

COMMON SENSE

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AAEM Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

Membership Information

Fellow and Full Voting Member: \$425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)

Affiliate Member: \$365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)

Associate Member: \$250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)

*Fellows-in-Training Member: \$75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)

Emeritus Member: \$250 (Please visit www.aaem.org for special eligibility criteria)

International Member: \$150 (Non-voting status)

Resident Member: \$60 (voting in AAEM/RSA elections only)

Transitional Member: \$60 (voting in AAEM/RSA elections only)

International Resident Member: \$30 (voting in AAEM/RSA elections only)

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President's Message

Advocacy Efforts in Support of Due Process

Mark Reiter, MD MBA FAAEM
AAEM President

Due process remains an extremely important issue for our membership. We continue to hear about egregious cases of emergency physicians being terminated after advocating for their patients or their emergency department, or for simply doing their job. Unlike most other physicians on the medical staff at hospitals, emergency physicians are routinely contractually denied due process. In the workplace, due process essentially means that an employer has to follow an appropriate pre-defined process to terminate your job. For most U.S. hospitals, due process will include the physicians' right to hear the charges and evidence against them justifying their termination, the ability to provide testimony and evidence in their defense, and having their actions judged by their peers rather than by non-physicians. In professional contracts that provide due process to physicians, a hospital administrator or contract management group (CMG) cannot immediately terminate you without cause or for arbitrary reasons.

AAEM's recent advocacy efforts related to due process are focused on changing regulations to guarantee due process. Over the past two years AAEM has been meeting with leaders from the Centers for Medicare and Medicaid Services (CMS), lobbying CMS to codify all physicians' right to due process and an employer's inability to require a physician to waive this right into their Conditions of Participation, so that every hospital in the country receiving CMS funding must comply. CMS has told the Academy that it needs to hear this isn't solely an AAEM or emergency medicine issue. As such, AAEM recently contacted a multitude of professional organizations requesting they sign a joint letter to CMS on this topic (see next page). We are pleased to report that the American

Society of Anesthesiologists, the Society of General Internal Medicine, the American College of Legal Medicine, the American College of Emergency Physicians, the Council of Emergency Medicine Residency Directors, the AAEM Resident and Student Association, and the

“AAEM remains committed to taking the lead on this essential issue.”

Emergency Medicine Residents' Association have signed on. In addition, the American Academy of Family Physicians sent a similar letter. These organizations collectively represent hundreds of thousands of physicians, demonstrating the importance of this issue.

AAEM has also been lobbying Congress on this topic. We have met with several dozen Members of Congress and their staffs on Capitol Hill. Several Members of Congress have sent letters and made phone calls to CMS advocating for further due process protections. In addition, we are in discussions with several Members of Congress to attempt to add amendments related to due process protections to health care legislation currently being considered by Congress. Our next AAEM Advocacy Day is tentatively scheduled for September 29th. All interested AAEM members are welcome to join us as we continue to advocate on Capitol Hill. Improving due process protections is an important endeavor, but success will take a lot of time and hard work. AAEM remains committed to taking the lead on this essential issue. ■



Strength in Numbers AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified and board eligible physicians. Each hospital/group that participates in the group program will now have the option of two ED Group Memberships.

- 100% ED Group Membership — receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- ED Group Membership — receives a 5% discount on membership dues. Two-thirds of all board certified and board eligible physicians at your hospital/group must be members.

For these group memberships, we will invoice the group directly. If you are interested in learning more about the benefits of belonging to an AAEM ED group, please visit us at www.aaem.org or contact our office at info@aaem.org or (800) 884-2236.

For a complete listing of 2015 100% ED Group members, go to www.aaem.org/membership/aaem-ed-group-membership.

CMS Due Process Sign-On Letter

Our Academy's Vision Statement says, in part, "A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference." Emergency physicians are open to the **worst** kind of outside interference when they can be fired without cause and without due process or peer review, on the whim of a hospital administrator or contract management group (CMG). CMG employment contracts commonly — almost universally — require emergency physicians to waive their rights to due process and peer review. And while independent, democratic groups always have a specified process for firing a member that includes peer review, they also often have a clause in their hospital contract that says a member must be fired at the request of the hospital administrator, negating the due process and peer review protections of the group's bylaws.

What can be done to protect emergency physicians from arbitrary firing, so we can practice good medicine and be advocates for our patients — patients who often have no one else in their corner? Employed physicians can unionize and bargain collectively for due process rights and peer review, and I believe the day is fast approaching when a movement to unionize will sweep emergency medicine and other hospital-based specialties. We can also lobby the federal government for protection. For instance, the Centers for Medicare and Medicaid Services (CMS) could include due process protections for hospital-based specialists in its Conditions of Participation in Medicare.

Our Academy has been working on that for quite some time, and is now leading a movement that includes other emergency medicine societies and even other specialties to achieve that goal. See the letter below.

— The Editor

May 4, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Administrator Slavitt,

We, the undersigned organizations, are writing to express concern about the systematic violation of physician due process rights at hospitals. The threat of termination from a hospital medical staff without the right of a fair hearing may prevent physicians from advocating for patients or system changes to their hospital administration or contract holder for fear of retribution. Physicians should have the right to due process prior to termination from a hospital's medical staff and that right should not be waived by a third party. Physicians with due process rights are more likely to protest fraudulent practices by some hospitals that threaten the integrity of the Medicare and Medicaid programs.

Some hospitals and physician staffing companies attempt to deny physicians their due process rights by including a clause in employment contracts allowing hospital administrators to directly or indirectly terminate a physician with or without cause, without a fair hearing. We believe that such clauses violate the constitutional rights of physicians who work at government owned hospitals and are a threat to patient safety. These clauses also violate the Health Care Quality Improvement Act of 1986, violate protections afforded in medical staff bylaws, and conflict with standards promulgated by the Joint Commission.

Physicians have a duty to advocate for their patients, even when such advocacy requires opposition to hospital interests. Due process rights protect physician autonomy, serve as a mechanism to protect patients, and assure physicians that they will not lose their practice rights for unfair reasons.

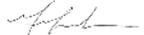
We, the undersigned, encourage the Centers for Medicare and Medicaid Services to consider the due process rights of physicians when advancing public policy. This can be accomplished by revising Medicare's Conditions of Participation for hospitals to guarantee that physicians must be entitled to a fair hearing and appellate review through medical staff mechanisms before any termination or restriction of their professional activity or medical staff privileges, and that these rights cannot be denied through a third party contract.

Physicians are on the front lines of health care delivery, and whether it is the reporting of Medicare waste, fraud, and abuse, or advocating on local issues such as hospital crowding, resource utilization, or the care of an uninsured patient, appropriate protections will augment the physician voice in critical patient care discussions.

Sincerely,



Mark Reiter, MD MBA FAAEM
President, American Academy of Emergency Medicine



Meaghan Mercer, DO
President, American Academy of Emergency Medicine
Resident and Student Association



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Jeffrey N. Love, MD
President, Council of Emergency Medicine Residency Directors

The Eternal City

Andy Walker, MD FAAEM
Editor, *Common Sense*



For centuries Rome was capital of the western world, and it remains one of the greatest cities in the world — a place unlike any other — and September 5-9 it will be the site of the Eighth Mediterranean Emergency Medicine Congress (MEMC-GREAT 2015). I personally attended MEMCs IV-VII in Sorrento, Italy; Valencia, Spain; Kos, Greece; and Marseilles, France, and was glad I did every time. MEMC is a consistently excellent and interesting meeting, and offers the

opportunity to meet emergency physicians from around the world and see things from perspectives you may never have imagined. In past years it has set records for the biggest international gathering of emergency physicians on the planet.

MEMC-GREAT 2015 is sponsored by the Mediterranean Academy of Emergency Medicine,¹ the Global Research on Acute Conditions Team — Italy (GREAT-Italy),² and of course the American Academy of Emergency Medicine (AAEM). It may be the best MEMC yet, and the fact that it is in Rome is icing on the cake. MEMC-GREAT 2015 is an incredible opportunity for AAEM members to use their CME stipends — or at least take a tax deduction if they don't have a CME allowance — to visit one of the greatest places on earth.

In fact, if you have an interest in history Rome is probably the greatest place on earth. Since I have a passionate interest in both history and art, it is my favorite city by far. That is why I was ecstatic to learn Rome had been chosen to host the upcoming MEMC. The great things to see and do there are too numerous to do in a week or even a month, and are worth repeat visits anyway, so visiting Rome never grows old. You can walk along the Via Sacra in the Forum, literally following in the footsteps of Julius Caesar; visit the Colosseum, an ancient but thoroughly modern sports venue; see the ruins on the Palatine Hill, the first of Rome's seven hills to be occupied, where Romulus and Remus were suckled by a she-wolf, Cicero lived, and the Emperor Augustus was born; explore several Roman baths and catacombs; or take a guided tour of the eerie Domus Aurea (Golden House), the palace Nero built but never had a chance to occupy, whose artificial lake was drained to build the Colosseum; and so, so much more.

The artistic treasures of Rome are as great as its historic treasures and for Christians, Rome is probably the second most important city on Earth, after Jerusalem. Even for those of other faiths or no religion, the religiously inspired art is magnificent. I highly recommend a visit to Vatican City. Not only for St. Peter's Basilica and the Sistine Chapel with Michelangelo's famous ceiling and *Last Judgment*, but also for Raphael's frescoes (including *The School of Athens*) in the old papal apartments and especially the Vatican Museums, one of the best museum complexes

in the world. The Villa Borghese is also not to be missed, both for its surrounding park and especially the Galleria Borghese, which houses an art collection second only to the Vatican's. Either its Bernini sculptures or Caravaggio paintings alone are worth the visit.

Then there are the fountains and outdoor spaces, like the Spanish Steps, Trevi Fountain, and piazzas. My favorite is the Piazza Navona. Its long elliptical shape is due to the fact that it was built on the circus erected by the Emperor Domitian in 56 A.D. Many of the buildings around its circumference are built on the stone bleachers where the audience sat. And of course there is the Pantheon, the largest domed building in the world until the Astrodome was built in Houston. Despite being in an area prone to earthquakes the Pantheon still stands, the oldest completely intact building in Rome. I doubt the Astrodome will still be around in 2,000 years. And then there is the food, the wine, the sidewalk cafes, the three-hour meals, and the gelato. Ah, the gelato.

“MEMC-GREAT 2015 gives you the opportunity to travel to perhaps the world's greatest city at a discount, and attend a worthwhile emergency medical meeting unlike any other.”

I could go on and on. In fact, if the dollar were worth more than the euro I just might learn Italian and move to Rome when I fully retire. But for you the bottom line is this: MEMC-GREAT 2015 gives you the opportunity to travel to perhaps the world's greatest city at a discount, and attend a worthwhile emergency medical meeting unlike any other. If you blow this chance you will regret it. On the other hand, if you go you just might be so grateful to me for talking you into it that you track me down and offer to buy me dinner. However, I'll settle for gelato.

Footnotes

1. About MAEM

The Mediterranean Academy of Emergency Medicine was established in 2014 for the purpose of promoting, securing and protecting excellence and integrity of emergency medicine in the Mediterranean region. Its mission encompasses the practice and management of emergency medicine as well its education, training, and research.

MAEM defines the Mediterranean region as any country or region contiguous with the Mediterranean basin. This includes all Europe, Turkey, Israel, and the Black, Adriatic and Aegean Seas, and the Arab North African and Middle Eastern Countries.

Currently, MAEM is currently incorporated through AAEM as an international regional chapter of AAEM. This multinational chapter has already

Submit a “Letter to the Editor” at www.aaem.org/publications/common-sense/letters-to-the-editor.

Continued on next page

begun its activities and establishing itself in the Mediterranean basin. This includes educational planning and executing activities such as congresses, national conferences and seminars, multinational leadership meetings. Over the next three to five years, MAEM will be incorporating itself and selecting its base and operations in countries around the "Big Blue."

2. About GREAT Italy Network

The GREAT Association is an International Network of multidisciplinary experts operating in the management of acute clinical conditions in the field of emergency medicine and critical care.

The aim of the Network is to build a new way in doing research through the concept of translational medicine. This is the emerging view of medical practice and interventional epidemiology. It integrates research inputs from basic sciences and political sciences to optimize both patient care and preventive measures which may extend beyond the provision of health care services.

Moreover, one of the main objectives of GREAT Association is to standardize the clinical and organizational system approach in acute conditions disease management all over the world, with the concept of globalization medicine.

The GREAT ITALY network is a branch of the GREAT International Network and operate with the same spirit of it and particularly devoted to link the Italian Academic Centers where are operating the postgraduate schools of emergency medicine with the objectives of:

- Teaching to young doctors to develop competencies to recognise and manage acute ill patients
- Encouraging young doctors on doing research on acute conditions through the concept of Translational Medicine
- Standardizing the clinical and organizational system approach in acute conditions disease management all over the world, with the concept of globalization medicine
- Cooperating with the National Health Commissions — to adopt standards for the management of acute conditions
- Carrying out clinical trials relating to acute diseases ■

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Letters to the Editor

Andy Walker, MD FAAEM
Editor, *Common Sense*



A "Letters to the Editor" feature is now available on the *Common Sense* section of the AAEM website. Members must login with their AAEM username and password to read or post letters, or to comment on letters (www.aaem.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a

case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in *Common Sense*.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make *Common Sense* an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the letters to the editor feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

Letter in response to the March/April "President's Message" article titled "A Dark Day for the Independent practice of Emergency Medicine":

Mark,

Great article "A Dark Day." Many of us appreciated your article out here.

I wanted to let you know that many of us read your article and liked it. It was a little surreal to see our groups name mentioned by you in a national publication.

— Name withheld by request

Letter in response to the March/April "President's Message" article titled "A Dark Day for the Independent practice of Emergency Medicine":

Mark,

I want to thank you for the great article in the most recent *Common Sense*. It was spot on and my wife read it and simply said "that's exactly what you (meaning me) have been saying." While I am saddened to leave _____ I am looking forward to starting with my new group and I feel confident this next step in my career won't end the way things did here.

As you might imagine there is turmoil here with lots of dissatisfied and disgruntled doctors. Some of the old guys even lament that all they built is in a tailspin.

— Name withheld by request

We're listening, send us your thoughts!



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King v. Burwell Ruling Sets Tone for Summer Health Care Agenda

Williams & Jensen, PLLC

For the second time in three years the Supreme Court delivered a major ruling in favor of the Affordable Care Act (ACA), and eliminated perhaps the most compelling remaining legal challenge to the law by upholding federal subsidies for state exchanges. In a 6-3 decision, Chief Justice John Roberts and Justice Anthony Kennedy joined Justices Ruth Bader Ginsburg,



Stephen Breyer, Sonia Sotomayor, and Elena Kagan in the majority. The Court interpreted a passage in the law that said tax credits are authorized for those who buy health insurance on marketplaces that are “established by the state.” Chief Justice Roberts acknowledged that the law’s wording was problematic but maintained that congressional intent was clear, stating that “Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible we must interpret the Act in a way that is consistent with the former, and avoids the latter.”

This case was closely watched by Congress and the Administration, and was viewed by many experts as the most significant remaining legal challenge to the law. In anticipation of a ruling against the Administration in *King v. Burwell*, Congress had been preparing legislative responses authored by several Republican Members that would significantly change elements of the ACA, while providing assistance to low-income individuals to purchase health insurance. In the event of that outcome, Members had also been preparing for gridlock on other health care bills as Congress contemplated legislation that would restore or replace the subsidies. The decision likely opens the door to Congressional consideration of changes to the ACA, and will allow the House and Senate to move forward with additional health-related legislation, which would otherwise have been stalled by efforts to restore the health insurance subsidies.

ACA Repeal

Congressional Republicans also vowed to continue efforts to repeal the ACA, and signaled their intent to pass a bill to do that. The House has voted dozens of times since 2010 to repeal the ACA, but the Senate has yet to approve such a measure. However, Republicans now hold a 54-46 advantage in the Senate, and could use a process known as budget reconciliation to repeal the ACA with 51 votes rather than 60. This maneuver could allow Republicans to send ACA repeal legislation to the President’s desk for the first time, but President Obama has indicated he would veto that bill and there are not sufficient votes in the House or Senate to override.

Other ACA Proposals

In June the House passed a pair of significant bills related to the ACA. The Protect Medical Innovation Act was approved by a vote of

280-140, with the support of 46 Democrats. The measure would repeal the Affordable Care Act’s (ACA) excise tax on medical devices for all sales since enactment of the law. The Chairman of the Senate Finance Committee introduced a similar bill in the Senate and said the Committee intends to hold a markup of the legislation. The House also approved the Protecting Seniors’ Access to Medicare Act, legislation introduced by Representative Phil Roe, MD (R-TN) to repeal the ACA’s Independent Payment Advisory Board (IPAB). The measure passed by a vote of 244-154, with some Democratic Members indicating their support for IPAB repeal but disagreement over the offset for the legislation, which would cut funds to promote public health and preventative care. IPAB has been among the most controversial provisions of the ACA since its passage, with critics asserting that the 15-member panel would ultimately be empowered to make decisions that would have a negative impact on coverage for seniors under the Medicare program. A number of physician groups have urged Congress to repeal IPAB. Proponents of IPAB have argued that the panel is an important tool to help bend the Medicare cost curve, and that an independent commission is necessary to make the tough decisions that Congress may not be willing to endorse.

“AAEM and AAEM/RSA will be highlighting the growing support for due process rights for physicians, and discussing other important issues such as GME funding, and medical student debt reform.”

The Senate could attempt to take up these and other ACA modification bills later in the year, although it is not clear whether 60 votes can be secured to take up the legislation or if 60 votes could again be achieved to end debate on the bills and vote them up or down. President Obama is expected to veto both bills.

21st Century Cures Legislation

In July the House is set to consider and approve the 21st Century Cures Act, a major bipartisan initiative that seeks to modernize the development and delivery of cures. Among other provisions, the bill would streamline elements of the clinical trials process and authorize nearly \$2 billion in annual additional funding for the National Institutes of Health (NIH) over the next five years. It would also create several new approval pathways for drugs and medical devices. The Senate is developing its own plan to modernize the development and delivery of cures, but no legislation has been formally introduced to the Senate Health, Education, Labor and Pensions (HELP) Committee.

Continued on next page

September Advocacy Day

AAEM and AAEM/RSA will hold their 2015 Advocacy Day in Washington, D.C. on September 29. Members will have the opportunity to come to Capitol Hill to meet with key Members of Congress and congressional staff, to advocate for issues important to emergency physicians. AAEM and AAEM/RSA will be highlighting the growing support for due process rights for physicians, and discussing other important issues such as GME funding, and medical student debt reform. With the permanent Medicare Sustainable Growth Rate (SGR) replacement signed into law in April, this is an ideal time to visit the Hill to discuss important issues facing physicians that deserve Congressional attention. Additional information about the fly-in and instructions for registration are available on the AAEM website at: www.aem.org/advocacy/aaem-advocacy-day. ■

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**AAEM & AAEM/RSA
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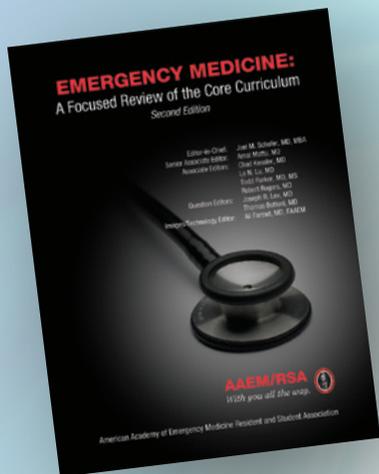
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AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care and (2) defending the rights of patients to receive such care and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

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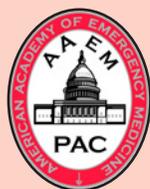
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February 17-21, 2016

- 22nd Annual AAEM Scientific Assembly
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Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Emily DeVillers to learn more about the AAEM endorsement and approval process: edevillers@aaem.org.

All provided and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

AAEM JOINTLY PROVIDED CONFERENCES

September 5-9, 2015

- Mediterranean Emergency Medicine Congress (MEMC-GREAT 2015)
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www.emcongress.org

Pre-Congress Courses

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- Ultrasound for Beginners
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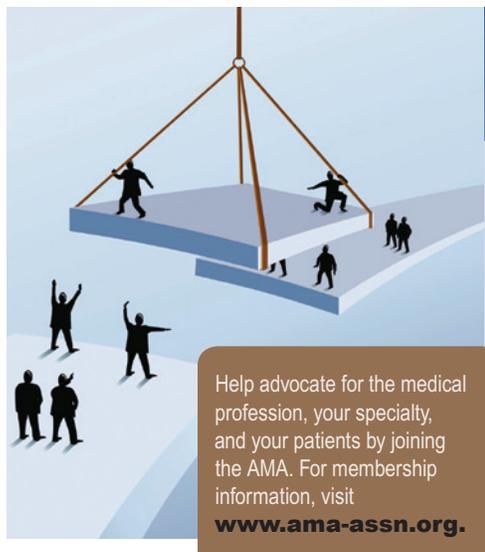
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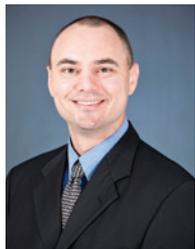
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Easy Way for Physicians to Plan for Retirement

Joel M. Schofer, MD MBA CPE FAAEM
Secretary-Treasurer, AAEM
Commander, U.S. Navy Medical Corps



The previous installment of “Dollars & Sense” reviewed the principles of investing for retirement, and this article discusses an easy way for physicians to plan for retirement. It isn’t necessarily the best way and certainly isn’t the only way, but it is a plan that will likely lead to a very successful and potentially even early retirement.

You may have other options, such as funding a Health Savings Account as a “stealth IRA.” Some believe in using life insurance as an investment, but I don’t recommend that. In general, after you’ve maxed out the contributions to all of your tax-advantaged accounts, you’ll have to put the rest in a regular, taxable investment account.

For some of the options above you’ll have to decide whether to pursue a Roth option (pay taxes now) or use the traditional tax-deferred approach (pay taxes when you withdraw the money in retirement). That decision will

Step 1 — Calculate How Much You Need to Save for Retirement

Total up your household’s gross (pre-tax) income for the year. Include all sources of income, literally all the money you make from anywhere. Multiply that number by 20%. That is how much you need to save annually for retirement. While the traditional recommendation is that you save 10-15% of your income for retirement, saving 20% (or more if you can) will ensure you save enough and have the option of an earlier retirement or the freedom to cut back on your workload at some point.

As an example, let’s pretend your household makes \$300,000 annually before taxes. Multiple that by 20% and you’ll see that you need to save \$60,000/year for retirement.

Step 2 — First Fill All Your Tax-Advantaged Retirement Accounts

You likely have many different retirement accounts available, so here is the order in which you should invest. Start with the first action and move down the list.

Contribute to any employer-provided retirement account up to the maximum that your employer will match. This is free money you can’t afford to leave on the table.

Maximally fund any tax-deferred retirement accounts you have, like your 401k or 403b. If you are self-employed you may have other options like a SEP-IRA or individual 401k.

Fund an IRA for both you and your spouse/partner, if applicable. If your income renders you ineligible to contribute to a Roth IRA but you still wish to do so, use the “backdoor” Roth IRA approach. (<https://personal.vanguard.com/us/insights/video/2505-Exc2>)

Put any remaining retirement funds into a taxable mutual fund.



“...Ensure you save enough and have the option of an earlier retirement or the freedom to cut back on your workload at some point.”

depend on your individual financial situation, current and anticipated future tax brackets, and what options your employer offers.

There are many online calculators to help you decide this.

Using our \$60,000 example from above, you would contribute \$18,000 to your 403b, and then fund \$5,500 toward an IRA for both you and your spouse, leaving \$31,000 to put into a taxable investment account. If your employer contributes to your retirement, you could also count that amount toward your \$60,000 total contribution.

Step 3 — Invest Your Retirement Savings in Low Cost, No Load, Index Mutual Funds

You will have to take a look at the investments offered by your various plans and select from that menu. The principles that should guide you:

Favor index funds over actively managed funds. You’re investing for the long term, and over that time frame almost no actively managed funds will beat index funds. In addition,

because past performance does not predict future performance, there is no way to predict which funds will beat their indexes.

Favor mutual funds with low expense ratios that do not charge a load. The expense ratio should be less than 1.0, preferably less than 0.5, and optimally less than 0.25. If you want to keep this really easy, just invest in Vanguard index funds as all of them meet these criteria.

Realize that in order to beat inflation over the long haul, you’ll likely need to invest some of your portfolio in stock index funds. What percentage you invest in stocks will depend on your time horizon, risk tolerance, and individual situation. A number of guidelines from trusted references are on the next page:

Continued on next page

- Malkiel & Ellis suggest this as a conservative asset allocation:

AGE GROUP	PERCENT IN STOCKS	PERCENT IN BONDS
20-30s	75-90	25-10
40-50s	65-75	35-25
60s	45-65	55-35
70s	35-50	65-50
80s+	20-40	80-60

- They suggest this as a more aggressive asset allocation, which is my personal favorite due to the security offered by my inflation-adjusted military pension:

AGE GROUP	PERCENT IN STOCKS	PERCENT IN BONDS
20-30s	100	0
40s	90-100	10-0
50s	75-85	25-15
60s	70-80	30-20
70s	40-60	60-40
80s+	30-50	70-50

- John Bogle suggests, as a conservative asset allocation rule, that your percentage of assets in bonds should equal your age. In other words, at age 30 you should have 70% in stocks and 30% in bonds. A more aggressive version is to subtract 10 from your age, so at age 30 you'd have 80% in stocks and 20% in bonds.

One very easy way to let someone else make this decision for you is to pick a target date retirement fund as your investment vehicle. Many investment companies offer these. You just pick the approximate year you plan to retire — that year will likely be in the name of the fund (Target

Retirement 2035, for example) — and invest in that fund. Your investments will gradually get more conservative as you age without any action on your part. Just make sure that the target date funds you have access to are composed of index funds with low expense ratios. Again, using Vanguard funds makes this a no-brainer. A target date retirement fund composed of actively managed funds with expense ratios greater than 1.0 is a target retirement fund to avoid.

To close out our running example, for your 403b you invest in the target retirement 2040 fund offered by your employer's investment firm. For both of your IRAs and your taxable account you apply the KISS (keep it simple stupid) principle, open all of them with Vanguard, and select their Target Retirement 2040 funds for all three accounts.

A simple approach like this should set you up well for retirement, and is easy enough that you can use the time you would have spent trying to manage your finances to play a little golf every now and then.

If you have ideas for future columns or have other resources you'd like to share, email me at jschofer@gmail.com.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense or the United States Government.

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AAEM Works for Antibiotic Stewardship on the National Stage

Michael S. Pulia, MD FAAEM

Chair, AAEM Antimicrobial Stewardship Task Force



Antibiotic stewardship is best summed up as the right antibiotic for the right patient at the right dose at the right time. This simple concept represents a major clinical, quality of care, public health, and patient safety challenge for emergency physicians.¹ It is with great pride that I report on AAEM's efforts on this important topic.

On June 2, 2015 it was my distinct honor to represent AAEM at the White House One Health Forum on Antibiotic Stewardship. This event brought together over 150 of the brightest minds in infectious disease, representatives from key professional societies, high-ranking government officials, and leaders from the medical diagnostic, pharmaceutical, agriculture, and food/retail industries.² AAEM was the only voice representing emergency medicine at this historic event. Participants were selected based on their specific commitments to implement initiatives over the next five years designed to combat the spread of resistant bacteria through the responsible use of antibiotics.

AAEM's invitation to this event reflects both the leadership role taken by the Academy in partnering with the CDC to raise awareness of the issue, and an appreciation by AAEM's board of directors of the significant impact antibiotic-resistant bacteria have on emergency physicians and the patients we treat. In 2013 AAEM signed on as a collaborating organization with the CDC's antibiotic stewardship campaign, Get Smart.^{3,4} The CDC sought this collaboration due to its increasing awareness that the ED is the nexus of our health care system, and decisions about antibiotic use made there affect both admitted and discharged patients. This partnership seeks to raise awareness among emergency physicians on the link between antibiotic stewardship and resistant bacteria.

As a participant in the White House forum, AAEM strengthened its national leadership role and committed to improving antibiotic stewardship in the ED over the next five years with the following initiatives.

1. Develop a series of position statements pertaining to best practices in emergency care antibiotic stewardship.
2. Support the development of antibiotic use quality measures specific to emergency medicine that take into account the health care system factors that influence physician prescribing.
3. Produce a series of podcasts on optimizing infectious disease management in the ED.
4. Continue to offer cutting edge educational sessions on infectious disease topics at the annual Scientific Assembly.
5. Seek opportunities to partner with other professional organizations on the development of infectious disease clinical practice guidelines for emergency physicians.
6. Publish an annual antimicrobial stewardship article in *Common*

Sense, to coincide with the CDC's Get Smart About Antibiotics Week activities each November.

7. Commission an AAEM Antimicrobial Stewardship Task Force to lead the Academy's effort to develop position statements and educational offerings, and guide the Academy's relationship with government agencies and other key professional organizations such as the Infectious Disease Society of America.

The forum represented the culmination of several years of accelerating activity among the federal government and international organizations regarding the danger to human health posed by antibiotic resistant bacteria such as carbapenem-resistant *Enterobacteriaceae* (CRE), methicillin-resistant *Staphylococcus aureus* (MRSA), and *Clostridium difficile*. In 2013 the Centers for Disease Control and Prevention (CDC) released the first comprehensive U.S. report on this threat, which revealed two million annual infections and 23,000 deaths directly attributed to antibiotic-resistant bacteria.⁵ These staggering figures were followed in 2014 by a World Health Organization report that revealed the global scope of increased bacterial resistance, and warned of the impending "post-antibiotic

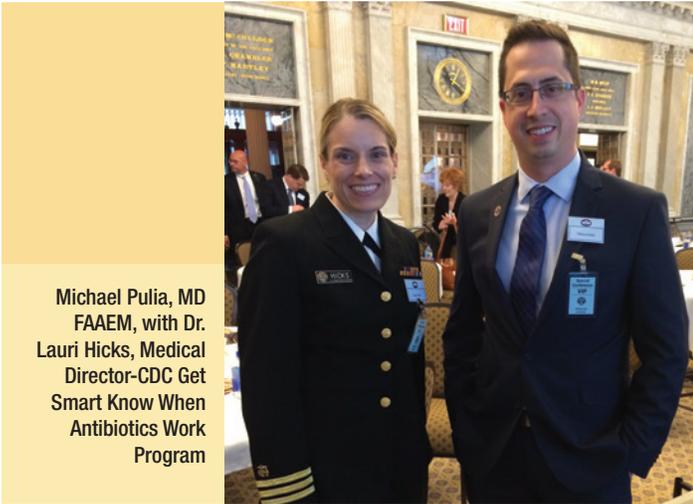
era."⁶ In response to these reports and CDC recommendations, the White House released a National Action Plan for Combating Antibiotic-Resistant Bacteria. The White House forum was the kickoff event for the National Action Plan, which has five central elements: 1) slow the emergence and spread of resistant bacteria, 2) strengthen national bacterial surveillance, 3) advance the development and use of rapid diagnostic tests to identify and characterize resistant bacteria, 4) accelerate research and development of new antibiotics and vaccines, and 5) improve international collaboration in each of these areas.⁷

The highlight of the forum's opening session was a panel discussion moderated by CDC Director Dr. Tom Frieden. The panel included executives from major health systems and food producers, each of whom made substantial commitments to improving responsible antibiotic use in their respective organizations. Lisa Monaco, Deputy National Security Advisor, closed the session with a powerful reminder that antibiotic resistance represents a threat to public health and is therefore treated as a serious national security issue by the administration. Participants were then divided into sessions based on their focus on either human or animal health. The human health session consisted of four panel discussions: 1) Improving Inpatient Prescribing, 2) Improving Outpatient Prescribing, 3) Improving Long-Term Care Prescribing, and 4) Developing New Tools-Better Therapies and Diagnostics.

During the Q&A session following the outpatient prescribing discussion, I was able to speak to all the attendees about the important role of the ED in American health care (nearly three-fourths of all hospital admissions and one-third of all acute care visits in the U.S.) and the unique challenges to antibiotic stewardship faced by emergency physicians,

Continued on next page





Michael Pulia, MD
FAAEM, with Dr.
Lauri Hicks, Medical
Director-CDC Get
Smart Know When
Antibiotics Work
Program



Michael Pulia, MD
FAAEM, with Dr.
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who provide care for acutely ill patients in an inherently stressful environment, often with incomplete information. Every head in the room shook in acknowledgment and support as I made that point and then called for increased funding on research and development of rapid bacterial diagnostics and biomarkers for use by front-line clinicians. I explained that emergency physicians desperately need better tools to rapidly identify patients in need of antibiotics, and to help guide the use of these powerful therapeutic agents in a precise and responsible manner. I also made a point of highlighting our role as the health care safety net and pointed out that our patients often do not have reliable follow up — another important consideration in the antibiotic decision making process.⁸ Following

my comments, many attendees expressed excitement that emergency medicine was represented and sought ongoing collaboration with AAEM, including representatives of the CDC, IDSA, and diagnostic industry.

The event also incorporated powerful testimonials from some who lost loved ones to antibiotic resistant bacterial infections, and then harnessed their sorrow into passionate advocacy. This served as the ultimate reminder of the impact these deadly organisms can have on individual patients and their families. AAEM is leading emergency medicine in raising awareness and turning the tide on antibiotic-resistant bacteria, so that we can more effectively care for our patients and reduce such tragic outcomes.

If you are interested in learning more about AAEM's antibiotic stewardship efforts or would like to volunteer to serve on the Antimicrobial Stewardship Task Force, please contact me at mspulia@medicine.wisc.edu.



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The Electronic Health Record — Are We the Tools of Our Tools?

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*But lo! Men have become the tools of their tools.*¹

— Henry David Thoreau

Electronic Health Records (EHRs) hold promise for transforming the health care system in remarkable ways by creating new efficiencies as well as possible cost reduction and quality enhancements. Unfortunately, innovations such as EHR that have the potential for ushering in great change have also historically had unintended consequences, and — as we have seen with new drugs and new devices — the most important unforeseen problems frequently come to light during “post-marketing surveillance.” Once they are used widely, the benefits of new medications and devices rarely live up to their original hype, while newly encountered risks and side effects often exceed expectations. This seems to be the state of EHR today. When a novel drug or a new device or a paradigm-shifting process shows unanticipated negative effects in the early stages of widespread adoption, careful study of the scope, severity, and implications of the undesirable actions is required. We confirm that the harmful effects of EHR use on patient care and medical education have been significant and are ongoing, but we also propose that future harm can be reduced if we change the way we use the system, and soon.

When our academic medical center adopted a newer, more complex EHR system in the fall of 2012, we encountered many of the same problems reported by other health care institutions. Outcries arose almost immediately. Patients, staff, and physicians were frustrated by the inefficiencies and delays in a system that had not been fine-tuned to deal with the normal flow of patient care. Essential tasks such as ordering tests, retrieving test results, and writing prescriptions required more time than previously and sometimes were impossible to complete. Clinic efficiency slowed dramatically, and significant glitches in the billing process led to a drastic fall in collections.²

At first, physician complaints were aimed at the technical, mechanical, and logistical challenges of navigating through a clinic visit and completing all of the required documentation, while maintaining a high quality of patient care. The new system did not make patient care easier; instead it added extra time requirements on physicians while subtracting from the time available for patients. This appears to be a common experience of doctors who use EHRs. A study of emergency room doctors in a community hospital in Pennsylvania revealed that putting information into the computer consumed more of their time than any other activity. Using a “click” of the computer mouse as the standard of measure, a doctor needed to make six clicks of the mouse to order an aspirin tablet, eight

clicks to get a chest X-ray, fifteen clicks to provide a patient with one prescription, and forty clicks to document the examination of a hand and wrist injury. Over forty percent of a typical emergency room shift was devoted to entering data into the computer; a ten-hour shift might require almost 4,000 clicks of the computer mouse.³

Even so, initially, an open-minded attitude prevailed among physicians and staff at our center. Perhaps it was just a matter of learning a new system? It was a newer technology, and maybe we just needed more practice and experience. Everyone had heard of the potential for better health care, greater efficiency, lower costs, and fewer errors. Like it or not, all realized, the era of the EHR was here to stay, and so the wise physician committed himself to mastering it. As technical problems came up the programmers worked hard to patch them.

But the practice and experience and fixes didn't seem to change anything. Disquietude grew.

Over time, the optimism for a technical resolution of the system's defects was gradually replaced by a growing and pervasive feeling that the root of the distress went beyond mechanical processes. Something was profoundly wrong, and it became increasingly apparent that the shortcomings of the system were deeper than technical flaws that could be remedied by technical attention. Whatever it was, the cause of dismay seemed to be something essential and elemental.

The Problem

Then, during an email discussion of problems related to the EHR, one of our residents succinctly explained the real problem to us:⁴

It had less to do with the machines than the rest of us were assuming, he ventured.

It had everything to do with people.

The core problem with our electronic medical record system, he told us, was not electronic. It was organic.

What had always been considered to be the most immutable aspect of medicine was under assault. The patient was no longer the most important thing in the examining room. The machine, rather than the patient,



Illustration by Jim M'Guinness

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had become the center of the doctor's focus. "I can remember my first encounter with one of my clinic patients using Epic," our house officer observed. "It was possibly one of the lowest times of my residency. Armed with this Rolls Royce of EHRs, I felt miles away from my patient."

The frustration extended beyond what the technology brought to the examining room; the resident's exasperation came from what had been taken away from his role as physician. The doctor-patient interaction was being warped and distorted; the underlying basis of patient-centered health care had been sacrificed on the altar of computer-centered health care. In his email, our resident summarized the origin of his annoyance: "Still can't seem to get past the urge to just toss the computer aside and actually talk to people when I see them."

Our resident, in his wisdom, pointed out that our disgruntlement with the EHR was not simply a product of imperfect software or an error-laden code that was hurriedly being patched. The distress was seated much deeper. It was visceral. It arose from the medical profession witnessing an undermining of what has always been the soul of medicine, the doctor-patient relationship.

In the meantime, the programmers continued hard at work creating more templates and encouraging more "smart phrases," as though the ability to type a single word that would balloon up into a full boilerplate paragraph on the computer screen would be the solution, if only enough of them could be created. Instead, the shortcuts were the problem. "The more bells and whistles these things have," our resident pointed out, "the harder it seems to be to actually find the patient amongst the sea of 'phrases' or 'presentations' in the medical record."

What did he say? "*Find the patient.*" Of course!

Isn't that the very core, the real essence, of what a doctor does? We have taught the process to our first-year students for as long as any of us can remember. Listen to the patient's story, ask some questions, and listen some more. Find the patient, find the problem, find out how the problem affects the patient, seek the cause, talk about options, and help the patient find the best answer.

But it always starts with finding the story within the patient (and then finding the patient within the story). Drs. Rita Charon⁵ and Danielle Ofri⁶ and a multitude of other physician-writers have taught us that we will never find the patient until we find the story. But it is the story itself, the necessary starting place, that has been eliminated from today's EHR with its prefabricated homogeneous scripts and standardized templates.

This dissonance between physician-think and programmerthink is exaggerated on the computer screen. The subtle places in the history where the patient is most likely to be found by the physician are unknown to the non-physician programmer, and so are devalued in the EHR. For instance, descriptors of types of pain, in their standardization, are reduced to click boxes in the EHR, as though there is nothing further unique or noteworthy to be noted about the pain of the patient in the room. Each of the clicks contributes to the formula for "meaningful use," and with enough clicks comes the cynical generation of higher levels of billing, all at the price of bypassing a true understanding of the patient.

Our thoughtful young colleague quickly recognized the tragedy. "With

family history and social history just another box in the meaningful use checklist," wrote our resident, "it seems like we've found a way to 'protocolize' even the art of getting to know our patients."

EHR and Residency Education

As we considered our resident's comments, we began to ponder the impact of the EHR on the education of our young physicians. In our national and local discussions on the role of the EHR, have we overlooked its impact on the future generation of physicians now in training? Has the EHR created incongruity between what we teach our students from the first year of medical school on, and how medicine is now being practiced in our clinics and on our wards? If so, what should change: the values we have traditionally championed to our students and residents, if those values have now become incompatible with their future as users of the EHR? Or something else?

In his email, our resident cited the spectrum of damages inflicted by the new EHR: "Education; rapport; compassion; bedside clinical reasoning; the physical exam; all seem to take a back seat in the current system."

All of these are essential to the development of a physician. The patient record has traditionally played an irreplaceable role in assessing and developing clinical reasoning skills. Each patient is unique, and the medical record has allowed us as teachers to see how our young colleagues incorporate that uniqueness into the care of the patient. Historically, reading the written note of a resident (or any physician) has been a rich source of information showing what she knows and understands about her patient, her differential diagnosis skills, and her ability to consolidate information and to demonstrate clinical reasoning. Dr. Deborah Nelson at the University of Tennessee-Memphis explains the educational scope of the clinical note. "Writing notes is a means of documenting history-taking and exam skills and the thought process that culminates in an assessment, differential diagnosis, and a plan of evaluation and treatment," she states.

"Writing the daily progress note is an important training tool by which residents experience and internalize the cognitive processes that constitute medical reasoning and analysis, and it is a means for a learner to demonstrate the development of these skills."⁷ The note is crucial to documenting the *context* and *implications* of each visit and of each episode of care.

And that is where the EHR has become a problem. Dr. Robert Wachter, chair of the American Board of Internal Medicine and professor of Medicine and chief of the Division of Hospital Medicine at the University of California, San Francisco, describes the challenges he now encounters in the EHR era as he supervises residents on an inpatient clinical service: "One really doesn't 'write a note' anymore; rather one charts on each of the patient's problems, one by one." This creates a string of verbiage that "outwardly appears to be the patient's progress note." But, Wachter observes, "It's not really a note, it's a series of problems (each accompanied by a brief assessment and plan) held together with electronic Steri-Strips."⁸

With the carry-forward option of the EHR that duplicates a prior note, it is not easy to see any semblance of a reasoning process after the original

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note was crafted, and the copy-and-paste process even makes it hard to identify the original author of a note, or the date of origin. The same note can appear day after day with minimal alteration beyond the addition of a new set of laboratory results, even when the patient's status changes dramatically.

The result of this word-shifting from day to day is predictable. The note becomes a snowball rolling down a snowy incline, becoming more massive by the day. The patient is lost in voluminous data with amazingly little evidence of any effort to synthesize or prioritize it. The noise-to-signal ratio is immense. The implications are frightening. "When I was on clinical service in July and read the notes written by our interns and residents," Wachter reports, "I often had no idea whether the patient was getting better or worse, whether our plan was or was not working, whether we need to rethink our whole approach or stay the course."⁸

Our experience has been the same. It is almost hopeless to try to follow the progress of a patient's care through EHR-templated notes, and it is virtually impossible to analyze any given resident or student's reasoning process. The strings of inpatient or outpatient notes rarely contain any perspective on the patient's overall health status and implications for future care. Verbal team communication on rounds can fill in many of the gaps, but it is the written record that trumps everything else, and the written record as delivered by current EHR is a dismal failure. EHRs are tools that may be able to count the number of times an event takes place, but not whether the event even needed to take place, and assessment of the quality of underlying reasoning around the plan for complex care is all but impossible.

In addition, the EHR appears to be reshaping behaviors in undesirable ways. As we observe the activities of our trainees throughout the day, they often appear to have been converted into "electronic processors" whose focus is on completing the mechanics required of each encounter, and maximizing their efficiency by minimizing the time spent with the patient. Our residents often resemble air traffic controllers, focusing more on the logistics of arrivals and departures than on understanding the patient's journey. As physicians trained in an earlier era, we considered the time spent in documentation as secondary to the actual patient encounter. Now the completion of the note is the primary goal.

Our observations are not unique to our medical center. A time motion study of internal medicine house officers in Baltimore in January 2012 revealed that interns spent twelve percent of their time in direct patient care and forty percent of their time in front of computers. On average, medical interns interacted with each patient for 7.7 minutes.⁹

Can a doctor-patient relationship be developed in less than eight minutes of daily interaction?

We wonder and worry about the message we are sending to our residents and to our students — and ultimately to ourselves — about the focal point of patient care. Both of us have observed that our younger physicians seem increasingly drawn to the computer at the expense of the patient interaction, consistent with the observations from Baltimore.

On rounds, we find our house staff fixating on the computer as they order more diagnostic tests or radiographs to diagnose congestive heart failure or stroke — instead of simply examining the patient. Are our younger and

more technologically oriented colleagues aware of both the benefits and the costs of new technology?

Are we aware?

And the disruptive influence of the EHR is not just a problem that happens in residency training, or a dilemma unique to internal medicine, or a frustration limited to practice in academic medical centers. A recent survey showed that emergency room physicians in a community hospital spend forty-three percent of their time doing computer data entry (not counting the twelve percent they spend reviewing records and test results, the traditional role of a medical record), far overshadowing the twenty-eight percent of their time devoted to direct patient contact.²

The Core of the Problem

The inherent design of the EHR is the real culprit. Information technology designers are apparently under the impression that patient care and computer programming utilize identical reasoning processes, and that, once identified, each patient with dementia or diabetes is the same as all the others. In the point-and-click world of EHR orientation sessions, the trainers of physicians actively discourage the actual writing of words and sentences to describe nuances and report individual variations. The EHR is designed to be a tool for creating sameness out of individuality. Each alteration to make the EHR more useful for the billing office diminishes its value to the medical profession that depends upon it for patient care. Attentiveness to the nuances of communication is an essential attribute of a skilled physician; in its quest for medical standardization, the EHR discourages nuances and promotes functional medical illiteracy.

Dr. James Cimino explained these concerns in an article in *JAMA* in 2013. The routine use of check boxes and various shortcuts encourages the "rapid inclusion of standard phrases and even boilerplate paragraphs," he writes, but these methods come with the liabilities of diminishing any likelihood "for capturing the complex concepts related to patient conditions and decision making." The injudicious insertion of previously recorded data into the new note not only adds to the substantial problem of "note bloat," but it contributes immensely to "inclusion of irrelevant or even erroneous information."¹⁰

Dr. Faith Fitzgerald wrote a cautionary paper in the *Annals of Internal Medicine* of 1999, prescient in its insight.⁹ She reported the story of a student standing at the bedside of a patient who possessed two intact legs as he presented his patient's history of bilateral below-the-knee amputations. An incredulous Dr. Fitzgerald asked the student how he had come to such a conclusion in the presence of two obvious legs. He reported, "It said so in the chart." A chart review confirmed that "BKA times two" had indeed been reported on three prior admissions and copied by the student. Due to a transcriptionist's error, a history of two episodes of diabetic ketoacidosis ("DKA times two") became bilateral amputations, and the error "became enshrined chart lore," even in the presence of overwhelming information to the contrary. "Technology is wonderful and seductive, but when seen as more real than the person to whom it is applied, it may also suppress curiosity," Fitzgerald noted. "For whatever reason — economics, efficiency, increased demands on physicians for

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documentation, technology, or the separation of education from patient care — curiosity in physicians is at risk.” This was in 1999, in the era of paper records when errors had to be transcribed one at a time in long hand with opportunities for double-checking and possible correction, and prior to the era of the EHR and its copy-forward and cut-and-paste functions that allow mistakes to “go viral” at the speed of light. The drive for “efficiency,” in which patients are seen as “work units,” Fitzgerald warned us in 1999, suppresses curiosity about the patient — such curiosity is essential to active thinking and quality care.

It is this “drive for efficiency” that keeps us from connecting with our patients.

Focus on the Patient: Does it Matter?

Our resident noted the loss of connection with his patient as he was obliged, first and foremost, to attend to the needs of the “visit navigator” on the computer screen; the needs of his patient were secondary.

In 2012 Dr. Elizabeth Toll explained in *JAMA* the importance of undivided physician attentiveness to the patient as an essential doctoring skill. “When a physician focuses on a patient with complete attention, this simple act of caring creates a connection between two human beings,” she explained. “Almost immediately, the patient begins to [feel well cared for], and this becomes a first step toward helping that person feel better.” The benefit is bilateral, as the connection between people is “one of the great satisfactions of our profession.” This connectivity has a critical place in this age of physician burnout and early retirement. It is a deterrent to cynicism and anger, she notes. “It makes us feel needed, and generous, and reinforces our sense of ourselves as healers, thereby restoring us and preparing us to give again.” It has a higher function, too, that goes beyond benefit to the doctor. “It also happens to be what patients want from their physicians. This human connection has always been a central tenet of the patient-doctor relationship and that mysterious process called healing.”¹²

That all sounds right and feels right, but is it so? Dr. Arnold Relman was as qualified as anyone to provide us with the answer. Dr. Relman, who served as editor-in-chief of the *New England Journal of Medicine* for many years, was a physician with six decades of experience and an insightful observer of health care delivery. He confirmed the observations made by others on the impact of the EHR on patient care when he required treatment for a severe injury. His time as a patient included both ICU hospitalization and rehabilitative care, and he saw what the rest of us are seeing: “Doctors now spend more time with their computers than at the bedside.” The extensive focus on the computer appeared to be a factor in the puzzling behavior of his doctors at the rehabilitation hospital, as “neither physician seemed to be actually in charge of my care, or spent much time at my bedside beyond what was required for a cursory physical exam.” It was not as though they were lazy, but they clearly had shifted their focus of attention, Dr. Relman observed. They spent little time with him, but “they did, however, leave lengthy notes in the computerized record.” On further investigation, though, he found little useful information in the notes, which mostly seemed to be “full of repetitious boilerplate language and lab data.” As he reviewed the progress notes that ostensibly described his own medical status, Dr. Relman found they had one overwhelming short-coming: he could read the notes, but

he could not find any accurate representation of his medical condition, much less any part of himself as a person, within the words. Anything that might have been of any importance was missing, and — most tragically to a distinguished physician, communicator, and teacher — he found his medical record to be “lacking in coherent descriptions of my medical progress, or my complaints and state of mind.”¹³

And then we remember our resident’s lament: “The more bells and whistles these things have, the harder it seems to be to actually find the patient.”

The medical profession is at a critical crossroad. We suspect that Dr. Relman and our resident would agree with Dr. Elizabeth Toll’s warning for all of us: “Physicians and patients must speak loudly and clearly, with a unified voice, to address the dehumanizing trends in our profession and insist that the move toward technological reform not leave us with a nation devoid of physician healers.”¹²

Principles and Solutions

EHR is here to stay. It will continue to be modified by business offices and programmers. Efficiencies may result from their efforts, but their tinkering will not make the EHR a better tool for patient-centered care. Only physicians are able to do that. It is essential that we do so.

We have a limited window of time to get it right, if we hope to preserve the traditional values of medicine.

We suggest the following as *principles*:

- The encounter time with the patient, in the hospital or examining room, belongs to the patient, not to the business office.
- During the face-to-face interaction, the patient deserves the undivided attention of the physician.
- Every patient has a story; it is incumbent upon us to listen to the story, try to understand the story, and use the medical record as the repository of that story, as we strive for patient-centered health care.

Our *recommendations* and *predictions* are the following:

- Documentation (beyond personal note-taking) of the history and exam should be restricted to a post-encounter activity (outside the clinic or hospital room), to be performed after the patient interaction has been completed. This was how medicine was practiced in the days when notes were either handwritten or dictated, when the note was written for documentation (not in anticipation) of the clinical interaction, and the medical record was in the domain of the physician and not the billing office. The EHR should not change that, but it has. A primary care doctor now focuses his gaze on the computer screen 30.7 percent of the time and on the patient 46.5 percent of the time.¹⁴ We have been heartened to see colleagues, including physicians-in-training, revert to older methods of listening to patients, interacting with patients, jotting notes on paper, re-focusing on the patient’s story, and enjoying being doctors again as they collect the data they need, organize it and prioritize it, share their thinking process, and strive to record and communicate it as clearly as they can.

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- There is a role for dictation. The dictation of a patient note demands that the doctor think about the content of the next sentence and the next paragraph and the conclusion, how the information fits together and how it should be woven in, and what doesn't fit, yet. Clicking boxes circumvents all of that.
- Copy-forward and cut-and-paste functions should be eliminated. Yesterday's information is not today's information, despite the impression one gets from reading many EHR entries. For the history and physical, templated paragraphs should be eliminated. Humans are unique; no two stories are ever the same. Transcribing the patient's story and exam can be a time for reflection, thinking, and gaining insights. It is a gift we give to the patient, and more: it is a duty of the physician. Cut-and-paste is coming under increasing scrutiny as a possible mechanism for fraud, up-coding, and overbilling; its days may be numbered.
- Some activities such as prescription writing, test ordering, requesting consults, printing of educational materials, or determining the interval to the next appointment are part of the physician's role, and obvious computer-driven efficiencies and accuracies may require that they be done electronically at the end of the encounter. There is a role for the computer in some components of medical care.
- The current EHR makes it impossible, on many occasions, to determine what is going on with the patient, and what the physician is thinking (or even *if* the physician is thinking). To provide perspective and insight, a synopsis at the end of each "clicked" note should be required, called "Summary and Implications." This would greatly improve the signal-to-noise ratio in our current EHR notes. It would be useful for education. It would communicate and model clinical thinking for all of us. This usually takes care of itself when the patient note is dictated, and it will come about spontaneously with a reformation of the EHR for use in health care.

The time is here to reclaim our profession and preserve its integrity by refocusing on our patients.

The computer must become our servant, not our master.

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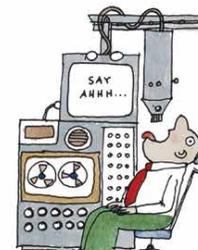
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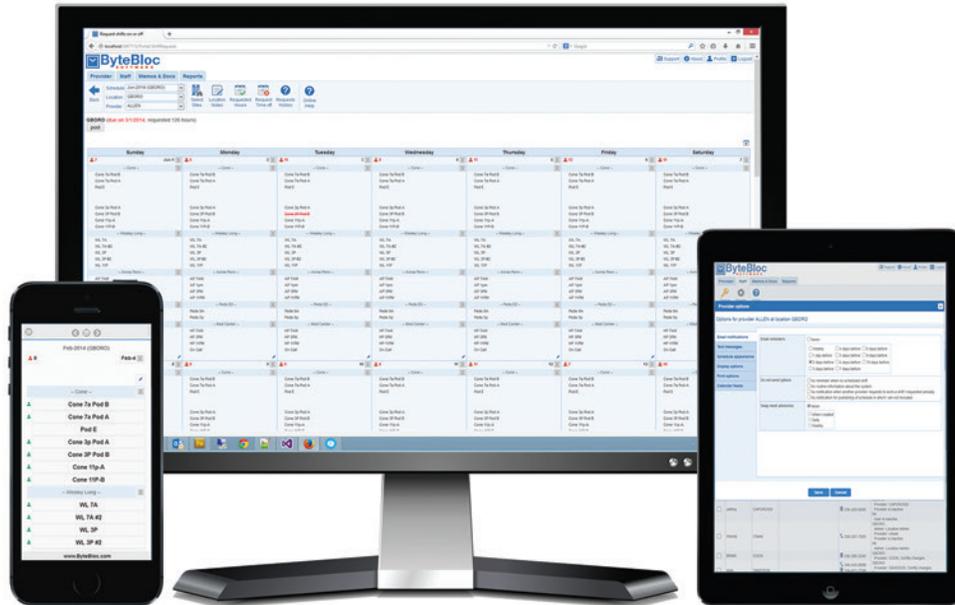
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What is Social Media and What Can it Do for You?

Bob Stuntz, MD RDMS FAAEM
Secretary-Treasurer, AAEM YPS
Chair, AAEM Social Media Committee

Maybe you wondered what #AAEM15 meant, and why it was everywhere this year at Scientific Assembly. Maybe you saw people sitting in lectures furiously typing on their phones and wondered what they were doing. Have you heard people talking about podcasts and wondered “what’s the big deal?” Perhaps you cringe at the words “social media,” immediately thinking of a news story you remember reading where a doctor was fired for posting patient information on Facebook. If this is you, then let me explain what social media is, what it can do for you, and how AAEM is involved.

“For you personally, interacting with others via social media can be a great way to network, learn in an asynchronous fashion, and connect with leaders in AAEM and emergency medicine.”

Social media is best described as any electronic outlet that allows users to exchange information and ideas. The goal of the AAEM Social Media Committee is to utilize these resources to promote AAEM as an organization, and promote the educational materials and services AAEM provides. For you personally, interacting with others via social media can be a great way to network, learn in an asynchronous fashion, and connect with leaders in AAEM and emergency medicine.

To most, Twitter and Facebook come to mind the minute the words “social media” are uttered. In the world of medical education, Twitter is especially popular, and most likely responsible for the folks you saw at Scientific Assembly working on their phones during lectures. Twitter can be used to highlight learning points from a lecture (Image 1) or to disseminate educational content from AAEM courses (Image 2). This year, with AAEM’s approval, we launched the @AAEM_Education twitter account. This account is run by members of the Social Media Committee and provides pearls of wisdom from AAEM educational events (Image 2).

How successful is Twitter in spreading the great education and services provided by AAEM? Statistics for the Scientific Assembly hashtag from February 1 to April 2 show that 1,317 people shared 7,280 tweets containing #AAEM15. Each time someone sends a tweet, that tweet is seen by anyone following the sender. Each follower has the chance to retweet as well, meaning the original tweet may be shared with even more people who might not be following the original tweeter. How many people did we potentially reach through Twitter? The number is staggering — 9,815,878 impressions during the months of February and March.¹ Almost ten million people were exposed to the great educational pearls and discussion coming out of Scientific Assembly between February 1 and April 2, 2015.

Talk about promoting the great work this organization does!

Of course, social media is so much more than Twitter and Facebook. Did you know free podcasts are available to our members? Free AAEM talks are available online and through iTunes that discuss legal matters, critical care, and ED operations management. AAEM and AAEM YPS have also partnered with Michele Lin from Academic Life in EM (ALiEM), to provide an ALiEM-AAEM Social Media and Digital Scholarship Fellowship. Dr. Matthew Zuckerman was named our first fellow, and will help optimize AAEM’s use of social media while also creating a dynamic digital product for AAEM’s *Rules of the Road for Young Emergency Physicians*. AAEM has also agreed to help with an exciting new project by Merck, to create a cache of online procedure videos.² You can also keep up to date with the AAEM Blog.³

As you can see, much is happening in the world of social media. In future columns members of the AAEM Social Media Committee and I will be tackling social media topics in more detail, to help you maximize your use of these great resources. In the meantime, if you are interested in helping out with the Social Media Committee or learning more, get in touch with me.⁴ You can email me (bobstuntzmd@gmail.com) or find me on Twitter (@BobStuntz). And please make sure to follow all of our great AAEM social media outlets.



Image 1: Tweets can highlight great educational points and share research to help your clinical practice

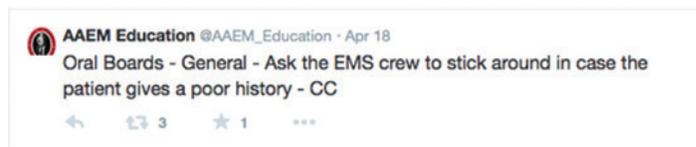


Image 2: Our AAEM Education account is a member-driven account to promote the great educational courses and resources AAEM provides.

References:

1. <http://www.symplur.com/healthcare-hashtags/AAEM15/analytics/?hashtag=AAEM15&fdte=02%2F01%2F2015&shour=00&smin=00&tdate=04%2F02%2F2015&thour=00&tmin=00>
2. <http://www.aaem.org/education/merck-manualaaem-video-project>
3. <http://americanacademyofemergencymedicine.blogspot.com>
4. <http://www.aaem.org/about-aaem/leadership/committees/social-media-committee> ■

New AAEM Interest Group: Geriatric Emergency Medicine

Nounou Taleghani, MD PhD FAAEM

Christopher R. Carpenter, MD MSc FACEP FAAEM AGSF

Why, you may ask, do we need an interest group in Geriatric Emergency Medicine? The population is aging rapidly, as baby boomers are now reaching retirement age. Heck, some of us are already at or at least getting close to the age at which the CDC labels us “older Americans,” and you know what they say: life is like a roll of toilet paper — the closer you get to the end, the faster it goes. I would like us to brainstorm and share ideas about how to be better emergency physicians when it comes to treating this population of patients.

According to the CDC, in 2012 (the last year for which we have complete data) the number of adults over age 65 in the U.S. was 43.1 million, with 22 % of those thought to be in poor health. From 2010 to 2012, a total of 19.6 million emergency department (ED) visits were made by person's aged 65 and over in the United States. In the five years since those data were collected the numbers have increased, and will continue to increase for years to come. Here are some factoids you might not know:

- 35% of community-dwelling older adults over age 65 demonstrate evidence of dementia when formally tested, but ED providers identify only 6%.
- Geriatric core competencies for EM residency graduates were developed in 2010. Can you name any of the 26 competencies?
- As of mid-2013 there were 36 U.S. hospitals with self-identified “geriatric EDs,” but the attributes of these older adult emergency care centers remain diverse and ill-defined.
- Geriatric ED guidelines were approved by ACEP, AGS, ENA, and SAEM in 2014, to provide actionable recommendations in regard to staff education, protocols, quality indicators, and infrastructure adaptations for frail, aging patients.
- International emergency medicine collaborations exist to address geriatric care issues, share resources, and develop high-yield curricula (<http://iceg.info/>).

The aging population has unique and distinct health problems, and the physicians treating them should be aware of the limitations and differences of this growing demographic. It is true that a lot of us see and treat these patients every day, and yes, we do it well — but we can be better, and I think sharing ideas through this interest group will be quite useful. What better way to improve than organizing a group of like-minded emergency physicians who are interested in learning more about these patients, sharing ideas, learning from each other, and then making their knowledge available to the entire community of physicians through publishing best practices, giving lectures, and sponsoring informative speakers at the AAEM Scientific Assembly?

Our colleagues are doing this at ACEP, SAEM, and the American Geriatrics Society and I suspect some of our members will also be members of ACEP's Geriatrics Section or SAEM's Academy of Geriatric Emergency Medicine, which can only add to collaboration in our specialty. We in AAEM can and should get involved in this process.

I ask that you send us an email if you are interested in being a member of this interest group. We need at least ten AAEM members to create an interest group, and once we have a critical mass of members we will meet, tele-conference, and exchange ideas on how to advance.

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The National Quality Forum and AAEM's Quality Standards Committee

Leslie Zun, MD MBA FAAEM and Robert Suter, DO MHA FAAEM
AAEM Board of Directors

Last year the American Academy of Emergency Medicine joined the National Quality Forum (NQF). It is the intent of AAEM to influence the approval of measures by the NQF, because these measures go on to the Centers for Medicare and Medicaid Services (CMS) and some affect the way we practice emergency medicine. As described in an earlier issue of *Common Sense*, the NQF is an organization that reviews measures to be adopted by CMS, with 430 members and 800 volunteer experts. The NQF currently has four action teams, in the areas of advanced breast cancer care, maternity care, antibiotic stewardship, and Patient Passport.* Some of these intersect with emergency medicine.

The National Quality Forum had its annual meeting at the end of May. Fellow AAEM director Bob Suter and I represented AAEM at the meeting. The president and CEO of the NQF, Dr. Christine Cassel, opened the meeting with a plan to embark on a two-year, ground-breaking program to evaluate socioeconomic and other demographic factors affecting population health. The organization has also decided to look at the intersection of quality and cost, and wants to go from reviewing quality measures to assessing value. It is important that AAEM be involved.

I also represented AAEM at the NQF's Behavioral Health Measures Committee meeting, where a measure on mental health follow-up from the ED was strongly opposed. Although this measure held insurers responsible for ensuring follow-up on these patients, we were concerned that the ED might be caught up in that responsibility too.

In order to respond appropriately to proposed NQF measures, AAEM established a Quality Standards Committee to review these and other issues related to quality. During the Scientific Assembly in Austin, the Quality Standards Committee met to discuss how we want to review and provide feedback on proposed NQF measures. We plan to submit comments on the recently proposed ENT measures that pertain to emergency medicine. One ENT measure of concern is a proposed requirement on testing patients for strep pharyngitis.

Another issue that surfaced in the committee meeting is the need for relevant and realistic benchmarks to assist emergency departments in assessing and improving the care they provide. The Quality Standards Committee will work with the Independent Practice Support Committee to develop these tools. Please let me (LZ) know if you have any questions about what the Quality Standards Committee is doing or if you wish to join us.

**Patients in the hospital are often given little opportunity to participate in shared decision making about their care — an experience that can be frustrating, confusing, and even frightening. A new tool, the Patient Passport, is designed to increase patient engagement and drive system-level change by helping patients start a conversation with providers in order to express their needs and preferences. ■*



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Resources for Young Physicians

S. Terez Malka, MD
President, AAEM Young Physicians Section



It's hard to believe it's been nine months since I finally made the transition from resident to attending! While I adjusted relatively easily to my new salary and to not taking call, finding my footing as a practicing physician and educator has been a new adventure. From finding, choosing, and then securing a job, to taking boards, to learning how to balance my own continu-

ing education with shifts and academic responsibilities, each step has brought unanticipated challenges.

I was fortunate enough to discover AAEM as a fourth year medical student. Studying abroad in Israel, I had little mentorship or guidance as I entered the match process. Luckily, I discovered *Rules of the Road for Medical Students*, which held my hand and walked me through choosing electives, preparing my ERAS application, and residency interviews. I truly believe I wouldn't have matched into emergency medicine without this tremendous resource.

Through residency and my first months in practice, I continue to rely on AAEM. *A Focused Review of the Core Curriculum* was my primary study guide for in-services and boards, I counted on the yearly Scientific Assembly to keep me up to date and informed, and I received ongoing and exceptional mentorship through my committee and board assignments.

I am delighted, as YPS president, to share these benefits with all our physician members and I want to take this opportunity to remind you of our resources for young physicians:

- CV and cover letter review: Receive a thorough analysis of your CV by a member of AAEM leadership
- Mentoring program: Be matched with a mentor by academic interest, location, or career goals
- Rules of the Road for Young Physicians
- EM Flash Facts mobile board review application
- ALiEM-AAEM Social Media and Digital Scholarship Fellowship
- Publication opportunities in Common Sense
- National Scientific Assembly speaking opportunities at the AAEM YPS Open Mic Competition
- And more!

In the coming year, we turn to you to help us expand these benefits. We will be distributing a survey to all of you and will analyze the results carefully to look for ways we can provide you more value for your membership. We look forward to finding new ways to provide support, mentorship, and the highest-level educational resources to our members. Mostly, we look forward to being with you through all your exciting career transitions! ■

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AAEM/RSA President's Message

AAEM/RSA Accomplishments & Looking Forward to the Coming Year

Victoria Weston, MD
AAEM/RSA President



My name is Vicki Weston, I am a PGY3 EM resident at Northwestern, and I am honored to serve as AAEM/RSA president for the 2015-2016 term. Prior to this, I served as AAEM/RSA vice president (2014-2015) and as Communications Chair (2013-2014). AAEM/RSA is an outstanding organization and I am proud to serve in a leadership role with a group that endorses workplace fairness, advocates for EPs, and

for the interests of our patients.

AAEM/RSA and the current board have achieved a number of accomplishments over the past year, which we hope to build upon in the coming year. Looking forward, we have several exciting projects and opportunities:

- **Congressional Fellowship:** AAEM/RSA, in collaboration with Congressman and emergency physician Raul Ruiz, is proud to announce the continuation of our Policy and Advocacy Congressional Fellowship. This one-month fellowship is an outstanding opportunity for AAEM/RSA members who seek to better understand medical policy, advocacy, and the legislative process. Congressman Ruiz practiced as an emergency physician prior to his election to Congress. For more information or to apply for a fellowship position, please visit the AAEM/RSA website.
- **Advocacy Day:** This past year, representatives of AAEM and AAEM/RSA visited Capitol Hill, met with Members of Congress, and advocated for physicians rights to due process and other important issues impacting our field. We plan to host this annual event again in the coming year.
- **Career Fair:** This year, we hosted our second annual Career Fair during the AAEM Annual Scientific Assembly in Austin, Texas. The event included exhibitors meeting AAEM's workplace fairness standards and filled to capacity with over 160 people in attendance. We look forward to hosting our third Career Fair in 2016 and continuing to build upon last year's success.
- **AAEM/RSA Blog:** Our blog is an excellent educational resource for residents and students. We are proud to contribute to and support FOAMed. More content is added every week. To read or contribute, please visit: <http://aaemrsa.blogspot.com>.
- **Toxicology App:** AAEM/RSA has been developing a toxicology app which will be available for iPhone and Android devices. We are excited to be launching this new app and look forward to sharing our completed product in the near future.
- **Education Tracks at AAEM and CORD:** In collaboration with the AAEM Young Physicians Section, AAEM/RSA hosted a well-received

education track at the AAEM Scientific Assembly. Additionally, AAEM/RSA contributed to an excellent education series at the CORD annual meeting as well.

- **Membership:** We continue to promote membership and outreach, with new 100% membership residency programs added each year. We also hosted a successful AAEM/RSA brunch program at several of our residency sites.
- **Modern Resident:** Our *Modern Resident* publication produced several issues with high quality educational articles. We also continue to share educational Facts of the Day through our AAEM/RSA social media presence on Twitter and Facebook.

We appreciate the ongoing support of AAEM as well as our AAEM/RSA members, and plan for continued collaboration with AAEM and with the AAEM Young Physicians Section. For resident and student members wishing to become more involved, committee applications will open in the fall through the AAEM/RSA website. Thank you for your support — our board is looking forward to another great year! ■

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All I Really Need to Know — Still — I Learned in Kindergarten

Andrew W Phillips, MD MEd
AAEM/RSA Blog Editor-in-Chief



While still being far from hitting my full stride as a “real” emergency physician, I feel that I’ve come a long way now that I’m finally finishing residency. And while I’m cautious of being overly nostalgic or simplistic at this point, I find myself reflecting that life’s core lessons change very little. The medicine changes every five to 10 years, but certain constants *never* change, and they all have to do with playing together well in the sandbox.

Thus, based on Robert Fulghum’s timeless classic, *All I Really Need to Know I Learned in Kindergarten*, I humbly submit my version of the top 10 things for the emergency physician.

1. Share everything. A patient neither lives nor dies by one person’s actions.
2. Play fair. Follow the Golden Rule.
3. Don’t hit people. Avoid being hit by the patient in a methamphetamine-induced psychosis.
4. Put things where you found them. Put extra supplies back yourself. They won’t walk there on their own.
5. Clean up your own mess. Put away your sharps (or suffer the RN wrath).
6. Don’t take things that aren’t yours. The staff refrigerator is sacred.
7. Say you’re sorry when you hurt somebody. This is controversial, but at least a generic “I’m sorry” can be very meaningful to patients and families. We’re not perfect.
8. Wash your hands before you eat. No one likes *C. diff* on their dinner.
9. Flush. Flush.
10. Warm cookies and cold milk are good for you. Sometimes it takes sugar and chocolate to make it through a night shift. ■

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Updates in Geriatric Emergency Medicine

Authors: Phillip Magidson, MD MPH; David Bostick, MD MPH; Erica Bates, MD; Robert Brown, MD
 Edited by: Jay Khapde, MD FAAEM and Michael C. Bond, MD FAAEM

Between the 2000 and 2010 U.S. Census, the population over age 65 increased at a higher rate than the overall U.S. population. For the purposes of this article, we will use age greater than 65 as the definition of a geriatric patient. By 2050, there will be over 83 million geriatric Americans, double the number from 2012.¹ Currently, over 15% of emergency department (ED) visits, equaling 20 million total visits, are from geriatric patients.² These numbers are certain to increase and will represent a unique challenge to the U.S. health care system, specifically to the ED. In this month's "Resident Journal Review," we focus on the evaluation, diagnosis, and treatment of geriatric patients presenting to the ED.

Medication Management for Pain and Agitation

One specific challenge emergency physicians (EPs) encounter with geriatric patients is medication administration, particularly with analgesic and sedatives. This patient population is at increased risk for adverse drug events (ADE); 40% of geriatrics take five or more medications while less than 20% of non-geriatrics take this many.³ Concerns about medications may lead to suboptimal care of geriatric patients despite evidence to suggest that these patients can be treated safely. Failure to provide these medications may also lead to adverse outcomes. Below, we review two articles regarding pain control and sedation of geriatric patients in the ED.

Calver L and Isbister GK. Parenteral sedation of elderly patients with acute behavioral disturbance in the ED.

American Journal of Emergency Medicine. 2013;31:970-3.

Elderly patients with acute behavioral disturbances (ABD) often require pharmacologic restraint in the ED. In this prospective Australian study, Calver and Isbister investigate the protocol use of the antipsychotic, droperidol, for parenteral sedation. Forty-nine patients aged 65-93 (median 81 years) presenting to the ED with ABD were included in the study. The study protocol called for an initial intramuscular dose of 10mg droperidol, followed by an additional 10mg dose if sedation was not achieved after 15 minutes.

Thirty patients received an initial dose of 10mg droperidol, 15 received 5mg droperidol, two patients received 2mg droperidol, and two received midazolam as the initial sedation agent. Of patients receiving 10mg droperidol, 33% (95% CI 18-53%) required additional sedation vs. 47% (95% CI 22-73%) of those who received 5mg droperidol. Five patients suffered ADE. Two patients receiving 10mg droperidol developed hypotension, one patient who received both 10mg droperidol and additional midazolam experienced airway obstruction, one patient who received 2.5mg droperidol was oversedated, and one patient treated outside the protocol guidelines was oversedated with a combination of midazolam and haloperidol. Evaluation of EKGs demonstrated no QT prolongation in any subject.

This study is limited by small sample size, lack of strict adherence to the study protocol, and limited availability of droperidol in the U.S. due to the QT prolongation black box warning, making it difficult to draw robust conclusions about optimal dosing for safety and effectiveness. The authors

conclude with a recommendation to start with an initial 5mg dose of droperidol, with the expectation that many patients may require additional medication. The selection of droperidol, which the authors suggest may be superior to haloperidol in terms of both sedation and risk of QT prolongation, also merits further study in the elderly.

Boccio E, Wie B, et al. The relationship between patient age and pain management of long-bone fracture in the ED.

American Journal of Emergency Medicine. 2014; 32: 1516-19.

Pain is one of the most common reasons patients present to the ED; however, delays often occur from presentation to administration of pain medication. Poor pain management in the ED may lead to worse patient outcomes.⁴ This article attempted to quantify the amount of time it took for patients, based on age, to receive pain medication for long bone fractures (LBF). This retrospective chart review examined time to first dose of pain medication in patients of all ages (divided as pediatric, adult, and geriatric) at a large, suburban, academic medical center.

A total of 1,255 patients were included in this study with the majority falling in the geriatric age group. Within the pediatric group, 78% of patients received medication, 86% in the adult group, and 80% in the geriatric group. The median and average times to initial medication administration were 44 and 52 minutes for pediatrics (95% CI 45.9-58.1), 39 and 54 minutes for adults (95% CI 48.8-58.4), and 55 and 73.2 minutes for geriatrics. Student t-tests showed a significant difference between the pediatric and geriatric groups as well as the adult and geriatric groups (both $P < 0.01$). The authors further divided the geriatric group to those 65-84 and those 85 and above. The median and average times for the 65-84 age group was 49 and 67.2 minutes respectively. The older group had a further delay ($P < 0.01$) in pain medication administration with median and average time to administration of 64 and 81.8 minutes (95% CI 73.6-90.0).

The delay in analgesia administration for geriatric patients was attributed to a decline in: the patients' ability to effectively communicate with health care providers due to hearing, vision or other sensory deficits or memory or reduced cognitive and linguistic abilities. Delays were noted for younger pediatric patients (those under the age of 3), which enhances the argument that communication deficits may be a factor. Other possible contributing factors may be concerns about ADEs or the specific fracture as the LBFs seen in geriatric patients (predominantly femoral neck) were different than the pediatric and adult group (predominately radius/ulna).

Limitations of this study include its retrospective design, reliance on provider documentation, physician practice patterns and opinions regarding pain management, and no clear pain score assessment among patients. Despite these limitations, this study suggests geriatric patients disproportionately suffer delays in receiving appropriate analgesia for LBFs. Although caution should be used, EPs still must ensure timely pain control in this vulnerable population.

Continued on next page

Diagnosis in Geriatric Patients

Geriatric patients may present atypically or without anticipated alterations in vital signs or laboratory values with certain diseases. These atypical presentations, combined with cognitive and sensory deficits, may make identification of time-sensitive diseases more challenging for the EP. Next, we review two articles aimed at improving diagnosis in geriatric patients.

Grosmaître P, Le Vasseur O, et al. Significance of atypical symptoms for the diagnosis and management of myocardial infarction in elderly patients admitted to emergency departments. *Archives of Cardiovascular Disease*. 2013;106:586-92.

This retrospective, multicenter study examined how elderly patients with ST segment elevation myocardial infarctions (STEMI) presented to the ED and the impact on management and mortality of presentation without chest pain. Patients with a primary diagnosis of STEMI were identified from four French hospitals over a four-year period. Exclusion criteria included: age under 75, incomplete charts, no troponin levels, and an alternative diagnosis. Analysis included chi-square test of qualitative measures and student's t test comparison of quantitative measures.

Of 255 STEMI patients identified, chest pain accounted for only 41.2% of presentations. Atypical presentations were faintness/fall (n=40, 16%), dyspnea (n=40, 16%), digestive symptoms/nausea (n=25, 10%), impaired general condition (n=17, 7%), delirium/impaired vigilance (n=13, 5%), and all other presentations (n=15, 6%). Residence in a nursing home (P=0.044), dementia (P<0.001), and impaired communication (P<0.001) were associated with atypical presentation, while diabetes was not (P=0.328). Symptom severity (Killip score >2) was greater in the atypical group (28%) versus the typical group (11%), (p=0.001), but the atypical cohort had longer prehospital delay times (P<0.001), longer delay to decision times (P<0.001), and less likelihood of reperfusion regardless of delay (P<0.001).

Limitations of this study include small numbers, underestimation of atypical STEMI, lack of uniform definitions of STEMI in the setting of a LBBB or pacemaker, lack of definition of impaired communication and elevated troponins, and no control for comorbid diseases.

The study's authors conclude a more liberal use of EKGs may be prudent with geriatric patients as atypical presentations for acute coronary syndrome are common in this population.

Chung M, Huang C, et al. Geriatric Fever Score: A New Decision Rule for Geriatric Care. *PLOS One*. 2014; 9(10): e110927.

This observational, prospective cohort study sought to create a prediction rule for stratifying mortality risk and choosing the best disposition for geriatric patients who present to the ED with fever. Patients were enrolled from a university medical center in Taipei. A total of 7,650 patients were evaluated for enrollment. Of those, 350 were identified as geriatric patients with fever. Twenty patients were excluded, mainly for insufficient data. The patients were evaluated for 12 mortality predictors including: severe coma (using GCS), hypotension, tachypnea, stroke history, degree to which patient was bedridden (ECOG score), nasogastric tube (NG) feeding, congestive heart failure (CHF) history, nursing home

resident, leukocytosis, thrombocytopenia, bacteremia, and elevated serum creatinine. The primary outcome was survival at 30 days.

After multiple logistic regression analysis, leukocytosis >12,000 (P<0.001), GCS <9 (P=0.017), and platelets <150,000 (P=0.013) were determined to be independent predictors of mortality, and thus, used to generate the prediction rule. In using the rule, the authors suggested assigning 1 point to each of the three mortality predictors and stratifying patients into low risk (0-1 points) or high risk (≥2 point) with respective 30-day mortality of <4% vs. 30.3%. The authors conclude high-risk patients should be admitted to an intensive care unit.

The study lacks external validation, especially significant given the findings come from a single center. Assuming mortality is higher in high-risk patients, there is no data suggesting ICU admission improves mortality. Also, the authors give no advice for the low risk group with regard to disposition home or admission to a non-ICU setting. Though blinded, the reviewers also gathered data after discharge by calling the patients for follow up, likely unblinding mortality. Hypotension (P=0.002), ECOG score=4 (P=0.001), NG tube feeding (P=0.007), CHF (P=0.029), bacteremia >10% (P=0.038) and serum creatinine >2 (P=0.001) were also independent predictors of mortality. Though intended to be prospective, some of the data had to be collected retrospectively.

This study was an excellent attempt to create a much-needed rule for geriatric fever risk stratification. EPs could use these findings to assist in determining disposition but more work is needed to create a clinical decision rule with wide spread applicability.

Disposition of Geriatric Patients

Disposition of geriatric patients from the ED can be a challenge. These patients frequently require more resources both in the ED and at time of disposition. They use more social services than younger patients and follow up with primary care physicians is of particular importance in this group. Below, we review an article that evaluates short-stay hospitalizations of geriatric patient and resource utilization based on the challenges associated with positioning these patients.

Greenwald PW, Stern ME, et al. Trends in short-stay hospitalizations for older adults from 1990 to 2010: implications for geriatric emergency care. *American Journal of Emergency Medicine*. 2014;32:311-314.

As discussed above, geriatric patients are responsible for 15% of ED visits and this number is projected to increase to 25% by 2030. The authors of this retrospective study examined data from the National Hospital Discharge Survey (NHDS) to identify trends in short-stay admissions (hospitalizations lasting ≤3 days) in geriatric patients from 1990-2010. The NHDS is a yearly survey which collected abstracted discharge records from over 4 million hospital visits in non-federal hospitals in all 50 states during the study period. Patients retained in the hospital on observation status were not included in the survey.

A total of 42% of the hospitalizations in the study involved geriatric patients. Of these geriatric hospitalizations, 39% were short-stay admissions, with 11% ≤1 day. Hospital admissions originating in the ED from

Continued on next page

2007-10 were analyzed separately to determine if the same trends applied to the ED geriatric population. Overall, the ED was the source of 52% of total geriatric admissions and 45% of geriatric short-stay admissions. Older patients represented a higher proportion of overall admissions from the ED, with the odds of an admission having originated from the ED increasing by 1.0287 for each year beyond age 65 (95% OR 1.0286-1.0288). The proportion of admissions from ED qualifying as short-stay also increased more quickly for the elderly than for younger adults over the study period; a 0.23% (0.04-0.4%) increase among ages 22-65, 0.9% (0.71-1.08%) ages 65-74, 1.0% (0.83-1.21%) ages 75-84, and 1.1% (0.96-1.3%) age ≥ 85 .

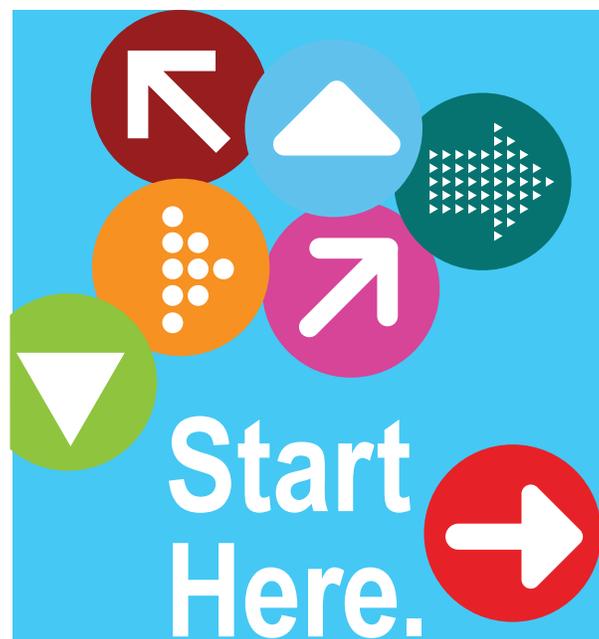
Although these hospitalizations may represent appropriate disposition for geriatric patients with medical concerns that are quickly resolved, the authors suggest several alternative factors which may be driving short-stay admissions for these patients. One is that the elderly tend to have more comorbidities than their younger counterparts and are more likely to have atypical presentations of serious medical problems. Additionally, EPs may feel compelled to admit older patients when insufficient outpatient resources exist to guarantee timely follow up. Unfortunately, the scope of this study did not include analysis of the admission diagnoses or clinical context involved in these geriatric short stay visits. Patients admitted under observation status were also excluded from this study, but it was unclear what criteria, if any, was used in selecting observation vs. admission status.

Further study is needed to identify the reasons for this growing trend toward geriatric short-stay admissions and to explore barriers to outpatient management in this population.

Geriatric patients represent a growing population of ED patients. This demographic has unique biologic, physiologic, and social needs. Managing these needs, coupled with a continued focus on providing high quality, cost-effective care will require that EPs are familiar with the most current literature and techniques in the care of geriatric patients seen in the acute setting.

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Medical Student Council President's Message

Quotes from the Year Behind Us

Mike Wilk, MS3

Medical Student Council President



With another new academic year already upon us, I want to reflect on a few interesting and important quotes from various emergency physicians that I heard over the past year. Before getting to that, however, I also want to mention that I hope you will take advantage of all the AAEM/RSA resources available to help you land your number one choice on Match Day. Please consider attending some of our upcoming

events, including the Midwest Regional Symposium at Loyola Chicago Stritch School of Medicine on September 26th, the Mid-Atlantic Regional Symposium at Georgetown School of Medicine (date TBA), and the national Scientific Assembly in Las Vegas from February 17-21, 2016.

"Most people would say that not everyone is equipped for a career in neurosurgery, and the same can be said for a career in emergency medicine." Dr. Matthew Pirotte, MD, Assistant Program Director, Northwestern University Department of Emergency Medicine

All careers in medicine are difficult. However, the field of emergency medicine has a number of unique challenges medical students should be aware of before selecting it as a specialty. With shift work, circadian rhythms are constantly thrown off. Critical decisions must be made before all essential information about the patient can be obtained. For many patients and their families, the day they walk into the emergency department will be the worst day of their lives and you may be the only physician available. Before committing to this field, make sure you have the physical and emotional qualities required not just to survive, but to thrive in such an environment.

"Don't look for an easy residency; look for one that will challenge you. You need easy days and hard days, but push yourself during residency. Push yourself to see the sickest patients or push yourself to see the most patients." Jonathan S. Jones, MD FAAEM, Program Director, University of Mississippi Medical Center, Jackson, MS

I like this quote in particular because it was applied to the notion that emergency physicians have high burnout rates. It makes sense that if a physician is not properly trained in emergency medicine, he or she will likely feel overly stressed and thus be more likely to burn out. Do your

best to find a residency that will push you beyond your comfort zone and challenge you to become the best physician possible. If you are properly trained, you will be less likely to burn out and more likely to enjoy your work environment and career.

"The seven most dangerous words in the English language are 'we have always done it this way.'" Joseph R. Lex, Jr., MD MAAEM FAAEM, Temple University Hospital

While not original to Dr. Lex, I believe he made an important point during his talk at the 2015 Scientific Assembly's medical student track. One example is the administration of morphine for acute coronary syndromes (ACS). Most medical students are still taught the MONA mnemonic for ACS: Morphine, Oxygen, Nitroglycerin, and Aspirin. However, a paucity of evidence exists demonstrating any benefit of morphine for ACS patients, and research continues to accumulate indicating that it may actually do harm. As your career progresses you must continue to question what we do and why we do it. The future of medicine lies increasingly in evidence-based practice, so the sooner you make that a mental habit the better.

"Living like a resident for two to five years after residency is the key to eliminating student loans, buying your dream home, building wealth, and becoming a millionaire by 40." James M. Dahle, MD, emergency physician and founder of whitecoatinvestor.com

We have no control over rapidly increasing tuition, other school fees, and board exam fees. For all other expenses though, find a way to live as cheaply as possible. The key is delayed gratification. Unfortunately most medical schools provide little if any education on money management. Read as much as possible and become educated on money management. Whitecoatinvestor.com is a fantastic resource and great place to start, as is the ongoing series in *Common Sense* by Dr. Joel Schofer, "Dollars and Sense."

Keep in mind that whether you have an income of \$50,000 or \$500,000, if you don't manage it correctly you will never achieve financial success. Your income will grow rapidly in the years following medical school and residency. Those who have large debt burdens — which is most of us — should live as economically as possible until the loans are under control or completely paid off. ■



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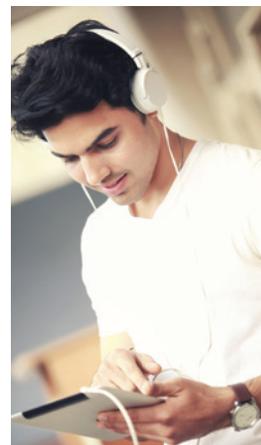


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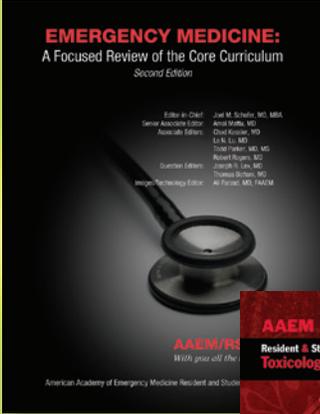
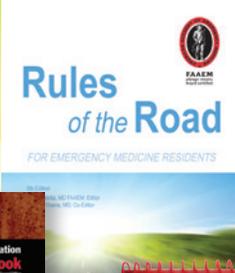
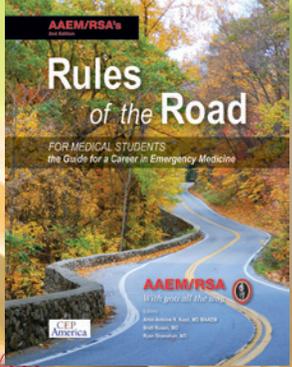
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