

**ACEP 2018 EMRA Repco Meeting  
Reference Committee Report  
Monday, October 1, 2018**

#### **DEFINITIONS OF AVAILABLE COUNCIL ACTIONS**

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

##### **ADOPT**

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

##### **ADOPT AS AMENDED**

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

##### **REFER**

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

##### **NOT ADOPT**

**Defeat (or reject) the resolution in original or amended form.**

Mr. Speaker, your reference committee submits to the council to following recommendations on resolutions referred to the council for consideration.

### **Unanimous Consent Agenda**

#### **To adopt**

- Resolution 2: The Emergency Medicine Workforce
- Resolution 4: Increasing Emergency Medicine Clerkship Opportunities for Medical Students
- Resolution 7: Systems-Building for Critical Illness and Injury: Improving Bystander Intervention in Out-of-Hospital Critical Illness and Injury
- Amended Resolution 9: Telemedicine oversight for Mid-level Providers

#### **To not-adopt**

- Resolution 1: Leave Policy for EM Residents
- Resolution 3: The Emergency Medicine Workforce

### **Non-consent recommendations**

#### **Recommendation to adopt:**

- Amended Resolution 5: Firearm Safety and Injury Prevention
- Amended Resolution 6: Maintenance of Certification
- Amended Resolution 8: Support for Point of Care Ultrasound Training in Undergraduate Medical Education

#### **Recommendation to not adopt:**

- Resolution 10: Board Compensation Bylaw Change
  - Amended Resolution 11: Bylaws Amendment: Inactive Members' Rights on Serving on Committees
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### **Resolution 2: The Emergency Medicine Workforce**

#### **RECOMMENDATION TO ADOPT:**

RESOLVED, that a new section of the policy compendium be created called "The Emergency Medicine Workforce" and that it and existing Section III Policy IV - "Board Certification" be amended by addition and deletion divided as follows:

#### **New Section: The Emergency Medicine Workforce**

#### **IV. Board Certification Policy I. The Physician Led Workforce**

Only physicians who have completed an ACGME or AOA accredited emergency medicine residency program should be eligible for emergency medicine board certification. That certification should only be obtained through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM). EMRA believes that the only pathway to the independent practice in of emergency medicine in the 21st century is the completion of an ACGME/AOA accredited emergency medicine residency training program and board certification by ABEM or AOBEM. Only those physicians who are board certified or board eligible should be considered as part of the Emergency Medicine Physician workforce.

## II. Board Certification Supersedes Medical Merit Badges

EMRA believes that completion of residency training and board certification by ABEM or AOBEM replaces the need for any third-party credentialing requirements, such as medical merit badge courses (ie: ACLS, ATLS, PALS, NRP) or condition-specific CME requirements. *[restated policy moved from below]*

### Section III: Healthcare

#### Policy IV. Board Certification Medical Merit Badges During Residency Training

EMRA recognizes that while medical merit badge courses such as ACLS, PALS, NRP, CPR, and ATLS may offer valuable content, the knowledge provided by these courses is fundamental to the core content of emergency medicine residency training. Completion of residency and subsequent ABEM/AOBEM certification replaces the need for any third-party credentialing requirements (medical merit badge courses or condition-specific CME requirements). *[moved to section above]* While attendance of these courses may provide useful knowledge and a base for junior residents and medical students and may play a role in the curriculum, they should only be considered a starting point rather than an ending point in residency training. These medical merit badge courses or other such courses should not be required for clinical training as a resident in emergency medicine or as a prerequisite for employment after completion of residency.” Be it further

RESOLVED, that “Section IV: Education and Professional Development, Policy XLI. Role of Physician Extenders in Emergency Medicine” be moved to a new section called “The Emergency Medicine Workforce” and amended by addition and deletion as follows:

#### “Section III: The Emergency Medicine Workforce

#### XLI Role of Non-Physician Extenders Providers in Emergency Medicine

EMRA believes that there exists within medicine a group of health care providers whose role is to serve as a mid-level adjunct to patient care by physicians. Included in this group are Physician Assistants and Nurse Practitioners.

EMRA believes that these mid-level providers serve an important, supportive role in providing care within the United States Healthcare System. physician assistants and nurse practitioners are valued-members of the health care team who under the direct supervision of an onsite board-certified, residency-trained emergency physician can provide care for patients seen in the emergency department.

EMRA believes that physician organizations should play an active role in determining the minimum acceptable standards for the education, licensing, and determination of scope of practice of mid-level non-physician providers is the responsibility of physician organizations, in order to guarantee consistency, reliability, and quality of mid-level skills and training. Thus, those same entities that define the education and practice parameters for physicians, should likewise define the education and practice parameters for mid-level providers.to ensure that patients continue to receive high-quality, high-value, evidence-based, patient-centered care in the emergency department.

Physician organizations should work with government agencies, hospitals, licensing boards, and midlevel provider organizations to ensure that the scope of these providers remains strictly defined, thereby ensuring continued high quality emergency health care.

EMRA firmly believes that the specific role of mid-level providers within any given Emergency Department should be defined by the Emergency Physician with continued oversight by an Emergency Physician.”*[incorporated above]*. Be it further

RESOLVED, that existing “Section III: Healthcare, Policy X. Use of the Title ‘Doctor’ in the Clinical Setting” be moved to new section called “The Emergency Medicine Workforce” and amended by addition and deletion as follows:

### **“The Emergency Medicine Workforce**

#### **X Use of the Title “Doctor” in the Clinical Setting**

EMRA supports policies, regulations, and legislation restricting the use of the term “doctor” in the clinical setting (except for those settings in which a patient does not expect to be seen by a physician) to individuals who are licensed physicians.” Be it further

RESOLVED, that existing “Section IV: Education and Professional Development, Policy XIV. Education in Practice Opportunities” be moved to new section called “The Emergency Medicine Workforce” and amended as such:

## **“The Emergency Medicine Workforce**

### **XIII. Education in Practice Opportunities**

Both EMRA and individual residency programs should provide Residents should receive information regarding diverse resident education about the diversity of practice opportunities and environments available to them including the variety of practice types and setting. This should include information about contracts, financial arrangements, academic careers, rural opportunities and group practices.” Be it further

RESOLVED, that “Section IV: Education and Professional Development, Policy XXIV. Medical Licensure” be amended by deletion

### **XXIV. Medical Licensure**

EMRA will advocate that state medical boards maintain the requirements for unrestricted medical licensure as one or two years of post-graduate training and passage of USMLE Step 3/COMLEX Level 3.

References: None

Relevant EMRA policy: Stated above where applicable

Financial Note: Minimal, this is a change in policy only.

### **Testimony**

This resolution serves mainly to reorganize and streamline the policy compendia and thus there was little debate on its merits during the town hall. With this in mind, the committee recommends that this resolution be adopted and included as part of the consent agenda.

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## **Resolution 4: Increasing Emergency Medicine Clerkship Opportunities for Medical Students**

### **RECOMMENDATION TO ADOPT**

**Resolved** that EMRA support the creation and expansion of policies and opportunities aimed at exposing medical students to the field of emergency medicine, including but not limited to elective and mandatory clerkships before the final year of medical school.

**Resolved** that EMRA advocate for the removal of currently existing caps on the number of Emergency Medicine Elective rotations allowed to senior medical students.

**Testimony:**

Testimony was overwhelmingly supportive of the resolution with minimal recommendations for change in the text of the resolution. With this in mind, the reference committee recommends adoption as part of the consent agenda.

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**Resolution 7: Systems-Building for Critical Illness and Injury: Improving Bystander Intervention in Out-of-Hospital Critical Illness and Injury****RECOMMENDATION TO ADOPT:**

**RESOLVED** that EMRA

shall amend Policy Compendium Section III, Policy XIV by addition and deletion as follows:

**Systems-Building for Critical Illness and Injury: Improving Bystander Intervention in Out-of-Hospital Critical Illness and Injury**

EMRA will support increased access to and utilization of cardiopulmonary resuscitation, and first aid training programs, [direct pressure hemorrhage control, and training with tourniquets](#) by the public, and support targeted campaigns in high-risk populations to reduce disparities in survival from critical illness and injury, and collaborate with public health departments, schools, and other stakeholders to accomplish these goals.

**TESTIMONY:**

Testimony was overwhelmingly supportive of the resolution with minimal recommendations for change in the text of the resolution. With this in mind, the reference committee recommends adoption as part of the consent agenda.

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**Resolution 9: Telemedicine oversight for Mid-level Providers****Recommendation to adopt as amended:**

Resolved that EMRA amend their policy on telemedicine to read as follows:

“L. Support for Telemedicine in EM  
EMRA will:

1) Support telemedicine training opportunities for emergency medicine residents where available and appropriate.

- 2) Encourage interstate licensure compacts to allow physicians to provide services across state lines.
- 3) Support reimbursement policies that promote current practice of and future innovations in telemedicine.
- 4) Work with relevant stakeholders to support the creation and implementation of a teleconsult system for those critical access areas where only mid-level provider or non-EM boarded physician may be available.”

#### **TESTIMONY:**

“EMRA firmly believes that the specific role of mid-level providers within any given Emergency Department should be defined by the Emergency Physician with continued in person oversight by an Emergency Physician.”

Discussion: Limited discussion was had on this issue, but centered around the need to create the system we were asking to support. There was also concern that by acknowledging in our policy compendium that non-EM board certified physicians work in critical access ED that could be construed as support of the practice.

Though it was not discussed during the reference committee hearing, the committee noted that this policy may be seen as inconsistent with current EMRA policy which states:

“EMRA firmly believes that the specific role of mid-level providers within any given Emergency Department should be defined by the Emergency Physician with continued in person oversight by an Emergency Physician.”

However, since the proposed policy only addressed critical access hospitals, it was felt by the committee that this could be seen as addressing a separate issue to the prior policies (critical access vs non-critical access) and thus, congruent with current policy.

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### **Resolution 1: Leave Policy for EM Residents**

#### **Recommendation to not adopt.**

**RESOLVED,** To amend the EMRA Family Leave policy by addition of the following:

#### **“Family Leave**

Policy EMRA believes that emergency medicine residency programs should have a clear policy on maternity/paternity leave, rights and responsibilities under the Family Medical Leave Act, and that programs provide this policy to residents and applicants, and made publicly available.

EMRA also believes that programs should address coverage expectations and remuneration in their residency employment contracts.

The Family Medical Leave Act provides a framework for extended time away from all forms of employment, including residency training. According to the ACGME guidelines, such leave may extend the length of training beyond the initial 36 month (or 48 month) requirement. [According to ABEM guidelines, residents must complete at least 46 weeks of training in each residency level. EMRA believes that vacation time, sick time, leaves of absence, should be allowed to accrue from year to year such that an average of 46 weeks of training are successfully completed by the completion of a three of four year residency. Thus, if new parents exceed six weeks of leave time in one academic year, he or she can take less than leave time in the subsequent academic years such that if the average leave does not exceed six weeks per year, he or she should not require an extension of residency training.](#)

Although most residents are aware that they can take maternity/paternity leave, most programs do not provide clear procedures on maternity/paternity leave, the FMLA, and the impact on residents. Other residents are often asked to cover clinical responsibilities beyond their assigned schedule. This extra clinical time may negatively impact the education of those residents.

EMRA believes that programs should develop a comprehensive policy regarding coverage for a resident on leave. This policy should detail how a resident on leave makes up for missed clinical time in a non-punitive manner. It should also include specifics of how coverage will be provided. Options to provide this coverage should include the possibility of staffing sources other than residents. If a resident provides coverage, such activity should be voluntary and not compromise their education. Residents providing coverage should be compensated in fair and equitable manner.

EMRA believes that access to maternity/paternity leave should be equal for men and women with newly born or adopted children. EMRA further believes that individuals taking maternity and paternity leave should be paid for part or all of these leaves. EMRA should work with local, state, and federal policymakers to advocate for paid leave for physicians, physicians-in-training, and all persons.” Be it further

**RESOLVED,** That EMRA work with ABEM to modify the “Policy on Emergency Medicine Residency Training Requirements” to allow residents to accrue leave time (including vacation, sick time, parental leave, leaves of absence) from year to year.

**TESTIMONY:**

There may be unintended consequences for residents given the resolution as it is currently written. By rejecting this resolution EMRA, ABEM, and other stakeholders will be able to form a task force to determine what language would capture the same spirit of this resolution while also shielding residents from possible unintended consequences.

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### **Resolution 3: The Emergency Medicine Workforce**

#### **RECOMMENDATION TO NOT ADOPT:**

RESOLVED, that EMRA bring forth a resolution in the ACEP Council requesting revision of ACEP's Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department to include provisions on optimal supervision depending upon practice environment; AND BE IT FURTHER

RESOLVED, that EMRA bring forth a resolution in the ACEP Council to create a campaign to communicate the value of residency-trained, board-certified Emergency Medicine Physicians to the government agencies, hospitals, insurance companies, and the general public; AND BE IT FURTHER

RESOLVED, that EMRA bring forth a resolution to the ACEP council requesting that ACEP develop a consensus-based Emergency Medicine workforce research agenda to exemplify the workforce needs and value of residency-trained, board-certified Emergency Medicine Physicians.

#### **TESTIMONY:**

Reject the first and third resolve clauses in that they are redundant: these processes are already being carried out by ACEP. Given that there is an ACEP task force working on this issue now, we will leave it to their discretion on how best to promulgate information regarding the importance of having EM trained board-certified physicians staffing emergency departments.

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## **END OF CONSENT AGENDA**

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### **Resolution 5: Firearm Safety and Injury Prevention**

#### **Recommendation to Adopt as Amended.**

**RESOLVED**, that EMRA

1) Modify Policy Compendium Section III Policy VII. "Gun Violence Research" be renamed to "Firearm Safety and Injury Prevention" and

2) [EMRA-will actively promote regulatory, legislative, and public health efforts that:](#)

- [Improve public and privately funded research on firearm safety and injury prevention;](#)
- [Support repeal of the Dickey Amendment, which directly influences funding allocated to firearm-related research;](#)

- Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm related injuries;
- Investigate the effect of socioeconomic and other cultural risk factors on firearm injury and provide public and private funding for firearm safety and injury prevention research;
- Strengthen universal background checks for all firearm purchases;
- Restrict sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use;
- Promote access to effective, affordable, and sustainable mental health services;
- Never prevent physicians from educating and discussing with their patients the use of firearms, prevention of injury, both intentional and unintentional, and means to safeguard weapons;
- Support a high standard of firearm safety and operation training for firearm purchase similar to that of the United States Armed Forces;

EMRA will collaborate with other organizations and coalitions to study the health impact of ~~gun violence~~ ~~firearm safety~~ and make efforts to educate their members, the medical community, the public, and any interested parties on the results of any significant studies on the health impact of ~~gun violence~~ ~~firearm safety~~ .”

#### **TESTIMONY:**

Discussion for this resolution as a whole was generally in support of the resolution, with some changes. Discussion supported the strike out of proposed language in line 64 “similar to that of the United States Armed Forces”. Discussion was mixed regarding striking out lines 56-58 that list specific policies that EMRA would support. It was noted that the policies listed in lines 56-58 are basic policies that would essentially bring EMRA up to date and in line with other national health care organizations have already publicly endorsed similar firearm safety policies. There was request that the terms “gun violence” in the final sentence be changed to “firearm safety” to promote consistency with pre-existing language.

There was also discussion about adding language to support existing legislation that prohibits individuals under the age of 21 from buying a gun. There was extensive discussion about this addition, and participants were both strongly in favor and strongly in opposition of this additional language. As there was not a clear consensus among participants regarding the addition of this language, it was not included.

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### **Resolution 6: Maintenance of Certification**

#### **Recommendation to Adopt as Amended.**

**RESOLVED**, EMRA will support ~~advocacy for~~ the ability of hospitals to require maintenance of the Board Certification when obtaining and retaining hospital privileges-, ~~E~~Ensuring patients presenting to emergency departments during their time of greatest need will receive high quality care from a physician who is committed to life-long learning and ongoing practice improvement. EMRA supports longitudinal MOC processes with more frequent check-ins as opposed to infrequent high stakes exams.

## TESTIMONY:

Discussion participants were generally in favor of this resolution. There was a recommendation to fix the grammar in the second sentence fragment. There was also discussion by an individual to remove the language about hospitals in the first line of the resolved statement, however this was not backed up with further discussion. As there was not clear consensus about whether this additional edit was supported, it was not included.

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## Resolution 8: Support for Point of Care Ultrasound Training in Undergraduate Medical Education

### Recommendation to Adopt as Amended.

**RESOLVED** that EMRA supports the integration of point of care ultrasound curricula into undergraduate medical education; and be it further

~~**RESOLVED**, that EMRA supports the establishment of national standards for undergraduate medical education ultrasound curricula; and be it further~~

**RESOLVED**, that EMRA will collaborate with other organizations including, but not limited to, the American Institute of Ultrasound in Medicine (AIUM) and the Society of Ultrasound in Medical Education (SUSME) to craft guidelines describing the content of a complete undergraduate medical education ultrasound curriculum.

**RESOLVED**, EMRA supports further research into the benefits of ultrasound education in undergraduate medical education.

## TESTIMONY:

Generally, discussion was in support of this resolution. There was a general consensus that ultrasound is valuable for many different fields of medicine, and should be included in undergraduate medical education. There was a recommendation that the second resolved clause be removed secondary to financial cost of this endeavor and lack of existing national standards. It was also recommended that the fourth resolved clause be added, which was generally a well received idea by discussion participants. Due to the lack of national standards, further research is necessary to elucidate the benefits of this additional training in order to further advocate for this in the future.

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## Resolution 10: Board Compensation Bylaw Change

### Recommendation to not Adopt.

**RESOLVED** that EMRA will amend Article IV, section 6 of its bylaws to read as follow:

~~“Officers and directors of the Association shall not receive any compensation for their services, other than reimbursement for expenses.”~~ may be compensated, the amount and manner of which shall be determined annually by a Compensation Committee. This committee shall be appointed by the President and composed of the chair of the Finance Committee plus four members of the Association who are currently neither officers nor members of the Board of Directors.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Association at the next meeting of the Association. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of representatives voting at the next meeting. If the Representative Council does not ratify the Board’s proposed compensation, the Compensation Committee’s recommendation will then take effect.”

References: Article 11, Section 7, ACEP Bylaws:

“Section 7 — Compensation Committee

College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board’s proposed compensation, the Compensation Committee’s recommendation will then take effect.”

Bock B. "Report of the House of Delegates Committee on Compensation of the Officer." *AMA HOD A-18 Proceedings*. Internet. June 2018. <https://www.ama-assn.org/sites/default/files/media-browser/public/hod/a18-house-committee-reports.pdf>

## **TESTIMONY:**

There was much discussion for and against this resolution. The spirit of this resolution was wholeheartedly supported. The hidden costs of being a national representative with EMRA may prohibit well qualified members from running for positions secondary to financial constraints or concerns. Adopting this policy or one similar would promote diversity, which was unanimously agreed on as a good thing moving forward. However, this resolution, as worded, does not provide clear checks and balances for the allotment of funds for EMRA board member compensation. This was very concerning for many members, and therefore a consensus was not reached. As such, the reference committee is recommending this resolution not be adopted so that the language can be clarified to include true checks and balances regarding the allotment of funds to EMRA's national leadership. One recommendation discussed during the reference committee meeting included that the final report written by the compensation committee on a yearly basis would be approved by the representative council. Recommended language includes:

~~"Officers and directors of the Association shall not receive any compensation for their services, other than reimbursement for expenses. may be compensated, the amount and manner of which shall be determined annually by a Compensation Committee. This committee shall be appointed by the President and composed of the chair of the Finance Committee plus four members of the Association who are currently neither officers nor members of the Board of Directors.~~

The Committee shall present an annual report to the Representative Council recommending the level of total compensation for the Board of Directors for the following year. The recommendations of this report may be adopted, not adopted, or referred back to the Compensation Committee.

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## **Resolution 11: Bylaws Amendment: Inactive Members' Rights on Serving on Committees**

### **Recommendation to not adopt**

Resolved that EMRA shall adopt the following changes to the EMRA bylaws:

### **ARTICLE III MEMBERSHIP**

## Section 2.7 — Inactive Members

### Section 2.7.1 — Qualifications

Medical school graduates who have not yet secured emergency medicine residency training positions are eligible for inactive membership. This includes, but is not limited to, persons taking time off for personal reasons, performing research, or obtaining an additional degree or further education. In addition, members who are temporarily unable to continue professional training during residency or fellowship may, upon application, be elected to inactive membership by the Board of Directors. Inactive members will become active members upon the first day of their return to an emergency medicine residency training program. Election to inactive membership shall be for the period remaining in the current fiscal year. Inactive members shall not be allowed to vote, hold office, or serve in EMRA leadership positions.

### Section 2.7.2 — Rights

Inactive members shall be entitled to attend and address meetings of the Association, **and to sit on committees**. Inactive members shall not be entitled to vote, ~~to sit on committees,~~ or to hold office.

## **TESTIMONY:**

It was noted by the author of the resolution, after discussion with the Executive Committee, that this bylaw change would not allow for an inactive member to serve as a Vice-Chair of a committee. As such, the committee recommends this bylaw change not be adopted.

If this recommendation is followed, the committee has the following suggested amendment to be the basis for a “bylaw amendment under initial consideration”

## **“ARTICLE III MEMBERSHIP**

### **Section 2.7 — Inactive Members**

#### **Section 2.7.1 — Qualifications**

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residency training program. Election to inactive membership shall be for the period remaining in the current fiscal year. ~~Inactive members shall not be allowed to vote, hold office, or serve in EMRA leadership positions.~~

#### Section 2.7.2 — Rights

Inactive members shall be entitled to attend and address meetings of the Association, ~~and to sit on committees.~~ Inactive members shall not be entitled to vote, ~~to sit on committees,~~ or to hold office.”