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## *Emergency Physician Involvement, Utilization, and Compensation During a Pandemic*

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The COVID-19 pandemic revealed critical weaknesses in the practice of medicine. The past three decades have seen the transition from physician owned hospitals, faith-based facilities, and community owned specialty centers, into multi-state corporate healthcare entities. Physicians have reduced input and control of their home institutions. Changes in hospital supply chains and focus on staffing precisely to volume while minimizing salary costs undermined facilities' ability to respond during unforeseen crises. Surge planning and staffing models are based on local seasonal conditions, not low frequency high consequence events.

***ACEP affirms the following as necessary and integral to the health and safety of the patients and communities their serve during disasters:***

- Emergency physicians must have input into emergency department staffing patterns inclusive of the unexpected surge during a high consequence event of low probability, ensuring the health and safety of patients and the community served.
- Due to the variable flux of such an event, hospitals and health systems must ensure the identification, acquisition, and maintenance of essential materials in preparation for, as well as the training and maintenance of, a defined healthcare workforce capable of responding to each phase of a disaster.
- Partnerships must be developed with hospitals, health systems and jurisdictional agencies to secure funding streams to sustain this critical workforce. This must occur prior to and during a disaster, thus ensuring community resilience.
- The behavioral health needs of healthcare workers must be given higher priority. Family needs of healthcare workers must be considered. Liability protections during disasters and Crisis Standards of Care situations must be put into place. Incentive pay needs to be considered if hospitals expect to retain and encourage critical clinical staff to respond during disasters.