



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

Minutes

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

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

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

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

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

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

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

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

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

AACEM

Ian B K Martin, MD, MBA, FACEP

ALABAMA CHAPTER

Jeffrey D Anderson, MD, FACEP
William Randall Davis, MD
Stephen William Knight, MD, FACEP
Sean Vanlandingham, MD, FACEP

ALASKA CHAPTER

Camilla Sulak, MD, FACEP

ARIZONA CHAPTER

Olga Gokova, MD, FACEP
Nicole R Hodgson, MD, FACEP
Paul Andrew Kozak, MD, FACEP
Wendy Ann Lucid, MD, FACEP
Wayne A Martini, Jr, MD, FACEP
Megan L McElhinny, MD, FACEP
Rebecca B Parker, MD, FACEP
Anthony C Wong, MD, FACEP

ARKANSAS CHAPTER

J Shane Hardin, MD, PhD, FACEP
Leslie Jewett, MD
Yusuke Kishimoto, MD

CALIFORNIA CHAPTER

Amy P Anton, MD, FACEP
Jailyn Avila, MD, RDMS
Rodney W Borger, MD, FACEP
Missy Brown, MD
Karen Chung, MD
Nida F Degesys, MD, FACEP
Fred Dennis, MD, MBA, FACEP
Cassandra Morgan Dewitt, MD
Adam P Dougherty, MD, FACEP
Nicole Elizabeth Exeni McAmis, MD
Jorge A Fernandez, MD, FACEP
Marc Allan Futernick, MD, FACEP
Marc Gautreau, MD, FACEP
Douglas Everett Gibson, MD, FACEP
Alicia Mikolaycik Gonzalez, MD, FACEP
Kamara W Graham, MD, FACEP
Jason Greenspan, MD, FACEP
Vikant Gulati, MD, FACEP
Puneet Gupta, MD, FACEP
Aaron J Harries, MD
Christopher Libby, MD, MPH, FACEP
Aimee K Moulin, MD, FACEP
Leslie Mukau, MD, FACEP
Valerie C Norton, MD, FACEP
Comfort Arinola Adeola Orebayo , DO
Bing S Pao, MD, FACEP
Matthew Richard, MD, FACEP
Susanne J Spano, MD, FACEP
Thomas Jerome Sugarman, MD, FACEP
Gary William Tamkin, MD, FACEP
Ashley Tarchione, MD
Patrick Um, MD, FACEP
Lori D Winston, MD, FACEP
Anna L Yap, MD

COLORADO CHAPTER

Ramnik S Dhaliwal, MD, JD
Laura Edgerley-Gibb, MD, FACEP
Douglas M Hill, DO, FACEP
William Martin Hilty, MD
Carla Elizabeth Murphy, DO, FACEP
Kristen Nordenholz, MD, FACEP
Parth Shah, DO

CONNECTICUT CHAPTER

Daniel Freess, MD, FACEP
Carlos Patrick Holden, MD, FACEP
Elizabeth Schiller, MD, FACEP
Gregory L Shangold, MD, FACEP
Douglas Anthony Smith, DO, FACEP
Listy Anam Thomas, MD, FACEP

CORD

Laura Roff Hopson, MD

DELAWARE CHAPTER

Kathryn Groner, MD, FACEP
John T Powell, MD, MHCDS, FACEP

DISTRICT OF COLUMBIA CHAPTER

Christopher T Clifford, MD
Rita A Manfredi-Shutler, MD, FACEP
Natasha N Powell, MD MPH MEd, FACEP

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Jacob Mark Altholz, MD
Anna Siobhan Heffron, MD
Katarina Jones, MD
Kelsey Mercedes Morgan, MD
Joe-Ann Moser, MD
Morgan Danielle Sweere, MD
David Wilson, MD
Pauline Wiltz, DO

FLORIDA CHAPTER

Patrick R Anderson, DO
Andrew I Bern, MD, FACEP
Blake Buchanan, MD, FACEP
Stuart James Bumgarner, MD
Damian E Caraballo, MD, FACEP
Jordan Celeste, MD, FACEP
Taylor Norelle Craig, MD
Edward A Descallar, MD, FACEP
Anton Gomez, DO, FACEP
Gabriel Gomez, DO
Kelly Gray-Eurom, MD, MMM, FACEP
Shayne M Gue, MD, FACEP
Saundra A Jackson, MD, FACEP
Steven B Kailes, MD, FACEP
Joseph M King, MD
Mike Lozano, Jr, MD, MSHI, FACEP
Ryan T McKenna, DO, FACEP
Brandy Milstead, MD
Ashley Norse, MD, FACEP
Todd L Slesinger, MD, FACEP
Ian David Storch, MD, FACEP
Zachary C Terwilliger, MD

GEORGIA CHAPTER

Matthew R Astin, MD, FACEP
Brett H Cannon, MD JD MBA, FACEP
Shamie Das, MD, MBA, MPH, FACEP
James Joseph Dugal, MD(E), FACEP(E)
Matthew Taylor Keadey, MD, FACEP
Jeffrey F Linzer, Sr, MD, FACEP
James L Smith, Jr, MD, FACEP
Johnny L Sy, DO, FACEP
Matthew J Watson, MD, FACEP

GOVT SERVICES CHAPTER

Michael Joel Chiappone, DO
Christine A DeForest, DO, FACEP
Alan Jeffrey Hirshberg, MD, MPH, FACEP
Aicha M Hull, MD
Micaela A LaRose, MD
David S McClellan, MD, FACEP
Torree M McGowan, MD, FACEP
Evan Miller, DO
Mike Ramirez, MD
Justine K Stremick, MD, FACEP
Sean Stuart, DO, FACEP

HAWAII CHAPTER

Mark Baker, MD, FACEP
John M Gallagher, MD, FACEP

IDAHO CHAPTER

Ken John Gramyk, MD, FACEP
Darin J Lee, MD
Christian Menard, MD, PhD, FACEP

ILLINOIS CHAPTER

Halleh Akbarnia, MD, MPH, FACEP, FACEP
Amit D Arwindekar, MD, FACEP
Kristen M Donaldson, MD, MPH, FACEP
Katarzyna Maria Gore, MD, FACEP
Samantha A Hay, MD
Adnan Hussain, MD, FACEP
Jason A Kegg, MD, FACEP
Janet Lin, MD, FACEP
Monika Pitzele, MD, PhD, FACEP
Yanina Purim-Shem-Tov, MD, MS, FACEP
Willard W Sharp, MD, PhD, FACEP
Deborah E Weber, MD, FACEP
William Weber, MD, MPH, FACEP

INDIANA CHAPTER

Michael D Bishop, MD, FACEP
Timothy A Burrell, MD, MBA, FACEP
Kyle D English, MD, FACEP
Emily M Fitz, MD, FACEP
Tracy Rene Rahall, MD, FACEP
Eric B Yazel, MD, FACEP

IOWA CHAPTER

Thomas E Benzoni, DO, FACEP
Ryan M Dowden, MD, FACEP

KANSAS CHAPTER

Joshua J Davis, MD
Trevor S Mattox, MD
Matthew S Sinnwell, MD, FACEP

KENTUCKY CHAPTER

Christopher W Pergrem, MD, FACEP
Isaac Shaw, MD, FACEP
Hugh W Shoff, MD MS, FACEP
Beth Spurlin, MD, PhD, MBA, FAAP

LOUISIANA CHAPTER

Blake Denley, MD
Deborah D Fletcher, MD, FACEP
Phillip Luke LeBas, MD, FACEP
Michael D Smith, MD MBA CPE, FACEP

MAINE CHAPTER

Garreth C Debiegun, MD, FACEP
Brandon E Giberson, DO, FACEP, FACEP
James B Mullen, III, MD, FACEP

MARYLAND CHAPTER

Michael C Bond, MD, FACEP
Gregory Scott Corcoran, MD
Daniel Benjamin Gingold, MD, MPH, FACEP
Jonathan Lewis Hansen, MD, FACEP
Edana Denise Mann, MD, FACEP
Patrick McCarville, MD
Debra Michele Ravert, MD, FACEP

MASSACHUSETTS CHAPTER

Amy Costigan, MD, FACEP
Stephen K Epstein, MD, MPP, FACEP
Gayle Marie Galletta, MD, FACEP
Kathleen Kerrigan, MD, FACEP
Matthew B Mostofi, DO, FACEP
Mark D Pearlmutter, MD, FACEP
Allison Ramler, MD, FACEP
Sundeep Shukla, MD, MBA, FACEP
Natalie Strokes, DO
Joseph C Tennyson, MD, FACEP

MICHIGAN CHAPTER

Michael J Baker, MD, FACEP
Abigail Brackney, MD, FACEP
Sara S Chakel, MD, FACEP
Pamela N Coffey, MD, FACEP
Bram A Dolcourt, MD, FACEP
Michael P Doyle, DO, FACEP
Gregory Gafni-Pappas, DO, FACEP
Michael Vincent Gratson, MD, FACEP
Antony P Hsu, MD, FACEP
Robert T Malinowski, MD, FACEP
Therese G Mead, DO, FACEP
Emily M. Mills, MD, FACEP
James C Mitchiner, MD, MPH, FACEP
David T Overton, MD, FACEP
Luke Christopher Saski, MD, FACEP
Jennifer B Stevenson, DO, FACEP
Andrew Taylor, DO, FACEP
Larisa May Traill, MD, FACEP
Bradley J Uren, MD, FACEP
Bradford L Walters, MD, FACEP

MINNESOTA CHAPTER

Paul C Allegra, MD, FACEP
Matthew E Herold, MD, FACEP
Kurt M Isenberger, MD, FACEP
Erin R Karl, MD
Benjamin Knutson, MD, FACEP
Donald L Lum, MD, FACEP
David Nestler, MD, MS, FACEP
Lisa M Roazen, MD, FACEP

MISSISSIPPI CHAPTER

Lisa M Bundy, MD, FACEP
Frederick B Carlton, Jr, MD, FACEP
Chester Duane Shermer, MD, FACEP

MISSOURI CHAPTER

Jeanise Marie Butterfield, MD, FACEP
Douglas Mark Char, MD, FACEP
Kene A Chukwuanu, MD, FACEP
Leslie A Hueschen, MD, FACEP
Timothy J Koboldt, MD, FACEP
Marc Mendelsohn, MD, MPH, FACEP
Robert Francis Poirier, Jr, MD, MBA, FACEP

MONTANA CHAPTER

Harry Eugene Sibold, MD, FACEP

NEBRASKA CHAPTER

Andrew R Barnett, MD
John Ukadike, DO MPH

NEVADA CHAPTER

Sabina A Braithwaite, MD, FACEP
Gregory Alan Juhl, MD, FACEP
Nehal S Naik, MD, FACEP
Erin Simmers Pearson, MD, FACEP

NEW HAMPSHIRE CHAPTER

Kathleen J Clem, MD, FACEP
Scott Weston Rodi, MD, MPH, FACEP

NEW JERSEY CHAPTER

Navin Ariyaprakai, MD, NRP, FAEMS, FACEP
Tanisha Arora, MD, FACEP
Kimberly T Baldino, MD, FACEP
Chris Bryczkowski, MD, FACEP
Rachelle Ann Greenman, MD, FACEP
Patrick Blaine Hinfey, MD, FACEP
Steven M Hochman, MD, FACEP
Marjory E Langer, MD, FACEP
J Mark Meredith, MD, FACEP
Scott H Pasichow, MD, MPH, FACEP, FAEMS
Chirag N Shah, MD, FACEP

NEW MEXICO CHAPTER

Lionel Michael Candelaria, Jr, MD
Lucas Maestas, MD
Aaron Snyder, MD

NEW YORK CHAPTER

David O Andonian, MD, FACEP
Brahim Ardolic, MD, FACEP
Joseph Basile, MD, FACEP
Kirby Black, MD, FACEP
Erik Blutinger, MD, MSc, FACEP
Robert M Bramante, MD, FACEP
Jay Miller Brenner, MD, FACEP
Lauren J Curato, DO, FACEP
Mark Curato, DO, FACEP, FACEP
Sydney E DeAngelis, MD, FACEP
Ugo A Ezenkwele, MD, FACEP
Sanjey Gupta, MD, FACEP
Abbas Husain, MD, FACEP
Adam Huynh, MD
Laura Iavicoli, MD, FACEP
Marc P Kanter, MD, FACEP
Stuart Gary Kessler, MD, FACEP
Penelope Lema, MD, FACEP, FPD-AEMUS
Sophia D Lin, MD, FACEP
Kurien Mathews, DO MBA, FACEP
Laura D Melville, MD
Nestor B Nestor, MD, FACEP
Norman Liang Ng, DO MBA, FACEP
Daniel A Novak, DO
Casey Lynn Palmer, MD
Eli Rogers, MD
Carly M Rosen, MD
Livia M Santiago-Rosado, MD, FACEP
Virgil W Smaltz, MD, FACEP
Jeffrey J Thompson, MD, FACEP
Asa Viccellio, MD, FACEP

NORTH CAROLINA CHAPTER

Melanie R Artho, MD, FACEP
Jill Lynn Benson, MD, FACEP
Thomas N Bernard, III, MD, FACEP
Scott W Brown, MD, FACEP
Gregory J Cannon, MD, FACEP
Christopher Allen Griggs, MD, MPH, FACEP
Eric Evan Maur, MD, FACEP
Swarup Misra, DO, FACEP
Madjimbaye Charles Namde, MD, MBA, FACEP
Bret A Nicks, MD, MHA, FACEP
Stephen A Small, MD, FACEP

NORTH DAKOTA CHAPTER

James R Humble, MD, FACEP

OHIO CHAPTER

Andrew Aten, MD, FACEP
Eileen F Baker, MD, PhD, FACEP
Marina N Boushra Freiberg, MD
Christina Campana, DO, FACEP
Joshua S da Silva, DO, FACEP
Joanna Elizabeth Henry, DO
Thomas W Lukens, MD, MS, PhD, FACEP
Anthony T Martella, MD
Daniel R Martin, MD, MBA, FACEP
Jesse A Park, DO
John R Queen, MD, FACEP
RJ Sontag, MD, FACEP
Ryan Squier, MD, FACEP
K Robert Thompson, III, MD, MBA, FACEP
Somy Monica Thottathil, MD, FACEP
Nicole Ann Veitinger, DO, FACEP

OKLAHOMA CHAPTER

Aimee Renee Blagovich, DO, FACEP
Laura Janneck, MD, FACEP
Derek Martinez, DO
Kurtis A Mayz, JD, MD, MBA, FACEP

OREGON CHAPTER

Brittany N Arnold, MD, FACEP
Patsy Chenpanas, MD
John C Moorhead, MD, FACEP
C Craig Rudy, MD, FACEP
Christian Smith, MD, FACEP

PENNSYLVANIA CHAPTER

Lauren Altomare, DO
Blake C Bailey, DO, FACEP
Christopher L Berry, MD, FACEP
Monisha Bindra, DO, MPH, FACEP
Jason R Burkett, DO, FACEP
Ankur A Doshi, MD, FACEP
Eric Eustice, DO
Adriana Facchiano, MD
Todd Fijewski, MD, FACEP
Avram Flamm, DO, FACEP
Richard Hamilton, MD, MBA, FACEP
Brian Kelly, DO
Zeenah Mansour, MD
Scott Mueller, DO, FACEP
Jennifer L Savino, DO, FACEP
Holly A Stankewicz, DO, FACEP

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

VIRGINIA CHAPTER

Benjamin Blackwood, MD
Caroline Hollis Cox, MD
Joshua Easter, MD
Joshua Lesko, MD, FACEP
Brooke Harris Lindborg, MD, FACEP
Katherine Dickerson Mayes, MD, PhD
Todd Parker, MD, FACEP
Jesse D Spangler, MD, FACEP
Theodore J Tzavaras, MD
Lauren Webb, MD, FACEP

WASHINGTON CHAPTER

Herbert C Duber, MD, MPH, FACEP
Joshua R Frank, MD, FACEP
Sarah M Hansen, MD
Erika Schroeder, MD
Vasisht Srinivasan, MD, FACEP
Jessica J Wall, MD, MPH, MSCE, FACEP
Aine Yore, MD, FACEP

WEST VIRGINIA CHAPTER

Christopher S Goode, MD, FACEP
Mark Gustafson, DO, FACEP
Carol Lea Wright Becker, MD, MBA, FACEP

WISCONSIN CHAPTER

Bradley Burmeister, MD, FACEP
William D Falco, MD, MS, MBA, FACEP
Susan E Good, MD, MBA, FACEP
Lisa J Maurer, MD, FACEP
Christopher Torkilsen, DO, FACEP
Stephanie J Wagner, MD, FACEP

WYOMING CHAPTER

Russell Lauver, DO

AAWEP SECTION

Jayne M Kendall, MD, FACEP

ACCESS, BELONGING, AND COMMUNITY SECTION

Christopher L Smith, MD, FACEP

AIR MEDICAL TRANSPORT SECTION

Woodrow James Sams, MD

CAREERS IN EMERGENCY MEDICINE SECTION

Skyler E Smith, DO

CRITICAL CARE MEDICINE SECTION

Katherine Allison Pollard, MD, FACEP

CRUISE SHIP MEDICINE SECTION

Cai Glushak, MD, FACEP

DEMOCRATIC GROUP PRACTICE SECTION

David G Hall, MD, FACEP

DISASTER MEDICINE SECTION

Kylie Hayes Klemann, MD

DUAL TRAINING SECTION

Allyssa M Abel, MD, MPH

EM PRACTICE MGMT & HEALTH POLICY SECTION

Robert M McNamara, MD

EMERGENCY MEDICAL INFORMATICS SECTION

Tricia Smith, MD, FACEP

EMERGENCY MEDICINE LOCUM TENENS SECTION

Jamila Goldsmith, MD, FACEP

EMERGENCY MEDICINE WORKFORCE SECTION

Ricki A Brown, MD

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

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

Past Presidents

Nancy J. Auer, MD, FACEP
Brooks F. Bock, MD, FACEP (CO)
Vidor E. Friedman, MD, FACEP (CO)
Angela F. Gardner, MD, FACEP (TX)
Michael J. Gerardi, MD, FACEP (NJ)
Nicholas J. Jouriles, MD, FACEP (OH)
Christopher S. Kang, MD, FACEP (WA)
Paul D. Kivela, MD, FACEP (AL)

George R. Molzen, MD, FACEP (NM)
Mark S. Rosenberg, DO, MBA, FACEP (NJ)
Andrew E. Sama, MD, FACEP (NY)
Robert W. Schafermeyer, MD, FACEP (NC)
Gillian R. Schmitz, MD, FACEP (GS)
Sandra M. Schneider, MD, FACEP (TX)
Richard L. Stennes, MD, FACEP (CA)

Past Speakers

Michael J. Bresler, MD, FACEP (CA)
Peter M. Fahrney, MD, FACEP (VA)
Peter J. Jacoby, MD, FACEP (CT)

Gary R. Katz, MD, MBA, FACEP (OH)
Todd B. Taylor, MD, FACEP (AZ)
Dennis C. Whitehead, MD, FACEP (MI)

Past Chairs of the Board

Stephen H. Anderson, MD, FACEP (WA)
John D. Bibb, MD, FACEP (CA)
Jon Mark Hirshon, MD, PhD, FACEP (MD)

Ramon W. Johnson, MD, FACEP (CA)
David P. Sklar, MD, FACEP (NM)

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

Council Standing Rules

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

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

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

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

between votes and notify the speaker.

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

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

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

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

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

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

Electronic Devices

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

Leadership Development Advisory Committee

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

Limiting Debate

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

Nominating Committee

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

Nominations

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

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

Parliamentary Procedure

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

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

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

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

Policy Review

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

Reference Committees

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

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

A Reference Committee may recommend that a resolution:

- A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.
- B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.
- C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee’s motion to refer may go fully into the merits of the resolution. If the motion to refer is not adopted, the speaker shall state the original resolution.

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

Reports

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

Resolutions

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

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

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

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

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

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

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

- ***Bylaws Resolutions***

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

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

- ***Late Resolutions***

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

- ***Emergency Resolutions***

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

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

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

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

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

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

Voting Immediately

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

Voting on Resolutions and Motions

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

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

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

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

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

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

Dr. Costello presented the Nominating Committee report.

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

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

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

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

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

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

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

2025 Council Resolutions

RESOLUTION 1

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

RESOLUTION 2

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

RESOLUTION 3

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

RESOLUTION 4

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

RESOLUTION 5

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

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

RESOLUTION 6

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

RESOLUTION 7

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

RESOLUTION 8

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

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

RESOLUTION 9

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

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

RESOLUTION 10

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

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

RESOLUTION 11

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

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

RESOLUTION 12

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

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

RESOLUTION 13

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

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

RESOLUTION 14

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

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

RESOLUTION 15

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

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

RESOLUTION 16

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

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

RESOLUTION 17

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

RESOLUTION 18

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

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

RESOLUTION 19

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

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

RESOLUTION 20

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

RESOLUTION 21

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

ARTICLE V — ACEP FELLOWS

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

1. Be candidate physician, regular, or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
 - A. At least three years of active involvement in emergency medicine as the physician’s chief professional activity, exclusive of residency training, and;
 - B. Satisfaction of at least three of the following individual criteria during their professional career:
 1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
 2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
 3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
 4. active involvement in emergency medicine administration or departmental affairs;
 5. active involvement in an emergency medical services system;
 6. research in emergency medicine;
 7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
 8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
 9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
 10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

Distinguished Fellows of the College shall meet the following criteria:

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

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

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

Section 2 – Fellow Status

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

RESOLUTION 22

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

Section 1 – Eligibility

Fellows of the College shall meet the following criteria:

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

International Fellows of the College shall meet the following criteria:

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

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

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

Section 2 – Fellow Status

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

RESOLUTION 23

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

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

RESOLUTION 24

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

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

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

A. Definitions

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

- matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee.
5. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee.
 6. Board Hearing Panel conducts all hearings and consists of ~~the~~ an ACEP Vice President, Chair of the Board, and Board Liaison to the Ethics Committee.
 7. ACEP review bodies are the Ethics Complaint Review Panel, the Bylaws Committee, the Board Hearing Panel and the ACEP Board of Directors.

B. Complaint Received

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

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

C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.
- b. If all elements of the complaint have been met, sends a written acknowledgement to the complainant confirming complainant's intent to file a complaint. Includes a copy of ACEP's *Procedures* providing guidelines and timetables that will be followed in this matter. Requests complainant sign acknowledgement specifying intent to file an ethics complaint and to be bound by the *Procedures*.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the *Procedures*.
3. Notifies the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. Determines, in consultation with the ACEP President and the Chair of the Ethics Committee or the Bylaws Committee, along with other committee designee(s) as appropriate given the subject matter of the complaint, that:
 - a. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, the Bylaws Committee, or other committee designee, that t~~The charges and conduct set forth in the complaint, as alleged by the complainant, is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the Code of Ethics or ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination; or
 - b. ~~Determines, in consultation with the ACEP President and the Chair of the Ethics Committee, or other committee designee, that t~~The complaint alleges conduct that may constitute a violation of a policy or principle included in the Code of Ethics, and if so, forwards the complaint and the response together, after both are received, to each member of the Ethics Complaint Review Panel after membership on the Ethics Complaint Review Panel has been confirmed; or
 - c. ~~Determines, in consultation with the ACEP President and the Chair of the Bylaws Committee, or other committee designee, that t~~The complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, after both are received, to each member of the Bylaws

Committee, or at the discretion of the Chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose and that has been screened for conflicts of interest; or

- d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, ~~the complaint will not be considered. The~~ the Ethics Complaint Review Panel or the Bylaws Committee, as appropriate, will review the President's ~~action~~ recommendation to reject the complaint. The President's action can be overturned by a majority vote of the applicable ACEP review body or adopted by the body.
5. Within ten (10) business days after the determination specified in Section-C.4.b. or Section C.4.c. of these *Procedures*, forwards the complaint to the respondent by USPS Certified Mail with a copy of these *Procedures* and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the applicable ACEP review body decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication. Such notice must also include a summary of the respondent's rights in the hearing, and a list of the names of the members of the applicable ACEP review body, including the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.
6. When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics-Complaint Review Panel or the Bylaws Committee appointed to review the complaint, as appropriate.

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

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

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

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

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

F. Right of Respondent to Request a Hearing

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

G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by USPS Certified Mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board Hearing Panel intends to call in the hearing.
2. The Executive Director will send a notification by USPS Certified Mail of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing.
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel ~~or any other person of their choice~~. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audiotape, **recording**, or videotape **recording** at the expense of the requesting party. **A copy of any such record must be provided to the Executive Director.**
6. The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person, except in circumstances in which it is ~~impossible or commercially impracticable~~ **impractical** for the parties and the Board Hearing Panel to hold an in-person hearing, at which time the Board Hearing Panel may choose to hold a virtual hearing.
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. **Any documents or materials to be provided or presented during the hearing not already in the record, including written documents, handouts, or slide presentations, must be provided to the presiding officer 14 days prior to the hearing to assess if the material and information contained therein are relevant to the proceedings.** Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board Hearing Panel will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.
9. The decision of the Board Hearing Panel will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board Hearing Panel's decision will be sent by USPS Certified Mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board Hearing Panel's decision and a

statement of the basis for that decision.

H. Notice to the Board of Directors

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

I. Possible Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Action

a. Censure

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

Private censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards but appears to be a minor isolated incident. The member's actions are not egregious in nature but fall outside of acceptable conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for single ethical violations in the course of a single legal case.

- ii. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section B.2. above. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action, disclosure of which shall be subject to the discretion of the Executive Director.

Public censure is appropriate in cases in which the member's conduct is not in conformity with the College's ethical standards and demonstrates a pattern of unethical behavior or a single example of egregious conduct. If the violation involves the College's Expert Witness Guidelines or the ethical principles regarding expert witness testimony in the Code of Ethics, this disciplinary action may be considered for multiple ethical violations in the course of a single legal case.

- b. Suspension from ACEP membership shall be for a period of twelve (12) months; the dates of commencement and completion of the suspension shall be determined by the-ACEP President. At the end of the twelve (12) month period of suspension, the suspended member may request reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action, disclosure of which shall be subject to the discretion of the Executive Director. ACEP is also required to report the suspension from membership and a description of the conduct that led to the suspension to the Board of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

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

- c. Expulsion from ACEP membership shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. The

expulsion announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or Bylaws provision was violated by and shall inform ACEP members that they may request further information about the disciplinary action, disclosure of which shall be subject to the discretion of the Executive Director. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

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

2. Scope and Manner of Disclosure

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

J. Ground Rules

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

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

RESOLUTION 25

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

RESOLUTION 26

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

RESOLUTION 27

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

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

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

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

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

RESOLUTION 28

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

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

RESOLUTION 29

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

RESOLUTION 30

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

RESOLUTION 31

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

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

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

RESOLUTION 32

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

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

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

RESOLUTION 33

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

RESOLUTION 34

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

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

RESOLUTION 35

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

RESOLUTION 36

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

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

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

RESOLUTION 37

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

RESOLUTION 38

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

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

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

RESOLUTION 39

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

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

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

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

RESOLUTION 40

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

RESOLUTION 41

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

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

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

RESOLUTION 42 *(This resolution was withdrawn.)*

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

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

RESOLUTION 43

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

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

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

RESOLUTION 44

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

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

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

RESOLUTION 45

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

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

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

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

RESOLUTION 46

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

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

RESOLUTION 47

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

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

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

RESOLUTION 48

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

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

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

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

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

RESOLUTION 49

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

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

RESOLUTION 50

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

RESOLUTION 51

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

RESOLUTION 52

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

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

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

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

RESOLUTION 53

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

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

RESOLUTION 54

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

RESOLUTION 55

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

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

RESOLUTION 56

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

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

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

RESOLUTION 57

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

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

RESOLUTION 58

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

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

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

RESOLUTION 59

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

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

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

RESOLUTION 60

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

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

RESOLUTION 61

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

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

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

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

RESOLUTION 62

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

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

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

RESOLUTION 63

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

and referrals; and be it further

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

RESOLUTION 64

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

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

RESOLUTION 65

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

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

RESOLUTION 66

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

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

RESOLUTION 67

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

RESOLUTION 68

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

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

RESOLUTION 69

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

RESOLUTION 70

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

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

RESOLUTION 71

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

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

RESOLUTION 72

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

RESOLUTION 73

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

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

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

RESOLUTION 74

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

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

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

RESOLUTION 75

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

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

RESOLUTION 76

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

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

RESOLUTION 77

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

RESOLUTION 78

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

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

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

RESOLUTION 79

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

RESOLUTION 80

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERENCE COMMITTEE A

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

The committee recommended the following resolutions by unanimous consent:

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

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

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

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

For referral to the Council Steering Committee: Resolution 23.

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

AMENDED RESOLUTION 21

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

ARTICLE V — ACEP FELLOWS SECTION 1 – ELIGIBILITY

FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING CRITERIA:

1. BE CANDIDATE PHYSICIAN, REGULAR, OR INTERNATIONAL MEMBERS FOR THREE CONTINUOUS YEARS IMMEDIATELY PRIOR TO ELECTION.
2. BE CERTIFIED IN EMERGENCY MEDICINE AT THE TIME OF ELECTION BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR IN PEDIATRIC EMERGENCY MEDICINE BY THE AMERICAN BOARD OF PEDIATRICS.
3. MEET THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF HIGH PROFESSIONAL STANDING AT SOME TIME DURING THEIR PROFESSIONAL CAREER PRIOR TO APPLICATION.
 - A. AT LEAST THREE YEARS OF ACTIVE INVOLVEMENT IN EMERGENCY MEDICINE AS THE PHYSICIAN’S CHIEF PROFESSIONAL ACTIVITY, EXCLUSIVE OF RESIDENCY TRAINING, AND;
 - B. SATISFACTION OF AT LEAST THREE OF THE FOLLOWING INDIVIDUAL CRITERIA DURING THEIR PROFESSIONAL CAREER:
 1. ACTIVE INVOLVEMENT, BEYOND HOLDING MEMBERSHIP, IN VOLUNTARY HEALTH ORGANIZATIONS, ORGANIZED MEDICAL SOCIETIES, OR VOLUNTARY COMMUNITY HEALTH PLANNING ACTIVITIES OR SERVICE AS AN ELECTED OR APPOINTED PUBLIC OFFICIAL;
 2. ACTIVE INVOLVEMENT IN HOSPITAL AFFAIRS, SUCH AS MEDICAL STAFF COMMITTEES, AS ATTESTED BY THE EMERGENCY DEPARTMENT DIRECTOR OR CHIEF OF STAFF;
 3. ACTIVE INVOLVEMENT IN THE FORMAL TEACHING OF EMERGENCY MEDICINE TO PHYSICIANS, NURSES, MEDICAL STUDENTS, OUT-OF-HOSPITAL CARE PERSONNEL,

- OR THE PUBLIC;
4. ACTIVE INVOLVEMENT IN EMERGENCY MEDICINE ADMINISTRATION OR DEPARTMENTAL AFFAIRS;
 5. ACTIVE INVOLVEMENT IN AN EMERGENCY MEDICAL SERVICES SYSTEM;
 6. RESEARCH IN EMERGENCY MEDICINE;
 7. ACTIVE INVOLVEMENT IN ACEP CHAPTER ACTIVITIES AS ATTESTED BY THE CHAPTER PRESIDENT OR CHAPTER EXECUTIVE DIRECTOR;
 8. MEMBER OF A NATIONAL ACEP COMMITTEE, THE ACEP COUNCIL, OR NATIONAL BOARD OF DIRECTORS;
 9. EXAMINER FOR, DIRECTOR OF, OR INVOLVEMENT IN TEST DEVELOPMENT AND/OR ADMINISTRATION FOR THE AMERICAN BOARD OF EMERGENCY MEDICINE OR THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE;
 10. REVIEWER FOR OR EDITOR OR LISTED AUTHOR OF A PUBLISHED SCIENTIFIC ARTICLE OR REFERENCE MATERIAL IN THE FIELD OF EMERGENCY MEDICINE IN A RECOGNIZED JOURNAL OR BOOK.

DISTINGUISHED FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING CRITERIA:

1. HAVE HELD FACEP STATUS FOR AT LEAST 12 YEARS.

2. MAINTAINED CERTIFICATION:

A. IN EMERGENCY MEDICINE BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, OR THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR

B. IN PEDIATRIC EMERGENCY MEDICINE BY THE AMERICAN BOARD OF PEDIATRICS, OR

C. HAVE ACHIEVED FACEP THROUGH THE ACEP LEGACY TRACK.

3. MEET A MINIMUM NUMBER OF POINTS WITHIN THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF COMMITMENT TO EMERGENCY MEDICINE:

A. RESEARCH AND SCHOLARSHIP, AS EVIDENCED BY GRANT AWARDS, PEER-REVIEWED PUBLICATION, OR REVIEW OR AUTHORSHIP OF BOOKS OR OTHER PROFESSIONAL RESOURCES.

B. TEACHING AND MENTORSHIP, AS EVIDENCED BY TEACHING HISTORY, FACULTY STATUS, STUDENT OR RESIDENT ADVISEMENT, OR RESIDENCY/FELLOWSHIP/CLERKSHIP LEADERSHIP.

C. SERVICE AND LEADERSHIP, AS EVIDENCED BY LEADERSHIP WITHIN THEIR EMERGENCY DEPARTMENT, HOSPITAL, STAFFING GROUP, STATE OR LOCAL MEDICAL SOCIETIES, COMMUNITY HEALTH PLANNING, OR OTHER ROLES WHICH HAVE ADVANCED THE FIELD.

D. CLINICAL EXCELLENCE, AS EVIDENCED BY CLINICAL OR INDUSTRY AWARDS, LETTERS OF SUPPORT FROM THEIR CHAIR OR MEDICAL DIRECTOR, OR PARTICIPATION IN QUALITY, SAFETY, OR WELLNESS ACTIVITIES.

4. MEET A MINIMUM NUMBER OF POINTS WITHIN THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF COMMITMENT TO ACEP.

A. LEADERSHIP ACTIVITIES, INCLUDING PARTICIPATION OR LEADERSHIP WITHIN ACEP SECTIONS, COMMITTEES, CHAPTERS, DELEGATIONS, ADVOCACY GROUPS, TASK FORCES, MEMBER INTEREST GROUPS, BOARD OF DIRECTORS, OR COUNCIL.

B. EDUCATION ACTIVITIES, INCLUDING PARTICIPATION AS FACULTY OR COURSE DIRECTORS IN ACEP IN-PERSON OR VIRTUAL EDUCATIONAL OFFERINGS.

C. PUBLIC AWARENESS ACTIVITIES, INCLUDING ACTIVE INVOLVEMENT IN ACEP'S ONLINE COMMUNITIES, MEDIA RELATIONS OR SPOKESPERSON NETWORK, OR PROMOTION OF COLLEGE WINS AND ACTIVITIES ON SOCIAL MEDIA.

D. RECOGNITIONS, INCLUDING INDIVIDUAL RECEIPT OF ACEP AWARDS OR HOSPITAL/EMPLOYER RECEIPT OF ACEP ACCREDITATION STATUS.

PROVISION OF DOCUMENTATION OF THE SATISFACTION OF THE ABOVE CRITERIA IS THE RESPONSIBILITY OF THE CANDIDATE, AND DETERMINATION OF THE SATISFACTION OF THESE CRITERIA SHALL BE BY THE BOARD OF DIRECTORS OF ACEP OR ITS DESIGNEE.

SECTION 2 – FELLOW STATUS

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

AMENDED RESOLUTION 22

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

SECTION 1 – ELIGIBILITY

FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING CRITERIA:

1. BE CANDIDATE PHYSICIAN, **OR** REGULAR, ~~OR INTERNATIONAL~~ MEMBER **S** FOR THREE CONTINUOUS YEARS IMMEDIATELY PRIOR TO ELECTION.
2. BE CERTIFIED IN EMERGENCY MEDICINE AT THE TIME OF ELECTION BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR IN PEDIATRIC EMERGENCY MEDICINE BY THE AMERICAN BOARD OF PEDIATRICS.
3. MEET THE FOLLOWING REQUIREMENTS DEMONSTRATING EVIDENCE OF HIGH PROFESSIONAL STANDING AT SOME TIME DURING THEIR PROFESSIONAL CAREER PRIOR TO APPLICATION.
 - A. AT LEAST THREE YEARS OF ACTIVE INVOLVEMENT IN EMERGENCY MEDICINE AS THE PHYSICIAN’S CHIEF PROFESSIONAL ACTIVITY, EXCLUSIVE OF RESIDENCY TRAINING, AND;
 - B. SATISFACTION OF AT LEAST THREE OF THE FOLLOWING INDIVIDUAL CRITERIA DURING THEIR PROFESSIONAL CAREER:
 1. ACTIVE INVOLVEMENT, BEYOND HOLDING MEMBERSHIP, IN VOLUNTARY HEALTH ORGANIZATIONS, ORGANIZED MEDICAL SOCIETIES, OR VOLUNTARY COMMUNITY HEALTH PLANNING ACTIVITIES OR SERVICE AS AN ELECTED OR APPOINTED PUBLIC OFFICIAL;
 2. ACTIVE INVOLVEMENT IN HOSPITAL AFFAIRS, SUCH AS MEDICAL STAFF COMMITTEES, AS ATTESTED BY THE EMERGENCY DEPARTMENT DIRECTOR OR CHIEF OF STAFF;
 3. ACTIVE INVOLVEMENT IN THE FORMAL TEACHING OF EMERGENCY MEDICINE TO PHYSICIANS, NURSES, MEDICAL STUDENTS, OUT-OF-HOSPITAL CARE PERSONNEL, OR THE PUBLIC;
 4. ACTIVE INVOLVEMENT IN EMERGENCY MEDICINE ADMINISTRATION OR DEPARTMENTAL AFFAIRS;
 5. ACTIVE INVOLVEMENT IN AN EMERGENCY MEDICAL SERVICES SYSTEM;
 6. RESEARCH IN EMERGENCY MEDICINE;
 7. ACTIVE INVOLVEMENT IN ACEP CHAPTER ACTIVITIES AS ATTESTED BY THE CHAPTER PRESIDENT OR CHAPTER EXECUTIVE DIRECTOR;
 8. MEMBER OF A NATIONAL ACEP COMMITTEE, THE ACEP COUNCIL, OR NATIONAL BOARD OF DIRECTORS;
 9. EXAMINER FOR, DIRECTOR OF, OR INVOLVEMENT IN TEST DEVELOPMENT AND/OR ADMINISTRATION FOR THE AMERICAN BOARD OF EMERGENCY MEDICINE OR THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE;
 10. REVIEWER FOR OR EDITOR OR LISTED AUTHOR OF A PUBLISHED SCIENTIFIC ARTICLE OR REFERENCE MATERIAL IN THE FIELD OF EMERGENCY MEDICINE IN A RECOGNIZED JOURNAL OR BOOK.

INTERNATIONAL FELLOWS OF THE COLLEGE SHALL MEET THE FOLLOWING

CRITERIA:

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

PROVISION OF DOCUMENTATION OF THE SATISFACTION OF THE ABOVE CRITERIA IS THE RESPONSIBILITY OF THE CANDIDATE, AND DETERMINATION OF THE SATISFACTION OF THESE CRITERIA SHALL BE BY THE BOARD OF DIRECTORS OF ACEP OR ITS DESIGNEE.

AMENDED RESOLUTION 36

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

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

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

The committee recommended that Amended Resolution 32 be adopted.

It was moved THAT AMENDED RESOLUTION 32 BE ADOPTED:

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

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

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

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

The committee recommended that Substitute Resolution 33 be adopted.

It was moved THAT SUBSTITUTE RESOLUTION 33 BE ADOPTED:

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

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

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

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

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

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

The committee recommended that Resolution 30 not be adopted.

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

The committee recommended that Resolution 35 not be adopted.

It was moved THAT RESOLUTION 35 BE ADOPTED.

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

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

The motion was then voted on and was not adopted.

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

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

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

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

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

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

REFERENCE COMMITTEE B

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 43, and Resolution 58.

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

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

Amended Resolution 41, Amended Resolution 45, Amended Resolution 49, Amended Resolution 56, Amended Resolution 59, and Amended Resolution 89 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 44

RESOLVED, THAT ACEP ~~DIRECT~~ **ENCOURAGE** ITS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION TO INTRODUCE AND SUPPORT AMA POLICY THAT PRIORITIZES ADDRESSING WORKPLACE VIOLENCE IN HEALTH CARE AS A TOP NATIONAL ADVOCACY ISSUE; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~DIRECT~~ **ENCOURAGE** ITS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION TO ADVOCATE FOR MANDATORY, STANDARDIZED REPORTING OF WORKPLACE VIOLENCE INCIDENTS ACROSS ALL HEALTH CARE SETTINGS AND SUPPORT THE AGGREGATION AND PUBLIC DISSEMINATION OF THIS DATA TO INFORM RESEARCH, BENCHMARKING, AND NATIONAL POLICY DEVELOPMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~DIRECT~~ **ENCOURAGE** ITS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION TO ADVOCATE FOR THE DEVELOPMENT, FUNDING, AND IMPLEMENTATION OF EVIDENCE-BASED, TRAUMA-INFORMED STRATEGIES TO PREVENT WORKPLACE VIOLENCE AND PROTECT THE HEALTH CARE WORKFORCE.

AMENDED RESOLUTION 47

RESOLVED, THAT ACEP RECOGNIZE THE DISPROPORTIONATE SHARE HOSPITAL CUTS ARE OF SPECIFIC CONCERN TO EMERGENCY PHYSICIANS AS THEY HAVE BEEN SHOWN TO INCREASE THE AMOUNT OF RURAL HOSPITAL CLOSURES; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH RELEVANT ORGANIZATIONS SUCH AS AMERICA'S ESSENTIAL HOSPITALS TO FURTHER THE CAUSE OF PROTECTING DISPROPORTIONATE SHARE HOSPITAL PAYMENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR ~~H.R. 2665, THE SUPPORTING SAFETY NET HOSPITALS ACT,~~ **EXISTING AND FUTURE LEGISLATION** TO REPEAL OR DELAY THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL CUTS SCHEDULED FOR FISCAL YEARS 2026 THROUGH 2028.

AMENDED RESOLUTION 48

RESOLVED, THAT ACEP AFFIRM THAT FEDERAL EMTALA OBLIGATIONS **SHOULD** SUPERSEDE CONFLICTING STATE LAWS OR MANDATES THAT WOULD PREVENT EMERGENCY PHYSICIANS **AND ALL MEMBERS OF THE MEDICAL STAFF** FROM PROVIDING MEDICALLY NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE FOR CLEAR FEDERAL PROTECTIONS FOR EMERGENCY PHYSICIANS **AND ALL MEMBERS OF THE MEDICAL STAFF** PROVIDING CARE IN ACCORDANCE WITH EMTALA REQUIREMENTS, PARTICULARLY WHEN SUCH CARE CONFLICTS WITH STATE LAWS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH RELEVANT FEDERAL AGENCIES, MEDICAL SOCIETIES, AND STAKEHOLDERS TO ENSURE CONSISTENT INTERPRETATION AND ENFORCEMENT OF EMTALA REQUIREMENTS THAT PROTECT BOTH PATIENTS AND PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE EDUCATIONAL RESOURCES AND SUPPORT TO EMERGENCY PHYSICIANS NAVIGATING COMPLEX LEGAL LANDSCAPES WHILE MAINTAINING THEIR PROFESSIONAL AND ETHICAL OBLIGATIONS TO PROVIDE EMERGENCY MEDICAL CARE.

AMENDED RESOLUTION 50

RESOLVED, THAT ACEP ADVOCATE FOR STRICTER ENFORCEMENT OF THE FEDERAL REGULATION REQUIRING HOSPITALS WITHOUT 24/7 ON-SITE PHYSICIAN COVERAGE TO CLEARLY POST SUCH NOTICES, INCLUDING AN EXPLANATION OF HOW EMERGENCY MEDICAL NEEDS WILL BE ADDRESSED WHEN A PHYSICIAN IS NOT PRESENT, **AND THAT ACEP WORK WITH JOINT COMMISSION AND OTHER REGULATORY BODIES TO ADVANCE EDUCATIONAL AND REGULATORY INITIATIVES THAT IMPROVE TRANSPARENCY FOR PATIENTS IN THE EMERGENCY SETTING.**

AMENDED RESOLUTION 51

RESOLVED, THAT ACEP **REAFFIRM CURRENT POLICY THAT THE GOLD STANDARD FOR EMERGENCY DEPARTMENT CARE IS PROVIDED BY AN EMERGENCY PHYSICIAN,** **AND** SUPPORT STATE AND FEDERAL LEGISLATIVE AND REGULATORY EFFORTS TO REQUIRE THAT A PHYSICIAN, ~~IDEALLY A BOARD-CERTIFIED OR ELIGIBLE EMERGENCY PHYSICIAN, BE PHYSICALLY PRESENT AND AVAILABLE IN EVERY EMERGENCY DEPARTMENT AT ALL TIMES, WHICH INCLUDES BUT IS NOT LIMITED TO DEVELOPING DRAFT LEGISLATION ON THIS TOPIC~~ **BE PRESENT AND AVAILABLE IN EVERY EMERGENCY DEPARTMENT.**

AMENDED RESOLUTION 53

RESOLVED, THAT ACEP SUPPORT FEDERAL AND STATE LEGISLATIVE AND REGULATORY EFFORTS TO REFORM PRIOR AUTHORIZATION PROCESSES, WITH THE GOAL OF REDUCING CARE DELAYS THAT RESULT IN **AVOIDABLE** EMERGENCY DEPARTMENT VISITS OR HOSPITALIZATIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP **COLLABORATE WITH RELEVANT STAKEHOLDERS TO** ADVOCATE FOR REAL-TIME TRANSPARENCY, STANDARDIZATION, AND ACCOUNTABILITY IN PRIOR AUTHORIZATION PRACTICES TO PROMOTE TIMELY, EQUITABLE, AND EFFICIENT PATIENT CARE ACROSS ALL HEALTH CARE SETTINGS.

AMENDED RESOLUTION 55

~~RESOLVED, THAT ACEP CONDUCT A COMPREHENSIVE REVIEW OF THE JOINT COMMISSION AND OTHER HEALTH CARE REGULATORY BODIES' REGULATORY REQUIREMENTS TO IDENTIFY MANDATES AND INTERPRETATIONS OF STANDARDS THAT DO NOT DEMONSTRABLY IMPROVE PATIENT CARE IN THE EMERGENCY DEPARTMENT SETTING; AND BE IT FURTHER —~~

RESOLVED, THAT ACEP COLLABORATE WITH ~~THE~~ JOINT COMMISSION AND OTHER HEALTH CARE REGULATORY BODIES TO **REVIEW AND** ADVOCATE FOR THE ELIMINATION OR MODIFICATION ~~OF SUCH NON-BENEFICIAL REQUIREMENTS, AIMING TO STREAMLINE PROCESSES, REDUCE ADMINISTRATIVE BURDENS ON EMERGENCY PHYSICIANS, AND ALLOW MORE TIME FOR DIRECT PATIENT CARE~~ **OF REQUIREMENTS THAT DO NOT**

DEMONSTRABLY IMPROVE THE CARE OF EMERGENCY DEPARTMENT PATIENTS.

AMENDED RESOLUTION 57

~~RESOLVED, THAT ACEP ADVOCATE FOR THE REPEAL OF CERTIFICATE OF NEED (CON) LAWS IN STATES WHERE SUCH LAWS EXIST AND DEVELOP A TOOLKIT TO SUPPORT LEGISLATIVE ACTION AIMED AT ELIMINATING THESE LAWS, INCLUDING EVIDENCE-BASED ARGUMENTS AND STRATEGIES FOR ENGAGING POLICYMAKERS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP COLLABORATE WITH OTHER HEALTH CARE ORGANIZATIONS TO RAISE PUBLIC AWARENESS AND EDUCATE STATE POLICYMAKERS ON THE ~~NEGATIVE~~ IMPACTS OF CERTIFICATE OF NEED (CON) LAWS ON PATIENT ACCESS TO EMERGENCY CARE, INCLUDING OVERCROWDING, BOARDING, AND LIMITED CAPACITY, AND ADVOCATE FOR THE REMOVAL OF THESE REGULATORY BARRIERS TO IMPROVE PATIENT FLOW AND HEALTH CARE ACCESS.

The committee recommended that Amended Resolution 41 be adopted.

It was moved THAT AMENDED RESOLUTION 41 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT THE DEVELOPMENT AND IMPLEMENTATION OF A NO-FAULT MEDICAL LIABILITY SYSTEM THAT PRIORITIZES PATIENT COMPENSATION AND SYSTEMIC HEALTH CARE IMPROVEMENTS OVER PHYSICIAN PUNISHMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT STAKEHOLDERS AND LEGAL EXPERTS TO **IDENTIFY MODELS THAT** ~~ADVOCATE FOR LEGISLATIVE AND REGULATORY CHANGES THAT~~ SHIFT MEDICAL LIABILITY FROM A FAULT-BASED SYSTEM TO A NO-FAULT COMPENSATION MODEL; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~PROMOTE A REEVALUATION OF THE LEGAL DEFINITION OF NEGLIGENCE IN HEALTH CARE, ADVOCATING~~ **ADVOCATE** FOR A **LEGAL** STANDARD THAT RECOGNIZES SYSTEMIC CONTRIBUTIONS TO MEDICAL ERRORS, ENCOURAGES ROOT CAUSE ANALYSIS OVER INDIVIDUAL BLAME, AND ~~ALIGNS WITH THE AMERICAN LAW INSTITUTE'S UPDATED GUIDELINES TO~~ BETTER REFLECTS MODERN HEALTH CARE PRACTICE AND PATIENT SAFETY GOALS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROMOTE AND ADVOCATE FOR AN ELEVATION OF THE CIVIL TORT BURDEN OF PROOF FOR EMTALA-RELATED CARE FROM A PREPONDERANCE OF EVIDENCE TO CLEAR AND CONVINCING EVIDENCE.

The motion was adopted.

The committee recommended that Amended Resolution 45 be adopted.

It was moved THAT AMENDED RESOLUTION 45 BE ADOPTED:

RESOLVED, THAT ACEP CONTINUE TO ADVOCATE FOR THE FULL PRESERVATION AND EXPANSION OF THE MEDICAID PROGRAM AS AN ESSENTIAL COMPONENT OF EQUITABLE ACCESS TO EMERGENCY CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP CREATE A UNIFIED POLICY STATEMENT **THAT RECOGNIZES** ~~AFFIRMING STRONG SUPPORT FOR~~ MEDICAID'S AND ITS IMPORTANCE AS A SAFETY NET INSURANCE TO EMERGENCY MEDICINE, AND INCLUDE WITHIN IT THE **CONCEPTS OF THE** CURRENT POLICY STATEMENTS "WORK REQUIREMENTS FOR MEDICAID BENEFICIARIES," "MEDICAID EXPANSION," AND "OPPOSITION TO COPAYS FOR MEDICAID BENEFICIARIES" TO CREATE A SINGLE, ROBUST POLICY STATEMENT ON MEDICAID; AND BE IT FURTHER

RESOLVED, THAT ACEP POLICY AFFIRM ACEP'S OPPOSITION TO ADMINISTRATIVE OR FINANCIAL BARRIERS, **INCLUDING THIRD-PARTY ADMINISTRATOR INTERFERENCE,** THAT REDUCE TIMELY ACCESS TO EMERGENCY CARE FOR MEDICAID BENEFICIARIES AND PROMOTES EMERGENCY PHYSICIANS' ROLES AS KEY STAKEHOLDERS IN MEDICAID POLICY DEVELOPMENT AND REFORM.

RESOLVED, THAT ACEP ADVOCATE FOR FEDERAL AND STATE MEDICAID FUNDING LEVELS THAT ALLOW FOR COMPREHENSIVE BENEFIT COVERAGE FOR

PATIENTS.

It was moved THAT THE FOURTH RESOLVED BE AMENDED BY ADDING “ADEQUATE” BEFORE THE WORD “FEDERAL” AND DELETING THE WORDS “THAT ALLOW FOR COMPREHENSIVE BENEFIT COVERAGE.” The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 49 be adopted.

It was moved THAT AMENDED RESOLUTION 49 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT LEGISLATIVE, REGULATORY, AND POLICY REFORMS TO STRENGTHEN THE EMTALA MANDATE AND ENSURE THAT PATIENTS REQUIRING TRANSFER TO A HIGHER LEVEL OF CARE ARE NOT INAPPROPRIATELY DENIED OR DELAYED;~~;-AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP INVESTIGATE LEGISLATION TO REPLACE OR UPDATE EMTALA WITH A MORE CONTEMPORARY ALTERNATIVE THAT REFLECTS THE CURRENT PRACTICE OF EMERGENCY MEDICINE AND BETTER ENSURES THAT PATIENTS RECEIVE THE MEDICAL CARE THEY NEED IN A SAFE AND TIMELY MANNER.~~

It was moved THAT THE FIRST RESOLVED BE AMENDED BY ADDING “REGARDING TRANSFERS AND ADVOCATE TO REDUCE BARRIERS THAT CREATE DELAYS IN TRANSFERRING PATIENTS TO A LEVEL OF CARE” AFTER THE WORD “MANDATE” AND DELETING THE WORDS “REQUIRING TRANSFER TO A HIGHER LEVEL OF CARE ARE NOT INAPPROPRIATELY DENIED OR DELAYED.” The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 56 be adopted.

It was moved THAT AMENDED RESOLUTION 56 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE FOR LEGISLATION AT THE STATE AND FEDERAL LEVELS REQUIRING THAT ~~ARTIFICIAL INTELLIGENCE-ASSISTED~~ REIMBURSEMENT DENIALS OR NEGATIVE COVERAGE DECISIONS BY INSURERS BE REVIEWED AND APPROVED BY QUALIFIED HUMAN PERSONNEL WHO ARE BOARD-CERTIFIED PHYSICIANS IN THE RELEVANT SPECIALTY OR SUB-SPECIALTY WITH AN UNRESTRICTED AND ACTIVE LICENSE, AND ARE PROVIDED NO ADDITIONAL FINANCIALS FOR DENIALS OF CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT PROHIBITING HEALTH INSURERS FROM RELYING SOLELY ON ARTIFICIAL INTELLIGENCE-BASED ALGORITHMS TO DENY, DELAY, OR ~~MODIFY~~ DOWNCODE HEALTH CARE CLAIMS OR SERVICES AND URGE BOTH CMS AND STATE REGULATORY AGENCIES TO ESTABLISH POLICIES REQUIRING HUMAN OVERSIGHT IN THESE DECISIONS; AND BE IT FURTHER

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT STAKEHOLDERS, INCLUDING INSURERS, TECHNOLOGY PROVIDERS, AND REGULATORS, TO ENSURE THAT ARTIFICIAL INTELLIGENCE ALGORITHMS USED IN HEALTH CARE DECISION-MAKING AND THE DATASETS THEY ARE TRAINED ON ARE TRANSPARENT, ACCOUNTABLE, BASED ON ACCURATE AND UP-TO-DATE CLINICAL CRITERIA DERIVED FROM NATIONAL MEDICAL SPECIALTY SOCIETY GUIDELINES AND PEER REVIEWED CLINICAL LITERATURE, AND SUBJECT TO OVERSIGHT BY QUALIFIED HEALTH CARE PROFESSIONALS.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY REPLACING THE WORDS “PROVIDED NO ADDITIONAL FINANCIALS FOR DENIALS OF” WITH THE WORDS “NOT INCENTIVIZED TO DENY PAYMENT FOR.” The motion was adopted.

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

It was moved THAT AMENDED RESOLUTION 56 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The amended main motion was then voted on and adopted.

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:47 pm on Saturday, September 6, 2025.

The Council then resumed discussion of the report of Reference Committee B.

The committee recommended that Amended Resolution 59 be adopted.

It was moved THAT AMENDED RESOLUTION 59 BE ADOPTED:

~~RESOLVED, THAT ACEP SUPPORT AND ADVOCATE FOR FEDERAL AND STATE LEGISLATIVE EFFORTS TO ALLOW PHYSICIANS WITH A PERMANENT AND UNRESTRICTED MEDICAL LICENSE IN ONE U.S. STATE TO PROVIDE TELEMEDICINE SERVICES TO PATIENTS IN ANY STATE WITHOUT REQUIRING ADDITIONAL STATE-SPECIFIC LICENSURE; AND BE IT FURTHER~~

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS TO ADVOCATE FOR STATES TO ESTABLISH A SPECIAL PURPOSE TELEHEALTH REGISTRY OR LICENSE ~~ESTABLISH A NATIONAL TELEMEDICINE LICENSURE FRAMEWORK MODELED AFTER FLORIDA'S SUCCESSFUL TELEHEALTH REGISTRATION SYSTEM;~~ AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATE ~~FOR PERMANENT REGULATORY CHANGES AT BOTH FEDERAL AND STATE LEVELS~~ TO EXPAND ACCESS TO EMERGENCY TELEMEDICINE SERVICES WITH LICENSURE RECOGNITION ACROSS STATE LINES WHILE ENSURING PATIENT SAFETY AND PHYSICIAN ACCOUNTABILITY.

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

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 89 be adopted.

It was moved THAT AMENDED RESOLUTION 89 BE ADOPTED:

RESOLVED, THAT ACEP RECOGNIZE AND COMMEND DEBRA HOURY, MD, FACEP; DEMETRE DASKALAKIS, MD; JENNIFER LAYDEN, MD, PHD; AND DANIEL JERNIGAN, MD, MPH, FOR THEIR PRINCIPLED STAND IN DEFENSE OF SCIENCE-BASED MEDICAL PRACTICE AND PATIENT SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~URGENTLY AND STRONGLY PUBLICLY~~ OPPOSE ~~ANY PARTISAN POLITICAL~~ INTERFERENCE IN THE LEADERSHIP, OPERATIONS, AND RECOMMENDATIONS OF CRITICAL PUBLIC HEALTH AGENCIES SUCH AS THE CDC, THUS AFFIRMING THE DEFINITIONAL ROLES OF SCIENTIFIC INDEPENDENCE AND ADHERENCE TO KNOWN FACTS AND EVIDENCE-BASED MEDICINE GUIDANCE IN SAFEGUARDING THE PRACTICE OF MEDICINE AND PUBLIC HEALTH.

It was moved THAT THE WORD “STRONGLY” BE ADDED BEFORE THE WORD “OPPOSE” IN THE SECOND RESOLVED. The motion was adopted.

It was moved THAT THE WORDS “THUS AFFIRMING” BE DELETED FROM THE SECOND RESOLVED. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 60 not be adopted.

It was moved THAT RESOLUTION 60 BE ADOPTED.

It was moved THAT THE SECOND RESOLVED BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP CLARIFY ITS CURRENT POLICY THAT THE GOLD STANDARD FOR EMERGENCY DEPARTMENT CARE IS PROVIDED BY AN EMERGENCY PHYSICIAN TO INCLUDE FURTHER GUIDANCE THAT, FOR SITES DESIGNATED AS SMALL RURAL, FRONTIER, OR EXTREME FRONTIER IN THE ACEP RURAL EMERGENCY CARE TASK FORCE 2020 REPORT ONLY, IF A TRAINED EMERGENCY PHYSICIAN IS NOT ON-SITE, A QUALIFIED EMERGENCY PHYSICIAN SHOULD BE AVAILABLE FOR REAL-TIME CONSULTATION VIA TELEHEALTH. The motion was not adopted.

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

It was moved THAT DEBATE ON ALL REMAINING RESOLUTIONS BE LIMITED TO 90 SECONDS. The motion was adopted.

It was clarified that debate on all remaining resolutions is limited to 90 seconds per speaker.

REFERENCE COMMITTEE C

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

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 72 and Resolution 76.

For adoption as Amended or Substituted: Amended Resolution 61, Amended Resolution 62, Amended Resolution 64, Substitute Resolution 65, Amended Resolution 66, Amended Resolution 67, Amended Resolution 68, Amended Resolution 71, Amended Resolution 73, Substitute Resolution 74, Amended Resolution 79, Amended Resolution 80, and Amended Resolution 90.

Not for adoption: Resolution 63, Resolution 69, Resolution 70, Resolution 75, and Resolution 78.

For referral to the Board of Directors: Resolution 77.

Resolution 70 and Resolution 75 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 61

~~RESOLVED, THAT ACEP ACKNOWLEDGE THE ENVIRONMENTAL IMPACT OF METERED DOSE INHALERS AND SUPPORTS EFFORTS TO REDUCE THEIR CARBON FOOTPRINT THROUGH SUSTAINABLE PRACTICES; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ENCOURAGE THE EDUCATION OF EMERGENCY PHYSICIANS, OTHER MEDICAL PERSONNEL, PHARMACISTS, AND PATIENTS REGARDING: THE ENVIRONMENTAL IMPACT OF METERED DOSE INHALERS, INCLUDING THE DIFFERENCES AMONG CANISTER WEIGHTS AND ASSOCIATED PROPELLANT VOLUMES; THE AVAILABILITY AND APPROPRIATENESS OF DRY POWDER INHALERS AS AN ALTERNATIVE, WHEN CLINICALLY INDICATED; AND PROPER DISPOSAL AND RECYCLING PROTOCOLS FOR METERED DOSE INHALERS, INCLUDING THE IMPORTANCE OF INCINERATION TO DEACTIVATE REMAINING HYDROFLUOROALKANE PROPELLANTS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ACKNOWLEDGE THE ENVIRONMENTAL IMPACT OF METERED-DOSE INHALERS AND SUPPORTS EFFORTS TO REDUCE THEIR CARBON FOOTPRINT THROUGH SUSTAINABLE PRACTICES.

AMENDED RESOLUTION 62

~~RESOLVED, THAT ACEP SUPPORT EFFORTS TO REDUCE UNNECESSARY WASTE AND CARBON EMISSIONS IN EMERGENCY DEPARTMENTS (EDS) THROUGH EDUCATION, POLICY DEVELOPMENT, AND SUPPORT FOR SUSTAINABLE CLINICAL PRACTICES; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE HOSPITALS ~~AND EMERGENCY DEPARTMENTS~~ TO IMPLEMENT ENVIRONMENTALLY RESPONSIBLE PRACTICES, INCLUDING BUT NOT LIMITED TO PROPER WASTE SEGREGATION, DEVELOPMENT OF RECYCLING PROGRAMS, REDUCTION OF LOW-VALUE MEDICAL INTERVENTIONS, AND THE USE OF SUSTAINABLE ALTERNATIVES WHEN CLINICALLY APPROPRIATE; ~~AND BE IT FURTHER.~~

~~RESOLVED, THAT ACEP DEVELOP RESOURCES TO HELP EMERGENCY PHYSICIANS AND EMERGENCY DEPARTMENTS ACHIEVE THE AIM OF REDUCING WASTE AND CARBON EMISSIONS FORM THE EMERGENCY DEPARTMENT.~~

AMENDED RESOLUTION 64

RESOLVED, THAT ACEP ENDORSE THE USE OF ELECTRONIC DISCHARGE INSTRUCTIONS FOR PATIENTS WITH ACCESS TO ELECTRONIC MEDICAL RECORDS AND ELECTRONIC COMMUNICATION CAPABILITIES; AND BE IT FURTHER

RESOLVED, THAT ACEP ENCOURAGE EMERGENCY DEPARTMENTS TO ADOPT POLICIES AND TECHNOLOGIES THAT SUPPORT ~~THE~~ PATIENT-CENTERED, SECURE, TIMELY, AND ENVIRONMENTALLY RESPONSIBLE ELECTRONIC DELIVERY OF DISCHARGE INSTRUCTIONS IN COMPLIANCE WITH HIPAA REGULATIONS ~~AND BEST PRACTICES.~~

SUBSTITUTE RESOLUTION 65

RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT OPPOSING THE ESTABLISHMENT OF COLLABORATIVE PRACTICE AGREEMENTS WITHOUT THE SPECIFIC AND INFORMED AUTHORIZATION OF THE SUPERVISING PHYSICIAN; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE THE EXECUTION OF COLLABORATIVE PRACTICE AGREEMENTS BY EMPLOYERS, HOSPITALS, OR CONTRACT GROUPS ON BEHALF OF EMERGENCY PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT THE PRIOR DISCLOSURE OF COLLABORATIVE PRACTICE AGREEMENTS WHEN REQUIRED FOR EMPLOYMENT OF EMERGENCY PHYSICIANS.

~~RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT OPPOSING THE FOLLOWING PRACTICES:~~

- ~~• THE ESTABLISHMENT OF COLLABORATIVE PRACTICE AGREEMENTS WITHOUT THE SPECIFIC AND INFORMED AUTHORIZATION OF THE SUPERVISING PHYSICIAN;~~
- ~~• THE EXECUTION OF COLLABORATIVE PRACTICE AGREEMENTS BY EMPLOYERS, HOSPITALS, OR CONTRACT GROUPS ON BEHALF OF EMERGENCY PHYSICIANS;~~
- ~~• THE IMPOSITION OF COLLABORATIVE PRACTICE AGREEMENTS AS A MANDATORY CONDITION OF EMPLOYMENT FOR EMERGENCY PHYSICIANS.~~

AMENDED RESOLUTION 66

~~RESOLVED, THAT ACEP ENDORSE A NATIONAL DOOR-TO-DOCTOR BENCHMARK OF NO LESS THAN 30 MINUTES TO PREVENT INCREASINGLY UNREALISTIC TARGETS THAT UNDERMINE CLINICAL JUDGMENT AND OPERATIONAL SUSTAINABILITY; AND BE IT FURTHER~~

RESOLVED, THAT ACEP OPPOSE PRACTICES THAT ENCOURAGE UNSAFE OR UNSUSTAINABLE DOOR-TO-DOCTOR EXPECTATIONS ~~WITHOUT ADEQUATE STAFFING OR CLEAR EVIDENCE OF IMPROVED PATIENT CARE.~~

AMENDED RESOLUTION 67

RESOLVED, THAT ACEP WORK WITH RELEVANT STAKEHOLDERS ~~INCLUDING THE FORENSIC MEDICINE SECTION, AMERICAN COLLEGE OF SURGEONS—COMMITTEE ON TRAUMA (ACS-COT), INTERNATIONAL ASSOCIATION OF FORENSIC NURSING (IAFN), ACADEMY OF FORENSIC NURSING (AFN), AND EMERGENCY NURSES ASSOCIATION (ENA)~~ TO IMPLEMENT A COLLABORATIVE STANDARD OF FORENSIC PROGRAMS AT ALL LEVEL 1

AND LEVEL 2 TRAUMA CENTERS.

AMENDED RESOLUTION 68

RESOLVED, THAT ACEP AMEND ITS POLICY STATEMENT “FIREARM SAFETY AND INJURY PREVENTION” TO INCLUDE ~~SUPPORT FOR THE~~ INTEGRATION OF FIREARM INJURY PREVENTION, SAFE STORAGE, AND COUNSELING EDUCATION INTO EMERGENCY MEDICINE RESIDENCY TRAINING AND CONTINUING MEDICAL EDUCATION ~~PROGRAMS~~; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP OR IDENTIFY ~~AND DISSEMINATE A~~ EASILY ACCESSIBLE PHYSICIAN-MEMBER-FACING CLINICAL GUIDE INFORMATION TO SUPPORT EMERGENCY PHYSICIANS IN CONDUCTING BRIEF, TRAUMA-INFORMED FIREARM SAFETY COUNSELING, PARTICULARLY FOR HIGH-RISK PATIENTS, ~~ALONGSIDE BOTH PRINTABLE AND DIGITAL FORMAT, EVIDENCE-BASED PATIENT HANDOUTS SUITABLE FOR EMERGENCY DEPARTMENT USE, POTENTIALLY LEVERAGING EXISTING MATERIALS AND PARTNERSHIPS WHERE APPROPRIATE AND~~ CONSISTENT WITH ACEP’S FIREARM SAFETY POLICIES.

AMENDED RESOLUTION 71

RESOLVED, THAT ACEP CURATE EXISTING AND FUTURE EDUCATIONAL MATERIALS AND WEBINARS FOCUSED ON BEST PRACTICES IN EMPLOYMENT NEGOTIATION, ~~GUIDANCE ON ASSESSING CONTRACT PROVISIONS, MALPRACTICE INSURANCE FUNDAMENTALS WITH PARTICULAR EMPHASIS ON SECURING TAIL COVERAGE PROVISIONS, AND RESPONDING TO EMPLOYER INSOLVENCY AND HAVE THESE RESOURCES AVAILABLE IN AN ORGANIZED, USER-FRIENDLY, INTO A~~ CENTRALIZED ~~AND~~ MEMBER-ACCESSIBLE HUB RESOURCE THAT IS EASILY IDENTIFIABLE ON THE ACEP WEBSITE.

AMENDED RESOLUTION 73

RESOLVED, THAT ACEP DEVELOP A PLAN TO PROMOTE AND FACILITATE THE INITIATION OF NATION-~~WIDE~~ EMERGENCY DEPARTMENT PROGRAMS TO IMPROVE SUBSTANCE USE DISORDER TREATMENT INCLUDING, BUT NOT LIMITED TO, STAFF TRAINING, DISPENSING HARM REDUCTION MATERIALS, INITIATING EVIDENCE-BASED MEDICATION ~~FOR OPIOID USE DISORDER WHERE APPLICABLE~~, AND RAPID CLINICAL REFERRALS TO OUTPATIENT TREATMENT WHERE AVAILABLE; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~POTENTIALLY~~ WORK WITH ~~OTHER RELEVANT~~ STAKEHOLDER ORGANIZATIONS ~~SUCH AS THE AMERICAN MEDICAL ASSOCIATION, STATE MEDICAL ASSOCIATIONS, BRIDGE TO TREATMENT, MATTERS, AMERICAN SOCIETY OF ADDICTION MEDICINE, AMERICAN COLLEGE OF ACADEMIC ADDICTION MEDICINE AND POTENTIALLY OTHERS~~, TO OBTAIN FUNDING FOR SUBSTANCE USE DISORDER PROGRAMS ~~FROM FEDERAL, STATE, AND/OR PRIVATE SOURCES~~; AND BE IT FURTHER

RESOLVED, THAT ACEP REPORT BACK TO THE COUNCIL IN ~~2026~~ A TIMELY MANNER ON THE DEVELOPMENT OF A PLAN TO PROMOTE AND FACILITATE THE INITIATION OF NATION-~~WIDE~~ EMERGENCY DEPARTMENT PROGRAMS TO IMPROVE SUBSTANCE USE DISORDER TREATMENT AND ANY PROGRESS MADE ON THE GOALS OF THE PLAN.

SUBSTITUTE RESOLUTION 74

RESOLVED, THAT ACEP DEVELOP STRATEGIES TO ADDRESS BARRIERS PREVENTING THE DISPENSATION OF ESSENTIAL MEDICATIONS IN SUFFICIENT QUANTITY UPON DISCHARGE FROM THE EMERGENCY DEPARTMENT DURING OFF HOURS AND WHEN PHARMACIES ARE NOT AVAILABLE.

AMENDED RESOLUTION 79

RESOLVED, THAT ACEP WORK COLLABORATIVELY WITH ~~THE AMERICAN PSYCHIATRIC ASSOCIATION~~ RELEVANT STAKEHOLDERS TO DEVELOP CONSENSUS RECOMMENDATIONS AND BEST PRACTICES REGARDING TRANSPORT REQUIREMENTS FOR PATIENTS BEING TRANSFERRED TO PSYCHIATRIC FACILITIES, WITH SPECIFIC ATTENTION TO THE TRANSFERRING FACILITY DETERMINING CLINICAL STABILITY, RESTRAINT USE, AND ACCEPTABLE MEANS OF TRANSPORTATION.

AMENDED RESOLUTION 80

RESOLVED, THAT ACEP COLLABORATE WITH RELEVANT STAKEHOLDERS, INCLUDING THE AMERICAN COLLEGE OF SURGEONS AND THE AMERICAN HOSPITAL ASSOCIATION, TO DEVELOP AND DISSEMINATE A COMPREHENSIVE ELECTIVE SURGERY SCHEDULING TOOLKIT AIMED AT GUIDING HOSPITALS IN IMPLEMENTING EFFECTIVE SCHEDULING PRACTICES TO MITIGATE ED CROWDING; ~~AND BE IT FURTHER,~~

~~RESOLVED, THAT A COMPREHENSIVE ELECTIVE SURGERY SCHEDULING TOOLKIT DEVELOPED BY ACEP INCLUDE EVIDENCE-BASED GUIDELINES, BEST PRACTICES, CASE STUDIES, AND DATA-DRIVEN MODELS DEMONSTRATING SUCCESSFUL IMPLEMENTATION OF ELECTIVE SURGERY SMOOTHING, WITH SPECIFIC RECOMMENDATIONS TAILORED TO DIFFERENT HOSPITAL SETTINGS AND RESOURCE LEVELS; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ADVOCATE FOR THE ADOPTION OF ELECTIVE SURGERY SMOOTHING PRINCIPLES AS PART OF BROADER HOSPITAL-WIDE PATIENT FLOW IMPROVEMENT INITIATIVES, RECOGNIZING ITS ROLE IN REDUCING ED CROWDING, IMPROVING PATIENT OUTCOMES, AND ENHANCING HEALTH CARE EFFICIENCY.~~

AMENDED RESOLUTION 90

RESOLVED, THAT ACEP PROMPTLY CREATE A POLICY STATEMENT ENDORSING THE USE OF ~~TYPICAL~~ **HIGH-QUALITY EVIDENCE-BASED** VACCINE SCHEDULES AS OUTLINED IN AND BASED UPON THE **MOST CURRENT** RECOMMENDATIONS AND VACCINE SCHEDULES **AS** PUBLISHED BY THE AMERICAN ACADEMY OF PEDIATRICS ~~ON AUGUST 19, 2025~~, THE AMERICAN COLLEGE OF CARDIOLOGY ~~ON AUGUST 26, 2025~~, AND THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY ~~ON AUGUST 27, 2025~~.

The committee recommended that Resolution 70 not be adopted:

It was moved THAT RESOLUTION 70 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 75 not be adopted:

It was moved THAT RESOLUTION 75 BE ADOPTED.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY REPLACING THE WORDS “IS USED EXCLUSIVELY TO DESCRIBE FACILITIES WHERE A PHYSICIAN IS PHYSICALLY PRESENT ON-SITE AT ALL TIMES DURING OPERATIONAL HOURS” WITH THE WORDS “ENSURING IT ACCURATELY REFLECTS THAT THE LEVEL OF CARE PROVIDED ALIGNS WITH BOTH FEDERAL EXPECTATIONS AND PUBLIC UNDERSTANDING, AND TO EXCLUSIVELY DESCRIBE FACILITIES WHERE A PHYSICIAN IS PHYSICALLY PRESENT AT ALL TIMES” AND ADDING A NEW SECOND RESOLVED TO READ:

RESOLVED, THAT ACEP REQUEST THAT REGULATORY AND ACCREDITING BODIES, SUCH AS CMS AND JOINT COMMISSION ENFORCE APPROPRIATE USE OF FACILITY TITLES SUCH AS “EMERGENCY DEPARTMENT” OR “URGENT CARE”, ENSURING THAT SUCH DESIGNATIONS ARE CONSISTENT WITH THE SERVICES AND STAFFING REQUIREMENTS AS DESCRIBED IN THE CODE OF FEDERAL REGULATIONS, IN ACCORDANCE WITH SERVICES PROVIDED, PARTICULARLY WITH REGARD TO THE AVAILABILITY OF PHYSICIAN-ON-SITE EMERGENCY CARE; AND BE IT FURTHER

It was moved THAT RESOLUTION 75 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

ACEP President-Elect L. Anthony Cirillo, MD, FACEP, addressed the Council.

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

The Tellers, Credentials, & Elections Committee conducted the Vice Speaker election. Dr. Traill was elected.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Freess, Dr. Kailes, and Dr. Pao were elected to a three-year term. Dr. McCabe-Kline was re-elected to a three-year term.

The Tellers, Credentials, & Elections Committee conducted the president-elect election. Dr. Stanton was elected.

There being no further business, Dr. Costello adjourned the 2025 Council meeting at 5:08 pm on Saturday, September 6, 2025.

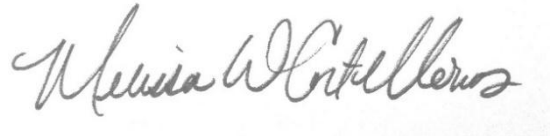
The next meeting of the ACEP Council is scheduled for October 3-4, 2026, at the Marriott Marquis Hotel, in Chicago, IL.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Sandra M. Schneider".

Sandra M. Schneider, MD, FACEP
Interim Council Secretary and Interim Executive Director

Approved by,

A handwritten signature in black ink, appearing to read "Melissa W. Costello".

Melissa W. Costello, MD, FACEP
Council Speaker