American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Annual ACEP Council Meeting

Reference Committee Reports

Sunday, October 4, 2026

ORDER OF DEBATE

Reference Committee B – Dr. McCrea Presiding

Reference Committee A – Dr. Traill Presiding

Reference Committee C – Dr. McCrea Presiding

DEFINITIONS OF AVAILABLE COUNCIL ACTIONS

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

ADOPT
Approve resolution exactly as submitted as recommendation implemented through the Board of Directors.

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 24-41

George RJ Sontag, MD, FACEP (OH) – Chair
Brittany Arnold, MD, FACEP (OR)
Blake Denley, MD, FACEP (LA)
Mike Lozano, MD, MSHI, FACEP (FL)
Micaela LaRose, MD (GS)
Christopher Pergrem, MD, FACEP (KY)

Brianna Hanson, MPH
Annalane Miller, MPH

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting

Final Report of REFERENCE COMMITTEE B

Presented by: RJ Sontag, MD, FACEP – Chair

Mr. Speaker and Councillors:

Reference Committee Reference Committee B gave careful consideration to the several items referred to it and submits the following report:

Unanimous Consent Agenda

For adoption as amended or substituted:

1. AMENDED RESOLUTION 24(26): Advocating for Scientific Integrity in Government Health Leadership
2. AMENDED RESOLUTION 25(26): Response Time Standards for Insurance-Based Transfer and Admission Authorization Requests
3. AMENDED RESOLUTION 26(26): Addressing Insurer Bad Behavior
4. AMENDED RESOLUTION 27(26): Conditional Support for a Single-Payer Health Care Financing System
5. AMENDED RESOLUTION 28(26): Creation of a Workgroup to Advance an ED-Based Medicare Three-Day Rule Waiver
6. AMENDED RESOLUTION 30(26): Inclusion of Physicians as Protected Persons Eligible for Personal Information Protection
7. AMENDED RESOLUTION 31(26): Protecting International Medical Graduates and Ensuring Stability of the Emergency Medicine Workforce
8. AMENDED RESOLUTION 32(26): Protection of the Right of Licensed Healthcare Professionals to Render Emergency Care at Law Enforcement Controlled Scenes
9. AMENDED RESOLUTION 33(26): Regulatory Governance of AI Independent Practice of EM
10. AMENDED RESOLUTION 34(26): Support of Safe and Physician Directed Care in Hyperbaric Medicine
11. AMENDED RESOLUTION 35(26): Standardized Signage Identifying When a Physician is Not Present Onsite in the ED
12. AMENDED RESOLUTION 36(26): Transparency in Emergency Department Physician Staffing
13. AMENDED RESOLUTION 38(26): Establishing Whistleblower Protections for Reporting Financial Mismanagement of Liability Reserves
14. AMENDED RESOLUTION 39(26): Safeguarding Physician Liability Reserves and Continuity of Professional Protection
15. AMENDED RESOLUTION 40(26): Opposing Settlement of Medical Malpractice Claims Without Consent of the Defendant Physician
16. AMENDED RESOLUTION 41(26): Transparency of Financial Solvency for Employer-Mandated Liability Coverage

Not for adoption:

17. RESOLUTION 37(26): Development of a HIPAA-Compliant Anonymous Database for Reporting Clinical Management Events Involving Non-Physicians

For referral to the Board of Directors:

18. RESOLUTION 29(26): Federal Tax Relief for EMTALA-Mandated Care

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Recommended for Adoption as Amended or Substituted

1. **AMENDED RESOLUTION 24(26): Advocating for Scientific Integrity in Government Health Leadership**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 24(26) be adopted.

~~RESOLVED, That ACEP advocate that individuals appointed to senior government health care and scientific leadership positions should possess relevant education, training, expertise, and professional experience in health care, medicine, biomedical science, public health, or related scientific fields; and be it further~~

~~RESOLVED, That ACEP support the principle that leaders of government health care and scientific agencies demonstrate commitment to evidence-based medicine, scientific integrity, ethical public communication, and established standards of public health practice; and be it further~~

RESOLVED, That ACEP **support and** incorporate into its advocacy efforts the principles that individuals appointed to senior government health care and scientific leadership positions possess relevant expertise and demonstrate commitment to evidence-based medicine, scientific integrity, ethical public communication, and established standards of public health practice, including through communications with policymakers, participation in national and state medical coalitions, and public statements related to government health care leadership and public health policy.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate that individuals appointed to senior government health care and scientific leadership positions should possess relevant education, training, expertise, and professional experience in health care, medicine, biomedical science, public health, or related scientific fields; and be it further

RESOLVED, That ACEP support the principle that leaders of government health care and scientific agencies demonstrate commitment to evidence-based medicine, scientific integrity, ethical public communication, and established standards of public health practice; and be it further

RESOLVED, That ACEP incorporate into its advocacy efforts the principles that individuals appointed to senior government health care and scientific leadership positions possess relevant expertise and demonstrate commitment to evidence-based medicine, scientific integrity, ethical public communication, and established standards of public health practice, including through communications with policymakers, participation in national and state medical coalitions, and public statements related to government health care leadership and public health policy.

Summary of Testimony

Asynchronous testimony was largely in support of the resolution by both chapters and individuals, although prudent concerns about implementation feasibility were raised, including if the work of this resolution was already captured by current initiatives of the College. The Reference Committee believes the third resolved captured the sentiments expressed in the first two resolveds more succinctly.

Live testimony was unanimously in support. The resolution author spoke in support of the amended language offered by the Reference Committee added after asynchronous testimony.

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2. **AMENDED RESOLUTION 25(26): Response Time Standards for Insurance-Based Transfer and Admission Authorization Requests**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 25(26) be adopted.

RESOLVED, That ACEP advocate ~~for policy~~ supporting enforceable emergency transfer and admission authorization standards ~~requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours,~~ **whereby an insurer cannot require prior authorization for emergency transfer and admission** and **an insurer provides** deemed approval ~~if those deadlines are not met~~; and be it further

RESOLVED, That ACEP advocate for state and federal legislation or regulation codifying emergency transfer and admission authorization standards ~~requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours,~~ **whereby an insurer cannot require prior authorization for emergency transfer and admission** and **an insurer provides** deemed approval ~~if those deadlines are not met~~ and**, in the absence of such a prohibition,** requiring insurers to publicly report emergency transfer and admission authorization metrics, including response times, denial rates, and deemed approvals; and be it further

RESOLVED, That ACEP advocate for state insurance commissioners and other regulators to monitor insurer compliance with emergency transfer and admission authorization standards ~~requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours,~~ **whereby an insurer cannot require prior authorization for emergency transfer and admission** and **an insurer provides** deemed approval ~~if those deadlines are not met~~ and publish annual compliance reports.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate for policy supporting enforceable emergency transfer and admission authorization standards requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours, and deemed approval if those deadlines are not met; and be it further

RESOLVED, That ACEP advocate for state and federal legislation or regulation codifying emergency transfer and admission authorization standards requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours, and deemed approval if those deadlines are not met and requiring insurers to publicly report emergency transfer and admission authorization metrics, including response times, denial rates, and deemed approvals; and be it further

RESOLVED, That ACEP advocate for state insurance commissioners and other regulators to monitor insurer compliance with emergency transfer and admission authorization standards requiring insurers to provide an initial response within one hour, a final determination including an authorization number if approved within two hours, and deemed approval if those deadlines are not met and publish annual compliance reports.

Summary of Testimony

Asynchronous testimony was mostly in support of the spirit of the resolution. Some commenters were concerned that policies describing how prior authorization should be used weakened the stance that it should never be allowed. A strong sentiment shared was that prior authorization should never be allowed, however given the existence of prior authorization, commenters proposed recommendations on how it should be used and timeframes to consider.

Live testimony was largely supportive, including the author supporting the amendments made in response to asynchronous testimony. There were a few questions raised about the language of "unstable" and interactions with EMTALA obligations and payment.

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3. **AMENDED RESOLUTION 26(26): Addressing Insurer Bad Behavior**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 26(26) be adopted.

RESOLVED, That ACEP ~~develop~~ **support** model legislation to be adapted for state legislative efforts to combat the automatic or algorithmic downcoding of medical encounters, including emergency department encounters; and be it further

RESOLVED, That ACEP ~~develop~~ **support** model legislation to be adapted for state legislative efforts to combat the use of artificial intelligence or similar evolving technology used to facilitate the automatic or algorithmic downcoding of medical encounters, including emergency department encounters; and be it further

RESOLVED, That ACEP assist state chapters in coordinating efforts with other chapters when insurer behaviors cross state lines.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP develop model legislation to be adapted for state legislative efforts to combat the automatic or algorithmic downcoding of medical encounters, including emergency department encounters; and be it further

RESOLVED, That ACEP develop model legislation to be adapted for state legislative efforts to combat the use of artificial intelligence or similar evolving technology used to facilitate the automatic or algorithmic downcoding of medical encounters, including emergency department encounters; and be it further

RESOLVED, That ACEP assist state chapters in coordinating efforts with other chapters when insurer behaviors cross state lines.

Summary of Testimony

Asynchronous testimony was generally in support. Commenters noted overlap with existing AMA efforts and suggested including a resolved explicitly calling for collaboration with the AMA, or to include language on AI.

Live testimony was largely in support, with one concern raised about spreading ACEP resources too thin. The Reference Committee amended the language to recognize work being done by other organizations that ACEP can support without having to redevelop existing resources.

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4. **AMENDED RESOLUTION 27(26): Conditional Support for a Single-Payer Health Care Financing System**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 27(26) be adopted.

RESOLVED, That ACEP develop a policy statement of conditional support for a single-payer **or unified financing** health care ~~financing~~ system, ~~contingent upon the following criteria being met~~ **promoting inclusion of the following** in any such legislation:

1) reimbursement rates for emergency services that fully cover the cost of providing care, including automatic inflation-based updates to prevent future erosion of payment adequacy;
2) inclusion of meaningful medical liability reform that reduces the burden of defensive medicine on emergency physicians and the health care system;
3) formal mechanisms for physician specialty organization input into payment rate-setting, benefit design, and program governance; and
4) provisions to address physician educational debt; and be it further

RESOLVED, That ACEP communicate conditional support for a single-payer **or unified financing** health care system ~~to Congress~~, including to sponsors of single-payer **or unified financing health care system** legislation, and engage with relevant stakeholders to advocate for the inclusion of specific criteria included in a policy statement

developed by ACEP regarding single-payer in any single-payer **or unified financing health care system** proposal, consistent with ACEP's broader commitment to universal health care coverage and adequate reimbursement for emergency services.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP develop a policy statement of conditional support for a single-payer health care financing system, contingent upon the following criteria being met in any such legislation:

1) reimbursement rates for emergency services that fully cover the cost of providing care, including automatic inflation-based updates to prevent future erosion of payment adequacy;
2) inclusion of meaningful medical liability reform that reduces the burden of defensive medicine on emergency physicians and the health care system;
3) formal mechanisms for physician specialty organization input into payment rate-setting, benefit design, and program governance; and
4) provisions to address physician educational debt; and be it further

RESOLVED, That ACEP communicate conditional support for a single-payer health care system to Congress, including to sponsors of single-payer legislation, and engage with relevant stakeholders to advocate for the inclusion of specific criteria included in a policy statement developed by ACEP regarding single-payer in any single-payer proposal, consistent with ACEP's broader commitment to universal health care coverage and adequate reimbursement for emergency services.

Summary of Testimony

Asynchronous testimony was largely in opposition. However, testimony from several chapters and sections was in support. Testimony highlighted differences between universal health care and single payer and that this is a perennial issue worth discussing annually.

Robust live testimony was received both in favor and opposed. There was broad support for the concept of universal coverage. Several raised concerns with "single payer" and the language of "contingent." The Reference Committee amended the language in response to concerns about the narrowness of "contingent" to make it less prescriptive while still being supportive of the concepts that should be considered in legislation, without preventing ACEP from supporting other good health reform legislation that does not include these aspects. The discussion on "single-payer" was split: those who were entirely opposed to the concept of single payer, and those who think ACEP needs to be at the forefront of the discussion.

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5. **AMENDED RESOLUTION 28(26): Creation of a Workgroup to Advance an ED-Based Medicare Three-Day Rule Waiver**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 28(26) be adopted.

RESOLVED, That ACEP create a member workgroup, with appropriate staff support, to develop an actionable Emergency Department–based Medicare Skilled Nursing Facility three-day rule waiver proposal**,** ~~using~~ **referencing** existing CMS waiver models, safeguards, and quality requirements**,** ~~for submission to Physician-Focused Payment Model Technical Advisory Committee (PTAC), the Center for Medicare and Medicaid Innovation (CMMI), the Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health and Human Services (HHS), or another appropriate federal pathway, with the goal of allowing participating hospitals to transfer eligible Medicare beneficiaries directly from the Emergency Department or observation setting to appropriate skilled nursing, rehabilitation-capable skilled nursing, or swing-bed care without an avoidable inpatient admission~~ **that does not worsen emergency department boarding nor increase emergency department staff workload.**

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP create a member workgroup, with appropriate staff support, to develop an actionable Emergency Department–based Medicare Skilled Nursing Facility three-day rule waiver proposal using existing CMS waiver models, safeguards, and quality requirements for submission to Physician-Focused Payment Model Technical Advisory Committee (PTAC), the Center for Medicare and Medicaid Innovation (CMMI), the Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health and Human Services (HHS), or another appropriate federal pathway, with the goal of allowing participating hospitals to transfer eligible Medicare beneficiaries directly from the Emergency Department or observation setting to appropriate skilled nursing, rehabilitation-capable skilled nursing, or swing-bed care without an avoidable inpatient admission.

Summary of Testimony

Asynchronous testimony was largely supportive. Some commenters raised the concern that this could potentially worsen boarding and the diverging outcomes of this resolution between well-resourced emergency departments and regional safety-net, rural, or under-resourced departments. Others noted that emergency physicians are not the ones directing Skilled Nursing Facility (SNF) care.

The live testimony was largely supportive, with many viewing this as a lever to reduce boarding. Some raised concerns about its overly prescriptive nature. Others recommended working with other groups such as the AMA. Those opposed were concerned that this waiver could worsen boarding and increase workload on the emergency department. The Reference Committee amended the language to address these concerns.

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6. **AMENDED RESOLUTION 30(26): Inclusion of Physicians as Protected Persons Eligible for Personal Information Protection**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 30(26) be adopted.

RESOLVED, That ACEP **work with the American Medical Association (AMA) to** develop model legislation for states to include ~~emergency~~ physicians among the categories of protected persons eligible for personal information protections, including public records home address exemptions, anti-doxxing statutes, and address confidentiality programs, under applicable state and federal law.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP develop model legislation for states to include emergency physicians among the categories of protected persons eligible for personal information protections, including public records home address exemptions, anti-doxxing statutes, and address confidentiality programs, under applicable state and federal law.

Summary of Testimony

Asynchronous testimony was unanimously in support. One amendment was proposed to include collaboration with the AMA and be inclusive of all physicians. Some commenters raised similarities to Resolution 19(26). Reference Committee review deemed the resolutions were different and should be considered separately. Live testimony was unanimously in support.

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7. **AMENDED RESOLUTION 31(26): Protecting International Medical Graduates and Ensuring Stability of the Emergency Medicine Workforce**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 31(26) be adopted.

RESOLVED, That ACEP affirm its commitment to protecting the legal immigration status and continued medical training of ~~international medical graduates who are medical students, physicians in training, or attending physicians~~ **physicians and trainees whose ability to train or practice in the U.S. depends on immigration status**; and be it further

RESOLVED, That ACEP ~~continue to advocate and support~~ **oppose** any federal or state immigration policy, rule, or enforcement action that ~~does not~~ disrupt**s**, terminate**s**, or jeopardize**s** the visa status, training continuity, or employment of physicians ~~in training or attending physicians holding international~~ **and trainees whose ability to train or practice in the U.S. depends on immigration** status, particularly when such disruption would harm patient access to emergency care; and be it further

RESOLVED, That ACEP continue to engage with the relevant federal agencies to establish clear, durable protections for ~~in training, attending physicians, and medical students holding international~~ **physicians and trainees whose ability to train or practice in the U.S. depends on immigration** status; including protections against abrupt visa revocation, deportation proceedings, or enforcement actions that would interrupt patient care or graduate medical education.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP affirm its commitment to protecting the legal immigration status and continued medical training of international medical graduates who are medical students, physicians in training, or attending physicians; and be it further

RESOLVED, That ACEP continue to advocate and support any federal or state immigration policy, rule, or enforcement action that does not disrupt, terminate, or jeopardize the visa status, training continuity, or employment of physicians in training or attending physicians holding international status, particularly when such disruption would harm patient access to emergency care; and be it further

RESOLVED, That ACEP continue to engage with the relevant federal agencies to establish clear, durable protections for physicians in training, attending physicians, and medical students holding international status; including protections against abrupt visa revocation, deportation proceedings, or enforcement actions that would interrupt patient care or graduate medical education.

Summary of Testimony

Asynchronous testimony was largely in support. Several commenters offered amendments to clarify the resolution language and there were subsequent comments in support of the amendments. Live testimony was unanimously in support.

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8. **AMENDED RESOLUTION 32(26): Protection of the Right of Licensed Healthcare Professionals to Render Emergency Care at Law Enforcement Controlled Scenes**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 32(26) be adopted.

RESOLVED, That ACEP ~~adopt as policy that law enforcement personnel should not obstruct, interfere with, or delay emergency medical care voluntarily offered by a licensed health care professional to an acutely ill or injured person at a law enforcement controlled scene; that such care proceed without delay except in the presence of an immediate and articulable safety threat that cannot reasonably be mitigated without temporarily restricting access; and that any such restriction be based on specific, observable conditions, use the least restrictive means necessary, be limited in scope and duration to the threat identified, and permit initial medical assessment under controlled conditions whenever feasible and that this policy be communicated to relevant federal agencies and congressional committees~~ **develop a voluntary universal credential that ACEP members can choose to use to clearly self-identify as a licensed emergency physician who has completed ACEP education on rendering aid to an ill or**

injured person outside the hospital setting, and work with national law enforcement, fire, and emergency medical services organizations to promote recognition of the credential at the scene;; and be it further

RESOLVED, That ACEP ~~urge the United States Congress to enact federal legislation prohibiting federal law enforcement officers from obstructing a licensed health care professional's access to render emergency care absent an immediate and articulable safety threat, requiring documentation of any such restriction, and requiring basic emergency care facilitation training (defined as instruction in scene safety assessment and the activation and support of bystander emergency care) for federal law enforcement personnel~~ **work with interested organizations to develop easily accessible education on Good Samaritan law, personal and crime scene safety, obligations incurred by rendering aid, and appropriate professional interactions with law enforcement, fire, and emergency medical services when volunteering aid at the scene of an ill or injured patient, with completion of this education required for any ACEP credential identifying emergency physicians who render aid outside the hospital setting**; and be it further

RESOLVED, That ACEP direct its American Medical Association (AMA) delegation to ~~work to advance~~ **propose appropriate changes to** AMA policy ~~addressing law enforcement obstruction of self-identified bystander physicians and licensed health care professionals~~ at emergency scenes~~, consistent with existing recognition in AMA Policy H-130.937 (Delivery of Health Care by Good Samaritans) that reasonable access frameworks for bystander physician assistance should exist~~ **that support reasonable access frameworks, developed in partnership with law enforcement, for self-identified bystander physicians**.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP adopt as policy that law enforcement personnel should not obstruct, interfere with, or delay emergency medical care voluntarily offered by a licensed health care professional to an acutely ill or injured person at a law enforcement-controlled scene; that such care proceed without delay except in the presence of an immediate and articulable safety threat that cannot reasonably be mitigated without temporarily restricting access; and that any such restriction be based on specific, observable conditions, use the least restrictive means necessary, be limited in scope and duration to the threat identified, and permit initial medical assessment under controlled conditions whenever feasible and that this policy be communicated to relevant federal agencies and congressional committees; and be it further

RESOLVED, That ACEP urge the United States Congress to enact federal legislation prohibiting federal law enforcement officers from obstructing a licensed health care professional's access to render emergency care absent an immediate and articulable safety threat, requiring documentation of any such restriction, and requiring basic emergency care facilitation training (defined as instruction in scene safety assessment and the activation and support of bystander emergency care) for federal law enforcement personnel; and be it further

RESOLVED, That ACEP direct its American Medical Association (AMA) delegation to work to advance AMA policy addressing law enforcement obstruction of self-identified bystander physicians and licensed health care professionals at emergency scenes, consistent with existing recognition in AMA Policy H-130.937 (Delivery of Health Care by Good Samaritans) that reasonable access frameworks for bystander physician assistance should exist.

Summary of Testimony

Asynchronous testimony was largely in opposition, with many raising concerns about crime scene safety.

Live testimony had robust support and many moving from oppose to support after amended language was offered. There were concerns about limiting otherwise qualified physicians' ability to provide care without this credential, and whether credentials should be necessary. Another testified with concern about liability for ACEP regarding credentialing. Many were supportive of the development of the credential.

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9. **AMENDED RESOLUTION 33(26): Regulatory Governance of AI Independent Practice of EM**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 33(26) be adopted.

RESOLVED, That ACEP oppose the marketing and sale of prescription medication kits that provide prescription-only medications ~~in advance of diagnosed illness even if based on a brief virtual clinical survey~~ **without active involvement of a licensed healthcare professional**; and be it further

RESOLVED, That ACEP advocate for state and federal regulation requiring that artificial intelligence systems require a "clinician-in-the-loop," particularly for prescription medications, and that such oversight not be reduced, waived, or phased out without FDA Class III Medical Device Approval; and be it further

RESOLVED, That ACEP collaborate with the American Medical Association as it considers policy arising from its 2026 annual meeting related to Artificial Intelligence Independent Practice of Medicine and Scope of Practice**,** and ~~the ACEP Board of Directors create~~ **develop** ACEP polices to address these topics~~.~~**; and be it further**

RESOLVED, That ACEP reaffirm its ongoing commitment to monitoring and addressing AI issues as they apply to emergency medicine; and be it further

RESOVLED, That ACEP consider adding an AI initiative to the ACEP Strategic Plan.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP oppose the marketing and sale of prescription medication kits that provide prescription-only medications in advance of diagnosed illness even if based on a brief virtual clinical survey; and be it further

RESOLVED, That ACEP advocate for state and federal regulation requiring that artificial intelligence systems require a "clinician-in-the-loop," particularly for prescription medications, and that such oversight not be reduced, waived, or phased out without FDA Class III Medical Device Approval; and be it further

RESOLVED, That ACEP collaborate with the American Medical Association as it considers policy arising from its 2026 annual meeting related to Artificial Intelligence Independent Practice of Medicine and Scope of Practice; and the ACEP Board of Directors create ACEP polices to address these topics.

Summary of Testimony

Asynchronous testimony was largely supportive, with several amendments proposed that were captured in the amended language. Several concerns were raised about the role of AI in advance prescribing rather than the issue of prescribing "in advanced of diagnosis illness." Some suggested amendments note that certain circumstances warrant advance prescribing.

Live testimony was supportive, including support from ABEM. An author's amendment was provided to align with current College activities and the strategic plan. No other comments were received regarding the amendment.

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10. **AMENDED RESOLUTION 34(26): Support of Safe and Physician Directed Care in Hyperbaric Medicine**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 34(26) be adopted.

RESOLVED, That ACEP support the safe practice of hyperbaric oxygen therapy, to include:

- Real-time and onsite supervision by a licensed **board-certified undersea and hyperbaric medicine** physician ~~trained in hyperbaric medicine~~;

- Compliance with safety standards outlined in Pressure Vessels for Human Occupancy (PVHO) and National Fire Protection Agency (NFPA) 99 (Health Care Facilities Code, Chapter 14);
- Use of FDA approved hyperbaric chambers;
- Regular audits or accreditation from independent third party to verify compliance with PVHO, NFPA 99, federal and state law. The UHMS Accreditation program is a credible option; and be it further

RESOLVED, That ACEP support and/or endorse state level or federal efforts to enforce standards for the safe practice of hyperbaric oxygen therapy; and be it further

RESOLVED, That ACEP support efforts to work with the Food and Drug Administration to enforce existing hyperbaric oxygen therapy device requirements and federal regulations.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP support the safe practice of hyperbaric oxygen therapy, to include:

- Real-time and onsite supervision by a licensed physician trained in hyperbaric medicine;
- Compliance with safety standards outlined in Pressure Vessels for Human Occupancy (PVHO) and National Fire Protection Agency (NFPA) 99 (Health Care Facilities Code, Chapter 14);
- Use of FDA approved hyperbaric chambers;
- Regular audits or accreditation from independent third party to verify compliance with PVHO, NFPA 99, federal and state law. The UHMS Accreditation program is a credible option; and be it further

RESOLVED, That ACEP support and/or endorse state level or federal efforts to enforce standards for the safe practice of hyperbaric oxygen therapy; and be it further

RESOLVED, That ACEP support efforts to work with the Food and Drug Administration to enforce existing hyperbaric oxygen therapy device requirements and federal regulations.

Summary of Testimony

Asynchronous testimony was mixed, but favored adoption. Most opposing comments were focused on the word "support" not being well defined, and what it would obligate the College to do, as well as the resource cost to support such a narrow initiative.

Live testimony was supportive, with a request to clarify the training required, given concerns with low barriers to entry leading to patient harm.

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11. **AMENDED RESOLUTION 35(26): Standardized Signage Identifying When a Physician is Not Present Onsite in the ED**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 35(26) be adopted.

~~RESOLVED, That ACEP develop model standardized signage informing patients of physician onsite duty hours 24 hours per day, 7 days per week; and be it further~~

RESOLVED, That ACEP advocate to the **American Medical Association for the** adoption of standardized signage informing patients of physician onsite duty hours 24 hours per day, 7 days per week by all emergency departments, including EDs utilizing staffing models without continuous onsite physician coverage.~~; and be it further~~

~~RESOLVED, That ACEP collaborate with The Joint Commission (TJC), DNV (Det Norse Veritas) Healthcare, The Center for Improvement in Healthcare and Quality (CIHQ), and other hospital accrediting organizations to incorporate model standardized signage regarding physician availability into accreditation standards to provide for patient transparency and patient informed decision making for their medical care.~~

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP develop model standardized signage informing patients of physician onssite duty hours 24 hours per day, 7 days per week; and be it further

RESOLVED, That ACEP advocate for adoption of standardized signage informing patients of physician onsite duty hours 24 hours per day, 7 days per week by all emergency departments, including EDs utilizing staffing models without continuous onsite physician coverage; and be it further

RESOLVED, That ACEP collaborate with The Joint Commission (TJC), DNV (Det Norse Veritas) Healthcare, The Center for Improvement in Healthcare and Quality (CIHQ), and other hospital accrediting organizations to incorporate model standardized signage regarding physician availability into accreditation standards to provide for patient transparency and patient informed decision making for their medical care.

Summary of Testimony

Asynchronous testimony was largely supportive of the intent of the resolution but noted feasibility and financial concerns. Many found it duplicative and thought the intent of the resolution was being carried out through the current work of the College through Resolution 50(25).

Robust live testimony was received both in favor and opposed. The majority of the opposition was in support of the concept but thought it was an idea better addressed by the AMA. There was also opposition to the prescriptive nature of the third resolved.

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12. **AMENDED RESOLUTION 36(26): Transparency in Emergency Department Physician Staffing**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 36(26) be adopted.

RESOLVED, That ACEP support the development and implementation ~~of standardized reporting of emergency department physician staffing characteristics by hospitals to the~~ **by** Centers for Medicare & Medicaid Services (CMS) and other appropriate ~~accrediting or~~ regulatory **or accrediting** organizations **of standardized reporting regarding whether emergency departments maintain continuous onsite physician coverage, with reporting definitions that appropriately account for facility type and applicable federal and state staffing requirements**; and be it further

RESOLVED That ACEP advocate for public ~~reporting of emergency department physician staffing~~ **availability of such** information in a standardized, accurate, **appropriately contextualized,** and ~~easily~~ understandable manner ~~that promotes transparency for patients, communities, researchers, and policymakers~~ **while minimizing unnecessary administrative reporting burden**.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP support the development and implementation of standardized reporting of emergency department physician staffing characteristics by hospitals to the Centers for Medicare & Medicaid Services (CMS) and other appropriate accrediting or regulatory organizations; and be it further

RESOLVED That ACEP advocate for public reporting of emergency department physician staffing information in a standardized, accurate, and easily understandable manner that promotes transparency for patients, communities, researchers, and policymakers.

Summary of Testimony

Asynchronous testimony was generally in support. Several comments clarified that CMS would be

responsible for collecting and maintaining the data, not ACEP. The proposed amendments make this distinction clear. Live testimony was largely supportive.

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13. **AMENDED RESOLUTION 38(26): Establishing Whistleblower Protections for Reporting Financial Mismanagement of Liability Reserves**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 38(26) be adopted.

RESOLVED, That ACEP advocate for federal and state "safe harbor" legislation that provides comprehensive whistleblower protections for physicians who report suspected financial mismanagement or insolvency of ~~employer-provided~~ liability funds to appropriate regulatory authorities; and be it further

RESOLVED, That ACEP support policies that prohibit the use of contract termination, non-renewal, or other retaliatory measures against physicians acting in good faith to disclose the underfunding of malpractice reserves.

RESOLVED, That ACEP direct its American Medical Association (AMA) delegation to advocate that the AMA develop a state model bill to provide whistleblower protections for physicians who report suspected financial mismanagement or insolvency of liability funds, and prohibit the use of contract termination, non-renewal, or other retaliatory measures against physicians acting in good faith to disclose the underfunding of malpractice reserves.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate for federal and state "safe harbor" legislation that provides comprehensive whistleblower protections for physicians who report suspected financial mismanagement or insolvency of employer-provided liability funds to appropriate regulatory authorities; and be it further

RESOLVED, That ACEP support policies that prohibit the use of contract termination, non-renewal, or other retaliatory measures against physicians acting in good faith to disclose the underfunding of malpractice reserves.

Summary of Testimony

Asynchronous testimony was unanimously in support. While it was suggested ACEP consider explicitly requesting this issue be advanced to the AMA, the Reference Committee believes this is captured implicitly in the current resolves. Some testimony recommended combining Resolutions 38, 39, and 41. However, the Reference Committee review deemed that each resolution addresses a distinct problem and should be considered separately.

Live testimony was largely in support. Amendments were offered to make it inclusive of a range of employment situations and clarify the language used.

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14. **AMENDED RESOLUTION 39(26): Safeguarding Physician Liability Reserves and Continuity of Professional Protection**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 39(26) be adopted.

RESOLVED, That ACEP advocate for statutory requirements mandating that all employer-sponsored liability coverage vehicles, including captives and self-insured retentions, and physician tail funds be pre-funded and held in independent, legally segregated escrow accounts.

RESOLVED, That ACEP advocate that all liability coverage vehicles, including commercial, captives,

self-insured retentions, and physician tail funds be adequately funded as defined by actuarially sound regulatory requirements.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate for statutory requirements mandating that all employer-sponsored liability coverage vehicles, including captives and self-insured retentions, and physician tail funds be pre-funded and held in independent, legally segregated escrow accounts.

Summary of Testimony

Asynchronous testimony was unanimously supportive. Some testimony recommended combining Resolutions 38, 39 and 41. However, Reference Committee review deemed that each resolution addresses a distinct problem and should be considered separately.

Live testimony was largely in support, with an author's amendment provided in response to questions raised in asynchronous testimony.

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15. **AMENDED RESOLUTION 40(26): Opposing Settlement of Medical Malpractice Claims Without Consent of the Defendant Physician**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 40(26) be adopted.

RESOLVED, That ACEP adopt policy supporting the principle that professional liability insurers should not settle a medical malpractice claim on behalf of an insured emergency physician without **meaningful collaboration with** that physician~~'s~~ **in reaching the settlement decision.** ~~informed written consent; and be it further~~

~~RESOLVED, That ACEP adopt policy opposing consent-to-settle provisions that shift financial risk to the physician, such as hammer clauses, which coerce consent rather than protect it.~~

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP adopt policy supporting the principle that professional liability insurers should not settle a medical malpractice claim on behalf of an insured emergency physician without that physician's informed written consent; and be it further

RESOLVED, That ACEP adopt policy opposing consent-to-settle provisions that shift financial risk to the physician, such as hammer clauses, which coerce consent rather than protect it.

Summary of Testimony

Asynchronous testimony, while supportive of the resolution's intent, recognized that this is a complex issue with many unintended consequences and was largely in opposition. The Reference Committee believes the amended version sufficiently addresses the concerns raised while preserving the resolution's intent.

Live testimony was largely in support, with a co-sponsor offering amended language on the first resolved statement. In response to testimony raising concerns with the second resolved statement, the Reference Committee deleted it.

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16. **AMENDED RESOLUTION 41(26): Transparency of Financial Solvency for Employer-Mandated Liability Coverage**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 41(26) be adopted.

~~RESOLVED, That ACEP advocate for state and federal legislative and regulatory standards that require any entity providing medical malpractice coverage via a captive or self-insured retention to provide physicians with clear, written disclosure of the fund's precise regulatory domicile, guaranty fund status, and a statement of financial risk at the time of any material negative change in the fund's capital reserves.~~

RESOLVED, That ACEP advocate that any entity providing professional liability coverage make available to physicians information regarding their coverage including the regulatory domicile of the coverage, current fund status as determined by the relevant regulator or independent actuarial review, and any lapses in coverage or missed funding as required by the relevant regulators; and be it further

RESOLVED, That ACEP advocate that any entity providing professional liability coverage that is found to be in fiscal risk by a regulator or actuary if self-insured, has a duty to disclose these findings and the corrective action plan to their clinicians.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate for state and federal legislative and regulatory standards that require any entity providing medical malpractice coverage via a captive or self-insured retention to provide physicians with clear, written disclosure of the fund's precise regulatory domicile, guaranty fund status, and a statement of financial risk at the time of any material negative change in the fund's capital reserves.

Summary of Testimony

Asynchronous testimony was unanimously supportive. There were a few requests for the authors to expound on some of the language used around types of liability coverage including "captive," "self-insured retention," and "any material negative change." Some testimony recommended combining Resolutions 38, 39 and 41, however, Reference Committee review deemed that each resolution addresses- a distinct problem and should be considered separately.

Live testimony was largely in support, with the author providing an amendment to clarify questions raised in asynchronous testimony.

Recommended NOT for Adoption

17. **RESOLUTION 37(26): Development of a HIPAA-Compliant Anonymous Database for Reporting Clinical Management Events Involving Non-Physicians**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 37(26) not be adopted.

RESOLVED, That ACEP study the feasibility of creating and maintaining a secure, anonymous, HIPAA-compliant repository for voluntary reporting of significant clinical events associated with non-physician practitioner care in emergency medicine.

Summary of Testimony

Asynchronous testimony was largely in opposition. Commenters believe this resolution can create divisiveness across health care providers and that the College's focus should be on physician-led care and not

targeting advanced practice providers. Other comments believe ACEP is not the appropriate entity to build a repository on adverse events, and that it would be costly.

Live testimony was largely in opposition. Many supported the spirit but raised concerns about costs and implementation challenges and recommended referring to the board. Most of the opposition was focused on cost and the implementation of a potential repository, as well as concern that this activity would be divisive, has a risk of backfiring, and would have limited utility if it's voluntary and anonymous.

Recommended for Referral

18. **RESOLUTION 29(26): Federal Tax Relief for EMTALA-Mandated Care**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 29(26) be referred to the Board of Directors.

RESOLVED, That ACEP advocate for federal legislation providing targeted tax relief for income derived from EMTALA-mandated care, recognizing such care as a federally required public service.

Summary of Testimony

Asynchronous testimony was largely supportive. Significant concerns were raised about the feasibility of the proposal and suggested referral to the Board of Directors to address these challenges. One comment highlighted the imminent report by the Federal Government Affairs Committee (FGA) on tax relief and malpractice protections that has been submitted to the Board of Directors for discussion.

Testimony in opposition received live was concerned that this could be too limiting for ACEP's broad approach to advocacy on EMTALA-related relief, including the work by the FGA Committee. However, there was support for the spirit and intent of the resolution.

Mr. Speaker, this concludes the final report of Reference Committee B. I would like to thank Brittany Arnold, MD, FACEP; Blake Denley, MD, FACEP; Mike Lozano, MD, MSHI, FACEP; Micaela LaRose, MD; Christopher Pergrem, MD, FACEP; Brianna Hanson, MPH; and Annalane Miller, MPH, for their excellent work in developing this preliminary report.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting
Reference Committee Members

Reference Committee A – Governance, Education, & Wellness
Resolutions 12-23

Jennifer L. Savino, DO, FACEP (PA) – Chair
Jacob M. Altholz, MD (CO)
Marina N. Boushra-Freiberg, MD (OH)
Daniel S. Udrea, MD, FACEP (IN)
Will Weber, MD, MPH, FACEP (MN)
Sandra Williams, DO, MPH, FACEP (TX)

Laura Lang, JD
Amber Williams, MSOL

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting

Final Report of REFERENCE COMMITTEE A

Presented by: Jennifer Savino, DO, FACEP – Chair

Madam Speaker and Councillors:

Reference Committee A gave careful consideration to the several items referred to it and submits the following report for consideration:

Unanimous Consent Agenda

For adoption:

1. RESOLUTION 12(26): Councillor Allocation for Sections of Membership – Bylaws Amendment
2. RESOLUTION 13(26): Councillor Allocation for Sections of Membership – Housekeeping Change – Council Standing Rules Amendment
3. RESOLUTION 19(26): Public Identification of Physicians in Training

For adoption as amended or substituted:

4. AMENDED RESOLUTION 16(26): Emergency Medicine Recommendations for Guidelines on Occupational Ergonomics
5. AMENDED RESOLUTION 17(26): Importance of the Arts and Humanities as Applied to Emergency Medicine
6. AMENDED RESOLUTION 18(26): Emergency Physician Specific Peer-to-Peer Support Programs Across EM Practice Settings
7. AMENDED RESOLUTION 20(26): Simulation-Based Continuing Education Certification
8. AMENDED RESOLUTION 22(26): Reducing Unnecessary Non-Sterile Glove Use in Emergency Departments
9. AMENDED RESOLUTION 23(26): Incorporating ED Climate Resilience and Sustainability into ACEP's ED

Not for adoption:

10. RESOLUTION 21(26): Exploring the Feasibility of Renewably Powered EMS Vehicles

For referral to the Board of Directors:

11. RESOLUTION 14(26): Codifying the Audit Committee in the Bylaws – Bylaws Amendment
12. RESOLUTION 15(26): Proposed Bylaws Changes – Bylaws Amendment

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Recommended for Adoption

1. **RESOLUTION 12(26): Councillor Allocation for Sections of Membership – Bylaws Amendment**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 12(26) be adopted.

RESOLVED, That the Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph 8, be amended to read:

Each chartered section shall be entitled to one councillor as representative of all of the members of such chartered section if the number of section ~~dues-paying and complimentary candidate~~ members meets the minimum number established by the Board of Directors for the charter of that section based on the membership rolls of the College on December 31 of the preceding year.

Summary of Testimony

Asynchronous testimony was limited but supportive. Testimony in support noted that the amendment was submitted in conjunction with the Steering Committee and makes the language consistent across the Bylaws and Council Standing Rules. A concern was raised whether there was an inconsistency between the Bylaws and the Council Standing Rules regarding whether only dues-paying members count toward the charter minimum and the possibility that complimentary memberships could be used to reach the threshold. Sections, however, may not bestow complimentary membership; individual members control which sections they join, and those with a complimentary section membership determine to which section it applies.

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2. **RESOLUTION 13(26): Councillor Allocation for Sections of Membership – Housekeeping Change – Council Standing Rules Amendment**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 13(26) be adopted.

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

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

Summary of Testimony

The resolution was submitted by the Steering Committee to simplify language in the Council Standing Rules to reflect that a section must have the total minimum number of members established by the Board of Directors rather than differentiating between dues paying and complimentary section members. Testimony was limited and focused primarily on clarifying membership eligibility for section charter requirements.

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3. **RESOLUTION 19(26): Public Identification of Physicians in Training**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 19(26) be adopted.

RESOLVED, That ACEP work with other organizations to develop policy discouraging the unnecessary public identification of physicians in training in media reports, public statements, and external institutional communications related to patient care events or allegations, unless disclosure is legally required or necessary to protect the public.

Summary of Testimony

Testimony was entirely supportive. Several component bodies testified in support, emphasizing that trainees are not the final decision makers in patient care and should not bear the brunt of public disclosure, and noting the importance of protecting the psychological safety of the learning environment.

Recommended for Adoption as Amended or Substituted

4. **AMENDED RESOLUTION 16(26): Emergency Medicine Recommendations for Guidelines on Occupational Ergonomics**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Amended Resolution 16(26) be adopted.

RESOLVED, That ACEP ~~develop~~ **support best practices and** guidelines to reduce work-related musculoskeletal injury among emergency physicians**.** ~~and that the guidelines address, emergency department procedural ergonomics, airway management, cardiopulmonary resuscitation, point-of-care ultrasound, patient positioning, monitor and equipment placement, workstation and documentation ergonomics, prolonged standing, and be it further~~

~~RESOLVED, That ACEP encourage emergency medicine residency programs and emergency departments to incorporate ergonomics education into procedural training, ultrasound training, simulation, faculty development, and departmental quality and safety initiatives.~~

ORIGINAL RESOLUTION AS SUBMITTED

RESOLVED, That ACEP develop guidelines to reduce work-related musculoskeletal injury among emergency physicians and that the guidelines address, emergency department procedural ergonomics, airway management, cardiopulmonary resuscitation, point-of-care ultrasound, patient positioning, monitor and equipment placement, workstation and documentation ergonomics, prolonged standing, and be it further

RESOLVED**,** That ACEP encourage emergency medicine residency programs and emergency departments to incorporate ergonomics education into procedural training, ultrasound training, simulation, faculty development, and departmental quality and safety initiatives

Summary of Testimony

Testimony supported the intent of the resolution but was mixed. Supporters highlighted the toll of musculoskeletal injuries on emergency physicians and encouraged ACEP to take a leadership role. Opposition testimony questioned the need for ACEP to develop new guidelines when existing guidelines are available, and raised concerns about the breadth of the first resolved, its fiscal impact, and the burden on rural emergency departments. There was opposition to the second resolved adding to already demanding training requirements.

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5. **AMENDED RESOLUTION 17(26): Importance of the Arts and Humanities as Applied to Emergency Medicine**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Amended Resolution 17(26) be adopted.

RESOLVED, That ACEP recognize the importance and relevance of the arts and humanities to emergency medicine; ~~and be it further~~

~~RESOLVED, That ACEP support the application, evaluation, and dissemination of arts and humanities-based approaches across the spectrum of emergency medicine education and training towards enhancing clinical care and emergency physician well-being.~~

ORIGINAL RESOLUTION AS SUBMITTED

RESOLVED, That ACEP recognize the importance and relevance of the arts and humanities to emergency medicine; and be it further

RESOLVED, That ACEP support the application, evaluation, and dissemination of arts and humanities-based approaches across the spectrum of emergency medicine education and training towards enhancing clinical care and emergency physician well-being.

Summary of Testimony

Testimony supported the spirit of the resolution but was mixed on the second resolved. Supporters emphasized that the arts and humanities develop skills difficult to teach in a traditional didactic setting and noted the value of ACEP's formal recognition. Opposition testimony cited cost, time, existing avenues within ACEP, and the added strain on residency curricula, and questioned prioritizing the arts over the varied interest held by members. Testimony noted that delivering difficult news is now addressed in ABEM's certifying exam.

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6. **AMENDED RESOLUTION 18(26): Emergency Physician Specific Peer-to-Peer Support Programs Across EM Practice Settings**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Amended Resolution 18(26) be adopted.

RESOLVED, That ACEP recognize confidential emergency physician specific peer-to-peer support programs as a crucial practice for promoting emergency physician well-being, professional satisfaction, and sustainability; and be it further

RESOLVED, That ACEP continue development and dissemination of resources for emergency medicine physicians specific peer-to-peer support programs; and be it further

RESOLVED, That ACEP extend confidential support programs to relevant trainees.

~~RESOLVED, That ACEP support implementation of emergency physician specific peer-to-peer support programs in all emergency medicine practice settings (groups, departments or practice entities) by 2031; and be it further~~

~~RESOLVED, That ACEP annually assess and report progress toward implementation of emergency physician specific peer to peer support programs in all emergency medicine practice settings through existing wellness, workforce, or practice related committees.~~

ORIGINAL RESOLUTION AS SUBMITTED

RESOLVED, That ACEP recognize confidential emergency physician specific peer-to-peer support programs as a crucial practice for promoting emergency physician well-being, professional satisfaction, and sustainability; and be it further

RESOLVED, That ACEP continue development and dissemination of resources for emergency physician specific peer-to-peer support programs; and be it further

RESOLVED, That ACEP support implementation of emergency physician specific peer-to-peer support programs in all emergency medicine practice settings (groups, departments or practice entities) by 2031; and be it further

RESOLVED, That ACEP annually assess and report progress toward implementation of emergency physician specific peer-to-peer support programs in all emergency medicine practice settings through existing wellness, workforce, or practice-related committees.

Summary of Testimony

Testimony strongly supported the intent of the resolution, with debate focused on the third and fourth resolved statements. Opposition to the implementation deadline and annual reporting requirement cited workforce and financial feasibility and overly prescriptive language. Testimony noted that developing peer support resources and training is already an objective of the Professional Well-Being Committee. EMRA testified in strong support, noting that trainees may hesitate to use programs where they could be identified by those evaluating them. The Reference Committee believes the intent of the fourth resolved is already met by the existing annual report to the Council on actions taken on Council resolutions.

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7. **AMENDED RESOLUTION 20(26): Simulation-Based Continuing Education Certification**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Amended Resolution 20(26) be adopted.

RESOLVED, That ACEP work with the American Board of Emergency Medicine (ABEM) to advocate that participation in emergency medicine simulation **based activities** (cadaver, virtual reality, high-fidelity) counts toward ABEM **Improvement in Medical Practice (IMP)** ~~Maintenance of Certification~~ requirements; ~~and be it further~~

~~RESOLVED, That ACEP work with the American Board of Emergency Medicine to develop a simulation-based continuing certification pathway that allows qualified emergency medicine simulation activities to satisfy a portion of MyEMCert or Practice Improvement requirements.~~

ORIGINAL RESOLUTION AS SUBMITTED

RESOLVED, That ACEP work with the American Board of Emergency Medicine (ABEM) to advocate that participation in emergency medicine simulation (cadaver, virtual reality, high-fidelity) counts toward ABEM Maintenance of Certification requirements; and be it further

RESOLVED, That ACEP work with the American Board of Emergency Medicine to develop a simulation-based continuing certification pathway that allows qualified emergency medicine simulation activities to satisfy a portion of MyEMCert or Practice Improvement requirements.

Summary of Testimony

Testimony was offered in support of the intent of the resolution, but opposed to potential implications as written. Concerns were centered around the possibility of increased Maintenance of Certification requirements, and testimony from ABEM, whose concern centered around their independence in decision-making. An amendment was submitted to clarify that any such simulations would support practice-based learning and improvement, rather than counting toward Maintenance of Certification requirements.

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8. **AMENDED RESOLUTION 22(26): Reducing Unnecessary Non-Sterile Glove Use in Emergency Departments**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Amended Resolution 22(26) be adopted.

~~RESOLVED That ACEP endorse efforts such as the "Gloves Off!" campaign to reduce unnecessary non-~~

~~sterile glove use in emergency departments; and be it further~~

RESOLVED That ACEP encourage ~~incorporation of~~ evidence-based, sustainable glove use practices ~~into institutional policies and clinical guidelines, highlighting associated hand hygiene compliance, environmental benefits and cost savings.~~

ORIGINAL RESOLUTION AS SUBMITTED

RESOLVED That ACEP endorse efforts such as the "Gloves Off!" campaign to reduce unnecessary non-sterile glove use in emergency departments; and be it further

RESOLVED That ACEP encourage incorporation of evidence-based, sustainable glove use practices into institutional policies and clinical guidelines, highlighting associated hand hygiene compliance, environmental benefits and cost savings.

Summary of Testimony

Testimony was divided, with supporters arguing that unnecessary non-sterile glove use contributes significantly to healthcare waste and emissions, and that ACEP should endorse evidence-based efforts such as the international "Gloves Off!" campaign to reduce environmentally harmful overuse while maintaining appropriate infection control practices. Opponents generally agreed with the science but expressed concerns that the initiative could be misinterpreted by patients, hospitals, and trainees, potentially undermining infection prevention messaging, physician autonomy, and public trust in a post-pandemic environment.

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9. **AMENDED RESOLUTION 23(26): Incorporating ED Climate Resilience and Sustainability into ACEP's ED**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Amended Resolution 23(26) be adopted.

RESOLVED, That ACEP ~~include climate resilience and sustainability into the planned general emergency department accreditation program, utilizing evidence-based standards and measurable performance metrics to promote environmental sustainability, climate resilience, and operational stewardship in emergency care; and be it further~~ **direct the Emergency Department Accreditation (EDAc) Board of Governors to query stakeholders, including leaders of emergency departments that have been accredited, and those that are now undergoing the accreditation process, about the feasibility of and any barriers to potential accreditation process revisions, which would include climate and sustainability criteria in future EDAc practice improvement guidelines.**

~~RESOLVED, That ACEP collaborate with the International Federation for Emergency Medicine, the Royal College of Emergency Medicine, the Australasian College for Emergency Medicine, and other relevant organizations to identify best practices and opportunities for harmonization of sustainability and climate resilience initiatives in emergency medicine.~~

ORIGINAL RESOLUTION AS SUBMITTED

RESOLVED, That ACEP include climate resilience and sustainability into the planned general emergency department accreditation program, utilizing evidence-based standards and measurable performance metrics to promote environmental sustainability, climate resilience, and operational stewardship in emergency care; and be it further

RESOLVED, That ACEP collaborate with the International Federation for Emergency Medicine, the Royal College of Emergency Medicine, the Australasian College for Emergency Medicine, and other relevant organizations to identify best practices and opportunities for harmonization of sustainability and climate resilience initiatives in emergency medicine.

Summary of Testimony

Testimony was largely in opposition, citing the significant costs associated with developing appropriate metrics for consideration and concerns that such a requirement would deter departments from utilizing ACEP's accreditation system and should be hospital level endeavors. Other testimony, including from the EDAc Board of Governors and the ACEP Board of Directors, offered support for continued exploration of environmental sustainability within ED accreditation, particularly the amended fact-finding component. Speakers emphasized that ED accreditation is still in its pilot phase and that any future accreditation requirements should be carefully evaluated for operational and financial impact before implementation.

Recommended NOT for Adoption

10. **RESOLUTION 21(26): Exploring the Feasibility of Renewably Powered EMS Vehicles**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 21(26) not be adopted.

RESOLVED, That ACEP engage with international EMS leaders who have implemented renewable-powered EMS vehicles to identify best practices and lessons applicable to EMS systems in the United States; and be it further

RESOLVED, That ACEP evaluate and summarize strategies used to overcome operational, financial, and infrastructure barriers to renewable-powered EMS vehicle implementation; and be it further

RESOLVED, That ACEP share learned strategies of renewable-powered EMS vehicles with EMS leaders and other stakeholders to support informed consideration of renewable-powered EMS vehicles in the United States.

Summary of Testimony

Testimony was largely in opposition to the resolution with an emphasis on costs, how it might apply to volunteer-based services, and questioning whether it was appropriate for ACEP to make this issue a priority when it might be better suited to an Emergency Medical Services organization and/or state and local governments. Those offering support cited the need to reduce negative environmental impacts of medical work and procedures and a lack of other organizations' efforts to address the use of renewable powered EMS vehicles.

Recommended for Referral

11. **RESOLUTION 14(26): Codifying the Audit Committee in the Bylaws – Bylaws Amendment**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 14(26) be referred to the Board of Directors.

RESOLVED, That the ACEP Bylaws Article XI – Committees. Section 1 – General Committees be amended as follows and by addition of a new Section 8 – Audit Committee:

ARTICLE XI — COMMITTEES
(No changes are proposed for Sections 2 or 5-7.)
Section 1 — General Committees

The president shall ~~annually~~ appoint committees and task forces **annually** to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be

necessary that the chair of a committee be a member of the Board. A majority of the voting membership of a committee shall constitute a quorum.

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

Section 8 – Audit Committee

The Audit Committee shall consist of the Audit Committee chair, who must also serve concurrently on the Finance Committee, the Finance Committee chair, the secretary-treasurer of the College, and two additional members of the Finance Committee. A sixth member may be considered by the president and may or may not serve concurrently on the Finance Committee. The Audit Committee shall oversee the audit functions of the College as outlined in the Audit Committee Charter.

Summary of Testimony

Asynchronous testimony supported codifying the Audit Committee in the Bylaws but noted inconsistencies in the proposed language and concerns about the committee's composition that should be resolved before adoption. Live testimony was limited. Testimony was offered that the amendment is clean-up language and that no inconsistencies remained after review, while additional testimony raised concerns about how the proposed language interacts with the Compensation Committee and supported referral.

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12. **RESOLUTION 15(26): Proposed Bylaws Changes – Bylaws Amendment**

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 15(26) be referred to the Board of Directors.

RESOLVED, That the ACEP Bylaws be amended as follows:

ARTICLE IV – MEMBERSHIP
(No changes are proposed for Sections 1 – 4 or 6.)
Section 5 – Dues, Fees, and Assessments

Application fees and annual dues shall be determined annually by the Board of Directors. Assessments of members may not be levied except upon recommendation of the Board of Directors and by a majority vote of the Council. Notice of any proposed assessment shall be sent to each member of the College by mail**, electronic mail,** or **other** official **ACEP communication** at least 30 days before the meeting of the Council at which the proposed assessment will be considered. The Board of Directors shall establish uniform policies regarding dues, fees, and assessments.

ARTICLE VI – CHAPTERS
(No changes are proposed for Sections 1 or 3-6.)
Section 2 — Chapter Bylaws

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

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

ARTICLE VIII – COUNCIL

(No changes are proposed for Sections 1, 2 or 5-8.)

Section 3 — Meetings

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

Special meetings of the Council may be held within or outside of the State of Texas and may be called by an affirmative vote of two-thirds of the entire Board of Directors, by the speaker with concurrence of a two-thirds vote of the entire Steering Committee, or by a petition of councillors comprised of signatures numbering one-third of the number of councillors present at the previous annual meeting, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee, provided that the time and place of such meeting shall be announced not less than ~~40~~ **10** nor more than ~~50~~ **60** days prior to the meeting.

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

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

All members of the College shall be notified of all Council meetings by mail**, electronic mail** or **other** official ~~publication~~ **ACEP communication**.

Section 4 — Quorum

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

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

ARTICLE IX – BOARD OF DIRECTORS

(No changes are proposed for Sections 1, 2, 4, or 5.)

Section 3 – Meetings

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

Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors, members of the Board of Directors may participate in and hold additional meetings of such Board by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person

at such meeting, except where a director participates in such meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

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

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

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

(No changes are proposed for Sections 1-4, 6, or 8-13.)

Section 5 — President

The president shall be a member of the Board of Directors, and shall additionally hold ex-officio membership in all committees. The president's term of office shall begin at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated. **No president may serve more than one term as president.**

Section 7 — Vice Presidents

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

~~**Section 14 — Assistant Secretary-Treasurer**~~

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

ARTICLE XI — COMMITTEES

(No changes are proposed for Sections 2 or 5-7.)

Section 1 — General Committees

The president shall ~~annually~~ appoint committees and task forces **annually** to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board. A majority of the voting membership of a committee shall constitute a quorum.

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

Section 3 — Steering Committee

A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall

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

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

Section 4 — Bylaws Interpretation Committee

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

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

ARTICLE XIII — AMENDMENTS

(No changes are proposed for Sections 1-3.)

Section 4 — Contested Amendment

If an Amendment Under Initial Consideration fails to receive an affirmative vote of at least two-thirds of the members of the Board of Directors, then such proposed Bylaws amendment shall be deemed a Contested Amendment. The positions and vote of each member of the Board regarding such Contested Amendment shall be presented to the Council's Steering Committee at the Steering Committee's first meeting following said vote of the Board of Directors. The Council's component bodies and councillors shall be notified within 30 days of the Board action. The Steering Committee shall not have the authority to amend or adopt a Contested Amendment. The speaker may call a special meeting of the Council to consider a Contested Amendment. The time and place of such meeting shall be announced no less than ~~40~~ **10** and no more than ~~50~~ **60** days prior to the meeting.

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

If the unmodified Contested Amendment receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the chair of the Tellers, Credentials, & Elections Committee, then such

proposed Bylaws amendment shall be adopted, and these Bylaws shall be ~~so~~ amended immediately.

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

Summary of Testimony

Testimony highlighted concerns that the proposed bylaws revisions contain substantive governance changes and internal inconsistencies that warrant further review rather than immediate adoption. Opponents were particularly concerned about shifting the Bylaws Interpretation Committee from annual appointments to appointments made only when needed, arguing this could create delays or staffing challenges during urgent situations, while supporters noted the changes were intended to align the bylaws with current practice and expressed openness to revising language based on feedback.

Overall, discussion favored referring the resolution for additional refinement, with several speakers emphasizing the importance of carefully evaluating the broader governance implications before implementing multiple significant bylaw changes.

Madam Speaker, this concludes the final report of Reference Committee A. I would like to thank Jacob M. Altholz, MD; Marina N. Boushra-Freiberg, MD; Daniel S. Udrea, MD, FACEP; Will Weber, MD, MPH, FACEP; Sandra Williams, DO, MPH, FACEP; Laura Lang, JD; and Amber Williams, MS for their excellent work in developing this preliminary report.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 42-56

Hilary Fairbrother, MD, FACEP (TX) – Chair
Patsy Chenpanas, MD (OR)
Frank Y. Duncan, III, MD, FACEP (MI)
Laura Janneck, MD, MPH, FACEP (OK)
Ira R. Nemeth, MD, FACEP (TX)
Monika Pitzele, MD, PhD, FACEP (IL)

Joya Coffman MS, CHES, ASQ-CQIA
Travis Schulz, MLS, AHIP

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2026 Council Meeting

Final Report of REFERENCE COMMITTEE C

Presented by: Hilary Fairbrother, MD, FACEP – Chair

Mr. Speaker and Councillors:

Reference Committee C gave careful consideration to the several items referred to it and submits the following report:

Unanimous Consent Agenda

For adoption:

1. RESOLUTION 42(26): Clarification and Revision of ACEP Policy on Medical Cannabis in the Era of Emerging Psychoactive Cannabinoids
2. RESOLUTION 49(26): Ensuring Transparency and Accountability in Emergency Department Staffing Proposals
3. RESOLUTION 53(26): Protecting Emergency Physician Privacy in Hospital Identification and Directories

For adoption as amended or substituted:

4. AMENDED RESOLUTION 44(26): Contraceptive Provision is Within the Scope of Emergency Medicine Practice
5. AMENDED RESOLUTION 45(26): Medical Management of Early Pregnancy Loss in the Emergency Department
6. AMENDED RESOLUTION 46(26): Strengthening ACEP Educational Resources and Guidelines on the Ultrasonographic Diagnosis of Early Pregnancy Loss
7. AMENDED RESOLUTION 50(26): Law Enforcement Presence in the Emergency Department
8. AMENDED RESOLUTION 51(26): Physician Staffing Requirements for Pediatric Ready Designation
9. AMENDED RESOLUTION 54(26): Radiology Turn-Around Time
10. AMENDED RESOLUTION 56(26): Strengthening ACEP Policy on the Appropriate Use of ED Patient

Not for adoption:

11. RESOLUTION 48(26): No-Cost Solutions to ED Boarding
12. RESOLUTION 52(26): Prioritizing Inpatient Medical Admission for Geriatric Psychiatric Patients When Psychiatric Beds Are Unavailable

For referral to the Board of Directors:

13. RESOLUTION 43(26): ED-Initiated Pharmacotherapy Pathways for Alcohol Use Disorder
14. RESOLUTION 47(26): ED of the Future
15. RESOLUTION 55(26): Responsible Use of AI in Emergency Medicine Documentation

Recommended for Adoption

1. **RESOLUTION 42(26): Clarification and Revision of ACEP Policy on Medical Cannabis in the Era of Emerging Psychoactive Cannabinoids**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 42(26) be adopted.

RESOLVED, That ACEP revise its policy statement “Medical Cannabis” to include a clear and explicit definition of “medical cannabis,” distinguishing between FDA-approved cannabinoid medications, state-regulated

cannabis products, and non–FDA-approved hemp-derived psychoactive cannabinoids; and be it further

RESOLVED, That ACEP update its policy statement "Medical Cannabis" to specifically acknowledge the emergence of hemp-derived psychoactive cannabinoids (including but not limited to delta-8 THC and similar compounds) and their associated clinical and public health risks; and be it further

RESOLVED, That ACEP incorporate language in the policy statement "Medical Cannabis" to address the risks of unintentional pediatric exposures to cannabinoid-containing products and support measures to reduce such exposures, including improved labeling, packaging, and public education; and be it further

RESOLVED, That ACEP advocate for standardized nomenclature, regulation, and research regarding emerging cannabinoid products to better inform emergency physicians and protect public health.

Summary of Testimony

Asynchronous testimony was primarily in support. Testimony in support highlighted the critical gap in ACEP's medical cannabis policy statement caused by the proliferation of unregulated, hemp-derived psychoactive cannabinoids like delta-8 THC and increasing pediatric exposure risks. Testimony both in support and against the resolution supported the intent but highlighted fulfillment of the resolution could be accomplished through the existing ACEP policy and the usual committee-based revision process and did not necessitate a new initiative. Further testimony emphasized the need to incorporate existing state statutes and federal regulatory frameworks to prevent duplicating work during the revision process.

Live testimony supported revising ACEP's medical cannabis policy to more clearly distinguish medical cannabis from hemp-derived products, extracted cannabinoids, and other emerging psychoactive substances. Testimony highlighted concerns about serious adverse effects, particularly in children, and also suggested that broader cannabis guidance may be needed to address risks associated with both medical and recreational use.

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2. **RESOLUTION 49(26): Ensuring Transparency and Accountability in Emergency Department Staffing Proposals**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 49(26) be adopted.

RESOLVED, That ACEP develop and disseminate best practice guidelines for emergency department Request for Proposal (RFP) processes that promote transparency by encouraging:

- objective disclosure of the clinician workforce and operational resources available to support implementation of the proposed contract at the time of award;
- clear distinction between existing resources and projected future recruitment or expansion;
- transparent description of implementation plans, assumptions, and anticipated timelines; and
- disclosure, upon request by interested parties and consistent with applicable law and contractual obligations, of the evaluation criteria and materials used during the contract selection process, including scoring methodologies and other documentation supporting the award decision; and be it further

RESOLVED, That ACEP advocate for emergency department Request for Proposal (RFP) processes that promote objective evaluation of proposals using transparent criteria and accurate representations of organizational capabilities, while recognizing the diversity of emergency medicine practice structures and employment models; and be it further

RESOLVED, That ACEP support transparency regarding implementation outcomes following emergency department contract transitions by encouraging reporting, upon request by interested stakeholders and consistent with applicable law and contractual obligations, comparing key elements of proposed implementation plans with actual implementation one year following transition.

Summary of Testimony

Asynchronous testimony was almost exclusively in support. Testimony highlighted that despite ACEP's limited direct control over hospital decisions, establishing transparent hospital RFP guidelines through a low-cost, accessible white paper would be beneficial to the membership. Further testimony suggested that since hospitals control the RFP process, any endeavor should emphasize that success relies on actively disseminating these best practices to hospital leaders and external health organizations. Testimony cautioned that engaging hospitals on RFP practices could inadvertently encourage them to employ individual physicians rather than contracting with independent groups.

Live testimony was mixed. Proponents of the resolution emphasized that emergency departments frequently treat alcohol use disorder and suggest that expanding evidence-based medication pathways is a worthwhile investment given positive regional results. Opponents raised concerns about redundancy and cost, noting that SAEM published guidelines in 2024 and ACEP has already authorized broader work on substance use disorders. Several members providing testimony suggested a compromise, supporting the initiative's clinical intent while recommending it be integrated into existing board-directed projects rather than run as a separate effort.

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3. **RESOLUTION 53(26): Protecting Emergency Physician Privacy in Hospital Identification and Directories**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 53(26) be adopted.

RESOLVED, That ACEP develop a policy statement supporting emergency physicians' discretion over the extent of personally identifying information displayed on hospital identification badges, attire, and public-facing directories.

Summary of Testimony

Asynchronous testimony was largely in support. Testimony in support highlighted that reducing public identifiers provides a critical safeguard against workplace violence, stalking, and online harassment. Testimony also emphasized that patient transparency can be maintained since physician identities remain readily available in medical records, discharge paperwork, and secure portals. Testimony in opposition questioned the practical feasibility of withholding names, arguing that limiting public identification could impede care coordination, reduce accountability, and infringe on a patient's right to know who is directing their care.

Live testimony was mostly in support. Proponents of the resolution supported giving clinicians discretion to limit their full names on badges and public directories, citing rising workplace violence, stalking, and online harassment. Opponents commented that restricting badge information offers a false sense of security – because physicians remain easily searchable through public databases and medical records – while also hindering patients' ability to identify their providers and verify credentials. Clarifications from authors emphasize that legitimate patients would still access physician details through charts and billing, leading some critics to suggest redirecting safety efforts toward protecting home addresses instead.

Recommended for Adoption as Amended or Substituted

4. **AMENDED RESOLUTION 44(26): Contraceptive Provision is Within the Scope of Emergency Medicine Practice**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 44(26) be adopted.

RESOLVED, That ~~the~~ ACEP ~~Board of Directors~~ assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed to develop and publish an educational resource and model residency curriculum to equip emergency physicians with the knowledge and skills necessary to provide contraceptive care (including contraception counseling, prescribing and initiation) in the ED; and be it further

RESOLVED, That ~~the~~ ACEP ~~Board of Directors advocate for~~ **support** the removal of systemic barriers to ED-based contraception provision, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles that limit patient access to contraceptive services in the emergency care setting.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That the ACEP Board of Directors assign an appropriate committee or task force to collaborate with the Reproductive Health Section and other relevant committees and sections as needed to develop and publish an educational resource and model residency curriculum to equip emergency physicians with the knowledge and skills necessary to provide contraceptive care (including contraception counseling, prescribing and initiation) in the ED; and be it further

RESOLVED, That the ACEP Board of Directors advocate for the removal of systemic barriers to ED-based contraception provision, including formulary restrictions, insurance and reimbursement barriers, and regulatory obstacles that limit patient access to contraceptive services in the emergency care setting.

Summary of Testimony

Asynchronous testimony was almost exclusively in support. Proponents of the resolution supported the development of optional resources for contraceptive counseling and initiation citing that it is a vital safety-net service for patients lacking primary care. Proponents also supported the reduction of systematic and regulatory barriers as well as insurance obstacles but cautioned against the ever-expanding expectations of emergency care that can strain limited resources. Concerns highlighted continuation of care after ED-initiated contraception. It was suggested the first resolved be amended to assign the resolution directly to the Reproductive Health Section to save costs and prevent duplicate staff work. Additionally, it was suggested changing "ACEP Board of Directors" to "ACEP" in the second resolved to reflect the entity responsible more accurately for fulfilling the resolution. Another amendment was suggested for the second resolved requesting "advocate" be changed to "support" to reflect the language typically used when collaborating with partner organizations such as the American College of Obstetricians and Gynecologists.

Live testimony reflected both support and concern regarding contraception as part of emergency medicine practice. Testimony in support emphasized patient access, existing emergency medicine scope, and providing physicians with education and resources when contraception is appropriate, while opposing testimony raised concerns about ED resource limitations, procedural competency, reimbursement, and whether broad policy language could create unintended standard-of-care or liability expectations.

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5. **AMENDED RESOLUTION 45(26): Medical Management of Early Pregnancy Loss in the Emergency Department**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 45(26) be adopted.

RESOLVED, That ACEP, supporting clinical practice ~~in line with the American College of Obstetricians and Gynecologists Practice Bulletin~~ and clinical guidelines for medication management of early pregnancy loss, update the existing policy statement "Emergency Physicians' Role in the Medical and Procedural Management of Early Pregnancy Loss" to include the medication management ~~regimens~~ that can be offered to patients with early pregnancy

loss in the ED; and be it further

RESOLVED, That ACEP expand on the miscarriage management resources available on the website by collaborating with ~~Council of Residency Directors in Emergency Medicine and other~~ relevant groups to develop a curriculum for emergency medicine clinicians for diagnosis and treatment of early pregnancy loss in the emergency department, highlighting medication management regimens~~, as standard~~ in emergency medicine.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP, supporting clinical practice in line with the American College of Obstetricians and Gynecologists Practice Bulletin and clinical guidelines for medication management of early pregnancy loss, update the existing policy statement "Emergency Physicians' Role in the Medical and Procedural Management of Earl Pregnancy Loss" to include the medication management regimens that can be offered to patients with early pregnancy loss in the ED; and be it further

RESOLVED, That ACEP expand on the miscarriage management resources available on the website by collaborating with Council of Residency Directors in Emergency Medicine and other relevant groups to develop a curriculum for emergency medicine clinicians for diagnosis and treatment of early pregnancy loss in the emergency department, highlighting medication management regimens, as standard in emergency medicine.

Summary of Testimony

Asynchronous testimony was primarily in support. Testimony highlighted the need for education resources on the legal barriers and proper treatment of early pregnancy loss. Consensus among those providing testimony recommended deleting "regimens" from the first resolved since specific dosing is not provided in policy statements. In addition, it was suggested that the phrase "as standard" be deleted or replaced in the second resolved since using "standard" implies a legal "standard of care," creating severe medical-legal liability for emergency physicians operating in restricted states or religious hospital systems. Additional testimony cautioned against directly anchoring ACEP policy to external American College of Obstetricians and Gynecologists guidelines to ensure the College is not automatically bound to future policy changes made by outside organizations.

Live testimony was largely in support. Proponents argued that emergency physicians, particularly in rural settings lacking timely OB backup, need clearer guidance and training on medication management for early pregnancy loss to address gaps in clinical knowledge, legal ambiguities, and repeat ED visits. Opponents countered that such treatment should already be covered during residency training or be addressed through current ACEP initiatives or resources rather than a new Council directive.

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6. **AMENDED RESOLUTION 46(26): Strengthening ACEP Educational Resources and Guidelines on the Ultrasonographic Diagnosis of Early Pregnancy Loss**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 46(26) be adopted.

RESOLVED, That ~~the Board of Directors~~ **ACEP** request the Emergency Ultrasound Section to explore including early pregnancy loss into the evaluation of first trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines; and be it further

RESOLVED, That ~~the Board of Directors~~ **ACEP** assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant committees and sections as needed to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the emergency department.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That the Board of Directors request the Emergency Ultrasound Section to explore including early pregnancy loss into the evaluation of first trimester pregnancy during the next revision cycle of the ACEP Ultrasound Guidelines; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee to collaborate with the Emergency Ultrasound Section, the Reproductive Health Section, and other relevant committees and sections as needed to develop and publish a clinical resource on the ultrasonographic diagnosis of early pregnancy loss in the emergency department.

Summary of Testimony

Asynchronous testimony was primarily in support. Testimony in support indicated that a guideline addressing early pregnancy loss would fill a critical clinical gap in the prevention of misdiagnosing viable pregnancies. Proponents emphasized that the development of any new material should include collaboration with radiologists and OB/GYN stakeholders and must clearly define the scope and limitations of point-of-care ultrasound (POCUS) while offering management pathways for indeterminate findings. Testimony against the resolution expressed caution regarding medical liability, operator-dependent measurements, and whether emergency physicians possess sufficient training repetitions for definitive diagnostic calls. Further testimony recommended a virtual workgroup in place of the suggested in-person meeting to reduce anticipated costs. The Reference Committee recommended changing "Board of Directors" to "ACEP" in the resolveds to reflect the entity responsible more accurately for fulfilling the resolution.

Live testimony was primarily in support. Testimony in support emphasized the need to update ACEP's ultrasound guidance to reflect current evidence-based criteria for diagnosing early pregnancy loss and to improve physician confidence in distinguishing viable from nonviable pregnancies, particularly in rural or resource-limited settings. Further testimony focused on implementation, including collaboration among relevant ACEP sections and committees, appropriate oversight of the work, and ensuring that the guidance supports both point-of-care and consultative ultrasound without implying that every emergency physician must independently perform definitive diagnostic imaging.

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7. **AMENDED RESOLUTION 50(26): Law Enforcement Presence in the Emergency Department**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 50(26) be adopted.

RESOLVED, That ACEP **continue to** recognize the impact of federal law enforcement in hospital spaces and how it may deter vulnerable populations, regardless of immigration status, from seeking care, or providing pertinent health information during visits due to fear of confidentially breaches, in emergency departments leading to worsening disparities in health outcomes of an already marginalized population; and be it further

RESOLVED, That ACEP affirm that emergency departments are spaces dedicated to unbiased, nondiscriminatory emergency medical care, and supports policies that protect safe access to emergency care regardless of immigration status; and be it further

RESOLVED, That ACEP reaffirm that no legal or law enforcement process, including immigration enforcement, should interfere with patient care in the ED absent immediate safety threats or specific applicable laws; and be it further

RESOLVED, That ACEP **continue to** encourage emergency departments to adopt or develop clear hospital policies to guide medical staff in navigating the presence of immigration agents, thereby reducing confusion and uncertainty and promoting accessible, equitable, patient-centered care, consistent with ACEP's existing policy

encouraging hospital partnerships with community groups and law enforcement agencies to develop clear ED access policies; and be it further

RESOLVED, That ACEP discourage the routine inclusion of immigration status in clinical documentation, including EMS records, unless clinically relevant or required by law; and be it further

RESOLVED, That ACEP reaffirm that a medical screening examination and any resulting documentation reflect emergency medical evaluation only, do not constitute a fitness-for-confinement determination, and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP recognize the impact of federal law enforcement in hospital spaces and how it may deter vulnerable populations, regardless of immigration status, from seeking care, or providing pertinent health information during visits due to fear of confidentially breaches, in emergency departments leading to worsening disparities in health outcomes of an already marginalized population; and be it further

RESOLVED, That ACEP affirm that emergency departments are spaces dedicated to unbiased, nondiscriminatory emergency medical care, and supports policies that protect safe access to emergency care regardless of immigration status; and be it further

RESOLVED, That ACEP reaffirm that no legal or law enforcement process, including immigration enforcement, should interfere with patient care in the ED absent immediate safety threats or specific applicable laws; and be it further

RESOLVED, That ACEP encourage emergency departments to adopt or develop clear hospital policies to guide medical staff in navigating the presence of immigration agents, thereby reducing confusion and uncertainty and promoting accessible, equitable, patient-centered care, consistent with ACEP's existing policy encouraging hospital partnerships with community groups and law enforcement agencies to develop clear ED access policies; and be it further

RESOLVED, That ACEP reaffirm that a medical screening examination and any resulting documentation reflect emergency medical evaluation only, do not constitute a fitness-for-confinement determination, and should not be relied upon by law enforcement or immigration agencies for custodial health decisions.

Summary Testimony

Asynchronous testimony broadly supported protecting vulnerable patients and emergency department staff from law enforcement deterrence in the emergency department, particularly by discouraging the routine inclusion of immigration status in medical records. Testimony opposed highlighted many of the resolveds reaffirm current policy and does not advance the College or the issue. An amendment removing redundant reaffirmations to strictly focus the resolution on discouraging routine immigration status documentation was proposed.

Live testimony was primarily in support of maintaining the resolution's broader protections for immigrant patients and emergency department staff. Testimony in support emphasized that reaffirming existing ACEP policy remains meaningful given current concerns about immigration enforcement in and around emergency departments and its potential effect on patients seeking care and on immigrant physicians and trainees. Some testimony opposed the original language, but favored the Reference Committee's narrower approach, insisting that reaffirming existing policy alone does not advance the issue and that the resolution should remain focused on more specific, actionable protections.

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8. **AMENDED RESOLUTION 51(26): Physician Staffing Requirements for Pediatric Ready Designation**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 51(26) be adopted.

RESOLVED, That ACEP advocate for amendment of the current "Pediatric Readiness in the Emergency Department" policy statement, developed in collaboration with the American Academy of Pediatrics, to require that any hospital designated as "pediatric ready" maintain continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year~~; and be it further~~.

~~RESOLVED, That ACEP work collaboratively with national stakeholders to support implementation of the standard to require continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year, including consideration of resource allocation, workforce development, and rural access to care.~~

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP advocate for amendment of the current "Pediatric Readiness in the Emergency Department" policy statement, developed in collaboration with the American Academy of Pediatrics, to require that any hospital designated as "pediatric ready" maintain continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year; and be it further

RESOLVED, That ACEP work collaboratively with national stakeholders to support implementation of the standard to require continuous on-site physician presence in the emergency department 24 hours per day, 7 days per week, 365 days per year, including consideration of resource allocation, workforce development, and rural access to care.

Summary of Testimony

Asynchronous testimony was primarily in support. Testimony supported requiring onsite physician coverage for emergency departments seeking "Pediatric Ready" designations, framing it as essential to maintaining physician-led care for children. Further testimony emphasized tiered readiness levels create positive incentives toward physician staffing without shutting down small, critical access departments in rural communities and high-risk pediatric interventions, such as emergency intubation, warrant dedicated physician expertise. Additional testimony suggested strengthening the proposal further by requiring board-certified or emergency medicine–experienced physicians rather than general credentials. To streamline the text, testimony recommended deleting the second resolved clause because its call for 24/7 physician-led EDs merely reaffirms policy adopted in 2025.

Live testimony was almost exclusively in support. Proponents of the resolution strongly supported amending pediatric-ready emergency department standards to explicitly require 24/7 in-person physician coverage, contending physical availability is essential for critical pediatric care. While the resolution received broad organizational backing, including support from ABEM, a key concern was raised regarding implementation flexibility for resource-constrained facilities. Critics specifically cautioned that rigid staffing mandates might prompt struggling hospitals to abandon pediatric readiness initiatives altogether rather than pursuing incremental improvements.

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9. **AMENDED RESOLUTION 54(26): Radiology Turn-Around Time**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 54(26) be adopted.

~~RESOLVED, That ACEP promote the following standard: from the time the patient is ready for a plain film or CT to the time the test is completed and definitively interpreted should be no more than 60 minutes; and be it further~~

RESOLVED, That emergency department radiology turn-around time should be included in ACEP's Clinical Emergency Data Registry.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP promote the following standard: from the time the patient is ready for a plain film or CT to the time the test is completed and definitively interpreted should be no more than 60 minutes; and be it further

RESOLVED, That emergency department radiology turn-around time should be included in ACEP's Clinical Emergency Data Registry.

Summary of Testimony

Asynchronous testimony was largely in opposition. Testimony pointed out that "ready for study" is not a standardized health record timestamp and that integrating this metric into data registries would carry heavy financial costs. It was also emphasized that imaging delays are driven by systemic factors beyond physician control, such as transport, IV access, lab processing, and scanner capacity, making a single national threshold unrealistic. Additional testimony reflected that setting a 60-minute radiology turnaround time would impose practice mandates on another specialty and would encourage reciprocal standards on emergency medicine and the establishment of a hard cutoff would create severe medical-legal liability. It was suggested that instead of a top-down mandate, collaborating with the American College of Radiology and local hospital leadership would help address throughput bottlenecks.

Live testimony was mixed, with broad agreement that radiology turnaround times affect ED flow, patient experience, and operational efficiency. Testimony in support emphasized the value of measurable expectations and data collection to drive accountability and resource advocacy, while testimony opposed focused on the proposed 60-minute benchmark, citing concerns about limited evidence for a fixed target, variation across practice settings, administrative burden, and potential liability.

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10. **AMENDED RESOLUTION 56(26): Strengthening ACEP Policy on the Appropriate Use of ED Patient Experience Surveys**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Amended Resolution 56(26) be adopted.

~~RESOLVED, That ACEP reaffirm its existing policy opposing the inappropriate use of patient experience survey results for physician reimbursement, compensation, credentialing, or employment decisions; and be it further~~

RESOLVED, That ACEP advocate that patient experience survey results should not be used for physician performance evaluation, physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or other contractual determinations when the survey population excludes admitted, observation, transferred, or other emergency department patients and therefore does not represent the physician's overall emergency medicine practice; and be it further

RESOLVED, That ACEP oppose the use of patient experience survey results for physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or physician performance evaluation unless the survey is administered, sampled, analyzed, scored, and reported in accordance with the scientifically validated methodology established for that survey instrument; and be it further

RESOLVED, That ACEP advocate that physician performance assessment in emergency medicine prioritize evidence-based clinical quality measures, patient safety outcomes, operational performance measures, and other scientifically valid metrics that accurately reflect the delivery of emergency care.

ORIGINAL RESOLUTION LANGUAGE AS SUBMITTED

RESOLVED, That ACEP reaffirm its existing policy opposing the inappropriate use of patient experience survey results for physician reimbursement, compensation, credentialing, or employment decisions; and be it further

RESOLVED, That ACEP advocate that patient experience survey results should not be used for physician performance evaluation, physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or other contractual determinations when the survey population excludes admitted, observation, transferred, or other emergency department patients and therefore does not represent the physician's overall emergency medicine practice; and be it further

RESOLVED, That ACEP oppose the use of patient experience survey results for physician compensation, contractual subsidies, staffing agreements, professional services agreements, incentive payments, credentialing, employment decisions, or physician performance evaluation unless the survey is administered, sampled, analyzed, scored, and reported in accordance with the scientifically validated methodology established for that survey instrument; and be it further

RESOLVED, That ACEP advocate that physician performance assessment in emergency medicine prioritize evidence-based clinical quality measures, patient safety outcomes, operational performance measures, and other scientifically valid metrics that accurately reflect the delivery of emergency care.

Summary of Testimony

Asynchronous testimony largely supported the resolution. Testimony supported restricting the use of patient experience surveys in physician compensation, credentialing, and employment decisions unless the survey instrument is scientifically validated for individual attribution and emphasized that individual performance evaluations should prioritize evidence-based clinical quality and safety metrics rather than subjective satisfaction scores. Multiple members warned against clauses that merely reaffirm existing policy and recommended the fulfillment of the second and third resolveds could be achieved by being incorporated into the 2025 policy statement "Patient Experience of Care Surveys." Addressing the widespread nature of the issue, ACEP leadership highlighted ongoing collaboration with the American Medical Association to advance survey reform across the broader House of Medicine.

Live testimony was predominantly opposed to the authors' revised language, although there was continued support for addressing concerns about the validity and appropriate use of patient experience surveys. Testimony opposed raised concerns about including admitted patients in survey populations, restricting physician groups' discretion to use survey results, and revisiting issues already addressed in existing ACEP policy, while testimony supporting the Reference Committee's approach emphasized scientifically valid methodology and accounting for system factors outside an individual physician's control.

Recommended NOT for Adoption

11. **RESOLUTION 48(26): No-Cost Solutions to ED Boarding**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 48(26) not be adopted.

RESOLVED, That ACEP have a focused message on crowding and boarding solutions including:

1. Practical solutions to boarding and capacity exist at little or no cost that are not being implemented.
2. Smoothing of elective admissions have been shown to improve capacity to the benefit of patients, staff, physicians, and hospital finances.
3. Early discharge of patients to a sufficient degree has shown to decrease length of stay and increase capacity to the benefit of the patient, staff, physicians, and hospital finances.

4. Enhanced weekend discharges has been shown to decrease length of stay and increase capacity to the benefit of the patient, staff, physicians, and hospital finances.
5. Expanded hours for ancillary services on evenings and weekends improves flow, increases capacity, and shortens length of stay.

Summary of Testimony

Asynchronous testimony was mixed with many of those providing testimony requesting further clarification from the authors as to what new value the resolution adds. Testimony highlighted that ACEP already has resources titled "Emergency Department Crowding: High Impact Solutions" and "Toolkit for Enacting Meaningful Legislative and Regulatory Solutions for ED Boarding and Hospital Crowding" that already address the five points the resolution request fulfilled. Testimony also highlighted that boarding is a systemic hospital problem rather than an isolated ED issue and the primary challenge is no longer identifying interventions, but actively convincing hospitals, legislators, and regulators to implement them.

Live testimony was also mixed, with several testimonies questioning whether the resolution added new value beyond ACEP's existing boarding resources, while other testimony emphasized that a shorter, more focused message could help elevate proven interventions that have not been consistently implemented. Testimony in support highlighted the need for clearer advocacy to hospital leaders, regulators, and payers, including stronger attention to financial incentives, while testimony opposed raised concerns that some proposed "no-cost" solutions do carry operational expenses and that broader system barriers remain the primary obstacle to implementation.

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12. **RESOLUTION 52(26): Prioritizing Inpatient Medical Admission for Geriatric Psychiatric Patients When Psychiatric Beds Are Unavailable**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 52(26) not be adopted.

RESOLVED, That ACEP develop a policy statement supporting admission to an inpatient medical unit, with appropriate psychiatric consultation and geriatric-focused care, as the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients who require inpatient-level mental health care when an appropriate psychiatric bed cannot be secured within 24 hours; and be it further

RESOLVED, That ACEP advocate, through policy, education, and external partnerships, that admission to an inpatient medical unit with appropriate psychiatric consultation and geriatric-focused care should be the preferred alternative to prolonged emergency department boarding for geriatric psychiatric patients who require inpatient-level mental health care when an appropriate psychiatric bed cannot be secured within 24 hours; and be it further

RESOLVED, That ACEP work with accrediting and regulatory bodies, hospital leaders, and health systems to remove barriers and clarify that admission to inpatient medical services for such patients is an acceptable and preferred safety practice when psychiatric beds are unavailable; and be it further

RESOLVED, That ACEP advocate for national quality standards that discourage prolonged emergency department boarding of geriatric psychiatric patients and support timely admission to inpatient medical settings when psychiatric placement is unavailable; and be it further

RESOLVED, That ACEP evaluate incorporation of more explicit guidance into the Geriatric Emergency Department Accreditation (GEDA) Program encouraging accredited emergency departments to establish policies that prioritize inpatient admission for geriatric psychiatric patients when psychiatric placement is unavailable and prolonged emergency department boarding would otherwise occur.

Summary of Testimony

Asynchronous testimony was largely in opposition. Testimony argued that inpatient bed allocation should be based strictly on clinical medical necessity rather than demographic profiles or specific patient cohorts. Testimony also warned that medical units and nursing staff are frequently unequipped to safely care for unstable psychiatric patients, especially in rural and community settings and urged caution against attaching contentious admission requirements to the fledgling Geriatric Emergency Department Accreditation (GEDA) program, favoring broader solutions such as telepsychiatry and expanding overall psychiatric bed capacity. It was suggested softening phrasing in the resolution's title by replacing "prioritizing" with "recommending."

Live testimony was largely in opposition, while recognizing the vulnerability and high resource needs of geriatric psychiatric patients boarding in the ED. Testimony opposed emphasized that admission priorities should remain clinically based and raised concerns about displacing other patients and creating challenges for rural and critical access hospitals, while testimony in support focused on the harms of prolonged ED boarding for this population.

Recommended for Referral

13. **RESOLUTION 43(26): ED-Initiated Pharmacotherapy Pathways for Alcohol Use Disorder**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 43(26) be referred to the Board of Directors.

RESOLVED, That ACEP create a policy statement for emergency department-initiated treatment of moderate-severe alcohol use disorder, including the use of anti-craving medications; and be it further

RESOLVED, That ACEP promote multidisciplinary care models, analogous to emergency department medication assisted treatment (MAT) programs for opiate use disorder, that integrate medication initiation, patient education, and coordinated follow-up for individuals with alcohol use disorder.

Summary of Testimony

Asynchronous testimony was largely in support. Testimony highlighted that EDs currently do very little for patients with alcohol use disorder once discharged from the ED and research has shown success with ED-initiated medication for opioid use disorder. Testimony also reflected that the anticipated cost of fulfilling the request of the resolution appeared to be high and much of the groundwork for this resolution has been initiated with Amended Resolution 73(25) Promoting Comprehensive Treatment of Substance Use Disorders Across the Nation. Further testimony suggested the work to fulfill this resolution could be appended to the work being done to complete Amended Resolution 73(25).

Live testimony was mixed. Proponents of the resolution testified that emergency departments frequently manage alcohol use disorder and that creating practical anti-craving medication pathways yields proven clinical benefits. Opponents, although they supported the intent of the resolution, questioned the extra cost and potential redundancy, pointing out that SAEM recently issued guidance and ACEP previously approved broader work on substance use disorders. Due to the mixed testimony and its specificity to alcohol use disorder rather than substance abuse disorder, several spoke in favor of referral to the Board.

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14. **RESOLUTION 47(26): ED of the Future**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 47(26) be referred to the Board of Directors.

RESOLVED, That ACEP appoint a task force to define the ED of the present and near future, including scope of practice, structural and functional needs, anticipating future changes in medicine, such that patients are assured the best care possible.

Summary of Testimony

Asynchronous testimony was mixed. Testimony in support stressed that ACEP must shape the specialty's future standards proactively rather than letting external organizations such as the ACGME define them retroactively. Further testimony in support added that ED operational flow and physical design have stagnated for over a decade, necessitating stronger institutional drive to modernize. Testimony opposed suggested that a separate task force is redundant with existing resources, including ED architecture literature, current accreditation programs, and that ACEP lacks regulatory enforcement power over hospital systems. Clarification was requested as to what this resolution is asking, what value it would add, and how it would benefit the College, members, and patients.

Live testimony was mixed. Proponents of the resolution emphasized the need to rethink emergency department design to keep pace with technological advancements, demographic shifts, and persistent operational flaws. Opponents questioned the expense and utility of establishing a dedicated task force, warning that speculative strategic planning could consume limited resources without producing actionable deliverables. To reconcile these viewpoints, several members testifying recommend referring the proposal to the Board of Directors to clarify project goals, ensure cost-effectiveness, and align the effort with existing initiatives.

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13. **RESOLUTION 55(26): Responsible Use of AI in Emergency Medicine Documentation**

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 55(26) be referred to the Board of Directors.

RESOLVED, That ACEP support the use of responsible AI-enabled documentation tools in emergency medicine while recognizing clinical documentation as a core component of the emergency physician's practice and affirming that such tools should augment, not replace, physician work; and be it further

RESOLVED, That ACEP affirm that the treating emergency physician remains responsible for the accuracy, clinical reasoning, and narrative integrity of the medical record and must ensure that the documentation reflects their clinical judgment; and be it further

RESOLVED, That ACEP support development of educational resources and practical guidance for the safe, effective, and responsible use of AI-enabled documentation tools in emergency medicine, while recognizing variation in documentation workflows and physician practice styles.

Summary of Testimony

Asynchronous testimony supported the intent of the resolution widely agreeing that artificial intelligence in emergency medicine will ease documentation, particularly for clinical documentation, requires regulation and oversight, but pointed out that much of the work requested in this resolution will likely be accomplished through ACEP's Health Information Technology Committee/Artificial Intelligence Subcommittee. EMRA cautioned against algorithmic bias and urging balanced training so residents master core skills before using artificial intelligence. Several members providing testimony suggested withdrawing the resolution, referring it to the Board, or deleting clauses that duplicate existing 2026 consensus statements.

Live testimony consisted of testimony from one member. The single piece of testimony supported referring the resolution to the Board instead of having the Council amend the language on the floor. It was emphasized that because artificial intelligence is complex and rapidly changing, Board review is better suited to direct development of a nuanced policy.

Mr. Speaker, this concludes the final report of Reference Committee C. I would like to thank Patsy Chenpanas, MD; Frank Y. Duncan, III, MD, FACEP; Laura Janneck, MD, MPH, FACEP; Ira R. Nemeth, MD, FACEP; Monika Pitzele, MD, PhD, FACEP; Joya Coffman MS, CHES, ASQ-CQIA; and Travis Schulz, MLS, AHIP, for their excellent work in developing this preliminary report.