status.

Resolution 54(86) Fellow Status adopted. Directed the Board of Directors to augment the qualifications for fellow status and report to the 1987 Council.

Resolution 6(84) Fellow Status postponed to the 1985 Council meeting. Called for additional professional criteria for fellow status eligibility.

Amended Resolution 4(81) Fellow Status adopted. Called for a Bylaws amendment establishing fellow criteria.

Substitute Resolution 17(80) Fellow Status postponed to the 1981 Council meeting. Called for the establishment of criteria for fellow status.

Substitute Resolution 7(74) adopted. It directed the Board of Directors to establish a category of membership to be called fellow and establish its qualifications and requirements.

Prior Board Action:

Amended Resolution 11(07) Fellowship adopted.

Resolution 24(05) Fellowship and Its Implications adopted

Resolution 1(03) Fellow Reapplication adopted.

Resolution 4(03) ACEP Members with Disabilities adopted.

March 2000 adopted a motion that former fellows who desire to regain membership have their ACEP fellow status immediately reinstated upon initiation of their new membership in ACEP, provided that the new membership in ACEP, provided that their board certification and previous fellow status is current.

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Resolution 5(92) Fellowship Status adopted.

January 1992 adopted key elements of the process for handling recertification of fellows.

Endorsed Amended Resolution 7(90) Fellow Status. The Board did not adopt Bylaws amendments prior to 1993.

Endorsed Amended Resolution 6(90). The Board did not adopt Bylaws amendments prior to 1993.

Council Action:

Reference Committee A recommended that Resolution 10(08) not be adopted.

The Council defeated Resolution 10(08) on October 26, 2008.

Testimony:

The preponderance of testimony was opposed to Resolution 10(08).

Board Action:

N/A

References:

Implementation Action:

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 11: Honorary Fellowship – Bylaws Amendment

Council Action: **NOT ADOPTED**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Rolly B McGrath, MD
Gabor David Kelen, MD, FACEP
Theodore A Christopher, MD, FACEP
Kathleen J Clem, MD, FACEP
Jedd Roe, MD, FACEP
Brent Russell King, MD

Purpose:

Amends the ACEP Bylaws to specify that members meeting the second set of criteria for fellowship be designated as Honorary Fellows and includes a proviso that Fellows who have been previously elected to Fellow status under the second set of criteria will be redesignated as Honorary Fellows.

Fiscal Impact:

None

WHEREAS, The majority of members of the Association of Academic Chairs of Emergency Medicine (AACEM) are also members of the American College of Emergency Physicians (ACEP); and

WHEREAS, AACEM has expressed the position of the organization regarding the recent action taken by ACEP granting fellowship status to “Legacy Emergency Physicians” who are not board certified in emergency medicine by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics; and

WHEREAS, The difficulty yet importance of recognizing the work of “legacy emergency physicians,” particularly those who helped create and define our emergency medicine discipline is recognized by many, including AACEM; and

WHEREAS, ACEP recognizes that many “legacy emergency physicians” were unable to seek fellowship status in the very College they helped strengthen and whose mission they have inspired and worked to realize; and

WHEREAS, An alternative and less controversial designation for “legacy emergency physicians” would both serve the needs of the specialty of Emergency Medicine and at the same time recognize and honor the founders of our specialty; and

WHEREAS, ACEP has led emergency medicine in gaining recognition and rightful status as a respected primary specialty; and

WHEREAS, Virtually all major medical associations require board certification as a cornerstone for membership or special recognition; and

WHEREAS, Awarding fellowship status to physicians not board certified in emergency medicine will undermine the work of true “legacy emergency physicians” by weakening the definition of “emergency specialist” and may undermine the legitimacy of the discipline of emergency medicine; and

WHEREAS, An admirable goal is the appropriate acknowledgement and acceptance of long-term leaders, those who have either helped create our discipline or have greatly advanced its standing; therefore be it

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

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

1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.
2. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
3. Satisfaction of at least three of the following individual criteria during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
    iv. active involvement in emergency medicine administration or departmental affairs;
    v. active involvement in an emergency medical services system;
    vi. research in emergency medicine;
    vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
    viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
    ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
    x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.
4. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:
5. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
6. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
    ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
    iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
    iv. active involvement in emergency medicine administration or departmental affairs;
    v. active involvement in an emergency medical services system;
    vi. research in emergency medicine;
    vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
    viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
    ix. examiner for, director of, or involvement in test development and/or administration for the American

Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;

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

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

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

Fellows **elected under the first set of criteria in Article V, Section 1 (subsection 1),** shall be **designated "Fellows" and shall be** authorized to use the letters **"**FACEP**"** in conjunction with professional activities. **Fellows elected under the second set of criteria in Article V, Section 1 (subsection 2), shall be designated "Honorary Fellows" and shall be authorized to use the letters "FACEP (Hon.)" in conjunction with professional activities.** Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

Section 2 — Fellow Emeritus

Members in good standing who are either fellows or former fellows who are ineligible for another class of fellowship may be elected by the Board of Directors to Fellow Emeritus status. A Fellow Emeritus shall be authorized to use "FACEP (Emeritus)" in conjunction with professional activities. Fees, procedures for election, and reasons for termination of Fellow Emeritus status shall be determined by the Board of Directors.

PROVISO: Fellows who have been previously elected to Fellow status under the set of criteria in Article V, Section 1 (subsection 2, lines 68-95 above) as revised in 2007, shall be redesignated "Honorary Fellows."

Background:

This Bylaws resolution amends the ACEP Bylaws to specify that members meeting the second set of criteria for fellowship, which were approved by the 2007 Council, be designated as Honorary Fellows. It also includes a proviso that Fellows who have been previously elected to Fellow status under the second set of criteria will be redesignated as Honorary Fellows.

In summary, as reflected in the Whereas statements, the authors concur with the purpose of recognizing long-term leaders who have either helped create the specialty of emergency medicine or have greatly advanced its standing. However, they also contend that awarding fellow status to physicians who are not board certified in emergency medicine will undermine the work of the College and past leaders by weakening the definition of "emergency specialist" and may undermine the legitimacy of the discipline of emergency medicine. The proposed alternative is suggested as a less controversial designation for "legacy emergency physicians" that would both serve the needs of the specialty and at the same time recognize and honor the founders of the specialty of emergency medicine.

The inclusion of the proviso to redesignate Fellows who have been previously elected to Fellow status under the second set of criteria as Honorary Fellows is unusual, although the Council has adopted resolutions in the past that contained a proviso. For example, Amended Resolution 11(04) Election of the President-Elect of the Council, which was a Bylaws amendment, contained a proviso that if the resolution were adopted by the Board, the Council would elect the president-elect for the first time at the 2005 Council meeting. The proviso also included instructions in the event there was a vacancy in the office of president-elect prior to the 2005 Council meeting and that if the Board did not ratify the resolution, it would become a contested amendment. The companion Standing Rules resolution, Amended Resolution 12(04), contained a proviso that it would not go into effect unless Resolution 11(07) were adopted by the Council and the Board. *The Standard Code of Parliamentary Procedure, 4th Edition* (aka *Sturgis*) does mention provisos (p. 205), with the following example given:

"The bylaws go into effect immediately with the announcement of the vote adopting them unless the motion to adopt provides that the bylaws, or some portion or provision in them, is not effective until a later date. For example: "I move that the bylaws be adopted as amended, with the proviso that Article IX, Section 4, that provides for regular monthly meetings, will not go into effect until January 1 of next year."

In this example, the proviso is part of the motion to adopt the bylaws (or a part of the bylaws, such as an amendment). Although part of the motion, it is clearly not a part of the bylaws. As part of the motion, it requires the same vote to pass as the bylaws, which is two-thirds per ACEP's rules. However, it is not part of the bylaws amendment itself and is not incorporated into the bylaws if adopted. It is merely part of the motion and after it has been implemented it only appears in the minutes of the meeting.

Retroactive changes to the Bylaws are unusual. The adoption of Resolution 26(05) Honorary Membership, which changed the criteria for honorary membership, resulted in current honorary members remaining in that category of membership with their current benefits as long as they met the revised requirements for honorary membership. Previous Wiegenstein Award recipients, who were automatically classified as honorary members by virtue of receiving the award, were changed in ACEP's membership system to "Life Membership-Wiegenstein Award Winner" and the benefits of waived membership dues and waived *Scientific Assembly* registration were unchanged. Current presidents of organizations in the International Federation of Emergency Medicine were previously awarded honorary membership for one year. These individuals, as well as the six leaders of the Casualty Surgeons Association of Great Britain who were given honorary membership, are now designated "International –Honorary" members. However, the designation of Life Fellow was not removed from those who had already achieved it when the Life Fellow category was eliminated with the adoption of Amended Resolution 11(07).

Note: The remaining background information for this resolution contains similar information to that written for the other fellowship resolutions submitted to the 2008 Council.

Proponents of Amended Resolution 11(07) testified last year that, since any new active member of the College must either be board certified, residency trained in emergency medicine or have been active in emergency medicine prior to January 1 2000, the active membership category advances the College's position that the future of emergency medicine is board certification and that, therefore, the FACEP designation need not advocate board certification but instead should be the designation of the College recognizing member contribution to the College and the specialty of Emergency Medicine.

Current requirements are listed in the Bylaws excerpt listed above. Below is a table which summarizes the differences between the two current options for fellow status.

Option 1

Option 2

Board Certification

3 years of active involvement in emergency medicine

Ten years of involvement in emergency medicine

Active member for three continuous years

Active member for six continuous years

Eligible for membership prior to 1/1/2000 (this is a member requirement)

Letter of recommendation by two fellows or chapter

Satisfaction of 3 (min) individual criteria

Satisfaction of 3 (min) individual criteria of which one must be active involvement in ACEP chapter activities attested by chapter president or member of national committee, ACEP Council or national Board of Directors

The 2007 Bylaws amendment also omitted the previous requirement of continuous board certification to retain

fellow status.

The attached report summarizes a survey of medical specialty societies completed in June 2008 by the Membership Directors Section of the Council of Medical Special Societies. The survey purpose was to determine whether or not board certification was required by medical special societies for membership (as opposed to fellow status). It should be noted that fellow is a membership category with associated privileges for most medical specialty societies. Although board certification is not required for membership in many of these organizations, survey results indicates that board certification is generally required for fellow membership. An alternate survey by the same group completed two years ago indicates that most medical specialty societies require board certification within their specific medical specialty; however, several accept board certification in alternate medical specialties. This previous survey also indicates that, of the four medical specialty societies that have fellow status as a distinction (including ACEP), two require board certification and two do not.

At the end of August 2008, there were 19,204 members in the active and life categories of membership. Approximately 3,700 of these are within the first three years of active membership and not yet eligible for fellow status. 15,011 members (including an estimated 2000 in their first three year of active membership) are currently board certified in emergency medicine by ABEM, AOBEM or ABP in Pediatric Emergency Medicine. There are also 240 members who were at one time board certified by one of these groups but are no longer diplomates. 9,937 of those eligible have chosen to become fellows of the College. There are approximately 1,160 active and life members who may currently be eligible for fellow status through the alternate pathway. This count is based solely on years of membership for those members who are not board certified. As of August 2008, 209 applications have been received using the alternate pathway. 127 have been approved, 62 have been declined and 20 are pending approval.

To date, seven members have cancelled citing the new requirements for board certification as their reason for resigning membership. In addition, two residency programs that previously paid for their residents' member dues have opted not to pay (total residents affected by this decision is 66.)

Stragegic Plan Reference:

None

Prior Council Action:

Amended Resolution 11(07) Fellowship adopted. This resolution created an additional pathway to fellowship, removed the requirement for recertification after election as a fellow, and deleted sections of the Bylaws that became moot upon adoption of the proposed changes.

Resolution 24(05) Fellowship and Its Implications adopted. The resolution directed that a task force be established to study the political, economic, and personal implications of opening ACEP fellowship to all active members of the College and provide a report to the Board and the Council.

Resolution 15(04) Simplification of Requirements to Retain Fellow Status defeated. Called for a Bylaws amendment simplifying the requirements for fellow status by allowing those members who are elected to fellow status to maintain their status whether or not they remain diplomates of their respective Boards as long as they maintain membership in ACEP.

Resolution 1(03) Fellow Reapplication adopted. It called for a Bylaws amendment omitting the requirement that fellows must reapply for fellow status when they recertify with their respective Boards.

Resolution 4(03) ACEP Members with Disabilities adopted. It called for a Bylaws amendment establishing of a mechanism for a member who has attained fellow status within the College to maintain their fellow status indefinitely in the event that member is permanently disabled.

Resolution 1(00) Membership Requirement for Fellowship defeated. Called for a Bylaws amendment eliminating restrictions in the fellow criteria that keep new active members from applying for fellow status until after their third year in the active category of membership.

Resolution 1(99) Fellowship – AOBEM and ABP adopted. It called for a Bylaws amendment allowing board certification by the American Board of Osteopathic Emergency Medicine to be acceptable criteria for fellow status in ACEP.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted. It called for the recognition of the American Board of Osteopathic Emergency Medicine as an emergency medicine certifying body.

Amended Resolution 35(95) Fellow Status Extension adopted. Allowed the Board to grant an extension of fellow status for a period of up to one year past their certification expiration date for fellows who for reasons of illness or other significant personal obstacles are unable to take the board examination.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted. It called for a Bylaws amendment expanding fellowship criteria to include the subspecialty certification in pediatric emergency medicine by either the American Board of Pediatrics or the American Board of Emergency Medicine.

Substitute Resolution 31(94) Fellow Status adopted. It called for the College to establish fellow status eligibility for ACEP members certified in the joint ABEM/AAP subspecialty certification of pediatric emergency medicine.

Resolution 28(94) Fellow Status defeated. It called for a Bylaws amendment expanding fellowship criteria to include BCEM certification.

Resolution 5(92) Fellowship Status adopted. It called for a Bylaws amendment omitting the requirement that candidates for fellow status submit letters from two fellows of the College and allowed the Board of Directors to define the documentation required from a candidate.

Amended Resolution 6(90) Fellow Status adopted. It called for refinement of the requirements for fellow status including the addition of the requirement for active involvement in emergency medicine as the physician's chief professional activity exclusive of training.

Amended Resolution 7(90) Life Fellow adopted. It called for a Bylaws amendment creating the Life Fellow status.

Resolution 8(89) Fellowship Requirements adopted. It called for the implementation of a notice period of three years before the requirements for fellow status adopted in 1988 took affect.

Resolution 4(89) Fellow Requirements adopted. Instructed the College to review fellow criteria and revise old criteria or add new criteria as deemed appropriate and to report to the 1990 Council.

Amended Resolution 11(88) Fellowship Requirements adopted in lieu of resolutions 10(88) and 12(88). Called for a Bylaws amendment modifying fellow requirements to make them more stringent.

Resolution 6(87) Fellowship Requirements postponed to the 1988 Council meeting. Called for a Bylaws amendment tightening the requirements for fellow status.

Resolution 54(86) Fellow Status adopted. Directed the Board of Directors to augment the qualifications for fellow status and report to the 1987 Council.

Resolution 6(84) Fellow Status postponed to the 1985 Council meeting. Called for additional professional criteria for fellow status eligibility

Amended Resolution 4(81) Fellow Status adopted. Called for a Bylaws amendment establishing fellow criteria.

Substitute Resolution 17(80) Fellow Status postponed to the 1981 Council meeting. Called for the establishment of criteria for fellow status.

Substitute Resolution 7(74) adopted. It directed the Board of Directors to establish a category of membership to be called fellow and establish its qualifications and requirements.

Prior Board Action:

Amended Resolution 11(07) Fellowship adopted.

Resolution 24(05) Fellowship and Its Implications adopted.

Resolution 1(03) Fellow Reapplication adopted.

Resolution 4(03) ACEP Members with Disabilities adopted.

March 2000 adopted a motion that former fellows who desire to regain membership have their ACEP fellow status immediately reinstated upon initiation of their new membership in ACEP, provided that the new membership in ACEP, provided that their board certification and previous fellow status is current.

Resolution 1(99) Fellowship – AOBEM and ABP adopted.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted the first resolved and contested the second resolve.

Amended Resolution 35(95) Fellow Status Extension adopted.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted.

Substitute Resolution 31(94) Fellow Status adopted and asked the Bylaws Committee to provide language for the 1995 Council.

March 1993 adopted a change to the deadline for reapplication for fellow status to May one of each year and allowed for members to reapply for fellow status as they recertify with ABEM.

January 1993 adopted a change to the deadline for new fellow applications to December 15.

Resolution 5(92) Fellowship Status adopted.

January 1992 adopted key elements of the process for handling recertification of fellows.

Endorsed Amended Resolution 7(90) Fellow Status. The Board did not adopt Bylaws amendments prior to 1993.

Endorsed Amended Resolution 6(90). The Board did not adopt Bylaws amendments prior to 1993.

Council Action:

Reference Committee A recommended that Resolution 11(08) not be adopted.

Those in favor testified that the resolution would be an equitable solution to honor founding fathers and other "legacy" physicians.

Those opposed testified that the resolution is divisive and a step backwards.

The Council defeated Resolution 11(08) on October 26, 2008.

Testimony:

The Reference Committee received a significant amount of written testimony in favor of Resolution 11. A preponderance of testimony given during the Reference Committee hearing opposed Resolution 11.

Board Action:

N/A

References:

Implementation Action:

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 12: Legacy Fellowship Requirements – Bylaws Amendment

Council Action: **WITHDRAWN**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: New York Chapter ACEP

Purpose:

Creates a sunset date for Amended Resolution 11(07) Fellowship closing the date for “legacy” fellowship applications and confirmation.

Fiscal Impact:

None

WHEREAS, A qualified emergency physician is best defined as one who possesses training in emergency medicine to evaluate and manage all patients who seek emergency care; and

WHEREAS, Emergency Medicine in the 21st century should be practiced by physicians who have certification by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics; and

WHEREAS, Residency training in emergency medicine is an integral component of preparation for fellowship status in the College; and

WHEREAS, ACEP has acknowledged the contributions of certain legacy physicians to the college by allowing those qualified individuals to apply for fellowship status for the past year; and

WHEREAS, The future workforce of emergency medicine will be composed by physicians who have completed an accredited emergency medicine residency training program; therefore be it

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

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

1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.
2. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
3. Satisfaction of at least three of the following individual criteria during their professional career:
    i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or

appointed public official;
   ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
   iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
   iv. active involvement in emergency medicine administration or departmental affairs;
   v. active involvement in an emergency medical services system;
   vi. research in emergency medicine;
   vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
   viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
   ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
   x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

4. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. **Application for fellowship status by this criterion must be submitted to the College by the close of business on December 31, 2008.** Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates sometime during their professional career prior to application:
5. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
6. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
   i. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
   ii. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
   iii. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
   iv. active involvement in emergency medicine administration or departmental affairs;
   v. active involvement in an emergency medical services system;
   vi. research in emergency medicine;
   vii. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
   viii. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
   ix. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
   x. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

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

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

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

Background:

This Bylaws amendment creates a sunset date for Amended Resolution 11(07) Fellowship closing the date for “legacy” fellowship applications and confirmation suggesting that, by this date, ACEP will have acknowledged the contributions of certain legacy physicians by allowing those qualified to apply for fellow status during the past year. The date specified as the last date upon which applications may be received is December 31, 2008. In the Whereas statements, the authors submit that a qualified emergency physicians is one trained in emergency medicine and is certified by ABEM, AOBEM or in Pediatric Emergency Medicine by ABP and that residency training in emergency medicine is an integral component of preparation for fellow status.

Proponents of Amended Resolution 11(07) testified last year that, since any new active member of the College must either be board certified, residency trained in emergency medicine, or have been active in emergency medicine prior to January 1 2000, the active membership category advances the College's position that the future of emergency medicine is board certification and, therefore, the FACEP designation need not advocate board certification but instead should be the designation of the College recognizing member contribution to the College and the specialty of Emergency Medicine.

Note: The remaining background information for this resolution contains similar information to that written for the other fellowship resolutions submitted to the 2008 Council.

Current requirements are listed in the Bylaws excerpt listed above. Below is a table which summarizes the differences between the two current options for fellow status.

Option 1

Option 2

Board Certification

3 years of active involvement in emergency medicine

Ten years of involvement in emergency medicine

Active member for three continuous years

Active member for six continuous years

Eligible for membership prior to 1/1/2000 (this is a member requirement)

Letter of recommendation by two fellows or chapter

Satisfaction of 3 (min) individual criteria

Satisfaction of 3 (min) individual criteria of which one must be active involvement in ACEP chapter activities attested by chapter president or member of national committee, ACEP Council or national Board of Directors

Residency training in emergency medicine is not currently a requirement for either option.

The 2007 Bylaws amendment also omitted the previous requirement of continuous board certification to retain fellow status.

The attached report summarizes a survey of medical specialty societies completed in June 2008 by the Membership Directors Section of the Council of Medical Special Societies. The survey purpose was to determine whether or not board certification was required by medical specialty societies for membership (as opposed to fellow status). It should be noted that fellow is a membership category with associated privileges for most medical specialty societies. Although board certification is not required for membership in many of these organizations, survey results indicates that board certification is generally required for fellow membership. An alternate survey by the same group completed two years ago indicates that most medical specialty societies require board certification within their specific medical specialty; however, several accept board certification in alternate medical specialties. This previous survey also indicates that, of the four medical specialty societies that have fellow status as a distinction (including ACEP), two require board certification and two do not.

At the end of August 2008, there were 19,204 members in the active and life categories of membership. Approximately 3,700 of these are within the first three years of active membership and not yet eligible for fellow status. 15,011 members (including an estimated 2000 in their first three year of active membership) are currently board certified in emergency medicine by ABEM, AOBEM or ABP in Pediatric Emergency Medicine. There are

also 240 members who were at one time board certified by one of these groups but are no longer diplomates. 9,937 of those eligible have chosen to become fellows of the College. There are approximately 1,160 active and life members who may currently be eligible for fellow status through the alternate pathway. This count is based solely on years of membership for those members who are not board certified. As of August 2008, 209 applications have been received using the alternate pathway. 127 have been approved, 62 have been declined and 20 are pending approval.

To date, seven members have cancelled citing the new requirements for board certification as their reason for resigning membership. In addition, two residency programs that previously paid for their residents' member dues have opted not to pay (total residents affected by this decision is 66.)

Stragegic Plan Reference:

None

Prior Council Action:

Amended Resolution 11(07) Fellowship adopted. This resolution created an additional pathway to fellowship, removed the requirement for recertification after election as a fellow, and deleted sections of the Bylaws that became moot upon adoption of the proposed changes.

Resolution 15(04) Simplification of Requirements to Retain Fellow Status defeated. Called for a Bylaws amendment simplifying the requirements for fellow status by allowing those members who are elected to fellow status to maintain their status whether or not they remain diplomates of their respective Boards as long as they maintain membership in ACEP.

Resolution 1(03) Fellow Reapplication adopted. It called for a Bylaws amendment omitting the requirement that fellows must reapply for fellow status when they recertify with their respective Boards.

Resolution 4(03) ACEP Members with Disabilities adopted. It called for a Bylaws amendment establishing of a mechanism for a member who has attained fellow status within the College to maintain their fellow status indefinitely in the event that member is permanently disabled.

Resolution 1(00) Membership Requirement for Fellowship defeated. Called for a Bylaws amendment eliminating restrictions in the fellow criteria that keep new active members from applying for fellow status until after their third year in the active category of membership.

Resolution 1(99) Fellowship – AOBEM and ABP adopted. It called for a Bylaws amendment allowing board certification by the American Board of Osteopathic Emergency Medicine to be acceptable criteria for fellow status in ACEP.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted. It called for the recognition of the American Board of Osteopathic Emergency Medicine as an emergency medicine certifying body.

Amended Resolution 35(95) Fellow Status Extension adopted. Allowed the Board to grant an extension of fellow status for a period of up to one year past their certification expiration date for fellows who for reasons of illness or other significant personal obstacles are unable to take the board examination.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted. It called for a Bylaws amendment expanding fellowship criteria to include the subspecialty certification in pediatric emergency medicine by either the American Board of Pediatrics or the American Board of Emergency Medicine.

Substitute Resolution 31(94) Fellow Status adopted. It called for the College to establish fellow status eligibility for ACEP members certified in the joint ABEM/AAP subspecialty certification of pediatric emergency medicine.

Resolution 28(94) Fellow Status defeated. It called for a Bylaws amendment expanding fellowship criteria to include BCEM certification.

Resolution 5(92) Fellowship Status adopted. It called for a Bylaws amendment omitting the requirement that candidates for fellow status submit letters from two fellows of the College and allowed the Board of Directors to

define the documentation required from a candidate.

Amended Resolution 6(90) Fellow Status adopted. It called for refinement of the requirements for fellow status including the addition of the requirement for active involvement in emergency medicine as the physician's chief professional activity exclusive of training.

Amended Resolution 7(90) Life Fellow adopted. It called for a Bylaws amendment creating the Life Fellow status.

Resolution 8(89) Fellowship Requirements adopted. It called for the implementation of a notice period of three years before the requirements for fellow status adopted in 1988 took affect.

Resolution 4(89) Fellow Requirements adopted. Instructed the College to review fellow criteria and revise old criteria or add new criteria as deemed appropriate and to report to the 1990 Council.

Amended Resolution 11(88) Fellowship Requirements adopted in lieu of resolutions 10(88) and 12(88). Called for a Bylaws amendment modifying fellow requirements to make them more stringent.

Resolution 6(87) Fellowship Requirements postponed to the 1988 Council meeting. Called for a Bylaws amendment tightening the requirements for fellow status.

Resolution 54(86) Fellow Status adopted. Directed the Board of Directors to augment the qualifications for fellow status and report to the 1987 Council.

Resolution 6(84) Fellow Status postponed to the 1985 Council meeting. Called for additional professional criteria for fellow status eligibility.

Amended Resolution 4(81) Fellow Status adopted. Called for a Bylaws amendment establishing fellow criteria.

Substitute Resolution 17(80) Fellow Status postponed to the 1981 Council meeting. Called for the establishment of criteria for fellow status.

Substitute Resolution 7(74) adopted. It directed the Board of Directors to establish a category of membership to be called fellow and establish its qualifications and requirements.

Prior Board Action:

Amended Resolution 11(07) Fellowship adopted.

Resolution 1(03) Fellow Reapplication adopted.

Resolution 4(03) ACEP Members with Disabilities adopted.

March 2000 adopted a motion that former fellows who desire to regain membership have their ACEP fellow status immediately reinstated upon initiation of their new membership in ACEP, provided that the new membership in ACEP, provided that their board certification and previous fellow status is current.

Resolution 1(99) Fellowship – AOBEM and ABP adopted.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted the first resolved and contested the second resolve.

Amended Resolution 35(95) Fellow Status Extension adopted.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted.

Substitute Resolution 31(94) Fellow Status adopted and asked the Bylaws Committee to provide language for the 1995 Council.

March 1993 adopted a change to the deadline for reapplication for fellow status to May one of each year and allowed for members to reapply for fellow status as they recertify with ABEM.

January 1993 adopted a change to the deadline for new fellow applications to December 15.

Resolution 5(92) Fellowship Status adopted.

January 1992 adopted key elements of the process for handling recertification of fellows.

Endorsed Amended Resolution 7(90) Fellow Status. The Board did not adopt Bylaws amendments prior to 1993.

Endorsed Amended Resolution 6(90). The Board did not adopt Bylaws amendments prior to 1993.

Council Action:

Reference Committee A recommended that Resolution 12(08) not be adopted.

Both Resolution 9 and Resolution 12 propose deadlines for the alternate path to Fellow status. As a result of the testimony, the Reference Committee recommends that Resolution 9 be adopted and that Resolution 12 not be adopted.

The Council withdrew Resolution 12(08) on October 26, 2008.

Testimony:

The preponderance of testimony opposed Resolution 12(08) because the resolution's proposed deadline was too soon. Alternate deadlines were suggested during the Reference Committee hearing and were supported by some of those giving testimony.

Board Action:

N/A

References:

Implementation Action:

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 13: Member Compliance with Code of Ethics for Emergency Physicians – Housekeeping Bylaws Amendment

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Bylaws Committee
ACEP Board of Directors
Council Steering Committee

Purpose:

Clarifies that membership eligibility is contingent upon compliance with the *Code of Ethics for Emergency Physicians.*

Fiscal Impact:

None beyond staff time to update the Bylaws document.

WHEREAS, ACEP's Bylaws specify that membership eligibility is contingent upon abiding by the "Principles of Ethics for Emergency Physicians"; and

WHEREAS, The "Principles of Ethics for Emergency Physicians" are one component of the *Code of Ethics for Emergency Physicians*; and

WHEREAS, The *Code of Ethics for Emergency Physicians* is composed of:

1. "Principles of Ethics for Emergency Physicians"
2. "Ethics in Emergency Medicine: An Overview"
3. A Compendium of ACEP policy statements on ethical issues; and

WHEREAS, Although the "Principles of Ethics for Emergency Physicians" are intended to encompass the scope of ACEP's ethics-related positions and policies, the applicability of the entire "Code of Ethics for Emergency Physicians" to questions of membership eligibility provides increased clarity, focus, and guidance to ACEP members; therefore be it

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

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

RESOLVED, That the ACEP Bylaws Article XII – Ethics, be amended to read:

"The ~~"Principles of Ethics for Emergency Physicians," which are contained in the current~~ "Code of Ethics for

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

Background:

This is a housekeeping Bylaws amendment clarifying that membership eligibility is contingent upon compliance with the *Code of Ethics for Emergency Physicians*. It is necessary that the Bylaws section concerning member eligibility be expanded to include members' agreement to abide by the entire *Code of Ethics for Emergency Physicians* and not merely the "Principles of Ethics for Emergency Physicians." The *Code of Ethics for Emergency Physicians* includes three sections: 1) "Principles of Ethics for Emergency Physicians;" 2) "Ethics in Emergency Medicine: An Overview;" and 3) a Compendium of ACEP policy statements on ethical issues.

Stragegic Plan Reference:

None

Prior Council Action:

None

Prior Board Action:

June 2008, approved submitting Resolution 13(08) to the 2008 Council.

Council Action:

Reference Committee A recommended that Resolution 13(08) be adopted.

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

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

RESOLVED, That the ACEP Bylaws Article XII – Ethics, be amended to read:

"The ~~"Principles of Ethics for Emergency Physicians," which are contained in the current~~ "Code of Ethics for Emergency Physicians," shall be the ~~principles of ethics~~ **ethical foundation** of the College. Charges of violations of ~~these~~ ethical principles **or policies contained in the "Code of Ethics for Emergency Physicians"** may be brought in accordance with procedures described in the College Manual."

The Council adopted Resolution 13(08) on October 26, 2008.

Testimony:

Testimony was unanimously in favor of Resolution 13(08).

Board Action:

The Board adopted Resolution 13(08) on October 30, 2008.

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

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

RESOLVED, That the ACEP Bylaws Article XII – Ethics, be amended to read:

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

References:

Implementation Action:

The Bylaws were updated.

Background Information Prepared by: Cal Chaney, JD

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 14: Associate Membership Category

Council Action: **SUBSTITUTE RESOLUTION ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians

Purpose:

Directs ACEP to study the feasibility of adopting an associate member category for emergency physicians who do not meet the criteria for active membership.

Fiscal Impact:

None beyond budgeted expenses for committee assignment as an objective to conduct the study. Fiscal impact would be affected by the number of members projected, services provided, dues assessed, and the number of members projected for this category of membership.

WHEREAS, Ideally, all EDs should be staffed by EM residency trained, board certified physicians; and

WHEREAS, Emergency Medicine residency training is the only pathway to achieve board certification in Emergency Medicine; and

WHEREAS, New data suggests that the goal of staffing all US Emergency Departments (EDs) with residency-trained, board certified physicians will not be fulfilled for the reasonably foreseeable future; and

WHEREAS, Many EDs are staffed by physicians who are not residency trained in Emergency Medicine, are not board certified, and are not candidates for ACEP membership; and

WHEREAS, These individuals represent a considerable proportion of the nation's Emergency Medicine workforce; and

WHEREAS, These individuals benefit from efforts undertaken by ACEP such as improving the delivery of emergency care, ensuring appropriate reimbursement for emergency physician services, representing the specialty to the house of medicine, state and federal legislature despite not being members or paying ACEP dues; and

WHEREAS, A revenue stream from these emergency physicians would be desirable for ACEP; be it

RESOLVED, That ACEP study the feasibility of adopting an associate member category for emergency physicians who do not meet criteria for active membership.

Background:

This resolution calls for ACEP to study the feasibility of an associate category of membership for licensed physicians who devote a significant portion of their medical endeavors to emergency medicine and do not otherwise meet the requirements for any other category of membership.

Affiliate membership in ACEP for both physicians and allied health care professionals existed from 1969 until 1975 when the Council removed this membership category because it was not being used. In 1970, the Board

rejected a proposal for an associate membership category in which associate members were defined as "physicians…who devote some of his (sic) active professional practice to the practice of emergency medicine…" In 1977, the Council defeated a resolution for associate membership for part-time emergency physicians defined as "physicians who desire to be associated with this College…who may practice emergency medicine part time…." Also defeated that year was a resolution attempting to create an affiliate category for "physicians involved in emergency medicine." In 1980, the Council considered a resolution proposing affiliate membership for "physicians or other health related professionals who endeavor in a field related to emergency medicine…" This resolution was postponed to the 1981 Council meeting where it was defeated. Subsequently, the Council defeated affiliate membership resolutions in 1985, 1989, and 1991. The 1992 Council defeated a resolution calling for section associates and in 1993 defeated a "section affiliate membership" resolution.

In light of the 1997 ACEP Council action limiting eligibility as of January 1, 2000 to emergency medicine residency trained and/or board certified physicians, the Membership Committee was asked to investigate the feasibility of an associate category of membership. During these discussions the committee identified a small group of physicians (General Medical Officers), serving in the military between internship and residency who would be ineligible for continued membership under the new criteria for active membership. A Bylaws amendment was approved in 1998 that allowed this group to continue their candidate membership for a limited number of years. At the same time, the Membership Committee recommended that affiliate membership not be recommended to the Council. Committee members felt that an affiliate or associate category of membership was not consistent with the spirit of the new membership requirements and the will of the Council. The committee also noted that non-members, including non-physicians and part time emergency physicians are welcome to attend

ACEP conference, obtain ACEP publications and benefit from the vast resource of information offered by the College.

In 2002, the Membership Committee once again was asked to consider alternatives for membership and considered various opportunities for non-member involvement in ACEP. Currently non-members may purchase any ACEP publication, including all subscription publications, such as Annals of Emergency Medicine, Critical Decisions in Emergency Medicine, ACEP News and section newsletters. Non-members may attend any course offered by ACEP. However, non-members are excluded from other member privileges, such as the right to vote or hold office, leadership activities, participation in ACEP political advocacy initiatives, and access to the members' only area of the ACEP web site, although most of these materials may be obtained at minimal cost.

The Membership Committee identified five possible alternatives for involvement by those ineligible for membership, including an associate category of membership, a non-member affiliation, section membership without requiring membership, creating a subscription with limited benefits and publications, and creating a coalition of emergency medicine. Although the committee remained undecided as to the best alternative, Bylaws language was developed and submitted to the Board for their consideration. Ultimately, the Board decided to remain consistent with the decision made by the Council in 1997. Further, the Board believed that there was sufficient access to all ACEP educational products and publications affording non-members the opportunity to remain abreast of clinical and organizational developments in the specialty.

ACEP has continued to see new membership growth and the last few years has exceeded expectations. (See chart below.) However, what is not known is exactly how big the universe of eligible EM physicians for membership in ACEP is. We do know that as of 2008 ACEP has approximately 18,969 cancelled members in our database. We also know that ABEM reports having 23,320 diplomats. ACEP currently has 14,491 ABEM certified members.

It should be noted that many currently counted as new members were at some time members in the past. In 2002 the Board of Directors authorized a change in procedure such that individuals no longer need to reinstate (i.e., pay back dues) to regain their membership and Fellowship status. As a result more members are returning to ACEP as "new" members instead of renewal or reinstated members.

New Member vs. Restart

Year Ending

Total

New to ACEP

Restarts

2008

973

222

751

2007

1011

235

776

2006

789

168

621

2005

592

72

520

2004

616

100

516

2003

557

93

464

2002

521

432

89

The majority of membership growth in the 3 years prior to January 1, 2000, was physicians who were not

emergency medicine residency trained. Since July 2000 the College gained 7057 members eligible under the new criteria (new to ACEP = 3320 and restarts =3737).

In 2003, the Membership Committee surveyed other medical organizations to determine whether or not an alternate category of membership was offered and associated rights and privileges. Of 23 associations surveyed, 12 responded. All respondents required residency training within their specialty for primary membership. Eight required board certification in addition to residency training. Eight offered alternate categories of membership for those who did not meet these qualifications and of these, four indicated they have either an associate or affiliate category of membership that allowed membership by physicians not trained or board certified in their specialty of practice.

More recently, ACEP participated with the Council of Medical Specialty Societies survey on associate membership. Ten medical specialty societies participated in the survey. Of the ten participants, only three did not offer an associate membership category.

In July 2005, ACEP polled medical specialty societies specifically asking for information regarding associate or affiliate categories. Of 14 respondents, 13 indicated that they had an affiliate or associate membership and the remaining respondent indicated they were considering it. Eleven of those responding have an associate or affiliate membership for physicians who do not meet their qualifications for primary membership. For one, affiliate membership is reserved for physicians in training. For two, this alternate category of membership is reserved for affiliated non-physician groups. None allow voting privileges and 5 also prohibit holding office. See Chart 4.

Although a few years old, but potentially still relevant, ACEP solicited member opinions in March of 2003 regarding an alternative membership category. 625 of about 1200 surveys were completed and returned (52%). The objectives of this survey was to assess overall satisfaction with ACEP; assess support/opposition to offering a non-member affiliation; assess support/opposition to full or associate membership; and to identify the impact of offering any membership option to non-residency trained, board certified emergency physicians on member intention to renew membership.

Summary:

- Overall, members had a strong positive opinion of ACEP
- Members are supportive of ACEP offering membership to practicing emergency physicians who are not board certified or residency trained in EM
- Members support an Associate category of membership with no right to vote or hold office.
- The non-membership affiliation is viewed more favorably.
- About 80% would renew their membership if a non-membership affiliation or an associate membership with no right to vote or hold office was offered.

An in-depth phone interview was also conducted during the March 2003 suvey with non-member physicians practicing emergency medicine but not eligible for membership in ACEP. Objectives of this survey included: assess membership in emergency medicine professional associations and perceptions of these associations; identify attitudes toward ACEP; assess general interest in joining ACEP; identify attitudes toward a non-membership affiliation with ACEP; identify attitudes toward a full membership or two associate member options; and assess interest in membership or non-membership affiliation at the current active national dues.

Summary:

- Overall, non-members have a relatively positive opinion of ACEP.
- ACEP should offer some form of membership to practicing emergency physicians.
- Professional interaction and access to educational materials are the primary drivers.
- Political issues or the right to vote or hold office are not key reasons for wanting to join ACEP.
- Reasons for feeling that ACEP should offer some form of membership -
    - Improve patient care by promoting physician education
    - Support large number of physicians who are not board certified
    - Enhance ACEP's membership/lobbying efforts
- The membership options are likely to appeal more to younger physicians.

Stragegic Plan Reference:

Organizational Vitality – Membership:

1. Increase ACEP's membership by 3%.
2. Enhance the perceived value of membership, particularly the development of members-only value-added benefits.

Prior Council Action:

Resolution 8(07) Chapter Membership Requirements defeated. Would have allowed chapter membership for physicians who are ineligible for national ACEP membership.

Resolution 22(05) Associate Membership defeated. The resolution would have created an associate membership category for emergency physicians who did not meet the requirements for other classes of membership.

Substitute Resolution 13(02) Alternative Associate Membership adopted. Referred the issue of ACEP involvement of physicians who are not currently eligible for membership in ACEP to the Board of Directors and called for the findings to be reported to the 2003 Council.

Resolution 2(02) Associate Membership defeated. Called for the establishment of an Associate category of membership allowing emergency physicians who do not meet the current criteria an avenue to membership in the College.

Resolution 29(00) Emergency Nursing and Emergency Medicine defeated. Called for the evaluation of creating a class of membership for emergency nurses.

Substitute Resolution 25(00) Membership defeated. Called for an impact study and a suggested mechanism for an alternative membership status for physicians who practice emergency medicine by are not currently eligible for full membership in the College.

Resolution 18(99) Membership Qualification Change Impact Study defeated. Called for the College to conduct a study of the short-term and long- term affects of the new active membership criteria.

Resolution 10(98) Associate Membership Category defeated. Called for the establishment of an Associate Category of Membership for physicians who have no other avenue to membership in the College.

Resolution 2(97) College Membership adopted in lieu of Resolutions 2, 3, 4, and 5. Called for the establishment of criteria based active membership requirements to be effective on January 1, 2000.

Resolution 6(95) Active and Candidate Membership defeated. Called for the establishment of criteria limiting active members to those certified by the American Board of Emergency Medicine or the Royal College of Physicians and Surgeons of Canada and the establishment of an associate category of membership for physicians who do not meet the certification criteria.

Resolution 35(93) Criteria for Membership defeated. Called for the analysis of current classes of membership and their requirements.

Resolution 5(93) Section Affiliate Membership defeated. Called for the creation of an affiliate category of membership for health professionals who have a special interest in the goals and objectives of an approved section of membership.

Resolution 46(92) Section Associate defeated. Called for the establishment of a section membership called "section associate."

Resolution 2(91) Affiliate Membership Category defeated. Called for the creation of an affiliate membership category for allied health professionals.

Resolution 10(89) Sections of Membership, Requirements for Membership defeated. Called for the establishment of a section affiliate membership allowing non-physicians to be members of sections.

Resolution 3(81) Affiliate Membership defeated. Called for the establishment of an affiliate category of membership for physicians and other health care professionals in fields related to emergency medicine.

Resolution 12(80) Affiliate Membership postponed to the 1981 Council. Called for the establishment of an affiliate membership category for health care professionals in fields related to emergency medicine.

Substitute Resolution 9(79) Associate Membership adopted. Called for the Membership Committee to develop an associate membership category for non-emergency physicians.

Resolution 14(77) Associate Membership Category (part-time) defeated. Called for the establishment of an associate membership category for part-time emergency physicians.

Resolution 3(75) Eliminating Affiliate Membership adopted. Called for the elimination of the affiliate membership category from the Constitution.

Prior Board Action:

Submitted report to the 2003 Council in response to Substitute Resolution 13(02) Alternative Associate Membership.

Resolution 2(97) College Membership adopted.

Resolution 9(79) Associate Membership referred to the Membership Committee

October 1973 approved the affiliate membership category for Robert E Armstrong, DVM.

June 1970 rejected proposal for associate membership for "a physician…who devotes some of his active professional practice to the practice of emergency medicine."

Council Action:

Reference Committee B recommended that Substitute Resolution 14(08) be adopted.

~~RESOLVED, That ACEP study the feasibility of adopting an associate member category for emergency physicians who do not meet criteria for active membership.~~

RESOLVED, That ACEP appoint a task force to identify the common ground among different constituencies regarding the issue of an associate member category for emergency physicians who do not meet criteria for active membership; and be it further

RESOLVED, That this task force report its findings to the 2009 Council.

The Council adopted Substitute Resolution 14(08) on October 26, 2008.

Testimony:

Lengthy testimony was heard on both sides of this issue with the majority being in favor of the concept of the resolution. The authors suggested a wording change asking for a report of the proposed study to the 2009 Council. Testimony was heard from many speakers in support of the concepts of inclusiveness and recognition of the benefits to ACEP in increased membership numbers and dues revenue. Several expressed a desire to extend ACEP membership to emergency physicians who are not currently eligible. Testimony was provided regarding the realities of the workforce and that there are not enough board certified emergency physicians to fill every shift in every ED. A question was raised about whether the goal of this resolution was to provide a title or educational resources to associate members. Others testified that educational resources are currently available to non-members. Testimony against the resolution centered on preferences from some groups restricting membership to only board certified residency trained emergency physicians and that the creation of a category of associate membership would lead to the loss of some current ACEP members.

There was considerable testimony favoring stronger wording and more direct language than that contained in the original resolution as it was believed that simply restudying theses issues without action would be futile. For this reason the Reference Committee combined some of the alternative language offered in testimony to craft Substitute Resolution 14.

Board Action:

The Board adopted Substitute Resolution 14(08) on October 30, 2008.

RESOLVED, That ACEP appoint a task force to identify the common ground among different constituencies regarding the issue of an associate member category for emergency physicians who do not meet criteria for active membership; and be it further

RESOLVED, That this task force report its findings to the 2009 council.

References:

Implementation Action:

A task force was appointed. The task force report was approved by the Board in August 2009. The report was distributed to the 2009 Council and assigned to Reference Committee A for comments. No comments were offered on the report.

Background Information Prepared by: Robert Heard, MBA, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP

Bruce Alan MacLeod, MD, FACEP

2008 Council Resolution 15: Board of Directors and Council Officer Candidates

Council Action: **NOT ADOPTED**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians

Purpose:

Directs ACEP to require that Board of Directors and Council officer candidates be actively involved in the practice of clinical Emergency Medicine at the time of their nomination.

Fiscal Impact:

None

WHEREAS, It is the mission of ACEP to be the leading advocate for emergency physicians; and

WHEREAS, Those who represent our specialty must represent the needs that members face on a daily basis; and

WHEREAS, While there may be some value to nonpracticing emergency physicians serving in College leadership, emergency physicians are best served by individuals who actively experience the rewards and challenges of clinical emergency medicine practice; and

WHEREAS, There is precedent for requirement for involvement in the practice of clinical Emergency Medicine elsewhere in the house of Emergency Medicine, specifically as criteria for ABEM examiner appointment; therefore be it

RESOLVED, That ACEP require that Board of Directors and Council officer candidates be actively involved in the practice of clinical Emergency Medicine at the time of their nomination.

Background:

This resolution directs ACEP to require that Board of Directors and Council officer candidates be actively involved in the practice of clinical Emergency Medicine at the time of their nomination. The Nominating Committee is a committee of the Council (ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee) appointed to identify nominees for positions elected by the Council, which include the Board of Directors, Council officers, and president-elect. The Council Standing Rules states: “The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committees shall consider activity and involvement in the College, the Council, and chapter or sections when considering the slate of candidates.”

The ACEP Bylaws Article IX – Board of Directors, Section 2 – Composition and Election states:

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

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

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

The Council Standing Rules and the Bylaws do not specify particular skills sets or practice requirements for potential nomineess. The Nominating Committee has developed Nominee Guidelines (Attachment A) and Areas of Competence to be Represented on the Board of Directors (Attachment B) to assist in identifying potential nominees. Limiting the potential candidate pool to only those actively involved in the practice of clinical Emergency Medicine at the time of their nomination could possibly eliminate desirable candidates. Formalizing this requirement may necessitate amendments to the Council Standing Rules, the College Manual, the Nominee Guidelines, or a Bylaws amendment.

Stragegic Plan Reference:

None

Prior Council Action:

None

Prior Board Action:

None

Council Action:

Reference Committee B recommended that Resolution 15(08) not be adopted.

The Council defeated Resolution 15(08) on October 26, 2008.

Testimony:

The overwhelming testimony offered was opposed to the resolution. Principal points raised included that ACEP needs leadership with a wide range of skills and that one of the privileges of an ACEP member is the ability to seek election for office. Several others raised concerns about restricting the pool of viable candidates for the Nominating Committee given the time and demand requirements of the leadership position. Nearly every person testifying expressed confidence in the Council to make good choices from an unrestricted slate of candidates. At the close of testimony, the author requested that the resolution be withdrawn.

Board Action:

References:

Implementation Action:

Background Information Prepared by: Sonja R Montgomery, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 16: Dues Discount for Groups Participating in the “100% Club”

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Washington Chapter ACEP

Purpose:

Directs ACEP to provide a dues discount for members participating in the “100% Club.”

Fiscal Impact:

The actual fiscal impact cannot be calculated without a specific discount percentage, the number of groups, and the total number of members in those groups. This information is not available at this time. As a historical reference, a 10% discount applied to each of the 83 groups currently in the 100% Club representing 1,834 members or $935,811 in dues. 10% of this total is a $93,581 loss of revenue for the College. This program has brought in 278 new and restarted members with a total dues value of $145,007. This does not take into consideration the expense of maintaining a member or the cost of the group recognition and billing process, which would have to be considered in a formal fiscal impact study. If dues are the only consideration, a 10% disccount applied to the 83 groups currently in the program would provide a positive net revenue of $51,426. Additionally, to implement, there will be staff time involved in amending computer programs and processes to facilitate discounts for groups at the national and chapter level. The cost of this venture would depend on whether the % is applied consistently across chapter and national levels, and whether or not chapters were allowed to opt out of this program.

WHEREAS, The American College of Emergency Physicians is the recognized voice for 26,432 Emergency Physicians; and

WHEREAS, An estimated 80% of eligible Emergency Physicians are current members of ACEP; and

WHEREAS, The 100% *Club* was implemented in 2006 to recognize groups in which all physicians are members of ACEP and encourage group ACEP involvement; and

WHEREAS, Incentives to join the 100% *Club* include simplified group billing, acknowledgment in ACEP publications, and a plaque; and

WHEREAS, As of July 2008 there are 79 groups enrolled in the 100% Club; and

WHEREAS, There are more than 1,200 groups nationwide that currently are not enrolled in the 100% Club; and

WHEREAS, The Washington Chapter of ACEP offers discounted dues for groups participating in the 100% Club; and

WHEREAS, Giving a discount for group membership would incentivize individuals and groups to join the 100% Club and thus increase ACEP membership; therefore be it

RESOLVED, That the American College of Emergency Physicians create a discount program for members of

the 100% club as a benefit to those groups willing to commit.

Background:

This resolution asks that ACEP create a discount program for emergency physician groups that are enrolled in the 100% Club.

Promotion of group master billings and ACEP's group recognition program began in 2006. Besides master billings, which reduce administrative costs to groups, the current 100% Club also includes the following:

ACEP 100% Club – Annual recognition for groups that have all eligible emergency physicians enrolled as members of ACEP.

- Acknowledgment in *ACEP News*.*
- Recognition in the *ACEP Reference & Resources Guide*.*
- ACEP.org recognition with a 100-word description and link to your Web site.
- Listing in ACEP On-site Conference Program for *Scientific Assembly*.*
- Display certificate for your exhibit booth at *Scientific Assembly*.
- 100% Club Recognition Plaque.
- Use of the 100% Club logo for your publications and promotions. ACEP application fee waiver (a savings of $30) for each ACEP member that is added to your physician employment group.
- A $250 rebate for groups with 5 or more physicians registered to attend the same ACEP educational meeting. A rebate form is available online. **Note**: To receive this rebate, groups must provide a list of registered members attending the meeting for verification by ACEP. EMBRS, all Teaching Fellowships, and the Leadership and Advocacy Conference are excluded.

ACEP's records indicate that there may be approximately 1,400 formal emergency physician groups. Currently, there are 99 groups enrolled in the group billing program and 83 in the 100% Club. Of those in the 100% Club, six have not taken advantage of the group billing. There are, therefore, 105 groups currently enrolled in group billing or one of the recognition programs (which alsso includes the Circle of Distinction). This number is continuing to increase. There are currently 49 groups in the process of enrolling. Over the past two years, three have declined enrollment after receiving ACEP's approval for participation. Two of these three groups indicated that discounted dues would be required to activate their applications.

As a fiscal incentive, the application fee of $30 is waived for each new member brought in by participating groups and the 100% Club offers a $250 rebate for groups that send five or more physicians to ACEP educational programs. The product discounts were added in 2007.

The Membership Committee suggested a discount program for all groups in 2007. Because our data regarding group employees is incomplete, a fiscal analysis could not be completed. As an alternative, a 10% discount for new members was suggested by the Membership Committee and considered by the Finance Committee. It was agreed that using only new members would have a positive fiscal impact. The recommended discount program was considered promising, but it was not pursued because this is a fairly new program, and also because ACEP does not have a computer program and coding that would easily support these discounts. Implementation of this program would require revision of the current billings processes and systems and it was determined to be in the best interest of the College to continue the program as currently implemented with the continuous oversight and analysis by the Membership Committee. Though a current program is not available to accommodate discount programs specific to groups, changes to the system are possible that would allow for discount programs of this nature. As with other types of discount programs, variable discount rates selected by the various chapters do create implementation issues. It is hoped that such a program, if implemented, would require that a specific % discount be consistently applied across all chapters that opt for a discount program.

As indicated in the Whereas statements, the Washington Chapter Board of Directors voted to offer a 10% discount to emergency physician groups. There are currently 8 groups participating in this program from Washington, with a total of 135 members.

Stragegic Plan Reference:

Organizational Vitality, Strategy 1, Tactic 1.2: Work proactively with chapters to recruit new members and increase member retention and provided resources to support chapter membership development efforts.

Prior Council Action:

Amended Substitute Resolution 55(05) Recognition of Group Participation in ACEP adopted. The resolution directed that a recognition program be developed for groups with 100% participation of eligible members.

Prior Board Action:

April 2007, supported the Membership Committee's member recruitment recommendations which included a continued promotional plan with an ultimate goal of 50% participation by groups.

January 2006, approved Membership Committee recommendation to implement and promote a comprehensive master billing and recognition program to emergency physician groups.

Amended Substitute Resolution 55(05) Recognition of Group Participation in ACEP adopted.

Council Action:

Reference Committee B recommended that Resolution 16(08) be adopted.

RESOLVED, That the American College of Emergency Physicians create a discount program for members of the 100% club as a benefit to those groups willing to commit.

The Council adopted Resolution 16(08) on October 26, 2008.

Testimony:

Testimony was overwhelmingly in favor of adoption. It was widely believed that offering such a discount would increase membership numbers and dues revenue. Concerns raised about implementation and definitions will be addressed by the ACEP Membership and Finance Committees, both of whose Chairs testified in favor of adoption.

Board Action:

The Board adopted Resolution 16(08) on October 30, 2008.

RESOLVED, That the American College of Emergency Physicians create a discount program for members of the 100% club as a benefit to those groups willing to commit.

References:

Implementation Action:

Assigned to Member Services staff to develop a program for review by the Membership Committee and approval by the Board of Directors. The Board approved a group membership benefit program in April 2009 and implementation began in July 2009. The program has been very successful in increasing ACEP membership.

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP

Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 17: Felony Conviction for Assaulting Emergency Physicians

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians

Purpose:

Directs ACEP to advocate for felony convictions for assaulting emergency physicians, on-call physicians, or staff members working in a hospital's emergency department.

Fiscal Impact:

Budgeted staff time to advocate for federal passage of assault legislation. The issue would be added to the list of legislative/regulatory priorities.

WHEREAS, Violence in health care settings, and particularly in hospital emergency departments (EDs), is becoming more common and more severe; and

WHEREAS, According to the Bureau of Labor Statistics data, health care workers are in one of the more dangerous professions, being twice as likely as those in other fields to experience an injury from a violent act at work; and

WHEREAS, Many physicians, including emergency physicians (EPs) and on-call physicians (OCPs), spend a considerable amount of time evaluating and treating patients in Pennsylvania's EDs; and

WHEREAS, Physicians and staff members working in EDs are particularly at risk to encounter patients exhibiting violent behavior because by federal mandate, EDs in this country are not allowed to turn away any patients, and

WHEREAS, Both EPs having to perform a medical screening examination on any patient who presents to the ED, and other physicians working in EDs, are essentially working under a government mandate as civil servants; and

WHEREAS, In a recent survey, 75% of emergency physicians had experienced at least one verbal threat in the previous year, 28% reported being physically assaulted, 12% were confronted outside the ED, 3.5% were stalked and 82% reported occasionally fearful of ED violence; and

WHEREAS, Many researchers claim these numbers most likely low, given evidence that health care workers underplay the verbal and physical abuse that takes place in their work environments every day; and

WHEREAS, Similar assault data and concerns for violence holds true for nurses, technicians and other staff members who assist physicians caring for these patients; and

WHEREAS, Currently in many states, including Pennsylvania, individuals convicted of assaulting health care workers in health care settings, including EDs, are charged only with a misdemeanor; and

WHEREAS, Although it is already a felony to assault a police officer, there is a trend towards elevating the

punishment to felony convictions for those assaulting other government civil servants, such as traffic agents, as the law recently passed in New York City demonstrates; therefore be it

RESOLVED, That the American College of Emergency Physicians (ACEP) work with the appropriate government agencies to enact federal law making it a felony to assault any emergency physician, on-call physician or staff member working in a hospital's emergency department.

Background:

This resolution calls for the College to advocate for a federal law making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital emergency department.

Violence in the emergency department is shockingly prevalent. According to a study published in the February 2005 issue of Annals of Emergency Medicine, 131 of 171 Michigan emergency physicians responding to a survey indicated that they had experienced at least one violent act in the previous twelve months, with 48 of them stating that they were victims of a physical assault.

ACEP originally adopted a policy statement in 1993 entitled "Protection from Physical Violence in the ED." The policy statement, which was revised and approved in April of 2008, focuses on the responsibility of hospitals to ensure the security of the emergency department environment. It also states that "the American College of Emergency Physicians believes that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department (ED) are protected against violent acts occurring within the department." Additionally, ACEP worked with several chapters in the early 1990's to support the enactment of state laws that would make it a felony to assault an emergency health care worker.

Several states have enacted such provisions. For example, the Minnesota statute reads: "Whoever assaults any of the following persons and inflicts demonstrable bodily harm is guilty of a felony and may be sentenced to imprisonment for not more than two years or to payment of a fine of not more than $4,000, or both: (1) a member of a municipal or volunteer fire department or emergency medical services personnel unit in the performance of the member's duties; or (2) a physician, nurse, or other person providing health care services in a hospital emergency department." However, many state laws fail to specifically address emergency care providers in their assault statutes. Some state assault laws include references to the assault of EMS workers, but not emergency department personnel. In the past year, the Emergency Nurses Association has launched an initiative that is supported by the College to advocate for tougher state laws and stiffer penalties for the assault of health care workers.

These efforts all focus on the state level primarily because assault laws fall almost exclusively within the purview of state governments. Federal law related to assaults essentially is contained to the assault of federal workers. Title 18 U.S.C. chapter 7 §111 prohibits "assaulting, resisting, or impeding" officers and employees of the United States while engaged in or on account of the performance of official duties, and the assault or intimidation of 'any person who formerly served' as an officer or employee of the United States 'on account of the performance of official duties during such person's term of service'."

An argument could be made that since federal law requires emergency physicians to screen all patients, even those who appear dangerous or threatening, the federal government should help protect those providers by enacting tougher penalties for those who assault them. However, this mechanism would require unusual action on the part of the federal government in crafting and adopting special assault legislation that is primarily handled at the state level.

Stragegic Plan Reference:

Promote Quality Care and Patient Safety

Ensure Access to Emergency Medical Care

Prior Council Action:

Amended Resolution 26(93) Violence in Emergency Departments adopted. Directed ACEP to develop a plan to address the problem of violence in the ED.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the ED.

Prior Board Action:

October 1993, Amended Resolution 26(93) Violence in Emergency Departments adopted.

January 1993, approved the policy statement "Protection from Physical Violence in the ED." The policy statement was reaffirmed in October 1997 and revised in April 2008 with a new title of "Protection from Physical Violence in the Emergency Department Environment."

October 1991, Amended Resolution 44(91) Health Care Worker Safety adopted.

Council Action:

Reference Committee B recommended that Amended Resolution 17(08) be adopted.

RESOLVED, That the American College of Emergency Physicians (ACEP) work with the appropriate national and state organizations ~~government agencies~~ to enact ~~federal~~ **state** laws making it a felony to assault **a health care worker rendering emergency medical care**. ~~any emergency physician, on-call physician or staff member working in a hospital's emergency department.~~

The Council adopted Amended Resolution 17(08) on October 26, 2008.

Testimony:

Testimony was unanimously in support of the resolution. The amendment only alters the focus from the federal to state level and broadens the scope of coverage to all health care workers rendering emergency medical care. This formula has been successful in many states in adding emergency health care providers in the performance of their duties into current legislation protecting police and firefighters.

Board Action:

The Board adopted Amended Resolution 17(08) on October 30, 2008.

RESOLVED, That the American College of Emergency Physicians (ACEP) work with the appropriate national and state organizations to enact state laws making it a felony to assault a health care worker rendering emergency medical care.

References:

Implementation Action:

Assigned to Chapter & State Relations staff to develop and disseminate information to the chapters. In April 2009, a package of resources was developed and distributed to chapters on this issue, including sample laws, model legislation developed by the Emergency Nurses Association, talking points, potential allies, etc. to help them in advocating for the passage of laws in their states.

Background Information Prepared by: Craig Price, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 18: Retaining Retired and Disabled Members

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians

Purpose:

Directs ACEP to study the feasibility of a no cost retired membership category or reducing the cost of Life Membership as a means of retaining retired members.

Fiscal Impact:

None beyond budgeted expenses for committee assignment as an objective to conduct the study. The study will include a fiscal analysis to implement a program.

WHEREAS, It has been a goal of ACEP to recognize the dedication of individuals who helped to build the specialty of Emergency Medicine; and

WHEREAS, As the specialty matures, many of these physicians are moving toward retiring from clinical practice; and

WHEREAS, Many of these physicians still wish to be active members of ACEP; and

WHEREAS, This growing group of retiring physicians should be realized as an important voice within ACEP and should be retained as members; and

WHEREAS, Other organizations such as the American Medical Association and the American Academy of Pediatrics offer deeply discounted membership dues for retired physicians; and

WHEREAS, Although ACEP has a “Life Member” category, some retired and disabled physicians may find the cost prohibitive to continuing to retain membership in ACEP, be it

RESOLVED, That ACEP study the feasibility of a no cost retired membership category or reducing the cost of Life Membership as a means of retaining retired members.

Background:

This resolution directs ACEP to study the feasibility of a no cost retired membership category or reducing the cost of Life Membership as a means of retaining retired members. The Bylaws requirements for life membership are delineated in Article IV – Membership, Section 2.4 – Life Members, which states:

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

life member."

As indicated, the life membership category includes members who meet specific member terms and age, who are retired from medical practice, or who are permanently disabled. Dues are $188, regardless of the member's pathway to life membership. Retired membership is a relatively new category (now sub-category) adopted in 2000 and combined with the Life category in 2005. The minimum age of 55 for retired members was eliminated in 2007 to allow members who choose alternate non-clinical career paths or early retirement to continue membership at a reduced rate.

Because of a high rate of transfers from the active to the life category of membership and chapter concern regarding the associated reduction in dues revenue, the Membership Committee has been assigned an objective to review the criteria for the life category of membership. The committee has determined that more direction is needed from the Board of Directors and will seek their guidance at the October 2008 Board meeting. The Council's action on this resolution will provide the committee with needed detail regarding the desires of the College membership related to the section within life membership on retired members.

The attached report compares dues rates for retired categories of membership from other medical associations. Data was provided by the Membership Directors Section of the Council for Medical Specialty Societies and was a result of a voluntary survey of member medical specialty societies. Several of the respondents did not have a retired category; however, most provide a reduced rate to retired members who have met certain age and membership term requirements.

Stragegic Plan Reference:

Strengthen Organizational Vitality

Prior Council Action:

Resolution 7(07) Age Requirement for Retired Membership adopted. The resolution eliminated the age requirement for retired members to achieve life membership.

Amended Resolution 25(05) Combining Life and Retired Membership Categories adopted. This Bylaws amendment combined the categories of Life and Retired Memberships.

Amended Resolution 3(02) Chapter Membership for Retired Members adopted. Allowed retired members who move to another state after retirement to continue their chapter affiliation in the chapter of prior professional practice/residence.

Amended Substitute Resolution 5(00) Retired Membership adopted. Created a new category of retired membership.

Resolution 9(98) Life Membership defeated. This was a Bylaws amendment addressing the needs of a retired member wanting to continue membership on limited income.

Resolution 3(93) Criteria for Life Member Status defeated.

Resolution 7(88) Life Membership Category adopted.

Amended Resolution 14(86) Life Members adopted.

Resolution 13(84) Life Membership referred to the Board.

Resolution 9(80) Life Membership adopted.

Resolution 3(78) Life Membership adopted.

Prior Board Action:

October 2007, Resolution 7(07) Age Requirement for Retired Membership adopted.

October 2005, Amended Resolution 25(05) Combining Life and Retired Membership Categories adopted.

October 2002, Amended Resolution 3(02) Chapter Membership for Retired Members adopted.

October 2000, Amended Substitute Resolution 5(00) Retired Membership adopted.

September 2000, established dues for the proposed retired category of membership at 33.33% of active dues. June 2000, approval of the Membership Committee's recommendation for a retired category of membership and to submit a resolution to the 2000 Council. Also directed the committee to propose reduced dues rate for the Board to consider in anticipation that the Council would adopt the resolution.

March 2000, suggested revisions to the proposed recommendation and directed the committee to secure Bylaws Committee review.

October 1998, assigned an objective to the Membership Committee regarding retired membership that included directives to recommend a new status or revisions to a current status and to recommend a dues rate and options for retired member.

Note: The Board did not adopt Bylaws amendments prior to 1993.

March 1991, approved criteria for life fellows presented by the Membership Committee.

January 1989, rejected the Membership Committee's proposal that life members be assessed no dues

June 1984, referred resolution 13(84) Life Membership to the Membership, Constitution and Bylaws Committee for study.

Council Action:

Reference Committee B recommended that Resolution 18(08) be adopted.

RESOLVED, That ACEP study the feasibility of a no cost retired membership category or reducing the cost of Life Membership as a means of retaining retired members.

The Council adopted Resolution 18(08) on October 26, 2008.

Testimony:

Testimony was very limited and generally supportive. Two individuals testified that they favored the concept but cautioned about the fiscal impact of reducing dues without increasing membership.

Board Action:

The Board adopted Resolution 18(08) on October 30, 2008.

RESOLVED, That ACEP study the feasibility of a no cost retired membership category or reducing the cost of Life Membership as a means of retaining retired members.

References:

Implementation Action:

Assigned to Member Services staff to develop a recommendation for review by the Membership Committee and approval by the Board of Directors. In June 2009, the Board approved changing the dues structure for future Life members to eliminate the discount for dues and receive a 15% discount for *Scientific Assembly* registration fees

effective July 1, 2009. At that time there were 1,919 Life members who retained the discounted dues of 1/3 the current rate and *Scientific Assembly* registration fee benefit of 2/3 discount. The dues increase was implemented immediately.

In June 2010, the Board approved submitting a resolution to the 2010 Council to amend the criteria for Life members, create a new category of membership for Disabled members, and specify that retired members do not retain the right to vote or hold office. The Board approved further revising the discount for *Scientific Assembly* for future Life members to $200 in addition to the following benefits: 1) Be designated as a Life Member (active); 2) Retain all rights to vote and hold office; 3) Retain Fellow status designation (if obtained); 4) Be eligible for reduced dues should they meet the retired member criteria; and 5) If elected to Life Member from the Disabled Member category, retain the Disabled member dues rate. The Board approved the following benefits for Disabled members: 1) Be designated as a Disabled Member (active); 2) Retain all rights to vote and hold office; 3) Retain Fellow status designation (if obtained) and retain ability to become a Fellow of the College if not obtained prior to the disability; 4) Retain eligibility for the Life category of membership; and 5) Pay 1/4 of the prevailing active national dues rate and applicable chapter dues unless a waiver for hardship is granted by the College indicating that even 1/4 of the active national dues and applicable chapter dues would be a substantial hardship.

The resolution submitted to the 2010 Council did not create a separate category of membership for retired members. Since a member can only assume one class of membership at a time, Active members cannot currently be Retired and a Retired member cannot be an Active member. With this change, individuals that meet certain criteria would be eligible for reduced dues without it affecting the member benefits associated with their existing class of membership. The primary defining characteristic of retired members is retirement from active medical practice after sustained membership in the College. The latter is easily defined by a minimum of twenty (20) years of active, inactive, or international membership in the College or attaining the age of sixty-five (65). The former is more difficult to define. In June 2010, the Board approved the definition of "retired from active medical practice" as "one no longer engaged in the practice of clinical emergency medicine as evidenced by non-renewal of their medical license or less than 1/3 of their income comes from activities associated with being employed as a physician." This determination is based upon written attestation from the member and is generally not verified. Additionally in June 2010, the Board approved the following policy and benefits regarding Retired members:

Retired Members are considered any person who has held active, inactive, international, or life membership in the College for a minimum of twenty (20) years or who has attained the age or sixty-five (65), and who is retired from active medical practice may on application to and approval by the Board of Directors be classified as a retired member.

1. Retain the membership category at the time of "Retired" classification (active, inactive, international, or life).
2. Retain all rights associated with their membership category, except the right to vote or hold office.
3. Retain fellow status designation (if obtained).
4. Pay 1/3 of the active national dues and applicable chapter dues.
5. Retain Retired member dues benefits should the member be awarded Life membership.
6. Receive $200 discount for *Scientific Assembly* (The discount amount will be determined annually by the Board of Directors.)

Retired membership would not qualify toward tenure requirements for Life membership; however, the Board of Directors could make exceptions under unusual circumstances. Voting privileges at the chapter level are determined by the chapter.

The 2010 Council referred the resolution to the Board of Directors. The majority of testimony in the Reference Committee opposed adoption of the resolution and recommended referral. Those opposed cited issues with the purpose of the resolution, problems with the definition of member classifications and statuses, the number of permutations of current and proposed member types and how they relate to each other, concerns regarding proposed privileges of voting and holding offices, and continued conflicts within the Bylaws. The president assigned the referred resolution to the Bylaws and Membership Committees for further action and recommendations to the Board. In June 2011, the Membership Committee presented options to the Board. There was consensus from the Board to take no further action on the referred resolution and instead assign an objective to the Membership Committee for 2011-12 to revise the classes of membership. The committee also worked with staff to determine functionality and with the Bylaws Committee regarding any necessary changes to the Bylaws to propose to the Council.

Background Information Prepared by: Patty Stowe, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 19: Second Rural Workforce Task Force

Council Action: **SUBSTITUTE RESOLUTION REFERRED TO THE BOARD OF DIRECTORS**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Julia J Gies
John J Rogers, MD, FACEP

Purpose:

Directs the creation of a second Rural Workforce Task Force.

Fiscal Impact:

The Emergency Medicine Foundation (EMF) provided funding of $25,000 for the summit meeting in 2003. Similar expenses of $25,000-$30,000 would be incurred if another summit were held and a proposal would be submitted to EMF to consider providing funding. Other task force activities relating to conference calls and staffing would be allocated from the committee budget.

WHEREAS, The recommendations submitted by the first Rural Workforce Task Force in August 2003 have not been fully implemented; and

WHEREAS, Those recommendations that have been implemented have not been assessed as to their effectiveness; and

WHEREAS, According to the 2005 National ED Inventory conducted by the Emergency Medicine Network, 32% of emergency departments in the country have annual visits of less than 10,000; and

WHEREAS, The overwhelming majority of these emergency departments are located in rural settings; and

WHEREAS, The overwhelming majority of emergency physicians staffing these emergency departments have no formal training in emergency medicine; and

WHEREAS, There exists unique difficulties in recruiting and retaining residency trained or board certified physicians for these practices; and

WHEREAS, The problems and issues identified by the first Rural Workforce Task Force continue to exists; and

WHEREAS, The 2008 Technical Advisory Group will soon file its report on the current state of the Emergency Medicine Workforce; and

WHEREAS, Emergency medical care in rural areas is an essential public service; therefore be it

RESOLVED, That the ACEP Council will direct the Board of Directors to appoint a second Rural Workforce Task Force whose composition shall include but not be limited to representatives from the Rural Emergency Medicine Section, Certification and Emergency Medicine Workforce Section, Careers in Emergency Medicine Section, Young Physicians Section, and the Emergency Medicine Informatics Section; and be it further

RESOLVED, That this task force shall be empowered to convene a second Rural Emergency Medicine Summit; and be it further

RESOLVED, That the task force shall utilize the recommendations from the first Rural Workforce Task Force and the report from the 2008 Emergency Medicine Workforce Task Force in making recommendations to the ACEP Board of Directors; and be it further

RESOLVED, That the chair of the task force shall seek representatives from the following organizations to participate in the development of recommendations and to attend this second Rural Emergency Medicine Summit as they did during the first Rural Emergency Medicine Summit: American Board of Emergency Medicine; Emergency Medicine Residents Association; Society for Academic Emergency Medicine; Council of Emergency Medicine Residency Directors; Residency Review Committee for Emergency Medicine; American Academy of Family Physicians; National Rural Health Association; Federal Office of Rural Health Policy; Rural Health Resource Center; and Society of Emergency Medicine Physician Assistants; and be it further

RESOLVED, The chair of the second Rural Workforce Task Force shall submit the recommendations of the task force to the ACEP Board of Directors in writing no later than August 15, 2009.

Background:

This resolution directs the creation of a second Rural Workforce Task Force with the goal of discovering methods to improve the delivery of emergency care in rural areas and assist rural emergency physicians in delivering quality care.

A Rural EM Summit was held on March 29-30, 2003. The purpose of the summit was to consider ways to improve the delivery of emergency care in rural areas. While the summit participants acknowledged that the ultimate goal is to staff all EDs with board certified emergency physicians, the participants also recognized significant barriers to achieving this goal.

Recommendations from the summit addressed residency training, academic medical centers, advocacy, distribution of the ED workforce, research, and educational programs.

On August 27, 2004, the Rural Workforce Task Force submitted a status report to the ACEP Board on the summit recommendations:

 Residency training:

 The Residency Review Committee for EM (RRC-EM), the accreditation organization for EM residency programs, approved program requirements for rural training pertaining to ED volume, using teleconferencing/telemedicine or other approved methods for the weekly conference requirements, housing arrangements at rural rotations, and allowances for variations for rural sites regarding ancillary and institutional support.
 The Council of EM Residency Directors (CORD) performed an informal needs assessment to determine interest among EM residency programs in a combined EM/FM residency training; results indicated an almost 50-50 split among program directors. In spring 2006, the American Board of Emergency Medicine (ABEM) and the American Board of Family Medicine (ABFM) approved guidelines for a five-year combined training program that, upon completion, will provide graduates the opportunity to seek certification in both EM and FM. Currently there is one combined EM/FM residency program.

 Academic Medical Centers:

 Summit recommendations were mailed to CORD, the Society for Academic Emergency Medicine (SAEM), and the Association of Academic Chairs of Emergency Medicine (AACEM), and were discussed in subsequent meetings with these groups during SAEM's annual meetings in May. During its meeting with the Boards of SAEM, CORD, and AACEM in May 2005, ACEP's Executive Committee discussed potential collaborative efforts regarding residency training in rural sites. In addition to graduate medical education (GME) funding issues precluding EM residency programs from implementing such training, all three academic emergency medicine organizations expressed concerns that these recommendations were not realistic given the workload of residency programs and the disinterest of faculty and residents in rotating through rural sites. EM residency programs in Oregon. Nebraska and New Mexico do provide opportunities for rural training.
 In response to these comments, the Academic Affairs Committee was assigned an objective to revise the original summit recommendations relating to rural residency rotations to address rural emergency medicine practice in lieu of rotations.

Subcommittee members recommended the following revisions in lieu of the original recommendations for AMCs:

 Continue advocacy efforts relating to (DC staff continues to work on these recommendations – see “Medical Education Debt/Loan Repayment-Forgiveness” paper on ACEP’s GME Web page for details http://www.acep.org/practres.aspx?LinkIdentifier=id&id=22472&fid=1710&Mo=No&acepTitle=Medical%20Education%20Debt/Loan%20Repayment-Forgiveness):

 inclusion of emergency medicine in the loan forgiveness program under the National Public Health Service
 obtaining tax credits for medical school loans for physicians practicing in rural areas;
 increasing reimbursement for rural practice (under the Medicare Physician Fee Schedule, there are currently two bonuses paid to physicians in rural/shortage areas).

 Identify rural groups such as in Appalachia that provide loan forgiveness programs for working in rural EDs, and communicate information on these programs to residency programs (Academic Affairs Committee members and ACEP staff contacted the Rural Appalachian Organization and the National Rural Health Association).
 Encourage the Emergency Medicine Foundation (EMF) to fund grants to study recruitment and retention practices for emergency medicine residency trained physicians working in rural EDs.
 Identify research strategies, including implementation of the longitudinal workforce study, on the status and practice of emergency medicine residency trained physicians in rural EDs (the longitudinal workforce study is being conducted in 2008).

 In response to the June 2006, Institute of Medicine’s (IOM) report, “The Future of Emergency Care in the United States Health System, “a special contribution article in the March 2007 issue of Academic Emergency Medicine (Vol. 14, No. 3: 261-267), the authors addressed the need for “securing educational loan forgiveness for rural EM practitioners and the development of innovative educational programs linked with rural hospitals.”

 Advocacy:

 ACEP’s DC staff were successful in obtaining rural GME funding for redistribution of unused GME residency slots via the Medicare Modernization Act; this effort resulted in establishment of new EM residency programs in rural states such as Nebraska, Utah, and Iowa. ACEP’s DC staff continues to work on GME funding for outside rotations to assist residency programs in providing the broad clinical experience necessary for high-quality training in emergency medicine by working with the Centers for Medicare and Medicaid Services (CMS) to revise the regulations. These revisions would allow a training program’s parent institution to receive GME payment for residents engaged in outside rotations in those circumstances where the “outside rotation” institution does not receive GME funding for the residents’ time in that setting (see the Academic Affairs Committee paper, “Securing Medicare GME Funding for Outside Rotations” http://www.acep.org/practres.aspx?LinkIdentifier=id&id=22488&fid=3328&Mo=No&acepTitle=Securing%20Medicare%20GME%20Funding%20For%20Outside%20Rotations.) For medical debt, the Academic Affairs Committee, in collaboration with the Emergency Medicine Residents’ Association (EMRA), developed an information paper, “Medical Education Debt/Loan Repayment-Forgiveness,” that provides more detailed information on the issues and DC staff advocacy activities in addressing these issues.

 Distribution of Workforce:

 Summit participants identified barriers to EM residents pursuing rural practice: reimbursement, medical debt, lifestyle, skill maintenance, etc).
 EMRA conducted a survey in 2006 (see “Medical Education Debt/Loan Repayment –Forgiveness” paper on ACEP’s GME Web site for more detail http://www.acep.org/practres.aspx?LinkIdentifier=id&id=22472&fid=1710&Mo=No&acepTitle=Medical%20Education%20Debt/Loan%20Repayment-Forgiveness) that indicated 88% of residents would consider a job in a rural location if loan repayment was an incentive, while only 52% would consider taking a job in a rural location if loan repayment was not an option.
 ACEP’s Emergency Medicine Practice Committee reviewed appropriate policies regarding having a board certified, emergency medicine residency trained physician to manage or provide medical oversight of rural EDs. In June 2004, the Board approved new language for the “Emergency Department Planning and Resource Guidelines” (http://www.acep.org/practres.aspx?id=29208) and the “Physician Credentialing and Delineation of Clinical Privileges in EM” (http://www.acep.org/practres.aspx?id=29628) policies; these revised policies do not mandate oversight of rural EDs with a board certified, EM residency trained physician. The Board declined the recommendation to develop a separate policy on rural ED leadership.

 Research:

 Consider adding a Research Committee objective to identify a rural research agenda, and suggest that EMF

consider a similar priority.
 The ACEP/SAEM NIH Task Force and the Research Committee are developing emergency care research agendas; a subcommittee of the Research Committee is developing a stakeholder's conference on emergency care research.
 The Institute of Medicine's (IOM) "The Future of Emergency Care in the United States Health System," (http://www.acep.org/pressroom.aspx?LinkIdentifier=id&id=25222&fid=1258&Mo=No&acepTitle=Institute%20of%20Medicine%20Report%20on%20Emergency%20Medicine) addressed rural emergency care. Two of the four forums conducted by the IOM as part of this report related to rural emergency care and to research. Past ACEP President Frederick Blum, MD, FACEP, FAAP, testified in Salt Lake City at the IOM Forum on Rural Emergency Medicine in September 2006. In December 2006, ACEP members participated in the IOM's Forum on Emergency Care Research by presenting information on the challenges and opportunities in emergency care research.

 Educational Programs:

 Consider adding rural workforce issues to be addressed as Educational Committee and Public Relations objectives.

The task force was disbanded in 2006 because the IOM report and College strategies/tactics were addressing the task force recommendations, many of which had been completed.

Stragegic Plan Reference:

Support efforts to ensure better access for medically underserved communities:

Continue efforts to increase numbers of emergency physicians practicing in rural areas.

Prior Council Action:

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action:

October 2005, Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit.

February 2003. approved Rural EM Summit.

Substitute Resolution 20(01) Medical Education Debt adopted.

October 2001, Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

June 2000, approved policy statement “Resident Training for Practice in Non-Urban Areas.”

Council Action:

Reference Committee B recommended that Substitute Resolution 19(08) be adopted.

~~RESOLVED, That the ACEP Council will direct the Board of Directors to appoint a second Rural Workforce Task Force whose composition shall include but not be limited to representatives from the Rural Emergency Medicine Section, Certification and Emergency Medicine Workforce Section, Careers in Emergency Medicine Section, Young Physicians Section, and the Emergency Medicine Informatics Section; and be it further~~

~~RESOLVED, That this task force shall be empowered to convene a second Rural Emergency Medicine Summit; and be it further~~

~~RESOLVED, That the task force shall utilize the recommendations from the first Rural Workforce Task Force and the report from the 2008 Emergency Medicine Workforce Task Force in making recommendations to the ACEP Board of Directors; and be it further~~

~~RESOLVED, That the chair of the task force shall seek representatives from the following organizations to participate in the development of recommendations and to attend this second Rural Emergency Medicine Summit as they did during the first Rural Emergency Medicine Summit: American Board of Emergency Medicine; Emergency Medicine Residents Association; Society for Academic Emergency Medicine; Council of Emergency Medicine Residency Directors; Residency Review Committee for Emergency Medicine; American Academy of Family Physicians; National Rural Health Association; Federal Office of Rural Health Policy; Rural Health Resource Center; and Society of Emergency Medicine Physician Assistants; and be it further~~

~~RESOLVED, The chair of the second Rural Workforce Task Force shall submit the recommendations of the task force to the ACEP Board of Directors in writing no later than August 15, 2009.~~

RESOLVED, That the ACEP Board of Directors appoint a Second Rural Workforce Task Force whose composition shall be at the discretion of the ACEP Board; and be it further

RESOLVED, That this task force shall be empowered to convene a Second Rural Emergency Medicine Summit and shall utilize the recommendations from the First Rural Task Force and the report from the 2008 Emergency Medicine Workforce Task Force in making recommendations to the ACEP Board; and be it further

RESOLVED, That the ACEP Board shall determine the deadline for the submission of a written report from the task force.

The Council referred Substitute Resolution 19(08) to the Board of Directors on October 26, 2008.

Testimony:

The authors of the resolution offered the substitute resolution based on feedback received after submission. All testimony heard was on the substitute language and was unanimously in support. All expressed a desire to develop an action plan to address problems identified by the previous task force and related studies.

Board Action:

N/A

References:

Implementation Action:

In June 2009, the Board approved taking no further action on this resolution because the intent of the resolution would be met by the Future of Emergency Medicine Summit. In July 2009, ACEP's president convened the Future of Emergency Medicine Summit. The summit included representatives from all of the emergency medicine organizations and other key organizations. The purpose of the summit was to reach consensus on issues facing emergency medicine, most notably workforce realities. Additionally, the Council of Residency Directors (CORD) was hesitant about reconvening a rural workforce task force because without additional GME funding, program directors will not be interested. A report from the Future of Emergency Medicine Summit was developed, endorsed by the summit participants, and subsequently published in *Annals of Emergency Medicine*.

The 2009 Council meeting included a Strategic Issues Forum discussion on Emergency Medicine Workforce Issues. A summary report was developed and distributed to the Council.

A follow-up to the Future of Emergency Medicine Summit will be held January 26-27, 2011.

Background Information Prepared by: Marjorie A Geist, RN, PhD, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 20: Emergency Department Categorization Task Force

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Minnesota Chapter ACEP

Purpose:

Directs ACEP to convene a task force to explore the feasibility of sponsoring a national emergency center categorization program.

Fiscal Impact:

$8,000 for staff time, conference calls, research, materials, and report development costs.

WHEREAS, The Institute of Medicine's Committee on the Future of Emergency Care published the following recommendation in its June 2006 reports:

"The Department of Health and Human Services and the National Highway Traffic Safety Administration, in partnership with professional organizations, should convene a panel of individuals with multidisciplinary expertise to develop evidence-based categorization systems for emergency medical services, emergency departments, and trauma centers based on adult and pediatric service capabilities"; and

WHEREAS, The American College of Surgeons Committee on Trauma (ACS-COT) has defined the required resources and practice environments of level 1 and level 2 trauma centers through its trauma center designation process; and

WHEREAS, Hospitals expend tremendous resources (including the personal involvement of senior leaders during verification site visits) to meet the trauma center criteria designated by the ACS-COT; and

WHEREAS, The trauma center verification process has become a substantial revenue source for the ACS; and

WHEREAS, No similar process currently exists for emergency physicians to define the resources and practice environment required for high quality emergency care outside of the trauma verification process; and

WHEREAS, Recommendations to eliminate the boarding of inpatients in EDs have to date been largely unsuccessful; and

WHEREAS, A categorization and verification program, if properly designed, would establish specific criteria that hospitals would be motivated to meet if they desired public designation as a level 1 or level 2 emergency center; and

WHEREAS, A window of opportunity exists for ACEP to take the lead in a national categorization program if it chooses; and

WHEREAS, Failure to take the lead may allow non-emergency medicine organizations and/or regulatory agencies to define the ideal practice environment for high quality emergency care; and

WHEREAS, Previous efforts by other emergency medicine organizations to categorize EDs were unsuccessful for a variety of important reasons; and

WHEREAS, It would be inappropriate for ACEP to commit itself to sponsoring a national ED categorization program without exploring the feasibility of such a program on a variety of levels; therefore be it

RESOLVED, That ACEP convene a task force to explore the feasibility of sponsoring a national emergency center categorization program, with a preliminary report and recommendations due to the Board of Directors at its June 2009 meeting, and a final report due to the Council at its 2009 annual meeting; and be it further

RESOLVED, That the ACEP Categorization Task Force report include, but not be limited to, key findings and/or recommendations in the following areas:

- an analysis of prior emergency center categorization efforts;
- a final recommendation regarding ACEP's involvement in an emergency center categorization program; and
- if a categorization program is recommended, details in the following areas:
    - a categorization business plan;
    - a recommendation about the number of emergency center levels that would be designated by the program; and
    - draft criteria for each level in the categorization program.

Background:

This resolution calls for the College to convene a task force to explore the feasibility of sponsoring a national ED categorization program and to provide a preliminary report and recommendation to the Board of Directors at its June 2009 meeting and a final report to the Council at its 2009 annual meeting.

Historically the issue of categorization of emergency services dates to the 1970s. In 1971 the American Medical Association's Commission on Emergency Medical Services published its Guidelines for the *Categorization of Hospital Emergency Capabilities.* The guidelines provided the basis for state and local regionalization program and were endorsed by the American Hospital Association. In 1981 the AMA's commission published the *Provisional Guidelines for the Optimal Categorization of Hospital Emergency Capabilities.*

A College policy, no longer in effect, titled "*Categorization of Emergency Services"* supported the categorization of in-hospital emergency medical services as a means of identifying in advance the ability of an institution to respond to patient needs." The policy went on to note that any categorization plan must consider the depth of commitment of the institution in one or more critical care areas, while identifying emergency facility capabilities. However this policy was allowed to sunset in 1997 because categorization of EDs was considered to be an issue in which ACEP should not be involved.

The Joint Commission (TJC) established standards and criteria for hospitals to define themselves as a level 1-4 emergency department (ED). In 1995 TJC rescinded the standards and ceased surveying EDs for compliance with the criteria for a prescribed or designated level.

The *Role of Emergency Medicine in the Future of American Medical Care*, published by the Josiah Macy Jr Foundation in April 1994 stated "Currently, the United States has an inadequate system to classify emergency departments. As a result, it is impossible for the public to know what level of care an emergency department is capable of providing. In the interest of both protecting and informing the public, a classification system for emergency departments should be developed that is comparable to the one that classifies each hospital-based trauma center on the basis of the level of sophistication of care it provides."

In 1996 the College investigated the College's role in the area of accrediting EDs. It was learned that ACEP members would value this service if it replaced TJC or CMS survey, the costs to establish an accreditation program were viewed as not financially feasible, the hospitals surveyed were not interested in incurring costs for this service and felt it was somewhat duplicative of other required surveys to participate in Medicare and Medicaid. As a result of these findings, the Board of Directors elected not to pursue this service but encouraged the College to work with accrediting and certifying bodies to ensure emergency medicine issues are addressed.

In 1999 the Society for Academic Emergency Medicine (SAEM) developed an ED categorization program. Their intent was to help people understand which resources are available so that they can make an informed decision on what ED they choose. Two reasons were given as a deterrent to the success of the program: (i) the complexity and the time required to complete the application and (ii) the cost.

The American College of Surgeons Consultation and Verification program for trauma centers recognizes that emergency medicine and emergency physicians are integral components of the trauma system and team. They worked with the College in the establishment of levels of care, qualification of physicians providing care and resource requirements for the levels I, II, and III trauma centers.

The Institute of Medicine's 2006 report, *The Future of Emergency Care in United States Health System,* centers on three core principles: coordination, regionalization, and accountability. One step identified in the report asks that Congress establish a model program to encourage states to try new approaches toward improving emergency care. In addition, the report recommends that Congress establish a lead US Department of Health and Human Services (DHHS) agency for emergency and trauma care, and that federal agencies establish evidence-based categorization systems, prehospital protocols and indicators of system performance.

Increasingly hospitals are applying for or working toward certain designations or certifications that indicate their facility is, for example a designated burn center, trauma center or certified as a chest pain center or stroke center. Hospital administrators are committed to ensuring that each element or resource required are available to obtain or maintain this designation.

In some instances, these designations imply that outside funding will be available (trauma centers) and in other situations imply a marketing edge over competitors (chest pain centers.) Categorization, designation and certification all require the allocation and commitment to a level of resources that supports an established criteria.

Stragegic Plan Reference:

Access to Emergency Care

Prior Council Action:

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 24(87) Levels of Staffing for Hospital Emergency Department adopted.

Prior Board Action:

Resolution 15(98) Certifying Emergency Departments adopted. A task force was appointed to further study the issues and potentially collaborate with SAEM. The task force report was distributed to the 2000 Council.

September 1997, sunsetted policy, Categorization of Emergency Services; was previously reaffirmed June 1992 and approved April 1984.

September 1996, approved revised policy, Emergency Care Guidelines; previously approved June 1991.

January 1996, elected not to pursue ACEP certification of EDs but to continue to influence JCAHO and NCQA on emergency services certification issues.

April 1994, rescinded policy, Health Care Facility Definitions; was previously approved June 1985.

Council Action:

Reference Committee C recommended that Amended Resolution 20(08) be adopted

RESOLVED, That ACEP convene a task force to explore the feasibility of sponsoring a national emergency center categorization program, with a preliminary report and recommendations due to the Board of Directors at its June 2009 meeting, and a final report due to the Council at its 2009 annual meeting; and be it further

RESOLVED, That the ACEP Categorization Task Force report include, but not be limited to, key findings and/or

recommendations in the following areas:

- an analysis of prior emergency center categorization efforts;
- a final recommendation regarding ACEP's involvement in an emergency center categorization program; and
- if a categorization program is recommended, details in the following areas:
    - a categorization business plan;
    - **an implementation plan;**
    - a recommendation about the number of emergency center levels that would be designated by the program; and
    - draft criteria for each level in the categorization program.

The Council adopted Amended Resolution 20(08) on October 26, 2008.

RESOLVED, That ACEP convene a task force to explore the feasibility of sponsoring a national emergency center categorization program; ~~with a preliminary report and recommendations due to the Board of Directors at its June 2009 meeting, and a final report due to the Council at its 2009 annual meeting~~; and be it further

RESOLVED, That the ACEP Categorization Task Force report include, but not be limited to, key findings and/or recommendations in the following areas:

- an analysis of prior emergency center categorization efforts;
- a recommendation regarding ACEP's involvement in an emergency center categorization program; and
- if a categorization program is recommended, details in the following areas:
    - a categorization business plan;
    - **an implementation plan;**
    - a recommendation about the number of emergency center levels that would be designated by the program; and
    - draft criteria for each level in the categorization program.

Testimony:

Testimony was overwhelmingly supportive of developing emergency department categorization. Those providing testimony spoke regarding current categorization efforts in effect for burn centers, trauma centers, stroke centers, and centers of excellence. Testimony indicated that categorization will allow emergency departments to secure much needed funding and resources, similar to stroke and trauma centers. It was also noted that any categorization process must include freestanding emergency departments, hospital-based and non-hospital-based.

Board Action:

The Board adopted Amended Resolution 20(08) on October 30, 2008.

RESOLVED, That ACEP convene a task force to explore the feasibility of sponsoring a national emergency center categorization program; and be it further

RESOLVED, That the ACEP Categorization Task Force report include, but not be limited to, key findings and/or recommendations in the following areas:

- an analysis of prior emergency center categorization efforts;
- a recommendation regarding ACEP's involvement in an emergency center categorization program; and
- if a categorization program is recommended, details in the following areas:
    - a categorization business plan;
    - an implementation plan**;**
    - a recommendation about the number of emergency center levels that would be designated by the program; and

- draft criteria for each level in the categorization program.

References:

Implementation Action:

A task force was appointed. The task force report was accepted for information by the Board in October 2009. The report was distributed to the 2009 Council and assigned to Reference Committee C for comments. No comments were offered on the report.

Background Information Prepared by: Marilyn Bromley

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 21: Excited Delirium

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Ohio Chapter ACEP
Asa Viccellio, MD, FACEP
No Contact Submitter Match
Mark L DeBard, MD, FACEP
Sharon Shay Bintliff, MD
James Jerome Augustine, MD, FACEP
John D Bibb, MD, FACEP
Scott Jason Korvek, MD, FACEP
Robert Eduard Suter, DO, MHA, FACEP

Purpose:

To establish a multidisciplinary group to study “excited delirium” and make clinical recommendations.

Fiscal Impact:

Budgeted expenses for staff labor and approximately $580 for task force conference calls.

WHEREAS, “Excited Delirium” is a term applied to certain hyperadrenergic patients (mostly afflicted with mental illness, drug effects, or both) in the out-of-hospital and hospital environments that may be predisposed to the risk of sudden death during physical or electrical restraint (TASER), by drugs, physiologic derangements, or underlying unknown cardiac disease; and

WHEREAS, ACEP’s expertise is with such patients in all such environments; and

WHEREAS, Such patients sometimes die during or shortly after attempts to bring them under control, such as physical restraint or electrical shock (TASER), whether by police, EMS, or Emergency Department (ED) personnel; and

WHEREAS, There are questions whether the syndrome exists or whether its associated deaths are even related to restraint efforts; and

WHEREAS, Such patients are commonly encountered in the ED as well, with multiple methods of physical and chemical restraint advocated, none of which have been universally agreed upon; and

WHEREAS, Modern methods of chemical sedation may provide quick and easy control of such patients that may save their lives, in both the out-of-hospital and hospital environment; therefore be it

RESOLVED, That ACEP undertake the lead to establish a multidisciplinary group of involved and concerned out-of-hospital (police, EMS), professional medical, and other appropriate organizations or individuals to:

1. define the existence of “excited delirium” as a disease entity (or not);
2. define identifying characteristics that help establish the diagnosis and risk for death; and
3. define preferred methods of control and treatment to minimize patient and caregiver risks so that the patient may be successfully managed in a medical environment.

Background:

This resolution requests ACEP to establish a multidisciplinary group to study “excited delirium” and make clinical recommendations. Excited delirium is a term used to describe a person who is experiencing extreme agitation, paranoia, and aggression with extraordinary strength and appears to be numb to pain. The media have used the term as a cause of death for individuals in police custody who exhibit combative agitation and delirium, usually with drug and/or alcohol intoxication, who dies suddenly, frequently after a violent struggle requiring the use of a TASER or physical restraint.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, a classification system for mental disorders and the International Classification of Diseases (ICD), a worldwide statistical disease classification system for all medical conditions including mental disorders published by the World Health Organization do not recognize excited delirium as a medical or psychiatric diagnosis. DSM IV includes criteria for delirium due to a medical condition, substance intoxication or withdrawal, or not otherwise specified.

The symptoms of excited delirium as a cause of death was first described in American psychiatric literature in 1849 by Dr. Luther Bell and is known as Bell’s mania. Symptoms were described as occurring over days or weeks. In 1981, the term excited delirium was used in the *Annals of Emergency Medicine* in a Case Report describing a patient who presented to the ED with anxiety and became increasingly agitated, confused, combative and violent. Upon autopsy the patient was found to have retained a ruptured finger cot of cocaine. In 1985, an article in the *Journal of Forensic Science* described seven cases of cocaine induced psychosis and sudden death in recreational cocaine users. Five of the seven deaths occurred in police custody. Symptoms were described as an acute onset of an intense paranoia, unexpected strength, hyperthermia, a high pain tolerance and violent bizarre behavior resulting in forcible restraint.

There have been occurrences highlighted in the media concerning the use of force on individuals who exhibit the signs of excited delirium that have resulted in death. Some cases involved the use of Tasers, pepper spray, and/or physical restraints with accusations that unreasonable force or that the way the patient was restrained (“positional asphyxia”) caused the individual’s death. A study of 18 cases of excited delirium sudden deaths after struggle and physical restraint witnessed by EMS personnel from 1992-to 1998 was conducted to determine factors associated with these deaths. During the study period a total of 196 other individuals with excited delirium were also restrained with wrist and ankles bound and attached behind the back. The factors identified were: excited delirium, hobble restraint, prone position, forceful struggle against restraint, stimulant drug use (78%), autopsy evidence of chronic disease (56%), obesity (56%), known chronic cocaine use (45%), pepper spray (33%), and Taser (28%). “…Other than excited delirium requiring restraint with struggle during restraint, there were no risk factors found present in every case.”

Vincent J. M. DiMaio MD Chief Medical Examiner in Bexar County Texas in his book, *Excited Delirium Syndrome: Cause of Death and Prevention* and describes the excited delirium syndrome primarily associated with illegal stimulant drugs. Details of medical and legal investigation of deaths due to the condition, risk factors, prevention and the role of first responders are discussed.

A recent article in the *Journal of Emergency Medical Services*1 calls for EMS to take the lead in the development of protocols that address patient restraints by pre-hospital providers with local law enforcement and mental health professional involvement. Training and preparation is seen as critical to minimize the potential for patient or rescuer harm with protocols and training addressing the use of verbal defusing, and physical and chemical restraints.

Stragegic Plan Reference:

Promote Quality Care and Patient Safety

Prior Council Action:

None

Prior Board Action:

None

Council Action:

Reference Committee C recommended that Amended Resolution 21(08) be adopted.

RESOLVED, That ACEP **study:** ~~undertake the lead to establish a multidisciplinary group of involved and concerned out-of-hospital (police, EMS), professional medical, and other appropriate organizations or individuals to:~~

1. ~~define~~ the existence of "excited delirium" as a disease entity (or not);
2. ~~define identifying~~ characteristics that help ~~establish the diagnosis~~ **identify the presentation** and risk for death; and
3. ~~define~~ preferred methods of control and treatment to minimize patient and caregiver risks so that the patient may be successfully managed in a medical environment; and be it further

RESOLVED, That ACEP develop and disseminate a white paper on findings to appropriate entities (e.g. EMS, law enforcement).

The Council adopted Amended Resolution 21(08) on October 26, 2008.

RESOLVED, That ACEP **study:** ~~undertake the lead to establish a multidisciplinary group of involved and concerned out-of-hospital (police, EMS), professional medical, and other appropriate organizations or individuals to:~~

1. ~~define~~ the existence of "excited delirium" as a disease entity (or not);
2. ~~define identifying~~ characteristics that help ~~establish the diagnosis~~ **identify the presentation** and risk for death; and
3. ~~define~~ ~~preferred~~ **current and emerging** methods of control and treatment ~~to minimize patient and caregiver risks so that the patient may be successfully managed in a medical environment~~; and be it further

RESOLVED, That ACEP develop and disseminate a white paper on findings to appropriate entities (e.g. EMS, law enforcement).

Testimony:

Testimony was divided regarding the support for the resolution. Speakers suggested that, due to the absence of a defined standard or evidence, ACEP should consider developing a white paper. Those opposed stated that a policy on excited delirium would have unintended consequences for EMS and law enforcement. Several expressed concerns that the resolution as originally written was too prescriptive and does not allow the College the flexibility to address this issue before establishing a multidisciplinary group.

Concern was expressed regarding 1) the lack of scientific evidence for the development of a policy statement that would establish a standard of care; 2) the risk and liability incurred by a practitioner should they not elect to follow the policy; and 3) formation of a task force is premature prior to the adoption of the above resolves.

Board Action:

The Board adopted Amended Resolution 21(08) on October 30, 2008.

RESOLVED, That ACEP study:

1. the existence of “excited delirium” as a disease entity (or not);
2. characteristics that help identify the presentation and risk for death; and
3. current and emerging methods of control and treatment; and be it further

RESOLVED, That ACEP develop and disseminate a white paper on findings to appropriate entities (e.g. EMS, law enforcement).

References:

1. Bledsoe BE, Phillips D. Holding back: issues in patient restraint. *JEMS*. 2007;32(5):75-85.

Implementation Action:

A task force was appointed. The task force report was approved by the Board in October 2009. The report was distributed to the 2009 Council and assigned to Reference Committee C for comments. No comments were offered on the report. The report has had limited distribution as it is being considered for publication in emergency medicine journals. The report will be given wider distribution and added to the ACEP Web site once a decision has been made regarding publication.

Background Information Prepared by: Margaret Montgomery, RN, MSN

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 22: Order Sets and the Physician-Patient Relationship

Council Action: **SUBSTITUTE RESOLUTION ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Illinois College of Emergency Physicians

Purpose:

Directs the development of a position statement regarding the use of chief complaint based order sets.

Fiscal Impact:

None beyond budgeted expenses for committee assignment as an objective.

WHEREAS, Emergency departments across the nation are challenged by increasing patient volumes, decreasing inpatient bed availability, and throughput issues; and

WHEREAS, As a result of this change in the national profile of emergency services many departments have experienced a significant increase in door-to-doctor waiting times, increased numbers of patients in the waiting area, and a related increase in morbidity, adverse outcomes, and other risk issues; and

WHEREAS, Many emergency departments have responded to this “challenge” by initiating chief complaint related order sets that have been developed in order to begin the patient evaluation process prior to a physician evaluation; and

WHEREAS, The triage nurse may initiate these order sets independently or after a brief phone conversation with an on duty emergency physician; and

WHEREAS, In many cases the physician has had no patient contact, and is allowing the triage nurse to initiate orders or is agreeing by phone to allow a nurse to initiate an order set solely to alleviate waiting times and to expedite patient management; and

WHEREAS, In addition, the physician’s name on the orders may not be the physician who provides the medical evaluation or patient management; and

WHEREAS, The emergency physician in most cases has not seen, nor examined the patient, and has had no opportunity to develop a physician-patient relationship; and

WHEREAS, Physicians may be hesitant to initiate such order sets because of fear of exposure to medical malpractice liability; and

WHEREAS, A position statement by the American College of Emergency Physicians regarding the use of order sets under these circumstances, asserting that the use of order sets in this fashion does not, in and of itself, create a physician-patient relationship, may have a significant impact in the process of malpractice litigation; therefore be it

RESOLVED, That: 1) ACEP recognizes that the practice of utilizing order sets is reasonable and is consistent

with high quality emergency medical care; and 2) it is the position of the College that the use of order sets does not, in and of itself, create a physician-patient relationship.

Background:

This resolution directs the development of a position statement regarding the use of chief complaint based order sets. The terms standing orders, protocols and pre-printed order sets have all been used to describe chief complaint based sets of orders used in the emergency department (ED), developed to expedite safe and effective patient management prior to physician examination of the patient. In crowded EDs, the use of standing orders has decreased patient wait times. The protocols are frequently initiated by the triage nurse prior to the physician evaluation. In some facilities the protocol is initiated after the nurse discusses the patient with the emergency physician.

The Centers for Medicare and Medicaid Services (CMS) Interpretive Guidance on Hospital Conditions of Participation (COP) Section 482.232(2) states . "…orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient…" The interpretive guidance sent to state survey agency directors on February 8, 2008 states that "if a hospital uses other written protocols or standing orders for drugs or biologicals that have been reviewed and approved by the medical staff, initiation of such protocols or standing orders *requires an order from a practitioner responsible for the patient's care.*"

Since July 2007, there has been communication (e-mail, conference calls and formal letters) from ACEP, ENA and AAEM with The Joint Commission and CMS expressing great concern that nurses are prevented from implementing evidence-based medical staff approved protocols prior to the examination of a patient by a physician. Examples of how this prohibition to initiate care prior to physician examination can result in patient harm was provided to CMS and TJC. They include:

- Pediatric febrile seizure in the waiting room because antipyretic not given;
- Respiratory treatments initiated by EMS discontinued upon arrival to ED;
- Current PQRI measure calls for the immediate dispensing of aspirin for patients presenting with chest pain along with EKG; and
- Initiation of rapid response team and CPR protocols.

Response from The Joint Commission has been one of understanding but, because their standards are based on CMS regulations and interpretive guidelines, they have deferred to CMS. CMS recently indicated they will provide further clarification in the next few months on nurse initiated protocols.

A physician-patient relationship is most often established when the physician sees the patient. But a physician-patient relationship could be implied in other ways. The ACEP policy, *Code of Ethics for Emergency Physician*s, states, the "…emergency physician-patient relationship is usually episodic, dictated by the patient's urgent need for care. Thus, the patient's willingness to seek emergency care and trust the physician is based on institutional and professional assurances rather than on a personal acquaintanceship. The emergency physician's ethical duties in these relationships may be categorized into those dealing with beneficence, autonomy, fairness, and nonmaleficence." The Code of Ethics further states, "If multiple physicians work in the emergency department, each patient should have a clearly identified physician who is responsible for his or her care. Transfer of this responsibility should be clear to the patient, families, and staff involved, and should be clearly documented on the patient's medical record."

Concern has been raised about emergency physician liability when a nurse initiated protocol is used in the ED since a physician/patient relationship is not clearly established. Some emergency physicians resist the use of nurse initiated protocols for this reason. As the protocols are frequently developed and approved for use through the hospital medical staff and the patient is "coming to the ED" as part of a hospital, some would argue that the hospital is liable for the use of the protocols. If liability extended to the physicians that develop protocols, such liability may be covered by the hospital's liability policy since the physician could be considered as acting as an agent of the hospital

Under EMTALA regulation, physicians are viewed as agents of the hospital and any violation under the law is directly attributed to the hospital.

Stragegic Plan Reference:

Promote Quality Care and Patient Safety

Work to Eliminate Crowding and Boarding

Prior Council Action:

None

Prior Board Action:

June 2008 revised and approved policy statement, “Code of Ethics for Emergency Physicians.” Reaffirmed October 2001, approved June 1997 replacing original policy statement titled, “Ethics Manual” originally approved January 1991.

Council Action:

Reference Committee C recommended that Amended Resolution 22(08) be adopted.

RESOLVED, That: 1) ACEP recognizes that the practice of utilizing **nurse-initiated** order sets **prior to physician evaluation** is reasonable and is consistent with high quality emergency medical care; and 2) it is the position of the College that the use of order sets does not, in and of itself, create a physician-patient relationship; and **3) ACEP consider submitting this resolution to the American Medical Association for further action.**

The Council adopted Substitute Resolution 22(08) on October 26, 2008.

RESOLVED, That~~: 1)~~ ACEP ~~recognizes that the practice of utilizing~~ **nurse-initiated** ~~order sets~~ **prior to physician evaluation** ~~is reasonable and is consistent with high quality emergency medical care; and 2) it is the position of the College that~~ **develop policy that addresses** ~~the~~ use of **orders/**order sets **prior to the establishment of the** ~~does not, in and of itself, create a~~ physician-patient relationship~~; and **3) ACEP consider submitting this resolution to the American Medical Association for further action.**~~

Testimony:

The preponderance of testimony was in favor of the College supporting the contention that the use of order sets in and of itself does not establish a physician-patient relationship and may have a significant impact in the process of malpractice litigation.

Due to the magnitude of this issue, testimony was provided that the College should consider forwarding this issue to the AMA for further deliberation.

Board Action:

The Board adopted Substitute Resolution 22(08) on October 30, 2008.

RESOLVED, That ACEP develop policy that addresses use of orders/order sets prior to the establishment of physician-patient relationship.

References:

Implementation Action:

Assigned to the Medical-Legal Committee. The Board approved the policy statement, “Use of Nurse Implemented Order Sets,” in June 2010. The policy was added to the Web site and included in the Policy Compendium. http://www.acep.org/Content.aspx?id=48946

Background Information Prepared by: Margaret Montgomery, RN, MSN

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 23: Regulatory Process Misuse

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Iowa Chapter ACEP

Purpose:

Directs ACEP to request a study from the AMA on the ethics of the use of regulatory processes to resolve professional disagreements.

Fiscal Impact:

Less than $500. Minimal staff time including 5 hours developing and promoting a recommendation to the AMA.

WHEREAS, By definition, a profession has a defined body of knowledge and practice, polices it members, exercises autonomy, is accountable to itself and the society it serves, and protects its boundaries; and

WHEREAS, A specialty within a profession sets out the standards of professional conduct, the minimum competencies of its members, and monitors the maintenance thereof; and

WHEREAS, That specialty is then responsible to the House of Medicine and the general public to police its members; and

WHEREAS, A drug or device does not know the hand that wields it and any and all approved devices and pharmaceuticals, among other items, should be available to any physician to use for the benefit of his/her patient as long as such use is within his/her professional competence; and

WHEREAS, Each state has the right and obligation to regulate the practice of a profession in the interest of the common good; and

WHERAS, The scope of practice of a specialty is defined by that specialty society, and State Boards of Medicine and parallel professional boards exist to apply laws as passed from time to time by the legislature of the respective state; and

WHEREAS, Some specialty societies have used the regulatory power of the state to block physicians of other specialties from using certain pharmaceuticals or performing certain procedures, either directly or interfering with processes of care; and

WHEREAS, These regulations have caused to be written into statute blatant fallacies, serious errors, and malpractice minefields (e.g., that the PDR is a legally restricting document, using confusing language, and setting up dangerous precedent, among others) and physicians have used their stature as learned individuals to promote these viewpoints to the public, which viewpoints would be ridiculed by a group of physicians; and

WHEREAS, The use of the regulatory process can result in a monopoly situation, possibly running afoul of the pertinent law; and

WHEREAS, Restrictions on procedures performed by competent practitioners restrict access to care and have the paradoxical effect of reducing safety by causing the formation of non-standard systems of care; and

WHERAS, The use of the regulatory process, among other state processes, is an improper and unprofessional method of resolving professional disputes; and

WHERAS, ACEP welcomes and invites any and all other specialties that have issues with ACEP and, by extension, the Emergency Nurses Association policies to appear before and with ACEP to discuss and resolve these issues in the manner of professionals; and

WHEREAS, During times of stress, it is the responsibility of the House of Medicine to instruct, correct, and, when the occasion warrants, discipline its members and additionally, the House of Medicine must promote the highest standards of professionalism; and

WHEREAS, The Iowa Chapter of ACEP has an affirmative duty to bring these divisive actions to the larger House of Medicine; therefore be it

RESOLVED, That ACEP shall approach the American Medical Association (AMA) to request a finding, possibly by the Council on Ethical and Judicial Affairs to study the use of regulatory processes to resolve professional disagreements, with a potential finding of Unprofessional Conduct when using state powers to resolve professional issues.

Background:

This resolution calls for the College to seek a finding from the AMA, possibly by the Council on Ethical and Judicial Affairs, to study the use of the state regulatory process to resolve professional disagreements along with a potential finding of unprofessional conduct for utilizing state regulatory agencies for this purpose.

In recent years, numerous state nursing boards have considered adopting regulations that would prohibit emergency nurses from administering procedural sedation. In 2008, the Iowa Board of Nursing supported the enactment of such a regulation. Given the negative impact that this change would have on the administration of procedural sedation in the emergency department, the Iowa chapter of ACEP opposed the regulation. The chapter also opposed the public testimony and related efforts of some physicians in another specialty that actively supported passage of the regulation.

This resolution addresses the activities of such physician groups who may play a role in initiating or actively supporting efforts to use the state regulatory process to enact regulations that infringe on the practice of other specialties and potentially jeopardize quality patient care. The authors would like the College to ask the AMA to study this practice and consider finding that such actions represent unprofessional conduct.

ACEP has two policy statements supporting the rights and capabilities of certified emergency nurses in administering procedural sedation under the direct supervision of emergency physicians. “Delivery of Agents for Procedural Sedation and Analgesia by Emergency Nurses” is a joint policy statement with the Emergency Nurses Association. “Procedural Sedation in the Emergency Department” also outlines ACEP’s position on who is best qualified to make determinations on the administration of procedural sedation in the ED, stating that “ACEP is the authoritative body for the establishment of guidelines for procedural sedation and analgesia by emergency physicians.”

ACEP has worked within the current regulatory structure to advocate for its position on this issue. The College has assisted state chapters that have sought to defeat regulatory attempts to prohibit emergency nurses from administering procedural sedation. ACEP has provided chapters with policy statements, talking points, written testimony and other resources and has communicated with the Emergency Nurses Association whenever these issues come to light.

Additionally, the College has supported efforts to increase the role of state medical boards whenever other regulatory or legislative bodies consider action that impacts a physician’s scope of practice. In a 2004 letter cosigned by ACEP and 76 other medical societies, the AMA urged the Federation of State Medical Boards to adopt a policy that defines an active role for state medical boards when scope of practice changes are considered by state legislatures or regulatory bodies. The letter stated in part: “…not having the state medical boards willing to provide input to a legislature and/or regulatory body prior to the enactment of legislation and/or regulation, puts not only the medical societies, but the patients our physicians treat, at a serious disadvantage…When patient safety and protecting the public are at issue, we believe that a state medical board has no choice but to be involved.”

The AMA currently has policies related to the issue. The AMA policy statement entitled “Need for Active Medical

Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners" states in part that "It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities." Its policy statement "Limitation of Scope of Practice of Certified Registered Nurse Anesthetists" states: "Our AMA, in conjunction with the state medical societies, will vigorously inform all state governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals." Lastly, although the AMA is very active in scope of practice issues involving non-physician providers, it may be naturally reluctant to get involved in disputes involving different physician specialties. One of the core principles of the AMA's Scope of Practice (SOP) Partnership initiative states that "the SOP Partnership will not become involved in any SOP campaigns that involve two (or more) separate medical societies opposing one another on an SOP or SOP-related issue."

Stragegic Plan Reference:

Promote Quality Care and Patient Safety

Prior Council Action:

Amended Resolution 29(06) Procedural Sedation adopted. The resolution directed that the existing policy "Procedural Sedation and Analgesia in the ED" be updated to state that emergency nurses are trained qualified personnel to administer all agents for procedural sedation under the direct supervision of emergency physicians. The resolution also reinforced ACEP's opposition by other professional organizations or nursing boards to restrict the supervised administration of sedating agents by emergency nurses. The policy statement is being updated by the Clinical Policies Committee.

Amended Substitute Resolution 42(04) Procedural Sedation in the Emergency Department adopted. This resolution resolved that the College work with ENA to develop a position statement regarding the administration of agents for procedural sedation/analgesia by emergency nurses, so as to assist state chapters and hospitals in dealing with State Boards of Nursing.

Amended Substitute Resolution 21(92) Procedural Sedation and Analgesia adopted. This resolution asked the Board of Directors to consider development of a clinical procedural policy on sedation and analgesia in the emergency department.

Prior Board Action:

October 2007 approved clinical policy "Critical Issues in the Sedation of Pediatric Patients in the Emergency Department."

October 2006, Amended Resolution 29(06) Procedural Sedation adopted.

June 2006 approved policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine." Replaces a policy with the same title revised June 2004**, reaffirmed October 1999 with the same title; revised and approved in September 1995 with new title "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised in June 1991 with the same title; and originally approved in April 1985 titled "Guidelines for Delineation of Clinical Privileges in Emergency Medicine. "**

June 2006 approved policy resource education paper (PREP) Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine.

June 2005 approved policy statement, Model of the Clinical Practice of Emergency Medicine. Jointly approved by ABEM, ACEP, CORD, EMRA, RRC-EM, and SAEM. This policy statement replaces Model of the Clinical Practice of Emergency Medicine approved October 2000 and September 2003. The original policy statement, Core Content for Emergency Medicine was approved December 1996.

April 2005 approved policy statement, "Delivery of Agents for Procedural Sedation and Analgesia by Emergency Nurses." This policy statement was approved by the ENA Board in March 2005.

October 2004, Amended Substitute Resolution 42(04) Procedural Sedation in the Emergency Department adopted.

October 2004 approved “Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department.”

October 2004 rescinded the 1998 “Clinical Policy for Procedural Sedation and Analgesia in the Emergency Department.”

April 2004 approved clinical policy Evidence-Based Approach to Pharmacologic Agents Used in Pediatric Sedation and Analgesia in the Emergency Department. Endorsed by the American Academy of Pediatrics (AAP), American Pediatric Surgical Association (APSA) and the Emergency Nurses Association (ENA).

October 2001 reaffirmed policy statement The Use of Pediatric Sedation and Analgesia. It was originally approved in March 1992 and was replaced by a policy statement with the same title in January 1997.

January 1998 approved “Clinical Policy for Procedural Sedation and Analgesia in the Emergency Department.”

October 1992, Amended Substitute Resolution 21(92) Procedural Sedation and Analgesia adopted.

June 1984 approved the policy statement, “Nitrous Oxide Inhalation Analgesia.” It was amended in September 1986, and rescinded in October 1992.

Council Action:

Reference Committee C recommended that Amended Resolution 23(08) be adopted.

RESOLVED, That ACEP ~~shall~~ **explore options regarding** the use of regulatory processes to resolve professional disagreements, **including considering** approach**ing** the American Medical Association (AMA). ~~to the use request a finding, possibly by the Council on Ethical and Judicial Affairs to study. , with a potential finding of Unprofessional Conduct when using state powers to resolve professional issues.~~

The Council adopted Amended Resolution 23(08) on October 23, 2008.

Testimony:

The majority agreed no specialty should dictate scope of practice for another specialty. There was significant concern expressed that the original resolve as written did not allow for flexibility in how this issue could be handled within the AMA. Representatives from the AMA Section Council on Emergency Medicine articulated that this issue could have significant unintended consequences as well as harm ACEP’s relationship with other hospital-based specialties.

Board Action:

The Board adopted Amended Resolution 23(08) on October 30, 2008.

RESOLVED, That ACEP explore options regarding the use of regulatory processes to resolve professional disagreements including considering approaching the American Medical Association (AMA).

References:

Implementation Action:

Assigned to the AMA Section Council on Emergency Medicine. The Section Council discussed the resolution and expressed concerns about the issue and its complexity. The issue was submitted to AMA staff for review and recommendation as to options for addressing it through the AMA. After discussions with AMA staff, the

Section Council concluded that it would be difficult to champion this resolution in the AMA House of Delegates and agreed to support existing AMA policy.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Craig Price, CAE

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
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2008 Council Resolution 24: Single-Payer Health Insurance

Council Action: **SUBSTITUTE RESOLUTION ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Michigan College of Emergency Physicians

Purpose:

Support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach.

Fiscal Impact:

None other than budgeted staff time.

WHEREAS, There were approximately 47 million individuals without health insurance in 20061; and

WHEREAS, The consequences of being uninsured include delayed or denied access to care, increased morbidity, prolonged hospitalization, premature death and social stigma; and

WHEREAS, Incremental adjustments to the health care delivery system in this country through public programs that serve the uninsured (e.g., Medicaid and SCHIP) and limited voluntary activities in the private sector, have failed to reduce the number of uninsured1;and

WHEREAS, The ACEP Council adopted Resolution 15 in 1999, **stipulating t**hat ACEP formulate and implement a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; and

WHEREAS, Non-profit and for-profit health plans in the private sector are inefficient, with administrative costs of approximately 13 percent and 19 percent of total annual expenses, respectively2; and

WHEREAS, The most popular and most economically efficient health insurance plan in the United States is Medicare, a single-payer, government-financed, universal access program that serves 44 million beneficiaries, including seniors, those with End Stage Renal Disease, and qualified individuals with chronic disabilities3;and

WHEREAS, The much-heralded problems with the single-payer health care delivery system in Canada are in large part attributable to chronic under-funding at the federal level; and

WHEREAS, The most recent polls show that over 60 percent of the general public4,5,,and up to 64 percent of physicians6, are supportive of a national single-payer health care system; and

WHEREAS, Single-payer health insurance is supported by large national organizations such as the American College of Physicians, the American Public Health Association, the American Medical Women's Association, the National Medical Association, and the American Medical Students Association; therefore be it

RESOLVED, That ACEP support the adoption of a single-payer health insurance program in the United States; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the single-payer approach to providing health insurance to all Americans.

Background:

This resolution requires that ACEP support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach.

Employer-based coverage is the primary source of health insurance for a majority of workers and their families in the United States. In recent years, as costs have escalated, employers have shifted costs to employees and retirees via a variety of methodologies.

In the late 1980s to mid 1990s, various managed care programs (e.g. capitation, staff model HMOs, etc.) held promise of reigning in costs while assuring quality health care. Many public programs (e.g. Arizona AHCCCS, TennCare, etc) also adopted the managed care approach as a cost-control mechanism. At the same time, the number of uninsured individuals fluctuated from a low of 39 million to a high of approximately 45 million. Incremental expansion of public programs (e.g. SCHIP) were intended to meet the growing need for health care coverage. But despite these initiatives, the cost of health care, costs of health insurance, and patients without insurance remain a persistent challenge.

Supporters of the single-payer concept argue that it would greatly improve the efficiency of the U.S. health care system by eliminating the need for some 1200 different insurance companies. They argue this adds to the bureaucratic complexity and cost of the U.S. health care system and that the reduced administrative costs would offset the cost of providing expanded coverage to the poor and uninsured. Supporters also point out that the U.S. system is a high-cost, over-specialized system that doesn't deliver care to all of its citizens.

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

Opposition to the single payer system approach is equally entrenched in its support for market-based system solutions. They point out that after 30 years of government intervention, the Canadian system suffers from long waiting times for critical procedures, lack of access to current technology, increasing costs to taxpayers and patients, and a “brain drain” of doctors, who head south for better working conditions and more money. Opponents also point out the explicit rationing of resources that inevitably arises in such a system and the inadequate investment in medical technology and new drugs – all strengths of the market based approach.

Support for a single payer system in the Congress waned in recent years. But during the 2006 Congressional elections, healthcare reform emerged as a revitalized issue. Earlier this year, the House and Senate responded by passing differing versions of legislation to expand the State Children’s Health Insurance Program (SCHIP). Although the President has threatened to veto it, proponents argue it is an important step toward universal healthcare coverage. For others, it is a significant step toward “government run” healthcare, ultimately leading to a single-payer system.

At the 2007 Leadership & Advocacy Conference, ACEP members participated in a group debate over universal healthcare coverage. Support for a single payer system was articulated by several speakers. While there was no actual vote taken, it was clear that there is some sentiment in favor of the single-payer approach. A questionnaire soliciting Presidential candidates’ views on healthcare reform was one of the outcomes of that session.

In 1994, the Council adopted a similar resolution, Amended Resolution 38(94) “Single-Payer System,” which also called for ACEP to support organizations in favor of a single payor system.

The Council again debated this issue in 2005 with Resolution 34(05) “Single-Payer Health Insurance,” which was referred to the Board.

In June 2005 the Board discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits. While the Board agreed with the premise that public funding should be changed from the Medicare/Medicaid model, they did not believe that it is an achievable goal at that time. Further, the Board was unsure whether the implementation of such a plan would have a positive impact on emergency physician reimbursement and agreed to delay taking an active role.

In 2007, the Board adopted a set of reform principles calling for universal healthcare coverage. Those principles do not specify a financing mechanism nor a specific approach, but serve instead as the basis for further work.

ACEP's Federal Government Affairs Committee forwarded its comments on the Resolution 34(05) to the Board in July. The committee recommended that the Board reaffirm its support for the previously mentioned principles. At its August meeting, the Board agreed with the committee's recommendation that no further action on the resolution was needed in light of the reform principles and other policies of ACEP. The Board further expressed the view that healthcare reform was and will continue to be a critical issue in the years to come and that further debate over the merits of various proposals to reform healthcare should be explored.

At their January 2008 meeting, the Board 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 are ACEP's primary goals in the health care debate.

Healthcare reform has been an important issue in the campaigns for federal office this year. For part of the year, healthcare reform was the number two domestic issue. With the rise in gasoline prices, the flagging economy, and the war in Iraq and Afghanistan, healthcare reform has slipped to fourth place in many national polls. Nonetheless, healthcare reform will be an important issue when the new administration and the 111th Congress convene in Washington, DC in January 2009. Many observers expect any federal effort to be incremental in nature, avoiding the gridlock that more comprehensive approaches might generate.

Stragegic Plan Reference:

Ensure Access to Emergency Medical Care

Prior Council Action:

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.

Resolution 11(00) Funding the Mandate referred to the Board.

Resolution 15(99) Promotion of Health Care Insurance adopted. The resolution directed ACEP to forumlate and implement a strategic plan to promote expansion of health care insurance coverage for the uninsured and underinsured, continue to work with state, federal, and private agencies to expand health coverage for the uninsured and underinsured, and provide a report to the 2000 Council. This resolution was linked to Resolution 12(99).

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted. It called for ACEP to continue working with the AMA and other leaders on developing and implementing an educational program, on the issue of the medically uninsured and underinsured.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

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.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Resolution 18(92) Effect of Transfer Legislation on Emergency Medical Care referred to the Board of Directors.

Prior Board Action:

January 2008, the Board 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 are ACEP's primary goals in the health care debate.

August 2007, the Board 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).

January 2006, endorsed the "Principles of Reform of the U.S. Health Care System" developed by eleven physicians organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level. The committees continue to work on the issues identified in the resolution.

July 2000 revised policy "Health Promotion Revenues (Sin Taxes).

1999 approved policy "Universal Health Care Coverage."

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Amended Resolution 38(94) Single-Payer System adopted.

"Sin Taxes" policy statement approved in 1993.

In 1987, adopted a policy statement titled "Access to Emergency Medical Care: Emergency Physicians and Uncompensated Care."

Council Action:

Reference Committee C recommended that Resolution 24(08) not be adopted.

The Council adopted Substitute Resolution 24(08) on October 26, 2008.

~~RESOLVED, That ACEP support the adoption of a single-payer health insurance program in the United States; and be it further~~

~~RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the single-payer approach to providing health insurance to all Americans.~~

RESOLVED, That the Board of Directors derive a list of essential components to be included in any new healthcare system and create a white paper.

Testimony:

The preponderance of testimony was not in support of the resolution or a single-payer system as outlined in the resolution. There was diverse opinion among those providing testimony as to what system would facilitate the most expedient access to emergency care. Multiple plans were mentioned, such as the AMA plan, HMOs, and single-payer plans; however, there is no evidence to support any one plan over another. Therefore, those

providing testimony could not reach consensus on this issue.

Board Action:

The Board adopted Substitute Resolution 24(08) on October 30, 2008.

RESOLVED, That the Board of Directors derive a list of essential components to be included in any new healthcare system and create a white paper.

Principles for Reform of the U.S. Health Care System

ACEP joined with nine of the nation's leading physician associations to speak with one voice to release principles to reform the U.S. health care system. The eleven principles are intended to serve as a guide for Congress to encourage bi-partisan action to improve both individual health and the collective health care system in the United States.

PREAMBLE: Health care coverage for all is needed to facilitate access to quality health care, which will in turn in improve the individual and collective health of society.

1. Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.
2. The health care system in the U.S. must provide appropriate health care to all people within the U.S. borders, without unreasonable financial barriers to care.
3. Individuals and families must have catastrophic health coverage to provide protection from financial ruin.
4. Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.
5. In reforming the health care system, we as a society must respect the ethical imperative of providing health care to individuals, responsible stewardship of community resources, and the importance of personal health responsibility.
6. Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system which will allow individuals/employers to purchase additional services or insurance.
7. Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable and sustainable health care system.
8. Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.
9. Sufficient funds must be available for research (basic, clinical, translational and health services), medical education, and comprehensive health information technology infrastructure and implementation.
10. Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care and mental health services.
11. Comprehensive medical liability reform is essential to ensure access to quality health care.

The following groups participated:

- American Academy of Family Physicians
- American Academy of Orthopaedic Surgeons
- American College of Cardiology
- American College of Emergency Physicians
- American College of Obstetricians and Gynecologists
- American College of Osteopathic Family Physicians
- American College of Physicians
- American College of Surgeons
- American Medical Association
- American Osteopathic Association

References:

1 US Bureau of the Census, Health Insurance Coverage: 2006. Available at: http://www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html

2 Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med* 2003;349:768-75.

3 Geyman J. Myths as barriers to HC reform in the United States, *Intl J Health Services*, 33:315-329.

4 CNN Opinion Research Corporation, May 4-6, 2007

5 Catholic Healthcare West. Americans anxious about their health security, May 9, 2007

6 Albers JM. Lathrop BP. Allison KC. Oberg CN. Hart JF. Single-payer, health savings accounts, or managed care? Minnesota physicians' perspectives. *Minnesota Medicine*. 2007;90:36-40.

Implementation Action:

At the January 2009 Board retreat there was discussion about health care reform initiatives. The “Principles for Reform of the U.S. Health Care System” adopted by the Board and several other medical specialties, contains the essential components called for in this resolution. In June 2009, the Board of Directors had a comprehensive discussion regarding ACEP’s health care reform positions on some of the most controversial items currently under consideration in the reform debates. For many of the items, the Board believed it would need more information on how emergency medicine might be impacted before taking a definitive public position. ACEP, along with many other medical specialty societies, was actively engaged in the hearing and drafting stages of health care reform. ACEP’s President sent a letter to the Senate Finance Committee commenting on an options paper that was released. The goals ACEP embraces such as universal coverage, quality, affordability, etc., were addressed in the comprehensive bills that were in development.

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

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

In July 2009, the Federal Government Affairs Committee was given an objective to “Develop a list of guiding principles for health care reform to be used as an adjunct in developing ACEP policy as reforms emerge.” In March 2010, an information paper was distributed to the Council designed to convey the essential components of reform that exist in ACEP’s policies and positions and a brief summary of the history and/or strategy employed with regard to the health care debate.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (aka, “ACA”). According to the Congressional Budget Office (CBO), Public Law 111-148, the number of uninsured residents in the United States will drop from current levels (as many as 45 million) to 32 million by 2019. CBO estimated those still without insurance include as many as 23 million undocumented aliens, others who either opt not to enroll in Medicaid or those who elect to pay the penalty for not obtaining coverage. Since enactment, several law makers voiced their support for a single payer system, such as Medicare for all. Representative John Conyers (D-MI) and 87 colleagues introduced the United States National Health Care Act (also known as the

Expanded and Improved Medicare for All Act) on January 26, 2009. No action was taken on this bill during the First Session and Second Session of the 111th Congress. Similar bills beginning with the 108th Congress were introduced but were never considered.

Background Information Prepared by: Gordon Wheeler

Reviewed by: Arlo F Weltge, MD, MPH, FACEP
Bruce Alan MacLeod, MD, FACEP
Dean Wilkerson, JD, MBA, CAE

2008 Council Resolution 25: State Department of Health Crowding Surveys

Council Action: **SUBSTITUTE RESOLUTION ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians

Purpose:

Directs ACEP to survey all 50 state Departments of Health regarding policies, guidelines, and procedures for addressing hospital and ED crowding and report the findings to the 2009 Council.

Fiscal Impact:

80 hours of staff time to develop and distribute the survey, follow-up with state departments of health to maximize responses, and compile results for an estimated total of $5,236 in staff time.

WHEREAS, Crowding of our hospitals and emergency departments (EDs) is one of the major factors negatively influencing health care today; and

WHEREAS, Crowding results in increased waiting times to see a physician in an ED, increased ambulance diversions away from hospitals, increased medical errors, increased sentinel events, increased patient mortality and decreased patient safety and access to health care; and

WHEREAS, Hospitals and EDs in other states, including but not limited to, New York State, have responded to the problem of crowding by moving ED patients who have been admitted to the hospital ("boarded" patients) out of the ED to inpatient areas, such as hallways, conference rooms and solaria (see Full Capacity Protocol at www.hospitalovercrowding.com); and

WHEREAS, This practice has been highly successful at more evenly spreading "boarded" ED patients throughout the hospital without unduly stressing inpatient units, freeing the ED to function more efficiently and improving patient safety; and

WHEREAS, Departments of Health (DOHs) are state agencies responsible for promoting and regulating health care throughout each state independently; and

WHEREAS, DOHs license and regulate a variety of health facilities, such as nursing homes, ambulatory surgical facilities and hospitals; and

WHEREAS, A number of state DOHs, including the New York DOH, have embraced the concept of placing "boarded" ED patients in non-traditional areas within the hospital, such as inpatient hallways, conference room and solaria, during times of ED crowding; and

WHEREAS, This concept, despite its effectiveness in providing a solution to hospital and ED crowding, is not universally accepted by all state DOHs; and

WHEREAS, The Pennsylvania DOH, during a number of site visits to hospitals and EDs in the state, has repeatedly disallowed, and even threatened to fine hospitals for, the use of hallways and alternative hospital sites

to move ED “boarded” admitted patients out of the ED, unless there is a declared flu epidemic, or the hospital activates its emergency preparedness (disaster) plan; and

WHEREAS, Some DOH site reviewers have, in addition, begun to threaten hospitals with citations for simply placing ED patients in ED hallways; and

WHEREAS, EDs and hospitals nationwide remain crowded a majority of the time, leading to suboptimal, unsafe health care our patients; therefore be it

RESOLVED, That the American College of Emergency Physicians (ACEP) survey all 50 state Departments of Health regarding their policies, guidelines, and procedures for addressing hospital and ED crowding, to include their responses to common and effective solutions to crowding such as use of hospital inpatient and ED hallways; and further be it

RESOLVED, That the results of this survey be reported back to the Council in 2009.

Background:

This resolution directs the College to survey all 50 state departments of health regarding policies, guidelines, and procedures for addressing hospital and emergency department crowding and report the findings to the 2009 Council.

The resolution notes that state departments of health have taken dramatically different positions regarding the acceptability of moving boarded patients out of the emergency department and into hallways or other non-traditional areas within the hospital. A few states that have actively worked to address the problems of crowding and boarding have embraced the concept of moving boarded patients. The New York Department of Health has issued a guidance document for hospitals stating that “maintaining admitted patients within the emergency department is not acceptable” and adding that “during peak periods of overcrowding, as a temporary emergency measure, the use of beds in solariums and hallways near nursing stations should be utilized.” The Massachusetts Department of Public Health has provided guidance to hospitals on this subject including protocols that require hospitals to identify hallways or other alternative sites to hold patients awaiting bed placement. Similarly, the New Jersey Department of Health and Senior Services advised hospitals that placing stabilized patients from the emergency department in inpatient hallways was acceptable.

These states represent a small minority however; as it appears most states have taken little or no legislative or administrative action to address the problems of crowding and boarding. Lacking guidance from CMS, many state health departments may be reluctant to approve the movement of admitted patients from the emergency department to inpatient hallways or other alternative sites. While it is believed that the vast majority of states have not adopted any guidelines to effectively address the boarding problem, there has been no known effort to collect information on the crowding and boarding policies and procedures of all state departments of health. The ACEP Report Card Task Force investigated the possibility of including a metric related to boarding in the next Report Card, however, due to the absence of meaningful state data and recognition that the vast majority of states were not addressing the issue, the boarding problem will be addressed through narrative portions of the Report Card.

There are several national or federal entities addressing the issue of boarding and crowding. CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. The general provisions require that hospitals must meet certain specified requirements including but are not limited to adequate medical and nursing personnel to meet the needs anticipated by the facility. Further CMS requires that all accreditation or oversight bodies ensure that hospitals meet or exceed the Medicare standard set forth in the CoP. Additionally, CMS requires hospitals to measure, analyze and track aspects of the processes of care that impact patient safety. Arguably, boarding patients is significant to patient safety and quality of care.

The Joint Commission (TJC) requires that “leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.” (LD.3.15) TJC holds that managing the flow of patients through their episode of care is essential to the prevention of overcrowding, a problem that can lead to lapses in patient safety and quality of care.

National Quality Forum (NQF), an organization charged with developing quality measures for CMS, has

proposed a measure that will call for reporting time a patient arrives in the ED until the patient is discharged from the ED. (ACEP is currently advocating that the measure include departure of the admitted patient.)

ACEP's recently released Boarding Solutions Report has been widely distributed and received national attention.

Stragegic Plan Reference:

Work to Eliminate Crowding and Boarding

Ensure Access to Emergency Medical Care

Prior Council Action:

Amended Resolution 25(06) Redefining the Front End Process to Optimize ED and Hospital Flow adopted.

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.

Prior Board Action:

April 2008, approved revised policy, *Boarding of Admitted and Intensive Care Patients in the Emergency Department*; previously revised and approved January 2007; previously approved October 2000.

October 2006, Amended Resolution 25(06) Redefining the Front End Process to Optimize ED and Hospital Flow adopted.

September 2006, reviewed Approaching Full Capacity in the Emergency Department information paper.

January 2006, approved policy, Crowding.

October 2004, Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted.

March 2004 reviewed ED Operations Management information paper.

October 2001, Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Council Action:

Reference Committee C recommended that Substitute Resolution 25(08) be adopted.

~~RESOLVED, That the American College of Emergency Physicians (ACEP) survey all 50 state Departments of Health regarding their policies, guidelines, and procedures for addressing hospital and ED crowding, to include their responses to common and effective solutions to crowding such as use of hospital inpatient and ED hallways; and further be it~~

~~RESOLVED, That the results of this survey be reported back to the Council in 2009.~~

RESOLVED, That ACEP investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding; and be it further

RESOLVED, That ACEP encourage members to work with their state medical associations and/or their state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients; and be it further

RESOLVED, That ACEP identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Reference Committee C chose to include aspects of Resolution 28(08) in Resolution 25(08).

The Council adopted Substitute Resolution 25(08) on October 26, 2008.

Testimony:

The majority of those providing testimony did not support the resolution as originally written. However, testimony supported the intent of the resolution. One person providing testimony suggesting that the grading system of the Report Card be expanded to include how states are addressing the issue of boarding and crowding; however, there was no other support for this suggestion and several members spoke strongly against this suggestion, providing rationale for why this proposal is not feasible.

Board Action:

The Board adopted Substitute Resolution 25(08) on October 30, 2008.

RESOLVED, That ACEP investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding; and be it further

RESOLVED, That ACEP encourage members to work with their state medical associations and/or their state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients; and be it further

RESOLVED, That ACEP identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

References:

Implementation Action:

Assigned to Chapter & State Relations staff and Public Relations staff. In February 2009, the Board approved conducting a National Overview of Boarding in Emergency Departments Study (NOBEDS) point-in-time survey on crowding. The NOBEDS survey was distributed electronically to 1,000 members. The data is currently being analyzed.

Information regarding legislative and regulatory efforts to reduce crowding and boarding was provided to all chapters, along with sample state medical society resolutions to address crowding that were developed in Texas and New Mexico. Information on these initiatives and potential strategies to address crowding at the state level was also shared on ACEP's annual chapter lobbyists and leaders conference call and on a conference call with members who are leaders in the state medical societies. ACEP has a Spokespersons Network, maintained by the Public Relations staff, which includes members who can speak on this issue.

Background Information Prepared by: Marilyn Bromley
Craig Price, CAE

Reviewed by:

2008 Council Resolution 26: In Memory of Donald Malvern Thomas, MD

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Kentucky Chapter ACEP

WHEREAS, Donald Thomas, MD, was a charter member of an eclectic group of protagonists that formed the American College of Emergency Physicians; and

WHEREAS, Dr. Thomas was the founding chair of the second full academic Department of Emergency Medicine in the United States; and

WHEREAS, Dr. Thomas contributed as a charismatic speaker at the inaugural ACEP meetings, and “stirred the pot” on three ACEP committees; and

WHEREAS, Dr. Thomas contributed to the initial certification examination that was partially financed by ACEP members, was a reviewer for the *Journal of the American College of Emergency Physicians*, and served his state chapter in many offices including the presidency; and

WHEREAS, Dr. Thomas championed from day one the pivotal role of EMS in emergency medicine and revered all public safety services; therefore be it

RESOLVED, That the American College of Emergency Physicians commemorates with gratitude the contributions of Donald Thomas, MD, to our College, our specialty, and our patients; and be it further

RESOLVED, That ACEP and the Kentucky Chapter of ACEP convey to his wife Edna, and daughters Deborah, Susan Davis, and Larissa Cave, our gratitude for sharing this husband, father, and physician whose pioneering vision of emergency medicine was crystallized.

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

The Council adopted Resolution 26(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 26(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was presented to a representative of Dr. Thomas' family.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 27: In Memory of Benjamin H. Chlapek, DO

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Texas College of Emergency Physicians

WHEREAS, Benjamin H. Chlapek, DO, was an Associate Professor of Emergency Medicine, Texas A & M Health Science Center College of Medicine and Scott & White Hospital and Clinic, Temple, Texas where he served in many capacities; and

WHEREAS, Dr. Chlapek was a respected clinician and a dedicated teacher of medical students and residents; and

WHEREAS, Dr. Chlapek taught every emergency medicine resident from the beginning of the residency program until his death the pleasures of working night shifts; and

WHEREAS, Dr. Chlapek's remarkable ability to listen with an open heart and an open mind was a gift to his patients, his colleagues, his family, and his many friends; and

WHEREAS, Dr. Chlapek, graduated from Temple High School in 1956 and faithfully attended Wildcat football games; and

WHEREAS, Dr. Chlapek was an active member and leader of the Lion's Clubs and school boards in Temple, Texas and Liberty, Missouri; and

WHEREAS, Dr. Chlapek was a devoted husband of 52 years, a loving daddy of seven children, grandfather of 14, and a loyal friend; and

WHEREAS, Dr. Chlapek made a difference in the lives of many and is warmly remembered as "Gentle Ben" by all that knew him; and

WHEREAS, Dr. Chlapek died suddenly July 27, 2008; and

WHEREAS, Dr. Chlapek was an active member of the Texas Chapter and national ACEP until his death; therefore be it

RESOLVED, That the American College of Emergency Physicians honors Benjamin H. Chlapek, DO, a genuinely wonderful person, loving husband, leader, and educator in the specialty of Emergency Medicine; and be it further

RESOLVED**,** That ACEP extends to Dr. Chlapek's family, friends, and colleagues our sympathy, our great sense of sadness and loss, and our gratitude for having been able to share a part of his life.

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

The Council adopted Resolution 27(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 27(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was presented to a representative of Dr. Chlapek's family.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 28: Nationwide ED Crowding Crisis

Council Action: **NOT ADOPTED**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Texas College of Emergency Physicians

Purpose:

Requires ACEP members work with their state medical associations and/or state health departments to encourage hospitals and health care organizations to develop appropriate mechanisms to facilitate availability of inpatient beds.

Fiscal Impact:

WHEREAS, Numerous hospital emergency departments (EDs) in the nation are now severely crowded, due to multiple factors, including large numbers of uninsured and underinsured patients, many of whom seek treatment from the ED; and

WHEREAS, Ambulance services are being asked to divert from hospitals due to ED crowding at the highest rate that has ever been seen; and

WHEREAS, Waiting times can be excessive, increasing the chance that critical patients may be kept waiting along with the less emergent patients; and

WHEREAS, The flow of the patients through the ED is severely hampered because many patients are already admitted but are being held in the ED waiting for a bed, termed “boarding,” and this has now been realized to be a root cause of ED crowding; and

WHEREAS, The ED should not be utilized as an extension of the intensive care and other inpatient units, because patient care can be adversely affected by nurses attending to the acute and episodic needs of the emergency patients and not having adequate time to spend with the admitted patients, increasing the chances of errors such as missing timed medications, and subjecting their patients to noisy and chaotic surroundings; and

WHEREAS, The Joint Commission has required that each accredited hospital have a plan to move the patients out of the ED or that “patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital”; and

WHEREAS, Prompt transfer of admitted patients to inpatient units regardless of inpatient bed availability has been shown in published studies to effectively lessen ED crowding, hasten making the inpatient bed of a discharged patient available for use, and has improved patient satisfaction because patients would rather be in the hallway of the inpatient unit than in the hallway of the ED, and reduced hospital length of stay; and

WHEREAS, Crowding and boarding of patients in the ED often prohibits emergency physicians from practicing emergency medicine in the manner that best serves the needs of the patients; therefore be it

RESOLVED, That ACEP members work with their state medical associations and/or state health departments to encourage hospitals and health care organizations to develop appropriate mechanisms to facilitate availability of inpatient beds, which would include a workable plan to achieve prompt transfer of admitted patients, during “full capacity periods” in the emergency department (ED), to inpatient units regardless of inpatient bed availability,

when the number of patients needing evaluation or treatment in the ED is equal to or exceeds the ED treatment space capacity.

Background:

Background information was not prepared on this resolution because it was submitted as a late resolution.

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

Reference Committee C recommended that Resolution 28(08) not be adopted.

Reference Committee C chose to include salient provisions of Resolution 28(08) in Substitute Resolution 25.

The Council defeated Resolution 28(08) on October 26, 2008.

Testimony:

Single testimony was heard asking the College to encourage its members to work with their state medical associations and societies to address the issues of boarding and crowding.

Board Action:

N/A

References:

Implementation Action:

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 29: Reception Funding

Council Action: **NOT ADOPTED**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Massachusetts College of Emergency Physicians

Purpose:

Directs national ACEP to contribute 50% of the cost of a chapter's *Scientific Assembly* reception and that the contribution be included in the annual budget.

Fiscal Impact:

WHEREAS, The host states for the annual Scientific Assembly (SA) have, by tradition and custom, sponsored a reception primarily for all ACEP Council members, ACEP and chapter staff, and the host state chapter members and leaders; and

WHEREAS, These events are unique from any other type of reception held during SA, providing an environment for the purpose of honoring the work accomplished by council and staff; and

WHEREAS, ACEP selects from a limited number of states in which to hold SA each year; and

WHEREAS, The cost of sponsoring these receptions has traditionally been the sole responsibility of the host state; and

WHEREAS, These receptions can represent a substantial financial burden to the host states; and

WHEREAS, Past state-hosted receptions have incurred costs ranging from $30,000 to $70,000; and

WHEREAS, As PhRMA has new guidelines restricting types of interaction with healthcare professionals; and

WHEREAS, New changes in state laws regarding industry sponsorship have become more restrictive; and

RESOLVED, National ACEP contribute 50% of the costs of the Council meeting reception sponsored by the host state up to $15,000; and be it further

RESOLVED, This contribution be included in the annual *Scientific Assembly* budget.

Background:

Background information was not prepared on this resolution because it was submitted as a late resolution.

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

Reference Committee B recommended that Resolution 29(08) not be adopted.

The Council defeated Resolution 29(08) on October 26, 2008.

Testimony:

The only testimony in favor of the resolution was provided by the authors. All other testimony was in opposition. Concerns expressed included citing the many national ACEP resources, both monetary and staff support, available to chapters to advance emergency care at the state level, the fact that the host state is not required to hold a reception, that ACEP currently funds an opening party and many other states host receptions, and the belief that limited chapter resources could be better utilized in other pursuits. Others expressed concerns about starting a precedent to “earmark” national ACEP funds for this type of expenditure.

Board Action:

N/A

References:

Implementation Action:

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 30: Forensics DVD

Council Action: **REFERRED TO THE BOARD OF DIRECTORS**

Board Action: **NOT APPLICABLE**

Status: **Completed**

SUBMITTED BY: Michael L Weaver, MD
William M Green, MD, FACEP

Purpose:

ACEP purchase the Dartmouth 'Virtual Practicum for Sexual Assault Forensic Examinations' DVD and provide category I CME credit.

Fiscal Impact:

WHEREAS, Over the past 3 years, the Department of Justice has been working with Dartmouth Medical School's Interactive Media Lab to develop a state of the art highly interactive, comprehensive educational 12 hour CME DVD. That it is based on the DOJ's *'National Protocol for Sexual Assault Medical Forensic Examinations*,' and allows the user to conduct detailed interactive examinations of sexual assault victims and provides explanations of key concepts in a variety of adult/adolescent sexual assault forensic cases including HIV prophylaxis, elderly sexual assault, drug facilitated sexual assault, male sexual assault and complex mediolegal consent issues; and

WHEREAS, It is also unique in that it provide interactive education into the criminal justices aspects of forensic care which are not formally taught but desperately need by our members including preparation for courtroom testimony, legal terminology and working with prosecutors. It is ideal for training residents in academic settings as well as the emergency physician in the community or rural hospital that infrequently does a sexual assault exam and needs a resource rich distance learning tool; and

WHEREAS, Forensic medicine is a rapidly growing segment of our emergency medicine work and as such we now have a Forensic Section within ACEP. And that has from the DVD's inception and throughout its creation, ACEP physicians were the only physician specialty organization invited to participate in developing this unique tool; and

WHEREAS, In the final vetting process, the Forensic Section members were asked to vet this product and incorporate changes to benefit our members; and

WHEREAS, ACEP and the co-chairs of the Forensic Section are specifically credited in this product; and

WHEREAS, Currently, the only mechanism for our members to access this important DVD is to pay the International Association of Forensic Nurses (IAFN) $25 per DVD, and the $15 profit from each purchase will therefore go to that organization instead of ACEP; and

WHEREAS, IAFN will have a booth at this years ACEP Scientific Assembly and will be actively selling this DVD to our members; and

WHEREAS, The IAFN was originally required to purchase 1000 DVD's at $10 each, and in only 3 months has exceeded those numbers, and after discussion by your Forensic Co-Chairs, Dartmouth will now allow ACEP to make a minimum purchase of only 500 DVD's at the same $10 per copy, allowing ACEP to choose from zero to

a max of $25 profit margin on the sale of each DVD; and

WHEREAS, Our members would have to pay an additional $65 to Dartmouth for Category I CME credit; and

WHEREAS, This type of easily accessible, low cost, independent distance learning is desperately needed for our members especially those in the rural areas; and

WHEREAS, This type of educational tool is also needed by our residency training programs in that there is minimal consistency in the basic core knowledge/skills being provide; and

WHEREAS, There is now the National Protocol for Sexual Assault Medical Forensic Examinations established by the Department of Justice in addition to our own ACEP guidelines; which are being used as standards by which emergency physicians are being sued because of lack of knowledge regarding the care of sexual assault victims; therefore be it

RESOLVED, That ACEP invest $4500.00 (the remaining coming from our section members), to purchase for resale this educational DVD to our membership and all other healthcare providers; and be it further

RESOLVED, That showing this financial support will improve ACEP and its Forensic Sections role as leaders in education around issues of sexual assault world wide; and be it further

RESOLVED, That ACEP provide Category I CME credit which would save our members who request it the additional expense of CME.

Background:

Background information was not prepared on this resolution because it was submitted as an emergency resolution.

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

Reference Committee B recommended that Resolution 30(08) be referred to the Board of Directors.

The Council referred Resolution 30(08) to the Board of Directors on October 26, 2008.

Testimony:

Testimony from the author centered on the need to move quickly to make this product available through ACEP so as to produce revenue for the College. The author also testified that an organization is planning to offer this DVD for sale in our exhibit hall and immediate action could divert some of their potential profits to ACEP. Others testified that the product was a good teaching tool, but that it has not been vetted by the ACEP Educational Committee. Opposing testimony was offered that it would be wrong to undercut a vendor who purchased booth space in the exhibit hall solely to offer this product to our members, and that it is not the business of the Council to direct what products should be offered for sale. An amended resolution was offered that appeared to have unanimous support of all who had testified, but the result of that language was the same as referral to the Board. The Reference Committee suggests the more direct action of referral to the Board.

Board Action:

N/A

References:

Implementation Action:

Following the Reference Committee, staff discussed the resolution with its main author. The author requested that the ACEP Bookstore purchase at least 500 copies @$10 each from his university. Although this is an important issue, and one that members contend with regularly, ACEP's experience has been that it is not a topic in which members are willing to invest in furthering their education and staff were not confident that 500 copies of the DVD could be sold. Staff subsequently inquired if the author and his university might be interested in a consignment sales arrangement, which would allow ACEP to become a reseller of the DVD without risk. Unfortunately, the university was not willing to lower the minimum quantity for resale purposes. Members of the ACEP Education Committee reviewed the DVD and agreed that the content was very well done, but agreed that ACEP would likely not sell enough copies to cover all of the costs associated with reselling the product. In April 2009, the Board approved taking no further action regarding this referred resolution. The authors of the resolution were notified of the Board's actions and were encouraged to recommend that the university seek ACEP Category I CME credit to help make the program more attractive for purchase.

Background Information Prepared by:

Reviewed by:

2008 Council Resolution 31: In Memory of Mark Lindsey, MD

Council Action: **ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Georgia College of Emergency Physicians

WHEREAS, Mark Lindsey, MD, has served the American College of Emergency Physicians with complete dedication and distinction in the early formation of the College as a charter member; and

WHEREAS, Dr. Lindsey, a vascular surgeon, has served the College and the Council as vice speaker 1974-75 and speaker of the Council 1975-76; and

WHEREAS, Dr. Lindsey was an active advocate for board recognition in the early years of the College; and

WHEREAS, Dr. Lindsey has served as a passionate patient advocate as a Georgia emergency physician; and

WHEREAS, Dr. Lindsey has served in multiple leadership roles in the Georgia College of Emergency Physicians including committee chair, president, and serving on the Board of Directors since 1968; and

WHEREAS, Dr. Lindsey served with distinction in the creation of the Southeast Physician Section of the Southern Medical Society; and

WHEREAS, Dr. Lindsey, during his term as the vice speaker and speaker of the Council, represented the College with integrity, honor, and a southern gentlemanly approach to humor; therefore be it

RESOLVED, That the American College of Emergency Physicians extend heartfelt condolences to the family, colleagues, and friends of Mark Lindsey, MD, and acknowledge with gratitude his personal and professional accomplishments.

Background:

Stragegic Plan Reference:

Prior Council Action:

Prior Board Action:

Council Action:

The Council adopted Resolution 31(08) on October 26, 2008.

Testimony:

Board Action:

The Board adopted Resolution 31(08) on October 30, 2008.

References:

Implementation Action:

A framed resolution was prepared for Dr. Lindsey's family.

Background Information Prepared by:

Reviewed by: