Emergency Medicine Residents' Association

Representative's Handbook

April 12, 2021
Virtual Meeting

Emergency Medicine Residents' Association

Representative Handbook
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Emergency Medicine Residents' Association

April 11, 2021

Dear EMRA Program Representatives,

Welcome! We know you have committed a lot of time from your busy schedule to attend this virtual conference, and we want to thank you for making EMRA the best resident organization in the world!

The past year has brought many challenges, and EMRA has been working hard to protect you and your future. We have been engaged in conversations regarding the emergency medicine workforce, are helping many members establish connections for career opportunities, and have a workgroup dedicated to researching the challenges faced by displaced residents. Early April a summit will be held with many emergency medicine organizations attending, including EMRA, to address recent findings from a study on the current state of the emergency medicine workforce. Stay tuned for an EMRA Town Hall featuring the workforce issues we are currently facing that will take place after the meeting. We want to hear from you so that we can best represent you. If there are other ways that we can support you, please reach out to us!

We are also pleased to present 10 resolutions and the Sunset Review for consideration. These resolutions and open forum discussions are the foundation of our organization, directing the advocacy priorities of EMRA and its Board of Directors, and the guideposts toward the future of our specialty. As your Council officers, we extend our gratitude to the residents, medical students and fellows who authored these resolutions and for all members who choose to make their voices heard.

We've said it a thousand times, and it cannot be said enough, EMRA's greatest strength is our highly engaged Representative Council. Each of you, by taking on the responsibility of serving as a Program Representative, provides a leadership service in advancing our advocacy efforts, challenging EMRA to continue growing and strengthening our member benefits, and improving the work we do on behalf of our specialty and patients.

Don't forget to enjoy the different tracks and lectures at CORD.

Serving you with honor,

Tracy and Ashley

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Emergency Medicine Residents' Association

EMRA Representative Council Meeting
April 12, 2021 10:00am – 1:00pm CDT
Virtual Meeting

9:30 am **Credentialing Opens**

VIRTUAL PROGRAM:

10:03am **Welcome and Introduction**
Tracy Marko, MD, PhD, MS
EMRA Speaker of the Council

10:05am **A Conversation with ACEP**
ACEP - American College of Emergency Physicians
Mark Rosenberg, DO, MBA, FACEP
President

10:15am **A Conversation with ABEM**
ABEM – American Board of Emergency Medicine
Mary Nan Mallory, MD, MBA
President

10:25am **A Conversation with CORD**
CORD – Council of Emergency Medicine Residency Directors
Boyd (Bo) Burns, DO
Board of Directors

10:35am **Moment of Silence**
A time to honor EMRA members lost in the past year

10:36 am **Call to Order**

10:37am **Opening Remarks**
Tracy Marko, MD, PhD, MS
EMRA Speaker of the Council

10:38am **President's Address: State of the Association**
RJ Sontag, MD
EMRA President

10:50am **Parliamentary Review**
Sophia Spadafore, MD
EMRA Representative to the AMA

10:55am **Voting Overview**
Tracy Marko, MD, PhD, MS
EMRA Speaker of the Council

11:00am **Quorum Report / Test Vote**
Tracy Marko, MD, PhD
EMRA Speaker of the Council

BUSINESS MEETING AGENDA

11:05am **Approval of Representative Council Minutes from ACEP'20 Meeting**
October 26, 2020, Virtual Meeting

11:07am **Medical Student Council Chair Confirmation**
Chiamara Anokwute
EMRA Medical Student Council Chair

11:09am **ACEP/PEER Introduction**
Suzannah Alexander
Editorial Director

11:10am **Reports and Resolutions**
Sunset Report
Reference Committee Report

1:00pm **Announcements and Adjourn**

EMRA Representative Council Meeting Minutes
October 26, 2020
Virtual Meeting

COUNCIL OFFICERS: Karina Sanchez, MD; Tracy Marko, MD, PhD, MS

BOARD OF DIRECTORS Omar Maniya, MD, MBA; Hannah Hughes, MD, MBA; RJ Sontag, MD; Priyanka Lauber, DO; Erik Blutinger, MD, MSc; Deena Khamees, MD; Angela Cai, MD, MBA; Gregory Tanquary, DO, MBA; Breanne Jaqua, DO, MPH; Sophia Spadafore, MD; Jazmyn Shaw

PARLIAMENTARIAN: Sophia Spadafore, MD

TELLERS AND CREDENTIAL CHAIR: Madelyn Farris and James Bryant

SERGEANT-AT-ARMS: None present as the meeting was in a virtual setting

REFERENCE COMMITTEE: Cpt. Maggie Moran, MD, MC; Nishad Rahman, MD

GUESTS: Boyd Burns, DO; Gillian Schmitz, MD, FACEP; Jill M. Baren, MD; Christopher Clifford, MD

STAFF: Cathey Wise, CAE; Todd Downing; April Applewhite; Valerie Hunt; James Bryant; Alyssa Ceniza

PROGRAMS: Advocate Christ Medical Center; Alameda Health - Highland Hospital; Albert Einstein Medical Center; AMITA Health Resurrection Medical Center; Arrowhead Regional Medical Center; Ascension St. John Hospital; Aventura Hospital & Medical Center; Baylor College of Medicine; Beaumont Hospital - Royal Oak; Boston University Medical Center; Brandon Regional Hospital; Central Michigan University College of Medicine; Christiana Care Health; Conemaugh Memorial Medical Center; Cooper Hospital; Dartmouth-Hitchcock Medical Center; Desert Regional Medical Center; Detroit Medical Center/Wayne State University - Sinai Grace; Dr. Christopher Libby; Duke University Medical Center; Eastern Virginia Medical School; Emory University School of Medicine; EMRA Medical Student Council; Florida State University – Sarasota; Geisinger Medical Center; George Washington University; Harvard Affiliated Emergency Medicine Residency at Brigham and Women's; HealthPartners Institute/Regions Hospital; Hospital of the University of Pennsylvania; Indiana University School of Medicine; Jefferson Health Northeast (Aria Health); Kaiser Permanente San Diego Medical Center; Kent Hospital; Kern Medical Center; LAC Harbor UCLA Medical Center; LAC+ USC Medical Center;

Loma Linda University School of Medicine; Louisiana State University - New Orleans;
Maimonides Medical Center; Medical College of Wisconsin;
Mercy Health St Rita's Medical Center; Mercy St Vincent Medical Center; Merit Health Wesley;
MetroHealth Medical Center; Michigan State University/Sparrow Hospital – Lansing;
Midwestern University - Chicago COM; Mount Sinai Medical Center/Miami;
Mount Sinai School of Medicine - New York; New York Methodist Hospital;
North Florida Regional; Ohio Health Doctors Hospital; Oregon Health and Science University;
Penn State Health Milton S Hershey; Prisma Greenville Health System;
Riverside Community Hospital / University of California Riverside;
Riverside Regional Medical Center; Ronald Reagan UCLA / Olive View UCLA Medical Center;
Rutgers New Jersey Medical School;
San Antonio Uniformed Services Health Education Consortium (SAUSHEC);
Spectrum Health/Michigan State University; St John's Riverside Hospital;
St Louis University School of Medicine; State University of New York – Downstate;
Staten Island University Hospital; Texas A&M/Scott & White Medical Center – Temple;
Texas Tech University Health Sciences Center – Lubbock; University of California – Davis;
University of California - San Diego; University of California - San Francisco General Hospital;
University of California San Francisco – Fresno; University of Central Florida at Ocala;
University of Cincinnati College of Medicine; University of Connecticut;
University of Louisville – Kentucky; University of Michigan;
University of Nebraska Medical Center; University of Nevada - Las Vegas;
University of Oklahoma College of Medicine/Tulsa; University of Pittsburgh Medical Center;
University of Tennessee – Nashville; University of Texas at Austin Dell Medical School;
University of Texas Health Science Center at San Antonio;
University of Texas Southwestern Medical Center – Dallas; University of Utah Hospital & Clinics;
University of Virginia Health; University of Wisconsin; Valley Health System;
Virginia Commonwealth University - Medical College of Virginia;
Washington University St Louis; Wellspan York Hospital

Dr. Sanchez called the meeting to order at 1:15pm EST. She thanked the program representatives for their dedication to their programs and to EMRA.

Dr. Sanchez provided opening remarks to the Council. She introduced the liaisons to provide updates.

Dr. Schmitz, President-Elect of the American College of Emergency Physicians (ACEP), participated in a moderated Q&A with Dr. Marko.

Dr. Mallory, President of American Board of Emergency Medicine (ABEM) participated in a moderated Q&A with Dr. Marko.

Dr. Burns, Council of Emergency Medicine Residency Directors (CORD) Board of Directors, participated in a moderated Q&A with Dr. Marko.

Dr. Sanchez led a moment of silence for our colleagues who we have lost since our last meeting.

Dr. Hughes provided the President's Address to the Council.

Dr. Spadafore presented an overview of the use of parliamentary procedure and its importance in the deliberations of the Council.

Dr. Sanchez introduced the electronic voting system.

Dr. Marko introduced the Board of Directors voting system.

Dr. Sanchez stated that there are 82 of 268 residency programs present, representing a total of 2,080 of 12,786 total EMRA voting members. A quorum is present.

Dr. Marko introduced the candidates for President-Elect: Angela Cai, MD, MBA; Nick Cozzi, MD, MBA; Erin Karl, MD. She then asked for any nominations from the floor and received none. After the respective taped video speeches from each candidate, voting commenced. Dr. Sanchez addressed the council to announce a run-off between Dr. Cai and Dr. Karl. After a second round of voting, Dr. Sanchez addressed the council to confirm the election was valid with Dr. Cai announced as President-elect.

Dr. Marko introduced the candidate for Vice Speaker: Ashley Tarchione, MD. She then asked for any nominations from the floor and received none. Dr. Tarchione was approved as she was running unopposed.

Dr. Marko introduced the candidates for Resident Representative to ACEP: Pavitra Krishnamani, MD; and Nishad Rahman, MD. She then asked for any additional nominations with Dr. Cozzi indicating his running from the floor. After the respective taped video and live speeches from each candidate, voting commenced. Dr. Sanchez addressed the council to announce a run-off between Dr. Krishnamani and Dr. Cozzi. After a second round of voting, Dr. Sanchez addressed the council to confirm the election was valid with Dr. Cozzi announced as EMRA Resident Representative to ACEP.

Dr. Marko introduced the candidates for Director of Leadership Development:
Jonathan Chan, MD; Yevgeniy Maksimenko, MD; and Michael Messina, DO. She then asked for any nominations from the floor and received none. After the respective taped video speeches from each candidate, voting commenced. Dr. Sanchez addressed the council to announce a run-off between Dr. Maksimenko and Dr. Messina. After a second round of voting, Dr. Sanchez addressed the council to confirm the election was valid with Dr. Maksimenko announced as Director of Leadership.

Dr. Marko introduced the candidates for Director of Health Policy: Maggie Moran, MD. She then asked for any additional nominations with Dr. Krishnamani announcing her running from the floor. After the respective taped video and live speeches from each candidate, voting commenced. Dr. Sanchez addressed the council to confirm the election was valid with Dr. Moran announced as Director of Health Policy.

Dr. Sanchez called for break at 4:23pm EST and the meeting was called back in session at 4:30 pm EST.

Dr. Gregory Tanquary introduced the “Alumni of the Year" award video recognizing Dr. Andrew Little.

A motion was made to approve the minutes from the EMRA Representative Council Meeting held on March 9, 2020, in New York City, NY, at the CORD *Academic Assembly*. The motion was seconded and adopted by a voice vote of the Council.

Dr. Marko proposed a motion to extend the timeline for the creation of “Displaced Residents Bill of Rights”. The motion was seconded and adopted.

Dr. Marko asked for any emergency resolutions and there were none.

Dr. Marko introduced the Reference Committee’s proposal for the Consent Agenda. She informed the Council the recommendations was TO ADOPT Resolution:

- F'20-01 (Recognition for Exemplary Service for Dean Wilkerson)

She further informed the Council the recommendation was to ADOPT AS AMENDED Resolutions:

- F’20–2 (Fair Compensation for EM Physicians-in-Training)
- F’20-3 (Planning for EM Resident Illness and Occupational Exposure)
- F’20-04 (EM Resident Nourishment and Hydration While on Duty)
- F’20-5 (Policing and Emergency Medicine)

Dr. Marko then called for any extractions and received motions to extract the following resolutions:

- Amended F’20-3 (Planning for EM Resident Illness and Occupational
- Exposure)
- Amended F’20-4 (EM Resident Nourishment and Hydration While on Duty)
- Amended F’20-5 (Policing and Emergency Medicine)

There was a motion to accept the Consent Agenda, which was seconded and passed by a voice vote. The following resolutions were adopted as presented:

- F'20-01 (Recognition for Exemplary Service for Dean Wilkerson)
- Amended F’20-5 (Policing and Emergency Medicine)

There was a motion to limit each debate to 60 seconds per motion and 20 seconds per speaker. This motion passed.

Dr. Marko introduced resolution F'20-3 (Planning for EM Resident Illness and Occupational Exposure). After discussion, there was a motion TO ADOPT the Amended Resolution, seconded, and passed via the electronic voting system.

Dr. Marko introduced resolution F'20-4 (EM Resident Nourishment and Hydration While on Duty). After discussion, there was a motion TO ADOPT the Amended Resolution, seconded, and passed via the electronic voting system.

Dr. Marko introduced resolution F'20-5 (Policing and Emergency Medicine). After discussion, there was a motion TO ADOPT the Amended Resolution, seconded, and passed via the electronic voting system.

Dr. Marko introduced the Reference Committee's proposal for the Non Consent Agenda. As there was no discussion on the following discussion items, the Reference Committee was unable to provide recommendations.

- Report on Restrictive Covenants and Non-Competes
- Report on Artificial and Augmented Intelligence in Emergency Medicine

Dr. Marko discussed "Report on Restrictive Covenants and Non-Competes" which did not have any recommendations and thus did not need a vote. Thus, it was filed.

Dr. Marko discussed "Report on Artificial and Augmented Intelligence in Emergency Medicine" which did have recommendations and thus did need a vote. This report passed via the electronic voting system.

The meeting was adjourned by Dr. Sanchez at 5:45pm EST.

Addendum 1: Notes on Resolutions

EMRA Representative Council Meeting - ACEP SA 2020

DEFINITIONS OF AVAILABLE COUNCIL ACTIONS

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

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

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

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

NOT ADOPT
Defeat (or reject) the resolution in original or amended form.

Dr. Speaker & Councilors,

Your Reference Committee gave careful consideration to the Resolutions referred to the Council for consideration and submits the following report:

NON-CONSENT AGENDA

Report on Restrictive Covenants and Non-Competes

Report on Artificial and Augmented Intelligence in Emergency Medicine

CONSENT AGENDA

RECOMMENDATION TO ADOPT:

Resolution F'20-01 Recognition for Exemplary Service for Dean Wilkerson

RECOMMENDATION TO ADOPT AS AMENDED:

Amended Resolution F’20–2 Fair Compensation for EM Physicians-in-Training

Amended Resolution F'20-3 Planning for EM Resident Illness and Occupational Exposure

Amended Resolution F'20-04 EM Resident Nourishment and Hydration While on Duty

Amended Resolution F'20-5 Policing and Emergency Medicine

NON-CONSENT AGENDA

F' Report on Restrictive Covenants and Non-Competes

No recommendation given due to inability to hear testimony at the Reference Committee Meeting

Discussion: Due to time constraints, no testimony was given regarding the report precluding the reference committee from providing a recommendation.

F' Report on Artificial and Augmented Intelligence in Emergency Medicine

No recommendation given due to inability to hear testimony at the Reference Committee Meeting

Discussion: Due to time constraints, no testimony was given regarding the report precluding the reference committee from providing a recommendation.

RECOMMENDATION FOR ADOPTION

Resolution F'20-01 Recognition for Exemplary Service for Dean Wilkerson

Recommendation: Adopt

Text:

> **RESOLVED,** that EMRA recognize Mr. Dean Wilkerson for his exemplary dedication and service to residents, resident education and our organization.

Discussion: There was unanimous approval of this resolution.

RECOMMENDATION TO ADOPT AS AMENDED

F'20–2 Fair Compensation for EM Physicians-in-Training

Recommendation: Adopt as amended

Text:

> ~~**RESOLVED**, that the Emergency Medicine Residents' Association (EMRA) will advocate for 38 hospitals, healthcare systems, and/or government entities to increase resident salaries to at least match those of NPPs; and be it further~~
>
> ~~**RESOLVED**, that EMRA believes that the value residents bring to patient care and institutional financial returns match or outmatch the contributions of NPPs in a clinical environment; and be it further~~
>
> ~~**RESOLVED**, that EMRA believes that costs associated with elements unique to graduate medical education, such as resident education, are at least partially funded by the resources provided by the US government to hospitals for each residency program; and be it further~~
>
> **RESOLVED**, that EMRA will create a task force to ~~further explore~~ study EM resident compensation, productivity, and billability in the context of fair compensation for trainees ~~in comparison with the compensation, productivity, and billability of NPPs.~~

Discussion: The public hearing was largely against the addition of language comparing residents to NPPs, and wished to distance our compensation in relation to that of the NPP. Instead the public hearing was in support of uniform increase to resident compensation separate from RVUs. Finally, the public hearing was largely in support of changing language to remove comparing productivity and billability vs NPPs, as our role and the patients seen by residents is different from that of NPPs. The committee agrees with the proposed changes and heard no opposition to the proposed amendments.

F'20-3 Planning for EM Resident Illness and Occupational Exposure

Recommendation: Adopt as amended with reaffirmation and amendment to existing EMRA policy

Text:

~~**RESOLVED**, that the Emergency Medicine Residents' Association (EMRA) believes that communicable illness is an occupational hazard for EM residents and will take the opportunity to discuss it as such when indicated during national conversations on the topic; and be it further~~

RESOLVED, that EMRA reaffirms the Family Leave Policy (Section V, Policy V) with the following amendments:

V. 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.

~~**RESOLVED**, that EMRA will advocate for liberal paid sick leave policies for EM residents, calling for programs to create flexible sick leave plans that aim to avoid extending the duration of residency training for residents when expanded sick leave is required; and be it further~~

~~**RESOLVED**, that EMRA will strongly oppose repurposing resident vacation time for use as sick leave, instead encouraging the expansion of contractual paid sick leave policies for residents who require further days off for illness or sequelae associated with illness (eg self-quarantine); and be it further~~

~~**RESOLVED**, that EMRA will advocate for the implementation of non-punitive backup systems that achieve staffing goals for the ED when EM residents fall sick, acknowledging that these efforts are i~~

~~mportant in ensuring ED coverage without compromising the health and well-being of providers and patients; and be it further~~

~~**RESOLVED**, that EMRA supports flexible sick leave policies that do not punish residents and minimize disruption to graduation. EMRA will work with ABEM, ACGME, and other relevant parties to develop guidelines on sick leave that match these values.~~

RESOLVED, that 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; and be it further

RESOLVED, that EMRA will support a resident's and medical students' 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; and be it further

~~**RESOLVED**, that EMRA believes residents should not be expected to care for patients without proper PPE when indicated.~~

Discussion: Discussion during the public hearing was largely in support of the spirit of the resolution, with specific modifications to the 1st through 4th resolved clauses suggested by the medical student council which received wide support for improved language. This took the existing EMRA policy and added new language to emphasize medical leave separate from family leave as an additional protection. Additionally, the new language added prioritization of protection of vacation time for residents separate from sick leave and quarantine periods associated with illness. Resolved 5 was struck, as both sentences received wide opposition, and the resolved did not provide any additional language not otherwise previously discussed. There was significant discussion regarding the final three resolved clauses in a shift to PPE. Resolved 6 and 7 were widely supported with the amended language to include medical students. Resolved 8 was the most contentious, with debate regarding language as there was a mostly equal split between those in favor, those opposed, and those in favor with amended language to replace expected with mandated. The reference committee took the testimony from the various members of the public hearing and concluded that this clause did not add any protections or stances not previously covered in resolved 6 and 7, as residents would not be mandated/expected to see patients without proper PPE if proper PPE was being provided as is the goal of resolved 6 and 7. Therefore this contentious statement was removed.

F'20-04 EM Resident Nourishment and Hydration While on Duty

Recommendation: Adopt as amended

Text:

~~RESOLVED, that the Emergency Medicine Residents' Association (EMRA) will support policies and statements that encourage appropriate nourishment and hydration for EM residents on shift, as these elements are necessary for physician safety and well-being; and be it further~~

RESOLVED, that EMRA supports adequate accommodations to allow for the consumption of food and drink in the workplace ~~will advocate for hospitals to ensure that ED workspaces in which EM physicians spend most of their time meet institutional standards to allow for the consumption of food and drink within those spaces~~;

RESOLVED, that EMRA will support policies that encourage appropriate nourishment and hydration for EM residents and medical students while working ~~support and share existing educational materials on nourishment and hydration for EM physicians, including those created and disseminated by the American College of Emergency Physicians (ACEP)~~

Discussion: The reference committee heard testimony regarding nourishment and hydration of residents and students while at work. Based on the conversation and amendments, the reference committee decided to remove the first resolved clause and combine it with the third resolved clause to avoid redundancy. All other changes were based on amendments recommended by individuals and agreed upon by members in attendance.

F'20-5 Policing and Emergency Medicine

Recommendation: Adopt as amended

Text:

RESOLVED, That EMRA ~~believes~~ recognizes excessive use of force by police as ~~police brutality is~~ a public health issue that threatens the health and wellbeing of individuals, law enforcement ~~officers themselves~~, and ~~our~~ society with disproportionate effects on vulnerable communities including people of color; and be it further

RESOLVED, that EMRA work with ACEP and other relevant stakeholders to support legislation that restricts the excessive use of force by law enforcement and promotes ~~with~~ evidence-based harm reducing law enforcement tactics ~~officers which includes the use of choke and sleeper holds and crowd control weapons such as kinetic impact projectiles and chemical irritants~~; and be it further

RESOLVED, that EMRA opposes the use of medicine administration for the purpose of restraint or de-escalation ~~ketamine and other sedative/hypnotic agents~~ by non-medical personnel ~~for the purpose of restraining someone for law enforcement purposes and not for a legitimate medical reason~~; and be it further;

RESOLVED, that EMRA will work with relevant stakeholders to support a) implementation of evidence-based practices ~~standards and trainings~~ regarding the use of medicine administration for the purpose of restraint or de-escalation. ~~ketamine and other sedative/hypnotic for the purposes of restraint~~ in the prehospital setting and b) documentation of the use and effects of medicine administration for the purpose of restraint or de-escalation ~~ketamine and other sedative/hypnotic~~ in events involving law enforcement ~~agencies, particularly incidents involving the use of ketamine for non-medical purposes~~; and be it further

RESOLVED, that EMRA supports efforts by emergency departments, hospitals, law enforcement ~~agencies~~ and other organizations to document and publish data on the health impacts of the excessive use of force by law enforcement ~~officers to better protect patients from instances of police brutality.~~

Discussion: The reference committee recognizes the urgent need to address excessive use of force by law enforcement. After hearing testimony, the committee sought to remove inflammatory language and replace this language with more overarching themes. The committee heard testimony from multiple parties who wished to strike the language about specific medications to make a more broad definition of sedation medications; chemical restraints as a term was agreed upon by all parties. Furthermore, while the committee recognizes the concerns of some individuals about the specific use of the words "public health issue," the committee finds it important to retain these phrases to highlight the importance of this issue to EMRA as an organization.

Report on Artificial and Augmented Intelligence in Emergency Medicine

Recommendation: Adopt

Text:

- Augmented intelligence should have proven benefits to clinical decision making, clinical workflows, or patient safety
- Any required use of augmented intelligence must ensure that the entity requiring its use assumes applicable liability
- 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

- 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
- 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.

POLICY COMPENDIUM
SUNSET REVIEW
SPRING 2021

REAFFIRM

1. Section VI: III. Education in Regarding Human Trafficking

SUNSET

1. Section IX: III. High Fidelity Simulation

REAFFIRM

1. **Section VI: III. Education in 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

Sunset Committee Recommendation: Reaffirm

Gains have been made, as evidenced by this topic now being on Boards. Still a timely and important concept in Emergency Medicine and the sunset committee recommends this policy be reaffirmed.

SUNSET

1. **Section IX: III. High Fidelity Simulation**
   EMRA supports the transitioning the ABEM Oral Certification Examination to include more high fidelity simulation cases.

Original policy adopted RC, 10/16

The intent of this resolution has been accomplished. ABEM Oral Certification Examination has transitioned to a primarily electronic format. The sunset committee, therefore, recommends this policy be unsettled.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

SPRING 2021

RESOLUTIONS

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'21-1

Unconscious Bias and Cultural Sensitivity Education

Authors: Oluwatosin Ayotunde MD, Michael Rushton DO, Catherine Hixson MD

WHEREAS, The Emergency Department is the frontline for medical care and provides care to people of all races and genders that walk through the door, therefore, it is vital that emergency medicine providers are aware of any unconscious bias that might arise during treatment of our patients;[1] and

WHEREAS, Structural racism - a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups - exists today in the practice of medicine in the United States;[2] and

WHEREAS, It has been established that racial disparities exist in the consideration and treatment of Black, indigenous, and other people of color within emergency departments, ranging from thrombolysis treatment to restraints for psychiatric patients to pain management for renal colic;[3] and

WHEREAS, 30 states have declared racism a public health crisis or emergency, recognizing it as a threat to the physical, emotional, and social well-being of every person in a society that allocates privilege on the basis of race;[4] and

WHEREAS, The American College of Emergency Physicians believes that:

- Quality health care depends on the scientific competence of physicians as well as their cultural awareness.
- Cultural awareness should be an essential element in the training of physicians and to the provision of safe, quality care in the emergency department environment.
- Physicians should encourage patients and their representatives to communicate cultural issues that may impact their care.
- Resources should be made available to emergency departments and emergency physicians to assure they are able to respond to the needs of all patients regardless of their respective cultural backgrounds[5]. Therefore, be it

RESOLVED, that EMRA:

1. Support implementation of cultural training and educational sessions geared towards eliminating unconscious bias and systemic racism in Emergency Medicine residency curriculum; implementation may include online modules, lectures from diverse emergency medicine team members, or a combination of similar series.
2. Forward a similar resolution for consideration at the next American College of Emergency Physicians council meeting.

REFERENCES:

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2. Hardeman, R. R., Medina, E. M., & Kozhimannil, K. B. (2016). Structural Racism and Supporting Black Lives — The Role of Health Professionals. *New England Journal of Medicine, 375*(22), 2113-2115. doi:10.1056/nejmp1609535

3. Dark, C., MD. (2016, November 02). 4 Ways Emergency Physicians Can Help Reduce Racism in Their Hospitals. Retrieved January 24, 2021, from https://www.acepnow.com/article/4-ways-emergency-physicians-can-help-reduce racism-hospitals/

   • Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med*. 2007;22(9):1231- 1238.

   • Schnitzer K, Merideth F, Macias-Konstantopoulos W, et al. Disparities in care: the role of race on the utilization of physical restraints in the emergency setting. *Acad Emerg Med.* 2020;27(10):943-950.

   • Berger AJ, Wang Y, Rowe C, et al. Racial disparities in analgesic use amongst patients presenting to the emergency department for kidney stones in the United States. *Am J Emerg Med*. 2020;S0735-6757(20)30017-6.

4. Bonilla-Silva E. White supremacy and racism in the post-civil rights era. Boulder, CO: Rienner, 2001.
   Benjamin, G., MD. (2020, May 29). Racism is an ongoing public health crisis that needs our attention now. Retrieved January 24, 2021, from https://www.apha.org/news-and media/news-releases/apha-news-releases/2020/racism-is-a-public-health-crisis

5. American College of Emergency Physicians. (2020). Cultural Awareness and Emergency Care Statement. Dallas, TX.

EMRA POLICY:

SECTION IV - Public Health

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, 05/15

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

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

VII. Health Disparities

- EMRA collaborate with other organizations and coalitions to:

A. Urge government and private organizations to encourage research on reducing health disparities in Emergency Medicine and to increase funding for these studies.

B. Advocate for the creation and support of new or existing leadership positions that investigate health disparities.

Original policy adopted RC, 5/17

SECTION VI - Resident and Medical Student Education

II. 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

FINANCIAL IMPACT: None

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE CORD21 REPRESENTATIVE COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE REPRESENTATIVE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'21-2

Advocacy for the Acquisition of a Federal and State Personal Protective Equipment Strategic Supply

Author: Aaron R. Kuzel, D.O., MBA

WHEREAS, the 2020 SARS-CoV-2 Coronavirus Pandemic depleted personal protective equipment in hospitals across the United States of America;[1] and

WHEREAS, the World Health Organization has stated that the shortage of personal protective equipment has left physicians, nurses and other frontline workers dangerously ill-equipped to care for COVID-19 patients due to limited access to gloves, masks, respirators, goggles, face shields, and gowns;[2] and

WHEREAS, the effects of the SARS-CoV-2 have disrupted supply chains of personal protective equipment globally, nationally, and locally;[3] and

WHEREAS, the American Medical Association issued a statement in support of healthcare workers using their own face masks and respirators when such critical resources were unavailable nor provided by their employer;[4] and

WHEREAS, physicians, nurses, respiratory therapists, and other allied medical and support professionals were required to reuse personal protective equipment in less than ideal containment;[4] and

WHEREAS, states and other localities have had to compete in order to acquire personal protective equipment and are outbid for the purchase of personal protective equipment by the Federal Emergency Management Agency (FEMA);[5,6] and

WHEREAS, the threat of another global pandemic is constantly evolving.[7] Therefore, be it

RESOLVED, that the Emergency Medicine Residents' Association advocate Federal and State Legislatures for the production and maintenance of a strategic personal protective equipment supply with the ability to sustain national or statewide hospital and pre-hospital operations during a pandemic period. This strategic supply of personal protective equipment should include N-95 masks, gowns, face masks, face shields, and gloves.

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FINANCIAL IMPACT: Staff time to work with ACEP DC office.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE CORD21 REPRESENTATIVE COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE REPRESENTATIVE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Emergency Medicine Residents' Association

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'21-3

Accountable Organizations to Resident and Fellow Trainees

Authors: Sophia Spadafore, MD; Alysa Edwards

WHEREAS, The stated mission of the Accreditation Council for Graduate Medical Education (ACGME) is to, "improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation,[1]" and

WHEREAS, To achieve its mission the ACGME has determined that it has two main purposes, "(1) to establish and maintain accreditation standards that promote the educational quality of residency and subspecialty training programs; and (2) to promote conduct of the residency educational mission with sensitivity to the safety of care rendered to patients and in a humane environment that fosters the welfare, learning, and professionalism of residents,[1]" ; and

WHEREAS, While the ACGME has taken steps to advocate for residents, its ability to effectively and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and delay in providing feedback to programs[3]; and

WHEREAS, Resident and fellow trainees still endure suboptimal training conditions with recourse to address these issues limited by multiple factors, including a high debt burden and fear of their program losing accreditation thus affecting future career prospects, ultimately making reporting even gross ACGME guideline infractions difficult to encourage[4,5];and

WHEREAS, During the COVID-19 pandemic, residents and fellow trainees have been particularly susceptible to poor conditions including limited availability of PPE, longer hours, no hazard pay, and difficulty in securing workers compensation if trainees become sick, with many programs revoking promised stipend increases[5], and

WHEREAS, The rate of closure of family medicine residency programs is increasing, and the Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited training programs that have closed, with indications that more closures can be expected across the country in multiple specialties[6,7]; and

WHEREAS, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States,[8,9]; and

WHEREAS, Numerous organizations such as the ACGME, American Medical Association (AMA), American Osteopathic Association (AOA), American Board of Medical Specialties (ABMS), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies, National Board of Medical Examiners (NBME), Pennsylvania Medical Society (PAMED), Philadelphia County Medical Society (PCMS), and Educational Commission for Foreign Medical Graduates (ECFMG) responded to the Hahnemann closure as well as other residency closures with offers of legal assistance, grants, visa assistance, tail-insurance coverage, and other forms of support[10]; and

WHEREAS, The majority of funding for Graduate Medical Education (GME) is through Medicare and Medicaid, with additional funding through the U.S. Department of Veteran Affairs (VA) and Health Resources and Services Administration (HRSA), as well as private hospital funding[11]; and

WHEREAS, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[11]; and

WHEREAS, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests.[2,10] Therefore, be it

RESOLVED, EMRA will ask ACEP to establish a taskforce with the following goals:

(1) determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests;

(2) determine how these organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees; and

(3) determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability;

(4) in the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

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EMRA POLICY:

V- XI. Residency Closure

Due to the shortage of board certified emergency medicine physicians (EP) to properly staff emergency departments in the United States and to the potential increase in demand for EPs in the future, closure of residency programs or reduction in the number of residents in training would be detrimental to patient care and safety and would fail to meet the emergency health care needs of the country.

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.

January 2020 18 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.

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.

V-XVI. 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.

FINANCIAL IMPACT: Staff time

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE CORD21 REPRESENTATIVE COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE REPRESENTATIVE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Emergency Medicine Residents' Association

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'21-4

SUPPORTING VOTING CAPABILITIES AMONGST HOSPITALIZED PATIENTS WITH THE CAPACITY TO VOTE

Authors: Jason D. Vadhan, OMS-IV, Joel Haines, OMS-IV, Divy Mehra, OMS-IV, Carlos Garcia Galindo, OMS- IV, Matthew Mayeda, OMS IV

WHEREAS, studies have demonstrated that an individual's state of health can significantly affect their decision and ability to vote, with those who suffer from cardiovascular disease, uninsured individuals, those who suffer from long term disabilities, and those who self-report poor health status being more vulnerable to under-representation across local, state, and federal governments;[1] and

WHEREAS, lack of political representation is a significant determinant of health and health outcomes;[2] and

WHEREAS, Hospitalized and emergency department patients are especially at risk for underrepresentation, with nearly half of all patients requiring hospitalization for at least 4 days;[3]

WHEREAS, with the ongoing COVID-19 pandemic, the number of hospitalized persons, as well as the average length of hospital stay may be increased throughout the voter registration and election period;[4] and

WHEREAS, emergency departments offer the unique opportunity to engage diverse and underrepresented populations in the voting process. Several previous nonpartisan voter registration efforts within these settings have been shown to increase participation in the electoral process, especially among the elderly, adolescents, the medically underserved, and the critically ill;[5-8] and

WHEREAS, specifically, physician-led, nonpartisan voter registration initiatives at two different university-affiliated health centers demonstrated notable efficacy, with nearly 90% of previously unregistered patients successfully registering to vote via such efforts;[6] and

WHEREAS, there are over 138 million emergency department visits in the United States per year;[9] by assisting patients in exercising their constitutional right to vote, the Emergency

Medicine Residents Association (EMRA) can facilitate a positive electoral process and ultimately benefit the patients that their members treat;[10] Therefore, be it

RESOLVED, EMRA advocate for the adoption of policies, legislation, and practices that support voting registration capabilities for emergency department patients with the capacity to vote across all local, state, and federal government elections.

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FINANCIAL IMPACT: Staff time

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'21-5

Equity in Standardized Letter of Evaluation Attainment by International Medical Students for Residency Applications

Authors: Mohamed Hussein, M.B.B.Ch., Tiffany Chow, Andrea Marquez, Kyle Ackerman, M.D.

WHEREAS, International Medical Graduates (IMGs) face a variety of additional obstacles when applying to Emergency Medicine (EM) residency positions when compared to American Medical Graduates (AMGs)[1]; and

WHEREAS, IMGs are not a homogenous body of applicants, there are different subsets of that population, such as Caribbean Medical School IMGs, non-US IMGs, and US IMGs[2] each with a unique set of challenges for applying to EM residencies; and

WHEREAS, IMGs represent 15-20% of EM residency applicants every year[3], however each IMG subtype is granted varying access to EM subinternship opportunities, all of which do not meet the same level as similar AMG applicants; and

WHEREAS, Caribbean Medical School IMGs do not have access to VSAS but are able to obtain SLOE's due to bilateral agreements, that allow for clinical rotations, with health institutions in the U.S.[4-5]; and

WHEREAS, other IMGs that have access to VSAS have access to a very limited, if any, number of programs, which limits the ability for IMGs to do away rotations and obtain meaningful SLOE's; and

WHEREAS, SLOE's can only be obtained through hands on away-rotations, where a 4th year medical student receives a standardized evaluation of their competence in the Emergency Department, reducing the perceived risk regarding the quality of their training[6] and

WHEREAS, SLOE's are cited as the most important factor used by program directors to consider an IMG as an Emergency Medicine applicant[6]; and

WHEREAS, EMRA policy passed at CORD 2020 states that 'EMRA will work with relevant stakeholders to identify barriers for international medical students to obtain visiting student rotations.' ; and

WHEREAS, VSAS access does not guarantee access to EM sub-internship opportunities as U.S. institutions can limit if their clerkships are viewable by certain international medical schools and from which international medical schools they can receive applications for clerkships[7]; and

WHEREAS, 21.5% of clerkships listed on EMRA Match report accepting “IMG Students” for rotation[8]; and

WHEREAS, the lack of opportunities within and outside of VSAS limits the availability for away rotations[8], without which IMGs are not able to obtain SLOEs in turn decreasing their competitiveness as applicants; and

WHEREAS, only 0.05% (16/273) of the residency programs listed on EMRA Match will invite an applicant without SLOEs to interview and 49% (134/273) will invite an applicant with one SLOE to interview[8]; therefore, be it

RESOLVED, EMRA will work to advocate for all the subsets of IMGs to increase the amount of programs that allow IMGs to rotate thereby increasing equity in the residency application landscape; and be it further

RESOLVED, EMRA will work to increase longitudinal representation of the perspectives of different IMG subsets within EMRA through the creation or addition of specific positions and/or committees with the primary purpose of ensuring that their many unanswered questions and concerns are addressed; and be it further

RESOLVED, EMRA will work in conjunction with CORD to mitigate the pandemic’s disproportionate effect on IMGs that are unable to obtain SLOEs due to inability to obtain hands on rotations in emergency medicine at a U.S. hospital, possibly through the identification and implementation of other standardized methods of evaluation.

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EMRA POLICY:

Section VI. VI. 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, including but not limited to elective and mandatory clerkships before the final year of medical school. EMRA advocates for the removal of currently existing caps on the number of Emergency Medicine Elective rotations allowed to senior medical students.

FINANCIAL IMPACT: Staff time and reprioritization of projects.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution S'21-6

Increasing Evidence-Based Domestic Violence Screening in the Emergency Department

Authors: Naeha Haridasa, Varsha Parthasarathy, The George Washington University School of Medicine and Health Sciences; Alicia Khan, The Georgetown University School of Medicine;

WHEREAS, 1 in 4 women and 1 in 10 men in the United States (US) have experienced intimate partner violence (IPV), such as contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and nearly half of female homicide victims in the US were killed by a current or former male intimate partner[1]; and

WHEREAS, Most survivors IPV report some form of long-term IPV-related impact including PTSD, depression, substance abuse, chronic systemic health issues, concern for safety, severe physical injury, and death, etc.[2]; and

WHEREAS, IPV screening methods in healthcare settings have been shown to vary widely across institutions, with 41.6% out of 1,208 nationwide primary care, OB/GYN, and emergency department institutions unable to describe which screening tool they used or examples of questions they ask patients[3]; and

WHEREAS, A statewide survey of healthcare providers found that only 14% report consistently screening female patients for IPV and one third report never screening[4]; and

WHEREAS, Emergency departments (ED) are often the setting of choice for patients experiencing IPV compared to other healthcare settings due to higher average utilization of healthcare services compared with the general patient population, but only 6% of all survivors presenting to the ED are positively identified[5]; and

WHEREAS, Retrospective research suggests that failure to screen for IPV in the ED results in a significant missed opportunity for implementation of violence prevention strategies[6]; and

WHEREAS, Emergency medicine (EM) providers often self-report low confidence in IPV screening, referral, and record-keeping[7], with the most frequently reported resource barriers being lack of knowledge, education, or training regarding screening of abuse[8]; and

WHEREAS, A cross-sectional survey of 71 EM residency program directors revealed that only 41% of programs required residents to observe one sexual assault exam to achieve competency and 52% of programs did not know how their sexual assault competency requirement was established[9]; and

WHEREAS, Formal training on evidence-based IPV screening tools significantly aid ED providers in identifying survivors of IPV by increasing perceptions of preparedness and significantly reducing "professional role resistance/fear of offending the patient" and "blame victim items", while bolstering "perceived self-efficacy" and "victim/provider safety"[10]; and

WHEREAS, The United States Preventive Services Task Force (USPSTF) and Centers for Disease Control (CDC) have identified and published several evidence-based screening instruments which incorporate referral interventions that effectively identify survivors of IPV[11]; and

WHEREAS, Quality improvement trials focused on ED staff awareness of IPV and implementation of evidence-based screening methods (e.g. standardized documentation forms and screening tools, electronic medical record coding, and IPV sensitive communication) lead to a 75% increase in successful identification of survivors of IPV and referral to appropriate resources[12, 13]; and

WHEREAS, Current EMRA policy supports protection of women's health and reproductive health access without specific mention of IPV, screening or intervention[14]; Therefore be it

RESOLVED, that EMRA encourages emergency medicine training programs to provide robust formal instruction on intimate partner violence as a public health and emergency medicine crisis, evidence-based screening for identification of at-risk individuals, and opportunities for trainee participation in interdisciplinary safety planning and intervention for identified survivors.

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14. EMRA Policy IV Protecting Access to Women's Health, Reproductive Health and Organizations That Provide Increased Health Access to Women, EMRA Policy Compendium, Adopted 5/17.

RELEVANT EMRA POLICY:

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

American College of Emergency Physicians Policy Statement of Domestic Violence

Originally approved October 2007, replacing rescinded policies: Child Abuse; Domestic Violence; Emergency Medicine and Domestic Violence; Management of Elder Abuse and Neglect; Support for Victims of Family Violence; Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies
Reaffirmed June 2013
Revised April 2019

The American College of Emergency Physicians (ACEP) encourages emergency personnel to assess all patients for family violence in all its forms, including that directed toward children, elders, intimate partners, and other family members. Such patients should be appropriately referred for help and detailed evaluation. Identification and assessment can be difficult as violence and maltreatment can encompass abuse in many different forms including neglect, physical abuse, sexual abuse, emotional abuse, financial exploitation and intimidation. ACEP opposes mandatory reporting of domestic violence to the criminal justice system. Instead, ACEP encourages partnering with and reporting of domestic violence to local social services, victims' services, the criminal justice system, or any other appropriate resource agency to provide confidential counseling and assistance, in accordance with the patient's wishes. Safety planning should be an important component of any screening process. In jurisdictions that have mandatory reporting requirements, persons reporting in good faith should be immune from liability for compliance.

ACEP recommends that:

- Emergency personnel assess patients for intimate partner violence, child and elder maltreatment and neglect.
- Emergency physicians, nurse practitioners, and physician assistants are familiar with signs and symptoms of intimate partner violence, child and elder maltreatment and neglect.
- Emergency medical services, medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment and interventions in intimate partner violence, child and elder maltreatment and neglect.
- Hospitals and emergency departments (EDs) encourage research regarding the epidemiology of intimate partner violence, child and elder maltreatment and neglect as well as best practice approaches to screening, assessment and intervention for victims.

- Hospitals and EDs are encouraged to participate in collaborative interdisciplinary approaches for the screening, assessment, safety planning and intervention of victims of intimate partner violence, child and elder maltreatment and neglect. These approaches include the development of policies, protocols, and relationships with outside agencies that oversee the management and investigation of family violence.
- Hospitals and EDs should maintain appropriate education regarding state legal requirements for reporting intimate partner violence, child and elder maltreatment.

FINANCIAL IMPACT: Staff time

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE CORD21 REPRESENTATIVE COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE REPRESENTATIVE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Emergency Medicine Residents' Association

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution S'21-7

Equal Consideration for Osteopathic Medical Students Applying to Emergency Medicine Residency Programs in the United States

Authors: Breanne Jaqua, DO, MPH, Elizabeth McMurtry, DO, FACEP, Dhimitri Nikolla, DO, Gregory Tanquary, DO, MBA, Tommy Eales, DO, Sara N. Kirkpatrick, OMS-III, Sergio Karageuzian, OMS-I, Christian Casteel, OMS-IV, Kevin R. Trembley, OMS-I, Neel G. Patel, OMS-I, Xinna Chen, OMS-I

WHEREAS, "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;"[1] and

WHEREAS, "The residency selection process should be equitable for applicants, recognizing the diversity of learners and educational programs and the differing missions and priorities of schools, training programs, and institutions;"[2] and

WHEREAS, the number of osteopathic physicians has grown by over 300% over the past three decades,[3] and therefore one out of every four medical students in the United States are osteopathic medical students[4]; and

WHEREAS, 33% of EMRA's medical student members are from osteopathic medical schools;[5] and

WHEREAS, discrimination and bias against osteopathic medical students applying to emergency medicine residency programs is a known problem;[6,7] and

WHEREAS, the American Osteopathic Association now has a reporting and advocacy mechanism for osteopathic medical students that experience discrimination based on their status as an osteopathic applicant when applying for audition rotations and to residency programs;[8] and

WHEREAS, a recent study demonstrated osteopathic medical students' significant disadvantage in applying to emergency medicine residency programs compared to allopathic medical students based on several key points, including fewer osteopathic medical schools with affiliated emergency medicine residency programs, significantly less access to emergency medicine faculty mentorship, and infrequent medical school-provided education on Standardized Letters of Evaluation;[9] and

WHEREAS, osteopathic medical students face a financial burden by taking the USMLE in addition to the COMLEX-USA to enhance the competitiveness of their applications to emergency medicine residency programs as the USMLE is more widely accepted as a screening tool in the residency application process;[10] and

WHEREAS, osteopathic candidates on average apply to more programs per applicant (N=61) than their allopathic counterparts (N=52);[11] and

WHEREAS, 35 states currently host emergency medicine residency programs in the United States. In 2020, 10 out of those 35 states (28.6%) had 5% or less of graduates from osteopathic medical schools fill their emergency medicine residency slots;[7] and

WHEREAS, the match rate for senior medical students entering emergency medicine residency programs in 2020 from allopathic schools was 91.6%, compared to 83.0% from osteopathic schools;[12,13] and

WHEREAS, according to the 2020 NRMP Program Director Survey, 100% of Emergency Medicine residency programs "often" interview and rank senior medical student applicants from allopathic medical schools;[14] and

WHEREAS, according to the 2020 NRMP Program Director Survey, 26% of emergency medicine residency programs "seldom or never" interview senior osteopathic applicants, and therefore 22% of emergency medicine residency programs "seldom or never" rank senior osteopathic applicants;[14] and

WHEREAS, the disruption to medical education caused by the COVID-19 pandemic has exacerbated disparities for osteopathic medical students with limited access to clinical experiences in emergency medicine,[15] Therefore be it,

RESOLVED, EMRA advocates for equitable consideration of allopathic and osteopathic medical students applying to all emergency medicine residency programs in the United States; and be it further

RESOLVED, EMRA will partner with The Council of Residency Directors in Emergency Medicine (CORD) to address explicit and implicit bias towards students from osteopathic medical schools applying to emergency medicine residency programs in the United States.

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EMRA POLICY:

Section II-III. 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.

Section II -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.

FINANCIAL IMPACT: Staff time

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE CORD21 REPRESENTATIVE COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE REPRESENTATIVE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Emergency Medicine Residents' Association

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution S'21-8

Residency Application Process Improvement

Authors: Kenneth Kim, Alysa Edwards, Alex Gallaer, David Wilson

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WHEREAS, the number of residency applications per medical student increased by 7-45% across specialties, based on applicant type with a 23% increase in Emergency Medicine[1,2] between 2016 and 2020 with no associated increase in the number of residency spots available[3-5] ; and

WHEREAS, this increase in number of residency applications per medical student has not resulted in a change in the overall match rate[6] although the number of applicants matching to their first choice program has decreased by 6.4% between 2010 and 2020 with a 5% increase in the number of applicants matching to a program ranked 5th or lower on their rank lists[7-9]; and

WHEREAS, the number of applications submitted to a single residency program increased nearly 40% between 2010 and 2020, limiting the amount of time available for application review and leading to a reliance on imperfect convenience measures such as USMLE scores or AOA status rather than holistic review[4,5,10]; and

Whereas such convenience measures have been historically shown to perpetuate racial disparities[11-13]; and

WHEREAS, this increase in number of applications per applicant causes an undue financial burden on applicants and can exacerbate socioeconomic disparities by allowing wealthier applicants to apply to more programs than poorer applicants[7,14]; and

WHEREAS, analysis of NRMP match data demonstrates that an increased number of applications per applicant decreases the odds of an individual matching into their first-choice specialty unless they themselves increase their number of submitted applications[7,10]; and

WHEREAS, the current model of interview invitations operates on a "first come, first served" basis in which interviews are scheduled for whichever students are able to respond to the interview invitation first, with all interview spots often filled within 10 minutes to one business day[3,15]; and

WHEREAS, the "first come, first served" interview invitation model has contributed to dysfunctional applicant behavior including frequent interruptions of daily activities to check interview status and minimization of clinical responsibilities in order to facilitate interview acceptance,thus reducing overall applicant wellbeing, taking away from the time spent in a clinical environment, and serving as a distraction to effective medical training[3,6,15]; and

WHEREAS, the timing of when interview offers are released varies tremendously between specialties and programs with fewer than 40% of vascular surgery and 25% of general surgery residency programs making interview dates available on their websites[3]; and

WHEREAS, specialty or program consortiums could coordinate to set a common interview release date and or increase transparency by clearly outlining the interview offer process[3]; and

WHEREAS, ability to confirm interviews is also limited by unequal distribution of interview invitations with small cohorts of highly competitive applicants disproportionately filling interview slots which may jeopardize programs' ability to fill all available residency positions, particularly in the 2021 match[16,17]; and

WHEREAS, EMRA alongside other EM organizations released a consensus statement on the 2020-2021 residency application cycle encouraging students to interview at an ideal number of programs, recognizing over-interviewing as a potential problem for applicants and programs[18]; and

WHEREAS, the current system of uncapped applications and interviews incentivizes individual applicants to apply to and interview at an increasing number of programs in order to increase their individual chances of matching, and those applicants cannot be reasonably expected to work against their rational interests by under-applying or declining interviews unless the system as a whole is altered[6,7]; and

WHEREAS, large-scale changes to the residency application process will require the support of national organizations such as EMRA to ensure changes to the application process are transparent, well-studied, and coordinated in a way that individual programs and applicants could not by themselves enact. Therefore, be it

RESOLVED, that EMRA work with CORD and other relevant stakeholders to encourage the standardization of the residency interview invitation and scheduling process; and be it further

RESOLVED, that EMRA encourage CORD and other relevant stakeholders to study and recommend interventions by all relevant stakeholders to control the growth of overapplication and excessive interviewing in the residency application process; and be it further

RESOLVED, that EMRA establish an accessible avenue for medical student, resident, and fellow members to suggest improvements to the residency and fellowship application process that will be transparently evaluated by EMRA and other relevant EM organizations for potential implementation; and be it further

RESOLVED, that EMRA encourages the NRMP, residency programs, and other relevant stakeholders to transparently consider, trial, and implement novel application processes that would benefit applicants, programs, and the specialty even prior to a full evaluation of this change in the literature.

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EMRA POLICY:

Policy Compendium V.XVII - The Match and Residency and Fellowship Application Process

EMRA supports the National Residency Match Program and National Matching Services process as it exists in 2013, and opposes the hiring of emergency medicine residents through processes outside of the National Residency Match Program and National Matching Services 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. January 2020 21
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. 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.

FINANCIAL IMPACT: Staff time and reprioritization of projects

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE CORD21 REPRESENTATIVE COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE REPRESENTATIVE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution S'21-9

Medicare for All Would Obtain Affordable, Comprehensive, and Equitable Health Coverage for All

Authors: Joanna Watterson, James Blum, and Alec Feuerbach, MD

SECTION I: Towards healthcare as a human right

WHEREAS, EMRA firmly supports healthcare as a human right, including adequate insurance coverage for primary and emergency healthcare services [1]; and

WHEREAS, over 33 million Americans lacked health insurance as of 2019 [2] and the percent of uninsured Americans has continued to rise over the past four years [3]; and

WHEREAS, studies in the United States have repeatedly demonstrated that lack of health insurance is correlated with mortality [4] and that obtaining insurance decreases mortality [5]; and

WHEREAS, a single payer healthcare system, as proposed at the national level with H.R.1384 [6] and S.1299 [7], would universally provide health insurance to all residents of The United States.

SECTION II: Reducing the burden of costs on patients

WHEREAS, EMRA has recognized the burden of unexpected medical bills in their advocacy against surprise billing [8], citing data that medical expenses are responsible for up to 60% of American-household bankruptcies; and

WHEREAS, employer-sponsored health plans are increasingly unaffordable [9] for workers given that 82% of plans have deductibles and the average deductible was $1,655 for single coverage in 2018 [10]; and

WHEREAS, the costs of healthcare in the United States dissuade sizeable portions (up to 50% in some surveys [11]) of the American public from seeking healthcare due to costs, lack of health insurance and financial concerns are associated with delays in seeking emergency care for treatment of life-threatening conditions such as myocardial infarction [12], and high-deductible health plans deter patients from seeking care in the emergency department [13], and

WHEREAS, cost sharing reduces both needed and unneeded care equally [14] and is, therefore, not a safe way to deter Emergency Department overutilization; and

WHEREAS, a single payer healthcare system – such as proposed in the aforementioned bills H.R. 1384 and S. 1129 Section 202: No Cost Sharing [6,7]– would eliminate costs at the point of the care.

SECTION III: Curbing the unsustainable cost of our current system

WHEREAS, the United States currently spends 17% of GDP on health expenditures, more than any other OECD country by almost 5%, yet underperforms its peers as demonstrated by life expectancy in the United States being 28th among 37 OECD countries, and infant mortality being the 5th highest [15]; and

WHEREAS, multiple studies [16-20] have concluded that a single payer healthcare system could provide universal coverage, free at the point of care, to every American at a lower cost than our current healthcare system by reducing administrative costs and stabilizing prices; and

Whereas the majority of these savings could be obtained through reduced administrative costs allowing single payer healthcare to still increase total payments for emergency care, as modeled in *Annals of Emergency Medicine* [21].

SECTION IV: Addressing the inequities and disparities of our current system

WHEREAS, there are clear, measurable disparities in both healthcare access and outcomes with people of color and low-income Americans being more likely to lack health insurance, more likely to experience barriers to care, and more likely to suffer poor health outcomes [22]; and

WHEREAS, our current tiered health insurance model heightens inequity in health outcomes by limiting options for uninsured and Medicaid-insured patients – disproportionately people of color – and under-funding hospitals and providers serving primarily Medicaid and uninsured populations [23]; and

WHEREAS, single payer healthcare would ensure that no one is unable to receive the care they need because of the type of insurance they carry and would ensure that safety-net hospitals that today care for large Medicaid and uninsured populations are adequately reimbursed [23].

SECTION V: Improving access to primary care

WHEREAS, the provision of primary care helps prevent illness and death, promotes health equity, and decreases overall costs of care [24]; and

WHEREAS, significant barriers to accessing primary care lead patients to seek treatment for nonurgent and chronic health conditions in the Emergency Department [25]; and

WHEREAS, the provision of this care falls outside the scope of emergency medicine and is a considerable burden on emergency services [26]; and

WHEREAS, proposed single-payer bills include mechanisms for expanding primary care infrastructure focusing especially on medically underserved populations (see H.R. 1384 and S. 1129, Sections 615 and 613, respectively: Office of Primary Healthcare) [6,7].

SECTION VI: The COVID-19 pandemic highlights the need for bold action now

WHEREAS, the COVID-19 pandemic highlights and exacerbates the flaws of our current healthcare system as seen by the fragility of employer based insurance that led to an estimated 2 to 3 million people losing their health insurance along with their jobs [27] and hospitals suing patients unable to pay their pandemic-related bills [28]; and

WHEREAS, patterns in morbidity and mortality associated with COVID-19 reveal systemic inequality on many levels, with excess burden of infections and deaths experienced by poorer and more racially diverse counties [29], people forgoing care during the pandemic due to financial concerns [30], and Black, Indigenous, and Latinx populations bearing a much higher burden of morbidity than their white counterparts [31,32]; and

WHEREAS, the guaranteed access and more streamlined processes in countries with single payer systems are major assets in pandemic response and likely account for some degree of these countries' relative success responding to COVID-19 relative to the United States [33,34].

SECTION VII: Single payer healthcare versus other proposals

WHEREAS, recent polls reveal that the majority of Americans now support single payer healthcare and that support for single payer has been consistently increasing in the last two decades [35], and

WHEREAS, other proposed options to achieve universal coverage – such as a public option – may improve the current healthcare system but would not eliminate costs at the point of care, would fail to obtain the cost savings of a single payer system, and would not sufficiently address segregation and inequity in our current tiered insurance system model [36]. Therefore, be it

RESOLVED, that EMRA reaffirms its commitment to healthcare as a human right and strongly supports efforts to obtain universal access to quality healthcare; and be it further

RESOLVED, that EMRA endorses a single payer healthcare system that is free at the point of service as a way to achieve not only universal, but more equitable, comprehensive, and affordable healthcare coverage for all.

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RELEVANT POLICY:

Section IV Part VIII: Healthcare as a Human Right

EMRA firmly believes that all individuals should have access to quality, affordable primary and emergency healthcare services for all people (especially vulnerable and disabled populations, including rural, elderly, and pediatric patients) as a basic human right. EMRA will work with interested stakeholders, including its primary care medical colleagues, to develop and support health care policy that will ensure adequate insurance coverage for primary and emergency health care services. This work should include advocacy for incentives in reimbursement rates for physicians who choose to care for vulnerable and disabled populations. EMRA should also work with these groups to ensure vulnerable and disabled patients who present to the emergency department have access to timely follow up to prevent repeat emergency department visits and inpatient hospitalizations.

Section IV Part V: Emergency Medicine Training to Address 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.

FINANCIAL IMPACT: None

Emergency Medicine Residents' Association

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution S'21-10

Supporting Voter Registration Efforts in the Emergency Department

Author: Ryan O'Neill

WHEREAS, widespread and equitable participation in civic engagement through voting can be used as a measurement of the socioeconomic health of a society[1]; and

WHEREAS, studies have shown a positive correlation between self-reported health and voting[2][3]; and

WHEREAS, in the United States, voting registration rates are comparatively low among minorities, disabled individuals, and low socioeconomic status individuals[4][5]; and

WHEREAS, lack of voting among these groups can result in poor representation in government, which is in turn reflected by policies that do not always best address their needs[3]; and

WHEREAS, increased voting among these groups can be seen as part of the solution to addressing their disparities[5]; and

WHEREAS, patients who fall under these categories are more likely to utilize the emergency department[6]; and

WHEREAS, evidence has shown success with clinician lead voter registration projects[7]; and

WHEREAS, our role as physicians is to empower our patients to become advocates for their health and well-being; Therefore, be it

RESOLVED, that EMRA;

1. Issue a statement of support for voluntary on-site nonpartisan voter registration efforts by residents and other emergency department staff
2. Support dissemination of materials to residents in order to educate and empower them to take part in these efforts

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EMRA POLICY:

Section IV, 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

Section IV, 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.

Section IV, 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.

Section VI, II: 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.

FINANCIAL IMPACT: Staff time

Parliamentary Procedure at a Glance

(Based on *The Standard Code of Parliamentary Procedure* by Alice Sturgis)

Principal Motions (Listed in Order of Precedence)

TO DO THIS	YOU SAY THIS	May You Interrupt Speaker?	Must You Be Seconded?	Is The Motion Debatable?	What Vote is Required?
*Adjourn the meeting	"I move the meeting be adjourned"	NO	YES	YES (RESTRICTED)	MAJORITY
*Recess the meeting	"I move that the meeting be recessed until..."	NO	YES	YES**	MAJORITY
Complain about noise, room temperature, etc.	"I rise to the question of personal privilege"	YES	NO	NO	NONE
Postpone temporarily (Table)	"I move that this motion be tabled"	NO	YES	NO	MAJORITY (REQUIRES TWO-THIRDS IF IT WOULD SUPPRESS)
End debate	"I move to vote immediately"	NO	YES	NO	TWO-THIRDS
*Limit debate	"I move that each speaker be limited to a total of two minutes per discussion"	NO	YES	YES**	TWO-THIRDS
*Postpone consideration of an item to a certain time	"I move to postpone this item until 2:00pm..."	NO	YES	YES**	MAJORITY
*Have something referred to committee	"I move this matter be referred to…"	NO	YES	YES**	MAJORITY
*Amend a motion	"I move to amend this motion by…"	NO	YES	YES	MAJORITY
*Introduce business (the Main Motion)	"I move that..."	NO	YES	YES	MAJORITY
*Amend a previous action	"I move to amend the motion that was adopted..."	NO	YES	YES	MAJORITY
Ratify action taken in absence of a quorum or in an emergency	"I move to ratify the action taken by the Council..."	NO	YES	YES	MAJORITY
Reconsider	"I move to reconsider..."	YES	YES	YES**	MAJORITY
Rescind (a main motion)	"I move to rescind the motion..."	NO	YES	YES	MAJORITY
Resume consideration of a tabled item	"I move to resume consideration of...?	NO	YES	NO	MAJORITY

***Amendable**

****Debatable if no Other Motion is Pending**

Parliamentary Procedure at a Glance

(Based on *The Standard Code of Parliamentary Procedure* by Alice Sturgis)

Incidental Motions

TO DO THIS	YOU SAY THIS	May You Interrupt Speaker?	Must You Be Seconded?	Is The Motion Debatable?	What Vote is Required?
Vote on a ruling by the Chair	"I appeal the Chair's decision"	YES	YES	YES	MAJORITY
Consider something out of its scheduled order	"I move to suspend the rules and consider…"	NO	YES	NO	TWO-THIRDS
To discuss an issue without restrictions of parliamentary rules	"I move that we consider informally…"	NO	YES	NO	MAJORITY
To call attention to a violation of the rules or error in procedure, and to secure a ruling on the question raised	"I rise to a point of order"	YES	NO	NO	NONE
To ask a question relating to procedure	"I rise to a parliamentary inquiry"	YES	NO	NO	NONE
To allow the maker of a motion to remove the motion from consideration	"I move to withdraw my motion"	YES	NO	NO	NONE
To separate a multi-part question into individual questions for the purpose of voting	"I move division of the question"	NO	NO	NO	NONE
To verify an indecisive voice or hand vote by requiring voters to rise and be counted	"I move to divide the Assembly"	YES	NO	NO	NONE

***Amendable**
****Debatable if no Other Motion is Pending**

THE CHIEF PURPOSES OF MOTIONS

PURPOSE	MOTION
Present an idea for consideration and action	Main motion Resolution Consider informally
Improve a pending motion	Amend Division of question
Regulate or cut off debate	Limit or extend debate Close debate
Delay a decision	Refer to committee Postpone to a certain time Postpone temporarily Recess Adjourn
Suppress a proposal	Table Withdraw a motion
Meet an emergency	Question of privilege Suspend rules
Gain information on a pending motion	Parliamentary inquiry Request for information Request to ask member a question Question of privilege
Question the decision of the presiding officer	Point of order Appeal from decision of chair
Enforce rights and privileges	Division of assembly Division of question Parliamentary inquiry Point of order Appeal from decision of chair
Consider a question again	Resume consideration Reconsider Rescind Renew a motion Amend a previous action Ratify
Change an action already taken	Reconsider Rescind Amend a previous action
Terminate a meeting	Adjourn Recess

(From *The Standard Code of Parliamentary Procedure* by Alice Sturgis)

Parliamentary Strategy

(From *The Standard Code of Parliamentary Procedure* by Alice Sturgis)

TO SUPPORT A MOTION		TO OPPOSE A MOTION
1. Second it promptly and enthusiastically.		1. Speak against it as soon as possible. Raise questions; try to put proponents on the defensive.
2. Speak in favor of it as soon as possible.		2. Move to amend the motion so as to eliminate objectionable aspects.
3. Do your homework; know your facts; have handouts, charts, overhead projector slides, etc., if appropriate.		3. Move to amend the motion to adversely encumber it.
4. Move to amend motion, if necessary, to make it more acceptable to opponents.		4. Draft a more acceptable version and offer as amendment by substitution.
5. Vote against motion to table or to postpone, unless delay will strengthen your position.		5. Move to postpone to a subsequent meeting.
6. Move to recess or postpone, if you need time to marshal facts or work behind the scenes.		6. Move to refer to committee.
7. If defeat seems likely, move to refer to committee, if that would improve chances.		7. Move to table.
8. If defeat seems likely, move to divide question, if appropriate, to gain at least a partial victory.		8. Move to recess, if you need time to round up votes or obtain more facts.
9. Have available a copy of the organization's standing rules, its bylaws, and *The Standard Code of Parliamentary Procedure,* in case of a procedural dispute.		9. Question the presence of a quorum, if appropriate.
10. If motion is defeated, move to reconsider, if circumstances warrant it.		10. Move to adjourn.
11. If motion is defeated, consider reintroducing it at a subsequent meeting.		11. On a voice vote, vote emphatically.
		12. If the motion is adopted, move to reconsider, if you might win a subsequent vote.
		13. If the motion is adopted, consider trying to rescind it at a subsequent meeting.
		14. Have available a copy of the organization's standing rules, its bylaws, and *The Standard Code of Parliamentary Procedure,* in case of a procedural dispute.