American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Meeting
September 29-30, 2022
Hilton San Francisco Union Square Hotel
San Francisco, CA

Minutes

The 51st annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:02 am Central time on Thursday, September 29, 2022, by Speaker Kelly Gray-Eurom, MD, MMM, FACEP.

Seated at the table were: Kelly Gray-Eurom, MD, FACEP, speaker; Melissa W. Costello, MD, FACEP, vice speaker; Susan E. Sedory, MA, CAE, Council secretary and executive director; and Jim Slaughter, JD, CPP, parliamentarian.

Dr. Gray-Eurom provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance and singing the National Anthem. She then welcomed new councillors, new alternate councillors, first time attendees, and guests.

Lori D. Winston, MD, FACEP, president of the California Chapter, welcomed councillors and other meeting attendees.

Chadd K. Kraus, DO, DrPH, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 346 councillors of the 433 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Eric Joy 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.

Peter J. Jacoby, 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 2022 Council meeting:

AACEM	Theodore A Christopher, MD, FACEP
ALABAMA CHAPTER	Matt Heimann, MD, FACEP Stephen William Knight, MD, FACEP Annalise Sorrentino, MD, FACEP
ALASKA CHAPTER	Anne Zink, MD, FACEP
ARIZONA CHAPTER	Lawrence A DeLuca, MD Bradley A Dreifuss, MD, FACEP Olga Gokova, MD, FACEP Nicole R Hodgson, MD, FACEP Paul Andrew Kozak, MD, FACEP Megan L McElhinny, MD Rebecca B Parker, MD, FACEP Todd Brian Taylor, MD, FACEP Dale P Woolridge, MD, PhD, FACEP

ARKANSAS CHAPTER	J Shane Hardin, MD, PhD, FACEP Joshua N Keithley, MD Robert Thomas VanHook, MD, FACEP
CALIFORNIA CHAPTER	Zahir I Basrai, MD Rodney W Borger, MD, FACEP Reb J H Close, MD, FACEP Adam P Dougherty, MD, FACEP Carrieann E Drenten, MD, FACEP Andrew N Fenton, MD, FACEP Jorge A Fernandez, MD, FACEP Marc Allan Futernick, MD, FACEP Michael Gertz, MD, FACEP Alicia Mikolaycik Gonzalez, MD, FACEP Kamara W Graham, MD, FACEP Vikant Gulati, MD, FACEP Puneet Gupta, MD, FACEP Roneet Lev, MD, FACEP Christopher Libby, MD, MPH Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Valerie C Norton, MD, FACEP Bing S Pao, MD, FACEP Hunter M Pattison, MD Joshua Perese, MD Vivian Reyes, MD, FACEP Carolyn Joy Sachs, MD, MPH, FACEP Susanne J Spano, MD, FACEP Katherine Laurinda Staats, MD, FACEP Lawrence M Stock, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP David Terca, MD, FACEP Patrick Um, MD, FACEP Lori D Winston, MD, FACEP Anna L Yap, MD Randall J Young, MD, FACEP
COLORADO CHAPTER	Jasmeet Singh Dhaliwal, MD, MPH, MBA Ramnik S Dhaliwal, MD, JD Laura Edgerley-Gibb, MD, FACEP Anna Engeln, MD, FACEP Douglas M Hill, DO, FACEP Rebecca L Kornas, MD, FACEP Carla Elizabeth Murphy, DO, FACEP
CORD	Jason Cass Wagner, MD, FACEP
CONNECTICUT CHAPTER	Thomas A Brunell, MD, FACEP Daniel Freess, MD, FACEP Thuy Nguyen, MD Elizabeth Schiller, MD, FACEP David E Wilcox, MD, FACEP
DELAWARE CHAPTER	Emily M Granitto, MD, FACEP Kathryn Groner, MD, FACEP

DISTRICT OF COLUMBIA CHAPTER	Christopher T Clifford, MD James D Maloy, MD, MPH Rita A Manfredi-Shutler, MD, FACEP
EMERGENCY MEDICINE RESIDENTS' ASSOCIATION	Angela Cai, MD, MBA Nicholas Paul Cozzi, MD Blake Denley, MD Amanda Kay Irish, MD, MPH Maggie Moran, MD Abbey M Smiley, MD Sophia Spadafore, MD Ashley Tarchione, MD
FLORIDA CHAPTER	Jordan G R Celeste, MD, FACEP Edward A Descallar, MD, FACEP Elizabeth L DeVos, MD, FACEP Andrzej T Dmowski, MD, FACEP Vidor E Friedman, MD, FACEP Gabriel Gomez, DO Shayne M Gue, MD, FACEP Carolyn K Holland, MD, FACEP Saundra A Jackson, MD, FACEP William Paul Jaquis, MD, MS, FACEP Steven B Kailes, MD, FACEP Amy S Kelley, MD, FACEP Dakota R Lane, MD Kristin McCabe-Kline, MD, FACEP Patrick McKeny, DO Tracy G Sanson, MD, FACEP David Charles Seaberg, MD, CPE, FACEP Todd L Slesinger, MD, FACEP Zachary C Terwilliger, MD Martin P Wegman, MD, PhD
GEORGIA CHAPTER	Matthew R Astin, MD, FACEP Brett H Cannon, MD, FACEP Shamie Das, MD, MBA, MPH, FACEP James Joseph Dugal, MD(E), FACEP Mark A Griffiths, MD, FACEP Jeffrey F Linzer, Sr, MD, FACEP DW “Chip” Pettigrew, III, MD, FACEP Matthew Rudy, MD, FACEP James L Smith, Jr, MD, FACEP
GOVT SERVICES CHAPTER	Joshua S da Silva, DO Christine A DeForest, DO, FACEP Roderick Fontenette, MD, FACEP Katrina N Landa, MD, FACEP Micaela A LaRose, MD Linda L Lawrence, MD, CPE, FACEP Joshua Lesko, MD David S McClellan, MD, FACEP Torree M McGowan, MD, FACEP Justine K Stremick, MD Danielle Wickman, MD
HAWAII CHAPTER	John M Gallagher, MD, FACEP Lisa Jacobson, MD, FACEP

IDAHO CHAPTER	Sierra P Debenham, MD, MSPH Ken John Gramyk, MD, FACEP
ILLINOIS CHAPTER	Halleh Akbarnia, MD, FACEP Amit D Arwindekar, MD, FACEP E Bradshaw Bunney, MD, FACEP Kristen M Donaldson, MD, MPH, FACEP Cai Glushak, MD, FACEP John W Hafner, MD, FACEP Adnan Hussain, MD, FACEP Janet Lin, MD, FACEP Howard K Mell, MD, MPH, CPE, FACEP Henry Pitzele, MD, FACEP Yanina Purim-Shem-Tov, MD, MS, FACEP Lauren M Smith, MD Deborah E Weber, MD, FACEP
INDIANA CHAPTER	Michael D Bishop, MD, FACEP Timothy A Burrell, MD, MBA, FACEP Daniel W Elliott, MD, FACEP Kyle D English, MD, FACEP Emily M Fitz, MD, FACEP Lindsay Zimmerman, MD, FACEP
IOWA CHAPTER	Nicholas Holden Kluesner, MD, FACEP Stacey Marie Marlow, MD, JD, FACEP Rachael Sokol, DO, FACEP
KANSAS CHAPTER	Howard Chang, MD, FACEP John F McMaster, MD, FACEP Jeffrey G Norvell, MD, MBA, RDMS, FACEP
KENTUCKY CHAPTER	Christopher W Pergrem, MD, FACEP Melissa Platt, MD, FACEP Hugh W Shoff, MD, FACEP Steven Joseph Stack, MD, MBA, FACEP
LOUISIANA CHAPTER	James B Aiken, MD, FACEP Deborah D Fletcher, MD, FACEP Jamie Hoitien Do Kuo, MD Phillip Luke LeBas, MD, FACEP Michael D Smith, MD MBA CPE, FACEP
MAINE CHAPTER	Thomas C Dancoes, DO, FACEP Garreth C Debiegun, MD, FACEP Charles F Pattavina, MD, FACEP
MARYLAND CHAPTER	Michael C Bond, MD, FACEP Sydney E DeAngelis, MD, FACEP Karen Dixon, MD, FACEP Kerry Forrestal, MD, FACEP Jonathan Lewis Hansen, MD, FACEP Edana Denise Mann, MD, FACEP Richard Gentry Wilkerson, MD, FACEP
MASSACHUSETTS CHAPTER	Brien Alfred Barnewolt, MD, FACEP Alice Bukhman, MD

	Stephen K Epstein, MD, MPP, FACEP
	Kathleen Kerrigan, MD, FACEP
	Matthew B Mostofi, DO, FACEP
	Mark D Pearlmutter, MD, FACEP
	Jesse Rideout, MD, FACEP
	Deesha Sarma, MD
	James Joseph Sullivan, Jr, MD
	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
	Nicholas Dyc, MD, FACEP
	Michael W Fill, DO, FACEP
	Gregory Gafni-Pappas, DO, FACEP
	Michael Vincent Gratson, MD, FACEP
	Therese G Mead, DO, FACEP
	Emily M Mills, MD, FACEP
	James C Mitchiner, MD, MPH, FACEP
	Diana Nordlund, DO, JD, 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
	Mildred J Willy, MD, FACEP
MINNESOTA CHAPTER	Paul C Allegra, MD, FACEP
	Heather Ann Heaton, MD, FACEP
	Matthew E Herold, MD, FACEP
	Donald L Lum, MD, FACEP
	David A Milbrandt, MD, FACEP
	David Nestler, MD, MS, FACEP
	Thomas E Wyatt, MD, FACEP
	Andrew R Zinkel, MD, MBA, FACEP
MISSISSIPPI CHAPTER	Lisa M Bundy, MD, FACEP
	Fred E Kency, Jr, MD, FACEP
	Chester Duane Shermer, MD, FACEP
MISSOURI CHAPTER	Brian John Bausano, MD, MBA, FACEP
	Jonathan Heidt, MD, MHA, FACEP
	Dennis E Hughes, DO, FACEP
	Louis D Jamtgaard, MD, FACEP
	Marc Mendelsohn, MD, MPH, FACEP
	Robert Francis Poirier, Jr, MD, MBA, FACEP
	Evan Schwarz, MD, FACEP
MONTANA CHAPTER	Harry Eugene Sibold, MD, FACEP
NEBRASKA CHAPTER	Renee Engler, MD, FACEP
	Julie Query, MD
NEVADA CHAPTER	John Dietrich Anderson, MD, FACEP
	Bret Frey, MD, FACEP

	Gregory Alan Juhl, MD, FACEP
	Brian M Trimmer, MD, FACEP
NEW HAMPSHIRE CHAPTER	Sarah Garlan Johansen, MD, FACEP
NEW JERSEY CHAPTER	Navin Ariyaprakai, MD, NRP, FAEMS, FACEP
	Kimberly T Baldino, MD, FACEP
	Michael Joseph Gerardi, MD, FACEP
	Rachelle Ann Greenman, MD, FACEP
	Patrick Blaine Hinfey, MD, FACEP
	Steven M Hochman, MD, FACEP
	Tara Knox, MD
	Jessica M Maye, DO, FACEP
	J Mark Meredith, MD, FACEP
	Michael Ruzek, DO, FACEP
NEW MEXICO CHAPTER	Sarah Bridge, MD
	Eric M Ketcham, MD, MBA, FACHE, FACEP
	Scott Mueller, DO, FACEP
NEW YORK CHAPTER	Brahim Ardolic, MD, FACEP
	Joseph Basile, MD, FACEP
	Kirby Black, MD, FACEP
	Erik Blutinger, MD, MSc, FACEP
	Robert M Bramante, MD, FACEP
	Ashley Brittain, DO
	Joan Wang Chou, MD
	Arlene Chung, MD, FACEP
	Joshua R Codding, MD
	Lauren J Curato, DO, FACEP
	Mark Curato, DO, FACEP
	Keith Grams, MD, FACEP
	Sanjey Gupta, DO, FACEP
	Abbas Husain, MD, FACEP
	Marc P Kanter, MD, FACEP
	Stuart Gary Kessler, MD, FACEP
	Daniel Lakoff, MD, FACEP
	Penelope Lema, MD, FACEP
	Kurien Mathews, DO, MBA
	Mary E McLean, MD
	Laura D Melville, MD
	Nestor B Nestor, MD, FACEP
	Jeffrey S Rabrich, DO, FACEP
	James Gerard Ryan, MD, FACEP
	Livia M Santiago-Rosado, MD, FACEP
	Virgil W Smaltz, MD, FACEP
	Wilson Smith, MD
	Jeffrey J Thompson, MD, FACEP
	Asa Viccellio, MD, FACEP
	Luis Carlos Zapata, MD, FACEP
NORTH CAROLINA CHAPTER	Jill Lynn Benson, MD, FACEP
	Thomas N Bernard, III, MD, FACEP
	Scott W Brown, MD, FACEP
	Gregory J Cannon, MD, FACEP
	Jennifer Casaletto, MD, FACEP
	Eric E Maur, MD, FACEP

	Abhishek Mehrotra, MD, MBA, FACEP
	Bret Nicks, MD, MHA, FACEP
	Sankalp Puri, MD, FACEP
	Sean S Ray, MD, FACEP
	Stephen A Small, MD, FACEP
NORTH DAKOTA CHAPTER	K J Temple, MD, FACEP
OHIO CHAPTER	Eileen F Baker, MD, PhD, FACEP
	Christina Campana, DO, FACEP
	Laura Michelle Espy-Bell, MD, FACEP
	Purva Grover, MD, FACEP
	Hannah R Hughes, MD, MBA
	Megan Ladd, DO
	Thomas W Lukens, MD, PhD, FACEP
	Catherine Anna Marco, MD, FACEP
	Michael McCrea, MD, FACEP
	John R Queen, MD, FACEP
	Bradley D Raetzke, MD, FACEP
	Matthew J Sanders, DO, FACEP
	Imran Shaikh, MD, FACEP
	Ryan Squier, MD, FACEP
	Joseph P Tagliaferro, III, DO, FACEP
	Nicole Ann Veitinger, DO, FACEP
OKLAHOMA CHAPTER	Cecilia Guthrie, MD, FACEP
	James Raymond Kennedye, MD, MPH, FACEP
	Derek Martinez, DO
	Kurtis A Mayz, JD, MD, MBA, FACEP
OREGON CHAPTER	Brittany N Arnold, MD, FACEP
	John C Moorhead, MD, FACEP
	Chris F Richards, MD, FACEP
	Christian Smith, MD, FACEP
PENNSYLVANIA CHAPTER	Christopher L Berry, MD
	Monisha Bindra, DO, MPH, FACEP
	Karen M Custodio, DO
	Eleanor Dunham, MD, FACEP
	Marcus Eubanks, MD, FACEP
	Ronald V Hall, MD, FACEP
	Richard Hamilton, MD, FACEP
	Kirk S Hinkley, MD, FACEP
	Annahieta Kalantari, DO, FACEP
	Erik Ian Kochert, MD, FACEP
	Chadd K Kraus, DO, DrPH, CPE, FACEP
	Hannah M Mishkin, MD, FACEP
	Danielle Nesbit, DO
	Shawn M Quinn, DO, FACEP
	Meaghan L Reid, DO, FACEP
	Jennifer L Savino, DO, FACEP
	Rachael K Trupp, DO
	Theresa Ann Walls, MD, MPH
	Elizabeth Barrall Werley, MD, FACEP
PUERTO RICO CHAPTER	Angelisse M Almodovar Bernier, MD, FACEP
	Edwin J Garcia La Torre, MD, FACEP

RHODE ISLAND CHAPTER	Achyut B Kamat, MD, FACEP Michael Stephen Siclari, MD, FACEP Jessica Smith, MD, FACEP
SOCIETY FOR ACADEMIC EMERGENCY MEDICINE	Kathleen J. Clem, MD, FACEP
SOUTH CAROLINA CHAPTER	Ryan M Barnes, DO Matthew D Bitner, MD, FACEP Allison Leigh Harvey, MD, FACEP Kelly M Johnson, MD, FACEP Christina Millhouse, MD, FACEP Angel Lee Rochester, MD, FACEP
SOUTH DAKOTA CHAPTER	Donald Neilson, MD
TENNESSEE CHAPTER	Sanford H Herman, MD, FACEP Kenneth L Holbert, MD, FACEP Sudave D Mendiratta, MD, FACEP Matthew Neal, MD John H Proctor, MD, MBA, FACEP
TEXAS CHAPTER	Sara Andrabi, MD, FACEP Angela Pettit Cornelius, MD, FACEP Carrie de Moor, MD, FACEP Diana L Fite, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Robert Hancock, Jr, DO, FACEP Doug Jeffrey, MD, FACEP Alexander J Kirk, MD, FACEP Laura N Medford-Davis, MD, FACEP Sterling Evan Overstreet, MD, FACEP Heather S Owen, MD, FACEP Anant Patel, DO, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Richard Dean Robinson, MD, FACEP Marcus Lynn Sims, II, DO, FACEP Theresa Tran, MD, FACEP Gerad A Troutman, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, MPH, FACEP
UTAH CHAPTER	Jim V Antinori, MD, FACEP Alexander Franke, MD Alison L Smith, MD, MPH, FACEP Henry T Yeates, DO, FACEP
VERMONT CHAPTER	Matthew S Siket, MD, FACEP Alexandra Nicole Thran, MD, FACEP
VIRGINIA CHAPTER	Trisha Danielle Anest, MD MBA MPH, FACEP Caroline Hollis Cox, MD James R Humble, MD Sarah Klemencic, MD, FACEP Jessica Maerz, MD Joseph Mason, MD, FACEP Todd Parker, MD, FACEP

	Joran Sequeira, MD, FACEP Jesse D Spangler, MD, FACEP Theodore I Tzavaras, MD
WASHINGTON CHAPTER	Herbert C Duber, MD, MPH, FACEP Joshua R Frank, MD, FACEP Harlan Gallinger, MD, FACEP Sarah M Hansen, MD Carlton E Heine, MD, PhD, FACEP C Ryan Keay, MD, FACEP Elizabeth A McMurtry, DO, FACEP Jessica J Wall, MD, FACEP
WEST VIRGINIA CHAPTER	Adam Thomas Crawford, DO, FACEP David Benjamin Deuell, DO, FACEP Carol Lea Wright Becker, MD, FACEP
WISCONSIN CHAPTER	William D Falco, MD, MS, FACEP Jeffrey J Pothof, MD, FACEP Michael Dean Repplinger, MD, PhD, FACEP Jamie Schneider, MD Brian Sharp, MD, FACEP Christopher Torkilsen, DO
WYOMING CHAPTER	Stephen Pecevich, MD
AAWEP SECTION	Andrea Austin, MD, FACEP
AIR MEDICAL TRANSPORT SECTION	Sabina A Braithwaite, MD, FACEP
CAREERS IN EMERGENCY MEDICINE SECTION	Constance J Doyle, MD, FACEP
CRITICAL CARE MEDICINE SECTION	Nicholas Johnson, MD, FACEP
CRUISE SHIP MEDICINE SECTION	Ruben Dario Parejo, MD
DEMOCRATIC GROUP PRACTICE SECTION	David G Hall, MD, FACEP
DISASTER MEDICINE SECTION	Samantha Noll, MD, FACEP
DIVERSITY & INCLUSION SECTION	Ugo A Ezenkwele, MD, FACEP
DUAL TRAINING SECTION	Vinay Mikkilineni, MD
EM PRACTICE MGMT & HEALTH POLICY SECTION	Robert M McNamara, MD
EMERGENCY MEDICAL INFORMATICS SECTION	Mark Baker, MD, FACEP
EMERGENCY MEDICINE LOCUM TENENS SECTION	Angela F Mattke, MD, FACEP
EMERGENCY MEDICINE WORKFORCE SECTION	Harry W Severance, MD, FACEP
EMERGENCY TELEHEALTH SECTION	Deborah A Mulligan, MD, FACEP
EMERGENCY ULTRASOUND SECTION	Jeremy Boyd, MD, FACEP
EMS-PREHOSPITAL CARE SECTION	Dustin Holland, MD MPH, FACEP

EVENT MEDICINE SECTION	George-Thomas M Pugh, MD
FORENSIC MEDICINE SECTION	Monika Pitzele, MD, FACEP
FREESTANDING EMERGENCY CENTERS	Paul Daniel Kivela, MD, MBA, FACEP
GERIATRIC EMERGENCY MEDICINE SECTION	Shan W Liu, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE SECTION	Shama Patel, MD
MEDICAL DIRECTORS SECTION	Thomas F Spiegel, MD, MBA, MS, FACEP
MEDICAL HUMANITIES SECTION	Rachel H Kowalsky, MD
OBSERVATION SERVICES SECTION	Anthony R Rosania, MD, FACEP
PAIN MANAGEMENT SECTION	Donald E Stader, MD, FACEP
PALLIATIVE MEDICINE SECTION	Rebecca R Goett, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE SECTION	Jason T Lowe, DO
QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION	Collin Michels, MD
RESEARCH, SCHOLARLY ACTIVITY, & INNOVATION SECTION	Justin B Belsky, MD MPH
RURAL EMERGENCY MEDICINE SECTION	Benjamin Knutson, MD
SOCIAL EMERGENCY MEDICINE SECTION	Laura Janneck, MD, FACEP
SPORTS MEDICINE SECTION	Anne M Verlangieri, MD
TACTICAL EMERGENCY MEDICINE SECTION	Unrepresented
TOXICOLOGY SECTION	Jennifer Hannum, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Gregory Luke Larkin, MD, FACEP
UNDERSEA & HYPERBARIC MEDICINE SECTION	Drue Orwig, DO
WELLNESS SECTION	Susan T Haney, MD, FACEP
WILDERNESS MEDICINE SECTION	Brendan Harry Milliner, MD
YOUNG PHYSICIANS SECTION	Scott H Pasichow, MD, MPH, FACEP

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

Larry Bedard, MD, FACEP (CA)
Brooks F. Bock, MD, FACEP (CO)
Michael Carius, MD, FACEP (CT)
Angela F. Gardner, MD, FACEP (TX)
James Brian Hancock, MD, FACEP (MI)
Nicholas J. Jouriles, MD, FACEP (OH)
George Molzen, MD, FACEP (NM)
Andrew Sama, MD, FACEP (NY)
Robert W. Schafermeyer, MD, FACEP(NC)
Sandra M. Schneider, MD, FACEP (TX)
Richard L. Stennes, MD, FACEP (CA)
Robert E. Suter, DO, MPH, FACEP (TX)

Past Speakers
Michael J. Bresler, MD, FACEP
James M. Cusick, MD, FACEP (FL)
Peter J. Jacoby, MD, FACEP (CT)

Past Chairs of the Board
Stephen H. Anderson, MD, FACEP (WA)
Andrew I. Bern, MD, FACEP (FL)
John D. Bibb, MD, FACEP (CA)
Jon Mark Hirshon, MD, PhD, FACEP (MD)
Ramon W. Johnson, MD, FACEP (CA)
Robert E. O'Connor, MD, MPH, FACEP (VA)
David P. Sklar, MD, FACEP (NM)

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

Council Standing Rules

Preamble

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

Alternate Councillors

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

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

Amendments to Council Standing Rules

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

Announcements

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

Appeals of Decisions from the Chair

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

Board of Directors Seating

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

Campaign Rules

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

Conflict of Interest Disclosure

All councillors and alternate councillors will be familiar with and comply with ACEP's Conflict of Interest policy. Individuals who have a financial interest in a commercial enterprise, which interest will be

materially affected by a matter before the Council, will declare their conflict prior to providing testimony.

Councillor Allocation for Sections of Membership

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

Councillor Seating

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

Credentialing and Proper Identification

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

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

Debate

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

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

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

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

Distribution of Printed or Other Material During the Annual Meeting

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

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.

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 declare 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. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *Sturgis, 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, 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.

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The councillors reviewed and accepted the minutes of the October 23-24, 2021, Council meeting and approved the actions of the Steering Committee taken at their January 24, 2022, and May 1, 2022, meetings.

Dr. Gray-Eurom called for submission of emergency resolutions. None were submitted.

Dr. Gray-Eurom reported that seven late resolutions were received and reviewed by the Steering Committee. Six memorial resolutions were accepted by the Steering Committee. Memorial resolutions are not assigned to a Reference Committee for testimony. One late resolution was accepted for submission to the Council. "Emergency Physician Protection from Legal Jeopardy Related to Elective Abortion Management" was numbered 65 and assigned to Reference Committee B.

Dr. Gray-Eurom presented the Nominating Committee report.

Seven members were nominated for four positions on the Board of Directors: William B. Felegi, DO, FACEP; Jeffrey M. Goodloe, MD, FACEP; Gabor D. Kelen, MD, FACEP; Jeffrey F. Linzer, Sr., MD, FACEP; Kristin B. McCabe-Kline, MD, FACEP; Henry Z. Pitzele, MD, FACEP; and Ryan A. Stanton, MD, FACEP. Dr. Gray-Eurom announced that Dr. Felegi withdrew his name from nomination and then read a personal statement from him. Dr. Gray-Eurom called for floor nominations. There were no nominees. The nominations were then closed.

One member was nominated for President-Elect: Aisha T. Terry, MD, MPH, FACEP. Dr. Gray-Eurom called for floor nominations. There were no floor nominees. The nominations were then closed. With no objections, Dr. Terry was declared as the 2022-23 president-elect.

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

The Council recessed at 9:15 am for the Reference Committee hearings. The resolutions considered by the 2022 Council appear below as submitted.

2022 Council Resolutions

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting

impact of the contributions of Michael L. Callaham, MD, FACEP, to the advancement of science and success of *Annals of Emergency Medicine*; and be it further

RESOLVED, That the American College of Emergency Physicians commends Michael L. Callaham, MD, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians commends Virginia (Ginny) Kennedy Palys, JD, for her career of dedicated service, outstanding leadership, commitment to the College, the emergency physicians of Illinois, the specialty of emergency medicine, and the patients that we serve.

RESOLUTION 3

RESOLVED, That the American College of Emergency Physicians commends Paul R Pomeroy, Jr., MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

RESOLUTION 4

RESOLVED, That the American College of Emergency Physicians commends Loren Rives, MNA, for her outstanding service and commitment to the College and the specialty of emergency medicine.

RESOLUTION 5

RESOLVED, That the American College of Emergency Physicians commends Mark S. Rosenberg, DO, MBA, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

RESOLUTION 6

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Carey D. Chisholm, MD, to the specialty of emergency medicine, especially as an educator, and extends the College's condolences to his wife of almost 40 years, Robin Chisholm, as well as to their daughters, Kelsey and Tyler.

RESOLUTION 7

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Loren A. Crown, MD, FACEP, and extends condolences and gratitude to his wife, Elaine Kathleen Ellis, family, and friends for his service to the specialty of emergency medicine and to patient care.

RESOLUTION 8

RESOLVED, That the American College of Emergency Physicians, the Delaware Chapter, and the friends and colleagues of Sherrill Mullenix recognizes her longstanding dedication and incredible contributions to the current state and the future of emergency medicine and acknowledges that she is irreplaceable and is missed.

RESOLUTION 9

RESOLVED, That the American College of Emergency Physicians extends to the family of Adetolu "Tolu" Odufuye MD, FACEP, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of Florida and the United States.

RESOLUTION 10

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.3 – Candidate Members, paragraph two be amended to read:

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

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

"Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such

chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate ~~physician~~ members in accordance with the governance documents or policies of their respective sponsoring bodies."

RESOLUTION 11

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee be amended to read:

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

RESOLUTION 12

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 8 – Board of Directors Actions on Resolutions, be amended to read:

The Board of Directors shall act on all resolutions adopted by the Council, unless otherwise specified in these Bylaws, no later than the second Board meeting following the annual meeting and shall address all other matters referred to the Board within such time and manner as the Council may determine.

The Board of Directors shall take one of the following actions regarding a non-Bylaws resolution adopted by the Council:

1. Implement the resolution as adopted by the Council.
2. Overrule the resolution by a three-fourths vote. The vote and position of each Board member shall be reported at the next meetings of the Steering Committee and the Council.
3. Amend the resolution in a way that does not change the basic intent of the Council. At its next meeting, the Steering Committee must either accept or reject the amendment. If accepted, the amended resolution shall be implemented without further action by the Council. If the Steering Committee rejects the amendment, the Board at its next meeting shall implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.

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

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

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

A Board report on each resolution referred, in whole or part, by the Council to the Board of Directors, will be prepared and become business of the subsequent Council meeting. The Board report will include a summary of the discussion and the Board's recommendations regarding the referred matter. As business of the Council, the Board's recommendations will be subject to Council approval. The Council will review, discuss, and act on the Board report. This may include approval, rejection, amendment, or referral of the recommendations.

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

RESOLUTION 13

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two be

amended to read:

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

RESOLUTION 14

RESOLVED, That the "Debate" section, paragraph one, of the Council Standing Rules be amended to read:

"Councillors, **past and current** members of the Board of Directors, ~~past presidents,~~ **and** 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, **past or current** Board **member**, ~~past president,~~ past speaker, ~~past chair,~~ etc.), and whether they are speaking "for" or "against" the motion;" and be it further

RESOLVED, That the Council Standing Rules "Past Presidents, Past Speakers, and Past Chairs of the Board Seating" section be amended to read as follows with the proviso that the changes will become effective after the 2022 Council meeting and only upon adoption of the companion Bylaws amendment titled "Past Leader Participation in Council Meetings":

Past ~~Presidents,~~ **Members of the Board of Directors and** Past Speakers~~, and Past Chairs of the Board~~ Seating

Past ~~presidents,~~ **Members of the Board of Directors and** 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.

PROVISO: The provisions of this resolution shall not go into effect unless Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment is adopted by the Council and the Board of Directors.

RESOLUTION 15

RESOLVED, That the ACEP Council Standing Rules, "Election Procedures" section, paragraph one, and the "Voting on Resolutions and Motions" section be amended to read:

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. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

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. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

RESOLUTION 16

RESOLVED, That the ACEP Council Standing Rules, "Nominations" section, be amended to read:

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** declar~~e~~**ing** 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.***

RESOLUTION 17

RESOLVED, That ACEP study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That ACEP not schedule future national-level ACEP events in states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That with recognition of the necessity for both the College and its chapters to continue to function in states that limit access to a full range of reproductive health care options, the prohibition of scheduling meetings in these states shall apply to national-level ACEP events only, and shall not apply to individual chapters of the College.

RESOLUTION 18

RESOLVED, That information on the sources and amount of revenue for the Clinical Emergency Data Registry be disclosed in the Treasurer's report to the Council and to the membership.

RESOLUTION 19

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support, or otherwise be associated with the ACEP, as of January 1, 2023, shall remove all contractual restrictions on or waivers of due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but are not limited to physician group practices, hospitals and staffing companies."; and be it further

RESOLVED, That ACEP create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

RESOLUTION 20

RESOLVED, That ACEP provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

RESOLUTION 21

RESOLVED, That ACEP directly support the American Academy of Emergency Medicine – Physician Group litigation versus Envision by a donation of $1 million of the members' equity to the American Academy of Emergency Medicine Foundation.

RESOLUTION 22

RESOLVED, That ACEP return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year.

RESOLUTION 23

RESOLVED, That the Council Steering Committee study limits to the number of years individuals may serve in the ACEP Council and report back to the Council with actionable recommendations by the 2024 Council meeting.

RESOLUTION 24

RESOLVED, That ACEP support nationwide access to a full array of reproductive health care options.

RESOLUTION 25

RESOLVED, That ACEP affirms that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP supports the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP opposes the criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services and will advocate against any legislative efforts to criminalize self-induced abortion; and be it further

RESOLVED, That ACEP supports an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; and be it further

RESOLVED, That ACEP opposes the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.

RESOLUTION 26

RESOLVED, That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; and be it further

RESOLVED, That ACEP promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state of origin of their patients; and be it further

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; and be it further

RESOLVED, That ACEP broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; and be it further

RESOLVED, That ACEP continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and be it further

RESOLVED, That ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support of adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

RESOLUTION 27

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

RESOLUTION 28

RESOLVED, That ACEP will petition the appropriate state or federal legislative and regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis; and be it further

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP, will, as of January 1, 2023, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on monetary amounts billed and collected in the physician's name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities affected include but are not limited to revenue cycle management companies, physician group practices, hospitals, and staffing companies."

RESOLUTION 29

RESOLVED, That ACEP advocate on behalf of its patients and members that the FDA add buprenorphine to

its list of essential medications; and be it further

RESOLVED, That ACEP recommend and advocate that every emergency department stock buprenorphine and medications for opioid use disorder so that patients with opioid use disorder or in opioid withdrawal may receive the best evidence-based care; and be it further

RESOLVED, That ACEP work with the American Hospital Association, American Medical Association, state agencies, and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings; and be it further

RESOLVED, That ACEP support hospitals and emergency physicians in initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder to enhance best evidence-based practices in emergency medicine throughout the United States.

RESOLUTION 30

RESOLVED, That ACEP support allowing patients access to medical cannabis; and be it further

RESOLVED, That ACEP endorse and support the passage of Ryan's Law across the entire United States; and be it further

RESOLVED, That ACEP endorse, support, and assist ACEP chapters in the passage of Ryan's Law legislation in their states.

RESOLUTION 31

RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States instead making that a civil penalty with referral to treatment; and be it further

RESOLVED, That ACEP endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs and instead making that a civil penalty with referral to treatment.

RESOLUTION 32

RESOLVED, That ACEP support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

RESOLUTION 33

RESOLVED, That ACEP support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care; and be it further

RESOLVED, That ACEP advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of opioid use disorder treatment including medication therapy through telehealth into the continuum of addiction care.

RESOLUTION 34

RESOLVED, That ACEP work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

RESOLUTION 35

RESOLVED, That ACEP advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker who is at work and delivering care.

RESOLUTION 36

RESOLVED, That ACEP declare EMS an essential service and engage in a public information campaign to educate the public in this regard; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally- and locally-funded essential services.

RESOLUTION 37

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum,

from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

RESOLUTION 38

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

RESOLUTION 39

RESOLVED, That ACEP advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient Emergency Departments without onsite emergency medicine physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

RESOLUTION 40

RESOLVED, That ACEP develop a policy statement in support of the expansion of Medicaid to the levels allowable by federal law in recognition of the benefit of increasing health care access to eligible patients, including some of our most vulnerable, while decreasing the uncompensated care provided by emergency physicians; and be it further

RESOLVED, That ACEP develop a toolkit to assist ACEP state chapters in their efforts to advocate for such expansion of Medicaid in their states.

RESOLUTION 41

RESOLVED, That ACEP develop an educational program on identifying and addressing stigma in the emergency department that can be provided to residency programs as a standard part of residency training, highlighting the role of important practices such as person-first language.

RESOLUTION 42

RESOLVED, That ACEP establish policy to appreciate and support the efforts of other specialties to require emergency department or emergency medicine experience of their residents, with specific support for the equity of their experience with that of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to reaffirm existing requirements that residents from other specialties do not detract from the education of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to expand the program requirements for emergency medicine regarding the education of residents from other services; specifically stating that the following requirements apply equally:

a. Training site resources (e.g., clinical support personnel).
b. Training site volume and acuity, with sites for these residents subject to the same requirements as the primary clinical site for emergency medicine residents.
c. Qualifications of faculty members supervising these residents.
d. Designation of a physician qualified to supervise emergency medicine residents as a core faculty member of the other residency or residencies who is responsible for the emergency medicine experience of that residency.; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and other specialties to reference emergency medicine new requirements in the requirements for other residencies that require emergency department or emergency medicine experience (e.g., internal medicine, family medicine, transitional year, etc.) such that the required experience is substantially similar for all residents and specifically all residents who require emergency medicine or emergency department experience should receive a substantially similar experience at training sites with or without an emergency medicine residency regarding:

a. Training site resources.
b. Training site volume and acuity.
c. Faculty qualifications.

Designation of a core faculty member, qualified to supervise emergency medicine residents, responsible for the emergency medicine experience of the residency.

RESOLUTION 43

RESOLVED, That ACEP support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and be it further

RESOLVED, That ACEP coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency and should focus on identification of patients with opioid use disorder and initiation of buprenorphine treatment as well as sharing harm reduction information and resources such as clean syringes, naloxone, and fentanyl test strips, depending on local practice and availability.

RESOLUTION 44

RESOLVED, That ACEP adopt as policy, a position that every patient presenting to an emergency department should be assessed, in person, by a board-certified/board-eligible emergency physician as defined by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or a physician formerly board certified in emergency medicine as defined by ABEM or ABOEM who is now board certified by an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy a position that if no board-certified/board-eligible emergency physician is available, that the absolute minimum standard to providing emergency care is that every patient presenting to an emergency department is assessed, in person, by a licensed physician who is board certified/board eligible in an medical specialty as defined by the American Board of Medical Specialties or the American Osteopathic Association, or who was formerly so certified and is now a member of an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy, a position that nurse practitioners and physician assistants should never practice emergency medicine without in-person, real-time physician supervision; and be it further

RESOLVED, That ACEP advocate with the Centers for Medicare & Medicaid Services and third-party payers to exclude care provided by a nurse practitioners and physician assistants without in-person, real-time physician supervision from the definition of emergency medicine for the purposes of billing or reimbursement.

RESOLUTION 45

RESOLVED, That the ACEP policy statement "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" be revised so that onsite emergency physician presence to supervise nurse practitioners and physician assistants is stated as the gold standard for staffing all emergency departments.

RESOLUTION 46

RESOLVED, That ACEP research and make recommendations regarding the minimum staffing ratios of physicians to nurse practitioners and physician assistants, taking into account appropriate variables (such as patient acuity, non-physician provider competencies, available clinical resources, etc.) to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

RESOLUTION 47

RESOLVED, That ACEP work with the American Medical Association and call for an unbiased outside agency survey and report of nurse practitioner schools to provide recommendations for nurse practitioner reform to improve the quality of nurse practitioner education and to improve patient care.

RESOLUTION 48

RESOLVED, That ACEP endorse that before a physician assistant or nurse practitioner can work in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH) or Outpatient Emergency Department (OED) that they have a minimum of five years of experience working in an emergency department with onsite supervision.

RESOLUTION 49

RESOLVED, That ACEP support initiatives that encourage the placement of emergency medicine-trained and board-certified medical directors in all U.S. EDs, whether in person or virtual; and be it further

RESOLVED, That ACEP support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board-certified physicians; and be it further

RESOLVED, That ACEP support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

RESOLUTION 50

RESOLVED, That ACEP support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; and be it further

RESOLVED, That ACEP help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work rural; and be it further

RESOLVED, That ACEP support working with the Accreditation Council for Graduate Medical Education to increase resident exposure to rural emergency medicine.

RESOLUTION 51

RESOLVED, That ACEP support screening for social determinants of health with validated tools; and be it further

RESOLVED, That ACEP encourage screening for social determinants of health to be paired with feasible and appropriate responses.

RESOLUTION 52

RESOLVED, That ACEP appoint a task force or committee to identify minimum standards of care for health-related social complaints in the emergency department, acknowledging that these standards are only advisory in nature and must be reflective of standards that can be reasonably achieved in all emergency departments, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings, and submit a report to the 2023 Council.

RESOLUTION 53

RESOLVED, That ACEP investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and be it further

RESOLVED, That ACEP encourage law enforcement to stay with any patient they choose to bring to the ED who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

RESOLUTION 54

RESOLVED, That, to safeguard the welfare of our membership and patients, ACEP task a committee with developing a process to identify employers of emergency physicians and quantify the degree of moral injury imposed by said employers on their emergency physician employees and further making these findings available to the general membership.

RESOLUTION 55

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department against medical advice prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, and all indicated consults; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department against medical advice prior to completion of care will not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

RESOLUTION 56

RESOLVED, That ACEP adopt the following policy statement based on the California Medical Board's guidance:

ACEP Policy Statement on the Corporate Practice of Medicine

ACEP strongly believes that the physician-patient relationship should be free of commercialization and undue influence by business interests. The corporate practice of medicine prohibition is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. The following health care decisions should be made by a licensed physician and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to, or consultation with, another physician/specialist.
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient.
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

In addition, the following "business" or "management" decisions and activities, resulting in control over the physician's practice of medicine, should be made by a licensed physician and not by an unlicensed person or entity:

- Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a licensed physician.
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.
- Setting the parameters under which the physician will enter into contractual relationships with third-party payers.
- Decisions regarding coding and billing procedures for patient care services.
- Approving of the selection of medical equipment and medical supplies for the medical practice.

The types of decisions and activities described above cannot be delegated to an unlicensed person, including (for example) management service organizations. While a physician may consult with unlicensed persons in making the "business" or "management" decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

The following types of medical practice ownership and operating structures also are prohibited:

- Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care, or treatment.
- Management service organizations arranging for or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business).

In the examples above, non-physicians would be engaged in the unlicensed practice of medicine, and the physician may be aiding and abetting the unlicensed practice of medicine.

RESOLUTION 57

RESOLVED, That ACEP amend its policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" to reflect that alternate organizations that claim to provide "board certification" but that do not provide ongoing assessment of their diplomates, do not provide transparency about their certification process, do not provide transparency about the specialties and numbers of certified physicians, or merely verify continuing medical education and training, are not recognized by ACEP as equivalent to board certification by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or the American Board of Pediatrics for any purpose; and

RESOLVED, That ACEP affirm that board certification through the American Board of Medical Specialties or the American Osteopathic Association are currently the only ACEP-recognized means for emergency physician board certification in the United States.

RESOLUTION 58

RESOLVED, That ACEP support the cessation of invasive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking employment beyond that which is necessary to confirm ability to perform duties associated with the individual's role as hired.

RESOLUTION 59 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians recognize and salute Brian Robb, DO,

MBA, FACEP, and offer our heartfelt condolence to his wife of 43 years, Sharon, his three children, and many grandchildren.

RESOLUTION 60 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of James R. Roberts, MD, FACMT, FAAEM, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his partner Lydia (Forte) to whom he was married for over 40 years, daughter Martha, son Matthew, his grandchildren Eleanor Cronin and Liam Roberts, his brother George Roberts, his sister Mary Peterlin, nieces, nephews, and family-in-law gratitude for his tremendous service as one of the pillars of emergency medicine, a consummate clinician and educator, as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 61 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Douglas D. Rockacy, MD, FACEP, who dedicated himself to his patients, to his trainees, to his profession, and to his family; and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extend to his wife Wendy, daughter Claire, and son Russell gratitude for his tremendous service as one of the finest emergency physicians the University of Pittsburgh has ever seen, as well as for his dedication and commitment to the specialty of emergency medicine.

RESOLUTION 62 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Robert J. Teichman, MD, PhD, and extends condolences and gratitude to his wife, Geri Young, MD, of Kapa'a, Kaua'i, and his sons Kurt Teichman of Brooklyn, NY and Grant Teichman of Honolulu, Hawaii, and other family members for his service to the community, his patients, his students, and the specialty of emergency medicine.

RESOLUTION 63 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Jason M White, MD, FACEP, to the specialty of emergency medicine and extends the College's condolences to his wife of almost 40 years, Carol, and also to their sons and daughters, Ken, Christopher, Brittany, and Allison, and grandchildren Olivia, Finn, Rosalyn, Easton, and Cassius.

RESOLUTION 64 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by J. David Barry, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of J. David Barry MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of the Department of Defense, Veteran's Affairs, and the United States.

RESOLUTION 65 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP shall not establish policies or assert an ethical standard of care regarding management of patients seeking elective abortions in the emergency department.

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

Resolutions 10-23 were assigned to Reference Committee A. Nicole Veitinger, DO, FACEP, chaired Reference Committee A and other members were: Debra Fletcher; MD, FACEP; John M. Gallagher, MD, FACEP; Kurtis A. Mayz, JD, MD, MBA, FACEP; Alexandra N. Thran, MD, FACEP; Brad L. Walters, MD, FACEP; Maude Surprenant Hancock, CAE; and Laura Lang, JD.

Resolutions 24-40 and 65 were assigned to Reference Committee B. Abhi Mehrotra, MD, MBA, FACEP, chaired Reference Committee B and other members were: Erik Blutinger, MD, MSc; Angela P. Cornelius, MD, FACEP; Hilary E. Fairbrother, MD, FACEP; Puneet Gupta, MD, FACEP; Diana Nordlund, DO, JD, FACEP; Jeff Davis; and Ryan McBride, MPP.

Resolutions 41-58 were assigned to Reference Committee C. Dan Freess, MD, FACEP, chaired Reference Committee C and other members were: Andrea Austin, MD, FACEP; Lisa M. Bundy, MD, FACEP; Antony P. Hsu, MD, FACEP; James D. Maloy, MD, MPH; David Nestler, MD, MS, FACEP; Jonathan Fisher, MD, FACEP and Travis Schulz, MLS, AHIP.

Each of the Reference Committees held virtual hearings. Following the Reference Committee hearings, a Candidate Forum for the president-elect candidates was held. The Candidate Forum for the Board of Directors was recorded prior to the Council meeting and the recorded sessions were made available to councillors for viewing on demand.

At 12:45 pm a Town Hall Meeting was convened. The topic was "Strange Changes: Practice Innovations, Payment Impacts and Predicting the Future. Council Vice Speaker Melissa Costello, MD, FACEP, served as the moderator and the discussants were Angela Cai, MD, MBA; Nicholas Cozzi, MD, MBA; Sandy Schneider MD, FACEP; and James L. Shoemaker, Jr., MD, FACEP.

A Candidate Forum for president-elect candidates was not held since Dr. Terry was unopposed.

Dr. Gray-Eurom moderated a second Town Hall Meeting. The topic was "Running Up That Hill." Discussants were: Gillian R. Schmitz, MD, FACEP; Christopher S. Kang, MD, FACEP; and Susan E. Sedory, MA, CAE.

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. Gray-Eurom addressed the Council and then reviewed the procedure for the adoption of the 2022 memorial resolutions. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. Gray-Eurom then read the resolveds of the memorial resolutions for J. David, Barry, MD, FACEP; Carey Chisholm, MD; Loren Crown, MD, FACEP; Sherrill Mullenix; Adetolu Odufuye, MD, FACEP; Brian Robb, DO, MBA, FACEP; James Roberts, MD, FACEP; Douglas Rockacy, MD, FACEP; Robert Teichman, MD, PhD; and Jason White 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.

Samuel M. Keim, MD, FACEP, president of the American Board of Emergency Medicine, addressed the Council.

Dr. Goodloe presented the secretary-treasurer's report.

Angela Cai, MD, MBA, president of the Emergency Medicine Residents' Association, addressed the Council.

A video report regarding the activities of the Emergency Medicine Foundation was shown to the Council.

A video report regarding the activities of National Emergency Medicine Political Action Committee was shown to the Council.

Dr. Schmitz addressed the Council. She reflected on the past year as ACEP president and highlighted the successes of the College.

The Council recessed at 5:56 pm for the candidate reception and reconvened at 8:04 am on Friday, September 30, 2022.

Dr. Kraus reported that 418 councillors of the 433 eligible for seating had been credentialed.

Ms. Sedory, executive director and Council secretary, addressed the Council.

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

REFERENCE COMMITTEE A

Dr. Veitinger 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: Resolution 11 and Resolution 16.

For adoption as amended or substituted: Amended Resolution 15.

Not for adoption: Resolution 12, Resolution, 13, Resolution 14, Resolution 17, Resolution 18, Resolution 21, Resolution 22, and Resolution 23.

Not for adoption and for adoption as amended: Resolution 19

For referral to the Board of Directors: Resolution 10 and Resolution 20.

Resolution 13, Resolution 14, Amended Resolution 15, Resolution 17, Resolution 19, Resolution 20, and Resolution 22 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

The committee recommended that Resolution 13 not be adopted.

It was moved THAT RESOLUTION 13 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 14 not be adopted.

It was moved THAT RESOLUTION 14 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 15 be adopted.

It was moved THAT AMENDED RESOLUTION 15 BE ADOPTED:

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.**

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 motion was adopted.

The committee recommended that Resolution 17 not be adopted.

It was moved THAT RESOLUTION 17 BE ADOPTED.

It was moved THAT RESOLUTION 17 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT IN CONSIDERING WHERE TO SCHEDULE FUTURE NATIONAL LEVEL ACEP EVENTS, ACEP SHALL TAKE INTO CONSIDERATION WHETHER THAT LOCATION RESTRICTS ACCESS TO REPRODUCTIVE HEALTH CARE.

It was moved THAT SUBSTITUTE RESOLUTION 17 BE REFERRED TO THE BOARD. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that the first resolved of Resolution 19 not be adopted.

It was moved THAT THE FIRST RESOLVED OF RESOLUTION 19 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 19 be adopted.

It was moved THAT AMENDED RESOLUTION 19 BE ADOPTED:

RESOLVED, THAT ACEP CREATE A METHOD FOR MEMBERS TO REPORT INCIDENTS OF DENIAL OF DUE PROCESS, REVIEW MEMBER-SUBMITTED CONTRACTUAL CLAUSES OR OTHER METHODS OF DENYING SUCH THAT ARE OF CONCERN~~, AND TO INVESTIGATE THE MATTER ALLOWING THE ENTITY AN OPPORTUNITY TO RESPOND OR MODIFY ITS POLICY PRIOR TO EXCLUSION FOR VIOLATION OF THIS POLICY~~.

It was moved THAT AMENDED RESOLUITON 19 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP BELIEVES THAT EMPLOYEMENT AGREEMENTS SHOULD CONTAIN CLEAR PROVISIONS TO BOTH PROTECT A PHYSICIAN'S RIGHT TO DUE PROCESS BEFORE TERMINATION FOR CAUSE AND TO PROTECT A PHYSICIAN'S RIGHT TO REASONABLE NOTICE BEFORE TERMINATION WITHOUT CAUSE. PHYSICIAN EMPLOYMENT AGREEMENTS SHOULD ALSO SPECIFY WHETHER OR NOT TERMINATION OF EMPLOYMENT IS GROUNDS FOR AUTOMATIC TERMINATION OF HOSPITAL MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES. PHYSICIANS CANNOT BE ASKED TO WAIVE THESE RIGHTS AS DOING SO CAN BE DETRIMENTAL TO THE QUALITY AND SAFETY OF PATIENT CARE; AND BE IT FURTHER

RESOLVED, THAT ADOPT THIS POLICY: "ANY ENTITY THAT WISHES TO ADVERTISE IN ACEP VEHICLES, EXHIBIT AT ITS MEETINGS, PROVIDE SPONSORSHIP, OTHER SUPPORT, OR OTHERWISE BE ASSOCIATED WITH THE ACEP, AS OF JANUARY 1, 2023, SHALL BE REQUIRED TO CLEARLY DISCLOSE ENTITY CONTRACTUAL RESTRICTIONS ON AND/OR WAIVERS OF DUE PROCESS FOR EMERGENCY PHYSICIANS AND TO STATE (YES OR NO) WHETHER OR NOT THESE RESTRICTIONS AND/OR WAIVERS COMPLY WITH THE CURRENT PEER REVIEW AND DUE PROCESS POLICY DESCRIBED IN THE AMA CODE OF MEDICAL ETHICS OPINION 9.4.1. PHYSICIANS CANNOT BE ASKED TO WAIVE THIS RIGHT AS IT CAN BE DETRIMENTAL TO THE QUALITY AND SAFETY OF PATIENT CARE. THE ENTITIES AFFECTED INCLUDE BUT ARE NOT LIMITED TO PHYSICIAN GROUP PRACTICES, HOSPITALS AND STAFFING COMPANIES."

It was moved THAT THE SECOND RESOLVED BE DELETED. The motion was adopted.

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

The main motion was then voted on and was adopted.

The committee recommended that Resolution 20 be referred to the Board of Directors.

It was moved THAT RESOLUTION 20 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Resolution 22 not be adopted.

It was moved THAT RESOLUTION 22 BE ADOPTED.

It was moved THAT RESOLUTION 22 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP HAVE AN INCENTIVE SYSTEM IN PLACE FOR CHAPTERS OF 750 MEMBERS OR LESS AND REGULATED BY THE STATE LEGISLATIVE COMMITTEE TO PROVIDE 10% OF THE COST OF NATIONAL DUES PER REGULAR DUES-PAYING STATE MEMBER RETURNED BACK TO EACH CHAPTER PER YEAR FOR THE PURPOSE OF STATE-LEVEL ADVOCACY FOR EMERGENC PHYSICIANS. The motion was not adopted.

It was moved THAT RESOLUTION 22 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE C

Dr. Freess 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 45 with the amended title ~~Offsite~~ **Onsite** Supervision of Nurse Practitioners and Physician Assistants.

For adoption as amended or substituted: Amended Resolution 41, Amended Resolution 43, Amended Resolution 46, Amended Resolution 47, Amended Resolution 50, Amended Resolution 51, Amended Resolution 56, Amended Resolution 57, and Amended Resolution 58.

Not for adoption: Resolution 42, Amended Resolution 44, Resolution 48, Resolution 49, Resolution 52, Resolution 53, Resolution 54, and Resolution 55

Amended Resolution 44, Amended Resolution 46, Amended Resolution 47, and Resolution 53 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 41

RESOLVED, THAT ACEP DEVELOP AN EDUCATIONAL ~~PROGRAM~~ **RESOURCE** ON IDENTIFYING AND ADDRESSING STIGMA IN THE EMERGENCY DEPARTMENT THAT CAN BE PROVIDED TO **EMERGENCY PHYSICIANS** AND RESIDENCY PROGRAMS ~~AS A STANDARD PART OFFOR USE IN RESIDENCY TRAINING~~, HIGHLIGHTING THE ROLE OF IMPORTANT PRACTICES SUCH AS PERSON-FIRST LANGUAGE.

AMENDED RESOLUTION 43

RESOLVED, THAT ACEP SUPPORT THE INTEGRATION OF BUPRENORPHINE TRAINING AND HARM REDUCTION SKILLS INTO THE CORE CURRICULUM FOR RESIDENTS GRADUATING FROM ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

ACCREDITED EMERGENCY MEDICINE PROGRAMS; AND BE IT FURTHER

RESOLVED, THAT ACEP COORDINATE WITH OTHER ORGANIZATIONS IN EMERGENCY MEDICINE (COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE, SOCIETY FOR ACADEMIC EMERGENCY MEDICINE, AND THE AMERICAN BOARD OF EMERGENCY MEDICINE) TO FURTHER ENDORSE INTEGRATION OF BUPRENORPHINE TRAINING AND HARM REDUCTION SKILLS INTO CURRICULUM OR SIMULATION SESSIONS DURING RESIDENCY AND SHOULD FOCUS ON IDENTIFICATION OF PATIENTS WITH OPIOID USE DISORDER AND INITIATION OF BUPRENORPHINE TREATMENT AS WELL AS SHARING HARM REDUCTION INFORMATION AND RESOURCES ~~SUCH AS CLEAN SYRINGES, NALOXONE, AND FENTANYL TEST STRIPS, DEPENDING ON LOCAL PRACTICE AND AVAILABILITY~~.

*AMENDED RESOLUTION 50 SUPPORTING EMERGENCY PHYSICIANS TO WORK **IN** RURAL **SETTINGS***

RESOLVED, THAT ACEP SUPPORT AND ENCOURAGE EMERGENCY MEDICINE TRAINED AND BOARD CERTIFIED EMERGENCY PHYSICIANS TO WORK IN RURAL EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP HELP ESTABLISH, WITH THE COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE, A STANDARDIZED TRAINING PROGRAM FOR EMERGENCY MEDICINE RESIDENTS WITH ASPIRATIONS TO WORK **IN** RURAL **SETTINGS**; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT WORKING WITH THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION **AND CENTERS FOR MEDICARE AND MEDICAID SERVICES** TO INCREASE RESIDENT EXPOSURE **AND REMOVE REGULATORY BARRIERS** TO RURAL EMERGENCY MEDICINE.

*AMENDED RESOLUTION 51 IMPLEMENTATION OF SOCIAL DETERMINANTS OF HEALTH ~~SCREENING~~ **EVALUATION***

RESOLVED, THAT ACEP SUPPORT ~~SCREENING~~ **EVALUATION** OF SOCIAL DETERMINANTS OF HEALTH ~~WITH VALIDATED TOOLS~~ **IN THE EMERGENCY DEPARTMENT**; AND BE IT FURTHER

~~RESOLVED, THAT ACEP ENCOURAGE SCREENING FOR SOCIAL DETERMINANTS OF HEALTH TO BE PAIRED WITH FEASIBLE AND APPROPRIATE RESPONSES.~~

RESOLVED, THAT ACEP ADVOCATE FOR NATIONAL, STATE, AND LOCAL RESOURCES AND RESPONSES TO BE PAIRED WITH THE EVALUATION FOR SOCIAL DETERMINANTS OF HEALTH.

AMENDED RESOLUTION 56

RESOLVED, THAT ACEP ~~ADOPT THE FOLLOWING POLICY STATEMENT BASED ON THE CALIFORNIA MEDICAL BOARD'S GUIDANCE:~~**WORK WITH RELEVANT EXPERTS TO DEVELOP A POLICY STATEMENT OPPOSING THE CORPORATE PRACTICE OF MEDICINE.**

~~ACEP POLICY STATEMENT ON THE CORPORATE PRACTICE OF MEDICINE~~

~~ACEP STRONGLY BELIEVES THAT THE PHYSICIAN-PATIENT RELATIONSHIP SHOULD BE FREE OF COMMERCIALIZATION AND UNDUE INFLUENCE BY BUSINESS INTERESTS. THE CORPORATE PRACTICE OF MEDICINE PROHIBITION IS INTENDED TO PREVENT UNLICENSED PERSONS FROM INTERFERING WITH OR INFLUENCING THE PHYSICIAN'S PROFESSIONAL JUDGMENT. THE DECISIONS DESCRIBED BELOW ARE EXAMPLES OF SOME OF THE TYPES OF BEHAVIORS AND SUBTLE CONTROLS THAT THE CORPORATE PRACTICE DOCTRINE IS INTENDED TO PREVENT. THE FOLLOWING HEALTH CARE DECISIONS SHOULD BE MADE BY A LICENSED PHYSICIAN AND WOULD CONSTITUTE THE UNLICENSED PRACTICE OF MEDICINE IF PERFORMED BY AN UNLICENSED PERSON:~~

- ~~DETERMINING WHAT DIAGNOSTIC TESTS ARE APPROPRIATE FOR A PARTICULAR CONDITION.~~
- ~~DETERMINING THE NEED FOR REFERRALS TO, OR CONSULTATION WITH, ANOTHER PHYSICIAN/SPECIALIST.~~
- ~~RESPONSIBILITY FOR THE ULTIMATE OVERALL CARE OF THE PATIENT, INCLUDING TREATMENT OPTIONS AVAILABLE TO THE PATIENT.~~

- ~~DETERMINING HOW MANY PATIENTS A PHYSICIAN MUST SEE IN A GIVEN PERIOD OF TIME OR HOW MANY HOURS A PHYSICIAN MUST WORK.~~

~~IN ADDITION, THE FOLLOWING "BUSINESS" OR "MANAGEMENT" DECISIONS AND ACTIVITIES, RESULTING IN CONTROL OVER THE PHYSICIAN'S PRACTICE OF MEDICINE, SHOULD BE MADE BY A LICENSED PHYSICIAN AND NOT BY AN UNLICENSED PERSON OR ENTITY:~~

- ~~OWNERSHIP IS AN INDICATOR OF CONTROL OF A PATIENT'S MEDICAL RECORDS, INCLUDING DETERMINING THE CONTENTS THEREOF, AND SHOULD BE RETAINED BY A LICENSED PHYSICIAN.~~
- ~~SELECTION, HIRING/FIRING (AS IT RELATES TO CLINICAL COMPETENCY OR PROFICIENCY) OF PHYSICIANS, ALLIED HEALTH STAFF AND MEDICAL ASSISTANTS.~~
- ~~SETTING THE PARAMETERS UNDER WHICH THE PHYSICIAN WILL ENTER INTO CONTRACTUAL RELATIONSHIPS WITH THIRD PARTY PAYERS.~~
- ~~DECISIONS REGARDING CODING AND BILLING PROCEDURES FOR PATIENT CARE SERVICES.~~
- ~~APPROVING OF THE SELECTION OF MEDICAL EQUIPMENT AND MEDICAL SUPPLIES FOR THE MEDICAL PRACTICE.~~

~~THE TYPES OF DECISIONS AND ACTIVITIES DESCRIBED ABOVE CANNOT BE DELEGATED TO AN UNLICENSED PERSON, INCLUDING (FOR EXAMPLE) MANAGEMENT SERVICE ORGANIZATIONS. WHILE A PHYSICIAN MAY CONSULT WITH UNLICENSED PERSONS IN MAKING THE "BUSINESS" OR "MANAGEMENT" DECISIONS DESCRIBED ABOVE, THE PHYSICIAN MUST RETAIN THE ULTIMATE RESPONSIBILITY FOR, OR APPROVAL OF, THOSE DECISIONS.~~

~~THE FOLLOWING TYPES OF MEDICAL PRACTICE OWNERSHIP AND OPERATING STRUCTURES ALSO ARE PROHIBITED:~~

- ~~NON-PHYSICIANS OWNING OR OPERATING A BUSINESS THAT OFFERS PATIENT EVALUATION, DIAGNOSIS, CARE, OR TREATMENT.~~
- ~~MANAGEMENT SERVICE ORGANIZATIONS ARRANGING FOR OR PROVIDING MEDICAL SERVICES RATHER THAN ONLY PROVIDING ADMINISTRATIVE STAFF AND SERVICES FOR A PHYSICIAN'S MEDICAL PRACTICE (NON-PHYSICIAN EXERCISING CONTROLS OVER A PHYSICIAN'S MEDICAL PRACTICE, EVEN WHERE PHYSICIANS OWN AND OPERATE THE BUSINESS).~~

~~IN THE EXAMPLES ABOVE, NON-PHYSICIANS WOULD BE ENGAGED IN THE UNLICENSED PRACTICE OF MEDICINE, AND THE PHYSICIAN MAY BE AIDING AND ABETTING THE UNLICENSED PRACTICE OF MEDICINE.~~

AMENDED RESOLUTION 57

RESOLVED, THAT ACEP AMEND ITS POLICY STATEMENT "ACEP RECOGNIZED CERTIFYING BODIES IN EMERGENCY MEDICINE" TO REFLECT THAT **NO** ~~ALTERNATE~~ CERTIFYING ORGANIZATIONS **BEYOND THOSE ALREADY LISTED IN THE POLICY STATEMENT** ~~THAT CLAIM TO PROVIDE "BOARD CERTIFICATION" BUT THAT DO NOT PROVIDE ONGOING ASSESSMENT OF THEIR DIPLOMATES, DO NOT PROVIDE TRANSPARENCY ABOUT THEIR CERTIFICATION PROCESS, DO NOT PROVIDE TRANSPARENCY ABOUT THE SPECIALTIES AND NUMBERS OF CERTIFIED PHYSICIANS, OR MERELY VERIFY CONTINUING MEDICAL EDUCATION AND TRAINING,~~ ARE ~~NOT~~ RECOGNIZED BY ACEP ~~AS EQUIVALENT TO BOARD CERTIFICATION BY THE AMERICAN BOARD OF EMERGENCY MEDICINE, THE AMERICAN OSTEOPATHIC BOARD OF EMERGENCY MEDICINE, OR THE AMERICAN BOARD OF PEDIATRICS FOR ANY PURPOSE; AND~~.

~~RESOLVED, THAT ACEP AFFIRM THAT BOARD CERTIFICATION THROUGH THE AMERICAN BOARD OF MEDICAL SPECIALTIES OR THE AMERICAN OSTEOPATHIC ASSOCIATION ARE CURRENTLY THE ONLY ACEP-RECOGNIZED MEANS FOR EMERGENCY PHYSICIAN BOARD CERTIFICATION IN THE UNITED STATES.~~

*AMENDED RESOLUTION 58 REMOVING ~~UNNECESSARY AND INVASIVE~~ **INTRUSIVE** MEDICAL EXAMS AND QUESTIONNAIRES FROM EMPLOYMENT CONTRACTS*

RESOLVED, THAT ACEP SUPPORT THE CESSATION OF ~~INVASIVE~~ **INTRUSIVE** MEDICAL EVALUATION EXAMS AND QUESTIONNAIRES THAT MAY UNDULY AND UNNECESSARILY INVADE THE PRIVACY OF EMERGENCY MEDICINE PHYSICIANS SEEKING **AND CONTINUING**

EMPLOYMENT BEYOND THAT ~~WHICH IS~~ NECESSARY TO CONFIRM ABILITY TO PERFORM DUTIES ASSOCIATED WITH THE INDIVIDUAL'S ROLE AS HIRED.

The committee recommended that Amended Resolution 44 not be adopted.

It was moved THAT AMENDED RESOLUTION 44 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 46 be adopted.

It was moved THAT AMENDED RESOLUTION 46 BE ADOPTED:

RESOLVED, THAT ACEP ~~RESEARCH~~ **INVESTIGATE** AND MAKE RECOMMENDATIONS REGARDING ~~THE MINIMUM~~ **APPROPRIATE AND SAFE** STAFFING **ROLES,** RATIOS**,** ~~OF PHYSICIANS TO NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS~~ **RESPONSIBILITIES, AND MODELS OF EMERGENCY PHYSICIAN-LED TEAMS**, TAKING INTO ACCOUNT APPROPRIATE VARIABLES ~~(SUCH AS PATIENT ACUITY, NON-PHYSICIAN PROVIDER COMPETENCIES, AVAILABLE CLINICAL RESOURCES, ETC.)~~ TO ALLOW FOR SAFE, HIGH-QUALITY CARE AND APPROPRIATE SUPERVISION IN THE SETTING OF A PHYSICIAN-LED EMERGENCY MEDICINE TEAM.

It was moved THAT THE WORD "RATIOS" BE DELETED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 47 with the amended title ~~Unbiased~~ **Independent** ~~Outside~~ Agency Report for Nurse Practitioner Schools be adopted.

It was moved THAT AMENDED RESOLUTION 47 BE ADOPTED:

RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION AND CALL FOR AN ~~UNBIASED~~ **INDEPENDENT** OUTSIDE AGENCY SURVEY AND REPORT OF NURSE PRACTITIONER SCHOOLS TO PROVIDE RECOMMENDATIONS FOR NURSE PRACTITIONER **EDUCATION** REFORM TO IMPROVE THE QUALITY **AND STANDARDS** OF NURSE PRACTITIONER ~~EDUCATION~~ **TRAINING** ~~AND TO IMPROVE~~ **FOR THE PURPOSE OF IMPROVING PHYSICIAN-LED** PATIENT CARE.

It was moved THAT THE WORDS "AND CALL FOR AN INDEPENDENT OUTSIDE AGENCY SURVEY AND REPORT OF NURSE PRACTITIONER SCHOOLS" BE DELETED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 53 not be adopted.

It was moved THAT RESOLUTION 53 BE ADOPTED.

It was moved THAT THE TITLE OF THE RESOLUTION BE AMENDED TO "LAW ENFORCEMENT **AND SAFE HANDOFFS** AND INTOXICATED PATIENTS IN THE ED" AND THE RESOLUTION BE AMENDEDTO READ:

~~RESOLVED, THAT ACEP INVESTIGATE ALTERNATIVE CARE MODELS TO EVALUATE PATIENTS IN POLICE CUSTODY, SUCH AS TELEHEALTH, TO DETERMINE NECESSITY OF AN IN-PERSON EVALUATION; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE LAW ENFORCEMENT TO STAY WITH ANY PATIENT THEY CHOOSE TO BRING TO THE ED WHO ARE INTOXICATED, ALTERED, AGITATED, OR OTHERWISE POSE A RISK TO THE SAFETY OF THEMSELVES OR OTHERS UNTIL ~~A DISPOSITION HAS BEEN DETERMINED OR THE PHYSICIAN DETERMINES THEIR ASSISTANCE IS NO LONGER NEEDED~~ **THE ED PHYSICIAN AND LAW ENFORCEMENT**

AGREE THAT THE PATIENT NO LONGER POSES A SAFETY RISK TO THE STAFF OF THE EMERGENCY DEPARTMENT; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP A SAFE HANDOFF TOOL TO TRANSITION CARE FROM LAW ENFORCEMENT TO ED STAFF. The motion was not adopted.

It was moved THAT RESOLUTION 53 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:45 pm on Friday, September 30, 2022.

Dr. Kraus reported that 427 councillors of the 433 eligible for seating had been credentialed.

REFERENCE COMMITTEE B

Dr. Mehrotra 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 27, Resolution 29, Resolution 32, Resolution 33, Resolution 34, Resolution 37, and Resolution 40.

For adoption as Amended or Substituted: Amended Resolution 24, Amended Resolution 25, Amended Resolution 26, Amended Resolution 28, Amended Resolution 35, Amended Resolution 36, Amended Resolution 38, and Amended Resolution 39 with the amended title "Signage at **Emergency Departments** ~~Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs~~ With~~out~~ Onsite **Emergency** Physicians.

Not for adoption: Resolution 30, Resolution 31, and Resolution 65.

Amended Resolution 24, Amended Resolution 25, Amended Resolution 28, Resolution 31, Resolution 32, Amended Resolution 35, Amended Resolution 39, and Resolution 65 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 26

~~RESOLVED, THAT ACEP PROMOTE THE EQUITABLE AND KNOWLEDGEABLE TREATMENT OF PATIENTS SEEKING PERI-ABORTION AND POST-ABORTION CARE IN THE EMERGENCY DEPARTMENT IRRESPECTIVE OF THE STATE IN WHICH THE PATIENT IS SEEKING REPRODUCTIVE HEALTH CARE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP PROMOTE LEGAL PROTECTIONS FOR DOCTORS PRACTICING WITHIN THE BEST PRACTICES AND LAWS OF THEIR OWN STATES, IRRESPECTIVE OF THE STATE OF ORIGIN OF THEIR PATIENTS; AND BE IT FURTHER~~

RESOLVED, THAT ACEP ENCOURAGE HOSPITALS AND EMERGENCY MEDICINE RESIDENCY TRAINING PROGRAMS TO PROVIDE EDUCATION, TRAINING, AND RESOURCES OUTLINING ~~BEST~~ **EVIDENCE-BASED** CLINICAL PRACTICES ON **ACUTE PRESENTATIONS OF PREGNANCY-RELATED COMPLICATIONS, INCLUDING** MISCARRIAGE**,** ~~AND~~ POST-ABORTION CARE, **AND** ~~INCLUDING FOR PATIENTS WHO HAVE~~ SELF-MANAGED ABORTIONS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP BROADEN ITS CLINICAL POLICY ON ISSUES IN THE INITIAL EVALUATION AND MANAGEMENT OF PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT IN EARLY PREGNANCY TO INCLUDE CONSIDERATIONS FOR MISCARRIAGE MANAGEMENT; AND BE IT FURTHER~~

RESOLVED, THAT ACEP CONTINUE TO DEVELOP **CLINICAL** PRACTICES AND POLICIES THAT PROTECT THE INTEGRITY OF THE PHYSICIAN-PATIENT RELATIONSHIP**, THE LEGALITY OF CLINICAL DECISION-MAKING, AND POSSIBLE REFERRAL TO ADDITIONAL MEDICAL CARE SERVICES – EVEN ACROSS STATE LINES – FOR PREGNANCY-RELATED CONCERNS (INCLUDING ABORTIONS).** ~~INCLUDING DEVELOPING LEGAL RESOURCES FOR~~

~~PHYSICIANS CARING FOR PERI-ABORTION AND POST-ABORTION PATIENTS IN STATES WHERE ABORTION ACCESS IS LIMITED~~; AND BE IT FURTHER

RESOLVED, THAT ACEP **SUPPORT CLEAR LEGAL** ~~PROMOTE ADHERENCE TO LAWS THAT PROVIDE THE STRONGEST POSSIBLE~~ **PROTECTIONS FOR EMERGENCY PHYSICIANS PROVIDING FEDERALLY-MANDATED EMERGENCY CARE, PARTICULARLY IN CASES OF CONFLICT BETWEEN FEDERAL LAW AND STATE REPRODUCTIVE HEALTH LAWS** ~~HIGH QUALITY PATIENT CARE INCLUDING ITS CONTINUED SUPPORT OF ADHERING TO THE FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) OVER STATE ABORTION LAWS WHEN FAILURE TO TREAT OR SECURELY TRANSFER A PATIENT WITH A POTENTIALLY LIFE-THREATENING PREGNANCY-RELATED COMPLICATION, INCLUDING BUT NOT LIMITED TO ECTOPIC PREGNANCY, SEVERE HEMORRHAGE OR UTERINE INFECTION FROM EITHER ABORTION OR MISCARRIAGE CONTRADICTS EMTALA~~.

AMENDED RESOLUTION 36

RESOLVED, THAT ACEP ~~DECLARE~~ **ADVOCATE FOR** EMS **TO BE CONSIDERED AND FUNDED AS** AN ESSENTIAL SERVICE ~~AND ENGAGE IN A PUBLIC INFORMATION CAMPAIGN TO EDUCATE THE PUBLIC IN THIS REGARD~~; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE AMERICAN MEDICAL ASSOCIATION**, THE AMERICAN HOSPITAL ASSOCIATION, THE NATIONAL ASSOCIATION OF EMS PHYSICIANS,** AND OTHER STAKEHOLDER ORGANIZATIONS TO ACTIVELY PROMOTE THE INCLUSION OF EMERGENCY MEDICAL SERVICES AMONG FEDERALLY- AND LOCALLY-FUNDED ESSENTIAL SERVICES**, INCLUDING EFFORTS TO EDUCATE THE PUBLIC IN THIS REGARD**.

AMENDED RESOLUTION 38

RESOLVED, THAT ACEP, THROUGH LEGISLATIVE VENUES AND LOBBYING EFFORTS, FOCUS REGULATORY BODIES, I.E., CENTERS FOR MEDICARE & MEDICAID SERVICES, THE JOINT COMMISSION, ETC., TO ESTABLISH A REASONABLE MATRIX OF STANDARDS INCLUDING ACCEPTABLE BOARDING TIMES AND HANDOFF OF CLINICAL RESPONSIBILITY FOR BOARDING PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP PUBLISH BEST-PRACTICE ACTION PLANS FOR HOSPITALS TO IMPROVE EMERGENCY DEPARTMENT CAPACITY; AND BE IT FURTHER

RESOLVED, THAT ACEP~~, THROUGH TASK FORCE~~ WORK~~,~~ **TO** DEFINE CRITERIA TO DETERMINE WHEN AN EMERGENCY DEPARTMENT IS CONSIDERED OVER CAPACITY AND HOSPITAL ACTION PLANS ARE TRIGGERED TO ACTIVATE.

The committee recommended that Amended Resolution 24 be adopted.

It was moved THAT AMENDED RESOLUTION 24 BE ADOPTED:

RESOLVED, THAT ACEP SUPPORT~~S~~ **EQUITABLE,** NATIONWIDE ACCESS TO ~~A FULL ARRAY OF EMERGENCY~~ REPRODUCTIVE HEALTH CARE ~~OPTIONS~~ **PROCEDURES, MEDICATIONS, AND OTHER INTERVENTIONS** ~~IN THE EMERGENCY DEPARTMENT~~.

It was moved THAT THE WORD “EMERGENCY” BEFORE THE WORD “REPRODUCTIVE” BE REINSTATED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 25 be adopted.

It was moved THAT AMENDED RESOLUTION 25 BE ADOPTED:

RESOLVED, THAT ACEP AFFIRM~~S~~ THAT: 1) ABORTION IS A MEDICAL PROCEDURE AND SHOULD BE PERFORMED ONLY BY A DULY LICENSED PHYSICIAN, SURGEON, OR OTHER MEDICAL PROFESSIONAL IN CONFORMANCE WITH STANDARDS OF GOOD MEDICAL PRACTICE AND THE MEDICAL PRACTICE ACT OF THAT INDIVIDUAL’S STATE; AND 2) NO PHYSICIAN OR OTHER PROFESSIONAL PERSONNEL SHALL BE REQUIRED TO PERFORM AN

ACT VIOLATIVE OF GOOD MEDICAL JUDGMENT AND THIS PROTECTION SHALL NOT BE CONSTRUED TO REMOVE THE ETHICAL OBLIGATION FOR REFERRAL FOR ANY MEDICALLY INDICATED PROCEDURE; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT~~S~~ THE POSITION THAT THE EARLY TERMINATION OF PREGNANCY (PUBLICLY REFERRED TO AS "ABORTION") IS A MEDICAL PROCEDURE, AND AS SUCH, INVOLVES SHARED DECISION MAKING BETWEEN PATIENTS AND THEIR PHYSICIAN REGARDING: 1) DISCUSSION OF REPRODUCTIVE HEALTH CARE; 2) PERFORMANCE OF INDICATED CLINICAL ASSESSMENTS; 3) EVALUATION OF THE VIABILITY OF PREGNANCY AND SAFETY OF THE PREGNANT PERSON; 4) AVAILABILITY OF APPROPRIATE RESOURCES TO PERFORM INDICATED PROCEDURE(S); AND 5) IS TO BE MADE ONLY BY HEALTH CARE PROFESSIONALS WITH THEIR PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE~~S~~ THE CRIMINALIZATION OR MANDATORY REPORTING **OF REPRODUCTIVE HEALTH-RELATED PATIENT CONCERNS IN THE EMERGENCY DEPARTMENT WHEN PERSONAL PRIVACY, SAFETY, AND/OR HEALTH ARE POTENTIALLY AT RISK IN THE ACUTE SETTING** ~~FOR NON-PUBLIC HEALTH MONITORING REASONS OF SELF-INDUCED ABORTION AS IT INCREASES PATIENTS' MEDICAL RISKS AND DETERS PATIENTS FROM SEEKING MEDICALLY NECESSARY SERVICES AND WILL ADVOCATE AGAINST ANY LEGISLATIVE EFFORTS TO CRIMINALIZE SELF-INDUCED ABORTION~~; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT~~S~~ AN INDIVIDUAL'S ABILITY TO ACCESS THE FULL SPECTRUM OF EVIDENCE-BASED PRE-PREGNANCY, PRENATAL, PERIPARTUM, AND POSTPARTUM PHYSICAL AND MENTAL HEALTH CARE, AND SUPPORTS THE ADEQUATE PAYMENT FROM ALL PAYERS FOR SAID CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP OPPOSE~~S~~ THE CRIMINALIZATION, IMPOSITION OF PENALTIES, OR OTHER RETALIATORY EFFORTS AGAINST PATIENTS, PATIENT ADVOCATES, PHYSICIANS, HEALTH CARE WORKERS, AND HEALTH SYSTEMS FOR RECEIVING, ASSISTING, OR REFERRING PATIENTS WITHIN A STATE OR ACROSS STATE LINES TO RECEIVE REPRODUCTIVE HEALTH SERVICES OR MEDICATIONS FOR CONTRACEPTION AND ABORTION, AND WILL FURTHER ADVOCATE FOR LEGAL PROTECTION OF SAID INDIVIDUALS.

It was moved THAT THE FIRST RESOLVED BE AMENDED BY INSERTING THE WORD "AND" BEFORE THE WORD "SURGEON" AND THE WORDS "OR OTHER MEDICAL PROFESSIONAL" BE DELETED. The motion was not adopted.

It was moved THAT THE THIRD RESOLVED BE AMENDED BY DELETING THE WORDS "WHEN PERSONAL PRIVACY, SAFETY, AND/OR HEALTH ARE POTENTIALLY AT RISK IN THE ACUTE SETTING" BE DELETED. The motion was adopted.

It was moved THAT AMENDED RESOLUTION 25 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 28 be adopted.

It was moved THAT AMENDED RESOLUTION 28 BE ADOPTED:

RESOLVED, THAT ACEP **ADVOCATE** ~~PETITION THE APPROPRIATE STATE OR FEDERAL LEGISLATIVE AND REGULATORY BODIES~~ TO ESTABLISH THE REQUIREMENT THAT REVENUE CYCLE MANAGEMENT ENTITIES~~, REGARDLESS OF THEIR OWNERSHIP STRUCTURE,~~ WILL**, UPON REQUEST,** DIRECTLY PROVIDE EVERY EMERGENCY PHYSICIAN IT BILLS OR COLLECTS FOR WITH~~,~~ A DETAILED ITEMIZED STATEMENT OF BILLING AND REMITTANCES FOR MEDICAL SERVICES THEY PROVIDE ~~ON AT LEAST A MONTHLY BASIS; AND BE IT FURTHER~~**.**

~~RESOLVED, THAT ACEP ADOPT THIS POLICY: "ANY ENTITY THAT WISHES TO ADVERTISE IN ACEP VEHICLES, EXHIBIT AT ITS MEETINGS, PROVIDE SPONSORSHIP, OTHER SUPPORT OR OTHERWISE BE ASSOCIATED WITH ACEP, WILL, AS OF JANUARY 1, 2023,~~

~~PROVIDE EVERY EMERGENCY PHYSICIAN ASSOCIATED WITH THAT ENTITY, AT A MINIMUM, A MONTHLY STATEMENT WITH DETAILED INFORMATION ON MONETARY AMOUNTS BILLED AND COLLECTED IN THE PHYSICIAN'S NAME. THIS INFORMATION MUST BE PROVIDED WITHOUT THE NEED FOR THE PHYSICIAN TO REQUEST IT. PHYSICIANS CANNOT BE ASKED TO WAIVE ACCESS TO THIS INFORMATION. THE ENTITIES AFFECTED INCLUDE BUT ARE NOT LIMITED TO REVENUE CYCLE MANAGEMENT COMPANIES, PHYSICIAN GROUP PRACTICES, HOSPITALS, AND STAFFING COMPANIES."~~

It was moved THAT THE SECOND RESOLVED BE REINSTATED. The motion was not adopted.

It was moved THAT THE WORDS "UPON REQUEST" BE DELETED. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Resolution 31 not be adopted.

It was moved THAT RESOLUTION 31 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 32 be adopted.

It was moved THAT RESOLUTION 32 BE ADOPTED.

It was moved THAT RESOLUTION 32 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 35 be adopted.

It was moved THAT AMENDED RESOLUTION 35 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATE **FOR** LEGISLATION AT THE STATE AND FEDERAL LEVEL THAT INCLUDES CLEAR ~~PENALTY~~ LANGUAGE OUTLINING ~~PUNISHMENT AND~~ CONSEQUENCES FOR THOSE WHO ASSAULT A HEALTHCARE WORKER **AT THE WORKPLACE** ~~WHO IS AT WORK AND DELIVERING CARE~~.

It was moved THAT AMENDED RESOLUTION 35 BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP ADVOCATE FOR LEGISLATION AT THE STATE AND FEDERAL LEVEL THAT INCLUDES RESTORATIVE JUSTICE FOR THOSE WHO ASSAULT A HEALTHCARE WORKER AT THE WORKPLACE. The motion was not adopted.

The main motion was then voted on adopted.

The committee recommended that Amended Resolution 39 be adopted.

It was moved THAT AMENDED RESOLUTION 39 BE ADOPTED:

RESOLVED, THAT ACEP ~~ADVOCATE FOR REQUIRING~~ **ENCOURAGE ALL EMERGENCY DEPARTMENTS** ~~CRITICAL ACCESS HOSPITALS, RURAL EMERGENCY HOSPITALS, AND OUTPATIENT EMERGENCY DEPARTMENTS WITHOUT ONSITE EMERGENCY MEDICINE PHYSICIANS~~ **TO ADVERTISE THAT THEY ARE STAFFED BY A BOARD-CERTIFIED OR -ELIGIBLE EMERGENCY PHYSICIAN WHERE CARE IS DELIVERED** ~~POST CLEAR SIGNAGE IN THE WAITING ROOM AND EXAM ROOMS NOTING THE LACK OF PHYSICIAN COVERAGE~~.

It was moved THAT THE WORDS "BOARD-CERTIFIED OR ELIGIBLE EMERGENCY" BE DELETED. The motion was not adopted..

The main motion was then voted on and adopted.

The committee recommended that Resolution 65 not be adopted.

It was moved THAT RESOLUTION 65 BE ADOPTED.

It was moved THAT RESOLUTION 65 BE TABLED. The motion was adopted.

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Christopher S. Kang, MD, FACEP, president-elect, addressed the Council.

Dr. Kraus reported that 429 councillors of the 433 eligible for seating had been credentialed.

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

There being no further business, Dr. Gray-Eurom adjourned the 2022 Council meeting at 5:46 pm on Friday, September 30, 2022.

The next meeting of the ACEP Council is scheduled for October 7-8, 2023, at the Philadelphia Convention Center in Philadelphia, PA.

Respectfully submitted,

Susan E. Sedory

Susan E. Sedory, MA, CAE
Council Secretary and Executive Director

Approved by,

Kelly Gray-Eurom, MD, MMM, FACEP

Kelly Gray-Eurom, MD, MMM, FACEP
Council Speaker