MAINE CHAPTER
American College of Emergency Physicians

Quarterly Newsletter | Fall 2026

Dear Maine ACEP Members,



The last few months have brought to Maine many of the harsh realities of acute care across the nation: increasingly constrained services in rural communities, outside corporate influence on the local practice of medicine, and an election year in which how and where you will care for your patients is increasingly on the ballot. The purpose of this organization is to support emergency physicians, not to take sides. However, we cannot remain silent, nor should we view the increasingly tumultuous events around us as things happening to us; they also present opportunities.

With that in mind, I would like to share two important documents that reflect current issues facing emergency medicine in Maine. In encourage you to review them in their entirety.

The Basics

Press Release

Within the last month, Central Maine Healthcare abruptly terminated the contract of a Maine-based emergency physician group. President-Elect Brandon Giberson authored a press release, which was reviewed and approved by the Maine ACEP Board of Directors. BlueWater employees, including myself, recused themselves from the development and approval of this document. *See attached.*

Legislation Proposal: A Specialist Standard for Maine's Emergency Departments

What It Does

The proposal would require every Maine emergency department to have a board-certified or board-eligible emergency physician on site 24 hours a day. It does not replace Advanced Practice Providers (APPs) or physicians from other specialties. Rather, it sets a standard for who leads the team.

Why It Matters

EMTALA guarantees every patient emergency care. It says nothing about who provides that care, or to what standard. Across Maine, emergency departments rely on physicians from other specialties and on APPs, often out of necessity. These clinicians carry a heavy load in communities that depend on them. But the current model does not guarantee a consistent, verifiable standard of emergency care statewide.

We expect specialists to lead care in their own fields. Just as an orthopedist leads orthopedic care, an emergency physician should lead emergency care. This is particularly important in Maine, here the emergency department is often the only option for unscheduled medical, trauma, pediatric, and obstetric care. A small hospital may have few other specialists to call when a critical patient arrives at 3 a.m.

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Virginia, Indiana, and South Carolina already require a physician in every emergency department around the clock. Maine should be the first to require that this physician be trained in emergency medicine.

The rare, high-stakes cases make the point vividly: the failed airway, the thoracotomy, and the resuscitative hysterotomy. The everyday value matters just as much. Emergency training shapes routine decisions: what to test, when to consult, and when a patient can stay instead of being transferred. Specialist-led EDs order fewer tests, request fewer consults, and transfer fewer patients. In a state short on all three, doing more with less is a necessity, not a luxury.

Hospitals will raise two concerns: cost and workforce. Both are fair, and this change won't happen overnight.

The Objections



Cost: Many Maine hospitals already pay non-EM physicians in their EDs wages comparable to, or higher than, what emergency physicians earn in more populated states. And standards evolve. Thirty years ago, few small Maine hospitals had a CT scanner. Today everyone does.

Workforce: Residency programs are graduating more emergency physicians than ever. They can't all work in Boston or San Francisco. Maine has an opportunity to actively recruit emergency physicians.

Member Update

4th Quarter Holiday Meeting



- **Date:** December 3, 2026
- **Location:** Portland Regency Hotel – Portland, Maine
- **Time:** 4:30 PM – 8:30 PM
- **Social Hour:** 4:30 PM – 5:30 PM
- **Register Today!**

I hope to see you all in Portland in December!

Sheldon

Sheldon H. Stevenson, DO, FACEP
President, Maine Chapter ACEP

Press Release

Written Testimony in Support of Statewide Emergency Department Staffing Standards

Submitted to the Joint Standing Committee on Health and Human Services / Health Coverage, Insurance and Financial Services

Sheldon H. Stevenson, DO, FACEP

President, Maine Chapter, American College of Emergency Physicians

I submit this testimony on behalf of the Board of Directors of the Maine chapter of the American College of Emergency Physicians, representing more than 200 Maine Emergency Physicians.

Distinguished members of the Committee:

On behalf of my colleagues and our patients, I thank you for the opportunity to submit this testimony. We ask this body to begin building a legal standard that guarantees every Mainer, in every community, can go to an emergency department staffed and operated to a verifiable minimum standard, similar to what we expect in other medical environments.

The emergency department has quietly become the last unit standing.

Across Maine, inpatient and outpatient services are being consolidated, relocated, or closed. As those resources disappear, the local emergency department is increasingly left as the sole provider of unscheduled, acute care in its community. Recent closures of hospital birthing units have drawn heated public attention, but they are not an isolated change. They are the most visible symptom of a broader structural shift also seen with surgery, primary care access, and inpatient unit capabilities. When the OB unit closes, obstetric emergencies don't go away; they arrive at the emergency department. The same is true of the mental health crisis, septic child, or heart attack.

As we ask emergency departments to single-handedly manage an ever more complex and diverse spectrum of illness, it is no longer defensible to leave the qualifications of the physicians running them, and the operational standards of the departments themselves, entirely to individual hospital discretion.

Board certification is the verifiable standard this challenge demands.

Emergency medicine is a distinct specialty with its own rigorous, multi-year residency curriculum. Emergency physicians develop specialty-specific knowledge and procedural skills across a broad range of areas germane to modern emergency care—all through the lens of time-sensitive, resource-limited decision-making that defines no other setting in medicine. In the United States, the verified standard for this expertise is board certification through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM). Only physicians who complete an accredited emergency medicine

residency are eligible, and certification isn't a one-time credential: it requires an initial written and oral assessment, followed by career-long maintenance to ensure certified emergency physicians stay current and competent.

This is the paradox at the heart of our current system.

Nowhere in American medicine would we staff an orthopedic service with physicians who are not orthopedic surgeons. We would not accept it, and we do not — even though orthopedics carries no legal duty to treat anyone who walks through the door.

The emergency department is the one place in all of American medicine where care is federally *mandated* for every person, regardless of ability to pay, under the Emergency Medical and Active Labor Act (EMTALA). It is also the only specialty setting where we routinely tolerate the unit being staffed by physicians (or non-physicians) trained in another specialty. We have inverted the risk: we permit the least standardization precisely where the legal obligation, the acuity, and the stakes are highest. We have never codified a standard we consider obvious for elective knee replacements for a patient population that cannot be turned away.

Recommendations:

I respectfully urge the Committee to draft and report out legislation, for consideration in the next session, that establishes the following standard for all hospital emergency departments. This includes all units considered either Type A or Type B "dedicated emergency departments" under (42 C.F.R. § 489.24) of the Emergency Medical Treatment and Active Labor Act (EMTALA).

1. **24/7 board-certified physician coverage.** Every such emergency department shall be staffed during all operating hours by at least one physician board-certified in emergency medicine by ABEM or AOBEM. This physician may lead a care team that includes physician assistants, nurse practitioners, and non-boarded physicians — but the standard ensures a certified emergency specialist is always present and accountable.

This proposal is designed to protect rural access, not to threaten it.

The proposal must responsibly address a contemporary reality: Maine has emergency departments, particularly in rural and critical access settings, that rely in whole or in part on family medicine physicians, internists, and advanced-practice providers. A blunt, overnight mandate could put those departments at risk and harm the very communities we are trying to protect.

For that reason, this proposal should be built with two structural safeguards:

- **A meaningful phase-in period** (in the range of five to seven years) that gives hospitals genuine runway to recruit, credential, and build toward the standard, rather than an abrupt cutoff.
- **A time-limited hardship waiver** available to critical access and rural facilities that can demonstrate a good-faith, documented recruitment and compliance plan — providing a

pressure valve for the hospitals facing the steepest workforce challenges, while keeping the standard as the destination.

Thank you for your consideration. I would welcome the opportunity to serve as a resource to the Committee as it develops this legislation.

Respectfully submitted,

Sheldon H. Stevenson, DO, FACEP

President, Maine Chapter

American College of Emergency Physicians