American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2023 Council Meeting

Preliminary Report of REFERENCE COMMITTEE C

Presented by: Daniel Freess, MD, FACEP – Chair

Madam Speaker and Councillors:

Reference Committee C gave careful consideration to the asynchronous testimony of the resolutions assigned to it and submits the following report and summary information for inclusion and consideration during live testimony.

RESOLUTION 43(23) Adopt Terminology "Unsupervised Practice of Medicine"

RESOLVED, That ACEP adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Summary of Asynchronous Testimony

Asynchronous testimony was exclusively in support. Testimony praised the resolution for providing clarification that "the independent practice of medicine by non-physicians is "unsupervised practice of medicine" and the phrase "unsupervised practice of medicine" accurately describes the reality of the practice environment.

RESOLUTION 44(23) Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management safe and effective, and patient-centered compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management safe, effective, and patient-centered compared to expectant management.

Summary of Asynchronous Testimony

Asynchronous testimony was almost exclusively in support of the resolution. Testimony in support highlighted the need for better information on the proactive management of early pregnancy loss. Members of the Clinical Policies Committee supported the intent of the resolution but pointed out that the critical questions as written would not produce clear recommendations because of the lack of comparative literature on the listed outcomes. Further testimony recommended that the resolution be withdrawn and combined with resolution #45 since both resolutions seek to achieve the same goals. In addition, amendments were requested to make the resolveds specific to emergency medicine. Finally, the aspect of a treatment being "patient centered" was eliminated as this is subjective and not something that the Clinical Policies Committee would comment upon.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is medication management initiated **in the emergency department by an emergency physician** safe~~,~~ **and** effective~~, and patient-centered~~ compared to expectant management?; and be it further

RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation on the following clinical question: For patients experiencing early pregnancy loss, is procedural management **in the emergency department by an emergency physician** safe~~,~~ **and** effective~~, and patient centered~~ compared to expectant management.

RESOLUTION 45(23) Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss

RESOLVED, That ACEP, ABEM, CORD and other relevant stakeholders, form a task force to determine the best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, including prescribing medication management (utilizing ACOG best practice approaches), and to provide or support provision of manual uterine aspiration procedural management, such that future emergency physicians will be able respond to early pregnancy loss emergencies in care settings where immediate obstetrical services may not be available; and be it further

RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and be it further

RESOLVED, That ACEP develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

Summary of Asynchronous Testimony

Asynchronous testimony was largely in support of the resolution. Testimony in support highlighted the need for better information on the proactive management of early pregnancy loss. Two amendments were recommended to the first resolved. The first amendment is to clarify that ACEP cannot make the decision for ABEM or CORD to participate on this task force and the second amendment is to give the task force the flexibility to determine which specific procedures it will explore. Further testimony recommended that the resolution be combined with resolution 44(23) since they both seek to achieve the same goals.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That ACEP~~, ABEM, CORD~~ ~~and~~ **work** with other relevant stakeholders~~,~~ **to** form a task force to determine the best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, ~~including prescribing medication management (utilizing ACOG best practice approaches), and to provide or support provision of manual uterine aspiration procedural management,~~ such that future emergency physicians will be able respond to early pregnancy loss emergencies in care settings where immediate obstetrical services may not be available; and be it further

RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no obstetrical services available; and be it further

RESOLVED, That ACEP develop a policy statement acknowledging the emergency physician's role in the management of emergency medicine patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

RESOLUTION 46(23) Consensus with ACOG on the Care of Pregnant Individuals with Substance Use Disorder

RESOLVED, That ACEP endorse the American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist; and be it further

RESOLVED, That ACEP issue a publicly available policy statement: "Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and the fetus. In states with legislation that punishes women for substance abuse during pregnancy, ACEP advocates for the retraction of such policies."

Summary of Asynchronous Testimony

Asynchronous testimony was generally in support. The consensus of the testimony was that emergency departments should play no role in or support state mandates that require the testing or reporting of pregnant people with suspected substance use disorder. Further testimony highlighted ACEP's unique position and ability to challenge and end mandates in states that have them. An amendment was proposed to combine both resolveds into the single resolved for ownership and clarity.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following substitute language be considered during live testimony.

RESOLVED, That ACEP create a policy statement on Care of Pregnant Individuals with Substance Use Disorder, based upon the "American College of Obstetricians & Gynecologists Committee Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist."

RESOLUTION 47(23) Clarification of and Taking a Position Against Use of Excited Delirium Syndrome

RESOLVED, That ACEP clarify its position in writing, that the 2009 white paper is inaccurate and outdated, and that while the ACEP Board of Directors had previously approved the 2009 White Paper Report on Excited Delirium, it has withdrawn such approval; and be it further

RESOLVED, That ACEP and its sections either remove or update content and/or literature on its website that relies on the outdated information regarding "excited delirium" or conditions with a similar definition as that described in the 2009 White Paper Report on Excited Delirium; and be it further

RESOLVED, That ACEP disseminate their position that they no longer endorse or approve the 2009 White Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations, and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation; and be it further

RESOLVED, That future ACEP work on the evaluation and management of in-hospital and out-of-hospital behavioral emergencies should utilize not only experts in emergency medical services, neurology, emergency psychiatry, and health equity, but must also consider the perspectives of community and advocacy leaders.

Summary of Asynchronous Testimony

Asynchronous testimony was primarily in support of the resolution citing that the information presented in the 2009 white paper has been misinterpreted and misrepresented to justify law enforcement and other authorities to justify the abuse of human beings. Opposition testimony pointed out that the issue lies not in the term "excited delirium" but how it is used by nonmedical professionals and mandating the restriction of the use of a term would set

a bad precedent as to which words or terms can or cannot be used by emergency physicians. Further testimony opposed to the resolution pointed out that much of the work the resolution requests has already been completed. Other testimony requested the last resolved be amended to give the creators of future work the flexibility to consider incorporating feedback if it adds value to the work.

RESOLUTION 48(23) Medical Malpractice Certificate of Merit

RESOLVED, That ACEP recommend an affidavit of merit must be from a doctor who is board certified and licensed in the same specialty.

Summary of Asynchronous Testimony

Asynchronous testimony was exclusively in support. Testimony pointed out that many unnecessary lawsuits against physicians would end early if the physician reviewing the case is merit certified in the same specialty. It was further noted that the way the current resolution is written, board certified emergency physicians would be unable to write an affidavit of merit for physicians working in the emergency department who are board certified in other specialties. The following amendment was proposed to clarify the resolved:

RESOLVED, That ACEP recommend an affidavit of merit must be from a doctor who is board certified and ~~licensed~~ **practicing** in the same specialty.

RESOLUTION 49(23) Patients Leaving the ED Prior to Completion of Care Against Medical Advice

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may 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 physicians and hospitals/systems share a joint responsibility to notify patients who have left prior to the completion of care regarding testing requiring intervention that results after their departure and develop reasonable systems to help communicate these results; and be it further

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

Summary of Asynchronous Testimony

Asynchronous testimony was overwhelmingly in support of the first and third Resolveds stating that the suggested document could be used for patient education and discussion with regulatory and legislative bodies as to what does and does not happen when a patient leaves the emergency department before their evaluation is complete. Testimony was nearly unanimous in opposing the second resolved citing that ACEP taking the position proposed may establish a legal precedent making an individual emergency physician whole or in part responsible for following up with patients who have chosen to leave prior to the completion of care.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may 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 physicians and hospitals/systems share a~~

~~joint responsibility to notify patients who have left prior to the completion of care regarding testing requiring intervention that results after their departure and develop reasonable systems to help communicate these results~~ **work with relevant stakeholders such as the AHA to create a document or tool outlining responsibilities and systems of communication for the conveyance of information about testing and follow up of patients who leave the emergency department prior to the completion of care**; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department prior to completion of care may 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 50(23) Metric Shaming

RESOLVED, That ACEP develop practices and policies to prevent the publishing, transmitting, and releasing of unblinded metric-related information about individual emergency physician performance to safeguard the welfare of our membership.

Summary of Asynchronous Testimony

Asynchronous testimony was generally in support. Those in favor of the resolution highlighted that unblinded metric-related information can be useful to improve performance and reach goals when shared privately and internally within a physician group. Those opposed to the resolution pointed out that sharing unblinded metric-related information allows for transparency and increased face validity. Others agreed to support the resolution if an amendment was made to specifically discourage the sharing of unblinded metric-related information outside the physician group without the individual physician's or group's consent.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That ACEP develop practices and policies to prevent the ~~publishing~~ **public or external publication**, ~~transmitting~~ **transmission**, and/or ~~releasing~~ **release** of unblinded metric-related information about individual emergency physician performance to safeguard the welfare of our membership.

RESOLUTION 51(23) Quality Measures and Patient Satisfaction Scores

RESOLVED, That ACEP advocate for alignment with current policy and previous recommendations that patient satisfaction surveys be extended to all categories of emergency department patients for true validity; and be it further

RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient satisfaction surveys until external validity can be established and their effect on patient outcomes is known; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to study the correlation (or lack of) between following Merit-based Incentive Payment System (MIPS) quality measures and patient satisfaction.

Summary of Asynchronous Testimony

Asynchronous testimony was exclusively in support. Testimony highlighted that the metrics from satisfaction surveys are biased and not scientifically or statistically valid, and often capture the patient's satisfaction with factors outside the control of an individual physician. An amendment was proposed to the second resolved and the addition of two resolveds directing ACEP to work to decrease or eliminate satisfaction surveys in reimbursement decisions and oppose the use of reimbursement metrics in employment decisions.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That ACEP advocate for alignment with current policy and previous recommendations that patient satisfaction surveys be extended to all categories of emergency department patients for true validity; and be it further

RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or dependent on patient satisfaction surveys ~~until external validity can be established and their effect on patient outcomes is known~~; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to study the correlation (or lack of) between following Merit-based Incentive Payment System (MIPS) quality measures and patient satisfaction; and be it further

RESOLVED, That ACEP work with relevant stakeholders to decrease or eliminate the role of patient satisfaction surveys in reimbursement decisions; and be it further

RESOLVED, That ACEP develop a policy opposing reimbursement metrics and employment decisions correlated with or dependent on patient satisfaction surveys.

RESOLUTION 52(23) Summit and New Tools for Transforming Acute Care

RESOLVED, That ACEP convene a task force focused on crafting new strategies, quality care, and performance metrics for creating new alternative care models; and be it further

RESOLVED, That ACEP report back to the 2024 Council meeting with a strategy for expanding and transforming acute care delivery in the community setting.

Summary of Asynchronous Testimony

Asynchronous testimony was mixed. Testimony pointed out that the task force being requested has already been created and the barriers to implementation come from the Medicare & Medicaid Innovation Center (CMMI), the Department of Health and Human Services (HHS), and the White House. Further testimony suggested that the resolveds be expanded to include addressing aspects of health equity in any Acute Unscheduled Care Model (AUCM) developed and that ACEP implement its already existing plan on alternative care models and focus on advocacy and coordination with other professional medical societies to lobby for an AUCM.

RESOLUTION 53(23) Treating Physician Determines Patient Stability

RESOLVED, That ACEP enact policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and be it further

RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce a treating emergency physician, to transfer a patient when the treating physician believes the patient is unstable for transfer and that a transfer may compromise a patient's safety; and be it further

RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that it is unethical for an emergency physician, who has not personally evaluated the patient, to threaten a financial penalty for further treating the patient claiming treatment constitutes "post-stabilization care" when the treating emergency physician believes a transfer or discontinuation of care may compromise a patient's safety.

Summary of Asynchronous Testimony

Asynchronous testimony was generally in support of the resolution. All testimony agreed that the treating emergency physician is best able to assess a patient's clinical presentation and stability for transfer; however, there was discussion regarding the last two resolveds. The authors of the resolution pointed out that the "Code of Ethics for Emergency Physicians" is currently undergoing revision and provides an opportunity to address the issues featured in the resolution. Further testimony suggested that the last two resolveds could be combined to request that a new policy statement on ethics be created.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That ACEP enact policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and be it further

~~RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce a treating emergency physician, to transfer a patient when the treating physician believes the patient is unstable for transfer and that a transfer may compromise a patient's safety; and be it further~~

~~RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that it is unethical for an emergency physician, who has not personally evaluated the patient, to threaten a financial penalty for further treating the patient claiming treatment constitutes "post-stabilization care" when the treating emergency physician believes a transfer or discontinuation of care may compromise a patient's safety.~~

RESOLVED, That ACEP develop an additional policy statement on ethical issues that speaks to the unethical nature of an emergency physician who has not personally evaluated the patient to coerce or threaten financial penalties to force the treating emergency physician to transfer a patient when the treating physician believes that the patient is unstable and such a transfer may compromise the patient's safety.

RESOLUTION 54(23) Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions

RESOLVED, That ACEP engage with The Joint Commission to oppose credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

Summary of Asynchronous Testimony

Asynchronous testimony was in support of the resolution. Although testimony was in support, it was noted that ACEP has engaged with this issue for quite some time with limited success, much of it being at the national level. Testimony suggested the need to expand ACEP's approach to include focusing on hospital credentialing committees and create educational references and talking points to assist physicians in lobbying hospital administrators to use board certifications such as ABEM to validate training, core competencies, and scope of care. Finally, there was a question of exactly what is meant by "new language and changes" such that clarity is requested by the authors.

RESOLUTION 55(23) Uncompensated Required Training

RESOLVED, That ACEP convene a working group to evaluate supporting fair compensation for required training, including accurate estimates of the time to completion, time to completion is fairly compensated, and in employed physician compensation models, the appropriate time is protected to allow for training without requiring completion during off hours; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

Summary of Asynchronous Testimony

Asynchronous testimony was exclusively in support. Testimony vehemently highlighted the excessive demands from organizations for uncompensated time-consuming non-value-added training and the power a collective voice from ACEP may have on changing these practices.

Based on the comments provided in the asynchronous testimony, the Reference Committee suggests the following amended language be considered during live testimony.

RESOLVED, That ACEP convene a working group to evaluate fair compensation for required training, ~~including~~ accurate estimates of the time to completion, **and** appropriate protected time ~~to allow~~ **allowances** for training without requiring completion during off hours; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

Madam Speaker, this concludes the preliminary report of Reference Committee C. I would like to thank Angela P. Cornelius, MD, FACEP; Joshua R. Frank, MD, FACEP; Patrick B. Hinfey, MD, FACEP; Jeffrey F. Linzer, Sr., MD, FACEP; Jennifer L. Savino, DO, FACEP; Jonathan Fisher, MD, FACEP; and Travis Schulz, MLS, AHIP, for their excellent work in developing this preliminary report.