

# COMMON SENSE

VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

VOLUME 25, ISSUE 5  
SEPTEMBER/OCTOBER 2018



Save the Date  
25th Annual Scientific Assembly  
Las Vegas, March 9-13, 2019

Page **33**



President's Message:  
Due Process ...  
Or the Lack of It

**3**

From the Editor's Desk:  
I'm Mad as Hell and  
I'm Not Going to  
Take It Anymore!

**5**

Promoting Wellness  
in Resident  
Physicians:  
A Program  
Directors  
Approach

**32**

Young Physicians  
Section News:  
Building Your  
Financial Team

**33**

AAEM/RSA  
President's  
Message:  
"Everybody  
Gets a White  
Coat!"

**34**



#### Officers

##### President

David A. Farcy, MD FCCM

##### President-Elect

Lisa Moreno-Walton, MD MS MSCR

##### Secretary-Treasurer

Jonathan S. Jones, MD

##### Immediate Past President

Mark Reiter, MD MBA

##### Past Presidents Council Representative

Howard Blumstein, MD

#### Board of Directors

Kevin Beier, MD

Robert Frolichstein, MD

Megan Healy, MD

Bobby Kapur, MD MPH

Evie Marcolini, MD FCCM

Terrence Mulligan, DO MPH

Brian Potts, MD MBA

Thomas Tobin, MD MBA

#### YPS Director

Jennifer Kanapicki Comer, MD

#### AAEM/RSA President

MohammedMoiz Qureshi, MD

#### Editor, *Common Sense*

Ex-Officio Board Member

Andy Mayer, MD

#### Editor, *JEM*

Ex-Officio Board Member

Stephen R. Hayden, MD

#### Executive Director

Kay Whalen, MBA CAE

#### Associate Executive Director

Janet Wilson, CAE

#### *Common Sense* Editors

Mehruza Anwar Parris, MD, Assistant Editor

Nick Pettit, DO PhD, Resident Editor

Laura Burns, MA, Managing Editor

Articles appearing in *Common Sense* are intended for the individual use of AAEM members. Opinions expressed are those of the authors and do not necessarily represent the official views of AAEM or AAEM/RSA. Articles may not be duplicated or distributed without the explicit permission of AAEM. Permission is granted in some instances in the interest of public education. Requests for reprints should be directed to AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202, Tel: (800) 884-2236, Fax: (414) 276-3349, Email: [info@aaem.org](mailto:info@aaem.org)

AAEM is a non-profit, professional organization.  
Our mailing list is private.

## COMMONSENSE

# Table of Contents

### Regular Features

President's Message: Due Process ... Or the Lack of It .....	3
From the Editor's Desk: I'm Mad as Hell and I'm Not Going to Take It Anymore! .....	5
Foundation Donations .....	8
PAC Donations .....	9
LEAD-EM Donations .....	10
Upcoming Conferences .....	12
Dollars & Sense: How Much Value Can a Financial Advisor Add? .....	14
Young Physicians Section News: Building Your Financial Team .....	34
AAEM/RSA President's Message: .....	35
AAEM/RSA Editor: Empathy in the Emergency Department .....	37
Resident Journal Review: Update on Contrast-Induced Nephropathy .....	38
Medical Student Council President's Message: Wellness in Medical School .....	41
Job Bank .....	

### Special Articles

Blast from the Past .....	7
Highlights of AAEM's Legal Advocacy for Emergency Physicians .....	15
Make Operations Cool (Again?) .....	21
The Most Stable Pulseless Patient You'll Ever Meet! A Clinical Update on LVADs in the ED .....	22
The Economic Power of Diversity and Inclusion to Change Policy and Culture .....	25
Promoting Wellness in Resident Physicians: A Program Directors Approach .....	30
The Role of Geriatric Emergency Care .....	31
Palliative Care Series: Coping with Death in the Emergency Department .....	32

### Updates and Announcements

Join Us in Las Vegas for AAEM19! .....	27
International Scholarship Winner .....	28
Robert L. Muelleman, MD, Elected ABEM President .....	29

### 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: \$150 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program within their first year out of residency) or \$250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program more than one year out of residency)

\*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](http://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: \$40 (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](http://www.aaem.org) or send check or money order to:

AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202 Tel: (800) 884-2236, Fax: (414) 276-3349, Email: [info@aaem.org](mailto:info@aaem.org)

## President's Message

## Due Process ... Or the Lack of It

David A. Farcy, MD FAAEM FCCM  
President, AAEM



When I speak at emergency medicine residencies nationwide about what AAEM stands for, it still amazes me that the topic of due process is poorly understood, if even considered at all.

Due process is a fundamental part of the AAEM mission statement:

*"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."*

What is due process? The physician must be provided a fair hearing with a right of appeal, in front of their peers on the medical staff, prior to the alteration, restriction or termination of their privileges to practice medicine at their hospital.

Due process is typically required by the Joint Commission, guaranteed by medical staff bylaws, and the federal Health Care Quality Improvement Act so that every physician is supposed to have due process. Physicians without due process rights may not be able to fulfill their primary duty which is to act in the best interest of their patients. Good doctors have been terminated for raising concerns about quality of care, speaking out about ED wait times, or simply pointing out that more staffing is needed to ensure the best possible care. These are not hypotheticals; AAEM has dealt with many cases where emergency physicians were terminated without a fair hearing. Due process is the difference between you getting fired on a whim versus having a designated process of your peers to review and act appropriately.

Due process rights are important for a number of reasons. First, these are our most basic rights as members of a hospital medical staff. Without fair hearing rights, emergency physicians will never be treated as equal members of a medical staff. Second, we cannot advocate effectively for our patients if we face the possibility of termination without a hearing. Finally, such termination may result in a report to the National Practitioner Databank (NPDB) creating a permanent stain on the physician's record. When a hospital terminates the medical staff privileges of a physician due to any aspect of the physician's performance or behavior, such termination constitutes a mandatory report to the NPDB. In fact, the hospital must file the report within 30 days. Failure to report the physician may result in the hospital's loss of antitrust immunity for up to three years.

For years, AAEM has recognized that due process is a patient safety issue – physicians need to be free to speak up regarding legitimate concerns. Due process should be guaranteed and NOT something that is waived. Yet far too often, emergency medicine physicians and increasingly other hospital based specialists are being forced to waive this right as a condition of their employment.

Fortunately, Congress is listening to our voices. In July, Representatives Chris Collins (R-New York), Raul Ruiz (D-California), and Pete Sessions (R-Texas) introduced H.R. 6372, federal legislation that will require the Department of Health and Human Services to promptly issue a rule that protects emergency physician due process rights, and makes them irrevocable. This bipartisan legislation has attracted the attention of House Energy & Commerce Committee Members and staff, where the bill was referred. AAEM has also convened substantive due process conversations with Senate offices and are working to further legislative efforts in that chamber.

Representatives Collins, Ruiz, and Sessions stepped forward with a solution to this problem and they have the full support of AAEM as they work to get this measure signed into law. We still need your help. Write your representatives to ask them to co-sponsor H.R. 6372. Call them. Find them in your city while they are back home campaigning for reelection. Make your best effort to get their attention and ask for their support. Your practice rights and ability to do what is best for your patients quite literally depend on it. ●

#### Additional Resources:

- Due Process information: <https://www.aaem.org/resources/key-issues/due-process>
- AAEM Lauds Introduction of Federal Due Process Legislation: <https://www.aaem.org/resources/publications/news-releases/due-process-legislation>
- AAEM Position Statement on Due Process Reaffirmed (9/01/05): <https://www.aaem.org/resources/statements/position/position-statement-on-due-process>
- AAEM Due Process White Paper (5/15/07): <https://www.aaem.org/resources/statements/position/due-process-white-paper>

#### Podcasts:

- The Hospital Peer Review Process: How it Should Really Work: <https://www.aaem.org/resources/publications/podcasts/legal-and-policy-issues-in-emergency-medicine/episode-26>
- Medical Staff v. Avera Marshall: A New Source of Physician Due Process Rights: <https://www.aaem.org/resources/publications/podcasts/legal-and-policy-issues-in-emergency-medicine/episode-22>
- Due Process Rights: The Case of a Physician Who Fought Back and Won: <https://www.aaem.org/resources/publications/podcasts/legal-and-policy-issues-in-emergency-medicine/episode-15>



June 11, 2018  
 The Honorable Seema Verma  
 Administrator, Centers for Medicare and Medicaid Services  
 7500 Security Boulevard, Baltimore, MD 21244

Dear Administrator Verma,

We, the undersigned organizations, write to express concern about the systematic violation of physician due process rights and its impact on quality patient care and patient safety. The threat of termination from a hospital medical staff without the right of a fair hearing prevents physicians from advocating for patients for fear of retribution. The growing problem of denial of due process rights is a critical quality of care issue that is impacting patients.

The right to due process is well-established in our healthcare system. They exist through the Healthcare Quality Improvement Act of 1986, and are affirmed by the Joint Commission via the Comprehensive Accreditation Manual for Hospitals, and the 14<sup>th</sup> Amendment of the U.S. Constitution.

We believe that patients and taxpayers are best served when physicians have the right to due process prior to termination from a hospital's medical staff. Physicians with due process rights are more likely to bring attention to fraudulent practices that threaten the integrity of the Medicare and Medicaid programs. They are more likely to act in the best interest of the patient when it comes to test ordering, admission decisions, and coding/billing issues. The protection of physician autonomy is a critical mechanism to protect patients, and assure physicians that they will not lose their practice rights for unfair reasons.

Whether employed by hospitals or contracted groups, emergency physicians are often deprived of their due process rights via inclusion of a "waiver of due process rights" clause in employment contracts. This can be required by the hospital, health system, or group and can occur in a variety of practice environments. Physicians are often directly or indirectly terminated with or without cause, without a fair hearing. In a recent survey of emergency physicians, more than half of respondents report having been forced to waive their right to due process rights. We believe that such contractual clauses violate the physician right to due process established by Congress, the Joint Commission, and the Constitution. For these reasons, any employed or independently contracted physician should be protected from any clause in their individual contract requiring a waiver of due process unless the group loses or terminates their group contract with the hospital or health system.

We encourage the Centers for Medicare and Medicaid Services (CMS) to consider the original intent of current policies that provide for physician due process rights and to take the next step in **guaranteeing** those rights by making them unwaivable and irrevocable. We would greatly appreciate any actions that could be taken to support these rights, including changes through the Medicare Conditions of Participation or other appropriate avenues. 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.

Thank you for your consideration and we look forward to working with you and your staff to address this important problem.

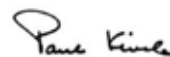
Sincerely,



David A. Farcy, MD FAAEM FCCM  
 President, American Academy of  
 Emergency Medicine



MohammedMoiz Qureshi, MD  
 President, AAEM Resident &  
 Student Association



Paul Kivela, MD MBA FACEP  
 President, American College  
 of Emergency Physicians



Charles A. McKay, MD FACMT  
 President, American College of  
 Medical Toxicology



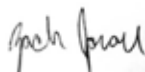
Christine F. Giesa, DO FACOEP-D  
 President, American College of  
 Osteopathic Emergency Physicians



Mark A. Baker, DO  
 President, American Osteopathic  
 Association



Christopher Doty, MD FAAEM  
 President, Council of Emergency  
 Medicine Residency Directors



Zach Jarou, MD  
 President, Emergency Medicine  
 Residents' Association



D. Mark Courtney, MD MSCI  
 President, Society for Academic  
 Emergency Medicine

From the Editor's Desk

# I'm Mad as Hell and I'm Not Going to Take It Anymore!

Andy Mayer, MD FAAEM  
Editor, *Common Sense*



"I'm as mad as hell, and I'm not going to take this anymore!"

—Howard Beale in *Network*, 1976

If you have never seen the brilliant movie, *Network*, you should find it and watch it as soon as you can.

One of the main characters is Howard Beale, a network news anchor who is slowly spinning into a disastrous emotional breakdown. Peter Finch won an Oscar for the role. In one of the most iconic scenes in American cinema, he exhorts his fellow citizens to rise up and refuse to take "this" anymore: <https://youtu.be/AS4aiA17YsM>. What does this have to do with emergency medicine?

The house of medicine is on fire, and emergency medicine's room of that house is fully involved. Where are the firemen? Do you think the federal government, state government, hospital administrators, corporate management groups, and parts of organized emergency medicine are spraying water or gasoline on this fire? There are many well-intentioned people working on America's health care problems, but it has sadly become increasingly difficult to tell which parties are interested in improving the system and which are simply trying to manipulate "reform" for their particular interests.

What should we do to advocate for what is right for our patients and our profession? Please try not to forget that you are in an honorable profession, and not simply a data entry clerk who (for now) cannot be replaced. Frankly, I think most emergency physicians are simply trying to keep their heads down and fly under the radar. This means you type mostly useless data into whichever EMR your hospital has forced on you, while trying to meet the latest and greatest quality measures put in your way, with sprinkles of Dilaudid and oxycodone dropped along the path. On top of this, many emergency physicians are never allowed to know what is billed or collected for their professional services. The corporate management group simply pats you on the head and tells you not to worry that pretty little head over all that billing stuff.

So who cares? While working your next weekend shift and missing your child's soccer game, will the administrator or contract-holder be worried about your wellbeing? The stroke and sepsis alarms will be going off and you will still have to make sure that your review of systems and medical decision-making components are complete. Your spouse or significant other may or may not understand why you are staying late to complete your charts — off the clock and unpaid. And on your next day off, you will have to respond to a complaint from a chronic pain patient who didn't feel that you fully appreciated the severity of his pain on his third ED visit of the month. My point is not to make you depressed, but to make you think.

This kind of work environment often leads to feelings of frustration, anger, and burnout. People can burn out and lose their empathy, humanity, and professionalism for reasons unrelated to medicine. However, the current burden of demands and obstacles emergency physicians face should be expected to cause burnout across the whole specialty. What can we do? Can one person or one organization fix such a badly broken system?

The growing burnout prevention and treatment toolbox may be useful to the emergency physicians who can find a wellness path that works for them, and allows them to either embrace their practice situation and feel fulfilled or become content in building a wall between their work and personal lives. Despite some rough patches, I have been able to manage a



"We cannot change stroke or sepsis protocols or patient satisfaction surveys overnight, but trying to influence the system for the sake of our patients and ourselves is important."

good work-life balance for myself. I am now 28 years in, and plan to work another five to ten years. But what percentage of emergency physicians have found a healthy path through a work environment in which they have no power, but are still held responsible for results? All the yoga, fishing, jogging, etc. in the world is not enough for many to feel good about their professional lives. The wellbeing of the individual emergency physician should be the main focus of our efforts.

So, the question is what to do — which brings me back to *Network*. Do you feel like Howard Beale? This is really about the loss of dignity we can feel in today's health care system. We worked and struggled to reach the top of the mountain, and now many of us feel betrayed.

How should emergency physicians express their discontent? Incoherent rage will accomplish little, but focused righteous anger can be put to good use. Channeling your anger for a useful purpose is often healthy and productive if directed towards a worthy goal. Working towards a goal, especially as part of a team, can help you regain a sense of professional dignity and purpose. We cannot change stroke or sepsis protocols or patient satisfaction surveys overnight, but trying to influence the system

Continued on next page

for the sake of our patients and ourselves is important. Throwing up our hands in helplessness is the path to burnout, not wellness. Righteous anger contrasts with rage, which usually has the intent to destroy. All of us know emergency physicians filled with unfocused rage. Instead of directing their frustration towards productive change, they mumble and moan and self-destruct.

Feeling isolated and alone while working in your emergency department can be counteracted by being part of a community of like professionals, with similar goals and concerns. I know many emergency physicians who work their shifts, get all their CME online, and never speak to emergency physicians from other practices and environments. In speaking to these isolated emergency physicians, I hear that their emergency department is uniquely dysfunctional, overburdened by administrative requirements, and has the world's worst patients and medical staff. Of course, this simply isn't true. We all face similar regulations, metrics, and administrative waste. The sense of community and belonging to a team of

professionals is what many are lacking, and despite a healthy home and family life they are unfulfilled professionally and burned out. Sadly, many of us do not feel like we are members of a team, but rather a cog in a slowly turning wheel — and our only remaining goal is not to be crushed by it.

That's the unhappy reality of American medicine currently, and especially emergency medicine. But don't give up hope. In my next article I will describe how to restore a sense of belonging and purpose while working as an emergency physician. ●

#### 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](mailto:info@aaem.org) or by calling 800-884-AAEM.

## Submit a Letter to the Editor

What stood out to you from this issue of *Common Sense*? Have a question, idea, or opinion? Andy Mayer, MD FAAEM, editor of *Common Sense*, welcomes your comments and suggestions. Submit a letter to the editor and continue the conversation.

Check out the redesigned *Common Sense* online at: [www.aaem.org/resources/publications/common-sense](http://www.aaem.org/resources/publications/common-sense)



Letter in response to January/February 2018 "From the Editor's Desk" article titled: *What is ACEP Thinking?*



Dr. Mayer,

It was your letter in *Common Sense* regarding the election of a non-ABEM trained president of ACEP that made me resign that organization ... I had also resigned the year they elected a VP of EmCare to one of their top leadership positions. I told ACEP that was the reason when one of the promoters called me personally to rejoin ... only the financial loss of paying members elicits real change it seems. I support your stance and thank goodness we have AAEM to represent those that become disillusioned with the larger of our professional organizations. Keep up the honest work you do.

Yours Truly,  
Leo Alonso, DO



As AAEM celebrates its 25th anniversary year, enjoy this "Blast from the Past" issue of *Common Sense* from 1993.



Page 4

## CARE FOR THE CAREGIVER

*The second in a series devoted to professional wellness.*

The Center for Physician Development in Brookline, Massachusetts evolved out of need. According to surveys done by the American Medical Association and the Robert Wood Johnson Foundation 35% to 50% of physicians surveyed would not choose a medical career if they had the opportunity to do so again. Such disturbing statistics indicate a national trend among physicians of dissatisfaction, burn out, and cynicism, all of which contribute to loss of self esteem and sense of life purpose. These issues have an impact on human relationships, family well being and security, and undoubtedly contribute to depression, substance abuse, and suicide in any population. For physicians there are the added factors of patient outcomes, quality of physician-patient interactions and medical malpractice, all of which are affected if the physician is not cared for. This is particularly true for Emergency Physicians who often find themselves practicing in isolation, in a specialty which does not provide for any emotional support, or even closure at the end of the work day or night. Emergency Medicine as a specialty suffers a greater than 12% attrition rate among practitioners, considerably higher than any other specialty, perhaps reflecting a common angst.

In 1992 the Center for Physician Development, an off-site program affiliated with Beth Israel Hospital and Harvard Medical School, was established to address the need. This program is committed to improving health care outcomes by designing support systems to maximize the clinical effectiveness, professional development, and career satisfaction of physicians. *Caring for the care giver.*

Dr. Gigi Hirsch is the founder and director of CPD. As an internist-psychiatrist and former Emergency Physician she has taken the lessons of her personal odyssey of burn out and disillusionment to create a vehicle of support and hope for the physician. Dr. Hirsch states that

*the "culture of medicine" encourages blaming the stressed physician for being inadequate and maladaptive, rather than addressing the sources and causes for professional unhappiness. She goes on to say, "The social scientists say that almost everyone, given the right set of environmental conditions will burn out." In medicine, however, the distressed physician is the defective physician. Medicine also tends to point fingers at trends outside of the profession as the source of our discontent; for example, the insurance industry, managed care, consumer movements, and government involvement. "It's the medical culture that makes it difficult for us to organize and communicate with each other and respond to the changes which are coming from the outside. We need to look at the cultural traits that make it hard for us to cope right now." One cultural culprit, Dr. Hirsch says, is the concept of the "patient comes first. But I disagree, and say that*

*"... if we don't take care of ourselves, we cannot reliably take care of our patients because of the toll that self-negligence will take on us."*

It is an irony that those of us involved in EMS and rescue training programs emphasize the importance of not endangering the rescuer. The endangered paramedic or EMT adds to the casualty count as well as complicating subsequent rescue maneuvers. We physicians do not follow our own dictates. We endanger our physical and emotional well being while pursuing our "careers."

We all remember the **crucible of residency**. In return for temporary self denial and an altruistic goal, we were promised a life work rewarded with respect, professional status, collegiality, financial security, and autonomy. For many, particularly for Emergency

Physicians, *the promise has never been fulfilled*. In confusion and disillusionment, we believe that the solution is to work harder and longer and more conscientiously. We become more alienated and more disillusioned when it is apparent that our ingrained coping skills do not produce the results we seek. Dr. Hirsch advises that we view our discontent as a career juncture rather than a career failure. This can be a signal to step back, reassess and reorient, and perhaps for the first time in our lives make conscious decisions and choices which support us as persons as well as physicians.

### **For every crisis there is an opportunity.**

The varied crises occurring in the Emergency Department and our interest and ability to address them rapidly and effectively brought us to Emergency Medicine in the first place. The crisis of the acute myocardial infarction gives us the opportunity to use our knowledge and dexterity to save a life. The occurrence of a complication during that intervention requires that we reassess and make other management choices. So it is with our lives and our work.

The CPD offers a variety of programs and consultants for the clinician. Balint groups in continuing medical education is one such program. Balint groups bring together physicians and a psychoanalyst as group leader to discuss difficult physician-patient relationships, and emotionally disturbing cases; to provide support and feedback in relationships with administrators, families, and colleagues; to address issues of burn out and stress. Programs similar to the CPD are being developed elsewhere. Dr. John Henry Pffferling established the Center for Professional Well Being in Durham, NC in 1979. Many managed care programs are now viewing the physician as an investment and see the value of addressing physician wellness. This is a welcome change in the attitude expressed by a medical director of a large regional HMO: *"It's not our job to provide them [doctors] with supports. The hospitals will handle those things. Or the professional societies... or the doctors themselves. If a doctor is having problems it usually shows up in our utilization review process. And then we just get rid of them."* Teaching hospitals and medical schools are now filling in this massive gap in medical training. Residents will learn how to learn from each other and how to facilitate each others work. This must occur with all physicians, for the benefit of our families, patients, and ourselves.

The Center for Physician Development  
1 Brookline Place, Suite 426  
Brookline, Massachusetts 02146  
TEL: (617) 735 2999 FAX: (617) 278-77570

Phyllis J. Troia, MD, Board of Directors  
**American Academy of Emergency Medicine**  
Emergency Medicine Relief Services

### **AAEM MISSION STATEMENT**

**T**he American Academy of Emergency Medicine is the specialty society of Emergency Medicine. AAEM is a democratic organization committed to the following principles:

- ¶ Every individual should have unencumbered access to quality emergency care provided by a specialist in Emergency Medicine.
- ¶ A specialist in Emergency Medicine is a physician who has achieved, through personal dedication and sacrifice, certification by the American Board of Emergency Medicine.
- ¶ The practice of Emergency Medicine is best conducted by a specialist in Emergency Medicine.
- ¶ The Academy supports the growth of 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 patient.
- ¶ The personal and professional welfare of the individual specialist in Emergency Medicine is a primary concern to the AAEM.
- ¶ 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.

# AAEM Foundation Contributors – Thank You!



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 1-1-2018 to 7-3-2018.

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.

## Contributions \$1,000-\$1,500

Robert M. McNamara, MD MAAEM FAAEM  
David G. Srour, MD FAAEM  
Christopher P. Visser, MD FAAEM

## Contributions \$500-\$999

Thomas R. Tobin, MD MBA FAAEM  
Larry D. Weiss, MD JD MAAEM FAAEM

## Contributions \$250-\$499

Brian C. Adams, MD  
Michael R. Burton, MD FAAEM  
Armando Clift, MD FAAEM  
William T. Durkin, Jr., MD MBA MAAEM  
FAAEM  
Mark A. Foppe, DO FAAEM FACOEP  
Christopher R. Grieves, MD FAAEM  
Victor S. Ho, MD FAAEM  
Shammi R. Kataria, MD FAAEM  
Bruce E. Lohman, MD FAAEM  
Michelle S. Nathan, MD FAAEM  
Isaac A. Odudu, MD FAAEM  
James Y. Park, DO FAAEM  
Steven Pasternak, MD FAAEM  
Howard M. Rigg III, MD FAAEM  
James Francis Rowley III, MD FAAEM  
Chester D. Shermer, MD FAAEM  
Keith D. Stamler, MD FAAEM  
David R. Steinbruner, MD FAAEM  
William E. Swigart, MD FAAEM  
Jalil A. Thurber, MD FAAEM  
Mary Ann H. Trephan, MD FAAEM  
Roland S. Waguespack III, MD FAAEM  
George Robert Woodward, DO FAAEM  
Zhao Yan, MD

## Contributions \$100-\$249

Jamie J. Adamski, DO FAAEM  
Halleh Akbarnia, MD FAAEM  
Justin P. Anderson, MD FAAEM  
Jennifer L. Baker, MD FAAEM  
Bradley E. Barth, MD FAAEM  
Mark Alden Batts, MD FAAEM  
Dale S. Birenbaum, MD FAAEM FACEP  
Erik Campbell, MD  
John W. Cartier, MD FAAEM  
Shu B. Chan, MD MS FAAEM  
Robert Lee Clodfelter Jr., MD FAAEM  
Benjamin W. De Witt, MD FAAEM  
Francis X. Del Vecchio, MD FAAEM  
Tyler Dickey, MD FAAEM  
David A. Farcy, MD FAAEM FCCM  
Ugo E. Gallo, MD FAAEM  
Frank Gaudio, MD FAAEM  
Albert L. Gest, DO FAAEM  
Daniel V. Girzadas Jr., MD RDMS FAAEM  
Emily Gorman, MD FAAEM  
Michael N. Habibe, MD FAAEM  
Neal Handly, MD FAAEM  
Hillary Harper, MD FAAEM FACEP  
Kathleen Hayward, MD FAAEM  
Christopher C. Hill, DO FAAEM  
Patrick B. Hinfey, MD FAAEM  
Kyle Howell, MD FAAEM  
Irving P. Huber, MD FAAEM  
Kathleen P. Kelly, MD FAAEM  
Adam Edwin Kennah, MD FAAEM  
Hyo J. Kim, MD FAAEM  
Louis King, MD FAAEM  
Stephanie Kok, MD FAAEM  
Chaiya Laoteppitaks, MD FAAEM  
David W. Lawhorn, MD MAAEM FAAEM

Stanley L. Lawson, MD FAAEM  
Theodore G. Lawson, MD FAAEM  
Linh T. Le, MD FAAEM  
John S. Lee, MD FAAEM  
R. Sean Lenahan, MD FAAEM  
Tim Lenz, MD FAAEM  
Christopher A. Lipinski, MD FAAEM  
Michael Malik, MD FAAEM  
John R. Matjucha, MD FAAEM  
Joanna Mercado-Alvarado, MD FAAEM  
Benson G. Messer, MD FAAEM  
Rachel Metz, MD FAAEM  
Daniel P. Montemayor, MD FAAEM  
Deborah R. Natale, MD FAAEM  
Melissa Natale, MD FAAEM  
David Nguyen, MD  
Juan M. Nieto, MD FAAEM  
Oyinkansola Okubanjo, MD  
Travis Omura, MD FAAEM  
Hector L. Peniston-Feliciano, MD FAAEM  
Gianna Petrone, MD  
David Pillus, MD FAAEM  
Jeffery M. Pinnow, MD FAAEM FACEP  
Matthew C. Ponder, MD FAAEM  
David C. Portelli, MD FAAEM  
Tracy R. Rahall, MD FAAEM  
Scott A. Rammig, MD FAAEM  
Jeffrey A. Rey, MD FAAEM  
Charles Richard, Jr., MD FAAEM  
James E. Ross Jr., MD FAAEM  
Sherri L. Rudinsky, MD FAAEM  
Nate T. Rudman, MD FAAEM  
Brad L. Sandleback, MD FAAEM  
Eric M. Sergienko, MD FAAEM  
Rakesh Singh, MD FAAEM  
Douglas P. Slabaugh, DO FAAEM

Donald L. Snyder, MD FAAEM  
Marc D. Squillante, DO FAAEM  
Robert E. Stambaugh, MD FAAEM  
Charles C. Stephens, MD  
Joshua B. Stierwalt  
Stephen A. Swisher, MD FAAEM  
Mark J. Tamsen, MD FAAEM  
Kay Whalen, MBA CAE  
Joanne Williams, MD FAAEM  
R. Lee Williams, MD FAAEM  
Janet Wilson, CAE  
Patrick G. Woods, MD FAAEM  
Marissa Shannon Cohen Zwiebel, MD

## Contributions up to \$50

Gaston A. Costa, MD  
Timothy J. Durkin, DO FAAEM  
Joseph Flynn, DO FAAEM  
Paul W. Gabriel, MD FAAEM  
Brad S. Goldman, MD FAAEM  
Neil Gulati, MD FAAEM  
Huda A. Karman, MD  
Benjamin Lerman, MD FAAEM  
Gregory S. McCarty, MD FAAEM  
Jonathan W. Meadows, DO MS MPH CPH  
Newsha Meyari  
Elizabeth A. Moy, MD FAAEM  
Brian P. Murray, DO  
Kevin C. Reed, MD FAAEM  
George J. Reimann, MD FAAEM  
Louis L. Rolston-Cregler, MD FAAEM  
Brendan P. Sheridan, MD FAAEM  
Henry E. Smoak III, MD FAAEM  
Mehrdad Soleimani, MD FAAEM  
Lisa R. Stoneking, MD FAAEM  
Shreni N. Zinzuwadia, MD ●

## Donate to the AAEM Foundation!

Visit [www.aaem.org](http://www.aaem.org) or call 800-884-2236 to make your donation.



# AAEM PAC Contributors – Thank You!

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 **1-1-2018 to 7-23-2018**.

## Contributions \$1,000-\$1,500

David G. Srouf, MD FAAEM

## Contributions \$500-\$999

Michael R. Burton, MD FAAEM

William T. Durkin, Jr., MD MBA MAAEM  
FAAEM

David A. Farcy, MD FAAEM FCCM

Thomas R. Tobin, MD MBA FAAEM

## Contributions \$250-\$499

Armando Clift, MD FAAEM

Mark A. Foppe, DO FAAEM FACOEP

Erik S. Fossum, MD FAAEM

Christopher R. Grieves, MD FAAEM

Christopher C. Hill, DO FAAEM

Victor S. Ho, MD FAAEM

Shammi R. Kataria, MD FAAEM

Kathleen P. Kelly, MD FAAEM

James F. Kenny, MD FAAEM

Robert E. Leyrer, MD FAAEM

Michelle S. Nathan, MD FAAEM

Isaac A. Odudu, MD FAAEM

James Y. Park, DO FAAEM

David C. Portelli, MD FAAEM

Charles Richard, Jr., MD FAAEM

James Francis Rowley III, MD FAAEM

Chester D. Shermer, MD FAAEM

Keith D. Stamler, MD FAAEM

Roland S. Waguespack III, MD FAAEM

George Robert Woodward, DO FAAEM

## Contributions \$100-\$249

Leonardo L. Alonso, DO FAAEM

Justin P. Anderson, MD FAAEM

Jeffrey R. Barnes, MD FAAEM

John W. Cartier, MD FAAEM

Francis X. Del Vecchio, MD FAAEM

Ugo E. Gallo, MD FAAEM

Steven H. Gartzman, MD FAAEM

Albert L. Gest, DO FAAEM

Daniel V. Girzadas Jr., MD RDMS FAAEM

Kathleen Hayward, MD FAAEM

Patrick B. Hinfey, MD FAAEM

John D. Howard, MD FAAEM

Mercy M. Hylton, MD FAAEM

Chaiya Laoteppitaks, MD FAAEM

Linh T. Le, MD FAAEM

Lawrence Martin Lewis, MD

Christopher A. Lipinski, MD FAAEM

Bruce E. Lohman, MD FAAEM

Mimi Lu, MD FAAEM

Benson G. Messer, MD FAAEM

Melissa Natale, MD FAAEM

Long Nguyen, MD FAAEM

Hector L. Peniston-Feliciano, MD FAAEM

Tracy R. Rahall, MD FAAEM

Jeffrey A. Rey, MD FAAEM

James E. Ross Jr., MD FAAEM

Nate T. Rudman, MD FAAEM

H. Edward Seibert, MD FAAEM

Brendan P. Sheridan, MD FAAEM

Douglas P. Slabaugh, DO FAAEM

David R. Steinbruner, MD FAAEM

Arlene M. Vernon, MD FAAEM

Christopher P. Visser, MD FAAEM

## Contributions up to \$50

Bradley E. Barth, MD FAAEM

Timothy J. Durkin, DO FAAEM

Peter W. Emblad, MD FAAEM

Neil Gulati, MD FAAEM

Adam Edwin Kennah, MD FAAEM

Frederick Kotalik, MD FAAEM

Jonathan Y. Lee, MD FAAEM

Gregory S. McCarty, MD FAAEM

Jason J. Morris, DO FAAEM

Elizabeth A. Moy, MD FAAEM

Brian P. Murray, DO

Louis L. Rolston-Cregler, MD FAAEM

Linda Sanders, MD

Marc D. Squillante, DO FAAEM ●

## Standing Up for You, Standing Up for EM

AAEM is the champion of the emergency physician. For over 25 years, we've protected board certification and supported equitable practice environments to allow you to deliver the highest quality of patient care.

## Renew for 2019 Today!

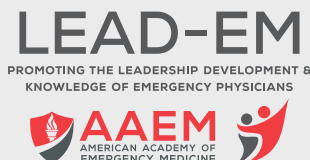
As a member of AAEM, you're part of a growing network of physicians from all over the U.S. and from all practice environments, committed to enhancing the EM specialty together.

[www.aaem.org/renewaaem](http://www.aaem.org/renewaaem)

### NEW for 2019:

Multi-year discounts available for full voting members when you sign up for 3 or more years.

# LEAD-EM Contributions – Thank You!



The AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM) was established after the tragic and unexpected death of AAEM president, Dr. Kevin G. Rodgers.

The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from 1-1-2018 to 7-23-2018.

## Contributions \$1,000-\$1,500

Association of Academic Chairs of  
Emergency Medicine  
Society for Academic Emergency Medicine

## Contributions \$500-\$999

Emergency Medicine Resident and Student  
Association

David A. Farcy, MD FAAEM FCCM  
Robert A. Frolichstein, MD FAAEM  
Jonathan S. Jones, MD FAAEM  
Bobby Kapur, MD MPH FAAEM  
Andrew P. Mayer, MD FAAEM  
Robert M. McNamara, MD MAAEM FAAEM  
Mark Reiter, MD MBA FAAEM  
Thomas R. Tobin, MD MBA FAAEM  
Kay Whalen, MBA CAE

## Contributions up to \$250-\$499

Brian C. Adams, MD  
Mustafa H A Al Kazaz, FRCS  
Pankaj Arora, MD MBBS FACEM  
Fayaz Ahmad Dar, MD  
John J. Grabher, MD  
Shahul Hameed, MD  
Gennady Katz, MD  
Amin Antoine Kazzi, MD MAAEM FAAEM  
Mohammed Faisal Kunhi Moideen Kutty, MD  
Joanna Lynn Balmores Leal, MD  
Vincelli L. Leal, MD

Jarmo M. Lehtonen  
Mohamed Mazen, MD  
Steven Pasternak, MD FAAEM  
Colin R. Pearson, MD  
Juha Peltonen, MD  
Brian R. Potts, MD MBA FAAEM  
Terri Prest, MD FACEM  
Andrus Rummelgas, MD  
Clement Stegen, MD  
Kristina Noelle Tune, MD  
Jukka P. Vaahersalo  
Spice Aura Villa, MD  
Ashley Wivel, MD FAAEM  
Peter J. Wyllie, MD

## Contributions \$100-\$249

Elizabeth S. Atkinson, MD FAAEM  
Heatherlee Bailey, MD FAAEM FCCM  
Sudhir Baliga, MD FAAEM  
Melissa Ann Barton, MD FAAEM  
Kevin H. Beier, MD FAAEM  
Mary Jane Brown, MD FAAEM  
Michael Brown, MD FAAEM  
Rebecca K. Carney-Calisch, MD FAAEM  
Amy F. Church, MD FAAEM  
Armando Cliff, MD FAAEM  
Nancy E. Conroy, MD FAAEM  
Gaston A. Costa, MD  
Robert L. Dickson, MD FAAEM  
Noah Einstein, MD

Angel Feliciano, MD FAAEM  
Deborah M. Fernon, DO FAAEM  
Timothy J. Fortuna, DO FAAEM  
Darcy E. Goldfarb, MD FAAEM  
Katrina Green, MD FAAEM  
Emily E. Gundert, MD FAAEM  
Neal Handly, MD FAAEM  
Dennis P. Hanlon, MD FAAEM  
Kathleen Hayward, MD FAAEM  
Mel E. Herbert, MD FAAEM  
Robyn Hitchcock, MD FAAEM  
Andrew LP Houseman, MD PhD FAAEM  
Mercy M. Hylton, MD FAAEM  
Heather L. Jimenez, MD FAAEM  
Michael D. Jones, MD FAAEM  
John C. Kaufman, MD FAAEM  
Stanley L. Lawson, MD FAAEM  
Christopher A. Lipinski, MD FAAEM  
Shahram Lotfipour, MD MPH FAAEM FACEP  
Tatiana M. Mamantov, MD FAAEM  
Jose L. Martinez, Jr., MD FAAEM  
Rick A. McPheeters, DO FAAEM  
Joel A. Miller, MD FAAEM  
Joel L. Moll, MD  
Deborah R. Natale, MD FAAEM  
Vicki Norton, MD FAAEM  
Timothy J. O'Brien, MD FAAEM  
Frank B. Parks, DO FAAEM FACEM FAWM  
Thomas A. Richardson, MD FAAEM

Mark Riddle, DO FAAEM  
Louis L. Rolston-Cregler, MD FAAEM  
James E. Ross Jr., MD FAAEM  
Tom Scaletta, MD MAAEM FAAEM  
Evan Scott, MD FAAEM  
Eric M. Sergienko, MD FAAEM  
Robert E. Suter, DO MHA FAAEM  
Michael E. Takacs, MD MS FAAEM  
Mary Ann H. Trephan, MD FAAEM  
Andrej Urumov, MD FAAEM  
Stephen N. Van Roekel, DO FAAEM  
Chad Viscusi, MD FAAEM  
Elizabeth Weinstein, MD FAAEM FAAP  
Janet Wilson, CAE  
Harry Charles Wolf IV, MD FAAEM  
Andrea L. Wolff, MD FAAEM  
Regan Wyllie, MD FAAEM

## Contributions up to \$50

Bryan Beaver, MD FAAEM  
Jeremy G. Berberian, MD FAAEM  
Danielle S. Davis  
Joseph Flynn, DO FAAEM  
Neil Gulati, MD FAAEM  
Fred E. Kency, Jr., MD  
Mark Liao, MD  
Jonathan W. Meadows, DO MS MPH CPH  
Linda Sanders, MD  
Mehrdad Soleimani, MD FAAEM ●



## There are over 40 ways to get involved with AAEM

Dive deeper with AAEM by joining a committee, interest group, task force, section, or chapter division of AAEM. Network with peers from around the U.S. sharing your clinical and/or professional interests or meet-up on the local level with members in your state.

Visit the AAEM website to browse the 40+ groups you can become a part of today.

**Get Started!**

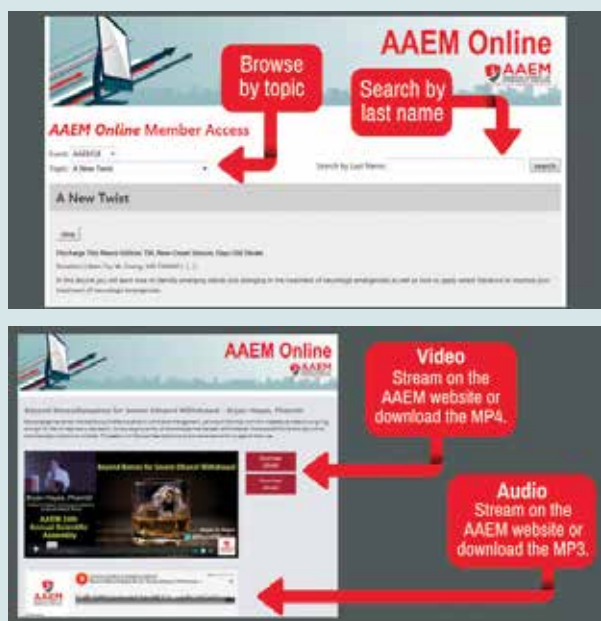
[www.aaem.org/get-involved](http://www.aaem.org/get-involved)



## AAEM18 is Now Available on AAEM Online!

Didn't get a chance to make it to AAEM18 or missed a couple lectures that you really wanted to see? AAEM Online is a FREE member's only benefit that allows you to stream video or audio from past AAEM scientific assemblies online, or download the MP3 or MP4 files.

### Browse the AAEM Online Catalog



## Other Featured Topics

Watch lectures on topics such as: Abdominal, Addiction Medicine, Behavioral Health, Cardiovascular, Care of Terminally Ill/End-of-Life Care, Chief Complaint, Child Abuse, Controlled Substance Prescribing, Critical care, Cultural Competency, Cutaneous, EM Careers, EMS, Endo/Metabolic, ENT, Financial, Infectious Disease, Geriatrics, Heme/Onc, Imaging, Immune System, Medical Ethics, Medicolegal, MSK, Neuro, OB/Gyn, Pain Management, Patient Safety, Pediatrics, Pharmacology/Devices, Practice of EM, Psych, Pulmonary, Renal, Risk Management, Suicide Assessment/Management, Systemic Infectious, Technology, Thoracic-Respiratory, Trauma, Ultrasound, Wellness, and WMD/Bioterrorism.



Start Watching

Watch • Listen • Download • FREE

## AAEM18 Plenary Sessions

- On the Frontlines: Understanding Violence in America - Roger A. Mitchell Jr., MD
- Pain and the Poppy: Managing Pain and Opioid Misuse During an Epidemic - Reuben J. Strayer, MD FRCP FAAEM
- Don't Make Me Blue! Mechanical Ventilation Choices in the Emergency Department that Change Outcomes - Peter M.C. DeBlieux, MD FAAEM
- What's New in Pediatrics - Mimi Lu, MD FAAEM
- Keeping Up With the Literature: Resuscitation - Corey M. Slovis, MD FAAEM FACP FACEP
- Critical Care Year in Review - Haney Mallema, MD FAAEM
- Keeping Up With the Literature: Knowledge Translation 2018 - Ryan P. Radecki, MD MS FAAEM
- Emergency Cardiology Literature Update: The Articles You've Got to Know! - Amal Mattu, MD FAAEM
- Avoiding Burnout: Better Living Through Boundaries - Susan R. O'Mara, MD FAAEM

Log-in and Start Watching Today!

[www.aaem.org/aaem-online](http://www.aaem.org/aaem-online)



# Upcoming Conferences: AAEM Directly, Jointly Provided & 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](http://www.aaem.org/education/aaem-recommended-conferences-and-activities).

## AAEM Conferences

### March 9-13, 2019

25th Annual Scientific Assembly – AAEM19  
Caesars Palace, Las Vegas, NV  
[www.aaem.org/AAEM19](http://www.aaem.org/AAEM19)

## AAEM Recommended Conferences

### October 26-28, 2018

The Difficult Airway Course: Emergency™  
New Orleans, LA  
[www.theairwaysite.com](http://www.theairwaysite.com)

### November 3-4, 2018

Lao People's Democratic Republic Emergency  
Medicine Conference  
Vientiane, Vientiane Capital, Lao PDR

### November 9-11, 2018

The Difficult Airway Course: Emergency™  
San Francisco, CA  
[www.theairwaysite.com](http://www.theairwaysite.com)

### November 11-14, 2018

Myanmar Emergency Updates 2018  
Yangon, Myanmar

### December 11-12, 2018

ACMT 2018 Seminar in Forensic Toxicology,  
"Opioids, Toxicology, and the Law: Medical-  
Legal Aspects of the Opioid Epidemic"  
Chemical Heritage Foundation - Philadelphia,  
PA  
[http://www.acmt.net/2018\\_ACMT\\_Seminar\\_in\\_Forensic\\_Toxicology.html](http://www.acmt.net/2018_ACMT_Seminar_in_Forensic_Toxicology.html)

### January 17-18, 2019

The University of Texas MD Anderson Cancer  
Center 2019 Oncologic Emergency Medicine  
Conference  
Houston, TX  
<https://www.mdanderson.org/education-training/professional-education/cme-conference-management/conferences/oncologic-emergency-medicine-conference.html>

### January 21-25, 2019

Puerto RicoFEST 2019  
San Juan, Puerto Rico  
<https://www.puertoricofest2019.com/>

### March 29-31, 2019

The Difficult Airway Course: Emergency™  
San Diego, CA  
<https://theairwaysite.com/>

### April 26-28, 2019

The Difficult Airway Course: Emergency™  
Boston, MA  
<https://theairwaysite.com/>

### May 17-19, 2019

The Difficult Airway Course: Emergency™  
Orlando, FL  
<https://theairwaysite.com/>

### September 13-15, 2019

The Difficult Airway Course: Emergency™  
Seattle, WA  
<https://theairwaysite.com/>

### October 4-6, 2019

The Difficult Airway Course: Emergency™  
Chicago, IL  
<https://theairwaysite.com/>

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Rebecca Sommer to learn more about the AAEM approval process: [rsommer@aaem.org](mailto:rsommer@aaem.org). All jointly provided and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

## Remarkable Testimony – Call for Case Submissions

**Purpose:** to make known to the emergency medicine community due process cases that are notable and to highlight those physicians whose testimony in malpractice actions is remarkable for any reason.

Emergency physicians who are aware of appropriate testimony are invited to submit the cases for submission.

Visit [www.aaem.org/aaemtestimony](http://www.aaem.org/aaemtestimony) to learn more and submit.



# ByteBloc Software

Scheduling Emergency Providers Since 1989



- ✓ Highly flexible
- ✓ Automates scheduling
- ✓ Saves time and money
- ✓ Mobile & web support
- ✓ Trade, split, and give away shifts
- ✓ Extensive reporting & payroll support
- ✓ Track requests, vacations, and worked hours
- ✓ And many more...

For a free trial, visit us at [www.bytebloc.com](http://www.bytebloc.com)

## Dollars &amp; Sense

# How Much Value Can a Financial Advisor Add?

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



I manage most of my finances, but I regularly get help from a Certified Financial Planner from Vanguard. I figure that it can only help to get an expert second opinion.

If you are one of those do-it-yourselfers who doesn't use a financial advisor, have you ever wondered if you should? If you did use one, how much value could they add, if any, to what you are already doing?

I recently stumbled upon a Vanguard paper for financial advisors from 2016 entitled "Putting a Value on Your Value - Quantifying Vanguard Advisor's Alpha." Remember, this paper is written for financial advisors, and it is talking about their "alpha."

## What's Alpha?

Investopedia defines alpha as:

"Alpha is used in finance as a measure of performance. Alpha, often considered the active return on an investment, gauges the performance of an investment against a market index or benchmark which is considered to represent the market's movement as a whole. The excess return of an investment relative to the return of a benchmark index is the investment's alpha."

To me, a financial advisor's alpha would be the excess return they can add to your portfolio when you hire them versus if you just managed your investment portfolio yourself.

## So What's Their Alpha?

In the paper, Vanguard estimates that advisors following their recommendations can add about 3 percent of net value. Three percent of additional return compounded over your investing lifetime could add significant value to your portfolio.

If I invested \$18,500 per year (the maximum I can put in my government retirement account) for 30 years and earned 4% annually, I'd have about \$1,037,000. If I earned 3 percent more (7 percent), I'd have about \$1,747,000, a difference of \$710,000. This is a simple example, but it can show you how small percentages can add up over time.

## How Do They Add This Value?

The paper points out a number of ways they add value, including:

- Providing wealth management with financial planning, discipline, and guidance.
- Providing sound advice during market highs and lows, helping investors avoid poor investor behavior like chasing market performance and buying high or overreacting and selling low.
- By following the sound investment principles espoused by Vanguard (which many advisors and do-it-yourselfers don't follow).

The sound Vanguard investment principles mentioned in that last bullet are the provision of:

- A suitable asset allocation using broadly diversified mutual or exchange-traded funds.
- Cost-effective implementation with a focus on low expense ratios.
- Assistance with rebalancing.
- Behavioral coaching.
- Optimized asset location.
- A proper spending/withdrawal strategy.
- A focus on total-return instead of income investing.

## The Caveats

There are a few caveats to the value an advisor can add. Most investors assume that an advisor will add value by trying to beat the market return, but that is so difficult that almost no one can succeed. They generate too many extra investment and trading costs trying to do it.

In addition, in the paper they talk about how an advisor who deviates from a standard portfolio (which is diversified, low-cost, and market-cap weighted) runs a higher risk of losing their clients due to significantly inferior investment returns.

The value added by an advisor is not consistent. The value they add is intermittent, most often during market highs or lows, also described as "lumpy" in the paper.

The value they add is not easily quantified, which presents a real problem for advisors when trying to demonstrate their worth.

## The Bottom Line

Vanguard feels that advisors following their methodology can add about 3% of alpha (or excess investment return) per year, concentrated during period of market highs and lows that tend to cause poor investment behavior. Some of the value provided by advisors is not quantifiable, though, such as the piece-of-mind provided by knowing you obtained expert help.

As I said in the beginning, I'm largely a do-it-myselfer, but appreciate the periodic second opinion that my Vanguard advisors provide.

If you'd like to contact me, please e-mail me at [jschofer@gmail.com](mailto:jschofer@gmail.com) or check out the two blogs I write for, [MCCareer.org](http://MCCareer.org) and [MilitaryMillions.com](http://MilitaryMillions.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. ●*



# Highlights of AAEM's Legal Advocacy for Emergency Physicians

Mark Reiter, MD MBA FAAEM, AAEM Past President  
Robert McNamara, MD MAAEM FAAEM, AAEM Past President  
Howard Blumstein, MD FAAEM, AAEM Past President



In the 25 years since AAEM's founding, the Academy has been very active in advocacy and legal efforts on behalf of individual emergency physicians and independent groups. AAEM continues to be the only emergency medicine (EM) professional society ever to take legal action against contract management groups (CMGs) in defense of emergency physicians. The Academy's willingness to put the interests of individual emergency physicians over corporate interests has had a major impact on our specialty.

## Corporate Practice of Medicine

### Catholic Healthcare West (CHW) and Emergency Physician Medical Group (EPMG)

In 1997, CHW, one of the largest hospital chains in the country, announced the purchase of EPMG, a privately held emergency medicine (EM) group. For the first time, a large hospital system had taken over a large EM group, converting hundreds of private practice emergency physicians into hospital employees. The \$36 million purchase price was to be recouped by CHW from revenue taken from the professional fees of those emergency physicians. EPMG's principal owners earned millions of dollars on the sale, and were then given jobs in the new CHW managed services organization, Meriten, which was essentially a contract management group. All current EPMG physicians — staffing eight of the 37 CHW hospitals — immediately became part of Meriten. Even more concerning, the independent emergency physician groups staffing the 29 CHW hospitals that were not part of EPMG were to be forced under the control of Meriten, which planned to take a 28% fee from its emergency physicians' fees for expenses and profit.

With 29 contracts at risk, the regional implications were profound. AAEM also recognized national implications, as every large hospital system would see the opportunity to control and profit from their emergency physicians. After AAEM wrote letters of concern to the board of CHW, CHW in turn threatened AAEM. Undeterred and with AAEM's help, the practicing emergency physicians of CHW organized into the Affiliated Catholic Healthcare Physicians (ACHP). With the support of AAEM, ACHP — along with the California Chapter of AAEM and the California Medical Association (CMA) — filed a lawsuit alleging violations of corporate

practice of medicine (CPOM) and fee-splitting laws. The CMA recognized both the threat to emergency physician autonomy and the wider threat, as Meriten would also be positioned to control other hospital-based specialists. ACEP was asked to participate in these actions but declined, saying it was a private business matter.

The amicus curiae (friend of the court) brief filed by AAEM in this case can be found here: [http://www.aaem.org/UserFiles/CAAmicusBriefCHWcase\\_2\\_.pdf](http://www.aaem.org/UserFiles/CAAmicusBriefCHWcase_2_.pdf).

After initial court hearings seemed to go against it, CHW sold EPMG back to its original owners, who then reorganized EPMG into a fairer, independent, physician-owned group. If CHW had been successful in this endeavor it would have opened the door to other hospital chains taking over emergency physician groups large and small, dipping into emergency physicians' professional fees as a new source of revenue, and dramatically reducing the number of private EM groups. AAEM, at the time a fledgling organization, was the only EM society willing to stand with the ACHP physicians. This stand changed the course of EM in California. In the aftermath of this failed attempted takeover of EM, the chief medical officer (CMO) and chief executive officer (CEO) of CHW both resigned.



AAEM continues to be the only emergency medicine (EM) professional society ever to take legal action against contract management groups (CMGs) in defense of emergency physicians.

The links below are further readings on this matter:

- <https://www.aaem.org/resources/key-issues/corporate-practice/epmg-purchases-meriten-from-chw>
- <https://www.aaem.org/resources/key-issues/corporate-practice/aaem-open-letter-west-coast-eps>
- <https://www.aaem.org/resources/key-issues/corporate-practice/eps-resist-takeover-of-epmg>
- <https://www.aaem.org/resources/key-issues/corporate-practice/amicus-curiae-achp-suit>
- <https://www.aaem.org/resources/key-issues/corporate-practice/chw-resign>

Continued on next page

## Restrictive Covenants

### Mount Diablo Hospital (MDH), California Emergency Physicians (CEP), and TeamHealth

In 2003, Quantum Health, a subsidiary of TeamHealth, the second largest EM contract management group (CMG) in the United States, lost its contract at Mount Diablo Hospital in Concord, California to CEP. Three of the emergency physicians there wanted to continue working at MDH, where they had each been on staff for years. One was even a former Medical Staff President. In response, Quantum Health filed suit against these doctors, seeking damages from them for their supposed role in the loss of the contract. The emergency physicians went to ACEP for help and were told, as in the CHW matter, that it was a private business matter. They then came to AAEM and were provided advice, support, and legal assistance. The doctors joined AAEM in a counter-suit against TeamHealth, alleging that TeamHealth was using corporate subsidiaries to hide its violation of California's prohibition on the corporate practice of medicine (CPOM). AAEM sought a declaratory judgment, requesting that all ED staffing contracts held by TeamHealth subsidiaries in California be voided, in light of California's CPOM laws. This counter-suit was the first legal action ever taken against a CMG by an EM professional society.

All parties reached a settlement whereby TeamHealth dropped its lawsuits against the emergency physicians, who were able to continue working at MDH, and AAEM dropped its lawsuit against TeamHealth for violating California CPOM laws. In 2005, AAEM assisted in similar cases in Rhode Island and Indiana, also with favorable outcomes.

A copy of the AAEM counter-suit can be found here: [http://www.aaem.org/UserFiles/AAEMTeamHealthComplaint-Intervention\\_2\\_.pdf](http://www.aaem.org/UserFiles/AAEMTeamHealthComplaint-Intervention_2_.pdf).

Read the full story from *Emergency Medicine News* here: [https://journals.lww.com/em-news/Fulltext/2004/03000/AAEM\\_Sues\\_Team\\_Health\\_for\\_Corporate\\_Practice\\_of.1.aspx](https://journals.lww.com/em-news/Fulltext/2004/03000/AAEM_Sues_Team_Health_for_Corporate_Practice_of.1.aspx).

## CMGs and Malpractice Coverage

### PhyAmerica Bankruptcy

In 2003, PhyAmerica, one of the largest CMGs, went bankrupt. In 2004, Sterling Healthcare, another large contract management group, purchased PhyAmerica's bankrupt assets, including its ED contracts. PhyAmerica then told its emergency physicians that their self-insured medical malpractice/legal defense fund had been exhausted. 200 PhyAmerica emergency physicians who had already been sued were told they no longer had malpractice coverage, and must pay all attorney fees and legal judgments out of their own pockets. And of course, PhyAmerica emergency physicians had no malpractice coverage for future suits. In response, AAEM organized a Working Group from among the affected emergency physicians, handled logistics, and offered free legal counsel. The Academy also filed an amicus curiae brief before the Baltimore Bankruptcy Court.

In April of 2005 a court order guaranteeing the protection of the physicians' personal assets was handed down. AAEM also negotiated with Sterling Healthcare for partial reimbursement of the emergency physicians' legal costs.

## Corporate Practice of Medicine

### Emergency Physicians Professional Association (EPPA) and EmCare

In 2004, EmCare, the largest emergency medicine CMG, acquired the contract at Methodist Hospital in St. Louis Park, Minnesota. EPPA, a private democratic group serving the hospital since 1969, was not even told the contract was up for bid until after the contract was awarded to EmCare. No request for proposals was issued. EPPA's physicians initially reached out to ACEP for support through its state chapter, but were told this was not allowed by national ACEP. EPPA then asked AAEM for help. AAEM Past President, Dr. Robert McNamara flew to Minnesota and met with nearly 100 emergency physicians. The Academy offered legal counsel, went to the hospital on EPPA's behalf, and filed complaints with the state attorney general and Board of Medicine. In December of 2004, AAEM and EPPA jointly filed suit against EmCare for violating CPOM and fee-splitting laws, and filed suit against the hospital for breach of contract. A copy of the suit can be found here: <http://www.aaem.org/UserFiles/MNEmCarecomplaint.pdf>.

Three weeks later, Methodist Hospital terminated its relationship with EmCare and re-contracted with EPPA. EPPA continues to serve Methodist Hospital and several other local hospitals. AAEM then sent a letter to every hospital administrator in the state of Minnesota, informing them of this matter and sending the message that AAEM is watching what they do with their EDs. This action had a chilling effect on the desire of layperson-owned CMGs to move into Minnesota, and they have been unable to establish a significant foothold in that state.

Read more from *EM News* at: [https://journals.lww.com/em-news/Fulltext/2005/04000/%20EPs\\_Rehired\\_After\\_Contract\\_Group\\_Ousted.2.aspx](https://journals.lww.com/em-news/Fulltext/2005/04000/%20EPs_Rehired_After_Contract_Group_Ousted.2.aspx).

## The Fight Against Alternate Boards

The American Board of Physician Specialties (ABPS) began approaching state medical boards seeking formal recognition beginning in the early 2000's. State boards do not generally control what specialties different physicians may practice, but several state boards limit how physicians may describe their specialization, typically in the form of advertising. The ABPS describes itself as "... the official multi-specialty board certifying body of the American Association of Physician Specialists (AAPS)." It offers certification in 20 different specialties, but review of its website reveals that the majority of its diplomats are certified in a single specialty: Emergency Medicine. Their designation is "Board of Certification in Emergency Medicine" (BCEM).

AAEM believes that "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)." The fundamental problem with the BCEM process is that it does not require formal ACGME accredited Emergency Medicine training. Rather, an applicant can qualify after completing one of a large number of alternative specialty training programs or even one of 14 EM fellowships, harkening back to the ABEM and AOBEM "Practice Track" provisions that closed in

Continued on next page

the late 1980's. State board recognition of BCEM allows these physicians to misleadingly represent themselves as EM specialists.

In 2002, AAPS certified physicians were approved by the Florida Board of Medicine for such advertising. In 2010, similar recognition was granted in Texas. However, AAEM has been a staunch opponent of back-door paths to proclaim "board certification" outside the ABEM/AOBEM process.

AAEM played a key role in successful efforts in Oklahoma, North Carolina, Utah opposing AAPS's attempts to gain similar status in these states. AAEM member Dr. Howard Roemer, was awarded AAEM's James Keaney Award for his key role in convincing the Oklahoma State Legislature to reject AAPS's proposal. AAEM remains the only EM organization requiring board certification to be a full voting member and a fellow of AAEM.

Read the February 6, 2006 letter to OK Board of Osteopathic Examiners: <http://www.aaem.org/UserFiles/aaemfebOBOE.pdf>

AAEM Values Statement, describing EM Specialist: <https://www.aaem.org/about-us/our-values>.

## Restrictive Covenants in Tennessee

In 2005, legislation was introduced to allow restrictive covenants in physician employment contracts in Tennessee. AAEM and its Tennessee chapter strongly opposed these efforts and made this issue a top legislative priority for the next two years. TN-AAEM Board members Dr. David Lawhorn and Dr. Andy Walker testified before the House committee reviewing the bill, and explained to committee members how such non-compete clauses harm both patients in general and emergency physicians in particular.

While TNAEM was not able to kill the bill entirely, emergency medicine was exempted. Emergency physicians in Tennessee remain free of restrictive covenants to this day.

Read more at *EM News*, [https://journals.lww.com/em-news/Fulltext/2007/08000/EPs\\_Exempt\\_from\\_Tennessee\\_Law\\_Reinstating.2.aspx](https://journals.lww.com/em-news/Fulltext/2007/08000/EPs_Exempt_from_Tennessee_Law_Reinstating.2.aspx)

## Corporate Practice of Medicine

### TeamHealth and the Memorial Hermann Hospital System (MHHS)

In 2007, MHHS, a large hospital network in Houston, awarded eight emergency department contracts to TeamHealth. Several emergency physicians contacted AAEM for assistance in this matter, including a private group with a 20-year history with MHHS, which was ousted in this move. AAEM and the private group — with AAEM's financial assistance — filed suit against TeamHealth and MHHS, citing violation of Texas CPOM laws. AAEM felt the case had substantial footing, as the Texas Medical Practice Act prohibits physicians from being employed by lay corporations for the practice of medicine. Additionally, previous Texas case law (*Flynn Brothers, Inc. v. First Medical Associates, Dallas 1986*) held that lay persons could not profit from an ED contract. AAEM's efforts were funded through donations to the AAEM Foundation.

Unfortunately, a state district court held that it did not have jurisdiction to hear the case. Despite an amicus curiae brief filed in support of AAEM by the Texas Medical Association, a state appeals court affirmed the district court's decision. The court of appeals held that AAEM lacked standing to challenge the contract between MHHS and TeamHealth, as well as the contracts between TeamHealth and its emergency physicians. One of the plaintiff physicians actually signed a contract with the TeamHealth subsidiary, but even then the court would not grant a declaratory judgment enforcing the state CPOM laws, holding that private individuals could not enforce the Texas Medical Practice Act. The court did leave open the possibility that physicians could file suit to nullify their contracts with a lay-owned corporation, as such contracts may violate state CPOM laws.

AAEM then appealed to the Texas Supreme Court, which refused to hear the appeal. As a result, neither the Academy nor the plaintiff physicians ever got the chance to argue the merits of their case before a judge or jury, and no judgment on the merits of AAEM's corporate practice of medicine claim was rendered. AAEM still believes it could win in court on the issue of the corporate practice of emergency medicine in Texas.

Read more from at: [http://journals.lww.com/emnews/Fulltext/2010/08000/Breaking\\_News\\_Texas\\_Court\\_Refuses\\_AAEM\\_Suit.2.aspx](http://journals.lww.com/emnews/Fulltext/2010/08000/Breaking_News_Texas_Court_Refuses_AAEM_Suit.2.aspx)

## Due Process / Whistleblower Case

### Dr. Genova versus Banner Health

In January of 2010, emergency physician Dr. Ronald Genova contacted the hospital administrator on-call, the hospital CEO, requesting to imple-



The Academy's willingness to put the interests of individual emergency physicians over corporate interests has had a major impact on our specialty.

ment a "Code Purple" to divert patients to other hospitals, because he believed the ED at North Colorado Medical Center could no longer provide appropriate and timely screening to patients due to excessive crowding. According to the facts alleged in Dr. Genova's lawsuit, a patient with a GI bleed had already collapsed in the waiting room bathroom while awaiting evaluation and two heart attack patients had just presented to the ED. According to Dr. Genova, the hospital CEO refused the request. Two weeks later, in apparent retaliation, Dr. Genova was removed from ED duties.

Dr. Genova filed a lawsuit noting that his removal from the schedule violated EMTALA whistle-blower protections and the covenant of good faith

Continued on next page



and fair dealing implied in contracts by Colorado law. The federal District Court dismissed Dr. Genova's suit, citing that Dr. Genova signed away his right to sue the hospital when his group contracted to provide physician coverage of the ED. Dr. Genova then asked for AAEM's assistance. In November of 2012, Dr. Genova appealed, and AAEM filed an amicus curiae brief asking the appellate court to overturn the dismissal and have the allegations in the complaint adjudicated on its merits. AAEM argued that the District Court imposed too narrow a reading of EMTALA's whistle-blower protections. AAEM also argued that a hospital should not be allowed to insist on a waiver of the covenant of good faith and fair dealing, as that implied covenant serves not only to protect the physician but also patients. While the 10<sup>th</sup> Circuit Court of Appeals favorably discussed the arguments made by AAEM, it ultimately upheld the dismissal. Although AAEM is disappointed with the outcome, this case demonstrates the Academy's willingness to come to a member's aid when their practice rights are threatened.

The AAEM amicus curiae brief can be accessed at: <http://www.aaem.org/UserFiles/Genovaamicuscuriaefiling.pdf>.

## Cross Subsidization, Fee Splitting, CPOM

### Tenet Health

In 2014, Tenet Health, one of the largest hospital networks in the country, put the contracts out for bid at 11 of its hospitals in California, to replace their emergency medicine, anesthesiology, and hospitalist groups. Many of these groups had served their hospitals and their communities well for decades. Such a change would be highly disruptive to the hundreds of physicians who have learned the systems and processes of their practice over time, and have developed relationships with their hospitals and medical staffs — not to mention the disruption to local nursing staffs, patients, and communities. Most of the hospitalist contracts and some of the anesthesiology contracts included a subsidy from Tenet, while most of the EM contracts generated enough revenue through collected professional fees to be entirely self-supporting and quite profitable.

Tenet solicited several large CMGs seeking a no-subsidy arrangement for all contracts. Essentially, Tenet wanted the profits from the emergency medicine contracts to cover its losses on the hospitalist and anesthesiology contracts. In addition, the emergency medicine practices will serve as a piggy bank to be raided by the CMG and the hospital. Of course, the CMG needs to show a nice profit to its investors too, which is hard to do without the anesthesiology and hospitalist subsidies. So, this also raised concern for future belt-tightening at the affected hospitals: less physician coverage, greater use of NPs and PAs, and lower pay for physicians. Federal fee-splitting laws, enacted to prevent kickbacks and abuse, prohibit the distribution of part of a physician's professional fee to any entity, in excess of the fair market value of services provided to that physician. When part of a physician's professional fee is being distributed to a hospital or CMG, the parties involved may be in violation of those laws. If an emergency physician's professional fees were to go towards subsidizing other hospital-based specialists, or to pad the bottom line of a for-profit corporation, this would appear to be an extreme violation of federal fee-splitting laws. It is also important to recognize that California has some of the strongest corporate practice of medicine (CPOM) laws in the country. These laws, drafted to protect the public due to the potential for abuse

when a corporation's fiduciary duty to its shareholders is in conflict with a physician's duty to his or her patients, prohibit non-physician, lay corporations from owning or controlling physician practices.

The leaders of several groups affected contacted AAEM and asked for our assistance. AAEM and its California chapter provided advice to the affected groups, sent letters outlining AAEM's concerns to the relevant hospital leaders, hospital boards, and medical staffs; and engaged in discussions with Tenet Health leadership. AAEM and the affected groups organized a highly effective public relations campaign. AAEM President Dr. Mark Reiter was quoted in many media outlets, noting his concerns that Tenet Health's proposal was bad for Tenet's hospitals, bad for its physicians, and bad for its patients. Soon after, Tenet's leadership informed AAEM that they were no longer considering this course of action, and that the local groups would remain.

Read the September/October 2014 President's Message: Tenet Wants Emergency Physicians to Subsidize the Rest of the Hospital at: [http://www.aaem.org/UserFiles/file/CS\\_SepOct2014\\_President.pdf](http://www.aaem.org/UserFiles/file/CS_SepOct2014_President.pdf)

Read the November/December 2014 President's Message: Tenet Health Update & Opportunities with AAEM at: [http://www.aaem.org/UserFiles/file/CS\\_NovDec2014\\_President.pdf](http://www.aaem.org/UserFiles/file/CS_NovDec2014_President.pdf)

## Fee Splitting, Anti-Kickback, CPOM

### Joint Ventures

Over the past decade, the largest hospital network in the country, Hospital Corporation of America (HCA), entered into a joint venture with EmCare/Envision, the largest CMG in the country. Under this arrangement, via the joint venture, the hospital and the CMG jointly own the emergency physician group and split the profits resultant from the emergency physician professional fees. Although CMGs have profited handsomely from emergency physician professional fees for decades, this was new territory for hospitals. In the past few years, HCA has brought most of its EDs under the joint venture, destroying dozens of independent EM groups. In return for being able to keep working in the same ED, many of these physicians are forced to take significant pay cuts and lose much of their independence and job security. Several other hospitals and CMGs have engaged in similar arrangements on a smaller scale.

Since hospitals and CMGs are typically not physician-owned corporations, having a hospital-CMG joint venture owning or controlling a physician practice may violate corporate practice of medicine laws in many states. In addition, federal fee-splitting laws, drafted to prevent kickbacks and abuse, prohibit any portion of the physician professional fee from being distributed to any entity in excess of the fair market value of any services provided. In addition, there is concern that these arrangements violate federal anti-kickback laws.

AAEM, in conjunction with a prominent law firm, has been actively investigating potentially illegal activities and hopes to enforce any prohibitions on such activity. AAEM has brought its concerns to a variety of federal and state agencies, many of which have voiced significant concerns with the legality of these arrangements and continue to investigate. AAEM has also passed a position statement noting its opposition to these joint venture arrangements and has discussed the issue with the media.

Continued on next page

Unfortunately, we have not been successful in shutting these joint ventures down, but we will continue to be the only professional organization that is fighting for its members on this important issue.

Read the May/June 2014 President's Message: Hospital-Contract Management Group Join Ventures: A Disturbing Trend at: [http://www.aaem.org/UserFiles/file/CS\\_MayJun2014\\_President.pdf](http://www.aaem.org/UserFiles/file/CS_MayJun2014_President.pdf)

### AAEM Physician Group

For years, AAEM has been the strongest advocate in the house of medicine for physicians owning and controlling their own practices. Practices owned by a small subset of their physicians or entirely owned by lay corporations are much more likely to lack transparency, political equity, and financial equity. This can create conditions ripe for exploitation. AAEM has worked hard to promote equitable, democratic, physician-owned practices throughout its existence. Despite AAEM's efforts, physician-owned practices are under significant threat. Small practices may have difficulty developing and maintaining the infrastructure needed to be successful in the new reality of health care reform, accountable care organizations, and value-based purchasing.

In 2016, the AAEM Physician Group was launched to combine the advantages of small, democratic groups of physician owners, with the economies of scale, expanded services, and clout of large groups. Likewise, the AAEM Physician Group can help minimize the time, resources, and risk to emergency physicians who want to create their own EM group, or to bring the control of their group back to the physicians actually practicing in their ED. AAEM has created a new paradigm whereby smaller EM groups could become part of a national collaborative with access to best-in-class practice management services provided at fair market value. For existing groups, we believe the addition of more professional management will help them maintain their contracts and facilitate possible expansion. Moreover, as part of AAEM, we believe affiliated groups will garner significant legal protection under the existing prohibitions on corporate practice of medicine and fee-splitting. Unlike the Memorial Hermann case mentioned above, AAEM will now have "standing" in any threat to the contract. Likewise, AAEM Physician Group can seek new, high quality ED contracts and then set up and install local, democratic groups at these sites. We developed a set of fairness principles that would be required for

participating groups to meet (i.e., financial transparency, reasonable path to partnership, due process, political and financial equity) to ensure that the commitment to a fair environment would be maintained.

The AAEM Physician Group is off to an excellent start. We now have multiple EDs representing hundreds of thousands of patient visits partnering with us as part of the AAEM Physician Group. Each group maintains local ownership and control while being obligated to follow AAEM's Fairness Principles. If your group is interested in learning more about the AAEM Physician Group, please contact its CMO, Dr. Robert McNamara at [cmo@aaempg.com](mailto:cmo@aaempg.com)

### [www.aaemphysiciangroup.com](http://www.aaemphysiciangroup.com)

Read the September/October 2015 President's Message: The AAEM Physician Group at: [http://www.aaem.org/UserFiles/file/CS\\_SepOct2015\\_President.pdf](http://www.aaem.org/UserFiles/file/CS_SepOct2015_President.pdf)

### Conclusion

As you can see, the Academy has been extremely active in protecting the practice rights and livelihoods of emergency physicians, who often have nowhere else to turn for support in such matters. Many of our advocacy and legal actions have been successful and substantial, with significant benefits to the emergency physicians involved — including saving their jobs. There is still much to do, however, especially in an environment where lay-owned, corporate, contract management groups — which often have a very poor track record regarding restrictive covenants, due process, and other practice rights — control a large proportion of emergency medicine jobs. Your AAEM membership, your active support of its work, your recruitment of new Academy members, and your donations to the AAEM Foundation provide the resources the Academy needs to be a successful advocate for the practicing emergency physician. ●



### Experience the Difference: Be Part of a Physician Owned Group

#### The Benefits:

- Enhance your practice performance with professional management — AAEM-PG offers bottom line improvement to our groups
- Boost your recruiting edge — residency grads and practicing docs trust the AAEM name
- Increase your ability to avoid takeover by a CMG — have the tools and the back-up of AAEM to protect your group
- There is no risk — AAEM-PG will perform a review at no cost to your group

### Work for yourself and your colleagues, not, a corporation or an individual

- You will not have excess amounts of your professional fees diverted to lay owners or a physician who has not treated the patient
- The AAEM-PG is not at risk of being sold; its purpose is to serve its members by creating fair work opportunities to enhance their professional lives



### Start Today: Learn how you can be a part of AAEM-PG



Contact our Chief Medical Officer:  
Robert McNamara, MD FAAEM, at [cmo@aaempg.com](mailto:cmo@aaempg.com)  
[www.aaemphysiciangroup.com](http://www.aaemphysiciangroup.com) 800-884-2236



**ACT NOW!**

**Exclusive 15% Off Discount Code: AAEM15**

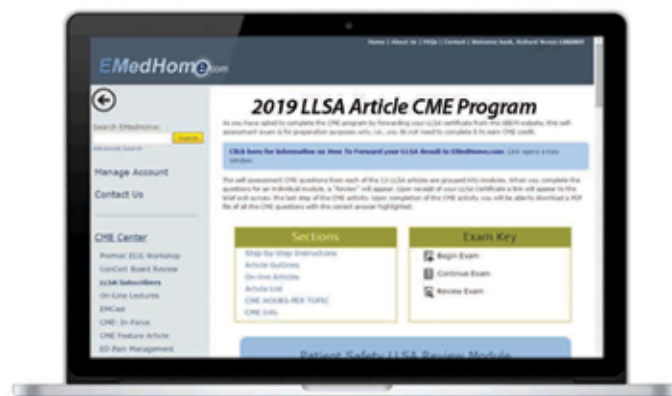


**NOW ONLINE!**

**OVER 75 CME VIDEOS  
FROM THE 2018 AAEM  
SCIENTIFIC ASSEMBLY**



**Taking an LLSA or COLA Exam This Year?**  
**Sign Up For the EMedHome LLSA or COLA Articles CME Program**



- Easily Pass the Exam
- Get Category 1 AMA/PRA CME Credit™
- Forward Your Certificate of Completion in Lieu of a CME Exam!

**www.EMedHome.com**



Operations Management Committee

# Make Operations Cool (Again?)

Kraftin Schreyer, MD CMQ FAAEM



When I first started my emergency medicine residency, I thought what all of you are thinking: operations (whatever that is) is boring. I was interested in other, cooler, things, like medical student education, ultrasound, and simulation. So, as I went through my residency, I became involved with hands-on sessions and electives for the medical students, improved my ultrasound skills, and even helped put together a few

SIM sessions. All of that was great, but whenever I worked a shift, I found myself increasingly frustrated.

No matter when, where, or with whom I worked, I could always count on one constant — inefficiency. And the inefficiency was inevitably met with even less efficient workarounds. I found myself running back and forth across the department to grab equipment that wasn't stocked in the right place or in the right amount. I pushed patients to CT scan when transport was nowhere to be found. I was constantly on the phone with admitting providers, arguing — having a discussion — about why or why not this admission was appropriate for their service. I was bombarded by overhead pages that I couldn't even understand, and that didn't seem to do anything to further patient care. I sat around, refreshing the screen again and again, hoping that some of the patients in the waiting room would magically be put in an area that had been closed all day because of staffing constraints. I was there to learn by seeing patients and doing procedures, but my time was consumed with all of these other unnecessary tasks.

Over time, these system inefficiencies began to really wear on me. And then, on one shift, sometime near the end of my second year, I had my 'aha moment'. These problems that seemed to suck the life out of every shift needed to be fixed. And, I wanted — no, needed — to be a part of the solution. It was the only way I could see to get back to what residency was supposed to be all about. But, I didn't know who to talk to, or where to go, to start making a change.

That's when I learned what emergency department (ED) operations was. ED operations is akin to the business concept of operational management, which strives to achieve the highest level of efficiency in an organization (in our case, an ED), by optimally converting resources (staff, equipment, space) into goods and services (patient care). Efficiency of an ED is measured in throughput metrics, most commonly door-to-doc time (how long it takes a patient to get seen by a provider), time-to-dispo

(how long it takes that provider to make a disposition decision, typically admission or discharge), and turnaround time (the total time a patient spends in the ED). Goods and services are measured in patient satisfaction scores and by the absence of adverse events, which serve as a proxy for a measurement of patient safety. Lots of people are involved in ED operations, including the medical director, the associate and assistant medical directors, nursing leaders, and even administrative leaders within the department and within the hospital. When it comes to ED operations, the whole department really is a sum of how it and the people within it function day-to-day, because all of those metrics are continuously measured over time.

But, ED operations isn't just about those numbers and scores. It's about using them for the greater good — to find errors (or potential errors) within a system and use those to improve upon the existing structure. Medical

error has been gaining more attention since the landmark publication from the IOM, "To Err is Human" back in 1999, which highlighted the alarming predominance of medical error in the US Healthcare System, and furthermore attributed the majority of those errors to failings within the existing system itself, rather than assigning blame to individual providers. In the classic "Swiss Cheese model" of error, the holes in the cheese are systems errors. But, the holes can't be seen unless they are visualized in the context of the cheese. The cheese is ED Operations.

The ED Operations team constantly works to close those holes and improve the ED environment for both patients and providers. It is through the operations team that new policies are cre-

ated, such as those that streamline processes for admission or transport, new protocols, developed with other departments, are put in place to coordinate care more effectively, that new guidelines are created to reduce variation in diagnostic and treatment plans, and that new par systems are put in place to eliminate an excess of supplies, to list just a few things. Yes, this often requires a meeting, or two (or ten), but your time is often well spent, and well worth the time and stress saved on future shifts.

Without an understanding of how your ED operates, you cannot improve the existing system. Quite simply, you can't fix what you don't know is broken. Operations is about identifying what is broken and coming up with ways to fix it. It's about finding ways to make your ED operate more efficiently, effectively, and safely. It's about making yours, and everyone else's, shifts (and lives) better. It's really not as boring as you might think. ●



Without an understanding of how your ED operates, you cannot improve the existing system. Quite simply, you can't fix what you don't know is broken.

## Critical Care Medicine Section

# The Most Stable Pulseless Patient You'll Ever Meet! A Clinical Update on LVADs in the ED

Authors: Gage Alexander Stuntz and Andrew Phillips, MD



The use of left ventricular assist devices (LVADs) has expanded rapidly beyond the initial use as bridge to transplant and bridge to recovery to destination therapy for many patients. While LVADs have significantly expanded quality of life and reduced mor-

tality for many patients with heart failure, they have several significant unique complications worth watching for in the ED.

Approximately 5.7 million patients in the USA have heart failure, half of those with HF will die within 5 years. Approximately 670,000 new diagnoses of heart failure are made per year. LVAD patients have a presentation rate of 3 per pt LVAD year. As the number of patients with LVAD implants present to the ED it will be increasingly important for physicians to be aware of appropriate standards of care for these patients and what to do/how to troubleshoot in an emergency.

## Anatomy of VAD

Modern LVADs are continuous flow devices that function by pulling blood from a weak left ventricle, propelling it to the aorta through a pump placed between the left ventricle and aorta. The pump and circulation connections are all in the body. The pump has a driveline which connects the outside battery packs to the pump. Note that some LVAD drivelines cross the diaphragm, and that location increases the risk of abdominal bacteria causing infection throughout the device. Each LVAD will have a control unit which displays warnings and gives diagnostic information if an error has occurred. The newer versions of LVADs work by using magnet rotors to propel the blood forward. For this reason, MRI is absolutely contraindicated in LVAD patients.

## Physical Exam

The most need-to-know physiologic change in the LVAD population is the lack of a reliable pulse, blood pressure reading, and oxygen saturation. Since the great majority of devices generate continuous flow, any pulse or pulse pressure measured is from the native contribution of the patient's cardiac function and should not be deemed reliable of the true pressure.

Basic clinical examination is sensitive for poor perfusion in VAD patients: pallor, capillary refill, and mental status (with frequent rechecks) can establish a baseline, and changes noted from there. In terms of blood pressure, the gold standard in VAD patients should be the doppler mean arterial pressure (MAP). Use the standard blood pressure cuff but instead of using stethoscope (can be used but is less accurate), use doppler to assess the pressure at which flow returns. There is some data to support a MAP of 70 being appropriate in VAD patients, with some patients having lower MAP readings and maintaining adequate perfusion status. Judge perfusion by clinical signs rather than the numbers. Auscultation

of heart sounds will be difficult, however, auscultation can tell you if the pump is working or not, which is a crucial aspect of the patient presentation.

Auscultation should sound like a steady high-pitched motor without clunking sounds. Invasive blood pressure monitoring is a potential option in unstable patients with arterial blood gas for estimation of oxygenation status. ECG will have an abnormal morphology, so compare to baseline for subtle changes. Importantly dysrhythmias such as VT and VF are still easily recognizable, accurate, and a problem. X-rays (AP / Lateral) can indicate gross connection or placement abnormalities. CT scan can indicate more precise dislocations and pockets of infection.

## Epidemiology of VAD Issues

The most commonly encountered VAD related complication is bleeding from required anticoagulation. Bleeding requiring transfusion is more common than bleeding requiring operation but up to 70% of VAD patients will encounter this complication. Infection is the second most common complication this statistic encompasses VAD related infection and non-VAD sepsis which alters systemic hemodynamics and VAD flow subsequently. Stroke (ischemic > hemorrhagic) is more common than in non-VAD patients and has higher morbidity. Device related complications

Continued on next page

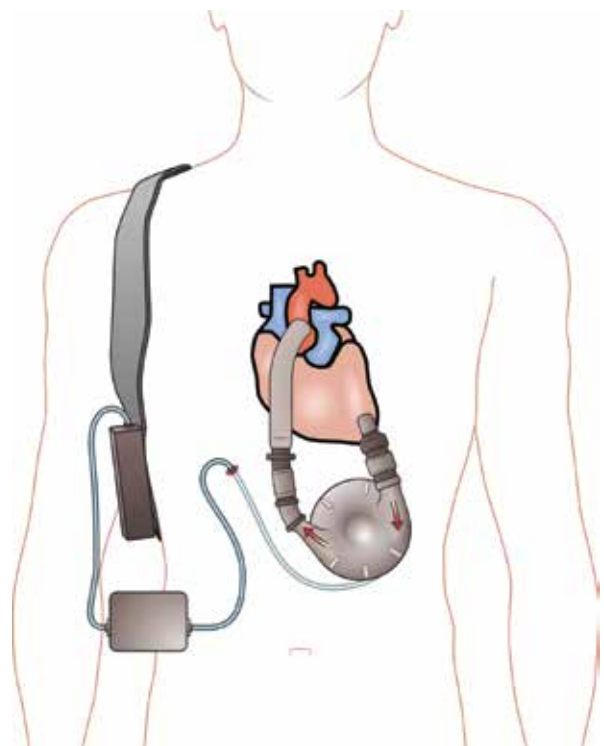
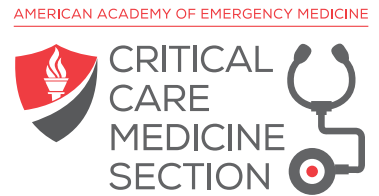


Photo courtesy of Wikimedia Commons

from intrinsic device failure are uncommon but do occur, with user related device complications being much more common. Pump thrombosis and right heart failure are more uncommon but concerning complications.

## Problems

In any VAD related issue contact the LVAD team that follows the patient or contact 24/7 operated advice lines by manufacturer. If the patient presents to a non-LVAD center, stabilization and transfer are the priorities.

## Device Problems - Alarm Will Sound

Worst case is the pump is not working. The vast majority of LVAD patients' native heart function will not be able to support their perfusion requirements, especially in states of physiologic stress. A good first pass at solving alarming LVADs is to run the circuit: is the driveline fractured, is it connected to the controller and are the batteries connected and charged? Consider plugging the whole setup into the AC wall outlet if your ED or the patient has the AC adapter.

If the device is off for too long the potential exists for clot formation in the ventricles and device pipelines which is potentially fatal. Restarting the device after a long pause is controversial. Vierecke et al. suggest that if the patient is unstable the pump should be restarted regardless of timeframe, if the pump malfunctioned and can be restarted in minutes it should be considered low risk for clot formation. If the patient is stable with a non-functioning pump, which has been off for a longer period of time (hours) then the patient should be transferred to a VAD center or seen by VAD team before restarting VAD.

Alarm types vary between VAD brands, however as a general rule the more persistent the alarm sound with red lights, the worse the problem and the higher potential for critical failures. These patients will be your 'ABC' patients. Most VADs have yellow warning lights which may indicate a malfunction that is non-emergent but should be evaluated. These will be your 'H&P' patients.

Use the LCD display to guide your differential. Some problems can be fixed easily, while core device faults and dislodgment (both of which are very rare) will require surgery to fix. Some issues such as suction event, high power output, and high RPM are VAD warnings that occur secondary to other systemic pathology such as arrhythmia, RV failure, and device thrombus.

## Non-Device Pathology - Alarm May Sound Bleeding

Because VAD patients are anticoagulated, the most common complication is coagulopathy. Many patients present with GI bleeds because of the anticoagulation and an acquired Von Willebrand Factor deficiency from the continuous flow LVAD. Careful consideration should be given to reversing coagulation, and it is an area of great contention. It should be noted that full reversal of anticoagulation represents high risk of device thrombosis or thromboembolism which can be fatal. There is middle ground, some sources recommend giving platelets, Vitamin K, or desmopressin. Talk to the LVAD team before reversing anticoagulation. It is always acceptable to hold further doses of anticoagulation while in the ED. Otherwise treat LVAD patients who have a GIB just like any other GIB patients: serial H&H, type and cross, transfuse to Hgb of 7, and schedule emergent endoscopy.

## Infection

Driveline and systemic infection are potentially fatal complications. Treat these patients like your standard sepsis patient, with cultures, broad spectrum antibiotics and source evaluation. Vasopressors are applicable in VAD patients, but remember that VAD patients already operate at low MAPs, hypertension can cause more harm than good but there is limited data, as a general rule MAPs should be between 70 and 80, not exceeding 100.

## Stroke: Ischemic / ICH

While ischemic stroke carries a high morbidity and mortality in LVAD patients, hemorrhagic strokes (other than traumatic subarachnoid hemorrhages) are often catastrophic with more than half dying. If an LVAD patient presents with an ischemic stroke, do not push thrombolytics without consulting with the LVAD team. Similarly, if an LVAD patient presents with a hemorrhagic stroke, do not reverse the anticoagulation without consulting the LVAD team. These are controversial areas without strong evidence and approach varies considerably by center, decisions are best made by those with expertise in the field.

## Arrhythmia

Tachyarrhythmias are very common in VAD patients. The urgency of intervention can be based upon the clinical presentation of the patients. Unstable patients should be defibrillated like normal. Do not disconnect the controller from the driveline to defibrillate. All currently available LVADs in the US can sustain the shock. Stable patients can be medically managed, even patients in VF/VT. The concern with arrhythmia is a loss of forward flow from the right heart which results in low LVAD flow and suction events.

## Hypovolemia

LVAD patients are preload dependent. Dehydration is common, diuretics and nitrates should be used very cautiously. Look for causes of low volume mainly hemorrhage owing to the anticoagulation.

## The Coding VAD Patient

In the coding VAD patient, do what you would normally do in an unconscious pulseless patient (pulse in VAD pt is doppler MAP). Call surgery team or device manufacturer or both. Chest compressions have not been shown in one small to increase risk of device malfunction or displacement, though theoretical risk is present and some do not recommend chest compressions. Do not do compressions unless you are sure the patient is not perfusing. There are several reports patients receiving compressions based on no pulses found later to have low MAPs but forward flow with the LVAD. The bailout for a dying LVAD patient is venous-arterial ECMO. Defibrillation is applicable and useful as some arrhythmias will decrease flow through the heart and increase risk of thrombosis.

## Conclusions

As LVADs become more common, the chances of seeing one in the ED near you will increase. The devices are complex and require a team of surgeons and critical care specialists to manage these patients. When unsure it is never wrong to contact the patients LVAD center or

Continued on next page



manufacturer as they can provide greater insight into the potential problems that can occur with the devices. ●

#### References

1. Heart Failure Factsheet. Division for Heart Disease and Stroke Prevention. [https://www.cdc.gov/DHDSP/data\\_statistics/fact\\_sheets/fs\\_heart\\_failure.htm](https://www.cdc.gov/DHDSP/data_statistics/fact_sheets/fs_heart_failure.htm). Published June 16, 2016. Accessed June 11, 2018.
2. Kroekel PA, George L, Eltokhy N. How to Manage the Patient in the Emergency Department With a Left Ventricular Assist Device. *Journal of Emergency Nursing*. 2013;39(5):447-453. doi: 10.1016/j.jen.2012.01.007.
3. Vierecke J, Schweiger M, Feldman D, et al. Emergency procedures for patients with a continuous flow left ventricular assist device. *Emergency Medicine Journal*. 2016;34(12): 831-841. doi:10.1136/emmermed-2015-204912.
4. Pistono M, Corrà U, Gnemmi M, Imparato A, Temporelli PL, Tarro Genta F, et al. How to face emergencies in heart failure patients with ventricular assist device. *Int J Cardiol*. 2013 Oct 15;168(6):5143-8.
5. Sen A, Larson JS, Kashani KB, Libricz SL, Patel BM, Guru PK, et al. Mechanical circulatory assist devices: a primer for critical care and emergency physicians. *Crit Care*. 2016 Jun 25;20(1):153.
6. Willey JZ, Demmer RT, Takayama H, Colombo PC, Lazar RM. Cerebrovascular disease in the era of left ventricular assist devices with continuous flow: risk factors, diagnosis, and treatment. *J Heart Lung Transplant*. 2014 Sep;33(9):878-87.
7. Wasson LT, Yuzefpolskaya M, Wakabayashi M, et al. Hypertension: an unstudied potential risk factor for adverse outcomes during continuous flow ventricular assist device support. *Heart Fail Rev* 2015;20:317-22.
8. Kilic A, Acker MA, Atluri P. Dealing with surgical left ventricular assist device complications. *J Thorac Dis*. 2015 Dec;7(12):2158-64.
9. Image Citation: Madhero88. Ventricular Assist Device. 2010. Available at: [https://commons.wikimedia.org/wiki/File:Ventricular\\_assist\\_device.png](https://commons.wikimedia.org/wiki/File:Ventricular_assist_device.png). Accessed June 27, 2018.

# SAVE THE DATE

# X<sup>th</sup> MEDITERRANEAN EMERGENCY MEDICINE CONGRESS



## Dubrovnik CROATIA 22-25 SEPTEMBER 2019

## MEMC19

[www.aaem.org/MEMC19](http://www.aaem.org/MEMC19)  
#MEMC19



# The Economic Power of Diversity and Inclusion to Change Policy and Culture

L.E. Gomez, MD FAAEM

Chair, Diversity and Inclusion Committee



Growing up in West New York in the seventies, neighborhood boys and I dodged cars as we played stickball in the street. Our racial spectrum skewed white: mostly Caucasian Hispanics and Europeans, with only a few Blacks (including me), hurling crass epithets at each other between pitches. There was enough anti-immigrant sentiment to make our present administration's callous policies seem civil by

comparison. These boys and I didn't know much about the world beyond our neighborhood, but we did know baseball fields were leveled by talent (and money). We knew diversity and inclusion were inevitable in sports, not because integration was driven by moral imperative, but because it made sense that, even in the street, race took a back seat to winning.

We knew what players on the most successful teams looked like and why teams were multiracial. Jackie Robinson had been drafted decades earlier by an innovative white businessman named Branch Ricky. He had drafted and mentored the most dynamic baseball prospect ever and made him the first Black player of the era in the major leagues. We reasoned Ricky did this, not because it was the right thing to do, but because Robinson gave his Dodgers the best chance to win (and sell tickets). We also knew that move had eventually led Reggie Jackson to become the highest paid player in the history of the game. In 1976, free agency allowed the Yankees to pay Jackson the full worth of his ability, not because they owed a debt to people of color, but because he could produce wins. Our reality as kids was that few, if any, minority professionals existed outside of sports, but they were at the very top of the game. I was convinced that meant change was coming to every realm of society and that inclusion at every level was inevitable, eventually. I wanted to be a part of that change and prove it would extend beyond sport. My streetwise peers reminded me we had few options with remarks like 'look around and tell me if you think any of us are getting out of this town unless it's through sports.' I knew I wasn't Jackie Robinson, so I had better find an alternative to baseball.

Fast forward forty years, and it turned out I was able to find another profession. Yet, anyone might wonder why it seems more has not changed outside of sports and entertainment. The Brookings Institute notes that over 40% of African Americans now own their own homes and about a third of the Black population now lives in suburbia. According to recent census data, roughly 15% of Black and mixed households earn over

\$100,000. My grown up colleagues at Howard University Hospital and I are a tiny part of that group. But these facts continue to be underreported in the media, a realm in which the Black underclass continues to define Black America. The media plays down the fact that most of us escaped ghettos, not through sports and entertainment, but through academics. A major obstacle is that progress for Blacks has stagnated in almost every field outside of sports and entertainment, and that we tend not make it into positions in the highest levels of our industries.

Our medical industry is a great illustration of why the challenges our society faced in those years persist. In the early 1970's only 2.2% of American physicians were Black. That figure only increased to about 4% by the late 1990's, where it appears to have become stuck. There is even

evidence Blacks comprise only about 3.8% of all physicians currently, and that figure has been gradually decreasing since 2015. This shows how complicated the equation can be for Black professionals as we are increasingly absent from the discussion.

The perception promoted in the media is that Blacks are poor, which biases institutions and health care corporations to undervalue their worth. Advocating for patients of color often has no place in corporate culture, particularly in emergency medicine, where the prevalent bias is this population more often represents charity work. As many of us do, I believe we treat patients, not service customers, but we can learn from Branch Rickey's pragmatic economic approach to changing policy: he took

advantage of an unrealized opportunity and let market forces and the economy of baseball drive change. What if there was evidence diversity and inclusion can drive economic success in health care systems?

Economic evidence for positive return on diversity in other industries has been around for decades now. In a 2003 study published in *Corporate Governance: An International Review*, Erhardt, et. al., looked at 127 large US companies and showed combined racial and gender diversity on boards was positively associated with financial indicators of performance. Beyond corporate image, diversity was found to improve return on investment (ROI), return on assets (ROA), and innovation, as well as market share. More recently, in 2017, Rocio Lorenzo, a managing Partner with Boston Consulting Group, used statistical methods to quantify the impact of diversity on innovation. She showed above-average levels of diversity correlated with a 38% increase in revenue from products and services.

Continued on next page



It will take more than education around explicit and implicit bias, it will take mentorship and collaborative efforts with physicians of color, advocacy, funding to promote and create diversity and inclusion in leadership.

Consider, for example, the potential economic impact of providing health care screening at neighborhood barbershops and beauty salons, to say nothing of possible savings from avoiding catastrophic illness, and critical presentations to the emergency department as a result of such initiatives.

Minority leaders have long recognized the value of advocating for their own community as the best way to gain power and wealth, capitalizing on what is typically ignored by large corporations. Take a look at the composition of the typical contract management group in the emergency medicine. Using Emergency Medicine Associates, P.A. as an example, no one in that organization in executive leadership is a person of color, though one of six execs and three out of forty Medical Directors are women. On the American College of Emergency Physicians Board of Directors 2017-2018, one of eighteen members is Black, and that same individual is one of a handful of women. In the Emergency Department Practice Management Association (EDPMA), none of the nineteen board members are Black and only five are women. Take a look back at our own board composition over the past decade. Before we can advocate for other organizations to address representational leadership, we could begin with ourselves. Recognizing this error of omission, and meeting the challenge authentically, could, for instance, put AAEM ahead of other professional organizations that fail to realize the value of taking an authentic tangible lead on diversity and inclusion.

Despite evidence that business value is created through diversity; the health care industry has only begun to put that knowledge into practice. It has certainly not yet led to representative leadership in emergency medicine (or most other areas of medical practice for that matter). Part of the challenge is that corporate image and reputation can be improved when the term diversity can be met by inclusion of cultures other than Black. Even efforts to approach gender inclusion, although not yet equitable, has fared far better and appears easier to implement than racial diversity inclusive of Blacks.

Finally, review of the literature suggests that maximizing the impact of minority leaders requires investment, including mentorship, advocacy, alliances, networks, and training to transcend racial identity. In a study of large US companies published in *Academy of Management Journal* in 2013, MacDonald, et. al., confirmed minorities were 72% less likely to receive mentoring from existing executive leadership. The case was also true for women, but much less so. More importantly, the power of networking is not just a matter of connecting with many people, but people in leadership. Minorities require multiple networks throughout their careers and Miller, et. al., pointed out in a 2009 study of board diversity published in the *Journal of Management Studies* that this broad range of contacts make them "more likely to maintain weak ties," rather than strong ones.

We are in a catch-22: overcoming barriers requires leadership at the highest levels, including in C-suites and boardrooms, but the path to those positions is often paved by leaders that identify with candidates for those positions. It will take more than education around explicit and implicit bias, it will take mentorship and collaborative efforts with physicians of color, advocacy, funding to promote and create diversity and inclusion in leadership. It will take risk, as some studies suggest diversity can challenge communication, especially with people who have differing values and perspectives. Let's reflect that baseball became an exponentially more powerful influence on American life and culture after becoming fully integrated by race. Finally, remember that Jackie Robinson debuted to jeers, boos, hisses and worse, yet rose to become the first rookie of the year in the major leagues, national league batting champion, MVP, stolen base leader, six time All-Star, World Series Champion, and went on to become one of the most influential political activists and American leaders of the 20<sup>th</sup> Century. ●

## Help Us Bridge the Gap *Join the AMA!*

Having the support of physicians from many specialties can help us resolve some of EM's most important problems. Currently, AAEM has no seats in the American Medical Association (AMA) House of Delegates (HOD). Help us reach our goal of 50% of AAEM members also holding membership in the AMA so we can add our voice to the deliberations with a seat in the HOD.

Help advocate for the medical profession, your specialty, and your patients by joining the AMA. For membership information, visit [www.ama-assn.org](http://www.ama-assn.org).

Help advocate for the medical profession, your specialty, and your patients by joining the AMA. For membership information, visit [www.ama-assn.org](http://www.ama-assn.org).



## Education Committee

## Join Us in Las Vegas for AAEM19!

Evie Marcolini, MD FAAEM and Joelle Borhart, MD FAAEM  
AAEM19 Planning Subcommittee Co-Chairs



Planning is well underway for the 25<sup>th</sup> Annual Scientific Assembly – AAEM19! Mark your calendars and plan to join us at Caesars Palace in exciting Las Vegas, Nevada, Saturday, March 9<sup>th</sup> through Wednesday, March 13<sup>th</sup>, 2019.

2019 is a very special year as we celebrate 25 years of the AAEM Scientific Assembly. AAEM was founded in 1993 and the first Scientific Assembly was held in Philadelphia in 1994. What began as a gathering of a few dozen emergency physicians has grown into the premier continuing medical education conference attracting more than 1,200 attendees. Throughout the conference we will be highlighting the history of AAEM and the milestones we have achieved as an organization and specialty.

One thing that has remained constant for 25 years is AAEM's commitment to featuring the best speakers and educators in the world. We, Dr. Evie Marcolini and Dr. Joelle Borhart, are leading the AAEM19 planning subcommittee again, and we are putting together an amazing line-up of the most talented presenters emergency medicine has to offer. At AAEM19 you will hear from your favorite seasoned speakers as well as the new rising stars in emergency medicine education.

For the third year in a row the innovative Small Group Clinics will be back. If you are looking for an alternative to the PowerPoint/lecture format, the Small Group Clinic provides a low teacher-to-participant ratio (1:6). Register in advance for an opportunity to receive personalized attention from expert instructors for a variety of hand-on skills.

The Breve Dulce (formerly PK) talks will also return and continue to cover a variety of exciting topics. The rapid-fire format of the Breve talks allows for brief, high-level exposure to many topics and ideas in less than seven minutes. Plan to catch several of the nearly three-dozen Breve Dulce talks at AAEM19 to round out your educational experience.

As always, AAEM19 will feature a number of high-yield pre-conference courses including Resuscitation, Beginner and Advanced Ultrasound, LLSA Review, Interpreting an EKG. New this year, additional educational opportunities will be available directly before AAEM19 including a course from The Teaching CoOp and a Written Board Review Bootcamp.

It is an honor to be charged with maintaining the high quality of emergency medicine's preeminent educational conference, the AAEM Scientific Assembly. We will provide you with the education you need to take great care of your patients, great care of your practice, great care of yourself, and be at the cutting-edge of medical trends and knowledge. We have had tremendous success over the past several years with educational innovations that we will be building upon this year. Please accept our invitation to join us in Las Vegas and see what we have to offer you! ●

SAVE  
THE DATE

 **AAEM**<sup>TM</sup>  
AMERICAN ACADEMY OF  
EMERGENCY MEDICINE  
CHAMPION OF THE EMERGENCY PHYSICIAN

25<sup>TH</sup> ANNUAL SCIENTIFIC ASSEMBLY  
LAS VEGAS, NV

FREE Registration and CME for members  
with refundable deposit.

Celebrating  
**25**  
YEARS  
of Education  
1994–2019

**MARCH 9-13, 2019**  
CAESARS PALACE • LAS VEGAS, NV  
#AAEM19

**REGISTRATION  
OPENS  
NOVEMBER 2018**  
[www.aaem.org/  
AAEM19](http://www.aaem.org/AAEM19)

## International Committee

## International Scholarship Winner

Rosa María Tercero Rodezno, MD/IMG  
 Universidad Católica de Honduras, Campus San Pedro- San Pablo (UNICAH)  
 San Pedro Sula, Honduras

*AAEM has a long history of involvement in international emergency medicine through conferences, committees and the operation of the AAEM Scientific Assembly. In recent years, AAEM had partially or fully funded multiple international EM physicians for participation in AAEM Scientific Assembly through an international scholarship program. The objective of this program is to aid development of liaisons and fostering of opportunities for exchange of information, education, and ideas with international EM societies and organizations.*

*The program is administered by the International Committee and participants are invited to apply. Applications are reviewed by committee members and applicants are ranked by several factors including the strength of their resume and potential to promote emergency medicine in their country of origin.*

— Ashely Bean, MD FAAEM, Chair, International Committee

I recently attended AAEM's 24th Annual Scientific Assembly in sunny San Diego, California. I was one of this year's International Scholarship recipients, and words truly cannot describe how grateful I am with the International Committee and AAEM's Board of Directors for this unique opportunity.

I found particularly interesting that this year's theme was "Breaking Down Barriers" because it is my perception that many barriers are being broken down in my country, and slowly, but surely, progress is being made in the medical field in Honduras.

Emergency medicine as a recognized field and specialty is not established in Honduras yet, though many changes in the past years are creating the momentum to make it happen. In August 2017, the Medical Emergency Unit (UME) was created to become the first responders for medical emergencies of the Honduran population. Their mission is to provide cost-free, prompt, quality pre-hospital care and transportation to a hospital setting to patients with a trauma or medical emergency. In October 2017, the Honduran Toxicology Information Center (CENTOX) was inaugurated, providing telephone assistance both to medical providers and the Honduran population in general that contacts them through a "9-1-1" phone call. Our public hospitals assisting approximately 90-94% of the population in medical emergencies, formally implemented in the past 5 years a color-coded triage system that would help reduce patient wait time in severe cases, improving patient medical care.

These developments are the sum of the efforts and struggles of generations and generations of physicians noticing a need in our health system and pointing it out, and a government who prioritized a budget to fund these expansions in the benefit of the Honduran population. Many barriers were broken to make this happen, and I'm aware that there are many more barriers to break, these steps have encouraged me to challenge myself into becoming the best emergency medicine physician I can be, in the service of this profession.

My pursuit and continual search for learning opportunities in emergency medicine led to my application to this Assembly.

The organization and level of detail of the Assembly was impressive. The lectures were all enticing, making it very difficult to pick one over another; the app was particularly useful for keeping track of the times, location of lectures, and events going on. I enjoy running, so I was excited to see the "Fun Run and Walk" as part of the program, and it was wonderful to see how AAEM sees an EM physician as more than just a physician, but as a person, taking into consideration the importance of having a healthy body, mind and soul. This observation also extends as to how AAEM sees a patient as more than just a patient, but as a person by including as part of their program and small group clinics the topic of "Cultural Sensitivity is a Must for Optimal Patient Care." It is my belief that having a holistic approach helps us as physicians understand and connect with each patient, aiding us to provide them the best we have to offer. I am very grateful to have been part of this group clinic.

Overall, what I take with me, which is probably the biggest barrier broken to date, is the fact that even though everyone attending the Assembly were from different backgrounds, schools of medicine, programs, levels of training and even countries, **we were all united by an invisible thread** of wanting to learn more of emergency medicine, and taking back with us what we learned at this point in time to our workplaces, in the benefit our patients.



Continued on next page

I look forward to the opportunity of being an instrument in this field to break down more barriers. As I mentioned before, many steps and progress has been made, but there is still work to be done. A Honduran Society for emergency medicine and the specialty as a primary residency in the country has not been established yet. Schools of Medicine have not yet formally included in their academic programs, a course in emergency medicine. These are some of the academic barriers that need to be addressed, along with everyday barriers that include, but are not limited to, shortage of physical and human resources in emergency rooms, and a standardized, unified approach of quality emergency care nationwide.

As much as I would like all of this to be already in motion, I acknowledge it takes a step-by-step approach that usually does not go in a linear fashion, time, and the sum of multiple efforts. I am truly grateful to have met so many leaders in this field at the Assembly who have inspired and fueled the fire in me to be part of this ongoing movement in my country. I

am thankful for AAEM's commitment in the development and quality assurance of emergency medicine at an International level, because they become and are active parts of the movement of establishing this field worldwide.

I would like to take this opportunity to formally thank Dr. Judith Tintinalli for nominating me for this scholarship, Dr. Wes Wallace and Dr. Justin G. Myers for working alongside and encouraging me to challenge the established limits, because my presence at this Assembly would not have been possible without them. I'd also like to thank Dr. Ashley Bean, Dr. Terrence Mulligan, Dr. Ashika Jain, and Dr. Lisa Moreno-Walton for being so welcoming, and for giving me the opportunity to be a part of this year's Scientific Assembly — I am humbled and honored to have met you and I can only hope to reach one person someday, the way you have all reached me and so many nationally and worldwide.

Thank you. ●

## Robert L. Muelleman, MD, Elected ABEM President

Robert L. Muelleman, MD, has been elected President of the American Board of Emergency Medicine (ABEM). Dr. Muelleman has been a member of the Board of Directors since July 2011, and was elected to the Executive Committee in 2015. He has served ABEM in a number of capacities, including as an examiner for the Oral Certification Examination since 2005, an item writer for the ConCert™ Examination. He also has served as Chair of the Academic Affairs and Finance committees, as well as the Board Eligibility and Single Accreditation System task forces. He is also a member of the Executive, MOC, Research, Test Administration, and Test Development committees, and the KSA Task Force.

Dr. Muelleman received a medical degree from the University of Nebraska School of Medicine, and completed residency training and a research fellowship at the University of Missouri-Kansas City and Truman Medical Center in Kansas City, MO. He is currently Professor and Past-Chair of the Department of Emergency Medicine at the University of Nebraska Medical Center.

At its July 2018 meeting, ABEM also elected the following directors to the 2018-2019 Executive Committee:

Terry Kowalenko, MD, Immediate-Past President; Jill M. Baren, MD, President-Elect; and O. John Ma, MD, Secretary-Treasurer. Newly elected members of the Committee are Michael S. Beeson MD, Member at Large; and Robert P. Wahl, MD, Senior Member-at-Large. Dr. Beeson is Program Director of the Emergency Medicine Residency Program under ACGME application at Summa Health in Akron, Ohio; he was elected to the Board in 2013. Dr. Wahl is Associate Professor (Clinician-Educator) in the Department of Emergency Medicine at Wayne State University School of Medicine, and an attending physician at Detroit Receiving Hospital. He was elected to the Board in 2012. ●





Wellness Committee

# Promoting Wellness in Resident Physicians: A Program Directors Approach

Lisa Stoneking, MD FAAEM  
AAEM Wellness Committee Member



Looking to cultivate wellness for your residency program? Not so simple, right? What does physician wellness mean? Wellness, resiliency, positivity, bouncing back – as program leaders we can't even agree on a definition, let alone on how to best implement a wellbeing program for our future generation of EM doctors. Therein lies the problem – wellness is relative to the person experiencing it. There is no

single meaning. So how do we ignite a wellbeing fire in our program for dozens of our tired, vulnerable, overworked, and stressed out residents when it may be different for each of them?

We ask them! We find out what they find meaningful, what helps them find balance, what they enjoy doing with their free time. And for most of us program directors without specific “wellness program” funding, this means we get creative.

Five years ago I sat down to write my program's official wellness policy. I thought why reinvent the wheel? Certainly this has been done before. So, I borrowed templates and copied experts from other policies. Counseling – check. Call rooms – check. Protocols to deal with drug and alcohol problems – check. Cab rides home for exhausted residents – check. Feeling proud of myself for crossing an important task off my to-do list, I re-read my new program wellness policy. We had a big problem. This was not wellness. This was manifesto of necessary afterthoughts, but not wellness. I wholeheartedly agree that these checks and balances are a necessary component of any residency program, but I was saddened to think that these were the items that I had listed on my wellness policy.

And so it began – my quest to integrate a true wellness program into our residency training. I polled my residents and asked what physician wellness meant to them and requested three things that program leadership could integrate into our program to improve wellbeing. They gave me four, of course. They asked for a place to work out and do yoga together, a medical literature book club, more social gatherings, and small celebrations (with food).

Today, in addition to the original policy, our wellness program has grown to encompass the following: (I hope you steal as many of these ideas as you can fit into your program).

- Passes to the YMCA to work out, to participate in group exercise classes, to play basketball, or to swim
- A fall wellness conference day held outside at a park that includes an hour of physical activity, and topics that lay foundation for physician wellness
- A spring wellness conference held at the YMCA that incorporates interval training between lectures and a healthy breakfast
- An annual retreat that is held outside at a state park allowing for camping the night before

- Monthly organized resident family-friendly social gatherings
- Monthly birthday breakfast celebrations at didactics
- Massage chairs during wellness week in the back of conference room
- Asynchronous learning (often from 7-8 am) to allow for an extra hour of sleep for residents on evening shift. ASL allows the resident to complete the task whenever convenient for him/her, not necessarily from 7-8.
- Creation of a narrative medicine curriculum that includes two novels per year that our group reads and discusses together upon completion
- A working walking treadmill to chart while moving.
- A mini fridge in our doc box and healthy snack options in our charting room
- A constant supply of good coffee
- Primary care provider phone number list during intern orientation
- Integrated wellness lectures to lay some wellbeing foundation
- Assigned faculty mentors and resident big-sibs prior to starting residency with the program goal of meeting in September and March (so that including the biannual reviews with the PD, the resident has someone checking in on them every three months)

I just finished the book, *The Happiness Advantage* by Shawn Achor.

The premise – that we are more successful when we are happier and more positive – is exemplified in the fact that physicians who are put in a positive mood before making a diagnosis show almost three times more intelligence and creativity than doctors in a neutral state, and they make accurate diagnoses 19% faster. So, I ask, why wouldn't we want to implement a wellbeing program to foster this? Look at cutting-edge companies that have foosball tables in their lounge, massage parlors in-house, and why employees are encouraged to bring their dogs to work. I'm not suggesting we go to the extreme, but I am suggesting five minutes in the sun, healthy available snacks, a few quiet minutes to breath after a difficult patient or tough code. I'm suggesting that these things are not only ok to do but that your return on investment will lead to bottom line results.

I am proud today of the attention we are giving to our own wellbeing, and that of our residents. Today's group of eager young physicians has different definitions of wellbeing than those who helped me originally develop our wellness curriculum five years ago. Time to ask this group what they find meaningful, what balances them, what they enjoy doing with their free time.

With the summer having flown by, I encourage each of us to ask our incoming interns and current group of residents what physician wellness means to them and how we can best support them on this journey. I think you'll find that just by asking the question, they feel heard, and that they will willingly participate in helping your leadership create a tailored wellness program. ●

Geriatric Interest Group

## The Role of Geriatric Emergency Care

Danya Khoujah, MBBS FAAEM  
Chair, Geriatric Interest Group



Although geriatric patients have been around since the beginning of time, awareness of the unique care required by this patient population seems like a new development in the world of medicine. Geriatric medical care was first mentioned in 1914, barely over a century ago, and geriatric medicine in its modern sense was not recognized until three decades later, when Dr. Marjory Warren started pro-

moting specific innovations in care and publishing articles on the matter. This new direction was followed by public recognition of the medical and social needs of older adults and the development of specialized medical societies. Recognition of this specialty has been increasing exponentially as the population ages: 61 million baby boomers will become older adults in 2030. With aging, the medical and social needs of vulnerable geriatric patients are intensified, both in magnitude and complexity. Furthermore, with the current changes in health care delivery in the United States, more patients are receiving a greater portion of their care through emergency departments (EDs); older adults constitute more than 15% of the current ED population.

These changes place emergency providers (EPs) in a unique environment that enables us to proactively address elderly patients' needs and to see them when their needs are greatest. All of these factors combined have made it essential to shift gears and address this "Silver Tsunami" head on. An early initiative was the development and adoption of Geriatric Emergency Department Guidelines in 2014 by several societies, which provide a standardized approach "that can effectively improve the care of the geriatric population and which is feasible to implement

in the ED." These guidelines, built on a combination of consensus and research, provided the cornerstone of the most recent development in the geriatric world, the launch of Geriatric Emergency Department Accreditation by the American College of Emergency Physicians in May 2018. This program accredits EDs in a three-tier system, in a manner similar to trauma center designations, according to their level of geriatric-focused education, equipment, policies, and personnel.

What is the role of the American Academy in Emergency Medicine (AAEM) in geriatric emergency care? As champions of emergency medicine, we need to bolster this awareness with widespread, practical education for EPs in all venues of emergency care. We cannot limit safe, evidence-based care to centers that have opted to undergo accreditation. Changing practice can start at the level of the individual EP. This is the mission of AAEM's Geriatric Interest Group: promoting best clinical practice by advocating acknowledgment of specific considerations related to this patient group and providing accessible, evidence-based education for all. These goals can be accomplished with the time and effort of interested, hard-working AAEM members who believe that all individuals should have access to quality emergency care, and we invite you to be one of them. Geriatric emergency medicine might not be as adrenaline-inducing as starting a patient on ECMO, but with your help, we can enable every EP to view it in the important light that it deserves.

At the end of the day, improving the care we deliver to the elderly is necessary, not only because they are our most vulnerable patients but also, as a selfish quest, to lay the groundwork to ensure that we get the care we need when we are checking the "above 65 years" box ourselves. ●

## Make a Difference with AAEM's Educational Programs

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](http://www.aaem.org/about-aaem/leadership/committees)

Palliative Care Interest Group

# Palliative Care Series: Coping with Death in the Emergency Department

Deniece Boothe, DO



It is never an easy task. To walk into a room and inform a family member that their loved one has died is a daunting responsibility that we face daily in the emergency department. For many of us it has become second nature, a procedure similar to that of placing a chest tube or intubating a patient. There are steps that we take to ensure that the procedure goes well. We introduce ourselves, perhaps ask a

question about what the patient was doing prior to the event that led to his or her death. The news is then delivered that the patient died despite our efforts. Another pause follows and time is allowed for any unanswered questions and eventually we leave the room. The family is left to begin their time of grieving and often times, we the care providers, neglect our own thoughts and feelings about what just transpired and move on to the next patient. Between the adrenaline rush and the mental focus many of us feel both depleted of energy and defeated because the battle was lost to “save” that patient’s life.

Many cases resonate with us in some way. For a brief period we are provided with a glimpse of a patient’s life and what that individual meant to his/her family. Pediatric cases are viewed as more difficult because of the patient’s age. Care providers who are parents themselves may project and think about their own child/children. In some instances the individual may have initially presented to the emergency department in a stable state but rapidly declined and succumbed to an unexpected death. As care providers it is essential that we establish a process when faced with the death of a patient. This process is an essential component of self-care and maintaining resilience in our field. Without it burnout looms and eventually those negative feelings take hold and remain. Sarcasm builds, cynicism and many other negative thoughts and feelings then define how we practice. This all eventually culminates into grief and compassion fatigue. We subsequently pass this on to the next generation of physicians, our residents who view the lack of “process” as the appropriate approach to death in the emergency department.

Information about the “process” is lacking in its focus on emergency medicine physicians. The literature primarily discusses the loss of a pediatric patient and its effect on health care professionals. Additional findings include a variety of articles about compassion fatigue amongst the nursing staff or resident physicians and their ability to cope with death in the emergency department. More research is needed in this setting with the primary focus on the attending physician’s ability to cope with death.

In the field of emergency medicine we are tasked with the leadership role. We initiate resuscitative efforts and are expected to have a calm and focused approach by our team. We may be overlooked as participants in the debriefing process often due to this expectation. Many of us believe that we should be able to “function” despite our chaotic work environments and the traumatic cases we face each day without attachment or reflection. Debriefing in health care is a format to facilitate discussion of actions and thought processes, encourage reflection, and ultimately assimilate improved behaviors into practice.<sup>2</sup> It can be used to determine ways in which team performance can be improved or as a time of reflection for all care providers involved. All should be encouraged to participate and share their feelings regarding the traumatic event. Debriefing should include a friendly atmosphere, open-ended questions, honest dialogue, and identification of behaviors or perceptions that led to improved outcomes.<sup>1</sup> Some may fear that one’s job will be comprised and as a result decline participation. It is of utmost importance that confidentiality is stressed and upheld during this process in an effort to build trust for current and future sessions. The discussion should be led by facilitator, favorably one who is unbiased and trained in the process of debriefing. One proposed model is the The CISD (Critical Incident Stress Debriefing) tool. This provides structure and serves as a guide for how the discussion should be held.

1. Introduction: Ground rules are stated and the role of the facilitator is defined
2. Facts: A brief overview of the events that occurred is stated
3. Thoughts: what was each participant thinking at the time of the event?
4. Reaction: What was it about this event that bothered participants most and why?
5. Symptoms: The evolution of feelings since the event occurred (immediate and delayed).
6. Teaching: Normalize the symptoms brought up and provide stress management information
7. Reentry: Closure of the meeting. Provide an opportunity to ask questions as well as additional resources for those who need more support.<sup>5</sup>

Debriefing may not be feasible in some circumstances. The practice of mindfulness has become a more popular concept. The foundation of mindfulness is to center oneself, to be present and use the innate knowledge and wisdom to address any stressful event. It can be also be viewed as a way of “pressing the reset button” before re-entering the chaos of the shift. This involves slowing your breathing, calming your mind and emotions in an effort to perform at your most optimal state. With repetition a stable foundation can be established and allow for appropriate processing when dealing with patient death in the emergency department. ●



## References

1. Fanning RM, Gaba, DM. The role of debriefing in simulation-based learning. *Simul Healthc*. 2007;2:115-125
2. Kessler, David & Cheng, Adam & Mullan, Paul. Debriefing in the Emergency Department After Clinical Events: A Practical Guide. *Annals of Emergency Medicine*. 10.1016/j.annemergmed.2014;65(6): 690-698.
3. Olsen JC, Bueneffe ML, Falco WD. Death in the emergency department. *Ann Emerg Med* 1998;31:758-765.
4. Papadatou D. A Proposed Model of Health Professionals' Grieving Process. *Journal of Death and Dying*. 2000; 41,(1): 59 – 77.
5. Mitchell JT [www.info-trauma.org](http://www.info-trauma.org). Critical Incident Stress Debriefing (CISD)
6. Schmitz GR, Clark M, Heron S, et al. Strategies for coping with stress in emergency medicine: Early education is vital. *Journal of Emergencies, Trauma, and Shock*. 2012;5(1):64-69. doi:10.4103/0974-2700.93117.
7. Wolfe H, Zebuhr C, Topjian AA, et al. Interdisciplinary ICU cardiac arrest debriefing improves survival outcomes. *Crit Care Med*. 2014;42: 1688-1695.
8. Sandhu N, Eppich W, Mikrogianakis A, et al. Postresuscitation debriefing in the pediatric emergency department: a national needs assessment. *CJEM*. 2013;15:1-10.
9. Staple L, O'Connell K, Mullan P, et al. National survey of pediatric emergency medicine fellows on debriefing after medical resuscitations. *Pediatr Emerg Care*. 2014 Sep 5.



## Palliative CORNER

Stay tuned for bi-monthly pearls about how to integrate palliative care into your daily emergency medicine practice. We will showcase best practices, common pitfalls, and challenging cases relevant to your everyday work. Even better, join the AAEM Palliative Care Interest Group for scholarship, mentorship, and networking:

[www.aaem.org/get-involved/committees/interest-groups/palliative-care](http://www.aaem.org/get-involved/committees/interest-groups/palliative-care)

## Join the AAEM Clinical Practice Committee

Research and publish the important cutting edge information for the practicing emergency medicine physician.

## Make an important statement to the world of emergency medicine.

## We want you!

### How to join?

Learn more and apply at: [www.aaem.org/get-involved/committees/committee-groups/clinical-practice](http://www.aaem.org/get-involved/committees/committee-groups/clinical-practice)

### Chair

Steve Rosenbaum, MD FAAEM

### Co-Chair

Michael Abraham, MD FAAEM

### Contact:

[info@aaem.org](mailto:info@aaem.org)  
800-884-2236



Current PGY-2 or greater  
EM residents



EM subspecialty  
fellows



Board certified  
EM attendings

# Building Your Financial Team

Danielle Goodrich, MD FAAEM and Jeffrey Goodrich, MBA MSFC CFP ChFC



After you have settled into your medical practice, it is important to make your financial health a priority. While your colleagues, friends, and family may be able to provide insight and advice, consider building your financial team with trusted advisors. There are many financial experts in specialized fields who are available to assist you: an attorney for legal advice, a tax advisor to address tax matters, a real estate

professional for property advice and a financial advisor to help put all of your financial pieces together. (Zweig 2016)

Before you start working with a financial advisor, first prioritize what financial goals you would like to accomplish. For example, if you have student loans outstanding, paying them off should be at the top of your priority list. In addition, you should look into ways to maximize your retirement options. It may feel like a long way off, but it is important to start saving for large expenditures such as a house or your child's education.

When working with a financial planner, their only objective should be to help you prioritize your financial goals by developing a financial plan to achieving them. Depending on your proposed savings rate, a financial advisor will help allocate your available funds and establish a timeline for the completion of all of your financial goals. (Dalton & Dalton 2017)

There are many different types of financial professionals and financial services firms available to assist you, depending on your specific needs. You may choose to work with financial representatives who work either for an investment brokerage firm, insurance company, bank, or credit union. Captive representatives sell the investment and or insurance based products of their parent company or you have the option to choose to work with financial and or insurance representatives that provide more of a holistic approach to financial management. While many financial professionals work on a commission, there are others who work on a fee-based platform. Likewise there are currently a number of discount brokered firms available in the marketplace.

While this may feel like a large task to begin, the first step you should be taking is where to start looking for a financial planner that you can trust. A great place to start is to look to relatives and colleagues for referrals and to check with local and national financial planning organizations that you can survey to find the right financial planner that best fits your needs. Ask these prospective candidates how long they have been in the financial services industry, their educational background, if they specialize, and if you could speak with one or more of their clients. (Shin 2013) A certified financial planner is expected to have passed the requisite exam and is required to complete continuing education so that their knowledge is up to date. (Stanzak 2007) Remember to always review the products they sell to ensure they are in line with your specific financial goals.

Just as we advocate for our patients on a daily basis, we should make sure that we have someone in our corner as well. The earlier you start planning, the closer your financial goals will be to materializing. Consider taking that first step today. ●

## References

1. Dalton, J. F., & Dalton, M. A. (2017). *Retirement Planning and Employee Benefits* (13th ed.). Metairie, LA: Money Education.
2. Shin, L. (2013). 10 Questions to ask when choosing a Financial Advisor. Retrieved from [www.forbes.com](http://www.forbes.com)
3. Stanzak, J. (2007). A Guide to Financial Planning Retrieved from [online.wsj.com](http://online.wsj.com)
4. Zweig, J. (2016). The Keys to the Best Financial Advice. Retrieved from <https://blogs.wsj.com/moneybeat/2016/06/03>



## AAEM

# Young Physicians Section (YPS)

FREE

\*AAEM membership required

**GET  
PUBLISHED IN  
COMMON SENSE  
NEWS**

**MENTORING  
PROGRAM**

**RULES OF THE  
ROAD FOR YOUNG  
EMERGENCY  
PHYSICIANS  
eBOOK**

**NETWORKING**

**CV REVIEW  
SERVICE**

**EM  
FLASH  
FACTS APP**

**AAEM**  
YOUNG PHYSICIANS SECTION  
INVESTED IN YOUR FUTURE

Personalized resources  
for your first 5 years out  
of residency!

[WWW.YPSAAEM.ORG](http://WWW.YPSAAEM.ORG)

[INFO@YPSAAEM.ORG](mailto:INFO@YPSAAEM.ORG)

## AAEM/RSA President's Message

# "You Get a White Coat! You Get a White Coat! Everybody Gets a White Coat!"

MohammedMoiz Qureshi, MD  
AAEM/RSA President



The subject of white coats in medicine often attracts varied and sometimes divisive opinions. Even as an EM resident who will never truly need to wear one again, I have to say that I am still a staunch proponent of their significance. Hospitals these days in my mind have become an Oprah Winfrey special: "The White Coat Giveaway." It seems like if you happen to have any sort of position that involves working around patients you are afforded a white coat. Now yes many will feel that is a wild exaggeration, but many physicians and medical students have echoed the sentiments that the symbolism behind the traditional white coat has gone by the way side. In a general hospital setting it seems most everyone is wearing a long white coat; everyone except of course the lowly medical student who of course is wearing the shorter derivation; but we'll address that in a moment. Care coordinators, phlebotomists, social workers, scrub techs, even janitorial services, have all been sighted flashing, what once was considered, a symbol of the utmost medical and surgical expertise. Now however, it has been cited as a reservoir for bacterial overgrowth and evidenced to induce medical conditions such as "white coat hypertension." And while these concerns appear legitimate, the underlying question becomes why, instead of doing away with the garment as a whole and replacing it with some other form of social identification, have we allowed instead for anyone and everyone to wear it?

Physicians in clean pressed white coats used to be a distinctive feature carried by those who obtained the highest level of training. The coat was given respect and relayed empathy and professionalism. But much like medicine as a whole, it has lost the respect that came with it. Physicians nationwide have felt a growing trend of disrespect and abuse from patients that was unheard of 50 years ago. And it's not to say that is because we have stopped wearing our white coats, but I believe it speaks to the bigger issue: we have stopped asking for the respect that we used to receive.

Emergency medicine seems to be one of the specialties affected by this phenomenon the most. We serve as the safety net of society, we have kept our doors open, but somehow along the way we also have allowed ourselves to be mistreated and abused, verbally and anecdotally physically, by our patients. We have been made to feel guilty about our decision making when it is not to the pleasure of our patients and are often pressed to ignore practicing evidence based medicine to appease a clientele. This trend, as we're all aware, however is not limited to EM alone.

The laxity in who is given a white coat I believe is a small glimpse in to that trend. The distinguishing feature that was once unique to us, has now been distributed widely and is no more than a sign of being employed in a hospital or lab. Putting on a white coat for the first time used to mark an important rite of passage for a young doctor in training. The "White Coat Ceremony," was meant to be a powerful reminder of

compassion, integrity, and professionalism as medical students embarked on their new role as health care providers. But, as a young resident myself, I feel like my current white coat and any previous shorter versions have all become and insignificant common accessory.

It begs me to wonder why medical students are still subjected to the short one. The juxtaposition of an undergrad research student shadowing in the ED in a long white coat against my MS4 who is taking histories and developing plans in the short white coat is baffling. Many argue tradition, but essentially we are putting them into an identifiable class of individuals and furthering the notion of hierarchy in medicine that we are imposing



"The coat was given respect and relayed empathy and professionalism. But much like medicine as a whole, it has lost the respect that came with it."

on ourselves. This hierarchy however seems to only pertain to physicians as we have allowed other professions to all wear the long white coat while subjecting our students to be identified as less experienced or capable when that is simply not true.

This has become not only confusing for patients but has also served to be dangerous. This process of destigmatizing the white coat has lead to various individuals throwing on the coat and in many cases misrepresenting themselves to patients and other health care professionals. It contributes to the confusion between advanced level practitioners and licensed physicians and has even seen a 14-year-old Florida teenager able to convince patients that he could perform pelvic exams, and issue fake prescriptions. When evaluating this root cause of general apathy towards the

Continued on next page



white coat, and with it the doctors that come in them, I believe that we, as physicians, should take accountability.

We wanted to abolish the white coat when we felt we were inducing “white coat hypertension” and wanted to appear approachable to pediatric patients. And while with all good intentions, what we have done in fact is given away a symbol of our specialty and profession without replacing it. This has led to the death of it and to me speaks as a symbol to something bigger in medicine. It boils down again to the fact that we have stopped asking for that respect for ourselves and our colleagues. This general trend to me is felt more personally in our emergency departments. And it doesn’t start or end with just patient interactions. We in the ED specifically, are more and more frequently being asked to give up on our expertise. Our certification requirements are questioned, our procedures and protocols are scrutinized, accessory credentialing merit badges are demanded, and we are losing claim to territory that has and should be ours. So let there be no mistake, my fundamental irritation with this “white coat for everyone” TV phenomenon is not with the garb itself but the overall trend that medicine has been growing towards. Drawing further and further away from the physician and the dedication and hard work that has come with patient care and muddying the lines in the name of inclusion. Looking forward, the future of the white coat looks bleak, but the future of emergency medicine doesn’t have to. By advocating for ourselves unapologetically, demanding an equal seat at tables discussing our practices, and standing our ground when our sound medical decision making is opposed, we can perhaps prevent the same fate as the white coats we once adorned. ●

## AAEM19 OPPORTUNITIES FOR RESIDENTS AND STUDENTS

### LEARN MORE AT

[www.aaem.org/AAEM19/program/residents](http://www.aaem.org/AAEM19/program/residents)

AND

[www.aaem.org/AAEM19/program/students](http://www.aaem.org/AAEM19/program/students)



AAEM19 is the ideal conference for residents and students to attend. With specialized sessions and content tailored to you, there are valuable opportunities to take advantage of every day of the assembly.

## AAEM/RSA Podcasts – Subscribe Today!



This podcast series presents emergency medicine leaders speaking with residents and students to share their knowledge on a variety of topics.

Don't miss an episode - subscribe today!



Steps to Building a Career in Emergency Medicine

Niches in EM

Physician Suicide

Wilderness Medicine Fellowships

Ultrasound Fellowships

Administration Fellowships

Caring for the Acutely Psychotic in the ED, Psychosis or Not?

Psychiatry in the Emergency Department

FOAM at the Bedside

Developing International Residency Programs

Global Emergency Medicine Development

Significance of Completing a Residency Rotation Abroad

RSA Advocacy Opportunities

RSA Advocacy

Corporate Practice of Emergency Medicine

FemInEM

American Board of Emergency Medicine (ABEM)

How to Match in EM

How to Excel on your EM Clerkship

TOPICS  
INCLUDE:

AAEM/RSA Editor

# Empathy in the Emergency Department

Nick Pettit, DO PhD

AAEM/RSA Board Member



Emergency medicine is hard! The emotional toll that this job has on providers and ancillary staff cannot be overstated. For example, think back to a shift where a patient waited hours to be evaluated, or where pain medication was delayed for a person that has an obvious injury, (due to a systems error), or where a patient receives news that they likely have cancer. These situations are stressful and can con-

siderably impact how a patient experiences their emergency department (ED) visit. Furthermore, these situations directly also impact the physician which in turn results in personal dissatisfaction, emotional fatigue, depersonalization, and ultimately burnout. Whether one is practicing in community emergency medicine or in the ivory tower of academia, patient care can continuously be improved and communication is one avenue that can always be improved. Communication is frequently a common source of complaints, issues, bounce-backs to the ED, and is a potentially easily altered part of our practice.

One avenue for circumventing burn-out and improving the patient-physician experience is through empathic communication. Several studies demonstrate that empathy, which is simply the ability to understand, recognize, and share the feelings with another human, improve the patient-physician experience. Demonstrating empathy 100% of the time seems challenging, especially within the chaotic confines of an emergency department. However, by practicing and honing one's skills on empathic communication, physicians can improve and control many variables of the patient's ED visit. To summarize multiple recent peer reviewed publications, empathy reduces litigation, improves clinical outcomes, improves patient satisfaction, and can reduce burnout. Most importantly, the cost to all consumers is free, and herein are some tips and tricks to improve empathetic communication.

Strategies for improving empathy and ultimately communication begin with recognizing that communication is the most important aspect of a clinician's job. Empathic communication begins with non-verbal communication at the bedside. Remember, time is not a limiting factor for effective empathic communication. Walk in to the room, sit next to the patient, and focus on that particular patient encounter. For a short period of time become disconnected with the STEMI alert that is 10 minutes or the 55-year old female with an acute COPD exacerbation in bed 13, but one's focus and attention should be on the patient in front of you.

In addition to non-verbal cues and communication, well demonstrated in the palliative care literature, a mnemonic NURSE is an excellent tool for responding and handling patient emotions and demonstrating empathy. In its entirety, this mnemonic only takes a minute or two to apply, which further develops and nurtures the necessarily close relationship between the physician and the patient and/or family.

**N.** Name the emotion in a suggestive manner that the family or patient may be experiencing. "I wonder if you are feeling sad?" "When patients hear this they are usually distraught or upset."

**U.** Understanding their feelings. Summarize what you hear the patient say. "Patients that go through this usually feel XYZ." "I am hearing that your family member was diagnosed with a stroke and that they had a hard time with it and since you had a stroke that must be challenging."

**R.** Respect. Demonstrate respect and match the intensity of the emotion in the room by acknowledging it. Use nonverbal and verbal cues to respect and validate their emotions. Accept their views without judgement and congratulate good coping mechanisms.

**S.** Support. Support the patient, the family, the friends of the patient. "I anticipate that you will be in the ED for approximately 4 more hours and I will be here with you the entirety of your stay." Provide and recruit social workers, chaplains, and case managers to help support the family. Rely on strong family members to help support struggling family members.

**E.** Explore. Ask them how else you can be of service. Express and explore interest in something someone said. Target the questions to their emotions.

Understanding and applying the NURSE mnemonic is an excellent, efficient, and commonly taught tool for improving empathic communication. As this tool is used more commonly in one's practice it becomes less of a rote-mnemonic but instead it develops and morphs into how we communicate daily. By applying the NURSE mnemonic, practicing nonverbal cues, and recognizing the importance of developing a relationship and effective and empathetic communication we can reduce burnout, improve patient satisfaction, and ultimately improve patient care. ●

## Resident Journal Review:

# Update on Contrast-Induced Nephropathy

Authors: Robert Brown, MD and Caleb Chan, MD MPH

Editors: Kami M. Hu, MD FAAEM and Kelly Maurelus, MD FAAEM

## Questions

1. Does the administration of intravenous iodinated contrast increase the risk of clinically-relevant kidney injury?
2. Does preventative hydration with intravenous fluids decrease the occurrence of kidney injury attributed to contrast administration?

## Introduction

Contrast-induced nephropathy (CIN), most commonly defined as an increase in serum creatinine of 0.5mg/dL or a 25% increase from baseline one to three days after an exposure to intravenous (IV) iodinated contrast, currently remains a diagnosis of exclusion with an uncertain prevalence. Documented estimates range from an incidence of 1% in general hospital patients to 50% of high-risk coronary angiographies.<sup>1</sup> It is thought to be associated with renal failure, need for dialysis, and death, but causality has never been definitively determined due to uncontrolled confounding variables in existing studies.<sup>2,3,4</sup> Despite changes to computed tomography (CT) protocols and the introduction of low- and iso-osmolar contrast agents, there are no recent prospective controlled trials examining contrast nephropathy. Recent articles in emergency medicine (EM), radiology, and nephrology society journals attempt to determine clinically-relevant outcomes associated with IV contrast administration, accurate estimates of risk, and the value of treatments proposed to mitigate that risk.

**Aycock RD, Westafer LM, Boxen JL, et al. Acute Kidney Injury After Computed Tomography: A Meta-analysis. *Ann Emerg Med.* 2018;71(1):44-53.**

The authors of this study wanted to examine patient-centered outcomes occurring in patients who received IV contrast for CT studies compared to those who underwent CT scans without. The primary endpoint was the rate of acute kidney injury (AKI); secondary outcomes included rates of renal replacement therapy (RRT) and mortality. The authors included existing journal articles through 2016 and abstracts from nephrology, radiology, and EM conferences from 2009 to 2016. They excluded case reports, review articles, other meta-analyses, and articles involving procedural contrast, pediatric patients, and studies evaluating prevention or prophylaxis.

A total of 28 studies met criteria, including roughly 107,000 patients, almost all of whom received low- or iso-osmolar contrast. All of the studies were observational and the majority (23 of the 28) were retrospective. Most of the studies evaluated and defined AKI (26/28), 13 measured the rate of RRT, and 9 measured mortality (all but one in the inpatient setting). The authors estimated the degree to which heterogeneity between studies affected the outcome of the meta analysis with an  $I^2$  statistic (with an  $I^2$  closer to zero indicating that differences between the studies in a meta-analysis having little impact on the trends in outcome, and an  $I^2$  closer to 1 if the heterogeneity between studies has impacted the meta-analysis). The authors found no difference between patients receiving contrasted versus non-contrasted CTs in rates of AKI (odds ratio (OR) 0.94, 95% CI 0.83-1.07), need for RRT (OR 0.83, CI 0.59-1.16),

or mortality (OR 1, CI 0.73-1.36). The  $I^2$  statistics were 0.65 for AKI, 0.2 for RRT, and 0.36 for mortality. Among studies matching cases and controls, the OR was 0.98 (CI 0.92-1.05) for AKI. Comparison between emergency department (ED), trauma, and critical care settings revealed no difference. The type of contrast administered, the follow-up timing of creatinine measurements, and the methods for matching cases and controls likewise demonstrated no differences. Additional planned subgroups with insufficient data for analysis included the body area scanned, patient comorbidities, and the definition of contrast-induced nephropathy used. A funnel plot and Harbord-Egger test of bias were calculated at -0.18 ( $p=0.7$ ), representing a low likelihood of publication bias.

The authors concluded there was no evidence of increased risk of AKI, RRT, or mortality associated with IV contrast. There was likely some amount of selection bias introduced by the inherent fact that whether or not a patient received a contrasted versus noncontrasted CT may have been affected by their physician's assessment of their risk of kidney injury. Additionally, there was some variation in different studies' definitions of acute kidney injury and different timing of follow-up renal function measurements, with less than 20% of the data collected beyond 72 hours, decreasing the likelihood of discovering RRT requirement or mortality. Significant confounding was likely as many studies controlled for neither potential nephrotoxic nor renoprotective treatments. Finally, only 7 studies (55% of patients) matched cases with controls.

**Hinson JS, Ehmann MR, Fine DM, et al. Risk of Acute Kidney Injury After Intravenous Contrast Media Administration. *Ann Emerg Med.* 2017;69(5):577-586.**

In an attempt to limit the confounding variables of past studies, Hinson et al. designed their single-center, retrospective, case-control study with two control groups and large sub-populations of all renal function levels. There were two control groups: patients receiving CT scans and patients not receiving CT scans. They included all ED patients 18 years of age or older who had measurements of their creatinine both in the 8 hours before and 48 to 72 hours after CT (or ED treatment, if they were a part of the non-CT arm). The CT arms included patients receiving both contrasted and noncontrasted studies. They excluded patients with extremely high ( $>4\text{mg/dL}$ ) or low ( $<0.4\text{mg/dL}$ ) initial creatinine, history of dialysis, a CT scan in the six months before the study start date, or a contrast study performed within 72 hours of discharge. They used propensity score matching by age, sex, race, initial renal function, comorbidities (diabetes, HIV, hypertension, congestive heart failure, and chronic kidney disease (CKD)), acuity (as measured by hypotension, critical care, anemia, and decreased albumin level), and the use of nephrotoxic or renoprotective medications. They made their results comparable to other studies by analyzing the incidence of CIN with both of the common definitions used in other studies: the AKI Network definition<sup>5</sup> and the traditional definition of CIN. The study was powered to detect differences as small as 1.5%.

Continued on next page



Thirteen thousand out of 55,000 patients with CTs and 5,000 of 115,000 patients without CTs met criteria for inclusion in the study. The vast majority of cases were excluded because of a recent CT at another encounter or the absence of an initial or follow up creatinine level (96% of exclusions). The multivariate analysis found no independent effect of contrast media on the development of AKI, a finding that persisted even after propensity score matching. The majority (86%) of AKIs were stage 1 (serum creatinine rise  $\geq 1.5$  times the baseline) but the ORs were similar among all stages of AKI. There were no differences in subgroups based on initial renal function, though only 62 patients presented with severe renal disease and only 4 of these received contrast, precluding analysis in this group. The probability of developing CKD or end-stage renal disease (ESRD) within 6 months of exposure was the same between groups after propensity score matching.

The authors concluded that the risk of AKI with contrast is likely overestimated in the literature but there are many limits to this conclusion. The contrast group was younger and had better initial renal function and fewer comorbidities than the control group. Outcomes like CKD and the need for dialysis were only followed as far as 6 months after exposure. The majority of patients were inpatient, overestimating the rate of AKI in the general ED population and leaving unaccounted for therapies and potential nephrotoxins received while patients were admitted. Though the authors made corrections for a thorough list of confounding factors, they could not account for practice patterns in which physicians already decline contrast for patients whom they judge to be at high risk for developing renal failure.

**Wilhelm-Leen E, Montez-Rath ME, Chertow G. Estimating the Risk of Radiocontrast-Associated Nephropathy. *J Am Soc Nephrol*. 2017;28(2):653-9.**

Noting the wide variance in the reported incidence of contrast nephropathy, the authors designed this retrospective case-control study to compare the incidence within subgroups based on specific comorbidities. They defined AKI as an absolute increase in creatinine of 0.5mg/dL or a 25% increase over baseline. They utilized the 2009 National Inpatient Sample (NIS) dataset, the largest publicly available all-payer inpatient health care database in the United States representing a sample of all payer types in 46 states and Washington, DC. They evaluated the percentage of patients diagnosed with AKI and then stratified these patients by significant comorbidities using Chi-squared testing for significance.

Of the almost 8 million hospitalizations available, they selected adults with hospitalizations of 10 days or less, leaving approximately 6 million visits. In the overall population, there was no difference in the incidence of AKI among those who received contrast and those who did not (5.5 vs 5.6% respectively,  $p=0.51$ ). When stratified according to severity of comorbidity, the rate of AKI increased in both contrast and noncontrast groups as severity increased. In patients with less severe comorbidity, however, the odds of AKI were found to be higher in the noncontrast group. Also, when adjusted for age, sex, mechanical ventilation, and comorbidity, there was a decreased incidence of AKI in the contrasted group compared to the group who did not receive contrast (5.1 vs 5.6%, OR 0.93, 95% CI 0.88-0.97). There were specific subpopulations in which the administration of contrast was associated with higher risk of AKI: sepsis, pneumonia, urinary tract infection or pyelonephritis, peritonitis, GI bleeding, COPD,

and acute pancreatitis. The increased absolute risk tended to be small (1.2-3.6% higher) with the exception of acute pancreatitis in which AKI was twice as likely in the contrast arm (16.4% vs 8.2%). Contrary to expectations, there were also specific subpopulations in which the incidence of AKI was lower in the contrast arm, including patients with congestive heart failure, endocarditis, acute coronary syndrome (ACS), venous thromboembolism, and stroke.

The authors conclude that the overall incidence of CIN is likely lower than previously estimated in the general population but significantly higher in specific pathologies. They propose that physician practices introduce bias inherently, minimizing contrast administration in patients deemed to be at high risk of AKI in low-risk illness settings but giving contrast to the sickest patients, with the highest likelihood of developing AKI, if it is deemed to be the best chance the patient has at survival. Similarly, to explain the higher incidence of AKI in acute pancreatitis compared to ACS, they propose that physician practices influence the correlation between AKI and contrast by withholding or delaying contrasted studies from ACS patients perceived to be at higher risk for AKI, while the sicker acute pancreatitis patients who are at high risk for AKI often receive contrasted CT scans looking for complications such as necrosis or abscess.

Despite a large, representative sample, this study is limited by its use of diagnosis codes in a dataset to define AKI, likely leading to missed cases or inclusion of potentially inappropriate diagnoses. Also, there was no means to relate the development of AKI temporally to contrast administration, only to determine that both occurred during the same hospitalization. The conclusion that selection bias exists because of physician practice patterns is common across many studies and the authors argue it is unlikely to be resolved, even if trials account for almost all confounding variables. Without randomization, the effect of the physician decision to withhold contrast is likely the most important uncontrolled variable.

**Nijssen EC, Rennenberg RJ, Nelemans PJ, et al. Prophylactic hydration to protect renal function from intravascular iodinated contrast material in patients at high risk of contrast-induced nephropathy (AMACING): a prospective, randomised, phase 3, controlled, open-label, non-inferiority trial. *Lancet*. 2017;389(10076):1312-22.**

There is no established treatment for CIN, and therefore the focus of current medical therapy is prophylactic hydration with IV fluids. Despite limited data, this prophylaxis is recommended especially for patients who already have some element of CKD, defined as an estimated glomerular filtration rate (eGFR) of less than 60mL/min/1.73m<sup>2.6</sup>. Due to the lack of data surrounding the efficacy and cost-effectiveness of prophylactic hydration, the authors designed a single center, prospective, parallel-group study to evaluate the non-inferiority and cost-effectiveness of no prophylaxis compared to prophylaxis with intravenous hydration. They selected adult patients receiving IV contrast, who had underlying risk factors to develop CIN. Patients met inclusion criteria if they had a pathology with a high risk for nephropathy (multiple myeloma or lymphoplasmacytic lymphoma with small chain proteinuria), or significantly decreased renal function (eGFR of 30-45 mL/min/1.73 m<sup>2</sup>), or if they had renal function closer to normal (45-59mL/min/1.73m<sup>2</sup>) but with additional risk factors, such as either diabetes or at least two of the following: age over 75 years, anemia,

cardiovascular disease, non-steroidal anti-inflammatory drug (NSAID) or diuretic nephrotoxic medication. Authors excluded subjects with an eGFR less than 30 mL/min/1.73 m<sup>2</sup>, those already on renal replacement therapy, patients who required emergent procedures, and intensive care patients. The primary endpoints were the occurrence of CIN and the cost-effectiveness of no prophylaxis compared with IV prophylactic hydration in the prevention of CIN. The authors defined CIN as an increase in serum creatinine more than 25% or 44 µmol/L within two to six days of exposure. Secondary endpoints were the mean change in serum creatinine from baseline both early (2-6 days from exposure) and late (26-35 days from exposure), as well as major adverse events (all-cause mortality, RRT, intensive care admission, and sequelae of fluid administration).

Ultimately, 660 patients were randomized into two groups matched by the presence or absence of diabetes, eGFR less than or greater than 45 mL/min/1.73m<sup>2</sup>, contrast administration route (IV vs intra-arterial) and procedure type (diagnostic vs interventional). One group received prophylactic hydration with 0.9% saline using either a short protocol of 3–4 mL/kg/hr during the 4 hours before and 4 hours after contrast administration, or a long protocol using 1 mL/kg/hr during the 12 hours before and 12 hours after contrast administration, chosen according to baseline patient comorbidities such as decreased ejection fraction. In the 328 patients with prophylactic intravenous hydration, the mean volume of IV fluids administered was 1637mL. Of 332 patients who received no prophylaxis, the volume was 0mL. There was no difference between the two groups in the incidence of contrast nephropathy (2.7% vs 2.6%, with an absolute difference in proportions of –0.10% (CI -2.25-2.06; one-tailed p=0.4710)). There was no significant difference in the incidence of CIN in pre-planned subgroups (diabetics, patients with an eGFR <45, type of contrast administration route, or those who had an interventional procedure). There were no instances of acute renal failure (eGFR <15), intensive care admission, or dialysis requirement in either group. Adverse events, defined as symptomatic heart failure, hypo- or hypernatremia, or arrhythmia, occurred in 5.5% (18/328) of the prophylaxis arm, resulting in premature discontinuation of IV hydration, diuresis, or extended hospital stay in 4% (13/328), compared to zero patients in the no-prophylaxis arm (p=0.0001). No hydration was significantly cost-saving compared to IV hydration, with increased hospitalization in the prophylaxis arm as the largest reason for increased cost.

The authors conclude that holding prophylaxis for CIN is non-inferior to and more cost-effective than prophylaxis with intravenous hydration, and that IV hydration can likely be withheld in patients with eGFRs greater than 29mL/min/1.73m<sup>2</sup>. Limitations include the open-label nature of the study, as well as the exclusion of some of the patients at highest risk for AKI, such as those with an eGFR less than 30mL/min/1.73m<sup>2</sup> and the critically ill. This exclusion may account for the lower general incidence of CIN overall (2.6-2.7% of patients). The generalizability of their findings is also weakened by the small sample size and restriction to a single center.

## Conclusion

As further evidenced by these studies, IV iodinated contrast is likely safe in most patients, even those with risk factors for contrast-induced nephropathy. It is important to note that this likelihood remains in the context of clinician judgment, which adjudicates which patients, at which risk levels, actually receive contrast and how much they receive. As a laboratory-based diagnosis of exclusion, this disease in particular lends itself to confounding and selection and measurement bias. We, as physicians, know it is unwise to administer contrast indiscriminately, and we maintain it is likewise incorrect to slavishly follow guidelines without data behind them, especially in situations where the benefits of contrast administration outweigh the actual risk of CIN.

## Answers

1. Current evidence does not indicate that the administration of IV contrast increases the incidence of clinically-relevant AKI in most patients.
2. Hydration with IV normal saline does not decrease the incidence of AKI after contrast in patients with an eGFR of 30mL/min/1.73m<sup>2</sup> or greater. ●

## Additional References

1. Lopez-Ruiz A, Chandrashekar K, Juncos LA. Changing paradigms in contrast nephropathy. *J Am Soc Nephrol*. 2017;29(2):397-9.
2. Coca SG, Peixoto AJ, Farf AX, et al. The prognostic importance of a small acute decrement in kidney function in hospitalized patients: a systematic review and meta analysis. *Am J Kidney Dis*. 2007;50(5):712-20.
3. Mitchell AM, Kline JA, Jones AE, Tumlin JA. Major adverse events one year after acute kidney injury after contrast enhanced computed tomography. *Ann Emerg Med*. 2015;66(3):267-74.
4. Solomon RJ, Mehran R, Natarajan MK, et al. Contrast induced nephropathy and long-term adverse events: cause and effect? *Clin J Am Soc Nephrol*. 2009;4(7):1162-9.
5. Mehta RL, Kellum JA, Shah SV, et al. Acute Kidney Injury Network: report of an initiative to improve outcomes in acute kidney injury. *Crit Care*. 2007;11(2):R31.
6. Kidney Disease: Improving Global Outcomes (KDIGO) Acute Kidney Injury Work Group. KDIGO Clinical Practice Guideline for Acute Kidney Injury. *Kidney Int*. 2012;2:124–138

Medical Student Council President

# Wellness in Medical School

Shae Boles

Medical Student Council President



Attention to wellness in medical school has been increasing over the years. The AAMC issued a statement on clinician well-being which also applies to medical students stating, "The AAMC supports a culture in academic medicine that values the well-being of faculty, staff, and learners. An environment that prioritizes health professionals' well-being aligns with the AAMC mission of improving the health of all."

Medical schools have been following suit and increasing their resources and focus on wellness.

## What exactly are schools doing about it?

There is no one-size-fits all model that works for every medical school, but attempts have been made to create a generalized model that has proven success. The program at Vanderbilt University School of Medicine has gained attention and appears to be leading the way as a national model. The program has 3 major components: Advisory College to provide counseling and wellness advice, Student Wellness Committee, and Vanderbilt Medical Student Live, a longitudinal curriculum-adjunct program focusing on the personal development of medical students. This program is a way to curb the results of a study done at Vanderbilt that showed that 25% of students were at least mildly depressed and around 20% of men and 40% of women had clinically significant anxiety. Another way medical schools are trying to reduce stress are by switching to pass/fail grading. Researchers have found a reduction in perceived stress and an improvement in overall well-being, group cohesion, and satisfaction with the quality of medical education in institutions with pass/fail<sup>1-3</sup>, and a multi-institutional study involving seven medical schools found higher levels of stress, emotional exhaustion, and depersonalization in schools that used grading schemes with three or more levels, compared with schools that used pass/ fail grading.<sup>4</sup> Many schools have Wellness programs run by Student Affairs. These programs aim to promote health and stress reduction in a community environment. Schools have also tried reducing strain on students by creating elective opportunities for them to explore other interests and find peers with similar curiosities.

## What can students do about it?

There is no doubt that medical school can be a trying time, causing some students to at times feel depressed, uncertain, incompetent, and alone in their struggles. Implementation and awareness of wellness programs at various medical schools is important. Students should be encouraged to take advantage of the resources available to them. In addition, some things students can do on their own include:

1. Exercise, especially in groups. Checking the local gym for classes is a good way to get involved. Exercise is important for the mind and improves memory and thinking skills. Something like yoga is additionally relaxing.
2. Eat healthy. Go for nutrient dense, unprocessed snacks to feel well and stay healthy.
3. Take breaks. The Pomodoro Technique is a time management method that uses a timer to break down work into intervals separated by short breaks. This is a great way to stay focused and reward your hard work.
4. Sleep! Sleep is necessary for memory priming. As students, sometimes we have no choice but to stay up late and get up early, but time management can usually ensure at least 6-8 hours, which is important for long term learning.
5. Find a hobby. Medical school is time consuming but having outside interests can make you feel well-balanced, and can benefit you come time for residency applications and interviews! It gives reviewers a sense of who you are.
6. Get involved! Join your wellness committee at school, or start one if it is lacking! Even something as simple as getting a group together at the gym can be a great way to bond outside of medicine.
7. Support each other. A recent multi-institutional study reported that 11.2% of medical students reported experiencing suicidal ideation in the previous year.<sup>5</sup> Reach out to those in need and do not feel ashamed for asking for help. Many schools have anonymous reporting systems in place if you are concerned about a colleague or friend. **And, if you are in crisis, please call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255), or contact the Crisis Text Line by texting TALK to 741741.** ●

## References

1. Bloodgood RA, Short JG, Jackson JM, Martindale JR. A change to pass/fail grading in the first two years at one medical school results in improved psychological well-being. *Acad Med*. 2009;84:655-662
2. Rohe DE, Barrier PA, Clark MM, Cook DA, Vickers KS, Decker PA. The benefits of pass-fail grading on stress, mood, and group cohesion in medical students. *Mayo Clin Proc*. 2006;81:1443-1448
3. Robins LS, Fantone JC, Oh MS, Alexander GL, Schlafer M, Davis WK. The effect of pass/fail grading and weekly quizzes on first-year students' performances and satisfaction. *Acad Med*. 1995;70:327-329
4. Reed DA, Shanafelt TD, Satele DW, et al. Relationship of pass/fail grading and curriculum structure with well-being among preclinical medical students: A multi-institutional study. *Acad Med*. 2011;86:1367-1373
5. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and suicidal ideation among U.S. medical students. *Ann Intern Med*. 2008;149:334-341





# { Job Opportunities }

Assistant Medical Director  
Pediatric Emergency Medicine Leadership  
Assistant Program Director  
Vice Chair, Research



## What We're Offering:

- We'll foster your passion for patient care and cultivate a collaborative environment rich with diversity
- Salaries commensurate with qualifications
- Sign-On Bonus
- Relocation Assistance
- Retirement options
- Penn State University Tuition Discount
- On-campus Fitness Center, day care, credit union and so much more!

## What We're Seeking:

- Experienced leaders with a passion to inspire a team
- Ability to work collaboratively within diverse academic and clinical environments
- Demonstrate a spark for innovation and research opportunities for Department
- Completion of an accredited Emergency Medicine Residency Program
- BE/BC by ABEM or ABOEM
- Observation experience is a plus

## What the Area Offers:

We welcome you to a community that emulates the values Milton Hershey instilled in a town that holds his name. Located in a safe family-friendly setting, Hershey, PA, our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Known as the home of the Hershey chocolate bar, Hershey's community is rich in history and offers an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

**FOR ADDITIONAL INFORMATION PLEASE CONTACT:**



**PennState Health**



Susan B. Promes, Professor and Chair, Department of Emergency Medicine c/o Heather Peffley,  
Physician Recruiter, Penn State Health Milton S. Hershey Medical Center  
500 University Drive, MC A595, P O Box 855, Hershey PA 17033  
Email: : [hpeffley@pennstatehealth.psu.edu](mailto:hpeffley@pennstatehealth.psu.edu)  
or apply online at: <http://hmc.pennstatehealth.org/careers/physicians>

The Penn State Health Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.

# CALL FOR 2019 AAEM AWARD NOMINATIONS

DEADLINE: DECEMBER 8, 2018 at 11:59PM CT

WWW.AAEM.ORG/AWARDS



## AAEM/RSA Awards

Recognize outstanding program directors and coordinators with the AAEM/RSA Awards. Nominators and nominees must be AAEM/RSA or AAEM members to qualify.

- Kevin Rodgers Program Director of the Year Award
- Program Coordinator of the Year Award

Learn more at: [www.aaem.org/awards](http://www.aaem.org/awards) and  
[www.aaemrsa.org/about/values/awards](http://www.aaemrsa.org/about/values/awards)

# AAEM AWARDS

Know someone with an outstanding record of service to AAEM? Recognize them! Nine awards are available - browse each description on the AAEM website: [www.aaem.org/about-us/our-values/awards](http://www.aaem.org/about-us/our-values/awards).

- Administrator of the Year Award
- Amin Kazzi International Emergency Medicine Leadership Award
- David K. Wagner Award
- Joe Lex Educator of the Year Award
- James Keaney Award
- Robert McNamara Award
- Resident of the Year Award
- Young Educator Award
- Master of AAEM (MAAEM)

# Board of Directors Election

## 2019 AAEM Election Nominations Now Open!

WWW.AAEM.ORG/ELECTIONS



## Submit a Nomination

In AAEM, any member may nominate a full-voting or emeritus member for election to the board of directors. Any YPS member can nominate a fellow YPS member for the YPS director position. Self-nominations are allowed and encouraged.

- **What Sets Us Apart:** These election procedures are truly what make AAEM unique among professional medical associations.
- **Democratic Principles:** We believe the democratic principles that guide us are one of AAEM's greatest strengths.

## Open Positions

- At-Large Directors (5 positions)
  - Must be a full-voting or emeritus member
- Young Physicians Section (YPS) Director - Must be a YPS member



**COMMONSENSE**  
555 East Wells Street / Suite 1100  
Milwaukee, WI 53202-3823

Pre-Sorted  
Standard Mail  
US Postage  
PAID  
Milwaukee, WI  
Permit No. 1310

# SAVE THE DATE



## 25<sup>TH</sup> ANNUAL SCIENTIFIC ASSEMBLY

# LAS VEGAS, NV

Registration opens November 2018

**FREE**  
REGISTRATION  
and CME  
for members with  
refundable  
deposit.

Celebrating  
**25**  
YEARS  
of Education  
1994–2019

**MARCH 9–13, 2019**  
CAESARS PALACE • LAS VEGAS, NV  
[www.aaem.org/AAEM19](http://www.aaem.org/AAEM19) • #AAEM19