Policy Compendium

March 2025

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Section I – Introduction

This document is the summation of all policies adopted by the Emergency Medicine Residents' Association Representative Council and/or Board of Directors. This document has been completely reviewed and approved by the EMRA Representative Council and Board of Directors.

Legend:
BOD = EMRA Board of Directors
RC = EMRA Representative Council

Section II – Emergency Medicine Workforce

I. 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.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/01
Amended and Reaffirmed, 3/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Amended & Reaffirmed RC, 6/11
Reaffirmed RC, 5/12
Amended and Reaffirmed BOD 5/13
Amended BOD, 12/16
Amended BOD, 1/18
Amended RC, 10/18
Reaffirmed RC, 10/23

II. Clarity of Titles

EMRA believes that the use of the unqualified terms "resident" and "residency", "fellow" and "fellowship" in the emergency medicine clinical setting should connote a physician with acceptance, enrollment, and participation in a nationally accredited allopathic, osteopathic, dentistry, or podiatry residency program, or a pharmacist enrolled in an accredited pharmacy residency program.

Original policy adopted BOD, 9/20

III. Code of Ethics for Emergency Physicians

The basic professional obligation of beneficent service to humanity is expressed in various physicians' oaths. In addition, emergency physicians assume more specific ethical obligations that arise out of the special features of the practice of emergency medicine. The principles listed

below express fundamental moral responsibilities of emergency physicians and shall be exemplified by EMRA members.

Emergency physicians shall:

A. Embrace patient welfare as their primary professional responsibility.
B. Respond promptly without prejudice or partiality, to the need for emergency medical care.
C. Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
D. Communicate truthfully with patients and secure their informed consent for treatment unless the urgency of the patient's condition demands an immediate response.
E. Respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law.
F. Deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired, incompetent, or who engage in fraud or deception.
G. Work cooperatively with others who care for, and about, emergency patients.
H. Engage in continuing study to maintain the knowledge and skills necessary to provide high quality care for emergency patients.
I. Act as responsible stewards of the health care resources entrusted to them.
J. Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and increase access to emergency and other basic health care for all.

Original Policy adopted BOD, 10/05
Reaffirmed BOD, 1/06
Amended and Reaffirmed RC, 6/10
Reaffirmed BOD, 3/15
Amended and Reaffirmed BOD, 8/20

IV. Diversity and Inclusion

EMRA recognizes and supports diversity and inclusion for medical students and EM physicians-in-training on the basis of gender, race ethnicity, sexual identity, sexual orientation, age socioeconomic status, religion, cultural, disability, spirituality, and other characteristics through education, collaboration, advocacy, and research. EMRA will create and maintain a committee to ensure advocacy for increasing diversity and inclusion in emergency medicine for medical students, residents, fellows and faculty. EMRA will consider diversity and inclusion of all types for all future EMRA initiatives and will support new initiatives aimed to increase diversity and inclusion in Emergency Medicine.

Original policy adopted by RC, 10/16
Amended BOD, 1/18
Reaffirmed RC, 10/23

V. Education in Practice Opportunities

Both EMRA and individual residency programs should provide resident education about the diversity of practice opportunities and environments available to them. This should include information about contracts, financial arrangements, academic careers, rural opportunities and group practices.

Original policy adopted, 3/92

Amended and Reaffirmed, 1/97
Reaffirmed, 1/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 5/12
Reaffirmed RC, 10/18
Amended RC, 10/18
Reaffirmed RC, 10/23

VI. Employment Rights of the Emergency Physician

EMRA believes that emergency physicians should be protected by due process rights in their employment contracts.

Original policy adopted RC, 3/20

VII. International Emergency Medicine

EMRA recognizes foreign medical graduates (FMGs) for their important contributions to the health care workforce.

EMRA recognizes the value of FMG physicians who work in underserved areas in the US and supports opportunities for collaboration between International and US emergency medicine residents.

Original policy adopted RC, 5/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 6/11
Amended BOD, 1/18
Amended RC, 9/24

VIII. Licensing Exam Parity for Emergency Medicine Resident Selection and Evaluation Process

EMRA promotes equal acceptance and consideration of the USMLE and COMLEX-USA at all United States emergency medicine residency programs.

Original policy adopted RC, 3/20

IX. Medical Merit Badges During Residency Training

EMRA believes that while medical merit badge courses such as ACLS, PALS, NRP, CPR, and ATLS may offer educational value, the knowledge provided by these courses is already fundamental to the core content of emergency medicine residency training and certification in 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.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/01
Amended and Reaffirmed, 3/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Amended & Reaffirmed RC, 6/11
Reaffirmed RC, 5/12
Amended and Reaffirmed BOD 5/13
Amended BOD, 12/16
Amended BOD, 1/18
Amended RC, 10/18

Amended and Reaffirmed BOD, 3/24

X. Nourishment and Hydration While on Duty

EMRA supports adequate accommodations to allow for the consumption of food and drink in the workplace.

EMRA supports policies that encourage appropriate nourishment and hydration for emergency medicine residents and medical students while working.

Original policy adopted RC, 10/20

XI. Occupational Exposure

EMRA will unequivocally support easy and unconditional access to PPE for residents, medical students, and other EM physicians caring for patients in the Emergency Department.

EMRA will support a resident's and medical student's choice to use PPE not provided by a hospital that meets or exceeds the minimum institutional standards if they do not feel adequately protected by the PPE provided by their institution.

Original policy adopted RD, 10/20

XII. Equitable Occupational Protection Measures for Emergency Medicine Trainee

EMRA supports the protection of medical trainees including residents, fellows, and medical students from occupational exposure including but not limited to open, timely, and free access to relevant PPE, vaccinations, and any other protections from occupational exposures, both routine and public health emergency-related, facilitated by their training institutions and in a situation of scarcity of such protective measures, supports the prioritization of and early allocation to all medical trainees, particularly those practicing in high-risk clinical environments.

Original policy adopted RC, 3/22

XIII. Procedural Sedation

EMRA believes:

A. That graduates of accredited emergency medicine residency programs possess the medical knowledge and procedural skills necessary to safely administer procedural sedation, without the need for additional credentialing requirements.
B. That graduates of accredited emergency medicine residency programs should have the ability to choose among the full breadth of pharmacologic agents available for procedural sedation, including but not limited to opioids, benzodiazepines, barbiturates, ketamine, propofol, dexmedetomidine, etomidate, and nitrous oxide.

Original policy adopted RC, 4/18
Reaffirmed RC, 10/23

XIV. Role of Non-Physician Providers in Emergency Medicine

EMRA believes that the gold standard of emergency care is real-time, on-site care provided, or supervised, by a board-certified/board-eligible (BC/BE) emergency physician. Where this is not possible, we support real-time tele-supervision of non-physician providers (NPPs) by BC/BE emergency physicians.

The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means are as follows:

- Critical Access Hospitals (CAHs)
- Rural Emergency Hospitals (REHs)

EMRA believes that physician assistants and nurse practitioners are valued-members of the health care team who, under direct supervision of board-certified/board-eligible emergency physicians, 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 non-physician providers to ensure that patients continue to receive high-quality, high value, evidence-based, patient-centered care in the emergency department.

Original policy adopted, 6/01
Reaffirmed BOD, 1/06
Amended and Reaffirmed RC, 5/08
Original policy sunsetted RC, 6/11
New policy adopted RC, 6/11
Amended RC, 5/17
Amended RC, 10/18
Amended RC, 3/22

XV. Scribes in the Emergency Department

EMRA supports resident use of scribes in the Emergency Department

Original policy adopted RC, 5/12
Amended and Reaffirmed, 10/18
Amended and Reaffirmed RC, 10/23

XVI. The Physician Led Workforce

EMRA believes that the only pathway to the independent practice of emergency medicine in the 21st century is completion of an ACGME accredited emergency medicine residency training program and board certification by ABEM or AOBEM.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/01
Amended and Reaffirmed, 3/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Amended & Reaffirmed RC, 6/11
Reaffirmed RC, 5/12
Amended and Reaffirmed BOD 5/13
Amended BOD, 12/16
Amended BOD, 1/18
Amended RC, 10/18
Amended and Reaffirmed RC, 10/23

XVII. 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 to individuals who are licensed physicians.

Original policy adopted RC, 5/13
Amended RC, 10/18

Reaffirmed RC, 10/23

XVIII. Violence in the ED

The Emergency Medicine Residents Association (EMRA) believes in upholding legal penalties for verbal threats, physical violence, or any other form of assault against medical students, Emergency Medicine staff or learners.

EMRA advocates for increased awareness of this problem and increased safety measures in all emergency departments, including prevention and enforcement of legal penalties.

Original policy adopted RC, 6/10
Reaffirmed BOD, 3/15
Amended and reaffirmed BOD, 8/20

XIX. Workplace Violence and Residency Safety in the Emergency Department

EMRA:

- Rejects the notion that experiencing violence and harm as an emergency medicine professional is “part of the job.”
- Advocates for protection of emergency medicine physicians-in-training through structural improvements to security and safety in EDs.
- Supports training residents in conflict resolution, de-escalation, and self-defense
- Partners with the American College of Emergency Physicians (ACEP) to identify educational and practical resources addressing workplace violence that may be disseminated to members.
- Calls for research and dissemination of best practices for preventing and addressing workplace safety in response to violence in EDs.
- Suggests that ACEP work with the AMA to advocate for a streamlined mechanism to report incidents within EDs to an appropriate centralized source, and to address liability issues that stem from these violent encounters.
- Advocates for protected time off and, when appropriate, disability insurance programs to assist residents who face physical or emotional harm.
- Supports a zero-tolerance policy with regard to violence from patients towards healthcare workers, including a process to safely treat or, if indicated, discharge patients who threaten or commit acts of violence toward ED staff.

Original policy adopted RC, 3/22

XX. Restrictive Covenants and Non-Competes

EMRA opposes restrictive covenants upon emergency physicians which prevent them from working clinically at any location or facility for any period of time, regardless of geographical or temporal proximity to a prior place of employment, while supporting reasonable non-disclosure and non-solicitation agreements.

Original policy adopted RC, 3/22

XXI. Mental Health

EMRA continues to support medical students and physicians with mental illness, and advocates for free or affordable mental health resources provided by their institutions

EMRA supports the removal of questions on medical licensure applications related only to mental health and not the ability to perform the professional and ethical duties of a physician, as these may act as a barrier to physicians and medical students seeking mental health care.

Original policy adopted RC, 3/22

Section III: Healthcare System

I. Boarding and Diversion

EMRA encourages exploration of new, alternative, and creative solutions to help minimize the need for diversion. This includes the hospital finding ways to expedite patient admission and decreasing emergency department holding times. Solving this problem requires significant national and local support that focuses on resolving this complicated issue.

Original policy adopted, 5/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Amended and Reaffirmed BOD, 5/08
Reaffirmed RC, 6/11
Reaffirmed RC, 10/18
Reaffirmed RC, 10/23

II. Palliative Care in the Emergency Department Setting

EMRA recognizes the importance of formal training in palliative care to Emergency Medicine Residents given that palliative care topics such as symptom management and goals of care discussions are skills that require training and practice.

EMRA supports increased access to palliative care in the emergency department for patients with serious illness or chronic conditions.

EMRA encourages treatment and interventions that: align with the patient's identified goals and values, employ shared decision-making with the patient or their surrogate if the patient lacks decision-making capacity, and use plain language comprehensible at the patient's health literacy level.

Original policy adopted RC, 10/12
Reaffirmed RC, 10/18
Amended RC, 9/24

III. Pharmaceutical Drug Pricing

EMRA firmly believes that unaffordable prices of medications used to treat acute and chronic disease pose a threat to our patients and impose challenges on the emergency medical system. EMRA further believes that prescription medications should be affordable and fairly priced.

EMRA will advocate for policies that:

A. Improve the transparency of drug pricing
B. Support value-based pharmaceutical pricing
C. Advocate to abolish all current statutes prohibiting CMS from negotiating lower drug prices for its beneficiaries
D. Facilitate bulk purchasing arrangements
E. Explore the lawful importation of drugs from other countries so that prices remain competitive while preserving innovation for drug makers

Original policy adopted RC, 5/17
Amended BOD 10/17
Amended BOD, 3/18
Amended and Reaffirmed RC, 10/23

IV. Protecting Access to Women's Health, Reproductive Health, and Organizations That Provide Increased Health Access to Women

EMRA will advocate for policies that protect access to women's health care including reproductive health care. Support increased funding for organizations that provide access to reproductive care. Support continued health coverage for reproductive health care regardless of gender identity

EMRA collaborates with ACEP to develop policy stating that EMTALA apply to all emergency medical conditions and there should be no exceptions to EMTALA for any specific emergency medical condition or the evidence-based treatment that would be used to stabilize a patient, especially with state-level abortion restrictions that conflict with EMTALA-mandated care, including those that prevent hospitals from providing abortions as a necessary stabilizing treatment in emergency situations

EMRA supports the legal protection of physicians in providing stabilizing care in emergency settings, including abortion, without the risk of criminal prosecution or loss of medical licensure.

EMRA encourages collaboration with ACEP on developing policies that protect access to comprehensive reproductive healthcare services for patients, including emergency contraception and abortions.

EMRA reinforces the need to prevent any interference by the government or third parties that forces a physician to compromise their medical judgment regarding the best treatment for their patient.

Original policy adopted RC, 5/17
Reaffirmed RC, 10/22
Amended RC, 9/24

V. Social Work in the Emergency Department

EMRA promotes the consistent inclusion of social workers and/or care coordinators in the team of clinicians caring for patients in the ED.

EMRA supports resident education on and access to social workers and/or care coordinators in the ED at all emergency medicine residency training programs.

Original policy adopted RC, 10/19

VI. Support for Infrastructure and Regulations Related to Freestanding ED's and Care Coordination

EMRA will support the creation of policies and infrastructure development locally and regionally that allows for Freestanding Emergency Departments (FSED) to serve as appropriate stabilizing care for sudden onset life-threatening illness and the safe transfer of patients from FSEDs to facilities able to offer definitive care and long-term management.

Original policy adopted RC, 5/17
Reaffirmed RC, 10/22

VII. 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, 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 relevant stakeholders to accomplish these goals.

Original policy adopted RC, 5/17
Amended RC, 10/18
Amended and Reaffirmed RC, 10/23

VIII. Corporate Practice of Medicine

EMRA believes that the practice of caring for patients and training of emergency physicians must be free from interference from any non-clinical persons or entities, including corporations.

EMRA believes that corporate investors in emergency medicine practice and training create conflicts of interest and incentives that infringe upon physician and patient well-being. While all business models in emergency medicine have a profit motive, profit incentives are more powerful when outside stakeholders are invested.

EMRA advocates for the fair employment, treatment, and contracting of emergency physicians. EMRA believes that:

1. Physicians must have the opportunity to review contracts thoroughly and seek legal counsel before signing.
2. Key terms, including compensation, benefits, work schedules, and termination conditions, must be clearly outlined.
3. Emergency physicians should retain control over clinical decision-making to ensure the highest standard of patient care.
4. Employment agreements should not impose unreasonable restrictions that limit physicians' professional judgment.
5. Compensation packages should be fair, competitive, and reflect the physician's experience, skills, and the demands of the position.
6. Working conditions must comply with applicable labor laws and support the physician's ability to provide quality care, including adequate rest periods and manageable patient loads.
7. Termination provisions should be explicitly stated, including conditions for termination without cause and for-cause.
8. Fair notice periods should be provided, and severance arrangements should be equitable, particularly in cases of termination without cause.

9. There should not be any restrictive covenants that unduly restrict the physician's ability to practice medicine for a specified period of time or in a certain geographical area
10. Physicians should have the right to due process in cases of termination or disciplinary action.
11. Grievance procedures should be clearly defined and include impartial review mechanisms.

Original policy adopted RC3/22
Amended RC 9/24

IX. Protecting and Promoting Gender-Affirming Care in the Emergency Department

EMRA:

- Supports policies promoting and protecting the provision of gender-affirming care in all care settings including the emergency department
- Opposes state and federal legislation that seeks to limit access to gender-affirming care and resources
- Opposes retaliatory efforts against healthcare providers providing gender-affirming care
- Encourages training programs to provide education and resources on best practices for delivering gender-affirming care in the emergency department. Where appropriate, programs should partner with LGBTQ+ organizations and resources, particularly those providing mental health and community resources to LGBTQ+ youth

Original policy adopted RC, 10/23

X. Protecting Rights of Pregnant People Who Use Opioids

EMRA:

- Recognizes disparities in care for pregnant individuals with opioid use disorder and the need for culturally sensitive and empathetic care for these patients
- Supports the use of opioid agonist therapy, both in the Emergency Department and through referral to outpatient treatment programs, to manage substance use disorder in pregnancy
- Opposes criminalization of, or retaliatory efforts against patients who use opioids while pregnant
- Opposes mandatory reporting of pregnant individuals who use opioids for non-public health monitoring reasons
- Encourages Emergency Medicine residency program to provide education, training, and resources on best practices for caring for pregnant patients who use opioids.

Original policy adopted RC, 10/23

Section IV – Public Health

I. Climate change, its impact on patient health, and implications for Emergency Medicine

EMRA supports research, education, prevention, monitoring, and assessment of the public health implications of climate change.

EMRA supports the dissemination of materials to residents which may guide future training, advocacy, and patient care as it relates to the public health implications of climate change.

Original policy adopted RC, 10/17
Reaffirmed RC, 10/22

II. Emergency Department's Role in Public Health and Social Welfare

EMRA encourages development of curricula in public health, preventive medicine, and social medicine for physicians-in-training.

Original policy adopted RC, 5/15
Reaffirmed RC, 3/20

III. Emergency Medicine to Support Evidence-Based Policy Reforms of the Criminal Justice System and Equitable Health Care for Incarcerated Patients

EMRA supports evidence-based policy reforms of the criminal justice system that contribute to individual and public health.

EMRA recognizes that incarcerated people form a vulnerable patient population with higher rates of chronic medical conditions including substance use disorders. As front-line practitioners in caring for patients who present while under the custody of law enforcement, EMRA:

Supports required and confidential screening of people under custody of law enforcement to identify medical conditions including substance use disorders, and prompt treatment of these conditions.

Upholds that addiction treatment including evidence-based harm reduction strategies, counseling, and prescribed treatments such as buprenorphine or naltrexone must be provided to incarcerated people who give consent for treatment.

Advocates for transition services and rehabilitation initiatives that support the comprehensive medical needs of patients upon release from incarceration. These needs include but are not limited to regular follow-up and access to addiction treatment to reduce the risk of relapse, reincarceration, and overdose death.

Original policy adopted RC, 5/17
Amended RC, 10/21

IV. Emergency Medicine Support of Research on Social Determinants of Health

EMRA will support research and education on ways social determinants of health contribute to individual and population health, as well as evidenced interventions seeking to address them. These determinants include, but are not limited to, social, psychological, environmental (built and natural), economic, political, legal, cultural, and spiritual factors.

Original policy adopted RC, 5/17
Reaffirmed RC, 10/22

V. Emergency Medicine Training to Address Social Determinants of Health

EMRA will strongly encourage emergency medicine residency programs and their residents to play active roles in supporting public health by helping to develop and execute creative solutions to public health problems in collaboration with other health professionals, organizations, and local communities.

Original policy adopted RC, 5/17
Reaffirmed RC, 10/22

VI. Firearm Safety and Injury Prevention

EMRA supports regulatory, legislative, advocacy, and public health efforts that:

A. Improve public and privately funded research on firearm safety and injury prevention.
B. Support repeal of the Dickey Amendment, which directly influences funding allocated to firearm-related research.
C. Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm related injuries.
D. 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.
E. Strengthen universal background checks for all firearm purchases.
F. Restrict sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use.
G. Promote access to effective, affordable, and sustainable mental health services.
H. Empower physicians to educate and discuss with their patients the use of firearms, prevention of injury, both intentional and unintentional, and means to safeguard weapons.
I. Support a high standard of firearm safety and operation training for firearm purchase.

Original policy adopted RC, 10/16
Amended RC, 10/18
Amended and Reaffirmed BOD, 3/24

VII. Universal Healthcare System for All

EMRA endorses a universal healthcare system as a way to achieve more equitable, comprehensive, and affordable healthcare coverage for all.

Original policy adopted RC, 3/21

VIII. Healthcare as a Human Right

EMRA firmly believes that all individuals (especially vulnerable populations, including rural, elderly, pediatric patients, and patients with disability)should have access to quality, affordable primary and emergency healthcare services for all people as a basic human right. EMRA

supports health care policy that will ensure adequate insurance coverage for primary and emergency health care services. EMRA supports incentives for physicians who choose to care for vulnerable populations. EMRA supports access to timely follow up to prevent repeat emergency department visits and inpatient hospitalizations, particularly in vulnerable populations.

Original policy adopted by RC, 10/03
Reaffirmed by RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed BOD 5/13
Amended BOD, 3/18
Amended and Reaffirmed BOD, 3/24

IX. Immigrant Family Separation

EMRA Stands with the American College of Emergency Physicians (ACEP) and other professional medical associations in opposing the separation of immigrant families in the context of deportation.

Original policy adopted RC, 10/19

X. Mental Health and Emergency Medicine

EMRA will:

A. Support the definition of addiction as a chronic and progressive disease.
B. Specifically support initiatives that protect insurance coverage for mental health, parity for mental health coverage on par with other medical illnesses, improve community mental health resources, and increase the number of inpatient mental health beds.
C. Encourage and support legislation or projects that aim to increase the mental health workforce.
D. Advocate for initiatives to decrease mental health boarding in emergency departments.

Original policy adopted RC, 5/17
Reaffirmed RC, 10/22

XI. Opioid Harm Reduction

EMRA:

A. Believes that practitioners of emergency medicine can play a leading role in reducing opioid abuse and death.
B. Should support research efforts geared toward opioid harm reduction.
C. Should encourage training for physicians-in-training regarding safe and appropriate use of opioid and non-opioid treatments.
D. Should support streamlining requirements for buprenorphine prescribing and access to buprenorphine access clinics in the emergency department.
E. Should support adoption of proven strategies in opioid harm reduction including enhanced public distribution of naloxone and increased patient awareness and access to syringe exchange programs.
F. Supports converting naloxone to over-the-counter status and legislation that mandates mandating insurance coverage of over-the-counter naloxone formulations.

Original policy adopted RC, 4/18
Amended RC, 3/23

XII. Policing and Emergency Medicine

EMRA recognizes excessive use of force by police as a public health issue that threatens the health and wellbeing of individuals, law enforcement, and society with disproportionate effects on vulnerable communities including people of color.

EMRA will work with the American College of Emergency Physicians and other relevant stakeholders to support legislation that restricts the excessive use of force by law enforcement and promotes evidence-based harm reducing law enforcement tactics.

EMRA opposes the use of medicine administration for the purpose of restraint or de-escalation by non-medical personnel.

EMRA will work with relevant stakeholders to support a) implementation of evidence-based practices regarding the use of medicine administration for the purpose of restraint or de-escalation in the prehospital setting and b) documentation of the use and effects of medicine administration for the purpose of restraint or de-escalation in events involving law enforcement.

EMRA supports efforts by emergency departments, hospitals, law enforcement and other organizations to document and publish data on the health impacts of the excessive use of force by law enforcement.

EMRA supports efforts to document, report, and research the effects of crowd-control weapons such as kinetic impact projectiles, chemical irritants, and electronic conduction devices, among others, and the resulting injuries and deaths they may cause as a result of their use.

Original policy adopted RC, 10/20
Amended RC, 10/23

XIII. Increasing Evidence Based Domestic Violence Screening in the Emergency Department

EMRA encourages emergency medicine training programs to a) implement and provide instruction on evidence-based screening for intimate partner violence, and b) involve trainees in interdisciplinary safety planning and intervention for survivors of intimate partner violence.

Original policy adopted RC, 3/21

XIV. Supporting Voter Registration Efforts in the Emergency Department

EMRA supports voluntary on-site nonpartisan voter registration efforts by residents and other emergency department staff, especially leading up to local, state, and federal government elections. EMRA also supports dissemination of materials to residents in order to educate and empower them to take part in these efforts.

Original policy adopted RC, 3/21

XV. Supporting Populations Experiencing Homelessness

EMRA supports utilization of a standardized, routine screening tool in the ED for identification of individuals at risk for homelessness.

EMRA supports residency programs providing guides and resources to residents, educating them about the barriers to care that exist with regards to housing, transportation, food, shelter, and other preventative health measures specific to their geographic area of training and local population so that resident physicians can best advocate for their patients.

EMRA supports the education of residents regarding the role of social work, registration, and nursing in the treatment of vulnerable populations patients and those experiencing homelessness.

EMRA supports continued education of residents regarding resources available to patients throughout their training to promote patient-centered care for vulnerable populations and effective collaboration between residents, social workers, nurses, and other staff on matters of resource acquisition and allocation.

Original policy adopted RC, 10/22

XVI. Reproductive Rights and Equitable Access to Emergency Contraception in the Emergency Department

EMRA supports the accessibility of emergency contraception in emergency departments nationwide.

EMRA will advocate for universal access to emergency contraception in the Emergency Department.

Original policy adopted RC, 10/22

XVII. Resolution in Support of Improving Quality of Care for Patients Who Are Incarcerated

EMRA:

- Supports implementation of training and education sessions for medical students and residents focused on optimizing care for patients who are legally confined including those that are detained, in police custody, or currently incarcerated.
- Supports the development and implementation of educational materials on evidence-based best practices for emergency care of patients who are legally confined, which aim to address the challenges related to proper history taking, physical examination, and privacy during an encounter. Specifically, support materials that recognize the health risks and safety issues surrounding the use of restraints, when restraints may be counterproductive to a patient's care, the importance of advocating for the removal of shackles when the situation allows, and interdisciplinary education on proper physical examination when restraints are not able to be safely removed.
- Encourages the development of curriculum that will allow students and residents to recognize and address their own biases towards patients who are legally confined.

Original policy adopted RC, 10/22

XVIII. Firearms in Emergency Departments

EMRA supports the banning of firearms and other weapons in all emergency departments across the United States, except for official purposes.

Original policy adopted RC, 3/23

XIX. Position on Excited Delirium

EMRA opposes “excited delirium” as a clinical diagnosis and its use in clinical settings.

EMRA supports multi-disciplinary initiatives regarding the subject of “excited delirium” with the purpose of creating new verbiage and definitions for the disease process(es) it intends to describe.

EMRA supports the inclusion of racially and demographically diverse emergency medicine physicians in any task forces or panels resulting from the aforementioned initiatives to further define and describe the term “excited delirium”.

Original policy adopted RC, 3/23

XX. Recognizing Voting Access Status as a Social Determinant of Health

EMRA:

- Supports efforts to research the relationship between voter participation and health outcomes
- Acknowledges voter registration status and access to voting as a unique social determinant of health metric to be included in social determinant screenings
- Encourages emergency departments to distribute non-partisan resources on voter registration to eligible patients identified as being not registered to vote.

Original policy adopted RC, 10/23

XXI. Immunizations in the Emergency Department

EMRA:

- Recommends emergency departments establish relationships with public health organizations, urgent care clinics, local pharmacies, and private physicians for referral of patients seeking vaccination
- Recommends emergency departments work with public health organizations and the local community to provide medical response for epidemic responses
- Supports the administration of routine annual preventative vaccinations, such as the influenza vaccine within the emergency department when clinically appropriate
- Encourages emergency departments to stock vaccines required for exposures such as tetanus, rabies, and other regionally specific vaccines.

Original policy adopted RC, 10/23

XXII. Availability and Accessibility of Fentanyl Test Strips in the Emergency Department

EMRA supports the universal availability and distribution of fentanyl test strips in emergency departments

Original policy RC, 10/23

XXIII. Language Justice and Health Equity in the Emergency Department

EMRA supports continuous availability of interpreter services in Emergency Departments.

EMRA supports readily available in-person interpreters which are preferred when possible, followed by video interpretation, which is preferred over telephone interpretation.

EMRA recognizes that ad-hoc interpreters may not be fully qualified or prepared to interpret in a clinical context, and should only be considered when use of a qualified interpreter is unavailable, impractical, or when preferred by the patient.

EMRA supports emergency departments making discharge information and after-visit summaries in the patient's preferred language available whenever possible.

EMRA recommends emergency medicine residency programs partner with appropriate entities to assess the adequacy of services currently provided.

EMRA supports training of medical students, residents, and faculty on appropriate interpreter use in the emergency department and supports staff seeking financial compensation for those that pass bilingual medical language certification.

EMRA supports policies promoting reimbursement and/or insurance coverage of qualified interpreter services for patients with non-English language preference in all healthcare settings.

Original policy adopted RC, 10/23

XXIV: Decriminalizing Victims of Human Trafficking and Individuals who Offer Sex for Money, Goods, or Other Transactional Exchanges

EMRA supports legislation that decriminalizes individuals who are victims of human trafficking or individuals who accept money, goods or other transactions for sex. EMRA acknowledges adverse health outcomes can occur due to the criminalization of victims of human trafficking or individuals who accept transactions for sex. EMRA supports legislation that acknowledges adverse health outcomes in the criminalization of human trafficking or individuals who accept transactions for sex, and encourages public posting of human trafficking resources in emergency departments.

Original policy adopted RC, 3/24

Section V – Residency Programs

I. Core Faculty Protected Time

EMRA recognizes the unique challenges of teaching in the Emergency Department and supports Emergency Medicine Core Faculty & Program Leadership (defined as Program Directors and Associate Program Directors) protected time.

Original policy adopted BOD, 5/19

II. Creation of Domestic Emergency Medicine Exchanges

EMRA supports and encourages increased coordination between Emergency Medicine programs to facilitate elective opportunities to meet residents' specific professional goals.

EMRA recognizes that elective opportunities allow residents in urban settings to get experience in a rural system, which may foster further interest in rural medicine.

Original policy adopted RC, 10/10
Reaffirmed BOD, 3/15
Reaffirmed RC, 3/20

III. Emergency Department Staffing and its Impact on Resident Education

EMRA supports research on the optimal ways to staff an emergency department to provide timely, efficient, and safe care to patients. EMRA also supports research on how emergency department staffing impacts resident education, and champions emergency department staffing models that positively impact resident education. Finally, EMRA advocates for models of emergency service delivery that allows residents to participate within the care of all patients across all acuities

Original policy adopted RC, 5/14
Reaffirmed RC, 3/20

IV. Enhancing Patient Sign-Out Supervision and Safety

EMRA recommends and supports that emergency medicine residency programs design, implement, and institutionalize standardized patient sign-out systems to ensure appropriate continuity of care and patient safety.

Original policy adopted, 5/09
Reaffirmed BOD, 3/15
Reaffirmed RC, 3/20

V. Exposure to Rural Emergency Medicine During Residency Training

EMRA supports the presence and formation of rural emergency medicine electives at emergency medicine residency programs within the United States.

Original policy adopted RC, 3/20

VI. Family and Medical Leave Policy

EMRA believes that emergency medicine residency programs should have a clear policy on family and medical leave, rights and responsibilities under the Family Medical Leave Act, and that programs provide this policy to residents and applicants, and that this policy is made publicly available. EMRA also believes that programs should address coverage expectations and remuneration in their residency employment contracts.

EMRA believes leaves should be structured in as flexible a manner as possible to accommodate the unique needs of the resident in new parenting roles, or with family, health, (including short- or long-term illness and illness associated sequelae, such as mandatory quarantine periods), or wellness issues. To that end, leave time should be allowed to accrue from year to year or pulled from future years. Programs should also prioritize the protection of resident vacation time as separate from leave periods when possible.

EMRA supports implementation of backup systems to ensure appropriate Emergency Department staffing when residents require leave. Extensions of residency training period may be disruptive to the early career of new physicians and thus should be minimized when possible. Residents and program leadership should work together to maximize the well-being of residents balancing the accrual of leave with consecutive clinical periods. Accordingly, EMRA should support residency programs establishing their own minimum required time off per clinical year.

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 a fair and equitable manner.

EMRA believes parental leave should be offered to emergency medicine residents, fellows and attendings. Access to parental leave should be equal for men and women with newly born or adopted children and be a minimum of 6 weeks in alignment with existing guidelines. EMRA further believes that individuals taking parental leave should be paid for the totality of these leaves. EMRA should work with local, state, and federal policymakers to advocate for paid parental leave for physicians, physicians-in-training, and all persons

Original policy adopted BOD, 5/03
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Amended and Reaffirmed BOD 5/13
Amended and Reaffirmed RC 5/17
Amended RC, 10/19
Amended RC, 10/20
Amended RC, 3/22

VII. Insurance

Emergency medicine residents should be informed of the health, life, disability, and malpractice insurance coverage provided as part of their residency program, along with the limitations and extent of that coverage. Adequate coverage should be provided by residency programs for any and all occurrences during residency.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/97
Reaffirmed, 1/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 5/12
Amended BOD, 1/18
Reaffirmed RC, 10/23

VIII. Mental Health and Emergency Medicine Providers

EMRA sets the following goals and standards for emergency medicine residency programs:

A. The issue of resident suicide and mental health should be discussed openly and often, to avoid stigmatization, to increase the likelihood that residents seek support, and to spread awareness – as would be done for any other public health crisis.

B. Mental health care should be easily accessible, affordable and confidential for all residents.
C. Residency programs should provide applicants with detailed information about mental health resources available to residents. Residency programs should also openly discuss residency activities that proactively support residents' mental wellness. This information should be included along with ACGME required materials, available in paper form or online.
D. There should exist a culture of support between and among residents and residency programs with regards to mental health.
E. Resident mental health and suicidality should be addressed in a proactive and confidential manner.
F. No resident should fear retribution or consequences for addressing mental health and suicidality.

Original policy adopted RC, 5/17
Amended RC, 10/19
Amended RC, 3/20

IX. Moonlighting

EMRA supports moonlighting by residents who possess the necessary medical licensure, who are in good-standing with their residency programs, that does not violate duty hours, with permission of their residency program director.

Original policy adopted, 5/94
Amended and Reaffirmed RC, 5/99
Reaffirmed RC, 5/00
Reaffirmed BOD, 8/00
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed BOD 5/13
Amended BOD, 7/15
Amended RC, 10/19

X. Pumping Breaks on Shift for Medical Students, Residents, and Fellows

Emergency Medicine Residency programs should have clearly delineated policies mandating regular breaks on shift for the expression of breast milk.

EMRA encourages provision of adequate time and facilities to express and store breast milk consistent with best practices to better support medical students, and resident, fellow, and attending physicians who produce breast milk.

Original policy adopted RC, 3/20

XI. Relationship with the Biomedical Industry

Emergency medicine residents should recognize the generally accepted guidelines for interaction with the biomedical industry. Gifts should be related to education and training. Gifts should not be excessive or require reciprocal responsibility which impacts patients.

Financial compensation may be accepted for residents' work in the biomedical industry including research and innovation. However, this should be considered a potential conflict of interest and therefore should be clearly disclosed.

These general guidelines do not encompass every potential interaction with biomedical companies, so individual responsibility must be exercised. Physicians may not be aware of the subtle influence of interaction with the biomedical industry. While the industry is important to promote the development of new technology and pharmaceuticals, residents should hold the needs and concerns of the patient in highest regard.

Original policy adopted, 3/92
Amended and Reaffirmed RC, 1/97
Reaffirmed, 3/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 5/12
Reaffirmed RC, 10/18
Amended and Reaffirmed BOD, 3/24

XII. Replacement of Live Animal Use in Emergency Medicine Residency Programs

EMRA strongly encourages the replacement of live animal use with previously sacrificed animals or non-animal training methods in emergency medicine residency programs.

Original policy adopted RC, 10/09
Reaffirmed BOD, 3/15
Reaffirmed RC, 3/20

XIII. Residency Closure

Although not ideal, EMRA recognizes the possibility of residency program reduction and closure. All program reductions/closures must be in accordance with the rules of the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee for Emergency Medicine (RRC-EM) for the ACGME. Any reductions should be phased in so as not to affect the salary lines or significantly affect the workload of the other residents.

In the event of a necessary residency program closure or size reduction, it is imperative that all residents be immediately notified and given support until separation through graduation, resignation, dismissal, or non-renewal. Closure of the residency program does not constitute grounds for dismissal or non-renewal of the resident.

In the event a residency program closure or size reduction is considered, it is imperative that representatives from both the Sponsoring Institution and residency program are included in the decision-making process.

If a program must close precipitously for some reason outside the program's control and the program cannot continue support as described above, the program must make every effort to enable current residents to continue their residency to completion. If allowing residents to finish at their current program is not possible, the program should be responsible for helping residents in identifying and relocating to another program so that they may complete their education if they so choose. EMRA believes that a displaced resident’s GME funding should follow the resident to their receiving hospital, in accordance with the ACGME.

Programs should disclose their accreditation status to interviewing medical students with reasons for any probationary actions. Medical students who have matched to a program that has lost its accreditation before the start of the program should be given the same consideration

as those currently in the residency for finishing the program, and the program should be responsible for assisting their placement as well.

EMRA will work with other organizations in Emergency Medicine to ensure that a system is in place to facilitate resident placement in this unfortunate circumstance.

Original policy adopted RC, 3/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 6/11
Reaffirmed RC, 10/18
Amended RC, 10/19
Amended BOD, 2/22
Amended RC, 9/24

XIV. Residency Training Format

EMRA recognizes the value of choice in emergency medicine residency training formats. EMRA urges the continued accreditation of three-year and four-year formats.

Original policy adopted RC 1/12
Reaffirmed RC, 10/18
Reaffirmed RC, 10/23

XV. Resident Duty Hours

The Emergency Medicine Residents' Association supports the guidelines for resident duty hours revised and approved by the Accreditation Council for Graduate Medical Education (ACGME) in 2017. EMRA believes residents should be allowed adequate rest and protected time from clinical responsibility before and during education program didactics, as well as before and during the annual ABEM In-Training Examination. EMRA will support the institution of resident wellness programs, as part of standard emergency medicine residency training, in order to enhance the well-being of residents and to improve education and patient safety.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/97
Reaffirmed, 3/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Amended and Reaffirmed BOD, 5/08
Amended and Reaffirmed RC, 5/09
Reaffirmed RC, 5/12
Amended and Reaffirmed RC, 10/18
Amended and Reaffirmed BOD, 3/24

XVI. Resident Transfers

Emergency medicine residents have a contractual obligation to their program and vice versa. Residents and residency programs must make all appropriate attempts to honor these agreements. Transfer between residency programs should be limited to extenuating circumstances.

Situations may arise in which personal, financial, or professional reasons compel a resident to consider transfer to another program. Open communication with the program concerning

potential transfer may create greater stress. In these situations, while early communication of intention to transfer is encouraged, residents need not always have the approval of the program prior to initiating the transfer process. Punitive responses by any program toward a resident who plans to transfer are unacceptable.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/97
Reaffirmed, 1/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 5/12
Reaffirmed RC, 10/18
Reaffirmed RC, 10/23

XVII. Flexible Scheduling for Pregnant and Early Post-Partum Residents

EMRA supports programs and policies significantly limiting or eliminating night shifts and off service overnight call for all pregnant trainees.

Original policy adopted RC, 3/20

XVIII. Scholarly Activity

EMRA supports scholarly activity requirements which include but are not necessarily limited to:

A. Peer-Reviewed Journal articles.
B. Non-Peer Reviewed articles such as abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer review process. Also educational videos, DVDs, podcasts, and other content on online venues that are not peer-reviewed such as blogs.
C. Textbook chapter(s).
D. Presentation or lecture at local/regional/national organization meetings and conferences.
E. Grand Rounds presentations within emergency or other hospital departments, and between the ED and other departments.
F. Regional or National Committee involvement or leadership (elected or appointed, with active engagement and completed work, not simply a member).
G. Editorial Services including being a journal or textbook editor, editorial board member, reviewer, or content expert, abstract reviewer, grant reviewer.
H. Grant recipient.
I. Participation in Research including funded and unfunded projects and QA/QI projects, which may or may not result in peer-reviewed publication.
J. Curriculum development regardless of implementation status.
K. Regional and National community engagement projects.

EMRA encourages a broad definition of scholarly activity which includes the breadth of projects accepted by the ACGME and affords residents the opportunity to complete a project that is meaningful to them as individuals. We believe this leads to a more quality contribution to a resident's career, and better contributes to the growth and advancement of our specialty as a whole.

Original policy adopted BOD, 11/17
Reaffirmed RC, 10/22

XIX. Securing GME Funding for Resident Education

EMRA will support research and studies aimed toward revising current Graduate Medical Education funding mechanisms and work to change current Direct Medical Education regulations that limit research and extramural educational opportunities.

EMRA will work with other healthcare organizations to better define the problem of Graduate Medical Education funding and propose alternatives and solutions that may involve both the public and private sectors. EMRA supports sponsoring institutions securing adequate federal funding of Graduate Medical Education (GME) and supports independent financing without replacing currently funded GME positions or violating the Match process to train emergency medicine residents. EMRA believes the primary purpose of residency is education before service; therefore, EMRA opposes the sale or commoditization of CMS residency slot funding.

EMRA opposes reductions in Medicare funding for Graduate Medical Education at the Federal and State level and supports diversified sources of funding that help meet the overall goals of residency training.

Original policy adopted RC, 5/08
Reaffirmed BOD, 5/13
Amended BOD, 1/18
Amended RC, 10/19

XX. The Match and Residency and Fellowship Application Process

EMRA supports the use of a match process that is fair, cost-effective, and evidence-based.

EMRA opposes the hiring of emergency medicine residents through processes that select or give preference to individuals for Emergency Medicine residency positions based on special financial relationships or agreements between individuals, hospitals, foreign governments, corporations, or other entities.

EMRA:

A. Supports proposed changes to residency and fellowship application requirements and match processes only when:
    1. Those changes have been evaluated by working groups which have adequate students and residents as representatives.
    2. There are published data which demonstrates that the proposed application components contribute to an accurate and novel representation of the candidate and are shown from an applicant and program perspective to add value to the application overall.
    3. There are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds.
    4. The costs to medical students and residents are mitigated.
B. Opposes the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application and match process until such time as the above conditions are met.
C. Will continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program, the American Medical Association, and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Original policy adopted RC, 5/13
Amended BOD, 1/18

Amended, 2/18
Amended and Reaffirmed BOD, 3/24

XXI. Residency Application Process Improvement

EMRA encourages the standardization of the residency interview invitation and scheduling process.

EMRA supports study and modifications of the resident application process to ensure an appropriate ratio of applicants, applications, and interviews to available post-graduate positions.

Original policy adopted RC, 3/21

XXII. Equity in the Standardized Letter of Evaluation for International Students

EMRA advocates that residency programs allow IMGs to rotate at their programs; thereby increasing equity in the residency application landscape by increasing the opportunities for IMGs to obtain a standard letter of evaluation (SLOE).

EMRA will work to increase longitudinal representation of the perspectives of different subsets of IMGs within EMRA.

Original policy adopted RC, 3/21

XXIII. Funeral and Bereavement Leave for Medical Students and Physicians

EMRA supports the following guidelines for, and encourages the implementation of, Funeral and Bereavement Leave for Medical Students and Physicians:

- EMRA will advocate for funeral and bereavement leave to be included in standard benefits packages.
- Recommended components of funeral and bereavement leave policies for medical students and physicians include:
    - Policy and duration of leave for funeral and bereavement after loss of a loved one, and whether cases requiring extensive travel for funerals qualify for additional days of leave and, if so, how many days;
    - Policy and duration of bereavement leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
    - Whether funeral and bereavement leave is paid or unpaid;
    - Whether obligations and time must be made up; and
    - Whether make-up time will be paid.
- EMRA supports the concept of equal bereavement leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
- Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
- These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.

Original policy adopted RC, 3/22

XXIV. Equal Consideration for Osteopathic Medical Students

EMRA advocates for equitable consideration of allopathic and osteopathic medical students applying to all emergency residency programs in the United States.

Original policy adopted RC, 3/21

XXV. Mitigation of Competition for Procedures Between EM Resident Physicians

EM resident physicians should be given priority, preference, and right of first refusal for medically necessary procedures over non-physician providers, to preserve the integrity of resident physician training.

Original policy adopted RC, 10/22

XXVI. Expanding Resident Experience to Rural and Critical Access Hospitals

EMRA recommends Emergency Medicine residency programs partner with Rural and/or Critical Access Hospitals in order to offer or incorporate rotations for residents at these centers as able.

EMRA encourages residency programs to explore options to help fund or defray costs residents may incur from participating in rotations at Rural or Critical Access Hospitals.

Original policy adopted RC, 10/22

XXVII. Improving Overall Wellness among Emergency Medicine Residents

EMRA encourages residency programs to:

- Implement shift scheduling that provides dedicated time for documentation and end-of-shift duties to mitigate working beyond scheduled hours.
- Adopt additional resident appreciation measures such as, but not limited to, a resident recognition program with regular communications highlighting positive peer-to-peer or faculty comments.
- Organize at least one annual retreat outside of the clinical setting.
- Adopt regularly occurring, protected debriefing sessions with the goal of shared reflection and discussion of distressing events encountered in the ED.

Original policy adopted RC, 3/23

XXVIII. Use of Virtual Interviews for Residency Program Interviews

EMRA encourages all emergency medicine residency programs to continue the use of virtual interviews to reduce financial burdens and socioeconomic barriers related to applying to residency.

Original policy adopted RC, 10/23

XXIX. Advocating for Equitable Implementation of Second- Look Day Programming

EMRA advocates for formal Coalition for Physician Accountability (COPA) and CORD policies to state second-look days shall not be a way for programs to evaluate the applicant, but solely to be offered as an option for the benefit of the applicant

EMRA encourages programs to not use attendance at second-look days as part of their consideration for rank order lists to the NRMP

EMRA encourages programs to release the dates of second-look events along with their intended date of rank order list submission as early and transparently as possible.

EMRA supports EM Residency Programs offering virtual options for second looks to alleviate financial burdens and socioeconomic barriers associated with the residency application process.

Original policy adopted RC, 10/23
Amended RC, 9/24

XXX. National System for Bias Reporting

EMRA supports the creation of a national system for residents to report bias and biased treatment towards protected classes by residency programs, faculty, and staff.

Original policy adopted RC, 3/24

XXXI. Advocating for Integration of Prehospital Medicine Exposure in Medical Education

EMRA supports efforts to formally integrate aspects of prehospital medicine and EMS exposure into the medical school curriculum, to provide medical students with comprehensive training that includes out-of-hospital care.

EMRA encourages medical schools and residency programs to develop and promote EMS rotations, ride-along programs, and other prehospital experiences as essential 58 components of medical education

EMRA supports collaboration between medical schools, EMS agencies, and other stakeholders to create standardized guidelines and best practices for prehospital training for medical students.

Original policy adopted RC, 9/24

Section VI – Resident and Medical Student Education

I. Advocacy and Emergency Medicine Training

The Emergency Medicine Residents' Association actively promotes all emergency medicine residencies to integrate formal education in health care systems and advocacy training as official components of their residency curricula.

Original Policy adopted RC, 6/10
Reaffirmed BOD, 3/15
Reaffirmed RC, 3/20

II. Education Regarding Human Trafficking

EMRA will support the need for human trafficking training and encouragement of further human trafficking research, policy development, and collaboration with local and national organizations that work with victims of human trafficking. Support will be provided for education on how to properly document the medical encounter for further health care use and also for the occasions when medical documentation becomes a part of a legal case.

Original policy adopted, 10/16
Reaffirmed RC, 3/21

III. Financial Literacy Among Residents

EMRA will advocate for further resources and research will be allocated towards improving financial literacy among residents.

Original policy adopted RC, 3/20

IV. Increasing Emergency Medical Clerkship Opportunities for Medical Students

EMRA supports the creation and expansion of policies and opportunities aimed at exposing medical students to the field of emergency medicine, through the creation of elective clinical rotation opportunities for medical students to gain exposure to the field prior to their traditional initial exposure early in 4th year.

EMRA supports the implementation of emergency medicine clerkships as core clinical rotations during the third year of medical school.

EMRA supports medical school accreditation standards which require medical schools to identify emergency medicine as a core clerkship.

EMRA advocates to the appropriate osteopathic bodies to remove from its accreditation standards language allowing for the substitution of EM with critical care

EMRA supports the creation of policies and practices which improve the quality of medical student education through the promotion of emergency medicine as a core medical school clerkship.

EMRA supports the removal of currently existing caps on the number of Emergency Medicine Elective rotations allowed to medical students.

EMRA believes that all medical students should have specific training experiences in Emergency Medicine. Such experiences is necessary for a broad medical education.

Original Policy adopted RC, 10/18
Amended, 4/21
Amended RC, 10/23
Amended RC, 9/24

V. Medical Student Education in Emergency Medicine

EMRA believes that all medical students should have specific training experiences in emergency medicine. Such experience is necessary for a broad medical education.

Original policy adopted, 3/92
Amended and Reaffirmed, 1/97
Reaffirmed, 1/01
Amended and Reaffirmed, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 5/12
Amended BOD, 1/18
Reaffirmed RC, 10/23

VI. Residency and Malpractice Claims

EMRA will encourage residency programs to implement dedicated resident education programs designed to educate residents about medical legal issues including information regarding the malpractice insurance provided by one's individual program and the law's regarding resident liability in one's state.

Original policy adopted 5/09
Reaffirmed BOD, 3/15
Reaffirmed RC, 3/20

VII. Resident Indebtedness

EMRA recognizes the cost of medical education is ever increasing and medical students are entering residency with increasing levels of debt. This substantial education debt often impacts the residency experience as residents attempt to begin repayment on these loans. EMRA supports efforts to increase the tax deductibility of student loan payments, reinstate residency loan forbearance and deferment, and recognize emergency medicine as eligible for state and federal loan relief programs.

Original policy adopted RC, 5/01
Reaffirmed RC, 5/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 6/11
Amended and Reaffirmed, 10/18
Amended and Reaffirmed RC, 10/23

VIII. Support of Point of Care Ultrasound Training in Undergraduate and Graduate Medical Education

A. EMRA supports the integration of point of care ultrasound curricula into undergraduate and graduate medical education.
B. EMRA supports further research into the benefits of ultrasound education in undergraduate and graduate medical education.

Adopted RC, 10/18
Amended RC, 10/19
Amended RC, 9/24

IX. Supporting Further Research into Possible Changes to the USMLE Step 1 Scoring System

EMRA supports further research regarding changes in Step 1 scoring and reporting, including but not limited to pass/fail scoring, categorical/tiered scoring, and composite scoring.

EMRA supports acceleration of research on the correlation of USMLE performance to measures of residency performance and clinical practice. EMRA supports minimization of racial demographic differences that exist in USMLE performance.

EMRA supports convening a cross-organizational panel including medical students and residents to create solutions for challenges in the UME-GME transition.

Original policy adopted RC, 10/19

X. Unconscious Bias and Cultural Sensitivity Education

EMRA supports the implementation of evidence-based cultural training and educational sessions geared toward addressing and reducing unconscious bias and systemic racism in emergency medicine residency curriculum.

Original policy adopted RC, 3/21

XI. Clarifying Residency Applicant Competitiveness through Transparent SLOEs

EMRA supports a standardized process for the disclosure of a subset of the Standardized Letter of Evaluation (SLOE) to students so they can better assess their competitiveness.

Original policy adopted RC, 3/22

XII. Standardizing Away Rotation Applications

EMRA encourages transparency from programs regarding an overview of the application selection process, application system, and timeline for emergency medicine away rotations and further recommend timely public listing on their respective website and EMRA Match.

EMRA suggests schools explore application of a platform free or low-cost to students for the purpose of creating a more equitable system for applicants, and be it further

EMRA advocates that any required institutional fees be equal for students from all MD, DO, and IMG institutions, if the program has the ability to standardize or reduce costs.

EMRA advocates for the expansion of Emergency Medicine residency programs that will accept IMG students for away rotations in an effort to relieve some of the additional burden traditionally carried by IMG students.

Original policy adopted RC, 10/22

XIII. Racially Equitable Language and Media in Education

EMRA recognizes race as a social construct as opposed to a surrogate for biology and supports medical education initiatives that promote this definition.

EMRA encourages residency programs to recognize the harms of recognizing race as a proxy for biology and how racism can worsen health disparities.

EMRA encourages racially equitable language and media in residency curricula, teachings, and examinations.

EMRA engages with other professional organizations and diversity, equity, and inclusion experts to identify and remove aspects of medical education that reinforce racism.

Original policy adopted RC, 3/23

XIV. Funding for Rural Emergency Medicine

EMRA supports the allocation of GME funding towards defraying costs for rural emergency medicine rotations during residency to include costs related to travel, lodging, and meals.

EMRA supports loan forgiveness programs for emergency medicine physicians who choose to work in rural settings.

Original policy adopted RC, 3/23

XV. Improving Equity/ Reducing DO Bias

EMRA will advocate to CORD and other involved parties, that residency programs accept a COMLEX Level 1 score report in lieu of a USMLE Step 1 score report for osteopathic students applying for away rotations and residency positions

EMRA suggests that programs update their Visiting Student Learning Opportunities (VSLO) systems and avenues of applications to reflect acceptance of these comparable licensing exams.

Original policy adopted RC, 10/23

XVI. Trauma- Informed Care Curriculum Incorporation into Emergency Medicine Residency Didactics

EMRA supports the incorporation of a trauma-informed care curriculum in emergency medicine residents' education.

EMRA encourages the practice of trauma-informed care.

Original policy adopted RC, 10/23

XVII. Emergency Medicine Disaster Preparedness

EMRA supports education efforts related to medical student and emergency medicine resident training in disaster preparedness.

Original policy adopted RC, 3/24

Section IX: Publications and Technology

I. Artificial and Augmented Intelligence in Emergency Medicine

EMRA believes that:

A. Augmented intelligence should have proven benefits to clinical decision making, clinical workflows, or patient safety
B. Any required use of augmented intelligence must ensure that the entity requiring its use assumes applicable liability
C. Any use of augmented intelligence ensures that all protected health information is securely stored and transmitted to safeguard patient privacy and that any use of the information be disclosed to the patient prior to using it
D. Any application or development of augmented intelligence must take steps to mitigate and prevent the perpetuation of historical and current bias and should undergo a rigorous review process to ensure stakeholder inclusion and participation
E. The methods behind augmented intelligence design and deployment must be transparent to the clinicians who are expected to use them, must provide reproducible results, and be peer reviewed.

EMRA recognizes the importance of transparency, security, and ethical considerations in the use of AI and augmented intelligence.

EMRA supports investigating and promoting the responsible use of AI applications within the emergency department.

EMRA advocates for increased research into AI applications within emergency medicine and integrating AI education into residency training programs.

Original policy adopted RC, 10/20
Amended RC, 9/24

III. Support for Telemedicine in EM

EMRA will:

A. Support telemedicine training opportunities for emergency medicine residents where available and appropriate.
B. Encourage interstate licensure compacts to allow physicians to provide services across state lines.
C. Support reimbursement policies that promote current practice of and future innovations in telemedicine.
D. Support the creation and implementation of a tele-supervision system for those critical access areas where only non-physician providers may be available

Original policy adopted RC, 5/17
Amended RC, 10/18
Amended and Reaffirmed RC, 10/23

IV. The Value of Electronic Health Information Exchange and Interoperability

EMRA will recognize that electronic health information exchange that is secure, timely, accurate and available facilitates efficient, high-quality care for the chronically and acutely ill patient. Support the adoption of interoperability standards for electronic health information exchange. Support the integration of electronic health records with additional sources of electronic health information, including prescription drug monitoring databases.

Original policy adopted RC, 5/17
Reaffirmed RC, 10/22

Section X – Relations with External Organizations

I. Communication with Organizations

EMRA, its Board of Directors, and designated officials will communicate with any and all entities in the course of representing the interests of emergency medicine trainees, EMRA, and the greater good of the specialty. When a subject arises warranting EMRA's official public position the Board of directors will research the subject and discuss it, and the President will function as the spokesperson for the organization. Liaisons to other organizations may be appointed by the President.

Original policy adopted, 10/01
Reaffirmed BOD and RC, 9/05
Reaffirmed BOD, 1/06
Reaffirmed RC, 6/11
Amended BOD, 3/18
Reaffirmed RC, 10/23

II. EMRA Policy on Supporting ACEP Board of Directors Candidates

EMRA, as an organization, will not officially endorse the campaign of any ACEP Board of Directors candidate. EMRA Board of Directors members are discouraged from doing so as well, even when speaking on behalf of themselves.

Original policy adopted BOD, 6/07
Reaffirmed RC, 5/12
Amended BOD, 3/18

III. EMRA-ACEP Strategic Collaboration

EMRA endorses the American College of Emergency Physicians as the physician home for emergency physicians throughout their careers.

EMRA commits to a bilaterally contingent joint membership model for medical students, residents, and fellows.

Original policy adopted RC, 9/24

Section XI – EMRA Administration and Operations

I. Availability of Childcare at Conferences

EMRA is committed to ensuring the availability of affordable child care for its members at a reasonable cost to members at conferences where EMRA hosts meetings of the Representative Council.

Original policy adopted RC, 10/19

II. Code of Ethics for the Leadership

EMRA leadership is considered any elected or appointed member of the Board of Directors (BOD), council, committees, or liaisons. This Code is intended to focus the Board and each leader on the duties and responsibilities of leaders of the Association, provide guidance to leaders to help them recognize and deal with ethical issues, provide mechanisms to report unethical conduct, and help foster a culture of honesty and accountability. Each leader must comply with the letter and spirit of this Code.

A. Conflicts of interest
    1. Board members have a paramount interest in promoting and preserving the best interests of the Association. Leaders should avoid any real or apparent conflicts of interest between themselves and the Association. Any situation that involves, or may reasonably be inferred to involve, a conflict between a leader's personal interests and the interests of the Association should be disclosed to the President or President-Elect. Leaders must disclose information on their financial interests in organizations doing business with EMRA.
    2. It is imperative that all leaders, whether appointed or elected, exercise good faith by disclosing information relating to conflicts or potential conflicts of interests and excusing themselves from voting on any issue before the Board that could result in a conflict, self-dealing, or any other circumstances wherein their privileged position as leaders would result in a detriment to EMRA or in a noncompetitive, favored, or unfair advantage to either themselves or their associates.
    3. Leaders may not engage in any conduct or activities that are inconsistent with the Association's best interests or that disrupt or impair the Association's relationship with any person or entity with which the Association has or proposes to enter into a business or contractual relationship.
    4. A leader, or any member of his or her immediate family, should avoid the acceptance of gifts where a gift is being made in order to influence the leader's actions as a member of EMRA, or where acceptance of such gift gives the appearance of a conflict of interests.
    5. Leaders should not accept compensation for services performed for the Association except as otherwise specified in the bylaws.
    6. Leaders may not use EMRA assets, labor, or information for personal use unless approved by the President or President-Elect or as part of an expense reimbursement program available to all leaders.
    7. Leaders cannot hold an officer position if the individual holds any elected or appointed positions at other national organizations that primarily serve the same or similar constituencies (i.e. emergency medicine residents and students) as

does EMRA. Leaders who hold an officer position in state or local organizations are exempt.

B. Association opportunities
Leaders are prohibited from: (a) taking for themselves personally opportunities related to the Association's business; (b) using the Association's property, information, or position for personal gain; or (c) competing with the Association for business opportunities, provided, however, if the Association will not pursue an opportunity that relates to the Association's business, a leader may do so with the consent of the board of directors.

C. Confidentiality
Leaders should maintain the confidentiality of information entrusted to them by the Association and any other confidential information about the Association that comes to them, from whatever source, in their capacity as a leader, except when disclosure is authorized or legally mandated. For purposes of this Code, "confidential information" includes all non-public information relating to the Association.

D. Compliance with laws, rules and regulations; fair dealing
Leaders shall comply, and oversee compliance by employees, officers, and other leaders, with laws, rules and regulations applicable to the Association. Leaders shall oversee fair dealing by employees and officers with the Association's customers, suppliers, competitors and employees.

E. Encourage the reporting of any illegal or unethical behavior
Leaders should promote ethical behavior and take steps to ensure the Association: (a) encourages the leadership to talk to the Board of Directors, staff, and other appropriate personnel when in doubt about the best course of action in a particular situation; (b) encourages leaders to report violations of laws or rules; and (c) inform leaders that the Association will not allow retaliation for reports made in good faith.

F. Compliance procedures
Leaders should communicate any suspected violations of this Code promptly to the President or President-Elect. Violations will be investigated by the Board or by a person or persons designated by the President.

Original policy adopted BOD, 1/05
Amended and Reaffirmed BOD, 1/06
Amended and Reaffirmed RC, 6/10
Reaffirmed BOD, 3/15
Amended and reaffirmed BOD, 11/19

III. Conference Calls

EMRA reserves the right to conduct business meetings via conference call as deemed appropriate by the presiding officer, in compliance with the organization’s Amended and Restated Bylaws.

Original policy adopted BOD, 9/94
Amended and Reaffirmed BOD, 6/97
Amended and Reaffirmed BOD, 6/98
Amended and Reaffirmed BOD, 1/06
Reaffirmed BOD 5/13
Reaffirmed RC, 10/18

IV. Governance

The purpose of the EMRA Board is to (1) achieve appropriate results for appropriate persons at an appropriate cost and (2) avoid unacceptable actions and situations.

A. Governing Style: The Board will govern with an emphasis on:
    1. outward vision rather than internal preoccupation,
    2. encouragement of diversity in viewpoints,
    3. strategic leadership more than administrative detail,
    4. clear distinction of Board and chief executive roles,
    5. collective rather than individual decisions,
    6. future rather than past or present, and
    7. productivity rather than reactivity. On any issue, the Board must ensure that all divergent views are considered in making decisions, yet must resolve into a single organizational position.

B. Board Member Job Description: The job of the Board members is to represent the members of EMRA in determining and demanding appropriate organizational performance.
C. Required Leader Agreement: All EMRA Leaders, including but not limited to, Board of Directors members, council officers, committee leaders, and the medical student council are required to sign a leader agreement, conflict of interest disclosure, and a confidentiality agreement upon beginning their term. Failure to comply will result in removal from office.
D. Representative Council: The EMRA Representative Council will be governed in accordance with the Emergency Medicine Residents' Association Council Procedures and the EMRA Bylaws.
E. Meeting Attendance Expectations: Board members are expected to attend all meetings of the Board and all other meetings and functions, as directed by the President. Committee Chairs will be invited to attend all Board meetings and expected at all other meetings and functions, as directed by the President and Board of Directors.
F. EMRA Executive Committee: The EMRA Executive Committee shall consist of the President, President-Elect, Immediate Past President/Treasurer, and the Executive Director.

Original policy adopted BOD, 1/06
Amended and Reaffirmed RC, 6/11
Amended and Reaffirmed BOD, 6/17
Amended by the BOD, 12/17
Amended BOD, 1/18
Amended, 2/18
Reaffirmed BOD, 12/19

V. Honorary Membership for Editors-in-Chief of EMRA Publications

For the purposes of honorary membership as defined in EMRA's Bylaws, the EMRA Board of Directors shall define "person of distinction" as including being a Editor-in-Chief of any EMRA publication. This should not be construed as limitation in definition, and shall not require additional vote to confirm honorary membership to members meeting this definition.

Originally policy adopted BOD, 5/19

VI. Lobbying

The Association does not directly engage in political lobbying efforts, although this practice is not expressly prohibited. EMRA supports lobbying efforts by other organizations as it pertains to the Association's mission and goals.

Original policy adopted BOD, 1/03
Amended and Reaffirmed BOD, 1/06
Amended and Reaffirmed BOD, 5/08
Reaffirmed BOD 5/13
Reaffirmed RC, 10/18
Amended and Reaffirmed RC, 10/23

VII. Member E-mails

The distribution of member emails will be limited to occasions by which the executive director feels that dissemination of such information is important for promoting the mission and goals of EMRA. Member emails will not be released to outside organizations.

Original policy adopted BOD, unknown date
Amended and Reaffirmed BOD, 1/06
Reaffirmed RC, 6/10
Reaffirmed BOD, 3/15
Reaffirmed BOD, 6/17
Reaffirmed RC, 10/22

VII. Membership Renewal

EMRA will honor membership services for new and renewing members for 12 months from the time of annual renewal.

Original policy adopted BOD, 3/96
Amended and Reaffirmed BOD, 2/06
Reaffirmed RC, 6/11
Amended and Reaffirmed BOD, 6/17
Amended and reaffirmed BOD, 11/19

IX. Paperless EMRA Representative Council

The Emergency Medicine Residents' Association believes in an environmentally conscientious approach to its proceedings, and therefore will regularly explore ways in which to reduce inefficiencies and to minimize utilization of natural resources, while maintaining its effectiveness, competitiveness, and ability to meet the goals and mission of the Association.

Original policy adopted RC, 10/09
Reaffirmed BOD, 3/15
Reaffirmed RC, 3/20

X. Sponsorship and Advertising Guidelines

EMRA recognizes the importance of transparency in corporate relationships (including advertisements, sponsorships, and educational grants). All corporate sponsorships must preserve EMRA's control over any projects and products bearing the EMRA name or logo.

EMRA retains editorial control over any information produced as part of an externally funded arrangement. When an EMRA program receives external financial support, EMRA must remain

in control of its name, logo, and EMRA content, and must approve all marketing materials to ensure that the message is congruent with EMRA's vision and values.

Products or services eligible for advertising in EMRA publications must be germane to and useful in the practice of medicine, medical education, or health care delivery. EMRA does not allow advertising by pharmaceutical, tobacco, alcohol or firearm companies.

EMRA reserves the right to refuse any advertising or sponsorship request at its discretion. Final sponsor approval is given by the EMRA Executive Director and EMRA Executive Committee.

Original policy adopted, 1/96
Amended and Reaffirmed BOD, 1/06
Amended and Reaffirmed BOD, 5/08
Reaffirmed RC, 6/11
Amended and Reaffirmed BOD, 9/15
Reaffirmed BOD, 6/17
Amended and Reaffirmed BOD, 10/18
Amended and Reaffirmed BOD, 3/24

Appendix B – EMRA Representative Council Procedures

I. General Principles

The *Emergency Medicine Residents' Association* (EMRA) *Representative Council Procedures* is the official method for handling and conducting the business brought before the Representative Council ("the Council"). The Council transacts its business according to a blend of rules imposed by the current Bylaws of the Emergency Medicine Residents' Association ("the Association"), established by tradition, decreed by its presiding officer, and generally pursuant to the guidance of the current edition of Sturgis' *Standard Code of Parliamentary Procedure*. The majority opinion of the Council in determining what it wants to do, and how it wants to do it, should always remain the ultimate determinant. It is the obligation of the Speaker to sense this will of the Council, to preside accordingly, and to hold their rulings ever subject to challenge from, and reversal by, the assembly.

II. Representatives

A. **Eligibility**
Program Representatives ('representatives') to the Council and their alternates shall be selected and have their credentials verified according to the provisions of the Bylaws of the Association. No officer or director of the Association may serve as a program representative or alternate.

B. **Credentialing**
Representatives and their alternates are required to be registered and verified by Association staff prior to admission to the Council meeting floor for the purpose of voting. There shall be only one vote card, or designation, distributed to the credentialed representative and/or alternate per program. Credentialed representatives are allotted one vote for each EMRA member at their residency program and associated fellowship programs at the institution as described in the Association Bylaws. Association staff will report the number of credentialed representatives prior to the beginning of each session of the Council to the Speaker.

Amended, 10/23

C. **Alternate Representatives**
Alternate representatives may make motions and vote in place of the program representative during council meetings at the discretion of, or in the absence of, the program representative.

If a credentialed representative or alternate is not present at a meeting of the Council, another member of the same program who is present may be seated as a representative *pro tem* by Association Staff.

Amended, 10/23

D. **Board of Directors**
Members of the Board of Directors will be seated on the floor of the Council. Such members may address the Council on any matter under discussion but shall not have voting privileges in Council sessions.

Amended, 9/05

III. Introduction of Business

A. **Addresses, Remarks, and Awards**
Addresses by outgoing and incoming presidents, remarks by the Speaker, presentation and acceptance of awards, recognition of distinguished guests and the like are in a special category of tradition. It is the prerogative of the Speaker to permit these niceties as may be appropriate without unduly intruding upon the time necessary for the Council to accomplish its regular business. In general, such items are scheduled in advance in the published order of business. Unscheduled presentations may be arranged with the Speaker. It is to be recognized that the Speaker must usually discourage extraneous unscheduled presentations, not because of any lack of merit to the proposals, but because of the primary obligation to conserve the time of the Council for its immediate deliberations.

B. **Reports**
Reports are routinely received as business of the Council when they come from the Board of Directors, standing and *ad hoc* committees and certain officials of the Association. Any report including recommendations for policy initiatives or Council action is referred to the Reference Committee so that hearings may be held on the substance thereof. Reports exceeding five pages must be accompanied by a one page or less executive summary. Submitted reports will be accessed only by the Speaker, Vice Speaker, Parliamentarian, and necessary Association administrative staff until the general release of the online or printed Representatives' Handbook to the Association website.

Amended, 10/23

C. **Resolutions**
Business is introduced into the Council through the presentation of resolutions. A resolution is a formal motion that states a policy belief of the Association or directs the Association to take specific action. If adopted, a resolution will become official Association policy and will apply henceforth to future business of the Association.

Amended, 10/23

3. **Authorship**:
Any member or group of members of the Association in good standing from a membership class eligible to serve as members of EMRA's Representative Council may introduce a resolution to be considered by the Council, including voting representatives on behalf of their program or on an individual basis. The Board of Directors may also submit resolutions to the Council.

Amended, 10/23
Amended RC, 9/24

4. **Submission**
   Resolutions should be submitted to the Association web portal. Emailed resolutions will be accepted in case of technical difficulties as long as received before the deadline.

Amended, 10/23

5. Processing of Resolutions

a) **Regular Resolutions**
Resolutions must be received by Association staff no later than 11:59 p.m. Central time of the forty-fifth calendar day prior to the upcoming Council meeting to be considered. Receipt of resolutions will be acknowledged by email upon receipt. Submitted resolutions will be accessed only by the Speaker, Vice Speaker, Parliamentarian, and necessary Association administrative staff until publication.

EMRA will publish Council resolutions on the Association website no later than thirty calendar days prior to the meeting.

Amended, 10/23

b) Late Resolutions
Occasionally, an urgent issue may arise after the due date for regular resolution submission. Any such resolution will be labeled as a “late resolution” and discussed at the Council meeting. Given that Council representatives will have limited time to fully review the resolution prior to the meeting, only pressing matters will be considered under this mechanism. A late resolution may be considered only if the Council deems the issue and the proposed action to be urgent, and the reasons for late submission appropriate. Acceptance as an item of business requires a two-thirds affirmative vote of the Council. However, the Reference Committee may consider the resolution during their deliberations, noting that the Representative Council must first accept the resolution by two-thirds vote before debate of or voting on the Reference Committee's recommendations. Any resolution not accepted under this late resolution mechanism may be resubmitted for routine consideration at a future meeting of the Council.

Amended, 10/23

c) Emergency Resolutions
Any resolution introduced after 11:59 p.m. Central time of the tenth calendar day prior to the opening of the Council shall be labeled an “emergency resolution.” Emergency resolutions are limited to substantive issues that could not have been considered prior to the Council meeting because of their acute nature. Emergency resolutions require both approval of the Speaker and a two-thirds vote

of the Council in order to be accepted as Council business. The Speaker is given broad discretion in determining whether to approve the resolution for acceptance as items of Council business. The Speaker should balance the responsibility to facilitate Council business and to honor the will of the representatives against whether consideration of the subject matter of the resolution would serve the best interests of the Association and whether internal or external time pressures make immediate consideration of such resolutions imperative. If the Speaker rules against acceptance of such a resolution, the resolution may still be accepted for business upon a three-fourths affirmative vote of the Council. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to the Reference Committee and may only be adopted or otherwise favorably acted upon by a three-fourths vote of the Council. If not approved for acceptance as Council business, such resolutions may be resubmitted as regular items of business at future meetings of the Council.

Amended, 10/23

d) Deferred Resolutions

When a resolution presents a potential legal problem, the Speaker and Association staff will contact the author to discuss the problem. If the sponsor is able to remedy the situation, the resolution will be published in a routine manner. However, if for whatever reason remedy of the legal problem is not possible, the Speaker will designate that resolution as “deferred;” it will not be published to the Association website or included in the *Representative’s Handbook*. No resolution will be taken for a vote or considered by the Reference Committee if it presents real, perceived, or potential legal problems to the Association.

Amended, 10/23

e) **Commendation Resolutions**

The introduction of commendation resolutions is prohibited in the Council. Commendations should be sent to the Board of Directors for consideration for an award or other appropriate recognition.

f) **Memorial Resolutions**

The Council may receive memorial resolutions to remember a physician who has made significant contributions to the Association. Memorial resolutions are published but not read. The Speaker will announce the memorial resolutions and call for a moment of silence at the regular meeting of the Council.

Amended, 10/23

g) **Bylaws Amendments**

Proposed amendments to the Bylaws must follow the procedures for amendments contained with the current Bylaws of the Association.

Any individual member or committee may offer a resolution to the Council recommending an amendment to the Bylaws. Resolutions recommending Bylaws amendments will be subject to testimony and analysis through the Reference Committee process prior to voting by the Council. The Council may then amend and vote on the amendment. A two-thirds vote of credentialed representatives is necessary for adoption.

6. Structure of Resolutions

A resolution serves as the main motion before the Council. Therefore, in order to be considered, a resolution must contain only "whereas" and "resolved" clauses. Improperly worded resolutions will be returned for modification. Preambles will not be accepted. For a guide to writing a resolution, please see the EMRA Representative Council Guide to Writing a Resolution. Council Officers are available for additional assistance but may not draft language or give the perception of influencing the author or other members of Council.

Amended, 10/23

a) Title

The resolution title should briefly summarize the intent of the proposed resolution. Titles should not routinely be debated or amended by the Council; however, these may be modified by the Reference Committee or Speaker to ensure congruence with adopted resolution language.

Amended, 10/23

b) **"Whereas" Clauses**

"Whereas" clauses serve to identify the problem at hand, advise the Council as to the timeliness or urgency of the problem, describe the effect of the issue upon the membership of the Association, and indicate if the action called for is contrary to, or will revise current Association policy. A "whereas" clause is a statement of fact. Information contained in the "whereas" clauses should be checked for accuracy. Inflammatory statements or other language that reflects poorly upon the Association is not be permitted. "Whereas" clauses cannot be amended or debated by the Council. "Whereas" clauses carry no binding effect and are discarded after Council action on the accompanying "resolved" clauses.

Amended, 10/23

c) "**Resolved" Clauses**

"Resolved" clauses are either statements of Association policy, or directives to take specific action. A single resolution may contain both types of "resolved" clauses. Each clause must be able to stand independently of the others, therefore each proposed action or policy statement must be written in a separate "resolved" clause. The "resolved" clauses should not refer back to the prefatory statements. For clarity, all proposed actions should be stated in the affirmative.

"Resolved" clauses are debatable and may be altered by the Council.

Amended, 10/23

d) **References**
All resolutions shall be accompanied by appropriate supporting background material. The Association will not be responsible for obtaining background research on any resolution.

e) Supporting policy
Any current Association policy that forms the basis for a resolution, or exists in support of it, must be referenced. If no Association policy exists, it must be explicitly stated that none exists. Supporting policies from outside organizations shall be included in the reference section.

Amended, 5/20

IV. Presentation of Reports and Resolutions

A. **Reports**
A report is "received" when it is introduced as the business of the Council. Reports will be made available by publication to the Association website. The Council may decline to receive a matter only by objecting to its consideration at the time of its introduction on the Council floor.

Amended, 10/23

B. **Regular Resolutions**
At the appropriate time, the Speaker will call for resolutions. For each resolution, there must be an author. Resolutions that have complied with the policies contained in these adopted procedures and the Association Bylaws shall be published to the Association website and regarded as officially received. Regular resolutions will be included in the *Representatives' Handbook* and regarded as business items before the Council.
The Council may decline to receive a matter only by objecting to its consideration at the time of its introduction on the council floor.

Amended, 10/23

C. **Late Resolutions**
Late resolutions will be distributed to the representatives as above, with denotation of such resolution being 'late' and subject to approval by the Council before consideration may be given to the merits of the resolution. The authors of late resolutions will be given an opportunity to explain the reason for late submission. The Council will then be asked to vote on the acceptance of individual late resolutions. A two-thirds affirmative vote is required for acceptance of a resolution as official business of the Council. At the time of introduction of any resolution, it is possible for any representative to object to its consideration. In the event that the Council does not approve consideration by a two-thirds vote, the resolution is not accepted as Council business, but may be considered at future Council meetings as a regular item of business. The Reference Committee may consider the resolution during their deliberations, noting that the Representative Council must first accept the resolution by two-thirds vote before debate of or voting on the Reference Committee's recommendations.

Amended, 10/23

D. **Emergency Resolutions**
Given the timing, emergency resolutions are those submitted after the Reference Committee has met and discussed regular and late resolutions. The Speaker will determine if an emergency resolution will be presented to Council. However, if the Speaker rules against acceptance of such a resolution, the resolution may still be accepted for business upon a three-fourths affirmative vote of the Council. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to the Reference Committee and may only be adopted or otherwise favorably acted upon by a three-fourths vote of the Council. If not approved for acceptance as Council business, such resolutions may be resubmitted as regular items of business at future meetings of the Council.

V. Reference Committee

A. **Members**
The reference committee is a group of members selected by the Speaker to conduct open hearings on matters of business of the Association. Committee members are not required to be program representatives, but must be Association members in good standing. No officer of the Association shall serve on a Council Reference Committee. The committee and its Chair will be appointed by the Speaker

Amended, 10/23

B. **Duties**
The committee will hold a hearing prior to the Council session. Having heard discussion on the subject before it, the committee then drafts a report with recommendations to the Council for disposition of its items of business.

C. **Procedures**
Reference Committee hearings are open to all members of the Association, invited guests, interested outsiders, and members of the press. Any member of the Association is privileged to speak on the resolution or report under consideration. Nonmember physicians, guests or interested outsiders may, upon recognition by the Chair, be permitted to speak. The Chair is privileged to call upon anyone attending the hearing if, in their opinion, the individual may have information which would be helpful to the committee.

Equitable hearings are the responsibility of the Chair, Speaker, Vice Speaker, and Parliamentarian. The aforementioned may establish rules regarding the presentation of testimony with respect to limitations of time, repetitive statements, and the like. Additionally, a decision will be made regarding allowing recordings of the hearing. If, in the Chair’s estimation, such factors would be, or become, undesirable for the conduct of an orderly hearing, the Chair may act to prohibit them. Reference committee chairs have the authority to go into executive session at any point during the hearing.

Reference committee chairs should not ask for an expression of the sentiments of those attending the hearing by an informal vote on particular items. The committee members may ask questions to be sure that they understand the opinions being expressed, or may answer questions if a member seeks clarification; however, the committee

members should not enter into discussions with speakers or express opinions during the hearings.

It is the responsibility of the Reference Committee to listen carefully and evaluate all the opinions presented so that it may provide the voting body with a carefully considered recommendation.

The Reference Committee hearing is the proper forum for discussion of controversial items of business. In general, representatives who have not taken advantage of such hearings for the presentation of their viewpoints or the introduction of evidence should be reluctant to do so on the floor of the Council. On the other hand, there is never compulsion for mute acceptance of reference committee recommendations at the time of the presentation of its report.

Following its open hearings, the Reference Committee will go into executive session for deliberation and construction of its report. It may call into such executive session anyone whom it may wish to hear or question.

Amended, 10/23

VI. Reference Committee Reports

A. **Purpose**

Reference committee reports comprise the bulk of the official business of the Council. They need to be constructed swiftly and succinctly after conclusion of the hearings in order that they may be processed, reviewed, formatted, and made available to the Council in advance of the meeting. Reference committees have wide latitude in their efforts to facilitate expression of the will of the majority on the matters before them and to give credence to the testimony they hear. They may amend resolutions, consolidate kindred resolutions by constructing substitutes, and they may recommend the usual parliamentary procedure for disposition of the business before them, such as adoption, rejection, amendment, referral and the like.

Amended, 10/23

B. **Main Motion**

Each report or resolution which has been accepted by the Council as its business is the matter which is before the Council for disposition together initiating from the Reference Committee recommendations. In the event that a number of closely related items of business have been considered by the Reference Committee and the consolidation or substitution has been proposed by the committee, the recommendations of the Reference Committee will be the matter before the Council for discussion.

The Speaker will open for discussion the matter which is the immediate subject of the Reference Committee report. The effect is to permit full consideration of this business, unrestricted to any specific motion for its disposal. Any appropriate motion for disposition by extraction may be made from the floor. In the absence of such a motion, the Speaker will state the question in accordance with the recommendation of the Reference Committee. Minority reports from reference committee members are in order.

Amended, 10/23

C. **Format**

Each item referred to the Reference Committee should be reported to the Council as follows:

- Identify resolutions by number and title;
- Identify reports by name of Committee or action;
- State concisely the Reference Committee's recommendation and placement on the consent agenda;
- Comment, as appropriate, on the testimony presented at the hearings; and
- Discuss and provide supporting evidence for the the recommendations of the Reference Committee.

Amended, 10/23

D. **Consent Agenda**

The Consent Agenda, or waiver of debate list, includes those items referred to the Reference Committee such as resolutions, reports, and Bylaws amendments. Such items of business are listed in the Reference Committee report with their recommendation for adoption (with or without amendments or substitutions), not adoption, referral, or other specific recommendation as contained in Subsection E. The Reference Committee recommendation is accepted unanimously and all debate is waived unless the item is extracted as described below.

Amended, 10/23

E. **Notes on Specific Recommendations**

1. **Filed**

   The Reference Committee is reporting on informational material provided to the Council which encompasses no specific proposal for action. The Reference Committee expresses appreciation of the report and recommends the matter be filed for information.

2. **Not adopt**

   The Reference Committee is reporting on a resolution which, in its opinion, should be rejected. If the item is extracted, the Speaker raises the question on adoption of the resolution before the Council for discussion, making it clear that the Reference Committee has recommended not adoption of the resolution.

   Amended, 10/23

3. **Refer**

   The Reference Committee is reporting on a resolution or report which it feels should be transmitted for further consideration to the Board of Directors, or to an appropriate Board-designated committee or working group. The Reference Committee may not recommend an amendment to a resolved clause or other specific recommendation pertaining to the referral. If extracted, the Speaker places the matter of referral before the Council for discussion

   The Council must first defeat referral if it prefers to adopt, not adopt, amend, postpone, or table the matter—any one of which it is free to do. If the Council does not vote down the Reference Committee recommendation, then the item is referred with no further debate.

   Amended, 10/23

4. **Amend**
   The Reference Committee is reporting on a resolution or report which it wishes to amend by addition, deletion, alteration or substitution. If extracted, in order to permit the normal procedures for parliamentary handling, the matter which is placed before the Council for discussion is the amended version as presented by the Reference Committee together with the recommendation for its adoption. It is then in order for the Council to apply amendments of the first and second order in the usual fashion to this Reference Committee recommendation. Such procedure and does not preclude the possibility that someone may wish to restore the matter to its original unamended form. This may be accomplished by a motion to amend the Reference Committee ‘s recommendation to restore the original language.

5. **Substitute**
   The Reference Committee is reporting on two or more kindred resolutions or reports. It wishes to recommend a consolidation into a single resolution, or it wishes to recommend adoption of one of these items in its own right and as a substitute for the rest. If extracted, for orderly handling, the matter before the Council for consideration is the recommendation of the Reference Committee to adopt the substitute or consolidated version. If the reference committee’s version is not adopted, the entire group of proposals has been rejected, but it is in order for any representative to move consideration and adoption of any one of the original resolutions.

   Amended, 10/23

6. **No Action**
   The Council should take a definite action on resolutions and only if necessary reaffirm current policy. In the event that “no action” is the only appropriate posture for the Association with respect to a particular resolution, the Chair of the Reference Committee, after consultation with the Speaker, may place such resolution on the consent calendar in a category designated “no action.” Such a motion if adopted is the equivalent of a motion to table (postpone temporarily) and results in suppression of the resolution for the current meeting if not extracted.

   Amended, 10/23

7. **Reaffirmation**
   From time to time, the reference committee will report on a resolution which calls for a policy position contrary to or at variance with existing policy. If the committee wishes to recommend reaffirmation of existing policy, it should recommend not adoption of the resolution. Reaffirmation is relatively indecisive since the previous policy has not been specifically reintroduced and debated.

VII. Form of Action upon Reports and Resolutions

A. **Disposition of Reports**
   When the Council wishes to acknowledge that a report has been received and considered, but that no action upon it is either necessary or desirable, the appropriate proposal for action is that the report be filed. This does not have the effect of placing the

Association on record as approving or accepting responsibility for any of the material in the report.

When a report offers recommendations for action, these recommendations may be adopted, which has the effect of making the Association responsible for the matter as described in the Association Bylaws.

When the Council does not wish to assume responsibility for the recommendation of a report in its existing form, it may take action to refer back to committee, refer elsewhere, reject the report in entirety or in specific part (not adopt), or to adopt as amended.

B. **Disposition of Resolutions**
The consent agenda will be placed at the beginning of the Reference Committee report, organized by the committee's recommendation. Any representative may extract any item from the consent agenda for individual debate or action by simple request. After all requests for extraction of items are heard, the remaining consent agenda recommendations will be unanimously approved en bloc without discussion. Consideration of the remaining resolutions in the Reference Committee report will proceed in the traditional manner, taking any extracted resolution(s) first. Adoption of resolutions or referral to the Board of Directors has the effect of making the Association responsible for the matter as described in the Association Bylaws.

Amended, 10/23

VIII. Parliamentary Procedure

A. **Governing Code**
In the absence of specific provisions to the contrary in the current Bylaws of the Association or in this manual of adopted procedures, the Council shall be governed by the parliamentary rules and usage contained in the current edition of American Institute of Parliamentarians (AIP) *Standard Code of Parliamentary Procedure*.

Amended, 10/23

B. **Recognition**
Representatives or members of the Board of Directors wishing to debate should proceed to one of the standing microphones. Each speaker shall provide their name and the delegation represented each time they are recognized by the Speaker. In addition, the representative should state their position for or against the pending motion if not proposing a new motion.

Amended, 10/23

C. Rules of Debate

The Council may alter the limits on debate at any time except when there is a pending motion to vote immediately or to table. If no such motion to limit debate is made, then the following standard limits shall apply:

1. Each speaker shall be limited to three minutes.
2. Each speaker may address the Council no more than two times on a particular motion.
3. No member will debate again on the same question until everyone has had an opportunity to debate once.

4. While representatives and their alternates have full privileges of the floor, other individuals may be recognized to address the Council at the Speaker's prerogative. This ruling may be overruled by a majority vote of the representatives.
5. A member speaking on the floor who has not exceeded their time limit may not be interrupted by another member unless that other member has a valid point of order.
6. Any member who has exceeded their time limit may be allowed to continue debate at the discretion of the Speaker.

Amended, 5/17
Amended, 5/20
Amended, 10/23

D. Precedence of Motions

Motions are made so that those that are lower in rank can be modified by those that are higher. It is perfectly acceptable to skip a step in the list when making motions (for example, it is not required to amend a motion in order to move to limit debate). Votes are taken, starting from those higher on the list toward those lower on the list, until complete disposition has been made of the matter at hand.

It is not uncommon to move up the list in making motions, then to move partway down the list in voting, and again to repeat the procedure before completely disposing of the matter at hand.

E. Principal Rules of Governing Motions

Principal Rules Governing Motions

	Interrupt Speaker?	Second Needed?	Debate Allowed?	Amendable?	Motions or Action to Which It Applies	Motions That Can Be Applied to It	Vote Required for Passage
Precedented Motions*							
Privileged Motions							
10. Adjourn	No	Yes	No	No	None	None	Majority
9. Recess	No	Yes	Yes	Yes	None	Amend	Majority
8. Table (Postpone Temporarily)	No	Yes	No	No	Main	None	Majority
7. Vote Immediately	No	Yes	No	No	Debatable	None	2/3
6. Limit Debate	No	Yes	Yes	Yes	Debatable	Amend	2/3
5. Postpone Definitely	No	Yes	Yes	Yes	Main	Amend, vote immediately, limit debate	Majority
4. Refer for Decision	No	Yes	Yes	Yes	Main	Amend, vote immediately, limit debate	Majority
3. Refer for Report	No	Yes	Yes	Yes	Main	Amend, vote immediately, limit debate	Majority
2. Amend	No	Yes	Yes	Yes	Rewordable	Vote immediately, limit debate	Majority
Main Motions							
1a. The Main Motion	No	Yes	Yes	Yes	None	Specific main, subsidiary	Majority
1b. Specific Main Motions							
Reconsider	Yes	Yes	Yes	No	Main	Vote immediately, limit debate	Majority
Rescind	No	Yes	Yes	No	Main	Vote immediately, limit debate	Majority
Resume Consideration (Take from Table)	No	Yes	No	No	Main	None	Majority
Incidental Motions#							
Appeal	Yes	Yes	Yes	No	Rulings of the Chair	Vote immediately, limit debate	Negative majority
Suspend Rules	No	Yes	No	No	None	None	2/3
Consider Informally	No	Yes	No	No	Main	None	Majority
Requests							
Conditional Requests†							
Question of Privilege	Yes	No	No	No	None	None	Majority
Withdraw Motion	Yes	No	No	No	All	None	Majority
Division of Question	No	No	No	No	Main	None	Majority
Mandatory Requests§							
Point of Order	Yes	NA	NA	NA	Any Error	None	No vote
Parliamentary Inquiry	Yes	NA	NA	NA	All	None	No vote
Division of Assembly	Yes	NA	NA	NA	Indecisive Vote	None	No vote

*Precedented motions are numbered 1 through 10 in order of precedence.
#Incidental motions must be decided immediately.
†Conditional requests must be granted or voted on immediately.
§Mandatory requests must be granted immediately
NA=Not applicable

F. Comments on Specific Procedures

1. Privileged Motions

a) **Postpone Temporarily (Table)**The motion to postpone temporarily is to set aside a pending main motion, which can be taken up and further considered at any time during the same meeting. This is the highest-ranking subsidiary motion to be applied to a main motion and requires a majority vote. It can have no other motions applied to it, requires a second, and is not debatable. It can be applied to a motion even after it has been determined that debate on the motion has been terminated. This would, in effect, temporarily postpone the vote on the main motion to which no other debate can be applied and allow the motion to be brought from the table for resumption of debate. When such debate is resumed, if the vote to terminate debate has been previously decided, it would simply require that the vote, at that time, be taken without further debate. If no motion to resume consideration is made prior to adjournment of the meeting, the motion dies without action.

b) Vote Immediately

When the assembly feels that it has heard enough and wishes to vote on the matter at hand at once it uses the motion to vote immediately. A motion to vote immediately requires a second and no debate is allowed. This motion applies only to the immediately pending question unless the representative making the motion to vote immediately qualifies the motion by specifically stating that it applies to all pending matters. A motion to vote immediately on all pending matters will only be accepted if the Speaker rules that both sides have been heard on all pending matters. In the event a motion to vote immediately prevails, the Council must act without further debate on the item of business and all pending amendments in proper order of precedence. The Speaker will not recognize the motion to vote immediately or terminate debate as being in order if it is added at the conclusion of the significant discussion of the immediately pending question. At the discretion of the Speaker, a motion to vote immediately will not be accepted until the Council has heard at least one speaker representing each side of the issue.

c) Limit or Extend Debate
Any representative may move to limit or extend debate on any item of business before the Council. A second is required. Further debate is restricted to the type and time of limitations or extensions proposed. Such a motion must be adopted by a two-thirds majority vote.

d) **Postpone Definitely** This motion serves to delay further consideration of a pending motion until a stated time. The procedure is exactly as described to postpone temporarily, with the exception that a specific time for the resumption of debate is specified.

A motion to postpone definitely requires a second and is debatable. This motion is useful to allow representatives time to construct amendments or otherwise discuss the issue informally before presenting a motion to the assembly, while other Council business continues. It also allows an urgent matter to preempt temporarily debate on the current item of business.

e) Refer for Decision
When the Council refers an item of business to the Board of Directors for decision, the Council gives authority to the Board of Directors to make the decision as to what action is appropriate. If the motion to refer is adopted, all pending or adopted amendments as well as the original resolution are referred. Once the Board of Directors determines the appropriate action they will subsequently inform the Council and implement, as applicable, by appropriate means.

f) Refer for Report
If it is desired that a matter be referred to the Board of Directors or through the Board to the appropriate committee, a motion is made to refer for report. It should be specifically indicated if a report back to the Council is desired at a definite time. Without such a directive, the matter

of reporting or its timing is up to the body receiving the referral. If the motion to refer is adopted, all pending or adopted amendments as well as the original resolution are referred. All referrals to specific committees are made through the Board of Directors. The Board of Directors shall not alter reports or recommendations of committees or individuals, when the Board has referred an issue, resolution, or report to that entity as a result of referral from the Council.

g) Amend

Amendments are used to alter a main motion under consideration. Amendments may be by addition, deletion, or substitution. A second is required to accept an amendment. Debate is then limited to the proposed amendment only. A second-order amendment (amendment to the amendment) may be proposed; however, third-order amendments are not in order. Second-order amendments are limited to the scope of the primary amendment. Should the main motion be postponed or referred, all pending amendments shall be debated on resumption of consideration of the main motion. All motions for substantial amendments to resolutions (more than three words in length) must be submitted to the Speaker in writing prior to being introduced verbally. When appropriate, the amendment will be projected on a screen for viewing by the Council.

2. Main Motions

a) **Reconsider**

If a motion to reconsider is approved, it allows the assembly to debate and to vote again on a main motion taken at the same meeting, as though no previous vote had been taken.

b) **Recall**

In order to undo a motion to refer which has been adopted by the Council at the same session, a technique for calling back a referral is the use of the motion to recall. The motion to recall is similar to the motion to reconsider in terms of its intent, but the motion to reconsider can be applied only to a main motion. The motion to refer is a subsidiary motion. The motion to recall requires a second and is debatable, but only as to the reasons for and the propriety of recall. Not debatable is the substance of the main motion itself or any of its pending amendments except as they might apply to the appropriateness of recall.

c) **Amend a Previous Action**

Not infrequently, it becomes desirable because of afterthought or further consideration to modify an action that has already been taken. If the modification is a simple addition to the action taken, rather than a substantive change, it is not necessary to reconsider. A motion to amend a previous action is in order and it becomes a main motion.

d) **Withdraw a Resolution**

Occasionally the sponsor of a resolution decides that it should be withdrawn. At any time prior to the acceptance of the resolution as the business of the Council, the sponsor may withdraw the resolution from the

Council's agenda. After acceptance as an item of business, it becomes the property of the Council. At the time of the Reference Committee hearings, the author may suggest to the Reference Committee that withdrawal would be preferable to other action. If the Reference Committee agrees, it may recommend to the Council in its report that leave to withdraw be accorded by the Council. The Speaker, having confirmed approval by the author, places the question on granting leave to withdraw. A majority vote in the affirmative accomplishes withdrawal.

3. Conditional Requests

a) Question of Privilege

Any member may rise to a question of privilege in order to make a request of the Speaker to ensure the safety, comfort, or convenience, or rights of the assembly.

b) Division of Question

Occasionally, in the course of debate, it becomes desirable to separate a proposal into its component parts. This situation often arises when discussing a complex or controversial proposal with many "resolves." Some items may be noncontroversial, while a particular clause may threaten defeat of the entire proposal. In such instances, a representative may request division of the question. The question may be divided only if it contains more than one independent proposition, so that if one proposition is defeated, the remaining "resolves" are still logical. An incidental request for division of the question may only be applied to the main motion.

4. Mandatory Requests

a) Point of Order

If a representative believes that a rule has been violated, he or she may rise to a point of order immediately after the error is discovered. A point of order on a procedural matter is not in order if raised after another motion has been decided. Any further discussion from the representative asking for the privilege is out of order unless recognized by the Speaker. The Speaker shall immediately rule on the point of order and does not require consultation with the Parliamentarian. If the representative disagrees with the propriety of the Speaker's ruling on any matter, they may appeal the decision by two-thirds vote of the Council.

Anyone wishing to invoke this right simply stands and announces, before any other business has taken place, that they appeal the ruling of the Speaker. The question becomes, "Shall the decision of the Speaker stand as the judgment of the Council?" Such a vote is then taken and the business of the Council may then resume.

Amended RC, 10/23

b) Parliamentary Inquiry

Any representative may rise to a point of parliamentary inquiry to request clarification on any matter. Questions requesting clarification on a procedural matter in question, a proposal one would wish to make, or of

another representative are in order. All inquiries shall be addressed to the Speaker. Any further discussion from the representative asking for the privilege is out of order unless recognized by the Speaker. The parliamentary inquiry itself is not debatable.

c) Division of Assembly
Should any member of the assembly be in doubt as to the outcome of a vote, they may request a division of the assembly. This motion may be applied only to the immediately preceding vote. It does not require a second, is not debatable, and requires no vote. Representatives shall then vote by raising their voting cards or by submitting their vote through an individually identifiable remote voting system as determined by the Speaker. Association staff shall then count every vote cast and report the result to the Speaker, who shall announce the outcome.

d) Voting Procedure
The method of voting is the Speaker's prerogative, and may be accomplished with the use of voting cards, voice votes, electronic votes or other means. The motion in question shall pass upon receiving the required majority of votes cast. In the event that a motion will fail for lack of one vote, the Speaker may, at his or her discretion, cast the deciding vote.

e) Announcements
Announcements of general interest to Council attendees may, at the discretion of the Speaker, be made from the floor. The Speaker will, however, discourage private announcements and those that are not germane to the business of the Council or the Association.

Amended RC, 10/23

f) Use of Electronic Devices
Electronic devices present in the Council meeting room must be kept in "silent" mode at all times during the Council meeting. Anything other than brief conversation should occur outside the Council meeting room.

Amended RC, 10/23

g) Smoking
Smoking or vaping are not permitted during Council meetings.

Amended RC, 10/23

IX. Sunset Policy

A. **Timing**
All EMRA resolutions and policies shall be reviewed on a five-year schedule commencing after the fall meeting the year in which the resolution is adopted. Policies in effect prior to the implementation of this sunset mechanism will be grouped by policy area and integrated into the five-year cycle.

B. **Composition of Committee**

Reviews shall be conducted by a policy review committee composed of the President, Immediate-Past President, Council Speaker and Vice-Speaker, Parliamentarian, Director of Health Policy, and two appointed program representatives. The Council Officers shall appoint the program representatives sixty days prior to the fall meeting.

Amended, 10/23

C. **Criteria for Consideration**

Policies shall be measured against the following criteria:

- Relevance to the Association's mission
- Relevance to the Association's interests and those of the specialty of Emergency Medicine. Core beliefs of the organization or specialty shall be retained.
- Current state of the policy.
    - Subject matters that have been resolved should be sunset. Policies addressing ongoing issues should be reaffirmed. Recent developments may prompt sunset, reaffirm, or referral for Board review of the policy.
- Effect of policy or action item.
    - If the outcome did not fulfill the intended goals of the resolution, then the policy should be renewed and further action proposed. If the outcome was satisfactory, then the resolution should be sunset.
- Concordance with other Association policy. No policy of the Association may contradict another.

D. **Committee Procedures**

The committee shall operate by consensus. No policy may be recommended for sunset unless two-thirds of committee members agree.

The committee may not recommend any amendment that would substantially alter the original intent of the policy as adopted by the Council. Furthermore, the committee may not propose an amendment that would direct new action, significantly expand existing policy, or grant new power or additional obligation to the Council or Board of Directors. All new policy initiatives must be submitted via the standard resolution submission process.

E. **Committee Report**

A consent agenda of recommended actions (sunset, reaffirm, or refer for Board review), along with a brief explanation for each recommendation, shall be submitted to the Council no later than forty-five days prior to the spring Council meeting. The consent calendar will become an item of business on the spring meeting agenda. Any representative may extract any item from the consent calendar for individual consideration by simple request. Debate on the item shall be limited to the policy review committee's recommendation only. Amendments to the policy itself shall be considered out of order.

Board review" requires review, report, and recommendation at the next Council meeting. If more time is required, the Board of Directors may request a six-month extension to be approved by the Council.

Amended, 5/20
Amended, 10/23

X. Staff Duties

A. Purpose

Association staff will perform critical duties to facilitate and ensure the proper function of the Council Meeting. Responsibilities include:

- Registration of all program representatives in attendance;
- Counting of all votes when requested by the Speaker during a meeting;
- Collection, tabulation, and recording of all votes during elections;
- Submission of a report recording the results of all votes and elections during the Council meeting to the Speaker during the meeting; and
- Distribution and collection of surveys from all representatives in attendance.

Amended, 10/23

B. Composition

Association staff will perform the necessary duties to ensure the aforementioned responsibilities are carried out in full. At times, staff may request assistance from available members of the Association's Board of Directors, which should be provided, However, no director or officer of the Association, candidate for office, or program representative, may credential representative or alternate members attending the Council meeting for the purpose of voting.

Amended, 10/23

C. Procedures

Association staff shall conduct the business of the Council in accordance with these adopted rules, the Bylaws of the Association, and adopted parliamentary authority. Association staff may not cast votes during the Council meeting.

1. Once a quorum has been established as defined by the Association Bylaws, the Representative Council is able to hold elections and/or vote on resolutions.
2. Program representatives must be credential prior to the 'Call to Order.' Marking the official beginning of the Council business agenda. Program representatives may be credentialed at any time before the 'Call to Order.'
3. Should a program representative need to leave the Council Meeting for the remainder of the meeting and prior to the completion of elections and/or voting on resolutions and an alternate is not available, the program representative ballots will not be counted. However, if the representative is able to give notice at the time of credentialing that they will need to leave the meeting, they may designate and leave their ballots with Association staff to have the remainder of their votes counted. However, should there be a run-off vote; their ballots will not be included in the run-off.
4. The Credentials and Tellers Committee will be responsible for keeping a running total of the number of representatives present at the meeting in the event that a vote requires a majority or two-thirds vote.

Amended, 6/10
Amended, 5/20
Amended, 10/23

XI. Parliamentarian

A. **Purpose**

The parliamentarian is a member skilled in parliamentary procedure. They serve to advise the Speaker when requested, but have no authority to make rulings on Council matters.

Amended, 10/23

B. **Appointment**
The EMRA Representative to the American Medical Association (AMA), as appointed by the Board of Directors, shall act as the Parliamentarian.

Amended, 10/23

XII. Sergeant-at-Arms

A. **Purpose**
The Sergeant-at-arms, under the direction of the Speaker, helps to maintain order and decorum at meetings of the Council. The Sergeant-at-arms acts as a doorkeeper and is responsible for the comfort and convenience of the Council.

B. **Appointment**
The duties of Sergeant-at-arms will be performed by the individual holding the office of the Immediate Past-President of the Association at the beginning of the Council meeting. Their service will continue until the gavel closes the Council business meeting.

Amended, 5/13
Amended, 10/23

XIII. Elections

A. **Campaign Rules**
Campaigning in any form, by the candidate, or any other person on their behalf, is prohibited before nominations have been formally announced by EMRA (approximately 45 days in advance of the election). Personal communications may be sent by the candidate soliciting support. The use of mass communication tools, by the candidate or any person on their behalf, for campaigning purposes, is prohibited. Campaigning by any other person other than the candidate, in any form, is prohibited.

1. **Campaign Materials**
Buttons, stickers, gifts, emails, parties, or socials with the intent of promoting a candidate are prohibited at any time. The distribution or display of campaign material or items will not be permitted during any sponsored Association function. Candidates are permitted to circulate campaign materials only at the Council meeting and pre-election Council sponsored candidate reception. Campaign materials are limited to a one-page paper handout. Negative materials pertaining to another candidate are prohibited at all times.

2. **Candidate Receptions**
Candidates may campaign in person at the EMRA Representative Council sponsored candidate reception, as well as the Medical Student Council Meeting, preceding the Representative Council Meeting. Candidates may not participate in other candidate receptions prior to elections.

3. **Endorsement**
The Officers and Directors of the Association shall not endorse candidates for election to Association leadership.

The Council Officers, in consultation with the Board of Directors, are the arbiters of questions or any violations of these Candidate Campaign Rules, with consequences to be determined by the Board, and potentially including removal from the ballot.

B. Election Protocol

1. Nominations

Nominations for election to the Board of Directors shall be taken from the Association web portal as well as from the Council floor. Pursuant to the Bylaws of the Association, nominations shall be taken for only one open office at a time. Nominations for other open offices shall be taken following the announcement of the result of the previous election. Any eligible member of the Association, as determined by the provisions of the Bylaws of the Association, may nominate themselves. No second is required for nomination. Nominations shall not be limited in number. Nominations for an open office will be closed by the Speaker after the call for floor nominations has been concluded.

Amended, 10/23

2. Candidate Address

Each candidate will be allotted three minutes to address the Council at the discretion of the Speaker. A question and answer period will follow, the format of which is determined by the Speaker. No other candidates will be allowed to be in the room while another candidate is addressing the Council.

Amended, 10/23

3. Balloting Procedure

a. Sealed Floor

Just prior to the elections, the floor will be sealed and monitored by the Sergeant- at- arms. Once the floor has been sealed, no representative will be permitted to enter or exit the floor of the Council meeting.

Amended, 10/23

b. **Ballot Requirements**

Voting shall be by a ballot approved by the Board of Directors. A vote shall be declared void if the number of invalid ballots is enough to alter the outcome or if the total number of invalid ballots is greater than ten percent of the total number of representatives credentialed and voting at the Council meeting. A ballot shall be considered invalid if there are greater or fewer votes on the ballot for candidates than the required number on a particular ballot. There shall be no write-in voting. The complete list of candidates' names will be shown on the screen at the same time for the office in question.

c. **Runoff Ballots**

Elections are determined by the majority of votes cast. If no candidate is elected, then the two candidates who received the highest number of votes on the inconclusive ballot will participate in a runoff ballot.

4. **Election Results**

If nominations have been closed with but a single candidate nominated for an open position, the Speaker shall declare the candidate elected to office by acclamation without taking a vote.

For all other candidates, upon completion of the voting and verification of votes for a candidate, Association staff will report the election result to the Speaker along with a breakdown of ballots received. The Speaker will then announce the results of the election. The Speaker, in consultation with staff, will make the final determination as to the validity of a vote.

Amended, 6/11
Amended, 10/23

XIV. Amending the Representative Council Procedures

Amendments to these procedures shall be through introduction of resolutions or reports to the Council. Such resolutions or reports shall follow the procedures described herein and in the Association Bylaws. Revisions should occur in tandem with regular Bylaws review to ensure compatibility of procedural guidelines.

Emergency amendments to these adopted procedures can occur immediately at any meeting of the Council by a two-thirds vote. Such emergent amendments shall expire at the close of the meeting in which they were adopted.

Amendments:

- September 2005: Section II and VIII (Resolution A' 05-02: Alternate Representatives)
- May 2006: title change from *Adopted Procedures of the Representative Council* to *Emergency Medicine Residents' Association Representative Council Procedures*
- June 2010: Section X, subsection C addition
- June 2011: Section XIII, subsection B amendments
- May 2013: Section XII, subsection A, paragraph 2 amendments
- May 2017: Section VIII, subsection F, paragraph 4, subparagraphs c and d amendments
- October 2023: Complete revision (please see executive summary)

Amended, 10/23