Emergency Medicine Residents' Association

Representative's Handbook

March 14, 2024

Spring Virtual Meeting

Emergency Medicine Residents' Association

Representative Handbook

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Emergency Medicine Residents' Association

March 14, 2024

Dear EMRA Program Representatives,

Welcome to Spring Virtual Representative Council! We are excited for our transition to a virtual spring meeting in order to increase accessibility to the meeting.

At this meeting we will receive updates from the EMRA President as well as our liaisons from CORD, ACEP, and ABEM. Additionally, there will be a joint panel from the Admin and Ops, and DEI Committee on Managing APPs in the Emergency Department. We are excited to introduce new programming into our Representative Council format through a panel discussion this Spring! Finally, the Reference Committee will present 11 resolutions that have been brought forward to the Representative Council.

Fall 2023 Representative Council passed 12 resolutions on topics including medical student interviews, trauma informed care, and language justice in the emergency department. The resolutions written by our membership inform EMRA's and its Board of Directors' advocacy priorities, ultimately guiding the future of our specialty.

If you are searching for ways to become more involved with the policy aspect of EMRA, we encourage you to look out for an opportunity to apply for the Sunset Committee and the Fall 2024 Reference Committee later this year!

As always, we appreciate you all for taking the time to shape EMRA's policy compendium and speak on behalf of your residency and the larger EMRA membership. Your dedication is one of many parts that allows EMRA to continue to be the largest independent resident organization.

We look forward to seeing you virtually!

Sincerely,

Michaela and Jacob

Michaela Banks, MD, MBA
Speaker of the Council

Jacob Altholz, MD
Vice Speaker of the Council

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EMRA Representative Council Meeting
March 14, 2024 | 10:00am – 1:30pm CDT
Virtual Spring Meeting Agenda

PROGRAMING:

10:00am	**Pre-credentialing check-in**	
10:03am	**Welcome and Introduction**	**Michaela Banks, MD, MBA**
10:05am	**EMRA President's Address**	**Blake Denley, MD**
10:15am	**Liaison Q&A** ACEP – American College of Emergency Physicians Aisha T. Terry, MD, MPH, FACEP President	**Jacob Altholz, MD**
10:20am	**Liaison Q&A** CORD – Council of Emergency Medicine Residency Directors Boyd (Bo) Burns, DO *Board of Directors*	**Jacob Altholz, MD**
10:25am	**Leadership in EM: Best Practices for Mentoring APPs** EMRA DEI and Admin & Ops Committee	**Michaela Banks, MD**
11:15am	**Liaison Q&A** ABEM – American Board of Emergency Medicine Ramon W. Johnson, MD, MBA *Board of Directors*	**Jacob Altholz, MD**
11:20am	**Opening Remarks & Call to Order**	**Michaela Banks, MD, MBA**
11:21am	**Moment of Silence**	**Jacob Altholz, MD**
11:22am	**Parliamentary Review** Angela Wu, MD, MPH, MSc *EMRA Representative to the AMA*	**Angela Wu, MD, MPH**
11:27am	**Voting Overview** Questions from attendees about format of meeting, parliamentary procedures and voting.	**Michaela Banks, MD, MBA**
11:29am	**Quorum Report / test vote**	**Michaela Banks, MD, MBA**

BUSINESS AGENDA

11:30am	**Approval of Minutes from Fall23 Meeting** October 10, 2023	**Michaela Banks, MD, MBA**
11:35am	**Reports and Resolutions** Emergency/Late Resolutions (NONE) Reference Committee Report	**Michaela Banks, MD, MBA**
1:30pm	**Announcements and Adjourn**	**Michaela Banks, MD, MBA**

EMRA is the voice of emergency medicine physicians-in-training and the future of our specialty

Representative Council Meeting Minutes
October 10, 2023
8:00 a.m. - 1:00 p.m. EST

Dr. Amanda Irish provided opening remarks.

Dr. Jessica Adkins Murphy provided the President's Address.

Dr. Michael Banks provided opening remarks for a Q&A Session with our Board Liaisons: Dr. Laura Hopson, CORD, and Dr. Ramon Johnson, ABEM.

Dr. Laura Hopson provided an update from CORD and answered questions regarding CORD's top initiative for trainees and training programs.

Dr. Ramon Johnson provided an update from ABEM and answered questions regarding the initiatives ABEM has taken to decrease board certification costs for newly graduated, board-eligible physicians.

Dr. Amanda Irish outlined parliamentary proceedings.

Dr. Michaela Banks presented PEER trivia questions.

Dr. Aisha Terry, ACEP President, addressed RepCo and provided updates regarding ACEP Council, elections, and initiatives.

At 9:22 a.m. Dr. Amanda Irish called the October meeting of the EMRA Representative Council to order.

Dr. Irish explained voting methods.

Dr. Adkins Murphy raised a point of personal privilege and presented other EMRA events at ACEP.

Dr. Irish mediated a test vote of the electronic voting system for quorum.

The following residency programs were present at the meeting:

AdventHealth Orlando, Advocate Christ Medical Center, Alameda Health - Highland Hospital, Albert Einstein Medical Center, Allegheny General Hospital, Ascension Macomb Oakland

Hospital, Ascension Resurrection Medical Center | AMITA Health Resurrection Medical Center, Ascension St John Hospital, Aventura Hospital & Medical Center, Baylor Scott & White Health – Temple, Baystate Medical Center, Boston University Medical Center, Carolinas Medical Center, Capital Health Regional Medical Center, Central Michigan University College of Medicine, Cooper Hospital, Denver Health Medical Center, Duke University Medical Center, Einstein Medical Center Montgomery, Emory University School of Medicine, EMRA Medical Student Council, Florida Atlantic University, George Washington University, HCA Florida Brandon Hospital, Henry Ford Wyandotte Hospital, Hospital of the University of Pennsylvania, Icahn School of Medicine at Mount Sinai, Indiana University School of Medicine, John H Stroger Jr. Hospital of Cook County, Johns Hopkins University, Kaiser Permanente San Diego Medical Center, LAC Harbor UCLA Medical Center, Loma Linda University School of Medicine, Louisiana State University - New Orleans, Madigan Army Medical Center, Medical College of Georgia at Augusta University, MetroHealth Medical Center, Naval Medical Center San Diego, Newark Beth Israel Medical Center, Northeast Georgia Medical Center, Ochsner Medical Center, Ohio Health Doctors Hospital, Rush University Medical Center, Spectrum Health/Michigan State University, Stanford University Emergency Medicine, State University of New York – Downstate, State University of New York - Stony Brook, State University of New York - Upstate Syracuse, Staten Island University Hospital, Sunrise Health GME Consortium, Texas Tech University Health Sciences Center – Lubbock, Thomas Jefferson University, University of Alabama Medical Center, University of California San Francisco – Fresno, University of Cincinnati College of Medicine, University of Connecticut, University of Iowa Hospital and Clinics, University of Florida – Jacksonville, University of Kansas School of Medicine, University of Kentucky, University of Louisville – Kentucky, University of Maryland, University of Miami / Jackson Health System, University of Missouri, University of Nebraska Medical Center, University of Nevada - Las Vegas, University of Oklahoma. College of Medicine/Tulsa, University of Tennessee College of Medicine at Memphis, 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 Vermont Medical Center, University of Virginia Health, University of Wisconsin, Valley Health System, Vanderbilt University, Virginia Commonwealth University - Medical College of Virginia, Wake Forest University, Warren Alpert Medical School of Brown University, Yale New Haven Medical Center.

Dr. Angela Wu, EMRA Representative to the AMA, parliamentarian, and Chair of the Bylaws committee, introduced the bylaws and revisions made by the committee.

Quorum was declared by Dr. Irish.

An electronic vote was conducted and the Bylaws revisions were adopted by the Representative Council.

Dr. Banks explained the election process as well as the order of elections.

Dr. Banks called for nominations from the floor for President-Elect. Candidates, who previously declared, Drs. David Wilson and Dr. Stephanie Berg gave their speeches and answered two questions from Dr. Banks.

Dr. Banks called for a vote for the position of President-Elect. Dr. David Wilson was elected by the Representative Council to the position of President-Elect.

Dr. Banks called for floor nominations for Vice Speaker. No candidates ran from the floor. The previously declared candidate was Drs. Jacob Altholz. He gave his speech and was elected by the Representative Council to the position of Vice Speaker by vote of acclamation.

Dr. Banks called for floor nominations for Secretary/Editor-in-Chief. No candidates ran from the floor. The previously declared candidate was Dr. Morgan Sweere. She gave her speech and was elected by the Representative Council to the position of Secretary/Editor-in-Chief by vote of acclamation.

Dr. Banks called for floor nominations for Director of Education. No candidates ran from the floor. The previously declared candidate was Dr. Joe-Ann Moser. She gave her speech and was elected by the Representative Council to the position of Director of Education by vote of acclamation.

Dr. Wu provided a parliamentary procedure review.

Dr. Banks called for a motion to approve the consent agenda. Motion was made to approve the consent agenda and seconded. The motion passed.

Dr. Altholz presented the Reference Committee Report. Resolutions 1, 2, 3, 6, and 12 were extracted. Motion to approve consent agenda except for extractions. Motion to extract was made and seconded. The motion passed.

Dr. Altholz introduced resolution 1. Discussion was opened. Dr. Ryan Hodgeman from the Medical College of Georgia proposed an amendment to remove “the ACGME” as this governing body is not involved in this process. Ashley Sholmire, MS4 from Midwestern Chicago, speaking as an author in support of the amendment. No opposing testimony was heard. There was a motion to approve the amendment and was seconded. The motion passes. A motion was made to adopt this resolution with amended language. This was seconded and the motion passed.

Dr. Altholz introduced resolution F’23-02 and discussion was opened, Dr. Ryan Hodgeman spoke on the behalf of the Medical College of Georgia and proposed an amendment to remove “for all future residency application cycles” secondary to the too-definitive nature of the statement.

Dakota Burke, MS4, from Michigan State University College of Human Medicine, spoke on behalf of the authors in opposition to the amendment and provided testimony.

A motion was made to adopt the amendment, this was seconded.

A point of personal privilege was made by Dr. Wu to inform the Representative Council of the right to divide the vote while an electronic vote was being set up.

The amendment was adopted through an electronic vote. The motion was made to adopt the resolution, the motion carried, and the resolution was adopted.

Dr. Altholz introduced resolution F'23-03 and discussion was opened. A point of clarification was raised from the floor regarding the ask of the last resolved "EMRA supports efforts to document, report, and research the effects of crowd-control weapons such as kinetic impact projectiles…" The speaker asked for clarification on *who* should document, report, and research these weapons and their effects. Dr. Kenneth Kim provided a point of information on the language: supports versus advocates. Dr. Morgan Deneke from Madigan proposed an amendment striking "misuse or abuse" and substituting with "their use." Nicholas Rodriguez, member of the MSC, spoke on behalf of the author in support of the amendment. There was a vote to approve the amended language, the motion was carried and the language was amended. There was a vote to adopt the resolution as amended, the motion carried and the resolution was amended.

Dr. Altholz introduced resolution F'23-06 and discussion was opened. Dr. Morgan Deneke submitted an amendment. No additional supportive or opposing testimony was heard. Motion was made and carried, the amended language was approved. There was a vote to adopt the resolution, the motion carried and the resolution was adopted as amended.

Dr. Altholz introduced resolution F'23-12 and discussion was opened. An amendment was proposed by Dr. Courtney Merlo from Henry Ford and testimony was provided. There was a vote to amend the resolution, the motion carried and the amended language was approved. Dr. Elisa Edwards spoke on behalf of the Madigan Army Medical Center Residency with an additional amendment. There was a vote to approve the amended language, the motion carried and the amended language was adopted. Dr. Jose Reyes from Cook County and Dr. Carmen Estrada from Duke proposed additional amendments which were adopted as well. There was a motion to adopt the resolution as amended. The motion was carried and the resolution was adopted.

Dr. Irish provided a statement of gratitude to Dr. Banks and Dr. Altholz.

Dr. Banks made a statement to thank Dr. Irish for her service.

Dr. Wilson made a point of personal privilege announcing a panel on resident unionization.

Dr. Irish moved to adjourn the meeting, seconded by Dr. Hodgemen, Representative Council voted to adjourn, the meeting was adjourned at 11:56 AM EST.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

REFERENCE COMMITTEE REPORT

SPRING 2024 EMRA REPRESENTATIVE COUNCIL MEETING

March 14, 2024

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 and submits the following report for consideration:

Consent Agenda

Recommendation to Adopt:

- Resolution S'24-01 Update to EMRA Policy XII - Sponsorship and Advertising
- Resolution S'24-02 The Match and Residency and Fellowship Application Process
- Resolution S'24-03 Resident Duty Hours Policy Amendment
- Resolution S'24-04 Amendment to Policy XI. Relationship with the Biomedical Industry
- Resolution S'24-05 Update to EMRA Policy IV.VIII - Healthcare as a Human Right
- Resolution S'24-06 Amendment to "Firearm Safety and Injury Prevention" Policy
- Resolution S'24-07 Update to EMRA's "Medical Merit Badges During Residency Training" Policy
- Resolution S'24-09 National Bias Reporting

Recommendation to Adopt as Amended:

- Resolution S'24-13 Emergency Medicine Disaster Preparedness
- Resolution S'24-14 Decriminalizing Victims of Human Trafficking and Individuals Who Offer Sex for Something

Recommendation to Not Adopt:

- Resolution S'24-08 The Time Was Yesterday Creation of Climate Change and Environmental Justice Committee

RECOMMENDATION TO ADOPT

Resolution S'24-01 Update to EMRA Policy XII - Sponsorship and Advertising

Recommendation: Adopt

Text:

RESOLVED, that EMRA Policy XII Sponsorship and Advertising be updated to read as follows:

Corporate Relationships

EMRA recognizes the importance of transparency in ~~sponsorship~~ corporate relationships (including advertisements, sponsorships, and educational grants). All corporate ~~sponsors~~ sponsorships must ~~sign a Sponsorship Agreement Form, which delineates rights and responsibilities of both parties~~ preserve EMRA's control over any projects and products bearing the EMRA name or logo. ~~EMRA recognizes The American Board of Emergency Medicine Model of the Clinical Practice of Emergency Medicine as a guideline to determine appropriate sponsorship. Final sponsor approval is given by the EMRA Executive Director and EMRA Executive Committee.~~

EMRA retains editorial control over any information produced as part of an externally funded arrangement. When an EMRA program receives external financial support, EMRA must remain in control of its name, logo, and EMRA content, and must approve all marketing materials to ensure that the message is congruent with EMRA's vision and values.

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

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

Discussion:

After introduction on behalf of the board, one comment made was on behalf of the Medical Student Council in support of the resolution. There were no points offered in opposition or for amendments.

Resolution S'24-02 The Match and Residency and Fellowship Application Process

Recommendation: Adopt

Text:

RESOLVED, that EMRA Policy Compendium Section V, policy XX "The Match and Residency and Fellowship Application Process" be amended as follows:

EMRA supports the use of a match process that is fair, cost-effective, and evidence-based. ~~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 opposes the hiring of emergency medicine residents through processes that select or give preference to individuals for Emergency Medicine residency positions based on special financial relationships or agreements between individuals, hospitals, foreign governments, corporations, or other entities.

EMRA:

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

Discussion:

After introduction on behalf of the board, support was voiced from 2 programs, the Medical Student Council, and one individual. The simplified language in this amended language to existing policy was appreciated. There were no points offered in opposition or for amendments.

Resolution S'24-03 Resident Duty Hours Policy Amendment

Recommendation: Adopt

Text:

RESOLVED, that EMRA Policy Compendium Section V, Policy XV. Resident Duty Hours be amended as follows:

The Emergency Medicine Residents' Association supports the guidelines for resident duty hours revised and approved ~~established~~ by the Accreditation Council for Graduate Medical Education (ACGME) in 2017. ~~During emergency medicine clinical rotations, residents shall not work more than 60 clinical hours per week and 72 total hours per week. Each resident shall have one full day out of every 7-day period free of all clinical and academic responsibility. Residents may not work emergency department shifts longer than 12 hours and shall have an equivalent length of time off between shifts. While emergency medicine residents are rotating on other services the duty hours should be in accordance with the ACGME guidelines of that specialty, but residents should not be on call more than every third night on average. Activities that fall outside of the educational program shall not interfere with a resident's performance in patient care or educational requirements.~~ EMRA believes residents should be allowed adequate rest and have protected time from clinical responsibility ~~so they may attend weekly didactic conferences~~. before and during educational program didactics. ~~Residents should be allowed adequate rest before didactics (i.e. conferences and lectures at the duty site), as defined by ACGME duty hour standards. Residency directors should arrange with all appropriate departments including emergency and off-service rotations to ensure that their residents will not be performing clinical duties after 7 P.M. the night preceding the~~ EMRA believes residents should be allowed adequate rest and protected time from clinical responsibility before and during the annual ABEM In-Training Examination ~~in order to ensure optimal performance on the examination~~. EMRA will support the institution of resident wellness programs, as part of standard emergency medicine residency training, in order to enhance the well-being of residents and to improve ~~adequate recovery time~~, education and patient safety.

Discussion:

After introduction on behalf of the board, testimony was unanimous in support of the amended language to existing policy, including from three programs, one group and one individual. From testimony provided, it is best practice to avoid referring to an outside organization's policy within our own, and this amendment aligns with that practice better than prior. There was no testimony offered in opposition or for amendments.

Resolution S'24-04 Amendment to Policy XI. Relationship with the Biomedical Industry

Recommendation: Adopt

Text:

RESOLVED, that EMRA Policy XI., "Relationships with the Biomedical Industry" be amended as follows:

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

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

~~Appropriate guidelines should include:~~

~~A. No direct compensation should be accepted.~~
~~B. Financial stipends should be administered through the residency program.~~
~~C. No gift should be excessive, nor should it require a reciprocal responsibility which impacts patients.~~
~~D. Any program or speaker sponsored by a biomedical company should make that relationship clear.~~

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

Discussion:

After introduction from the Board, there was a brief discussion regarding the term "excessive compensation" in the resolution. It was clarified by the Board of Directors that this is a legal term and will be determined by institutional definitions and policies at each program. The Medical Student Council, two programs, and two individuals offered testimony in support of the resolution, with the increased flexibility of this new policy being highlighted. There was no testimony in opposition.

Resolution S'24-05 Update to EMRA Policy IV.VIII - Healthcare as a Human Right

Recommendation: Adopt

Text:

RESOLVED, that EMRA Policy VIII Healthcare as a Human Right be amended to read as follows:

> **EMRA Policy Compendium IV.VIII - Healthcare as a Human Right**
> EMRA firmly believes that all individuals (especially vulnerable ~~and disabled~~ populations, including rural, elderly, and pediatric patients, and patients with disability) should have access to quality, affordable primary and emergency healthcare services as a basic human right. EMRA ~~will work with interested stakeholders, including its primary care medical colleagues, to develop and~~ supports health care policy that will ensure adequate insurance coverage for primary and emergency health care services. ~~This work should include advocacy for~~ EMRA supports 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~~ supports access to timely follow-up to prevent repeat emergency department visits and inpatient hospitalizations, particularly in vulnerable populations.

Discussion:
After introduction by the Board, there was unanimous testimony in support of the resolution from the Medical Student Council, three programs, and one individual. There was no testimony provided in opposition to this resolution.

Resolution S'24-06 Amendment to "Firearm Safety and Injury Prevention" Policy

Recommendation: Adopt

Text:

RESOLVED, that Section IV, policy VI "Firearm Safety and Prevention" be amended by addition and deletion as follows:

> EMRA ~~will actively promote~~ supports regulatory, legislative, advocacy, and public health efforts that:
>
> A. Improve public and privately funded research on firearm safety and prevention.

B. Support the repeal of the Dickey Amendment, which directly influences funding allocated to firearm-related research.
C. Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm-related injuries.
D. Investigate the effect of socioeconomic and other cultural risk factors on firearm injury and provide public and private funding for firearm safety and injury prevention research.
E. Strengthen universal background checks for all firearm purchases.
F. Restrict the sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use.
G. Promote access to effective, affordable, and sustainable mental health services.
H. ~~Never prevent~~ Empower physicians to educate and discuss ~~from educating and discussing~~ with their patients the use of firearms, prevention of intentional and unintentional injury, and means to safeguard weapons.
I. Support a high standard of firearm safety and operation training for firearm purchase.
~~J. EMRA will collaborate with other organizations and coalitions to study the health impact of firearm safety and make efforts to educate their members, the medical community, the public, and any interested parties on the results of any significant studies on the health impact of firearm safety.~~

RESOLVED that EMRA will collaborate with other organizations and coalitions to support the study of the health impact of firearm safety and make efforts to provide education on the results of any significant studies on the health impact of firearm safety.

Discussion:
After introduction by the Board, there was unanimous testimony in support of the resolution from the Medical Student Council and two programs. Testimony highlighted the concise language and updated the text of the policy to be within the scope and purview of EMRA.

Resolution S'24-07 Update to EMRA's "Medical Merit Badges During Residency Training" Policy

Recommendation: Adopt

Text:

RESOLVED, that Section II, policy IX "Medical Merit Badges During Residency Training" be amended by addition and deletion as follows:

> EMRA believes ~~recognizes~~ that while medical merit badge courses such as ACLS, PALS, NRP, CPR, and ATLS may offer educational value ~~valuable content~~, the knowledge provided by these courses is already fundamental to the core content of emergency medicine residency training, ~~. While attendance of these courses may provide useful knowledge and a base for junior residents and medical students and may play a role in the curriculum, they should only be considered a starting point rather than an ending point in residency training. These medical merit badge courses or other~~ and certification in such courses should not be required for clinical training as a resident in emergency medicine or as a prerequisite for employment after completion of residency

Discussion:
After an introduction by the Board, which explained the need for updated and clearer language regarding the "Medical Merit Badge" policy, there was testimony in support of the resolution from the Medical Student Council, five programs, and one individual. There was no testimony offered in opposition.

Resolution S'24-09 National Bias Reporting

Recommendation: Adopt

Text:

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

Discussion:
Testimony on this resolution was positive. An author speaking on behalf of the authorship team proposed the above resolution to call for a national reporting system to support a diverse, equitable, and safe working and learning environment in residency programs. While no system currently exists, the authorship team's intent was to voice support in creation of an incident

reporting system. The author clarified “protected classes”, as written, is defined under federal law to include “age, ancestry, color, disability, ethnicity, gender, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, pregnancy, race, religion, sex, sexual orientation, or veteran status, or any other bases under the law.” A medical student on behalf of the Medical Student Council offered support as a national reporting system would increase transparency between residency programs and current and future residents. Four residents on behalf of their respective residency programs supported the resolution as critical for the well being of residents. No one spoke in opposition to the resolution. The Reference Committee recommends adoption as written.

RECOMMENDATION TO ADOPT AS AMENDED

Resolution S’24-13 Emergency Medicine Disaster Preparedness

Recommendation: Adopt As Amended

Text:

~~**RESOLVED,** EMRA supports emergency medicine department coordination with local, regional, and national public health officials in the event of natural disasters, disease outbreak, and other public health needs of the community for the sake of emergency preparedness and response to the community.~~

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

Discussion:
After introduction by the author, there was overall support for the spirit of the resolution, however mixed testimony for the resolved clauses. There was an amendment proffered during the Virtual Resolution Review, but no testimony was provided for or against the proposed amendment. Without testimony to the proposed amendment that included production and utilization of a national study, there was no guidance for the Reference Committee to suggest this amendment be adopted in this policy.

Two programs voiced support of the original language. Two groups during the Virtual Resolution Review pointed towards redundancy of the first resolved clause. With no testimony defending

the novelty of the first resolved clause and in light of the concerns raised for redundancy of said resolved clause, the Reference Committee struck the first resolved clause and left the second as the sole resolved clause in this resolution. The Committee's final recommendation is for Adopt as Amended.

Resolution S'24-14 Decriminalizing Victims of Human Trafficking and Individuals Who Offer Sex for Something

Recommendation: Adopt as Amended

Text:

RESOLVED, EMRA supports legislation that decriminalizes individuals who are victims of human trafficking or ~~those that offer sex in exchange for something.~~ sex workers who accept money, goods or other transactional exchange.

Resolved EMRA acknowledges adverse health outcomes can occur due to the criminalization of victims of human trafficking and ~~those who offer sex for something.~~ sex workers who accept money, goods or other transactional exchange.

~~Resolved EMRA encourages public posting of information within emergency rooms about human trafficking resources such as the National Human Trafficking Hotline and reporting procedures in suspected cases of human trafficking.~~

Resolved, EMRA supports legislation that decriminalizes, acknowledges adverse health outcomes in criminalization and encourages public posting of human trafficking resources in emergency departments.

Discussion:

After introduction on behalf of the author, testimony was unanimous in support of the amended language to the resolved clauses including the author, board member and from four individuals. From testimony provided, it was recommended to redefine the phrasing to be more specific when discussion of services exchanged for sex. There was no testimony offered in opposition or for amendments.

RECOMMENDATION TO NOT ADOPT

Resolution S'24-08 The Time Was Yesterday Creation of Climate Change and Environmental Justice Committee

Recommendation: Not Adopt

Text:

RESOLVED, EMRA creates a Climate Medicine and Environmental Justice Committee

Discussion:

Clarification of this resolution was controversial. The primary authors of this resolution called for a new Climate Medicine and Environmental Justice Committee to be created within EMRA. This committee will be charged with advancing climate related policy, research, and education within Emergency Medicine. Clarification of the process of creating new committees was asked, and under current EMRA committee operations, the formation of a new committee is formed by majority vote of the board of directors. Concern was raised that passing of this resolution provides precedents for future committees to be created by a separate process outside of current EMRA policy. Dr. Blake Denley, EMRA president, provided clarification that the Representative Council provides an open forum and the opportunity for the council to bring forth and undertake all resolutions. Further, if passed, the Board of Directors would create and establish the committee. Dr. Denley clarified, the newly created committee would follow a two year provisional status, as per current EMRA bylaws, before being formally instated.

The primary author acknowledged this process advocating the creation of the Climate Medicine and Environmental Justice Committee through Representative Council is the most effective and appropriate process as it reflects the position and majority will of current residents. While there are subcommittees focusing on climate issues within EMRA, the author team advocated residents' interest and work in climate change and environmental justice has evolved to span across multiple fields including disaster medicine, health policy, and social EM thus outgrowing their parent committee. The authors clarified this committee will be charged with a specific task similar to the Health Policy and Sunset Committee.

A medical student on behalf of the Medical Student Council and a resident on behalf of their residency program voiced opposition to the resolution stating creating a new committee would be more appropriate through the Board of Directors to ensure a continued streamline process. No support was voiced for the resolution. The Reference Committee recommends to not adopt this resolution.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 1

Update to EMRA Policy XII - Sponsorship and Advertising

Authors: EMRA Board of Directors

Whereas EMRA accepts certain corporate relationships (in the form of both advertisements and sponsorships/educational grants) to fund the creation of many high-quality benefits that it provides for its members including events such as Quiz Show and publications like the Antibiotic Guide; and

Whereas an advertisement is a message created by a corporate partner with digital or print space purchased by the partner from EMRA; and

Whereas a sponsorship is an agreement between EMRA and a corporate partner in which a product or initiative is created by EMRA and its members but is financially supported by a corporate partner; and

Whereas EMRA commits to creating the best products for its members while remaining true to its vision and values without compromise by outside financial influences. Therefore, be it

Resolved that EMRA Policy XII Sponsorship and Advertising be updated to read as follows:

Corporate Relationships

EMRA recognizes the importance of transparency in ~~sponsorship~~ corporate relationships (including advertisements, sponsorships, and educational grants).

All corporate ~~sponsors~~ sponsorships must ~~sign a Sponsorship Agreement Form, which delineates rights and responsibilities of both parties~~ preserve EMRA's control over any projects and products bearing the EMRA name or logo. ~~EMRA recognizes The American Board of Emergency Medicine Model of the Clinical Practice of Emergency Medicine as a~~

~~guideline to determine appropriate sponsorship. Final sponsor approval is given by the EMRA Executive Director and EMRA Executive Committee.~~

EMRA retains editorial control over any information produced as part of an externally funded arrangement. When an EMRA program receives external financial support, EMRA must remain in control of its name, logo, and EMRA content, and must approve all marketing materials to ensure that the message is congruent with EMRA's vision and values.

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

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

Original Language

EMRA recognizes the importance of transparency in sponsorship. All sponsors must sign a Sponsorship Agreement Form, which delineates rights and responsibilities of both parties. EMRA recognizes The American Board of Emergency Medicine Model of the Clinical Practice of Emergency Medicine as a guideline to determine appropriate sponsorship. Final sponsor approval is given by the EMRA Executive Director and EMRA Executive Committee.

Products or services eligible for advertising in EMRA publications must be germane to and useful in the practice of medicine, medical education, or health care delivery. EMRA is not responsible to verify or endorse the information contained in the advertisement. EMRA does not allow advertising by pharmaceutical, tobacco, alcohol or firearm companies. EMRA reserves the right to refuse any advertising or sponsorship request at its discretion.

References:

EMRA Policy: (Citation for policy relevant to this resolution.)

Financial Note: None.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'24 - 2

The Match and Residency and Fellowship Application Process

Authors: EMRA Board of Directors

Whereas National Resident Matching Program (NRMP) is a private, not-for-profit corporation established in 1952 to provide a uniform date of appointment through an objective and standardized process to positions in graduate medical education (GME) in the United States[1]; and

Whereas Prior to the institution of a centralized process for appointment of medical students to residency in 1952, students frequently had to make a decision without knowing if other offers were forthcoming; and hospitals made offers as early as the beginning of the third year of medical school with little information about students' performance[1]; and

Whereas Graduate Medical Education (GME) funding comes from a variety of public and private sources, including $7.8 billion per year from Medicare, over $2 billion per year from Medicaid, and other funding from the Department of Defense, the Veterans Administration, and private payers. Because other hospital-based sources of funding are multifactorial and variable, programs rely significantly on this funding basis.[2] Therefore, be it

Resolved that EMRA Policy Compendium Section V, policy XX "The Match and Residency and Fellowship Application Process" be amended as follows:

EMRA supports the use of a match process that is fair, cost-effective, and evidence-based.~~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 opposes the hiring of emergency medicine residents through processes that select

or give preference to individuals for Emergency Medicine residency positions based on special financial relationships or agreements between individuals, hospitals, foreign governments, corporations, or other entities.

EMRA:

A. Supports proposed changes to residency and fellowship application requirements and match processes only when:

1. Those changes have been evaluated by working groups which have adequate students and residents as representatives.

2. There are published data which demonstrates that the proposed application components contribute to an accurate and novel representation of the candidate and are shown from an applicant and program perspective to add value to the application overall.

3. There are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds.

4. The costs to medical students and residents are mitigated.

B. Opposes the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application and match process until such time as the above conditions are met.

C. Will ~~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.

Original Language:

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.

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.

References:

1. Roth AE. The origins, history, and design of the resident match. *JAMA*. 2003;289(7):909-912. doi:10.1001/jama.289.7.909
2. Rich EC, Liebow M, Srinivasan M, et al. Medicare financing of graduate medical education: Intractable problems, elusive solutions. *J Gen Intern Med*. 2002;17(4):283-292. doi:10.1046/j.1525-1497.2002.10804.x

EMRA Policy: (Citation for policy relevant to this resolution.)

Financial Note: None.

Original policy adopted RC, 5/13
Amended BOD, 1/18
Amended, 2/18

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 3

Resident Duty Hours Policy Amendment

Authors: EMRA Board of Directors

Whereas EMRA's policy on Resident Duty Hours was originally adopted in March of 1992; and

Whereas EMRA's policy was deemed to be overly prescriptive by the 2023 Sunset Committee; and

Whereas the policy as written supports ACGME duty hour guidelines in perpetuity. Therefore, be it

Resolved, that EMRA Policy Compendium Section V, policy XV. Resident Duty Hours be amended as follows:

The Emergency Medicine Residents' Association supports the guidelines for resident duty hours revised and approved ~~established~~ by the Accreditation Council for Graduate Medical Education (ACGME) in 2017. ~~During emergency medicine clinical rotations, residents shall not work more than 60 clinical hours per week and 72 total hours per week. Each resident shall have one full day out of every 7-day period free of all clinical and academic responsibility. Residents may not work emergency department shifts longer than 12 hours and shall have an equivalent length of time off between shifts. While emergency medicine residents are rotating on other services the duty hours should be in accordance with the ACGME guidelines of that specialty, but residents should not be on-call more than every third night on average. Activities that fall outside of the educational program shall not interfere with a resident's performance in patient care or educational requirements.~~ EMRA believes residents should be allowed adequate rest and have protected time from clinical responsibility ~~so they may attend weekly didactic conferences.~~ before and during educational program didactics. ~~Residents should be allowed adequate rest before didactics (i.e. conferences and lectures at the duty site), as defined by ACGME duty hour standards. Residency directors should arrange with all appropriate departments including~~

~~emergency and off-service rotations to ensure that their residents will not be performing clinical duties after 7 P.M. the night preceding the~~ EMRA believes residents should be allowed adequate rest and protected time from clinical responsibility before and during the annual ABEM In-Training Examination ~~in order to ensure optimal performance on the examination~~. EMRA will support the institution of resident wellness programs, as part of standard emergency medicine residency training, in order to enhance the well-being of residents and to improve ~~adequate recovery time,~~ education and patient safety.

Original Language

The Emergency Medicine Residents' Association supports the guidelines for resident duty hours established by the Accreditation Council for Graduate Medical Education (ACGME). During emergency medicine clinical rotations, residents shall not work more than 60 clinical hours per week and 72 total hours per week. Each resident shall have one full day out of every 7-day period free of all clinical and academic responsibility. Residents may not work emergency department shifts longer than 12 hours and shall have an equivalent length of time off between shifts. While emergency medicine residents are rotating on other services the duty hours should be in accordance with the ACGME guidelines of that specialty, but residents should not be on-call more than every third night on average. Activities that fall outside of the educational program shall not interfere with a resident's performance in patient care or educational requirements. Residents should have protected time from clinical responsibility so they may attend weekly didactic conferences. Residents should be allowed adequate rest before didactics (i.e. conferences and lectures at the duty site), as defined by ACGME duty hour standards. Residency directors should arrange with all appropriate departments including emergency and off-service rotations to ensure that their residents will not be performing clinical duties after 7 P.M. the night preceding the annual ABEM In-Training Examination in order to ensure optimal performance on the examination. EMRA will support the institution of resident wellness programs, as part of standard emergency medicine residency training, in order to enhance the well-being of residents and to improve adequate recovery time, education and patient safety.

References: ACGME Common Program Requirements
ACGME Specialty Specific Duty Hour Requirements

EMRA Policy: XV. Resident Duty Hours

Financial Note: None.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 4

Amendment to Policy XI. Relationship with the Biomedical Industry

Authors: EMRA Board of Directors

Whereas EMRA's policy on relationship with the biomedical industry was adopted in March of 1992 and last amended in January of 1997; and

Whereas the spirit of the policy was to avoid conflicts of interest; and

Whereas the policy did not leave room for residents to be paid for their work and expertise in biomedical innovation. Therefore, be it

Resolved that EMRA Policy XI., "Relationships with the Biomedical Industry" be amended as follows:

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

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

~~Appropriate guidelines should include:~~

- ~~A. No direct compensation should be accepted.~~
- ~~B. Financial stipends should be administered through the residency program.~~
- ~~C. No gift should be excessive, nor should it require a reciprocal responsibility which impacts patients.~~
- ~~D. Any program or speaker sponsored by a biomedical company should make that relationship clear.~~

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

Original Language:

Emergency medicine residents should recognize the generally accepted guidelines for interaction with the biomedical industry. Gifts should be related to education and training. Appropriate guidelines should include:

A. No direct compensation should be accepted.

B. Financial stipends should be administered through the residency program.

C. No gift should be excessive, nor should it require a reciprocal responsibility which impacts patients.

D. Any program or speaker sponsored by a biomedical company should make that relationship clear. These general guidelines do not encompass every potential interaction with biomedical companies, so individual responsibility must be exercised. Physicians may not be aware of the subtle influence of interaction with the biomedical industry. While the industry is important to promote the development of new technology and pharmaceuticals, residents should hold the needs and concerns of the patient in highest regard.

References:

EMRA Policy: XI. Relationship with the Biomedical Industry

Financial Note: None.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'24 - 5

Update to EMRA Policy IV.VIII - Healthcare as a Human Right

Authors: EMRA Board of Directors

Whereas EMRA's policy on Healthcare as a Human Right (IV.VIII) was originally adopted in October of 2003; and

Whereas EMRA continues to believe that healthcare in the United States is a human right, with quality, affordable primary and emergency healthcare services as integral and intertwined components; and

Whereas EMRA's policy was deemed to be out of the scope of EMRA's capabilities by the 2023 Sunset Committee; and

Whereas the 2023 Sunset Committee also recommended amending the policy to include person-first language; and

Whereas EMRA can continue to use its voice as the largest, oldest independent residency organization to share its beliefs and support organizations with more scope in lobbying for and developing legislation/policy. Therefore, be it

Resolved that EMRA Policy VIII Healthcare as a Human Right be amended to read as follows:

EMRA Policy Compendium IV.VIII - Healthcare as a Human Right

EMRA firmly believes that all individuals (especially vulnerable ~~and disabled~~ populations, including rural, elderly, and pediatric patients, and patients with disability) should have access to quality, affordable primary and emergency healthcare services as a basic human right. EMRA ~~will work with interested stakeholders, including its primary care medical colleagues, to develop and~~ supports health care policy that will ensure adequate insurance coverage for primary and emergency health care services. ~~This work should include advocacy for~~ EMRA supports 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~~ supports access to timely follow-up to prevent repeat emergency department visits and inpatient hospitalizations, particularly in vulnerable populations.

Original Language

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.

References:

EMRA Policy: EMRA Policy Compendium IV.VIII - Healthcare as a Human Right (as of Fall 2023)

Financial Note: None.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'24 - 6

Amendment to "Firearm Safety and Injury Prevention" Policy

Authors: EMRA Board of Directors

Whereas firearm-related injuries and deaths are recognized as a public health crisis[1]; and

Whereas emergency physicians have played a key role in advocating for firearm safety[2]; and

Whereas the Sunset Committee review of policy Section IV, VI "Firearm Safety and Injury Prevention" found strong support for the spirit of the policy but concern that EMRA does not have the organizational scope to actively fulfill some of the aims that were stated as EMRA collaborates with other organizations but does not have its own dedicated staff involved in lobbying or monitoring regulatory affairs. Therefore, be it

Resolved that Section IV, policy VI "Firearm Safety and Prevention" be amended by addition and deletion as follows:

> EMRA ~~will actively promote~~ supports regulatory, legislative, advocacy, and public health efforts that:
>
> A. Improve public and privately funded research on firearm safety and injury prevention.
>
> B. Support the repeal of the Dickey Amendment, which directly influences funding allocated to firearm-related research.
>
> C. Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm-related injuries.
>
> D. Investigate the effect of socioeconomic and other cultural risk factors on firearm injury and provide public and private funding for firearm safety and injury prevention research.
>
> E. Strengthen universal background checks for all firearm purchases.

F. Restrict the sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use.

G. Promote access to effective, affordable, and sustainable mental health services.

H. ~~Never prevent~~ Empower physicians to educate and discuss ~~from educating and discussing~~ with their patients the use of firearms, prevention of intentional and unintentional injury, and means to safeguard weapons.

I. Support a high standard of firearm safety and operation training for firearm purchase.

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

Resolved that EMRA will collaborate with other organizations and coalitions to support the study of the health impact of firearm safety and make efforts to provide education on the results of any significant studies on the health impact of firearm safety.

Original Language

EMRA will actively promote regulatory, legislative, and public health efforts that:

A. Improve public and privately funded research on firearm safety and injury prevention.

B. Support repeal of the Dickey Amendment, which directly influences funding allocated to firearm-related research.

C. Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm related injuries.

D. Investigate the effect of socioeconomic and other cultural risk factors on firearm injury and provide public and private funding for firearm safety and injury prevention research.

E. Strengthen universal background checks for all firearm purchases.

F. Restrict sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use.

G. Promote access to effective, affordable, and sustainable mental health services.

H. Never prevent physicians from educating and discussing with their patients the use of firearms, prevention of injury, both intentional and unintentional, and means to safeguard weapons.

I. Support a high standard of firearm safety and operation training for firearm purchase.

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

References:

1. Firearm Safety and Public Health. Firearm Safety and Public Health - News & Events. December 23, 2022. Accessed January 22, 2024. https://health.gov/news/202212/firearm-safety-and-public-health.
2. Ranney ML, Betz ME, Dark C. #thisisourlane — firearm safety as health care's highway. *New England Journal of Medicine*. 2019;380(5):405-407. doi:10.1056/nejmp1815462

EMRA Policy: Section IV, VI "Firearm Safety and Prevention"

Financial Note: None.

EMERGENCY MEDICINE RESIDENTS' ASSOCIATION

Resolution: S'24 - 7

Update to EMRA's "Medical Merit Badges During Residency Training" Policy

Authors: EMRA Board of Directors

Whereas the 2023 EMRA Sunset Committee reviewed the following policies Section II, I "Board Certification Supersedes Medical Merit Badges" and Section II, IX "Medical Merit Badges During Residency Training"; and

Whereas the Sunset Committee unanimously reaffirmed "Board Certification Supersedes Medical Merit Badges" in line with the recommendation by The American Board of Emergency Medicine (ABEM) that ABEM certification supersedes any credentialing by third-party standards[1], but referred "Medical Merit Badges During Residency Training" to the EMRA Board of Directors for improved language to clarify the role of these competencies in the training environment; and

Whereas the American College of Emergency Physicians (ACEP) has policy that opposes the completion of courses such as Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), as conditions for privileges, renewal of privileges, employment, or qualification for both board certified and board eligible physicians[2]; and

Whereas the American Board of Surgery requires prior completion of ACLS and ATLS to qualify for the general surgery examination but does not require applicants to maintain current certification in these programs[3];

Whereas a systematic review found that ATLS was useful from an educational point of view but found no clear evidence that ATLS training reduced trauma deaths[4]. Therefore, be it

Resolved that Section II, policy IX "Medical Merit Badges During Residency Training" be amended by addition and deletion as follows:

EMRA believesrecognizes that while medical merit badge courses such as ACLS, PALS, NRP, CPR, and ATLS may offer educational value valuable content, the knowledge provided by these courses is already fundamental to the core content of emergency medicine residency training,. While attendance of these courses may provide useful knowledge and a base for junior residents and medical students and may play a role in the curriculum, they should only be considered a starting point rather than an ending point in residency training. These medical merit badge courses or other and certification in such courses should not be required for clinical training as a resident in emergency medicine or as a prerequisite for employment after completion of residency.

Original Language:

EMRA recognizes that while medical merit badge courses such as ACLS, PALS, NRP, CPR, and ATLS may offer valuable content, the knowledge provided by these courses is fundamental to the core content of emergency medicine residency training. While attendance of these courses may provide useful knowledge and a base for junior residents and medical students and may play a role in the curriculum, they should only be considered a starting point rather than an ending point in residency training. These medical merit badge courses or other such courses should not be required for clinical training as a resident in emergency medicine or as a prerequisite for employment after completion of residency.

References:

1. Policy on third-party standards. ABEM. January 2020. Accessed January 22, 2024. https://www.abem.org/public/docs/default-source/policies-faqs/policy-on-third-party-standards.pdf?sfvrsn=4.

2. Use of short courses in emergency medicine as criteria for privileging or employment. ACEP. January 2022. Accessed January 22, 2024. https://www.acep.org/patient-care/policy-statements/use-of-short-courses-in-emergency-medicine-as-criteria-for-privileging-or-employment.

3. General surgery qualifying examination. American Board of Surgery. January 18, 2024. Accessed January 22, 2024. https://www.absurgery.org/get-certified/general-surgery/qualifying-exam/.

4. Abu-Zidan FM. Advanced trauma life support training: How useful it is? *World Journal of Critical Care Medicine*. 2016;5(1):12. doi:10.5492/wjccm.v5.i1.12

EMRA Policy: Section II, I. Board Certification Supersedes Medical Merit Badges
Section II, IX Medical Merit Badges During Residency Training

Financial Note: None.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 8

The Time Was Yesterday Creation of Climate Change and Environmental Justice Committee

Leena Owen, DO, MPH, David Leon, MD, MS

Whereas climate change represents the definitive public health challenge of our lifetimes, and we are at a critical moment with the opportunity to mitigate negative impacts before it is too late[8,9,16] ; and

Whereas US Healthcare contributes 10**%** of national greenhouse gas emissions yet healthcare systems have yet to hold themselves accountable for their contributions[3,13,14] ; and

WHEREAS climate change will lead to unprecedented levels of natural disasters and negative health impacts due to both primary environmental health issues and secondary issues due to climate change for which emergency medicine (EM) will be the forefront of response[2, 4,5,7,8,9,10,11,15] ; and

Whereas climate change will have a disproportionate impact on vulnerable populations, which make up an increasingly large proportion of Emergency Department (ED) visits annually nationwide[2,4,5,7,8,9,12,15] ; and

Whereas COVID-19 strained our healthcare systems' resilience and placed additional stressors on the sustainability of our specialty as reflected in physician turnover and the recent residency MATCH[17,18,19], and climate change has a strong potential to do the same and to a greater degree[20, 21,22, 23, 24,25] ; and

Whereas EDs nationally and worldwide will be impacted by effects of climate change and there lies a necessity for leadership arising from the healthcare field to address these effects on our patients [6,8,9,26] ; and

Whereas EM physicians have a front-line role and strong connection to the communities they serve[6,8,9,26] ; and

Whereas EM physicians lead collaboration between existing niches within EM, such as EMS, disaster medicine, social EM, wilderness, administration and operations, and global health, and are the natural leaders to represent the field of Climate Medicine and Environmental Justice within healthcare systems[6,15] ; and

Whereas the American College of Emergency Physicians (ACEP) recognizes the need for Emergency Physicians to contribute to the field of Climate Medicine and Environmental Justice through policy, research and education[6] ; and

Whereas there is an increasing recognition of the need for education on the impact of climate change on health, emergency care and health systems in Emergency Medicine residency curricula[27,28,29,30,31,32] ; and

Whereas EMRA represents the future of emergency medicine and the largest resident organization with great potential for advocacy on behalf of emergency medicine.[1] Therefore, be it

Resolved that EMRA creates a Climate Medicine and Environmental Justice Committee.

References:

1. *Become A Member*. (2021). Emergency Medicine Residents' Organization. Retrieved January 28, 2024, from https://www.emra.org/about-emra/become-a-member
2. Crimmins AJ, Balbus JL, Gamble CB. Washington, DC: US Global Change Research Program; 2016. *The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment*. Available at: https://health2016.globalchange.gov. Accessed on January 26, 2024.
3. Eckelman, M. J., & Sherman, J. D. (2018). Estimated Global Disease Burden From US Health Care Sector Greenhouse Gas Emissions. *American journal of public health*, *108*(S2), S120–S122. https://doi.org/10.2105/AJPH.2017.303846
4. Haines, A., & Ebi, K. (2019). The Imperative for Climate Action to Protect Health. *The New England journal of medicine*, *380*(3), 263–273. https://doi.org/10.1056/NEJMra1807873
5. Helldén, D., Andersson, C., Nilsson, M., Ebi, K. L., Friberg, P., & Alfvén, T. (2021). Climate change and child health: a scoping review and an expanded conceptual framework. *The Lancet. Planetary health*, *5*(3), e164–e175. https://doi.org/10.1016/S2542-5196(20)30274-6
6. Impact of Climate Change on Public Health and Implications for Emergency Medicine. (2018). *Annals of emergency medicine*, *72*(4), e49. https://doi.org/10.1016/j.annemergmed.2018.07.033

7. IPCC, 2023: Summary for Policymakers. In: Climate Change 2023: Synthesis Report. Contribution of Working Groups I, II and III to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change [Core Writing Team, H. Lee and J. Romero (eds.)]. IPCC, Geneva, Switzerland, pp. 1-34, doi: 10.59327/IPCC/AR6-9789291691647.001
8. Kreslake, J. M., Sarfaty, M., Roser-Renouf, C., Leiserowitz, A. A., & Maibach, E. W. (2018). The Critical Roles of Health Professionals in Climate Change Prevention and Preparedness. *American journal of public health*, *108*(S2), S68–S69. https://doi.org/10.2105/AJPH.2017.304044
9. Maibach, E., Miller, J., Armstrong, F., El Omrani, O., Zhang, Y., Philpott, N., ... & Jensen, G. K. (2021). Health professionals, the Paris agreement, and the fierce urgency of now. *The Journal of Climate Change and Health*, *1*, 100002.
10. Masson-Delmotte V, Zhai P, Pörtner H-O, et al. Global warming of 1.5°C: special report. Geneva: Intergovernmental Panel on Climate Change, 2018.
11. McMichael, A. J., Woodruff, R. E., & Hales, S. (2006). Climate change and human health: present and future risks. *Lancet (London, England)*, *367*(9513), 859–869. https://doi.org/10.1016/S0140-6736(06)68079-3
12. National Center for Health Statistics. Health, United States, 2021: Table Emergency department visits within the past 12 months among adults aged 18 and over, by selected characteristics: United States, selected years 1997–2019. Hyattsville, MD. 2021. Available from: https://www.cdc.gov/nchs/hus/data-finder.htm.
13. Lenzen, M., Malik, A., Li, M., Fry, J., Weisz, H., Pichler, P. P., ... & Pencheon, D. (2020). The environmental footprint of health care: a global assessment. *The Lancet Planetary Health*, *4*(7), e271-e279.
14. Rodríguez-Jiménez, L., Romero-Martín, M., Spruell, T., Steley, Z., & Gómez-Salgado, J. (2023). The carbon footprint of healthcare settings: A systematic review. *Journal of Advanced Nursing*, 79, 2830–2844. https://doi.org/10.1111/jan.15671
15. Sorensen, C. J., Salas, R. N., Rublee, C., Hill, K., Bartlett, E. S., Charlton, P., Dyamond, C., Fockele, C., Harper, R., Barot, S., Calvello-Hynes, E., Hess, J., & Lemery, J. (2020). Clinical Implications of Climate Change on US Emergency Medicine: Challenges and Opportunities. *Annals of emergency medicine*, *76*(2), 168–178. https://doi.org/10.1016/j.annemergmed.2020.03.010
16. WHO calls for urgent action to protect health from climate change – Sign the call. *World Health Organization*. https://www.who.int/globalchange/global-campaign/cop21/en/
17. Pelletier-Bui, Alexis, et al. "COVID-19: A Driver for Disruptive Innovation of the Emergency Medicine Residency Application Process: Recommendations from the Council of Residency Directors Application Process Improvement Committee." *Western Journal of Emergency Medicine* 21.5 (2020): 1105.
18. Byrnes, Yasmeen M., et al. "Effect of the COVID-19 pandemic on medical student career perceptions: a national survey study." Medical education online 25.1 (2020): 1798088.
19. Preiksaitis, Carl, et al. "Characteristics of emergency medicine residency programs with unfilled positions in the 2023 match." Annals of Emergency Medicine 82.5 (2023): 598-607.
20. Sorensen, Cecilia J., et al. "Clinical implications of climate change on US emergency medicine: challenges and opportunities." Annals of Emergency Medicine 76.2 (2020): 168-178.

21. World Health Organization. (2021). Climate change and health: vulnerability and adaptation assessment.
22. Nori-Sarma, Amruta, et al. "Association between ambient heat and risk of emergency department visits for mental health among US adults, 2010 to 2019." JAMA psychiatry 79.4 (2022): 341-349.
23. Chen, Yuxiong, et al. "Association of extreme precipitation with hospitalizations for acute myocardial infarction in Beijing, China: A time-series study." Frontiers in Public Health 10 (2022): 1024816.
24. Tong, Michael Xiaoliang, et al. "Emergency department visits and associated healthcare costs attributable to increasing temperature in the context of climate change in Perth, Western Australia, 2012–2019." Environmental Research Letters 16.6 (2021): 065011.
25. Sun, Shengzhi, et al. "Ambient heat and risks of emergency department visits among adults in the United States: time stratified case crossover study." BMJ 375 (2021).
26. Spruell, Timothy, et al. "Environmentally sustainable emergency medicine." Emergency Medicine Journal (2021).
27. Moretti, Katelyn, et al. "Attitudes of US emergency medicine program directors towards the integration of climate change and sustainability in emergency medicine residency curricula." The Journal of Climate Change and Health 9 (2023): 100199.
28. Giudice, Catharina, and Caitlin S. Rublee. "Climate Change and Health: Addressing Gaps Through Patient Education in the Emergency Department." Annals of Emergency Medicine 82.5 (2023): 611-614.
29. Colbert, Colleen Y., et al. "An examination of the intersection of climate change, the physician specialty workforce, and graduate medical education in the US." Teaching and Learning in Medicine 34.3 (2022): 329-340.
30. Philipsborn, Rebecca Pass, et al. "Climate change and the practice of medicine: essentials for resident education." Academic Medicine 96.3 (2021): 355-367.
31. Brennan, Meagan E., and Diana L. Madden. "The evolving call to action for including climate change and environmental sustainability themes in health professional education: a scoping review." The Journal of Climate Change and Health 9 (2023): 100200.
32. Moretti, Katelyn. "An Education Imperative: Integrating Climate Change Into the Emergency Medicine Curriculum." AEM Education and Training 5.3 (2021).

EMRA Policy: Section IV, I: Climate change, its impact on patient health, and implications for Emergency Medicine, Section IV, IV: Emergency Medicine Support of Research on Social Determinants of Health, Section IV, V: Emergency Medicine Training to Address Social Determinants of Health

Financial Note: To create a new committee, the financial impact estimate will be $1,500 - $2,000 annually.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 9

National Bias Reporting

Authors: Ian Brodka, MD; Nicole Lund, MD, MPH; Kelsey Morgan, MD; Grace Bunemann, DO

Whereas maintaining a diverse, equitable, and safe working and learning environments in Emergency Medicine Residency programs is of great importance and within the mission statement of EMRA to be the voice of EM residents; and

Whereas a study in 2021 showed biased treatment exists based on gender identity amongst medical residents[1]; and

Whereas another study in 2022 found that second-year residents who identify as URiM by race and ethnicity received worse evaluations by faculty compared to their white counterparts [2]; and

Whereas residents who identify as URiM are experiencing bias and mistreatment compared to their non-URiM colleagues on a consistent basis[3,4,5,6]; and

Whereas resident mistreatment and discrimination is detrimental to mental health and well-being[7]; and

Whereas current standards of reporting are not reviewed by an external party, which may keep behaviors hidden; and

Whereas methods exist through the ACGME to report illegal questions in interviews, work hour violations, and other program concerns related to the application process and working conditions; and

Whereas residents and applicants deserve transparency in the historical and ongoing treatment of trainees in the programs they are employed with or interested in; Therefore, be it

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

References:

1. Rogers, E.A., Moser-Bleil, E.K., Duffy, B.L. *et al.* Gender Matters: Internal Medicine Resident Perceptions of Gender Bias in Medical Training. *J GEN INTERN MED* 36, 1448–1450 (2021). https://doi.org/10.1007/s11606-020-05772-8
2. Boatright D, Anderson N, Kim JG, et al. Racial and Ethnic Differences in Internal Medicine Residency Assessments. *JAMA Netw Open.* 2022;5(12):e2247649. doi:10.1001/jamanetworkopen.2022.47649
3. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. *JAMA Netw Open.* 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723
4. Garrison CB. The Lonely Only: Physician Reflections on Race, Bias, and Residency Program Leadership. Fam Med. 2019;51(1):59-60. https://doi.org/10.22454/FamMed.2019.339526.
5. Ray R. Racism in Medical Education: An Unfortunate Ending To My Time At Lehigh Valley Health Network. Robert Ray Jr. June 15, 2023. https://rrayjr.blog/.
6. Boatright, Dowin MD, MBA, MHS1; Edje, Louito MD, MHPE2; Gruppen, Larry D. PhD3; Hauer, Karen E. MD, PhD4; Humphrey, Holly J. MD5; Marcotte, Kayla MS6. Ensuring Fairness in Medical Education Assessment. Academic Medicine 98(8S):p S1-S2, August 2023. | DOI: 10.1097/ACM.0000000000005244
7. Hu Y-Y, Ellis RJ, Hewitt DB, et al. Discrimination, abuse, harassment, and burnout in surgical residency training. *New England Journal of Medicine*. 2019;381(18):1741-1752. doi:10.1056/nejmsa1903759

EMRA Policy: (Citation for policy relevant to this resolution.)

1. Section V:XX Residency Programs: The Match and Residency and Fellowship Application Process
2. Section V:XI Residency Programs: Unconscious Bias and Cultural Sensitivity Education

Financial Note: Minimal with EMRA Staff time.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 13

Emergency Medicine Disaster Preparedness

Author: Kyle Avery

Whereas natural disasters and disease outbreak pose a health risk to the community.[1]

Whereas disaster response hinges on effective communication and organized systems.[2]

Whereas a survey completed by 523 medical students concluded that only 17.2% believed they received adequate training and education for natural disaster medical management.[3]

Whereas EMRA Policy Compendium has no policy regarding disaster preparedness.[4]

Whereas AMA policy "Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training H-295.868" recommends that formal education and training in disaster medicine be incorporated into the curriculum at medical schools and residency programs.[5]

Resolved EMRA supports emergency medicine department coordination with local, regional, and national public health officials in the event of natural disasters, disease outbreak, and other public health needs of the community for the sake of emergency preparedness and response to the community.

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

References:

1. Walden University. (2018). *6 health impacts of natural disasters*. https://www.waldenu.edu/online-masters-programs/master-of-public-health/resource/six-health-impacts-of-natural-

disasters#:~:text=When%20a%20natural%20disaster%20destroys,in%20the%20spread%20of%20disease.

2. SAMHSA. (2023). Communications. https://www.samhsa.gov/dtac/disaster-response-template-toolkit/communications

3. Kaiser, H. E., Barnett, D. J., Hsu, E. B., Kirsch, T. D., James, J. J., & Subbarao, I. (2009). Perspectives of future physicians on disaster medicine and public health preparedness: challenges of building a capable and sustainable auxiliary medical workforce. *Disaster medicine and public health preparedness*, *3*(4), 210-216.

4. EMRA Policy Compendium. Accessed Jan 17, 2024.

5. AMA Policy H-295.868 Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training. Accessed on Jan 17, 2024.

EMRA Policy: None

Financial Note: None.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED DURING THE EMRA SPRING 24 VIRTUAL 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'24 - 14

Decriminalizing Victims of Human Trafficking and Individuals Who Offer Sex for Something

Author: Kyle Avery

Whereas International Labor Organization estimates 25 million people throughout the world are victims of forced sexual exploitation[3].

Whereas in a survey of street-based sex workers concluded that increased police presence impacted safety strategies the workers employed, had to rush screening clients, and were displaced to other areas with increased risk of violence[5].

Whereas AMA policy "Improving the Health and Safety of Individuals Who Offer Sex in Return for Money, Goods or Other Considerations H-65.948" recognizes adverse health outcomes of criminalizing individuals who offer sex in return for something and supports legislation decriminalizing these individuals including victims of human trafficking[4].

Whereas: AMA policy "Distribution and Display of Human Trafficking Aid Information in Public Places H-440.814" supports readily visible signs being posted in local clinics, emergency departments, or other medical settings regarding Human Trafficking Aid[1].

Whereas EMRA Policy Compendium has no specific policy on decriminalization of victims of human trafficking or those that exchange sex for something[2].

Whereas EMRA has policy in the Policy Compendium:Education Regarding Human Trafficking, but does not hold specific policy on distribution of Human Trafficking Aid information within emergency departments.

Resolved EMRA supports legislation that decriminalizes individuals who are victims of human trafficking or those that offer sex in exchange for something.

Resolved EMRA acknowledges adverse health outcomes can occur due to the criminalization of victims of human trafficking and those who offer sex for something.

Resolved EMRA encourages public posting of information within emergency rooms about human trafficking resources such as the National Human Trafficking Hotline andreporting procedures in suspected cases of human trafficking.

References:

1. AMA Policy H-440.814 Distribution and Display of Human Trafficking Aid Information in Public Places. Accessed on Jan 12, 2024.
2. EMRA Policy Compendium. Accessed Jan 12, 2024.
3. DOD (2018, January). 2018 National Slavery and Human Trafficking Month . https://dod.defense.gov/Portals/1/features/2018/0118_human_trafficking/pdf/hero-corps.pdf
4. AMA policy H-65.948 Improving the Health and Safety of Individuals Who Offer Sex in Return for Money, Goods or Other Considerations H-65.948
5. Krüsi, A., Pacey, K., Bird, L., Taylor, C., Chettiar, J., Allan, S., Bennett, D., Montaner, J. S., Kerr, T., & Shannon, K. (2014). Criminalisation of clients: reproducing vulnerabilities for violence and poor health among street-based sex workers in Canada-a qualitative study. *BMJ open*, *4*(6), e005191. https://doi.org/10.1136/bmjopen-2014-005191

EMRA Policy: EMRA Policy Section 4, II Education Regarding Human Trafficking

Financial Note: None.

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.