VOICE
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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COMMONSENSE

Table of Contents

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 quallity 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)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
International Student Member: $30 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

Pay dues online at www.aaem.org or send check or money order to:
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AAEM-0517-719

President's Message

Updates from the Board of Directors

Kevin Rodgers, MD FAAEM
AAEM President

In my last President's Message, I discussed the importance of EM physician advocacy for our patients and our specialty. The first week of June, AAEM hosted a highly successful Health Policy Symposium and Workshop (June 5th) with more than 40 people in attendance. Hats off to Janet Wilson, Terry Mulligan, Mary Haas, and Matt Hoekstra for their excellent job planning and executing this initial advocacy workshop — it was a "huge" success. Topics included Due Process; Balance Billing/Out-of-Network Fees; EMTALA/Liability; Quality Standards and Measures in Emergency Medicine; Emergency Medicine and the New Administration; AHCA/The New Health Care Law and Direction of HHS/CMS; MACRA and Physician Reimbursement; and Open Books. We followed this primer on advocacy with our most widely attended Advocacy Day on the Hill on June 6th. Our discussions with Congressional leaders focused on: guaranteed/unwaivable due process; funded access to emergency care; and protection of the prudent layperson standard. With all the fervor in DC from both parties over revisions to Obama Care and the proposed American Health Care Act (AHCA), it was a very prudent time to bring our concerns to Congress.

Since Congress began addressing the creation of a new health care act, it seems that every day brings a new controversy from both the Democratic and the Republican sides of Congress. Reporters, other organizations and our own members have repeatedly asked AAEM to comment on many of these politically fueled disputes. AAEM has chosen to remain apolitical (out of deference to our membership whose political affiliations belong to both parties) and avoid comment on most of these "political grenades." I want us to be the best EM organization at advocacy but we need to carefully pick our battles — if a political policy has a direct effect on EM and our patients, then we need to examine it carefully and develop a well thought out advocacy plan that is not polarizing. So regardless of your political affiliations, ensuring access to emergency care and the financial viability of our health care "safety net" should be a prime concern of every EM physician. Therefore the BOD sought to create a carefully drafted statement that would clearly delineate AAEM's concerns for Congress-people as the debate continues. The BOD unanimously approved the following statement initially crafted by Mark Reiter and Howie Blumstein.

AAEM supports the following principles which we believe should be addressed in any legislation regarding health care payment or reform:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. Coverage for emergency care should be provided based on the "prudent layperson" standard rather than retrospective review, which penalizes patients and discourages them from seeking appropriate care.
3. As a nation, we should seek to maximize the number of people with access to affordable health care.
4. Health care reform should seek to decrease the financial pressures on our already overburdened emergency care system by eliminating measures which would allow insurers to underpay for federally mandated care without recourse for physicians to recover fair value for those services.

AAEM is proud of our unwavering commitment to the rights of both our patients and the EM physicians that provide their care. The BOD believes this position statement concisely reflects the values that AAEM was built upon.

New Initiatives & Projects

I'd also like to take a minute of your time to highlight a variety of new initiatives/projects that the BOD and AAEM's committees have been working to develop and implement.

New Member Benefit: AAEM Insurance Program
AAEM has entered into an agreement with Emergency Physicians Insurance Exchange Risk Retention Group (EPIX) to provide the AAEM Insurance Program at cost savings to our members. Details on this new member benefit will be available on the website, shortly.

New Member Benefit: EvidenceCare
AAEM has entered into an agreement with EvidenceCare to provide AAEM members a discounted rate for use of EvidenceCare protocols (developed and continually updated by well-known topic leaders in EM) that easily interface with your EMR system. Included in the member benefit is a free 90 day trial.

New Logo & Website
The Marketing Task Force, following an indecisive vote at AAEM17, has completed its crowd-sourcing based design of a new AAEM logo which the BOD will consider at its next meeting. The TF has also started its update of our current website. Please feel free to make suggestions by emailing Laura Burns LBurns@aaem.org.

Listen to New Podcast Episodes
Be sure to check out the over 40 new podcasts developed by AAEM and RSA on a variety of topics including medicolegal, critical care, operations management as well as topics important to EM residents and new graduates.

Continued on next page

AAEM Antitrust Compliance Plan:

As part of AAEM's antitrust compliance plan, we invite all readers of *Common Sense* to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at info@aaem.org or by calling 800-884-AAEM.

Register for MEMC17 in Lisbon

MEMC planning is nearly complete and the lineup of speakers and topics is phenomenal! Lisbon is renowned for its celebration of history and culture. World class beaches, a UNESCO Heritage medieval village, castles, fortresses, ancient churches, modern parks and jogging paths, a zoo, an oceanarium, and an amusement park are only a few of the available diversions within the metropolitan area. And the magnificent bodegas where delicious Port wines are produced are only a few hours away. Indeed, Portugal has been voted the best emerging wine region in the world! Consider making the trip that combines world class CME with an amazing travel adventure.

Spread Our Message to the Next Generation

Help AAEM spread our message to the next generation of EM physicians. Take a minute to inquire of your residency's leadership if AAEM has had the opportunity to speak to their residents on a variety of workplace fairness issues such as due process, restrictive covenants and open books. If not, please encourage them to accept our offer for FREE education on these important and often neglected topics.

Encourage Physicians to Join AAEM

Finally, my perpetual plea, please consider recruiting a fellow EM physician to join AAEM. Our ability to accomplish AAEM's mission is directly related to our membership … as they say there is strength in numbers!

I love to hear feedback from our members — feel free to email me at kgrodger@iu.edu. ■

AAEM members gathered to make your voice heard on Capitol Hill.

(L-R) Past Presidents Council Representative, Howard Blumstein, MD FAAEM; President-Elect, David Farcy, MD FAAEM FCCM; Board Member, Terry Mulligan, DO MPH FAAEM; Past President, William T. Durkin, Jr., MD MBA CPE FAAEM

(L-R) RSA Board Member and Advocacy Chair, Jack Storey, MD and RSA President, Ashely Alker, MD MSc

Andy Walker, MD FAAEM, leads part of the AAEM Health Policy in Emergency Medicine (HPEM) Symposium on "Balance Billing/Out-of-Network Fees." The symposium was one-day introduction to the advocacy process.

Response to an Article? Write to Us!

We encourage all readers of *Common Sense* to respond to articles you find interesting, entertaining, educational, or provocative. Help us stimulate a conversation among AAEM members.

www.aaem.org/publications/common-sense

A New Beginning

Andy Mayer, MD FAAEM
Editor, *Common Sense*

Hello, my name is Andy Mayer and I have the honor of being the new editor of *Common Sense.* Andy Walker, who is now referred to as "Old Andy," very nobly performed this duty for the last few years and dubbed me "New Andy." I served with Old Andy for several years on the board of directors of the Academy and was always delighted by his quiet wisdom. We should all thank Andy Walker for his many years of service to the Academy. I hope to bring to *Common Sense* some of the same insightful articles and opinions. Dr. Jonathan Jones will continue to serve as the assistant editor and I deeply appreciate his continued role.

Even though I am "New Andy," I am not really new. My roots in emergency medicine go back to the late 1980s, as a resident in the LSU/Charity program in New Orleans during the peak of the crack cocaine epidemic. It was a wonderful and scary place to train and I grew up inside the walls of the now shuttered Charity Hospital. Entering the world of emergency medicine in 1990 was an interesting experience. Board certification was not yet the norm in my city and there were many types of practice.

Entering private practice

I split my time between three jobs, and to this day my main job is as a member of the West Jefferson Emergency Physicians Group. I recently had the honor of becoming Medical Director of this group, a single hospital, democratic group that has held the contract since 1968. We may be the oldest continuously operating, one-hospital emergency medicine group in the country. Does anyone know of an older emergency medicine contract? My contract there stated what I would be paid; my night, weekend, and holiday responsibilities; and when I would be made a partner. Fresh out of residency, I also had two part time positions. One as part-time clinical faculty teaching LSU residents at Charity Hospital and the other at a local hospital with EmCare.

The seedier side of emergency medicine quickly came into focus. Starting as a young and idealistic emergency physician, I soon learned what working for a contract management group meant. It always seemed that my three shifts a month were three night shifts in a row on a weekend, especially if it was a holiday. The billing was mysterious and I was required to buy their malpractice insurance, even though I had a full time policy already covering me. At the time I was starting a family, buying a house, and doing all the things you are supposed to do when you are all grown up. Putting my misgivings aside, I put my head down and continued to just take it.

The tipping point came when I was named in a nonsensical malpractice claim that quickly went away, but EmCare required me to "share" the costs of the suit with my private malpractice insurance — even though I was paying for their required insurance! During this episode another emergency physician working with me for EmCare handed me a small paperback book, and yes, it was *The Rape of Emergency Medicine*. Reading it opened my eyes to what had been happening to me and why it had never felt right. I soon severed ties with EmCare and have not worked for a contract management group (CMG) since that time.

The next event in my evolution to the Academy came in this same time frame, when I learned that Bob McNamara was speaking at the LSU Emergency Medicine Residency. Honestly, I had never heard of him and had not heard "The Talk." His "History of Emergency Medicine" speech made my blood boil and helped crystallize my professional beliefs about the importance of working for a democratic group and the value of board certification.

Assuming that the College represented my interests in my professional life, I decided to write them a letter. I had been a faithful member since starting residency and proudly earned the FACEP designation. The response I received from ACEP concerning my reservations about the ethics and practices of corporate management groups was cold, stating that these were private business matters and that ACEP had no ability to affect them. The letter also informed me that if I did not continue my membership in ACEP I could no longer use the FACEP designation. Some decisions become clear in a moment. I soon joined AAEM, quit ACEP, and have not looked back. I had been exploited and felt an overwhelming desire for fairness and justice. The Academy told me that the individual practitioner is important, and going to early Scientific Assemblies was also a positive change. The lectures were geared to board-certified physicians instead of the generic introductory talk I had become used to in other settings.

Larry Weiss, our former president, played another significant role in my early development in the Academy. Dr. Weiss organized a hundred doctors dressed in white coats, including myself, to attend a hearing of the

Continued on next page

Louisiana Supreme Court. The hearing concerned a malpractice case where a new type of tort was proposed. A doctor had not only lost a malpractice case, but had also been assessed a large penalty for the intentional tort of patient dumping, which would now have be covered by his malpractice insurance and would financially destroy him. The justices were visibly shaken by the presence of so many engaged physicians and the judges ruled in the doctor's favor. This was a formative moment, seeing that physicians can affect their future if they work together.

These experiences helped form my ideas and opinions about emergency medicine in general and the business aspects of our profession in particular. It became apparent that maintaining some control over my practice was going to be essential for me to prosper and survive the rigors of my chosen career. Seeing many fellow emergency physicians burn out made me determined to become active in the Academy, volunteer for different roles, and attend the Scientific Assembly.

As your editor, I hope to help produce an interesting and readable magazine. I encourage your ideas and opinions. Please feel free to contact me and reply to any article or share your thoughts. ■

AAEM17 Now Available Online!

AAEM Online is a FREE member's only benefit that allows you to stream video or audio directly on the AAEM website, or download the MP3 or MP4 files.

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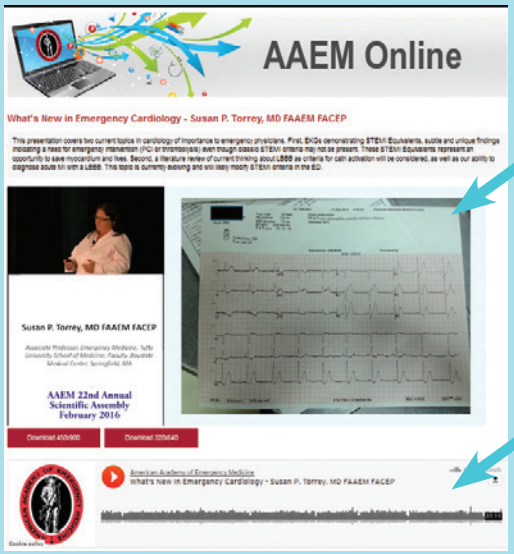

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- What's New in Emergency Cardiology: 2017 Literature Update
  - Amal Mattu, MD FAAEM
- #OrlandoUnited: Coordinating the Medical Response to the Pulse Nightclub Shooting
  - Hunter Christopher, MD PhD FAAEM
  - Amanda Tarkowski, MD
- And more selected lectures from AAEM17!

Health Care Reform Efforts at Critical Juncture as Senators Urge Changes

Williams & Jensen, PLLC

As of the end of June, Senate Republicans are working quickly to prepare legislation to bring to the floor repealing and replacing portions of the Affordable Care Act (ACA). The Senate bill, entitled the "Better Care Reconciliation Act of 2017" (BCRA), will be a substitute amendment to the House-passed American Health Care Act (AHCA). The bill aims to stabilize health insurance markets, repeal numerous mandates and taxes that were enacted with the ACA, and implement significant Medicaid reforms.

Key components of the legislation include a short-term stabilization fund to help address access and coverage issues, with $50 billion allocated between 2018 and 2021. The bill eliminates nearly all taxes in the ACA, including those on medical devices and health insurance. The bill's Cadillac Tax on high cost insurance plans, unpopular among Republicans and many unions, is delayed from taking effect until 2026. However, it is the bill's Medicaid reforms, the largest and most significant since the creation of the program in 1965, which could have the longest lasting impact on the health care landscape. The proposal would phase-out the ACA's Medicaid expansion. States would have the option to choose between per-capita funding or a block grant. Beginning in 2025, the spending growth rate would be tied to the rate of increase in the consumer price index for urban consumers (CPI-U). By using CPI-U rather than medical CPI, the bill is likely to significantly slow the rate of growth within Medicaid.

BCRA takes a similar, but slightly different approach to essential health benefits (EHBs). The legislation expands existing Section 1332 waivers to include EHBs. This change will allow states to use this program to waive the ten EHBs defined by the ACA, which includes emergency care. The EHB requirement under the Medicaid expansion would expire at the end of 2019. Under the Medicaid block grants, states' must provide certain benefits and services in their program, including inpatient and outpatient hospital care, physician services, and emergency medical transport.

The Congressional Budget Office (CBO) estimated that this legislation will save approximately $320 billion over the next 10 years, although it would increase the number of uninsured Americans by 22 million over the same timeframe. The Trump Administration and Congressional Republicans who support the legislation argue that the repeal is necessary to fulfill a key campaign promise to their voters. They contend that individuals will have better choices under BCRA, and that the ACA is quickly collapsing, evidenced by the decision of many insurance companies to pull out of health insurance markets. Congressional Democrats are unanimous in their opposition to the measure. They note that many will lose access to health insurance as a result of this legislation, and that Republicans should instead focus on fixing the ACA rather than starting over with a new law.

Five Republican Senators have expressed opposition to the proposal, representing the concerns of both the moderate and conservative wings of the party. A number of conservative Senators, including Senator Ted Cruz (R-TX), have urged for additional measures to reduce the cost of premiums. This could include an amendment allowing for catastrophic, low premium options for consumers. Republicans hailing from states that expanded Medicaid under the ACA, are also seeking to address concerns related to the phase-out and how their states Medicaid population will fare under the new law. In order to pass the legislation, Republicans must address the concerns of a majority of this group and possibly others that have not yet publicly committed to the legislation, as they can afford to lose no more than two votes given the opposition by all 48 Democratic Senators.

The passage of this legislation remains highly uncertain. One thing is clear, Congressional Republicans are under immense pressure to finalize a proposal before leaving for the August recess. Due to political reasons, it is very hard to imagine a successful legislative outcome that can be finished after the recess. Therefore, Republican leaders have raised the possibility of delaying the recess to complete consideration of ACA repeal legislation.

The Administration has indicated support for the Senate bill. The House is in "wait and see" mode, and will determine a path forward if the Senate is able to send them a product. Many uncertainties remain in this process, and at this point it remains possible that the Senate can find a way to cobble together the necessary 50 votes for the bill that would allow Vice President Pence to break the tie. However, it is not at all clear that this will be a product that the House can support, or if they will need to make further changes. In either case, the next six weeks will be crucial if Republicans hope to send an ACA repeal bill to President Trump's desk.

CMS Releases MACRA Proposed Rule for 2018

The Centers for Medicare and Medicaid Services (CMS) published a notice of proposed rulemaking outlining updates to the Quality Payment Program. The proposed rule seeks to promote flexibility making it easier for clinicians to participate and fully implement the Quality Payment Program. These changes are based on feedback CMS has received from clinicians. The Medicare Access and CHIP Reauthorization Act (MACRA) established a two-track value-based payment structure: the Merit-based Incentive Payments System (MIPS) and the Advanced Alternative Payment Models (APM).

For MIPS, the proposed rule for 2018 would continue the "pick-your-pace" option for provider reporting requirements as well as create a new virtual group reporting option allowing eligible providers to pool information on patient care for reporting and evaluation under the Qualify Payment Program. This is a continuation of the rules for 2017 which allows providers that report even a very minimal amount of data to avoid future negative payment adjustments beginning in 2019. The low-volume threshold for exempting small practices would increase to $90,000 or less in Medicare Part B allowed charges or 200 or less Medicare Part B patients. ■

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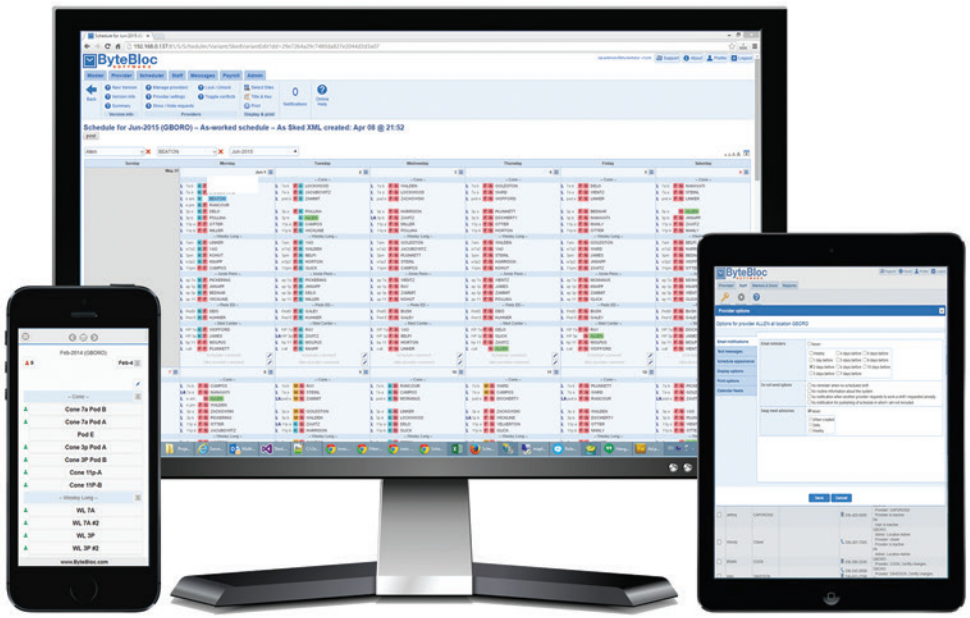

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Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 11-29-2016 to 4-11-2017.

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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Recognition Given to PAC Donors

AAEM PAC is the political action committee of the American Academy of Emergency Medicine. Through AAEM PAC, the Academy is able to support legislation and effect change on behalf of its members and with consideration to their unique concerns. Our dedicated efforts will help to improve the overall quality of health care in our country and to improve the lot of all emergency physicians.

All contributions are voluntary and the suggested amount of contribution is only a suggestion. The amount given by the contributor, or the refusal to give, will not benefit or disadvantage the person being solicited.

Levels of recognition to those who donate to the AAEM PAC have been established. The information below includes a list of the different levels of contributions. The PAC would like to thank the individuals below who contributed from 1-1-2017 to 5-30-2017.

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Upcoming Conferences: AAEM Directly & Jointly Provided and Recommended

AAEM is featuring the following upcoming conferences and activities for your consideration. For a complete listing of upcoming conferences and other meetings, please visit: www.aaem.org/education/aaem-recommended-conferences-and-activities.

AAEM CONFERENCES

September 16-17, 2017
- Fall Pearls of Wisdom Oral Board Review Course
  Philadelphia, Los Angeles
  www.aaem.org/oral-board-review

September 23-24, 2017
- Fall Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Orlando
  www.aaem.org/oral-board-review

September 27-28, 2017
- Fall Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org/oral-board-review

April 7-11, 2018
- 24th Annual AAEM Scientific Assembly – AAEM18
  San Diego Marriott Marquis & Marina
  www.aaem.org/AAEM18

AAEM JOINTLY PROVIDED CONFERENCES

September 6-10, 2017
- MEMC-GREAT 2017 Joint Congresses
  Corinthia Hotel Lisbon
  Lisbon, Portugal
  www.emcongress.org

October 4, 2017
- AAEMLa EM Resident Conference and Annual Chapter Meeting
  Baton Rouge, LA
  www.aaem.org/membership/chapter-divisions/aaemla

AAEM RECOMMENDED CONFERENCES

September 15-17, 2017
- The Difficult Airway Course: Emergency
  Chicago, Illinois
  www.theairwaysite.com

October 6-8, 2017
- The Difficult Airway Course: Emergency
  Washington, D.C.
  www.theairwaysite.com

October 19, 2017
- UGEMP: Ultrasound Guided Emergency Medicine Procedures Course
  Vancouver, Canada
  http://ubccpd.ca/course-group/emp

October 20, 2017
- SEMP: Simulation-Assisted Emergency Medicine Procedures Course
  Vancouver, Canada
  http://ubccpd.ca/course/SEMP-Oct2017

November 16-17, 2017
- The Combined ACLS/APLS Course 2017 #CPDaclsapls
  Vancouver, Canada
  https://ubccpd.ca/course/acls-apls-2017

November 17, 2017
- UGEMP: Ultrasound Guided Emergency Medicine Procedures Course
  Vancouver, Canada
  http://ubccpd.ca/course-group/emp

November 17-19, 2017
- The Difficult Airway Course: Emergency
  San Diego, California
  www.theairwaysite.com

December 6-9, 2017
- ESEM: Emirates Society of Emergency Medicine Conference
  Dubai, United Arab Emirates
  www.esemconference.ae

May 15-18, 2018
- SAEM18
  Indianapolis, IN
  www.saem.org/annual-meeting

June 5-9, 2018
- ICEM 2018 Conference
  Mexico City, Mexico
  www.pr-medicalevents.com/congress/icem-2018/

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kathy Uy to learn more about the AAEM endorsement and approval process: kuy@aaem.org.

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

The ACCME Subcommittee, a branch of the Education Committee that maintains AAEM's CME Program, is actively recruiting members.

Subcommittee activities include reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly provided activities to ensure all guidelines are met that are set by the ACCME (Accreditation Council for Continuing Medical Education).

To learn more about the responsibilities of all of our committees and to complete an application, visit: **www.aaem.org/about-aaem/leadership/committees**

Dollars & Sense

Three Things Every Young Medical Student and Physician Needs to Know

Joel M. Schofer, MD MBA CPE FAAEM
Commander, Medical Corps, U.S. Navy

I gave this lecture at the 2017 Scientific Assembly, but there are many people who find it hard to attend the meeting, especially the target of the lecture, young medical students and physicians. In that vein, here is the first of three things every young medical student and physician needs to know.

1. You can't control the investment markets, so focus on the two things you can control — investment costs and your asset allocation.

No one, and I mean no one, knows what is going to happen in the investment markets. Study after study have shown that the overwhelming majority of people who try to beat the markets fail. Because of this, you should forget about trying to predict the markets, and focus on things you can control — investment costs and your asset allocation.

All investments have costs, and the impact of these costs on your investment return compounds over time, taking a larger and larger bite out of your investment returns. If you invest $100K for 25 years and earn 6% per year, without costs you'd have $430K. With just a 2% annual cost you wind up with only $260K. That 2% annual cost consumed $170K, almost 40% of your potential investment! (Source: Vanguard.com)

In addition, because they have to overcome higher costs, investments with higher costs lag the performance of similar investments with lower costs. If you look at stock and bond mutual funds in the highest and lowest cost quartiles, you'll see what I mean:

Type of Fund	Highest Quartile of Cost	Lowest Quartile of Cost
Stock	6.9%	7.8%
Bond	4.0%	4.4%

Average yearly return from 2004-2014. (Source: Vanguard.com)

If you want to take one step that will guarantee that your costs are among the lowest in the industry no matter what you invest in, you should invest with Vanguard. Vanguard is actually owned by its own investors (you), and they leverage this corporate structure to provide the lowest investment costs across the board. With over $4 trillion (yes, trillion) under management, you can't go wrong by just investing in Vanguard.

If you can't invest with Vanguard, perhaps because your employer's retirement plan doesn't offer Vanguard investments, then you need to get into the weeds on your investment costs. While there are many different potential investment costs, the easiest one to look at is the expense ratio of your potential investments. According to Morningstar.com, the expense ratio is "the annual fee that all funds or ETFs charge their shareholders. It expresses the percentage of assets deducted each fiscal year for fund **expenses**, including 12b-1 fees, management fees, administrative fees, operating costs, and all other asset-based costs incurred by the fund."

Wow. That was a mouthful. Bottom line … high expense ratio bad, low expense ratio good. You should be able to find your investments' expense ratios on your investment website or Morningstar.com.

In addition to investment costs, the other things that you can control is your asset allocation. While there are many asset classes you can invest in, the two most basic are stocks and bonds. Here are some of the returns for stocks and bonds from 1926-2013 in commonly utilized portfolios:

Annual Return	50% Stocks & 50% Bonds	60% Stocks & 40% Bonds	80% Stocks & 20% Bonds	100% Stocks & 0% Bonds
Highest	32.3%	36.7%	45.4%	54.2%
Average	8.3%	8.8%	9.6%	10.2%
Lowest	-22.5%	-26.6%	-34.9%	-43.1%

%(Source: Vanguard.com)

As you can see, the higher your allocation to stocks over bonds, the more risk you are taking and the bumpier the ride. Along the way, though, you have historically been rewarded for this bumpy ride with a higher average annual return. Just like the extra 2% cost that was previously discussed compounds to make a huge difference, so will a small difference in your returns. In other words, the more risk you can take, the more money you will probably end up with.

The application of these principles is that you should take as much risk as you can. In other words, you should invest as much of your portfolio

Continued on next page

in stocks as you can while still sleeping at night and not lying awake worrying about the stock market's ups and downs. There will be another market downturn, and when that occurs you need to keep buying stocks because they are on sale, not sell out because you can't handle seeing your net worth and portfolio value decrease.

Invest in as high a percentage of stocks as you can without making the critical mistake of selling stocks during the next market downturn. For me, that has been 100% stocks for the majority of my career, but for some people they'll panic even at a much lower percentage of stocks. If a 50% stock and 50% bond portfolio is the only one that will keep you from selling during the next market downturn, then that is the right portfolio for you.

If you have been investing for long enough, look at your actual behavior during the 2007-2008 market downturn and what your asset allocation was at the time. Mine was 100% stocks and I kept on buying. Your allocation and actions will tell you a lot about your own risk tolerance.

In summary, you can't control the market, so focus on controlling investment costs and your asset allocation. Next issue we'll discuss the other two points every young medical student and physician need to know:

2. Your savings rate is the most important determining factor of your eventual net worth, and it should be at least 20-30% of your gross income.

3. You are your own financial worst enemy.

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. ■

Former AAEM Board Member Receives Highest Honor in Army Academic Medicine

Dr. Bob Suter, who recently completed the three consecutive terms allowed on AAEM's board of directors, has received the highest honor in Army Academic Medicine from the Surgeon General of the Army. The Major General Lewis Asply Malogne Award is given to one Colonel per year who the selection committee feels most emulates Maj. Gen. Malogne, by achieving a balance of excellence in both military medical leadership and academic excellence. Dr. Suter is the first emergency physician to win the award.

Maj. Gen. Malone was one of the first West Point graduates to be allowed to go to medical school and was the commander of Walter Reed Army Medical Center at the time of his death. The clinic at West Point is named after him.

The Academy congratulates Dr. Suter on receiving such a great honor, and is grateful for the service he and other veterans have given our nation. Well done, Bob, and thank you! ■

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

October 7, 2016

Medical Corps

Colonel Robert E. Suter
Commander, 2d Medical Brigade
2600 Castro Road
San Pablo, California 94806

Dear Colonel Suter:

It is with great pleasure and pride that I congratulate you on your selection as a recipient of the 2016 The Surgeon General's Award for Military Academic Excellence (The Lewis Aspey Mologne Award). You can be justifiably proud of your selection for this prestigious award.

The nominations considered by the board were a select group of senior Medical Corps officers who collectively represent the epitome of achievement in military academic medicine. Your selection for this award is a reflection of your achievements and contributions to the Army Medical Department as both a leader and an academician. Such a wide range of accomplishments is truly noteworthy.

In order to ensure that this recognition is properly documented, I request that a copy of this correspondence be placed in your Official Military Personnel File.

I offer you my sincere best wishes for continued success in all of your future endeavors.

Sincerely,

Nadja Y. West
Lieutenant General, US Army
The Surgeon General and
Commanding General,
US Army Medical Command

Assaults on Board Certification in Louisiana Halted

Andy Mayer, MD FAAEM
Editor, *Common Sense*

A recent bill (Senate Bill 194) was defeated in the Louisiana Senate Health and Welfare Committee by the collaborative work of physicians across the state. The proposed legislation would have allow a physician to advertize as being board certified if the board was merely verified to exist. This bill would have repealed the current requirement that the certifying board had ABMS membership or completion of ACGME training in the specialty or subspecialty certified for a physician to be allowed to advertize a status of board certified.

Please watch your state legislatures for this type of proposed legislation. The value of our board certification is continually being challenged. We must be ever vigilant. ■

Out-of-Network Providers and the "Surprise" Bill: California and Beyond

Brian Potts, MD MBA FAAEM
AAEM Board of Directors

Following AAEM's Advocacy Day in Washington last December, many Members of Congress and their staffers had questions and wanted input from us on the "surprise bill" or balance billing issue. Members hear from patient advocacy groups and constituents about being surprised by an out-of-network (OON) charge from an emergency medicine group after a trip to an in-network hospital's emergency department (ED), making the emergency physician look like the bad guy. Physician groups typically elect to stay out of an insurer's network because the contract terms for participating or being in-network provide inadequate reimbursement. The threat to stay OON provides leverage during negotiations, and is often the only leverage emergency physicians have. Will physicians continue to have this leverage in the future, to prevent reimbursement rates from being pushed lower and closer to Medicare rates?

"AAEM will continue its efforts with other interested parties at the state and national level to support fair reimbursement for emergency physicians. Contact your state legislators now and start educating them on this issue."

In California last year, legislation (AB 72 Bonta) was signed into law, making it more difficult for out-of-network physicians to balance bill patients who are in PPO networks if they receive care at an in-network facility. Headlines read, "California medical consumers will enjoy strong new protection against surprise out-of-network medical bills." AB 72 allows patients who received care at in-network facilities to pay only in-network cost-sharing for non-emergency services. Health plans are to pay non-contracting physicians the plan's average contracted rate or 125% of Medicare, whichever is greater. Doctors could appeal that through a binding independent dispute resolution process, which California's Department of Managed Health Care will establish. The bill's provisions do not apply to self-insured employer health plans, which are isolated from state regulations by the federal ERISA law.

Prior to passage of the bill, media outlets were fairly one-sided in supporting it. The California Medical Association and others in the organized medical community had a difficult time getting their voices heard. It's hard to describe the interaction between insurance companies and physicians in a quick soundbite, and how this bill gives insurance companies more leverage to push reimbursement rates down even further. The public found it hard to understand our message compared to the one they heard from insurers and advocacy groups, who pushed the narrative, "I was seen at the hospital and some ER doctor billed me $450… My insurance company told me they don't contract with that doctor but normally they would pay an ER doctor $150… My insurance does contract with the hospital but I was stuck with a large bill to pay out-of-pocket." The reality on our end of that story is the insurance company probably offered the emergency physician group lousy reimbursement for an in-network rate, and after being told to take it or leave it the physician group said, "No, we're not going to contract with you at that rate and we will stay out of network, thank you very much."

I see the passage of AB 72 with mixed emotions. It was a big win that emergency services, and hence emergency physicians, were excluded from the final language (big kudos to CAL/ACEP for lobbying very aggressively for this exclusion), but it is a significant loss for the rest of California's physicians. This will further hamstring physician groups as they attempt to negotiate contracts with insurance companies, who already have the upper hand.

In California, I don't think we should completely discount the possibility of patient advocacy organizations going back to the California state legislature or working with regulators to remove the current emergency services exclusion. Legislators and regulators will continue to face demands to mediate the feud between insurers and physician groups, with the goal of "patients not being stuck in the middle." It's something we need to watch closely.

With California often a trendsetter for the nation, this same issue will play out in even more states over the next couple years — and already is in many. In November, a New England Journal of Medicine article called for federal legislation to resolve the issue. Insurers and other payers will continue to look for legislative solutions because surprise OON bills undermine public support for narrow-network health plans, and narrow networks are a primary means of keeping insurers' costs down and profits up.

It is difficult for both legislators and patients to understand how proposed "solutions" to unexpected balance bills would significantly harm physician groups in their negotiations with insurance companies. They don't

Continued on next page

understand that insurance companies are deliberately setting up more and more narrow networks to cut their costs, shifting costs onto patients through increasing deductibles and co-pays, and sticking patients with a larger percentage of the bill. Physician groups don't want to contract with insurers who refuse to negotiate in good faith. We are left with angry patients who demand that politicians fix the problem, which injects the government deeper into our profession. If legislators do get in the middle and attempt to fix the problem by making it more difficult for OON providers to bill a patient or charge higher than in-network rates, physicians will be stuck with declining reimbursement rates whether they are in- or out-of-network. Insurers have less incentive to get physicians in-network when the difference between in-network and OON rates is insignificant, leaving them free to lower reimbursements for all.

We need to continue to educate the public, legislators, and regulators: by denying emergency physicians the ability to charge out-of-network rates to insurers and bill patients for charges not paid by insurance, they leave us no recourse against reimbursement levels that are often severely inadequate. Balance billing and OON fees are not tools emergency physicians use to price-gouge patients, they are the only means to receive fair compensation for the emergency services we provide to all. Efforts through legislation and regulation to completely prohibit balance billing and cap OON fees would have disastrous consequences for patients and the medical safety net. Without the ability to balance bill or the threat to stay OON, emergency physicians will be completely at the mercy of insurers. Insurance companies will have the ability to unilaterally set reimbursement rates for emergency medicine at whatever below-market rate they arbitrarily choose. Emergency physicians are already mandated by federal law (EMTALA) to provide care for all patients. Insurance companies know we must see their patients regardless of contractual status or network.

ACEP sued HHS last year claiming a provision of the Affordable Care Act allows insurers to underpay for out-of-network emergency medical services, and requested that insurers be transparent on the data they're using to pay for services rendered by an OON hospital. HHS has interpreted the law to mean that health plans must reimburse OON providers for a "reasonable" amount of their usual charges before a patient is on the hook for the balance. The government has decided that means providers should be paid whatever amount is the greatest of three options: the Medicare rate; the median in-network rate; or the usual, customary and reasonable charge or UCR (almost always the greatest of the three). Insurers have been caught manipulating UCR figures to lower their obligations and leave patients with a greater amount to pay out of pocket (http://www.nytimes.com/2012/04/24/nyregion/health-insurers-switch-baseline-for-out-of-network-charges.html). This led to the creation of FAIR Health, an objective database of charges insurers cannot manipulate as easily, which insurers now refuse to use.

AAEM will continue its efforts with other interested parties at the state and national level to support fair reimbursement for emergency physicians. Contact your state legislators now and start educating them on this issue. ■

American Board of Emergency Medicine (ABEM) Updates

Qualifying Examination Deadlines

The first step in becoming ABEM certified is to apply for certification. The second step is taking and passing the Qualifying Examination. If you want to take the November 2017 Qualifying Examination but have not yet applied for certification, you still have an opportunity. The last late application deadline is October 5. By midnight (Eastern) on that date you must complete the online application and submit the appropriate fee.

If your application is approved, ABEM will notify you, and you can then register for the exam without paying a late fee if you do so by October 26.

Application and examination deadline dates and fees are available on the ABEM website (www.abem.org). If you have any questions, please contact ABEM at 517-332-4800, ext. 384, or email qualify@abem.org.

What do I do if I think an exam question is strange or unclear?

If you come across a question on the Qualifying Examination that just doesn't seem quite right to you it could be a "field test" question. Field test questions are questions that appear on an exam for the first time and that do not factor into candidate scoring. Before any Qualifying Examination question is used to determine a candidate's score, the question must first be field tested to ensure its performance meets ABEM standards. Such field test questions have passed through several thorough reviews, but nothing takes the place of trying out questions with real test takers. Again, your responses to field test questions do not affect your score.

What can you do if you run across such a question? You can provide feedback about it (or any other test question) while you are taking the exam using the "Comment" button. This feedback is important to ABEM, especially for questions you think are not straightforward, might have multiple correct answers, or are less relevant to the clinical practice of emergency medicine. You can offer positive comments as well. Each comment is read by exam editors and taken into consideration when deciding whether to keep, revise, or eliminate a question. ■

Florida Chapter Division Celebrates a Successful 6th Annual Scientific Assembly

Michael Dalley, DO FAAEM
FLAAEM Board of Directors

The 6th Annual Florida Chapter Division of AAEM (FLAAEM) Scientific Assembly took place in Miami Beach at the iconic Fontainebleau Hotel on April 22-23, 2017. This conference was the best attended to date, with over 160 emergency care providers present. As in previous years participants received up to 12.75 hours of continuing medical education credit. Highlights from the conference include a keynote address from Dr. Stephen Ludwig, MD, a founding father of pediatric emergency medicine. The conference schedule included a robust guest speaker list with representatives from almost every academic residency program in the state of Florida, as well as Drs. Lisa Clayton and Patrick Hughes filling in for Dr. Richard Shih and his popular LLSA review.

We continued our successful medical student track on Sunday afternoon, moderated by Dr. David Edwards and Dr. Mark Foppe. There was a strong student presence with over 50 students from various medical schools at the meeting and this track was well received.

This year's meeting also continued the poster, abstract, and oral presentation competition. Overall there were 44 posters (original abstracts, case reports, and interesting photo submissions) submitted from residency programs and medical schools from across the nation. New this year, there was an oral presentation component, which was moderated by Dr. Lisa Moreno-Walton and FLAAEM board of directors representatives Drs. Vicki Norton and Mark Foppe. The winners are acknowledged below:

Original Research Abstracts

1st place: "Bedside Ultrasound Evaluation for Shoulder Dislocation and Reduction." Ben Boswell, DO; Michael Rosselli, MD; Rob Farrow, DO; Luanna Santana, BA; David Farcy, MD. Mount Sinai Medical Center. Miami Beach, FL.

2nd place: "The Association Between ADHD Severity with Risk of Head Injury, Traumatic Brain Injury, and Concussion." Semir Karic, MS 3; Michael DesRosiers, MS3. Florida International University College of Medicine. Miami, FL.

Interesting Case Report

1st Place: "A Case of Fulminant Myocarditis Treated with ECPR." Robert Farrow, DO[1]; Jackie Lorenzo, DO[1]; Michael T. Dalley, DO[1]; Dr. Madawali[2]. Mount Sinai Medical Center. Miami Beach, FL[1]. Jack Nicklaus Children's Hospital. Miami, FL[2].

2nd Place: "'Don't Skip Leg Day, Bro.' A Case of Unprecedented Exertional Rhabdomyolysis Without Acute Kidney Injury." Aadil Vora, MS 3. Nova Southeastern University. Davie, FL.

Interesting Photo Submission

1st Place: "Retro-Orbital Hematoma from a Taser Gun." Jennifer Bach, DO PGY 3. St. Mary Mercy Hospital. Livonia, MI.
2nd Place: "Intussusception Diagnosed with Bedside Ultrasound." Robert Farrow, DO. Mount Sinai Medical Center. Miami Beach, FL.

Finally, we were privileged to host AAEM president, Dr. Kevin Rodgers, as well as three members of the national board: president elect Dr. David Farcy, secretary-treasurer Dr. Lisa Moreno-Walton, and at-large board member Dr. Bobby Kapur. Dr. Rodgers followed the keynote address and spoke about the current state of emergency medicine, as well as how AAEM supports and advocates for emergency physicians.

A special thanks goes out to FLAAEM Scientific Assembly Planning Committee chair, Dr. Joseph Shiber, and to FLAAEM past president and current national AAEM president elect, Dr. David Farcy, without whom the conference would not be as outstanding and educational as it is. Thank you to all those who supported the conference this year, including the speakers, sponsors and exhibitors, attendees from near and far and all the people behind the scenes who contributed in making our state conference a huge success! ■

(L-R) AAEM President, Kevin Rodgers, MD FAAEM; AAEM Secretary-Treasurer, Lisa Moreno-Walton, MD MS MSCR FAAEM; and FLAAEM Past Presidents Council Representative, Mark Foppe, DO FAAEM, were pleased to welcomed Stephen Ludwig, MD (second from left) who presented on the "Development of Pediatric Emergency Medicine – A Case Study in Innovation."

(L-R) FLAAEM Competition Winners: Rob Farrow, DO; Ben Boswell, DO (2017 Salvatore Silvestri Award Recipient); Jen Bach, DO; Aadil Vora, MS 3; Semir Karic, MS 3; Michael DesRosiers, MS3

Members of the AAEM board of directors and FLAAEM board of directors.

AAEM President, Kevin Rodgers, MD FAAEM, speaks at the 6th Annual FLAAEM Scientific Assembly.

Delaware Valley Chapter Division Hosted Successful Resident's Day

Megan Healy, MD FAAEM
AAEM Board of Directors

On April 19, DVAAEM hosted another excellent Residents' Day for ten EM residency programs in the greater Philadelphia area. The theme of the citywide conference was "My Scariest Case(s) that Made Me a Better Physician." The fantastic lineup included Jill Posner, MD MSCE MSEd (Children's Hospital of Philadelphia), Manish Garg, MD FAAEM (Temple), Robin Naples, MD FAAEM (Jefferson) and Richard Byrne, MD (Cooper).

Themes of the day included cognitive errors and the impact they have on clinical reasoning in the emergency department. In her talk "Big Lessons Learned from Little People: Pediatric Patients that Have Made Me a Better Physician," Dr. Posner reminded the residents of the importance of vital sign trends and reassessment in pediatrics. She also stressed that "our words are our strongest medicines," and urged residents to practice the difficult conversations, such as delivering bad news. Dr. Byrne touched on similar themes as he humorously dissected "Lies My Medical School Taught Me," challenging trainees at every level to identify whether they are employing Type 1 (fast, instinctive) or Type 2 (slow, deliberate) thinking as they work through cases in the ED. Another lesson was to heed the words of William Osler and "acquire the art of detachment, the virtue of method, and the quality of thoroughness, but above all the grace of humility."

Dr. Naples highlighted the importance of thoughtful decision making in her talk "My Patient Who Was Clotheslined." She walked the residents through the rare but high stakes scenario of blunt neck trauma, imploring them to be advocates for patients in the trauma bay and take a minute to think through the consequences of each step in their management. Dr. Garg also highlighted a series of challenging presentations, from electrical storm to breech delivery. He then reminded the residents to take special care when it comes to the most difficult cases of all, those that involve our own loved ones.

The day finished with a talk covering "Updates from the Academy," with a special focus on lessons from the Summa Health case earlier this year, and an excellent LLSA/ConCert Review led by Ryan Gibbons, MD FAAEM and Clare Roepke, MD (Temple). Overall nearly 200 residents and faculty attended the event. The residents were fortunate to learn from the memorable clinical experiences of some very talented leaders in the field. ■

My Own Wellness Story

Madhu Hardasmalani, MD FAAEM
AAEM Wellness Committee

I have been a pediatric emergency physician for 15 years. I still remember my first day rotating through the emergency department as a pediatric resident. I loved it. I knew it was my calling from that very first day. I graduated from one of the busiest emergency departments in the country and then worked in both academic and community EDs. I was fortunate to work with the best in the field, and was enjoying every bit of it until I had a personal crisis. My Mom, whom I adored, was diagnosed with a progressive neurodegenerative disorder and my life changed drastically. I suddenly had two jobs, one in the ED and another at home. My sister and I took turns caring for our Mother. Many times I worked graveyard shifts and then spent the next day caring for her. Sometimes I had to have others cover a shift because of an acute emergency. I paid those back, of course, but I was fortunate to have excellent and supportive colleagues. As Mom's disease progressed I hired a caregiver, but I was still the major decision maker and it wore me down physically and emotionally.

Although I was initially able to manage both work and Mom, I started to feel physically exhausted and knew I had to change my lifestyle. First, I started eating healthy, including more fruits, vegetables, and healthy fats in my diet such as ghee, coconut oil, and nuts. I also realized that it wasn't just what I ate, but how and when that made me feel better, so I became mindful of my eating. I also made sleep a priority. On the days I wasn't in the ED I went to bed early. That was a huge adjustment because I liked to stay up with friends and family, but I realized that adequate sleep translates into better mental alertness and stuck to it. I started meditating, and that worked wonders. I attended a mindfulness/meditation class and started practicing meditation in ten minute sessions. Honestly, out of those ten minutes I managed to focus on my breathing for maybe two minutes, but the cool thing about meditation is that you don't have to fight those thoughts. I just let them pass, and felt thoroughly rested after each ten minute session. I also continued to practice yoga. I am fortunate to have learned Hatha yoga at the age of ten. Yoga is a very rewarding mind/body/spirit exercise. Pranayama, or the breath work of yoga postures, is the connection or bridge between body, mind, and spirit. Yoga is a sort of meditation because it forces you to concentrate on breath – our life force. Yoga brought more self-awareness. I was more conscious of my own being and of what needed attention, like my emotional state or my physical aches and pains. Because my awareness was drawn to these things, I could direct effort to mending them. Yoga made me more calm, more focused, and more content with my situation. It empowered me to face life's challenges and has yet to fail me.

My dearest mom recently transitioned. It was a sad moment to see her go, but I'm proud that my sister and I took good care of her in our home for ten years, and she died peacefully with us chanting spiritual hymns beside her. That is the way I wanted her to be received by God.

I continue with my wellness initiatives and continue to reap benefits. I incorporate self-care practices in my daily routine. In addition to making mindful food choices I also eat mindfully – meaning I spend time eating and enjoying food without rushing through meals. I continue to practice meditation for at least ten minutes a day, and do yoga for at least 20 minutes a day, which helps me connect with body, mind, and spirit. Finally, at the end of each day I say a prayer of thanks.

Life happens to all of us in different ways, but we all face challenges. Good and bad times are both part of life. It is important for us to be physically, mentally, and emotionally ready to face those challenges with resilience and emerge intact and healthy. ■

AAEM18 Wellness Activities

Be well with us at AAEM18

STAY TUNED for more information on wellness events available at the 24th Annual Scientific Assembly in San Diego — including the return of the Airway @ AAEM storytelling event!

AAEM/RSA President's Message

Represent Yourself

Ashely Alker, MD MSc
PGY 2 UCSD

Many argue that the current political climate of the United States is one of exclusion. As the national agenda seeks to strengthen our borders, some feel we are alienating many of our own people. The medical student and resident community responded with words of tolerance and a promise to provide exemplary care to all patients. Examples includes the ACGME's promise to "not give up" on foreign medical school graduates and the SUNY Upstate College of Medicine's video entitled, "Sincerely, the Future of Health Care." Although racism, sexism, and other forms of discrimination are still prevalent and demand intervention, the silent killer of diversity in more civilized circles is unconscious bias.

One of my physician friends once walked into a patient's room and was questioned about changing the linens. It was clear from the conversation that the patient thought he was a facilities employee, but he is a physician. Why is the assumption that he is anything but a physician? Could it be an unconscious bias associated with an accent, skin color, or gender that caused this confusion?

I replied to his story, with my own story. I always introduce myself as "doctor," but many of my patients still address me as "nurse." My friend and I often joke about the ways our patients address us, considering whether we should wear our badges on our foreheads or wear our white coats religiously to provide patients with more information about our hospital roles. We use humor as a coping mechanism, but these are dangerous assumptions and unconscious bias is responsible.

What is unconscious bias? The brain is given 11 million pieces of information in a moment and can only process 40 of these at a time.[1] In order to function efficiently, we must create adaptations, using past knowledge to make assumptions, informing our future decisions. Even the most ethical person is influenced by what they expect to be true. This is unconscious bias.

The danger that unconscious bias poses to our society is grave. In the example given above, the patients have simply mistaken their doctor for someone else. Pollianne Ward, MD FAAEM, in her article entitled "#ilooklikeanEMdoc" astutely noted that these assumptions can be dangerous for patients and bad for hospitals, when patients leave their hospital visit claiming they never saw a physician.[2] Even more dangerous, is a health care professional making assumptions about a patient due to unconscious bias that may affect a patient's care.

So how can we combat unconscious bias for the safety and betterment of our medical community? Diversity is the solution to the problem of unconscious bias. We need to be exposed to physicians and leaders from all races, ethnicities, religions, sex, and every other walk of life.

At the 2016 AAEM Scientific Assembly, there was a town hall meeting for members to ask questions of the AAEM board of directors. Someone stood and asked why the AAEM board had so few women. The reply came from then AAEM/RSA president, Victoria Weston, MD, "We are coming." AAEM/RSA has an impressive line of women in leadership roles. Past presidents include Drs. Meaghan Mercer, Victoria Weston, and Mary Haas. I am the president of RSA partly because of the women before me who have made AAEM/RSA an organization who elects women to leadership roles. But we had to run to get elected.

In order to create opportunities for exposure to diversity and to combat unconscious bias, we must encourage the cultivation of diversity in our specialty and in our leadership. You must be present and also have the courage to speak to have your voice heard. Your voice is amplified as your presence in an organization beckons others like you to follow in your footsteps.

This year, RSA has created the Diversity and Inclusion Committee to partner with AAEM's committee. While this type of committee is not a novel concept, it is a positive change. The goal is to increase diversity in

Continued on next page

"You must be present and also have the courage to speak to have your voice heard. Your voice is amplified as your presence in an organization beckons others like you to follow in your footsteps."

RSA with student and resident outreach, which in turn will increase future diversity in AAEM and emergency medicine.

RSA had also taken other steps in our inclusion initiative. RSA released a statement in response to the Executive Order on Immigration, stating they will support all students and residents. We have also worked with AAEM on diversity and inclusion outreach. I personally spoke at Howard University in May 2016 on behalf of AAEM's Diversity and Inclusion Committee, hoping to promote opportunities in emergency medicine and leadership roles in RSA for medical students and to provide guidance throughout the application process to emergency medicine residencies.

I am happy to see that this year's AAEM/RSA board is diverse in many aspects, but I urge anyone who feels unrepresented to step forward and represent yourself and those like you. AAEM/RSA has a place for you, whether in leadership, membership, committee volunteering, attending the AAEM Scientific Assembly in San Diego (free for RSA members) in April of 2018 or in the creation of new ideas. We need to create diversity in RSA today for the leadership of tomorrow to represent us well. Please represent yourself.

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AAEM/RSA Editor's Message

Preparing for the Worst

Aaron C. Tyagi, MD
Chair, RSA Social Media Committee

We in the world of emergency medicine like to think of ourselves as ready for anything. I have often heard the mantra that we are ready for anything that "walks, rolls, or crawls through the door." Our world is one of relatively controlled chaos. That is to say, when we receive the chaos, it has started somewhere else, far off and distant and we receive a microcosm of it in the form of a patient. That patient is delivered (for the most part) calmly to our home base. However, what happens when the chaos starts at our home base?

Code Silver. It's something no health care provider ever wants or expects to hear in his or her hospital. But it was something that became a reality for the patients and staff of Bronx-Lebanon Hospital at 2:50 PM on June 30th, 2017[1]. A disgruntled employee, a former physician at the hospital no-less, entered his former place of employ, traveled calmly to the 16th and 17th floors with an AR-15 neatly hidden under his coat. He was wearing a white coat, the symbol physicians traditionally wear to signify healing, and opened fire on his former colleagues. His brutal attack left one dead and six wounded requiring various levels of inpatient hospital care.

There seems to have been a relative up-tick in the number of active shooter events of late[2], from one event in 200 to 20 in 2015. This has naturally sparked all levels of debate and, more importantly, action. Multiple agencies have enacted policies and protocols to provide some level of preparedness for if and when these situations arise. Such agencies as the Department of Homeland Security (DHS), FEMA, the FBI and others have collaborated to establish such protocols.

The event at Bronx-Lebanon, however, brings things closer to home for us in the health care field. A hospital is thought of as a place of healing. A Code Silver or active shooter scenario is a nightmare for everyone and especially so in a hospital with an even further vulnerable population.

In 2011, the Presidential Preparedness Directive 8 set out guidelines for how health care facilities (HCFs) can approach better equipping themselves for such events. It details a five-point approach: Prevention, Protection, Mitigation, Response, and Recovery. Many, if not all of us who have trained in the modern era of emergency medicine training are familiar with the NIMS modules required as part of our EMS training during residency. This was extended to HCFs. For example, under this directive, HCFs were encouraged to establish Incident Command Systems (ICS) to help manage crisis situations.[3] Additionally, training modules were incorporated to better equip other non-physician and EMS personnel in HCFs to be prepared to deal in these situations. The three key tenets of this training are to recognize a potentially volatile situation, learn the steps to increase your likelihood of survival and survival of others, and how to effectively aid law enforcement during this time.

"A hospital is thought of as a place of healing. A Code Silver or active shooter scenario is a nightmare for everyone and especially so in a hospital with an even further vulnerable population."

The staff at Bronx-Lebanon were fortunate enough to have just undergone a Code Silver preparedness drill in the week prior to the incident, which many of the staff credit with their capability to respond in the commendable fashion they were able to. They incorporated their training and that, accompanied by their natural instinct to help those in need, helped a bad situation from becoming worse.

For those interested in further reading and resources on how to best prepare for active shooter scenarios, there are a number out for public access. I have included links to the Joint Commission's website that itself has multiple resources listed. I have also included two preparedness manuals, one from the Health care and Public Health Coordinating Council and one from FEMA, the DHS, DHHS, and the FBI. I encourage all to look through these resources and make sure that your HCF has a Code Silver plan and that you and your staff are well versed in it.

https://www.jointcommission.org/emergency_management_resources_violence_security_active_shooter/

http://www.calhospitalprepare.org/sites/main/files/file-attachments/as_active-shooter-planning-and-response-in-a-health care-setting_1.pdf

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Resident Journal Review

Updates in the Emergency Department Management of Acute Liver Failure

Authors: David Bostick, MD MPH; Megan Donohue, MD; Robert Brown, MD; and Nicholas Santavicca, MD
Edited by: Michael C. Bond, MD FAAEM and Kelly Maurelus, MD

Introduction

Patients with chronic liver disease and acute liver failure have disease specific needs for which EPs must be cognizant. Below we review topics related to acetaminophen hepatotoxicity, use of rifaximin and lactulose in hepatic encephalopathy, and thromboelastography (TEG) directed transfusion in patients with liver disease requiring procedures.

Unrecognized Acetaminophen Toxicity as a Cause of Indeterminate Acute Liver Failure. *Hepatology* 2011; 53:567-576.

Approximately half of all cases of acute liver failure are due to acetaminophen (APAP) toxicity[1], while in another 14%, no cause is found[2]. Given the prevalence of APAP liver toxicity and the often-unreliable histories obtained from patients, the authors of this study examined patients with an unknown etiology of liver failure for toxic metabolites of APAP (APAP-CYS adducts).

The patients presented to one of 23 tertiary care centers involved with the US Acute Liver Failure Study Group. Inclusion criteria was the presence of coagulopathy and any degree of hepatic encephalopathy within 26 weeks of onset of symptoms without previous history of liver disease. Overall, 118 patients were found to have an indeterminate case of acute liver failure and their blood samples from day one or two were tested for APAP-CYS. The group was divided into assay negative or assay positive. Another group of patients with known APAP toxicity were also tested and this group was also divided into APAP-CYS assay positive or negative.

Among the indeterminate cases, 18% (20 patients) had levels of APAP-CYS consistent with APAP toxicity. These patients may have benefited from the use of N-acetylcysteine (NAC); however, they were not prescribed NAC as the history provided by the patient or family was inconsistent, the patient had hepatic encephalopathy, or possible deception by the patient. While patients in the APAP overdose and clinically unrecognized APAP overdose group had similar demographic, laboratory findings, and other clinical characteristics, this paper was not developed to investigate the validity of using these characteristics in the early detection of these at-risk patients.

The use of NAC was lowest (18%) in patients with unrecognized APAP hepatotoxicity as determined by APAP-CYS. Conversely, 94% of patients with known APAP toxicity and elevated toxic metabolite levels received NAC. The indeterminate group without toxic metabolites suggestive of APAP hepatotoxicity had the highest rate of liver transplant (42% vs. 17%, 8%, and 22%, $p<0.05$) and the lowest rate of survival (21% vs. 63%, 55%, and 45%, $p<0.05$).

Major limitations of this study include its small sample size and the experimental nature and general unavailability of the APAP-CYS assay. Despite these limitations, this paper reinforces that a significant number of APAP toxicities are missed and that we should suspect APAP toxicity in instances of acute liver injury (a high ALT, low bilirubin pattern).

Take home point: APAP toxicity should be considered for all patients with an indeterminate cause of rapid onset acute liver failure and treatment with NAC should be considered.

WM Lee, LS Hynan, et al. Intravenous N-Acetylcysteine Improves Transplant-Free Survival in Early Stage Non-Acetaminophen Acute Liver Failure. *Gastroenterology* 2009; 137:856-864.

Acute liver failure is a syndrome that carries high mortality and frequently necessitates liver transplantation. Though NAC has been shown to minimize liver damage in acute liver failure secondary to APAP toxicity, its efficacy in non-APAP associated acute liver failure has yet to be established. As a result, the focus of this study was to determine the benefit of NAC in non-APAP induced acute liver failure.

This prospective, double-double blinded trial enrolled patients 18-70 years of age with non-APAP associated acute liver failure (as determined by encephalopathy and coagulopathy) across 22 sites over 8 years. Patients were stratified by site and coma grade, and then randomized to receive a 72-hour dosing regimen of placebo or NAC. Patients were excluded if they had a known APAP ingestion, had received NAC previously in the disease process, had hypotension or shock, or if their liver failure was due to hypotension, pregnancy, or cancer. The primary outcome was overall survival at 3 weeks after randomization. Secondary outcomes included transplant-free survival, transplant rate, hospital length of stay (LOS), and number of organ systems failing.

Of the 820 eligible patients, only 173 were not excluded and composed the final study group. Ninety-two patients received placebo and 81 patients received NAC. The placebo group had a higher number of females and longer duration of illness, but otherwise had similar characteristics than the NAC group. Only 58 patients in the placebo group and 48 patients in the NAC group completed the full 72 hours of therapy. 138 of the 173 total patients received at least 24 hours of therapy. The main reasons for early discontinuation included death, withdrawal of support, or transplantation.

Overall, three-week survival was noted to be similar (70% NAC v. 66% placebo). Of the secondary outcomes, only transplant-free survival was shown to be different. Transplant-free survival was significantly higher (40% NAC v. 27% placebo, OR 2.46) in the NAC group for patients with early stage hepatic encephalopathy (coma grades 1-2). There was a trend toward shorter hospital length of stay with NAC (9d NAC v. 13d placebo). Main adverse events with NAC were nausea and vomiting (14% NAC v. 4% placebo).

Continued on next page

No difference was found in patients with advanced coma grades. Incidentally this group was quite small mainly due to early expedited liver transplantation. As a result, their mortality was driven mainly by early transplantation and post-transplant care. Overall, survival in the placebo group was higher than predicted, possibly due disproportionate number of early coma grades enrolled in the study (66% early v. 33% late). Quality of intensive care could also have impacted survival rates.

Take home point: NAC may be beneficial for patients with early stage non-APAP acute liver failure.

A Randomized, Double-Blind, Controlled Trial Comparing Rifaximin Plus Lactulose with Lactulose Alone in Treatment of Overt Hepatic Encephalopathy. *Am J Gastroentero* 2013; 108:1458-1463.

Hepatic encephalopathy (HE) is a serious and deadly complication of advanced liver disease. Most drugs used to treat HE reduce and eliminate ammonia. The two mainstay treatments are lactulose, a non-absorbable disaccharide and rifaximin, a minimally absorbed semi-synthetic antibiotic. Rifaximin was more effective than lactulose in randomized studies, but no study has yet evaluated the efficacy and safety of using rifaximin and lactulose in combination. In this paper, Sharma et al., evaluate the efficacy and safety of rifaximin plus lactulose vs. lactulose alone in treatment of HE.

This prospective, double-blind, randomized controlled trial preformed at a tertiary care center enrolled patients ages 18-80 years with liver cirrhosis and HE over a two-year period (October 2010-September 2012). Cirrhosis was diagnosed clinically by lab test, sonography, or biopsy. Patients were excluded if other causes of encephalopathy were identified. These included creatinine >1.5, active alcohol use within the past four weeks, hepatocellular carcinoma, degenerative central nervous system disease, major psychiatric illness, or other metabolic encephalopathy.

Continued on next page

Medical Student Council President's Message

Medical Student Council President's Welcome

Christopher Ryba, MS3

Hello everyone! My name is Christopher Ryba, and I have been provided both the honor and privilege of serving as your AAEM/RSA Medical Student Council President for the coming 2017-2018 academic year. Born and raised in the Chicagoland area, I continue to call Chicago my home and will soon be beginning my fourth year of medical school at Loyola University Chicago Stritch School of Medicine. I got my start early on in emergency medicine working as a paramedic for about six years before making the jump to medical school. I have been a member of AAEM/RSA since my first year and have had the opportunity of helping plan the 2015 and 2016 AAEM/RSA Midwest Regional Medical Student Symposium and have been working on the 2017 symposium, which are in full swing for this September. Visit the RSA website for more information!

It is also my pleasure to announce the other members of the AAEM/RSA Medical Student Council for the 2017-2018 year: Vice President, Matthew Chapman (University of Michigan Medical School); Midwest Regional Representative, Kaitlin Parks (Oklahoma State College of Osteopathic Medicine); Northeast Regional Representative, Richa Manglorkar (University of Maryland School of Medicine); South Regional Representative, Natalie Cain (University of Miami Miller School of Medicine); West Regional Representative, Sasha Hallett (Midwestern – AZCOM); and Ex Officio International Representative, Alexander Rahnema (University of Queensland Ochsner Clinical School). On behalf of all of us on the AAEM/RSA Medical Student Council, we are honored to be serving you, and look forward to the year ahead.

We are extremely excited to get the year going and have been working on bringing many new features to the medical student council along with continuing the wonderful work of the student councils that preceded us. Looking ahead, we are planning the Midwest symposium as mentioned above and are working on other potential symposia in other regions. We have also been working on adding new podcasts geared towards medical students.

With a membership to AAEM/RSA, students will receive access to numerous published and electronic resources that can be found under the member benefits section on our website (aaemrsa.org). Some of the highlights include a free copy of *Rules of the Road* career guide for medical students, free access to the popular EM:RAP podcast, and free registration to the AAEM Scientific Assembly. There are several scholarship opportunities throughout the year as well as an opportunity for senior medical students to apply for a month-long advocacy elective with emergency medicine physician and Congressman Raul Ruiz.

Once again, we look forward to working with everyone in the coming year. If you would like to be a part of RSA this year, get involved by joining a committee or applying for one of the numerous leadership opportunities that RSA has to offer. Find everything you need to know about joining the team on our website, and feel free reach out with any questions or suggestions. And without further ado, let's get this year going! ■

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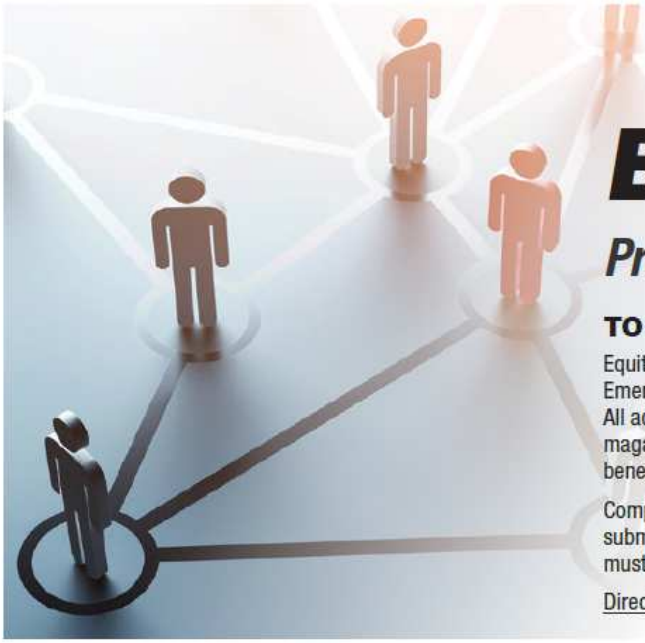

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