

THE NEWSLETTER
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMON**SENSE**

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AAEM Mission Statement

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

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

Membership Information

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

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

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

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

Emeritus Member: \$250 (Must be 65 years old and a full voting member in good standing for 3 years)

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

Resident Member: \$55 (voting in AAEM/RSA elections only)

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*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

AAEM President Out Advocating For EM!

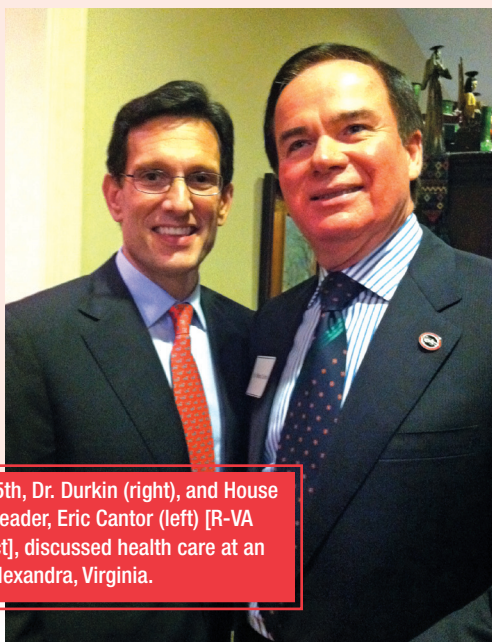
William T. Durkin, Jr., MD MBA FAAEM

Over the past two months, our lobbyists have arranged for me to meet and talk with members of Congress as well as state representatives. This is the first time that the Academy has ever had this kind of exposure. I have been with more members of Congress this year than the past several presidents. It is my plan to continue lobbying for our members.

However, there is one person missing in all of these photos ... you! Our lobbyists have arranged another Advocacy Day this fall in addition to the one we had this past June. They will provide you with training then get you to your appointments to meet with members of the Senate and Congress to discuss matters important to us. I urge as many of you as possible to save the date, October 9, 2013, and avail yourselves of this wonderful opportunity. If you are unable to make the trip this time, consider a donation to our PAC Fund. ■



On June 5th, Dr. Durkin (left), met with Barbara Comstock (right), a member of the VA House of Delegates. They spoke about the VA Medicaid issue.



On June 5th, Dr. Durkin (right), and House Majority Leader, Eric Cantor (left) [R-VA 7th District], discussed health care at an event in Alexandria, Virginia.



On May 6th, Dr. Durkin (right), met with US Senator John Barrasso [R-WY] (left) at a small breakfast gathering to discuss the Senator's health care agenda and hear from him on other issues before the U.S. Senate. Topics raised included the implementation of the Affordable Care Act and how this impacts the EM physician community.

AAEM Antitrust Compliance Plan:

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

Contact the President: president@aaem.org

Outrage

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors



Like most of you, I was outraged at the Boston Marathon bombing and the murder and mayhem that followed. Four people are dead, including an 8-year-old child killed because one of the bombers chose to place the bomb right next to him, and scores are maimed. Hundreds of lives will never be the same. And for what — to satisfy the blood-lust of two evil young men? Why were

these terrorists full of hatred for a country that never did anything to them except take them in and give them a home, and even grant one of them citizenship? How does anyone become so morally stunted that they think any cause can justify the deliberate murder of civilians? What kind of man puts a bomb next to a child and then walks away with a sense of satisfaction? A soldier does everything he can to minimize or avoid civilian casualties in the course of accomplishing his mission. For a terrorist, civilian casualties are the mission. That's the difference between the two. One is a warrior who seeks to do as little harm as possible in the course of war, the other a criminal who wants to do as much harm as possible whether in or out of war. I will never understand the mind that finds joy in suffering, death, and destruction — or in the intentional murder of a child.

Neither do I understand the fundamentalist mind. A mind that not only accepts some particular book or text as the literal and inerrant word of God, no matter what the evidence against the literal truth of that text, but that harbors no doubt whatsoever. No matter how strongly we believe something, no matter how convinced we are, in most of us — in some dark little corner of our minds — lurks the thought, "But I could be wrong." That tiny, buried doubt is what keeps us from killing or committing some other outrage in the name of our beliefs. Doubt is good. Doubt is protective. Doubt leads to tolerance. Doubt is a form of humility. To be utterly without doubt is a malignant type of hubris. It leads to bloodshed, and can even threaten civilization itself. Absolute certainty paves the road to savagery, death, and darkness.

As I write this, less than two weeks after the bombing, no motivation for this terrorist act has been made public other than the religion of the bombers. Yet these two young men did not seem to be living the life of Muslim fundamentalists — or Islamists or Jihadists — whatever label you prefer. They seemed to be well integrated into American society.

Obviously many questions remain to be answered. Not just questions about the terrorists, but questions about our security. More than a decade after 9/11, are our ports and borders truly secure, and if not, why not? Is that even possible? Should visitors and immigrants be subject to more thorough background checks and stricter entry criteria? On what basis did our security agencies decide the elder terrorist was not a threat, after being warned about him by both the Russians and Saudis? If both the elder terrorist and even his mother were on a CIA Jihadist

watch-list, why wasn't he expelled from the country or at least under surveillance? The most important question in the long run: how should we react to yet another terrorist attack?

I know what we shouldn't do. We shouldn't sacrifice more of our civil liberties in the hopeless quest for absolute security. If Western civilization is at war with a violent, dictatorial strain of Islamic fundamentalism, we must recognize that we are going to suffer casualties in the course of battle. In my opinion, we have already given up far too much freedom in the name of safety. For many years now, even before terrorism was a problem, we have allowed our government to seize the private property of an American suspected of selling drugs, even if that citizen is never charged with a crime — much less convicted. Now the government can examine our financial records and read our emails without a warrant. To top it off, for a while it looked like our president was going to claim the authority to order the execution of an American citizen, on American soil, without the full due process of law. I wonder what our founding patriots would think of that — and of the the law called the Patriot Act? Actually, I don't wonder at all.

The creativity and innovation that blossom with freedom, and the prosperity that comes with a free market, guarantee that we will win this war unless we destroy ourselves. The only way for us to lose is to throw away our own liberty — personal, economic, or both. Even wiping out an entire city won't destroy this nation. American resilience was evident immediately following the explosions in Boston, as bystanders aided the wounded, paramedics rushed them to hospitals, and police responded to the horrific crime. Our security apparatus may have failed to prevent the attack, but Boston's public safety system performed brilliantly afterward — including its emergency departments and trauma services. Boston Medical Center, Mass General, Brigham and Women's, Beth Israel-Deaconess, and Tufts shared the burden of mass casualty care. Many of the walking wounded went by private vehicle to other area hospitals. These hospitals and their EDs have done us proud. Several continued to function despite their own internal bomb scares. Tufts had to evacuate its ED for 45 minutes. Mass General even dealt with the possibility of poisoned food. AAEM's Dr. Leana Wen, immediate past-president of RSA, was on duty at Mass General during the bombing.

Finally, I am in awe of the police work that followed the bombing. Local, state, and federal law enforcement agents did an incredible job in identifying the perpetrators, locating them, and then killing one and capturing the other. Taking one alive says a lot about the professionalism and character of those involved in the manhunt, just as keeping him alive speaks highly of those who rendered medical care after his capture. Hopefully, we will eventually have the answers to many of our questions. In the meantime, remember the words of Ben Franklin: "Those who would give up essential Liberty, to purchase a little temporary Safety, deserve neither Liberty nor Safety." ■



NEW: AAEM PODCASTS

AAEM is proud to unveil three new podcast series:

Emergency Physician Advocates: Medical-Legal Issues on Emergency Medicine

Newest Episode: EP Advocacy issues in the Affordable Care Act. AAEM past president, Larry Weiss, MD JD FAAEM, discusses the single most significant event to occur in your career, the Affordable Care Act, and outlines ways you can advocate for our specialty.

Critical Care in Emergency Medicine

Premiere Episode: FLAAEM president, David Farcy, MD FAAEM FCCM, talks with Tiffany Osborn, MD MPH FACEP, about the recent update of the Surviving Sepsis Campaign and its application in patient treatment. Points covered include: lactate clearance, vasopressors, blood transfusions, and steroids.

Emergency Medicine Operations Management

Premiere Episode: AAEM Operations Management Committee chair, Joseph Guarisco, MD FAAEM, and AAEM past president, Tom Scaletta, MD FAAEM, discuss various issues related to emergency department patient satisfaction. Discussion points include: measurement and drivers of patient satisfaction, incentives for physicians, insights for leadership, and the how the changing landscape of health care will effect patient satisfaction moving forward.



AAEM podcasts are available on the AAEM website and on iTunes. Visit the AAEM blog, part of AAEM Connect, to leave comments and engage in a conversation around the issues discussed in these episodes.

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Letters to the Editor

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors

A "Letters to the Editor" feature is now available on the *Common Sense* section of the AAEM website. Members must log in with their AAEM username and password to read or post letters, or to comment on letters (www.aaem.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in *Common Sense*.

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

— The Editor

Letter in response the March/April 2013 editorial, titled "A Personal View on Burnout."

I wish I could have written the editorial myself because it expresses so well what is a common problem to so many of us. The hospital where I currently work (for the next two weeks) took the ineffective system which was instituted on February 24th (replacing ePower Doc which worked very well) and turned our well-run ED into a third world triage center; I handed in my resignation the same day it was installed, for many of the reasons detailed within the article. It is unsafe, it is cumbersome, it is inaccurate, it is dangerous, etc., etc. Bravo!

—Michael H. LeWitt, MD MPH FAAEM

Thank you for your kind comments and support. I hope more of our colleagues will write in with their experiences, and tell us how they coped with these issues. We can all learn from each other.

— The Editor

Letter in response to March/April 2013 "Blast from the Past" section and the editorial titled, "A Personal View on Burnout."

I'd like to concur with Dr. Andy Walker's articles. First, I had the same experience with ACEP and eventually made the same move.

It is worse in MA since our local ACEP leaders seem all too eager to side with hospitals over "pit docs." I was even told years ago not to speak up or I'd be labeled a trouble maker. I understand that they fear their head may roll if they stand up to the hospital administrators. It is just easier to take the big paycheck and go along. But we need a leader who seeks the best for his/her colleagues and stands up to obvious bullying. So should not national ACEP be involved in helping with that? What about enlisting other specialty doctors support? Safety in numbers...

I know I seem too idealistic, but eventually I decided not to send financial support to those who kept me "in the pits" and ultimately made the practice of EM less tolerable.

And this lack of control does lead to burnout. I am counting the years to being able to leave ER medicine. Not because I do not love the practice of medicine but because of all of the other peripheral issues. (The silliness exemplified by Dr. Leap's articles). The care of patients is what we trained for, not to document volumes of paper that no one reads. Nor to be held to standards dreamed up by someone who may have never practiced medicine. Talk about wasting resources! I could help to solve the cost of medicine overnight with a few practical changes.

I want to wish Andy the best and thank him for putting his heart out there.

I too hope to find a future career path that will take advantage of my training while allowing me to have peace of mind.

— Name withheld by request



COMMONSENSE

**SUBMIT YOUR
LETTER**

NEWS

Continued on next page

Thank you for your letter, which we agreed to publish anonymously because your reason for the request, "I am employed by the hospital and still need a job," makes perfect sense. Unfortunately it is all too easy to fire even an excellent emergency physician for purely political reasons. That physician is probably even more vulnerable when working as a hospital employee or for a contract management group.

You are not "too idealistic." Idealism is the force behind improvement, the righting of wrongs, and the advancement of society. If you weren't idealistic you wouldn't be a member of AAEM. Neither would I and neither would any of our fellow Academy members. Of course ACEP should be fighting to protect individual emergency physicians. In my opinion it has not and does not. That is one of the prime reasons AAEM was founded and continues to grow. Like you, I chose to quit paying dues to those I saw actively working for corporations and against my best interests — but I realize some Academy members will see that assessment of the College as an exaggeration, and I don't condemn anyone who maintains membership in both organizations.

As far as burnout goes, it sounds like both of us burned out for similar reasons, and on that issue I can offer hope. For one thing, I expect that the EMR and CPOE software that is so horrible now will improve with time — eventually allowing our focus to return to the patient, where it belongs, rather than remaining on the computer. I have already largely recovered from my burnout. Part of the reason is that the software I currently use is far superior to the crap I was saddled with at my former hospital. Part of it is working only part-time. A big part of it is working in an ED slow enough that I can take plenty of time to talk to patients, deal with the EMR and CPOE, and not feel crushed by the pressure to move meat as patients get backed up. My focus is on the individual patient again; whom I now have time to see as a human being rather than a task. That makes all the difference in the world. Change your work environment and work can become a pleasure again. When that happens, your burnout will be cured. Be flexible, look for solutions and alternatives, remember that you are not the problem, and don't give up hope. Good luck. ■

— The Editor

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20th Annual Scientific Assembly

February 11-15, 2014

New York Hilton Midtown • New York City, NY



The Summer Legislative Agenda

Williams & Jensen, PLLC

The federal government reached the debt ceiling on May 19, 2013, and the Treasury has begun taking “extraordinary measures” to continue to fund the government. According to current revenue projections, the debt ceiling could be reached again as early as September or as late as November, suggesting that Congressional action to raise the debt limit and continue funding the government (which must occur by September 30, 2013) could occur following Congress’ return from the August recess. The ability of Congress to pass significant healthcare legislation, such as permanent repeal of SGR, entitlement reform, or repeal of the 2.3 percent excise tax on medical devices, may depend on whether members can agree on a “grand bargain” of spending cuts, tax increases, entitlement reform, and comprehensive tax reform.

In coming months the House will work on fiscal year 2014 “security” appropriations bills, which include funding for the Department of Homeland Security and the Department of Defense. The House will also consider the Agriculture, Food and Drug Administration, and Related Agencies funding bill. The Senate is expected to spend several weeks considering a comprehensive immigration reform bill and to take up work on several fiscal year 2014 appropriations measures.

Prior to the August recess, the only legislation that is considered “must-pass” is a measure to prevent federal student loan rates from increasing from 3.4 percent to 6.8 percent on July 1. The House and Senate may also complete work on a multi-year reauthorization of the Farm Bill, which is set to expire on September 30.

As a result of sequestration, the two percent across-the-board cut to Medicare providers has remained in place since April 1. While Congress has acted to provide targeted relief to certain programs that have been adversely affected, the Medicare cut is unlikely to be addressed unless Congressional leaders are able to reach a deal to replace the sequester with other spending reductions or revenue increases, or there is an agreement in place to repeal the SGR.

Aside from symbolic votes, Congress continues to be in a holding pattern on enactment of major reforms to the Affordable Care Act (ACA). The House and Senate are closely monitoring the progress on implementation, and the Administration continues to assert that the health insurance exchanges will be up and running by January 1, 2014. Until this date, the Democratic-controlled Senate is likely to block attempts by congressional Republicans to make changes to the healthcare law. Similarly, Republicans will not support efforts by Democrats to increase funding for implementation of the law.

Marilyn Tavenner Confirmed as CMS Administrator

On May 15 the U.S. Senate voted 91-7 to confirm Marilyn B. Tavenner as Administrator of the Centers for Medicare and Medicaid Services (CMS). In April the Senate Finance Committee voted unanimously to approve the nomination, and the nominee won praise from members of both parties. Tavenner had served as Acting Administrator since

2011, following the resignation of Don Berwick. Tavenner is CMS’ first Senate-confirmed Administrator since 2006.

From 2006 to 2010, Tavenner served in Governor Tim Kaine’s (D-VA) cabinet, as Virginia’s Secretary of Health and Human Resources. Prior to her time in government, Tavenner spent 25 years working for the Hospital Corporation of America (HCA), employed first as a nurse before becoming CEO of a hospital in Richmond, VA, and then serving as Group President of Outpatient Services where she implemented the company’s national strategy for outpatient services. Tavenner received a B.S. in Nursing and a Master’s in Health Administration from Virginia Commonwealth University.

Key House Committees Release Draft SGR Repeal Legislation; Congress Convenes Additional Hearings on Medicare Payment Reform

In May, Republicans from both the House Energy & Commerce Committee and House Ways & Means Committee released draft legislation to repeal the Medicare Sustainable Growth Rate (SGR), and replace it with a fee for service system in which HHS would work with providers and stakeholders to develop quality measures to deliver more efficient care. Release of the draft bill follows two documents from the committees that outlined principles of a permanent SGR repeal and payment reform. The previous framework, which was entitled “Second Draft of SGR Repeal and Reform Proposal — Request for Feedback,” began with a letter from the committee’s Republican leadership to the “provider community.” The letter notes that fixing the SGR system is a “top priority” for the committees. It also states that the committees appreciate the provider interest in “medical liability reform, repeal of the Independent Payment Advisory Board, private contracting/balance billing, and hospital-physician gainsharing arrangements.” The letter concludes, “Designing a system that is inclusive of all specialties and practice types presents a great challenge, and this draft makes a concerted effort to avoid a “one-size-fits-all” approach in favor of a versatile and inclusive process that provides for the maximum amount of individual choice.”

Under the draft bill, providers will have the option of leaving the fee for service system for new ways of delivering care, with an enhanced emphasis on quality and efficiency of care. Providers will also have the option of applying as an individual or as a group practice. Similar to other SGR repeal legislation that has been introduced, the draft does not specifically outline how the full cost of permanent SGR repeal will be funded.

On June 5, the House Energy and Commerce Committee’s Health Subcommittee is scheduled to hold the first hearing on the draft legislation. In the committee’s press release, Chairman Fred Upton (R-MI) stated that “great progress” has been achieved on this issue, and that

Continued on next page

the committee will continue to get input from stakeholders. He said that Republicans will maintain an “ongoing dialogue” with committee Democrats to secure a long-term solution that will improve the quality of care.

In May, the House Ways and Means Committee’s Health Subcommittee convened a hearing on SGR reform. Subcommittee Chairman Kevin Brady (R-TX) said that payment stability, providing incentives through metrics, and allowing physicians to opt for alternative payment models were all principles that had support among the working group on the Ways and Means and Energy and Commerce Committees. He stated that Medicare reform is not a partisan issue and that permanently repealing the SGR is a goal shared by members in both parties. Brady emphasized the need to have continued collaboration with physicians throughout the reform process and acknowledged that the cost will be a challenge. He referenced a Congressional Budget Office (CBO) report that said freezing current Medicare payments will cost the government \$138 billion, and said that is a significant reduction from previous reports that predicted a cost of \$245 billion for the same policy. Brady called for bipartisan efforts to ensure payment policy reform is right and said that the goal is “not perfect policy but sound, good policy.” Subcommittee ranking member, Jim McDermott (D-WA), called on Congress to replace the current system and emphasized the importance of rewarding quality of care over quantity of care. He stressed the importance of coordinated team care, and placed emphasis on “the right care, to the right

patient, at the right time” and the importance of provider accountability. He expressed support for continued work with physicians to develop performance measurements. McDermott said that he agreed with the Chairman’s outline, but was still looking to ensure that common ground is found. He asserted that paying for Medicare payment reform may be a point of controversy and that it will be “difficult, if not impossible” to support a package that is financed by shifting costs to beneficiaries.

Meanwhile, the Senate Finance Committee also held a hearing in May to examine potential improvements to the Medicare payment system. Chairman Max Baucus (D-MT) said that the SGR has “dictated drastic reductions” in physician payment rates. He emphasized that Congressional intervention is necessary and said that it must be beyond the “doc-fix” ritual, which is unfair to both physicians and beneficiaries. He noted that since 2003, Congress has made 15 short-term fixes to the SGR, at a cost of almost \$150 billion, and in 2010 alone Congress passed six short-term fixes to the SGR. Baucus stated that in order for Medicare beneficiaries to be able to continue to see their physicians there must be a permanent repeal of the SGR. He expressed support for changing the underlying fee for service payment system that Medicare uses to pay physicians, stressing that this model promotes “volume over value.”

Chairman Baucus expressed concern that the current system rewards physicians for doing more tests and more procedures, even when

Continued on next page

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As the complexities of healthcare reform increase, many independent physician groups struggle with the rising challenge of managing the emergency department. CEP America is here to help. Partner with the largest democratic practice in the U.S. and be a part of a team that offers:

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unnecessary, and said that it does not encourage physicians to coordinate patient care to save money and improve health outcomes. He noted “promising payment systems” that would hold physicians accountable for providing high quality, efficient care and stated that the models include accountable care organizations (ACOs), payment bundles, and medical homes; and that they have the potential to control spending for both Medicare and beneficiaries and improve patient care. Baucus emphasized the need to ensure each service is valued appropriately, reduce unnecessary services, and help physicians transition to alternative payment models.

Ranking member Orrin Hatch (R-UT) said that there must be a better way to pay physicians, calling the SGR “fundamentally flawed.” He cautioned that the CBO score can fluctuate and warned against delaying action and missing the window of opportunity to act soon. Hatch said that a stable foundation for paying physicians is needed now or there will be a risk of physician shortages in the Medicare program.

Medicare Payment Advisory Commission (MedPAC) Executive Director Mark Miller stated that the Medicare payment system needs to be changed from “volume driven to quality driven” care. Miller warned that temporary, stop-gap fixes to the SGR have a destabilizing influence on Medicare by creating uncertainty for physicians, other health professionals, and beneficiaries. Miller outlined MedPAC’s recommendations for Medicare physician payment reforms, starting with repealing the SGR and replacing it with a 10-year path of legislated updates, including updates for primary care services that are different from specialized services. MedPAC’s other recommendations include rebalancing the physician fee schedule to improve payment equity through data collection, identifying overpriced services, adjusting the relative value units of those services, and encouraging physicians to move from fee for service to risk-bearing ACOs by creating opportunities for shared savings.

Generally, key members of both parties in the House and the Senate continue to agree that the current CBO cost estimate presents an opportunity to achieve permanent SGR repeal that did not exist last year. There is a recognition that these estimates can change, and that if Congress does not act this year the cost of a permanent fix could again become prohibitively expensive. Members share similar principles of reform, including the belief that physician stakeholders should play a role in developing performance measurements and that the current fee for service model should be replaced by a system that incentivizes quality and efficiency of care.

Despite these shared goals, both sides recognize that it will not be easy to offset the \$138 billion cost of full SGR repeal. Absent an agreement on a larger package that includes Democratic concessions on spending cuts and entitlement reform and Republican concessions on new revenues, Congress may well find itself in the familiar position of negotiating a smaller package of cuts at the end of the year that would offset the cost of a one or two year “fix,” in order to prevent the 25 percent Medicare rate cut set to take effect on January 1. In other words, there is a reasonable chance that a “grand bargain” on spending and taxes could facilitate a permanent SGR fix, but full repeal in 2013 will be challenging without that type of agreement.

President Obama Unveils Fiscal Year 2014 Budget

On April 10, President Obama released his fiscal year (FY) 2014 budget request, which included a proposed package of nearly \$400 billion in savings over the next ten years from the Medicare and Medicaid programs. The budget proposal replaces the across the board cuts from sequestration, but maintains the caps on discretionary spending included in the Budget Control Act of 2011.

The budget requests \$80.1 billion in discretionary budget authority for the Department of Health and Human Services (HHS), an increase of nearly \$4 billion over the FY 2012 level. The request also includes \$31.3 billion for the National Institutes of Health (NIH), \$11.3 billion for the Centers for Disease Control and Prevention (CDC), \$4.7 billion in total program resources for the Food and Drug Administration (FDA), \$9.0 billion for the Health Services and Resources Administration (HRSA), \$3.6 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), and \$1.3 billion for the Public Health and Social Services Emergency Fund (PHSSEF). All of these totals represent increases over FY 2012 levels.

The Senate Budget Committee held a hearing in April to examine the president’s request. Much of the discussion at the hearing focused on the budget’s Chained Consumer Product Index (CPI) proposal, which would utilize a different measure of inflation for the calculation of government benefit growth rates. Senate Budget Committee Chairman Patty Murray (D-WA) asked why the President chose to incorporate a component of a deal made with House Republicans last year, rather than seeking a new compromise that could be included in the budget. Acting OMB Director Jeffrey Zients responded that the President was willing to compromise with republicans in order to achieve normalcy in government operations and end the string of “manufactured crises.” Zients said that using Chained CPI was part of the budget’s overall strategy and reiterated that the most vulnerable populations utilize programs that are means tested to determine eligibility and would be protected.

The budget includes a package of Medicare and Medicaid legislative proposals that are outlined in the HHS FY 2014 “Budget in Brief”, which included the following headers:

Medicare

- (1) Encourage the Use of Generic Drugs by Low Income Beneficiaries;
- (2) Accelerate Manufacturer Drug Discounts to Provide Relief to Medicare Beneficiaries in the Coverage Gap;
- (3) Prohibit the Delay and Availability of New Generic Drugs and Biologics;
- (4) Reduce Length of Exclusivity for Biologics;
- (5) Rebates for Medicare Part D;
- (6) Reduce Overpayment of Part B Drugs;
- (7) Income-Related Premiums under Medicare Part B and Part D;
- (8) Part B Deductible for New Enrollees;
- (9) Reduce Medicare Coverage of Bad Debts;
- (10) Align Graduate Medical Education Payments with Patient Care Costs;
- (11) Reduce Critical Access Hospital Reimbursement;
- (12) Critical Access Hospital Designation;
- (13) Minimum Medicare Advantage Coding Intensity Adjustment;
- (14) Employer Group Waiver Plan;
- (15) Payment Updates for Certain Post-Acute Care Providers;
- (16) Inpatient Rehabilitation Facilities;
- (17) Inpatient Rehabilitation Facilities and Skilled Nursing Facilities;
- (18) Implement Bundled Payment for Post-Acute Care

Continued on next page

Providers; (19) Clinical Laboratory Services; (20) In-Office Ancillary Services Exception; (21) Medicare Data Sharing with Qualified Entities; (22) Medicare DSH Statute; (23) Home Health Copayments for New Beneficiaries; (24) Strengthen the Independent Payment Advisory Board; and (25) Part B Premium Surcharge.

Medicaid

(1) Clarify Medicaid Drug Rebate and Payment Definitions and Calculations; (2) Disproportionate Share Hospital (DSH) Allotments; (3) Delay in Disproportionate Share Hospital (DSH) Reductions; (4) Limit Medicaid Reimbursement for DME; (5) Expand State Flexibility to Provide Benchmark Benefit Packages; (6) Extend Transitional Medical Assistance (TMA) through CY 2014; (7) Extend the Qualified Individual (QI) Program through CY 2014; and (8) Establish Hold Harmless for Federal Poverty Guidelines.

Senate Panel Advances Drug Compounding Legislation; House Holds Additional Hearing Examining Need for Regulations

On May 22, the Senate Health, Education, Labor & Pensions (HELP) Committee convened a markup to consider the Pharmaceutical Compounding Quality and Accountability Act (S. 959). The legislation was introduced by a bipartisan group of four committee members. The committee approved an amendment that combined pharmaceutical “track and trace” legislation with the drug compounding bill, and the measure was unanimously approved by the committee without further amendment.

HELP Committee Chairman Tom Harkin (D-IA) said that the legislation would improve the safety of compounded drugs, especially in the wake of the deadly meningitis outbreak last year that was linked to medication packaged at the New England Compounding Center (NECC). Ranking Member Lamar Alexander (R-TN) noted the number of deaths from the meningitis cases and stressed that his main aim in the compounding legislation was to provide accountability. He noted that traditional drug stores will continue to be regulated by the states, while the bill puts the FDA in charge of compounding manufacturers, complete with regular inspections. He added that products made at compounding facilities must be reported to the FDA, and any problem at facilities must be reported as well.

The House the Energy and Commerce Committee’s Health Subcommittee held a hearing in May to examine drug compounding. Subcommittee Chairman Joe Pitts (R-PA) stated that, during a previous hearing, the FDA repeatedly cited differing court rulings as the reason it was unable to properly regulate the NECC and cited confusion about how the FDA is now fully engaging in regulatory inspections of compounding facilities even though no laws have been changed. Subcommittee ranking member Frank Pallone (D-NJ) said that compounding facilities must be properly regulated in order to maintain the public’s confidence in the safety and quality of these sites. He said that the industry is growing and meeting market needs not met by traditional compounders. Pallone expressed support for legislation that would give the FDA authority over the industry and for the development of a new category to classify the industry.

At the hearing, members focused questions on: (1) current FDA authority; (2) the need for additional authority; and (3) lessons learned from the 2012 meningitis outbreak. In the last several months a number of members and witnesses have urged Congress to examine the potential impact of compounding legislation on drug shortages, citing the need to avoid new regulations that could exacerbate this problem.

House Members Reintroduce Good Samaritan Legislation

Representatives Marsha Blackburn (R-TN) and Jim Matheson (D-UT) re-introduced the “Good Samaritan Health Professionals Act” (H.R. 1733), a bill that would limit the liability of certain healthcare professionals acting in a voluntary capacity in response to a public health emergency or declared emergency or major disaster. A healthcare professional would have no liability under Federal or State law if the act or omission (1) occurs during the period of the disaster and (2) if the volunteer acts in a good faith belief that the individual being treated is in need of health care services. In any proceeding where a health care professional argues that this liability exemption should apply, the burden of proof rests with the plaintiff to present clear and convincing evidence that the limitation should not apply.

The law provides an exception for cases in which the harm was caused as a result of “willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed by the health care professional,” or the professional is under the influence of intoxicating alcohol or an intoxicating drug. The legislation would build upon the limited protections afforded to individuals included in the Volunteer Protection Act of 1997 (Public Law 105-19). This act limits liability for volunteers acting for government entities or nonprofit organizations, provided that the harm was caused as a result of ordinary negligence.

Key Republicans Outline Medicaid Caps Proposal

In May, House Energy & Commerce Committee Chairman Fred Upton (R-MI) and Senate Finance Committee ranking member Orrin Hatch (R-UT) published a report entitled, “Making Medicaid Work.” In the blueprint, the authors propose the adoption of “per capita caps,” a limitation on the amount of Federal spending for each Medicaid beneficiary. The report cites the Federal government’s open-ended liability to match State Medicaid spending as a “significant risk to the program’s future financial soundness.” The level of Federal funding for each State would be determined by a formula using the number of Medicaid enrollees in the State that belong to each of the following four beneficiary groups: (1) aged; (2) blind and disabled; (3) children; and (4) adults. The model would also account for geographic spending variation in Medicaid programs across states. The blueprint also recommends several Medicaid integrity enhancements and advocates for the reduction of regulations that deter innovation. Finally, the report pledges to build upon existing efforts to coordinate care for dual-eligibles. The authors express optimism that the demonstration projects will help develop models that will reduce costs and enhance quality of care, and offer support for the “goal of better coordinated benefits and services for the dually-eligible populations.” ■

Recognition Given to Foundation Donors



Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1-1-13 to 5-10-13.

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

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Blast from the Past

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board Member



In reading this third issue of *Common Sense*, I was struck by several things. First was the news of AAEM's very first Scientific Assembly, now the best meeting in emergency medicine. Even the first one boasted some impressive speakers. It also featured the first Wagner Award, which went to Dr. David Wagner himself. Second, Coastal's lawsuit against Dr. Schwartz seems to have been going badly. Third,

several issues that I thought were of recent birth were already problems 20 years ago — see the articles on burnout and physician wellness, poorly done or sham peer review, and patient satisfaction surveys.

Most interesting, even after AAEM's founding, its leaders were still trying to reform ACEP from within — and their proposals were still being rejected. Plantz, McNamara, Schwartz, and others were still trying to

make ACEP more democratic; more open and transparent, especially in regard to the compensation of its leadership and staff; more of an advocate for board certification; and more protective of individual emergency physicians than of corporate interests. Resolutions calling for ACEP to lobby against restrictive covenants and for due process protections were "... soundly defeated largely due to the testimony of Dr. David Siegel, MD JD, who spoke as the Chair of NEMPAC and the ACEP Government Affairs Committee. Dr. Siegel testified that this effort would be costly and would divert funds from other lobbying efforts. *Dr. Siegel failed to disclose a major conflict of interest, that he is Chief Medical Officer for NES, a large contract management group.*" (Italics original).

Last, the announcement that everyone serving AAEM as an officer or director was doing so without compensation, as a volunteer. This remains true today. ■

EMERGENCY MEDICINE: THE LIVING LAW—San Francisco Jan 27-29 Register now or at the meeting. [See UPCOMING CONFERENCES, page 2.]



when minutes count

COMMON SENSE

The Voice of the Specialist in Emergency Medicine

January, 1995

Volume 2, Number 1

WAGNER AWARD ESTABLISHED

by Jim Keaney, MD, President, AAEM

in Philadelphia. This annual award for excellence in Emergency Medicine seemed most appropriate for none other than the award's namesake, Dr. Wagner, a pioneer in the specialty of Emergency Medicine, who, as a founding member of AAEM, continues to contribute enormously to the field. Originally, we chose to present an antique lantern to symbolize Dr. Wagner's career, lighting the way for others, warning of impending danger, and signifying vision for the future.

Those who know me wouldn't be surprised that 3 days before the assembly I phoned to notify George Schwartz that I still hadn't found an antique lantern worthy of the prestigious award. George, however, had been engaged as a key speaker at the *American Association of Physicians and Surgeons* annual meeting in Atlanta. Kathleen, his wife, and Corie Conwell, our organizational director, went into action, searching the numerous antique shops of Santa Fe for an award with a Revolutionary Era motif. Through a series of remarkable coincidences, she was led to a beautiful silver teapot

The **David K. Wagner Award**, the highest AAEM honor, was established at the First Annual Scientific Assembly

made from melted coins, *that had belonged to a British colonial governor*. After engraving, she sent it to our hotel, just blocks from Independence Hall. Symbolically, the teapot, having been reclaimed by Revolutionaries from the hands of an oppressive government, was now being sent to our nation's birthplace to be presented to a modern-day revolutionary, Dr. Wagner, who ironically, a Quaker, was not a coffee drinker, but a tea lover.

I, however, was in a pickle! I'd prepared my presentation speech describing Dr. Wagner's career in context of a lantern, and on short notice found myself about to present him with a teapot! Ascending the platform I concluded, lantern or teapot, Dr. Wagner had picked up the musket a second time in his revolutionary career. Initially, he had gone up against powerful and divisive forces to create a new department, a unique set of physicians specializing in the emergency evaluation and intervention covering all disciplines. Now, years later, seeing disgraceful business practices putting the dollar above excellence, he again fearlessly picked up the musket, leading the way for others.

Dr. Wagner exhibits a rare combination of brilliance, determination and courage. For this reason the *American Academy of Emergency Medicine* proudly names its highest honor the **David K. Wagner Award**.



COASTAL STONEWALLS AS STOCK FALLS!

Coastal vs. Schwartz and countersuit Schwartz vs. Coastal, the legal battle most closely watched by Emergency Physicians, continues to keep the specialty of Emergency Medicine hanging in the balance. Coastal, the *Goliath* of physician "management" services, initiated this attempt to eviscerate the movement which is currently restoring professional independence to Emergency Medicine decision-making. The economic giant is now *stonewalling* by refusing to provide critical documents, as required by law during the process of discovery. Interviewed by COMMON SENSE, Dr. Schwartz claims, on the other hand, he has freely and confidently provided the thousands of documents requested, stating "I am looking forward to presenting the true facts in court!"

Meanwhile, Coastal's stock continues to plummet from a yearly high of 42 down to a recent low of 22.5, its lowest price to date. One reason many think responsible for the

plunge, is also noted by Schwartz in his answer to Coastal's attack, where reference is made to "Increasing professional and public awareness of Coastal's poor conduct and abusive behavior." Coastal recently moved to the more prestigious New York Stock Exchange after more than a year on the NASDAQ, and now arrogantly lists itself as "DR" ! The physician "management" service has the audacity to grant itself what would appear to the public as a professional title, the same title *you* achieved only through years of intensive labor and at great expense! According to a reliable source, Jack Page, President of Coastal Emergency Services, recently stated the lawsuit his company initiated has become a "can of worms." Interviewed by phone, Page, informed COMMON SENSE he can't "confirm or not confirm" that he made such a statement. As to the fall in stock price, he could add nothing to "a story about anything having to deal with Dr. Schwartz" and the lawsuit. He repeatedly stated he desired to have

corporate attorneys contact me in the morning to to answer questions, but at press time a week later they have so far avoided my attempts for interview.

In related issues EMCARE joins InPhyNet on the NASDAQ exchange after an unusually long delay. Months had passed from the time of application and the official request by AAEM President Jim Keaney that the Securities and Exchange Commission require that blatant mistruths and serious omissions in their prospectus be corrected. However, upon final approval, millions of dollars immediately shifted into the pockets of those claiming to "manage" Emergency Physicians, the money coming from stockholders desiring to speculate on and share your professional fees. Such speculation on professional remuneration essentially has created a scenario in which stockholders may lie asleep at night in their warm beds dreaming about your ability to see as many patients as possible while minimizing expenditure. Poor medical care and the predictable injuries and deaths it can cause appear only as columns of red and black ink on the ledgers of accountants. As many of us are wearily driving home from a hard night of toil, well-rested stockholders are climbing out of bed and going to the front door for their newspapers. Over warm coffee they browse the business section to check our performance at the task they "share" with us. In these pages our professional concerns are translated into gains and losses in stock prices! And, realistically, how much concern could stockholders be expected to have for the welfare of our patients?!

Perhaps those of us climbing into bed this morning after a long night of saving lives and easing suffering can sleep peacefully dreaming that perhaps Coastal's ongoing decline in price, as well as InPhyNet stock selling for lower than expected are due to an awakening to the fact that profiteering from doctors' professional fees means **not only bad medicine, but also bad business!**

by Drew Fenton, MD, Editor, COMMON SENSE

TRUTH, THE FIRST CASUALTY?

THE NEXT ISSUE OF COMMON SENSE WILL FOCUS ON THE ANATOMY OF A LAWSUIT AND INVESTIGATIVE REPORTING ON THE REPERCUSSIONS OF CERTAIN SPECIFIC LEGAL ACTIONS ON OUR FIRST AMENDMENT RIGHTS AND THE SPECIALTY OF EMERGENCY MEDICINE!



Scientific Assembly participants, including AAEM Officers and Board Members, convene at the *City Tavern*, meeting place of the First Continental Congress in 1774. At this farewell luncheon the revolutionaries meet the revolutionaries.

Please keep Corie at our central office updated with current phone, and additionally, fax numbers. We are setting up a fax network to keep you informed of the latest events!



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 Pfifferling 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.

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

AAEM MISSION STATEMENT

The 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 ANNOUNCES ELECTIONS A TRIUMPH FOR DEMOCRACY IN OUR SPECIALTY!

As a *democratic organization*, we announce the opening of nominations for the officers of the *American Academy of Emergency Medicine*, as well as for three positions on the Board of Directors. Officers will serve a two-year term and Directors, six years.

To nominate someone (including yourself) please contact the AAEM office to supply necessary information and send the nominee's curriculum vitae. Nominations may be made by anyone in AAEM, however, the nominee must be a full voting member (Board Certified in Emergency Medicine). The nominations will be closed March 15th. Within two weeks all voting members will receive the list of candidates and brief statements from each candidate declaring

why they are appropriate candidates for that particular office. It is expected that candidates who are available will be at the candidates' forum at our Spring Meeting. Subsequent to that meeting, ballots will be sent to all voting members. The ballots will be closed and tabulated on August 15th. The Officers and Directors-elect will take office on April 30th, 1996.

Thank you for taking the time to make this democratic organization work.

George R. Schwartz, MD, FAAEM
Secretary, American Academy of Emergency Medicine

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AAEM President Jim Keaney Available for Conferences

WHY CAN'T ACEP AFFORD TO LOBBY FOR DUE PROCESS?

by Scott H. Plantz, MD, Vice President, AAEM

At the 1994 assembly, several resolutions were proposed that could have changed ACEP's course. Resolutions called for democratic elections, elimination of non-compete clauses, due process, and restriction of future membership to Board Certified Emergency Physicians. Many of these resolutions were based on the AMA's Code of Ethics. All were voted down or tabled. Even fundamental due process rights for Emergency Physicians, first introduced to ACEP by resolution in 1985, were again defeated.

David Siegel, MD, JD, Chair of NEMPAC and the Government Affairs Committee testified that ACEP did not have the funds to lobby for these resolutions. **Dr. Siegel is also Chief Medical Officer of NES.**

Why doesn't ACEP have the money to lobby for due process? With 17,000 members, *dues alone generate over \$7 million dollars!*

At the same conference I heard that the salary and benefits of Colin Rorrie, Jr., PhD, Executive Director of ACEP, was somewhere between \$300,000 - \$400,000. I thought this might be excessive and decided to look into the issue. A letter to Rorrie resulted in a referral to ACEP President Dr. Aghababian. A call and letter to Dr. Aghababian resulted in a long awaited "I'll get back to you." As a law student, I found Texas statutory law suggested that non-profit organizations are obligated to release executive salaries. ACEP's attorney found a loophole. The bylaws for ACEP revealed the "books of account" are open to member inspection. This too was found not to include Rorrie's salary. Out of frustration, my attorney threatened to sue.

Rorrie responded with the *ACEP News* article titled "ACEP Staff Salary Structure." Although the article does not specifically state his salary, it does indicate that the range is **between \$173,500 - \$263,000**. This does not include benefits or "golden parachute." **His salary, including benefits, could easily be over \$350,000!** In review of the salaries and benefits of the top five bureaucrats of ACEP, none of whom are Medical Doctors, **over \$1,000,000 is spent on these individuals alone.**

No wonder ACEP can't afford to lobby for due process!

AAEM President Jim Keaney, MD, MPH is available for speaking engagements nation-wide, as are Dr. George Schwartz and other AAEM Officers and Board Members. Whether for Grand Rounds, Scientific Assemblies, or Society meetings, we are committed to quality Emergency Medical care as a public interest issue and freely commit our time and energies to achieve these most important goals. Dr. Jim Keaney, famous for his humorous and personable, and simultaneously unbridled straight-forward approach to significant contemporary issues in medicine, has been applauded at scores of Residency Programs and Medical Society Meetings, and invariably sets the stage for an insightful and fascinating debate on critical issues germane to not only Emergency Medicine, but to other fields. Current issues in Emergency Medicine are not only interesting, but, in the words of a *NEJM* reviewer, "become compelling as they predict changes in other specialties and serve as a wake-up call to physicians who remain unaware of the risks of inattention." Feel free to contact the American Academy of Emergency Medicine, P. O. Box 1968, Santa Fe, NM 87504 Tel: (800) 884-AAEM(2236) Fax: (505) 983-1733.

AAEM ANNUAL FINANCIAL STATEMENT

THE AMERICAN ACADEMY OF EMERGENCY MEDICINE recognizes and appreciates the value of membership dues, and is committed to use these monies in a responsible and cost-effective manner to further the goals of the Academy as delineated in the Mission Statement. As such, the 1994 financial statement is available upon request to all members. Any suggestions or concerns will be welcomed and encouraged. The Officers and Board of Directors recognize the trust bestowed upon them by the membership's overwhelming financial support and other contributions, and wish to remind you that **no economic remuneration is received by Officers or Board Members from AAEM**, other than reimbursement for actual expenses incurred in crucial AAEM matters. In reality, the overwhelming majority of expenses incurred by Officers and Board Members has gone unreimbursed. These unreimbursed financial and time contributions represent that individual's personal and professional commitment to the Specialty of Emergency Medicine, and at times involves significant personal sacrifice. The knowledge that our specialty and the public welfare are in trusted hands warrants such sacrifice and is payment in itself.



REPORT TO AAEM ON THE 1994 ACEP COUNCIL MEETING

Held in Orlando on September 9th and 10th, 1994, the timing of the meeting was significant for its juxtaposition to the release of the Josiah Macy Foundation Report on the Future for Emergency Medicine. The Macy Foundation Report decried the state of Emergency Medicine specifically pointing out the shortage of board-certified Emergency Physicians. Members of AAEM who also hold membership in ACEP actively tried to seek reform of ACEP by proposing council resolutions. The issues of importance to AAEM that were voted on are as follows:

A. Board-Certification Issues:

Resolution 15 proposed by R. McNamara, MD and P. VanDevander, MD stated "as of January 1, 1995 all new active members will be certified in emergency medicine or an emergency medicine sub-specialty by the American Board of Emergency Medicine." Despite the fact that this would not exclude current ACEP members and in light of the Macy Foundation Report this was soundly defeated. Only 8 of over 200 Councillors, and no EMRA Councillors voted in favor of this resolution.

Resolution 26 submitted by an ACEP Task Force chaired by Michael Bresler, MD called for elimination of ABEM certification as a requirement for FACEP while opening a practice track type option for FACEP. However, despite the fact that other major specialty societies (ACP, ACS, AAP, ACOG, etc.) require board-certification for membership alone, this resolution nearly passed. Even more outstanding is the fact that the large majority of the Councillors voted in favor of this! Fortunately, as a By-laws amendment, this required a two-thirds majority vote to pass. The actual vote was 122 for (in favor of removing board-certification for FACEP), and 73 against. This failed to achieve a two-thirds majority by only 8 votes.



Dr. George Schwartz makes a point at the ACEP Assembly debate, which included Dr. John McCabe and Dr. Ian Cummings.

LETTER FROM THE SECRETARY

Let us indeed make 1995 The Year of the Emergency Physician. To do this we need your membership. We have a truly democratic organization. Perhaps some of you do not agree with one policy or another of AAEM. I understand that completely. However, as a democratic organization, change can occur every two years with the elections of officers and one-third of the Board of Directors. AAEM truly belongs to the members.

The January conference is unique and has a dazzling array of speakers. Interest is so high that some national news organizations will be in attendance. There is still time!!! We know it is "Super Bowl Weekend" and meetings have been arranged for those who do not wish to miss the big game.

Become a Founding Member or a Founding Member and Fellow in the American Academy of Emergency Medicine. Join those who will be leading the field and unifying all the elements into a concerted thrust. Unification of vision is a key phrase. We are free of debilitating third party interests and our overhead is so low we don't need to sell out or make financial compromises.

AAEM has a contract with America and a contract with American Emergency Physicians in 1995. We will focus on Resident and Colleague Education, Malpractice Reform and Surveillance, AMA liaison and the JCAH, Elements of the Anti-Profiteering Act, Managed Care and Capitation Guidelines, Due Process for Emergency Physicians, and Cost-Conscious Health Care Reform. Our committees and task forces are formidable. Don't expect wishy-washy statements or pronouncements. We are out to make a difference. JOIN US!!!

George R. Schwartz, MD, FAAEM, Secretary of AAEM

B. Practice Issues:

There were several resolutions proposed by AAEM members regarding restrictive covenants and due process. Resolutions 50 and 51 authored by Drs. Scott Plantz, Chris Minis, Robert McNamara and Patricia VanDevander called for ACEP to lobby state and federal governments for a ban on restrictive covenants. AAEM members testified regarding the importance of this issue to individual emergency physicians. This resolution was soundly defeated largely due to the testimony of David Siegel, MD, JD who spoke as the Chair of NEMPAC and the ACEP Government Affairs Committee. Dr. Siegel testified that this effort would be costly and would divert funds from other lobbying efforts. **Dr. Siegel failed to disclose a major conflict of interest, that he is Chief Medical Officer for NES, a large contract management group.**

Resolutions 52 and 54 by the same authors included similar wording as the above resolutions regarding the unethical use of due process exclusion classes in Emergency Medicine. *Again Dr. Siegel's testimony led to the sound defeat of these resolutions.* Resolution 53 stated "that the lobbying efforts of ACEP should be directed toward Federal legislation which would bar the sale of emergency department contracts." There was no support for this and was **defeated in a near-unanimous vote.**

C. Structure Issues:

In order to make ACEP a more democratic organization AAEM members prepared the following resolutions:

Resolution 14 proposed by Robert McNamara, MD and Patricia VanDeVander, MD called for all state ACEP Chapters to only "elect" rather than "elect or appoint" their Councillors. Many states including California and Pennsylvania have the Councillors appointed by the state Board of Directors. Therefore, the "representatives" of the members are never elected. This resolution was defeated by a near unanimous vote. Resolution 30 originally called for the President of ACEP to be elected by the members. **There was no support for this**, however, a modified resolution passed that will bring up the question of election of the President by the Council for the 1995 meeting.

D. Other Issues:

Three members of the AAEM Board of Directors, Drs. George Schwartz, Scott Plantz, and Robert McNamara were nominated for the ACEP Board of Directors from the floor of the Council. They ran on the issues of board-certification, fair and equitable practice arrangements, and service to the individual practicing Emergency Physician. None of these candidates were successful in their campaigns.

AAEM members expressed concern about the wording of proposed resolutions that called for lobbying the government. Unfortunately, claiming potential anti-trust actions, ACEP would not allow discussion of restrictive covenants, due process and the sale of emergency department contracts unless this was worded as a call for lobbying.

E. Summary

The earnest attempt of AAEM members to bring ACEP's structure and philosophy more in line with AAEM was met with overwhelming rejection by the ACEP Council. The issues of board certification as a defining characteristic of a specialist in Emergency Medicine, provision of due process for Emergency Physicians and limiting the use of restrictive covenants at present remain a priority focus of only one organization in Emergency Medicine, **The American Academy of Emergency Medicine.**

Submitted by Robert McNamara, MD, AAEM Board of Directors



PEER REVIEW - IS IT ALWAYS DUE PROCESS?

by John Libby, MD
AAEM Board of Directors

"A procedure which permits the prosecutor to select the evidence which it will divulge, determine whether legal representation will be permitted, shift the burden of proof, permit a witness for the prosecution to participate in the jury deliberations, and limit judicial review to a search for substantial evidence supporting the verdict is neither fair nor reasonably calculated to determine the truth." (California Medical Association, April 1988)

In keeping with AAEM's Mission statement, access to *equitable* peer review is germane. We cannot provide "*highest quality of care and optimally serve our patient populations*" unless we are provided equal and affordable access to the protection of the laws and precedents that govern professional conduct. There is no discipline of medical practice that has a more circuitous path to obtain protection of existing laws than Emergency Medicine.

The Semmelweis Society is a group of multi-disciplined physicians dedicated to educating physicians and other health care professionals about unbiased peer review and how to establish such a process to maintain high professional

standards while protecting the rights of all physicians who become involved in the process. Founded in 1986, it has over 400 members nationwide who believe that good faith peer review is essential to promoting and maintaining professionally recognized standards of health care. The accompanying text of an editorial in the American Journal of Surgery, July 1994, by Dr. Verner S. Waite, MD and Robert Walker, JD is a concise and critical review that warrants the close attention, understanding, and serious contemplation of all engaged in medical practice. Dr. Waite has agreed to make a presentation at our AAEM conference in San Francisco, January 27-29, 1995.

MEDICAL AND SURGICAL PEER REVIEW

by Verner S. Waite, MD, FACS, Robert Walker, JD

In medicine it is commonly found that asking 10 doctors for an opinion on medical care will result in at least 5 different suggestions. Peer review in medicine is conducted where validated guidelines often do not exist. There is still an ongoing study about tonsillectomy indications, with confusing ideas after many decades. Validated criteria are rare. With such lack of medical agreement, it is not surprising that peer review is often a contest of opinions. Unfortunately, it often has severe effects on a doctor's career. An adverse peer review is far more serious than a large malpractice award. The process has several sources for serious bias.

First, doctors on the same staff act as a jury in the case of another physician about whom they may have heard a great deal. Those bringing the charges often have enough influence within a hospital that finding against their view may be like committing professional hara-kiri. Second, the entity involved, usually the hospital or its medical staff, appoints the hearing officer. This person often has very warm feelings for the entity or does regular work for the entity and is compensated handsomely. Third, hearsay evidence is allowed. Opinions, and perhaps "facts" that can not be substantiated, are treated as legal fact. Fourth, there is no ability to overcome a hospital's refusal to provide supporting evidence or a comparison of habits and results of colleagues not under review. Fifth, the reasons for the hearing do not have to be specific.

In summation, one may be faced with a jury selected by one's accuser, as is the judge; prohibited access to evidence; vague charges; and a controversial opinion. No one should have trouble identifying this kangaroo court!

Now contrast this process with a malpractice trial. Here the judge is not selected by either party, and the jury is composed of strangers. No hearsay evidence is allowed. Both sides have a right to discovery, and subpoena powers exist. Crucially important, the charges are very specific.

Our forefathers formed the Constitution and the Bill of Rights when the Inquisition was still affecting the daily lives of many. After 200 years we no longer appreciate how very important these concepts were. Exceptions now are the over 1,000 doctors who have been expelled from a medical staff. Many have been suspended for trivial reasons, such as standing on the patient's left when doing a cholecystectomy, when the

chief favored the right. Surgeons who have uneventfully, and safely, done vascular procedures using techniques that include trivial differences have lost privileges. Doctors may be denied privileges because they have not done a newly selected number of cases. Of course, those determining the critical numbers often did not fulfill that requirement either. Turf is more dear day by day!

Fortunately, the federal courts are not allowing the immunity that perpetuated the Inquisition that lasted 700 years. One physician's shabby, unprincipled, and unprofessional review was exposed. Another was not forced to sign a sham contract and his "143 cases of substandard care" were found exemplary. A pathologist was not forced to give 11% of his gross income to the hospital administrator, and his colleague's false testimony was exposed. These are three examples from 400 with which we have been directly involved.

Currently, 1 in 20 physicians will undergo the peer review process. One in 5 will serve on such a committee. Contract physicians will often be asked to serve, for their contract is at risk with no peer review rights. Hospitals are using peer review as the tool to serve their business interest more and more. Ethical and excellent medical practices can be at risk.

The Semmelweis Society simply supports peer review with "clean hands." We believe the jury should be wholly comprised of outside peers. Evidence never presented during the examination is not to be considered and given weight during the deliberation phase of the hearing. This occurs when the accused is known to those sitting in judgment. The shadows raised by commonly known, but untrue, malicious gossip are hard to fight even if never identified. They should not influence the outcome. We wish written, agreed upon guidelines for practice recommendations, in contrast to ex post facto rules that reflect the whim of the reviewers. Our bylaws are the only shield to protect a doctor from abuses we see in over 50% of medical peer reviews. Most are based on economic



AAEM booth at ACEP meeting in Orlando, FL, with supporters, (from left) Minas, Schwartz, Buffaloe, Troia, and unsung heroine Gail Hubbel, MD, whose efforts made the display happen.

concerns, not bad medicine! Bylaws may be boring but are crucial to one's well being. There should be national standard bylaws rather than differences that favor the maintenance of monopolies. We wish data-driven peer review, thus there should be access to the computer data on unidentified colleagues on the staff. Physicians should not be second class citizens, but should have the same rights as those guaranteed by a malpractice trial. An adverse peer review often leads to progressive expulsion from all hospital staffs; a "domino" effect. This is based on an "extended liability" concept that allows a flawed peer review, at only one hospital, to be used as the sole reason for expulsion at all hospitals.

This process is expensive, averaging \$100,000, that is if one wins in the hospital! Physicians making the charge spend no money, but much time.

The profession of medicine is under attack. In the process no physician is safe from the abuse of peer review. We encourage physicians to examine their bylaws and to look at our collegial behavior. Who is brave enough to stand against an opinionated chief of any department, when the bylaws give minimal rights and state laws give the accuser immunity?

We need to draw together behind the bulwarks of the Constitution, and good bylaws, in these economic hard times. Splitting into warring camps plays into the hands of the many business and economic interests attacking quality medicine and surgery.



EDITORIAL COMMENTARY

"Popularity Contest"

by Christopher J. Minas, MD

Board of Directors

American Academy of Emergency Medicine

In my wildest dreams, I would never have imagined that a physician's professional abilities would be judged as a "popularity contest!" Let me explain.

Many hospitals are employing lay people to phone patients who have been seen in the Emergency Department to ask how they "liked" their doctor. They often use a questionnaire similar to what one would expect from a restaurant chain soliciting comments about the service. "Was your food served promptly? Was the waiter courteous? Did your waiter identify him/herself? Did you enjoy your food?"

The physician is being evaluated as a "waiter" emphasizing the philosophy that "the customer is always right," overlooking the critically more important "doctor-patient" relationship, with its inherent primary obligation to the patient's well-being. Physicians are being rated primarily on the basis of their popularity, often completely disregarding their level of medical expertise. This philosophy should not be employed in such a manner because a patient's desires may, at times, directly oppose

the provision of quality medical care. For example, if a patient presents to the Emergency Department seeking narcotics, the physician may feel the request is inappropriate and should then refuse it. Is the patient satisfied? Substance abusers and patients with psychiatric disorders may complain (sometimes with little or no merit) about their treatment, but the physician should exercise his medical judgment. Circumstances may dictate that the Emergency Physician cannot devote his full attention to any one patient at a given moment. A patient may feel neglected, while the physician is doing his best to differentiate true emergencies from non-emergent and minor cases and treat them accordingly. Simply put, the average patient is not unbiased as relates to medical treatment and understanding of the Emergency Department and is not qualified to review the appropriateness of medical care.

And yet, this "popularity contest" is used by some hospitals to help evaluate the physicians practicing in the Emergency Department. Many hospital administrators are inappropriately using customer relations questionnaires to monitor and supervise Emergency Physicians, and are thereby interfering with the practice of medicine. This business practice undermines the autonomy of the physician and intrudes upon the doctor-patient relationship.

A physician's primary concern must be to

provide the highest degree of medical care and to do what is best for the patient. "Satisfying the customer" is an important goal, but a physician's primary obligation is to treat and protect the patient and to relieve pain and suffering. This is what society expects of us; this is the oath we have sworn to uphold. Primary emphasis on "popularity" and "customer relations", over the physician's more important obligations to the patient is sophomoric, unprofessional, and dispiriting, and undermines the honored traditions of medicine. I maintain that only physicians are qualified to evaluate their peers and to determine how medicine is best delivered to the public. Complaints specific to medical care should be evaluated in a peer review setting by the Emergency Department medical staff.

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Drew Fenton, MD.

AAEM thanks Robert McNamara, MD FAAEM, for sharing his archives to reprint in *Common Sense*.

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Requiem for an “ER Doc”

Douglas White, MD MPH MBA

The invitation to contribute to this issue of *Common Sense*, in commemoration of the Academy's 20th year, was both welcome and propitious. Well into the twilight of a career in emergency medicine, it's hard not to reflect on the advances we've made as a specialty and the new challenges we face. Younger readers, and presumably nearly all readers of this column will be younger than the author, should know their history if they are to confront the future with confidence, optimism, and an open-minded vigilance. Our specialty has made great strides, silenced many adversaries, and become fully integrated into the house of medicine — but we face daunting challenges, some unique to our specialty, but many facing medicine as a whole. My generation may be entitled to a modest degree of self-congratulation at this point, and I'd like to think I personally deserve more credit than George Clooney, but this is no time for complacency.

The progress of emergency medicine from an academic/research/educational standpoint has been nothing less than astonishing, even to those of us that helped found AAEM. I can still quote my dean, who refused to write a dean's letter for me because he didn't want “one of my stronger students squandering a promising career working in the bowels of the hospital populated by impaired physicians, FMGs struggling with visa issues, and sundry others otherwise unable to secure reputable positions in traditional training programs.” Today we can point to funded researchers, multiple peer-reviewed and widely cited journals, and a nearly ubiquitous training presence in medical schools. Our residencies are highly competitive and we now lure more than our fair share of AOA graduates. While several troglodyte institutions still withhold academic department status from emergency medicine, capitulation is only a matter of time, and our senior faculty are tenured and treated equitably by promotion committees.

The quality control in our training and certification process sets an enviable standard that other specialties are only now, begrudgingly mirroring. I would have the utmost confidence presenting myself or a family member to any emergency department staffed by physicians trained in an EM residency and ABEM-certified. This is no small achievement. The care rendered in any “ER” 35 years ago, including at hospitals ranked in the nation's top 10 by *US News and World Report* — several of which I worked at in my day — would be appalling in comparison to that provided at the vast majority of community hospital EDs today.

Emergency departments today form a critical link in the public health and safety networks. The indigent have always relied upon the “ER,” but today virtually every patient relies upon the ED. There is a reason most of us surreptitiously donate a third of our income to care for the uninsured and indigent in this nation, but we also serve as the critical backstop for patients in Beverly Hills, Bethesda, Beacon Hill, and Buckhead. Both missions are truly “God's work,” so don't be shy about invoking this service when explaining to your kids next year why you won't be home on Christmas.

The evolution in working conditions has been more ambiguous. Our often frustrating struggle to be truly independent practitioners, chronicled on these pages for decades, is increasingly submerged under a wave of corporatization, commercialization, and consolidation. It will be interesting to see how our colleagues' attitudes toward EM evolve as they too become employees, and how the move to accountable care organizations may drive hospitals to hire emergency physicians directly rather than rely on multi-state staffing groups. It is not at all clear how these new, hospital-centered, oligarchic goliaths — which will dominate local health markets — will be able or willing to outsource their EDs to large staffing groups as they have in the past. While the precise outcome is uncertain, I am confident emergency physicians will increasingly be treated (or exploited) just like other specialists by hospitals, and that will doubtlessly feel like an improvement in our working conditions. Based on my career experiences, a closer alignment of interests between the hospital, admitting services, and emergency physicians can only be viewed as a positive.

We have technologies now that immeasurably improve our diagnostic, and to a lesser extent treatment abilities. Troponins, MRIs, helical CT scans, etc., were not imaginable when I started practicing emergency medicine. And while we got by using a stethoscope, history, and the atavistic ritual of a neurological examination, both we and our patients are better off now, despite concerns about cost and radiation exposure. Technology has also extended our treatment capabilities, so that numerous residency graduates are taking advantage of the Critical Care Medicine training pathway. It's hard to walk into any sizable ED these days and not appreciate its critical care role.

This has also expanded our responsibilities dramatically, and I would argue dangerously. Neither the quality nor quantity of our staffing has grown commensurately, even in those hospitals that have solved the problem of boarders. The challenge for EM in the future will be how to deal with its successes of the last 30 years. How do we place limits on what is expected of us? Have we really thought through the implications of CCM certification, the early adoption of EMRs that are not EM-centric, physician extenders, hospitalists that have displaced primary care physicians, public health screening in the ED for things like smoking and domestic violence, the expectation that we do all the ultrasound studies at night, etc.? At a time when hospitals are actively looking for ways to save on their global cost structure, we won't have access to our traditional escape valve of admitting patients that are marginally stable, questionably diagnosed, or uncertainly disposed. There will be increasing pressure to treat more patients, and more seriously ill patients, definitively in the ED. But where is the space, the staff, and the follow up going to come from? How many EDs have social workers, respiratory techs, etc., on duty full-time? In our desire to ingratiate ourselves with hospitals and other specialties, I fear we have made a Faustian bargain, and it's time to step back and consider how we slow this train down. We must determine and limit the scope of our practice, just like any other specialty.

Continued on next page



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This brings me to my final point. Emergency medicine today is a well compensated specialty, as it should be considering the nights and weekends we work, typically without a differential or comp time and without paid holidays. For someone who recalls that his first paycheck would not disqualify him for food stamps (known as SNAP today), this is as breathtaking as it is appreciated. However, emergency physicians must be cognizant of our unique staffing demands: 24 hours a day, 365 days a year. Even many intensivists don't have this commitment, and when they do, their patient loads and new admissions are capped by the number of ICU beds. It's rare that an intensivist doesn't get to sleep at least part of the night while on call, and in training centers with fellows, most of the night.

It's hubris to think you will be working 30-40 clinical hours a week into your 70s, 60s, or maybe even 50s without impacting your health. Moreover, we can't all be directors and limit our hours to nine to five, M-F. We may have a chronic shortage of board-certified emergency physicians, but we certainly have no shortage of board-certified ED directors, so that career option is increasingly closed. Sleep studies show that a third of medical students can't time-shift at all, a third time-shift somewhat well with planning, and a third time-shift with relative ease. Of

course those in the former group self-select out of emergency medicine, while those in the second group approach EM with some trepidation and know that their career length will be limited. The final group, arguably at least half of our trainees, assume their relative immunity to sleep deprivation as medical students will last indefinitely. Let me assure you, it will not. We have chosen a noble specialty to practice, but no one else will look out for your welfare and your health. Trust me, you can get by on far less than you're earning currently — my generation did. Be prepared for the inevitable curtailment in your ability to practice this exceedingly interesting but physically and emotionally demanding specialty after the age of 50.

You have been handed a mature, respected, and dynamic specialty — one that provides a stimulating career with fair remuneration. But as we have drawn even with other specialties, we increasingly find ourselves under the gathering clouds shadowing medicine as a whole: insurance companies, ACOs, fee splitting, hospital closings, reduced primary care availability, etc. Let's hope that as fully accepted members of the medical profession, we can harness our specialty's enthusiasm and energy to solve these professional challenges, as we have tackled those of the past. ■

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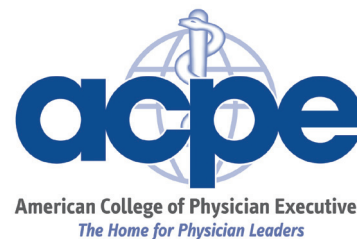


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Law and Emergency Medicine

Medical Liability and the Emergency Physician: A State by State Comparison — Part 1

Gregory Roslund, MD FAAEM
Legal Committee



"I don't want to miss badness when it presents in an unusual way." I recently read this quote on an emergency medicine discussion forum, and it got me thinking about the vulnerability of our specialty and the need for comprehensive tort reform. Working with limited information is what emergency medicine is all about, and when our initial information is limited and our ability to obtain additional information is re-

stricted, the door to legal action opens wide. Unfortunately, with mounting regulation and increased scrutiny of our resource utilization on the horizon, our ability to "find badness when it's less than obvious" will be challenged. We will be forced to limit our work-ups based on evidence-based protocols and cost-benefit ratios. If our ability to diagnose and treat is restricted beyond our control by the government, we deserve to be shielded from litigation when bad outcomes occur. Simply put, the current medical liability system is not compatible with government-run health care rationing. We need tort reform. That being said, we won't see tort reform at the federal level anytime in the foreseeable future. For now, it will remain an issue for each state. As we examine tort reform at the state level, there is immense interstate variability. As we all know, some states have passed laws limiting plaintiff awards and attorney fees, and other states have developed laws regarding pretrial physician panels and patient compensation funds. As one would expect, these laws have directly affected health care costs and lawsuit frequency, and indirectly affected resource utilization, physician retention, and physician practice style. I've seen this on a personal level throughout my career, as I've now practiced in three states with drastically different liability environments: Illinois, Indiana, and Texas.

Which states have good medical liability environments, and why? Are any states particularly favorable for emergency physicians? Which states have passed EMTALA-related tort reform? Which states have established a gross negligence standard? State by state information on medical liability has been compiled many times, but data specifically on emergency medicine has been hard to come by — until now. I have constructed a medical liability state by state comparison — hopefully the most accurate and comprehensive medical liability database yet for emergency physicians.

Methods

Each state's medical liability environment was carefully scrutinized and given a rating (one to five stars). These ratings were based primarily on (1) the presence of damage caps and their stability over time (weighted 30%), and (2) the approximate malpractice premium costs for emergency physicians (weighted 30%). States with meaningful laws specifically protecting emergency physicians received additional one or two stars.

Additional factors that received consideration included: limits on attorney fees (7.5%), expert witness reform (7.5%), statute of limitations (5%), joint and several liability reform (2.5%), collateral source reform (2.5%), whether periodic payments are allowed (2.5%), lawsuit frequency (5%), lawyers per capita (5%), pretrial panels (7.5%), patient compensation funds (7.5%), and average malpractice awards (5%).

I attempted to list the average 2012 annual premium (approximate) for emergency physicians. For states in which this information could not be obtained, I listed average 2012 annual premiums for Internal Medicine (IM) and General Surgery (GS) (approximate numbers representative of full time physicians with standard policy limits). This information was obtained from "The Medical Liability Monitor."¹ As a general rule, emergency medicine premiums are typically somewhere between IM on the low end and GS on the high end.

Primary sources for this state by state comparison included: The Medical Liability Monitor, The American Medical Association, Protect Patients Now, The American Tort Reform Association, The Kaiser Foundation and its statehealthfacts.org, discussion forums at sermo.com and studentdoctor.net, and countless conversations involving helpful emergency medicine colleagues all over the country.

I welcome questions, comments, and additions. Hopefully, this will stimulate increased cooperation and communication among emergency physicians practicing in different states. I'm curious, for those of you who practice in tort reform states, what's it like? Better for patients? Physicians? Can a state have a good climate despite the absence of tort reform?

I welcome any and all feedback. Please direct your comments or questions to the editor of *Common Sense*, Andy Walker at cseditor@aaem.org.

Before we scrutinize each state, I'd like to define a few terms that will be mentioned repeatedly in this paper.²

- **Tort:** in common law, compensating someone for the wrongdoing of another.
- **Tort reform:** proposed changes that would reduce tort litigation or damages.
- **Hard caps:** don't change over time, hold no exceptions, and are the same regardless of the number of defendants or plaintiffs.
- **Soft caps:** are individualized per defendant or plaintiff, change over time, and allow for exceptions.
- **Non-economic damages:** are paid to compensate an individual for physical and emotional pain, not monetary losses.
- **Punitive damages:** should be awarded only if there is clear and convincing evidence that the defendant acted with malicious intent.

Continued on next page

- **Collateral source rule:** says that juries need to be aware of payments to plaintiffs from other sources, such as health insurance, disability insurance, etc.
- **Joint and several liability:** a rule that allows any defendant in a lawsuit to be held liable for the entire amount of damages, regardless of that defendant's proportion of fault. Ideally, this rule is reformed/abolished so that defendants are held liable only for their own portion of the damages awarded to a plaintiff, in direct proportion to their percentage of fault.
- **Expert witness reform:** experts must have, "An appropriate level of knowledge about the specific matter in question and a sufficient level of expertise in the applicable field of medicine." Some states have passed laws requiring experts to be currently in practice, from the same specialty, and living in the same state in which the incident occurred.

Now, let's look closely at the first 10 states arranged alphabetically:

Alabama ★★★★★ 3.25 stars out of 5

Caps: None.³

Average 2012 premiums: ~\$22,000 for EM (personal communication, 2012).

Liability environment for emergency physicians: Alabama is not a particularly risky state for EPs (personal communication, 2012). Strengths include relatively low premiums (info obtained from helpful colleague), a low number of award payments,⁷ a two year statute of limitations,³ and a strong contributory negligence clause: "a claimant's proximate contributory negligence will bar recovery completely."⁶ Weaknesses include the absence of caps,³ no expert witness case certification requirement,⁸ no limits on attorney fees,³ and no joint and several liability reform.³ A \$400,000 cap on non-economic damages and a \$1 million cap on wrongful death damages were both overturned in the 1990s.⁴

Assessment: Premiums remain low despite the absence of meaningful tort reform. Grade: 3.25 stars out of 5.

Alaska ★★★★★ 4.5 stars out of 5

Caps: \$250,000 on non-economic damages, \$400,000 cap on non-economic damages for wrongful death or severe permanent physical impairment that is more than 70% disabling.³

Average 2012 premiums: ~\$8,000 to \$10,000 for IM, ~\$29,000 to \$33,000 for GS.¹

Liability environment for emergency physicians: With excellent liability reforms that have so far stood the test of time, Alaska is a fantastic state for emergency physicians. Strengths include caps on non-economic damages,³ expert witness reform,⁸ a two year statute of limitations,³ and joint and several liability reform.³ Unique among the states, Alaska has had a "loser pays" rule throughout its civil courts for many years — the "English Rule" that the entire world outside the U.S. follows. Unfortunately, in Alaska the rule is applied to no more than 20% of the winner's legal fees and is actually collected in only a minority of cases. Thus it has not had an obvious effect on medical liability in the state.²⁷ Minor criticisms include the absence of limits on attorney fees³ and no specific protection for emergency physicians and other physicians providing EMTALA-mandated emergency care.

Assessment: Formidable reforms have been upheld. Grade: 4.5 stars out of 5.

Arizona ★★★★★ 2 stars out of 5

Caps: None.³

Average 2012 premiums: \$30,000 to \$50,000 for EM.⁵

Liability environment for emergency physicians: Despite specific legislation designed to protect emergency physicians and those providing EMTALA-mandated emergency care,⁹ Arizona is still a dangerous state for EPs. There are several negatives: high premiums,¹ caps are prohibited by the state constitution,³ and there are no limits on attorney fees.³ On the positive side, Arizona does have a two year statute of limitations,⁸ joint and several liability reform,³ and this year the Supreme Court upheld expert witness reform requiring the plaintiff's experts to be physicians practicing in the same specialty as the defendant.¹⁰ Most notably, in 2009 Senate Bill 1018 added a new section to Arizona Statutes section 12-572, that increased the burden of proof on plaintiffs in cases involving emergency physicians and others providing EMTALA-mandated emergency care. Plaintiffs must present "clear and convincing evidence" rather than a "preponderance of evidence" that the provider committed malpractice.⁹

Assessment: Legislation providing additional protection for EMTALA-mandated emergency care is promising, but has yet to make an impact. Grade: 2 stars out of 5.

Arkansas ★★★★★ 3.25 stars out of 5

Caps: None.³

Average 2012 premiums: \$7,000 to \$10,000 for IM, \$21,000 to \$31,000 for GS.¹

Liability environment for emergency physicians: Arkansas is known as relatively non-litigious (personal communication, 2012) — the state is a safe bet for an emergency physician. Physicians enjoy some of the lowest annual premiums in the country.¹ The state has enacted a two year statute of limitations and expert witnesses are required to practice in the same specialty as the defendant.^{3,8} Despite these strengths, tort reform is nonexistent,³ opening the door for lawsuit abuse and increased costs down the road. Arkansas has no caps, no joint and several liability reform, no collateral source reform, and no limits on attorney fees.^{3,8} However, the state's political climate is slowly changing and tort reform in Arkansas may soon become a reality. In 2013 Senate Joint Resolution² was filed, introducing a "loser pays" penalty for those who file lawsuits determined to be frivolous, as well as additional expert witness reforms — further expert restrictions and a "certificate of good faith" requirement.¹¹

Assessment: Premiums remain low despite the absence of meaningful tort reform. Grade: 3.25 stars out of 5.

California ★★★★★ 5 stars out of 5

Caps: \$250,000 cap on non-economic damages (hard cap).³

Average 2012 premiums: \$4,000 to \$18,000 for IM, \$15,000 to \$64,000 for GS.¹

Liability environment for emergency physicians: In 1975, California passed MICRA, the Medical Injury Compensation Reform Act, and it has since become the gold standard for state-based medical liability reform.¹² Components of MICRA include a hard \$250,000 cap on non-economic damages — one of the only caps out there that is not indexed

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for inflation, limits on attorney fees, and a short statute of limitations.^{3,8} Despite having its constitutionality repeatedly challenged, this landmark reform package has stood the test of time and has served as a model for reform at the federal level.¹² MICRA is credited for reigning in health-care costs.¹³ Premiums in California are relatively low¹ and the state has one of the lowest average malpractice award payments in the nation.⁷

Assessment: CA is top dog when it comes to pertinacious reform. Low premiums, hard caps — thank you MICRA! Grade: 5 stars out of 5.

Colorado ★★★★★ 5 stars out of 5

Caps: \$300,000 cap on non-economic damages, \$1,000,000 cap on total damages (hard caps).³

Average 2012 premiums: \$11,000 to \$14,000 for IM, \$43,000 to \$60,000 for GS.¹

Liability environment for emergency physicians: In my opinion, Colorado is one of the top states in the union regarding medical liability. Despite lacking EMTALA-specific reforms, it is considered a safe haven for EM physicians. It is one of the only states to have upheld a hard cap on non-economic damages and a hard cap on total damages.³ Additional strengths include expert witness reforms such as a case certification requirement, experts must be in the same specialty as the defendant, and experts must be licensed in Colorado;⁸ joint and several liability reform;³ and a two year statute of limitations.⁸ Colorado has no limits on attorney fees.³

Assessment: A hard cap on total damages, low premiums, and superior expert witness reform make the centennial state an easy sell. Grade: 5 stars out of 5.

Connecticut ★★★★★ 1 star out of 5

Caps: None.³

Average 2012 premiums: \$15,000 to \$35,000 for IM, \$66,000 to \$93,000 for GS.¹

Liability environment for emergency physicians: Connecticut's medical liability environment is not particularly favorable towards EPs. Annual premiums are high,¹ average malpractice awards are high (over \$495,000 in 2011),⁷ damage caps are nonexistent,³ and last year trial attorneys came very close to passing a bill which would have weakened Connecticut's certificate of merit law passed in 2005.¹⁴ Strengths include some expert witness reform, joint and several liability reform, a limit on attorney fees, and a two year statute of limitations.^{3,8}

Assessment: Sky high premiums and the absence of caps make CT a no-go. Grade: 1 star out of 5.

Delaware ★★★★★ 0.5 stars out of 5

Caps: None.³

Average 2012 premiums: \$40,000 to \$60,000 for EM (3 million/5 million policy) (personal communication, 2012).

Liability environment for emergency physicians: Unfortunately, Delaware's medical liability environment is one of the nation's worst. You've been warned. Damage caps are nonexistent,³ premiums are high,¹ average malpractice awards are high (\$600,000 in 2011),⁷ the state lacks expert witness reform,⁸ and there is no joint and several liability reform.³ The state does limit attorney fees³ and Delaware enforces a two year statute of limitations.⁸ Apparently, pretrial screening panels are a voluntary option.⁸

Assessment: No caps, no expert witness reform, high premiums, and no hope on the horizon. Grade: 0.5 stars out of 5.

District of Columbia ★★★★★ 0 stars out of 5

Caps: None.³

Average 2012 premiums: \$24,000 for IM, \$73,000 for GS.¹

Liability environment for emergency physicians: Stay away, stay away! EM physicians who love DC and want to call it home are advised to commute to Maryland or Virginia to find work. No damage caps,³ no expert witness reform,⁸ no joint and several liability reform,³ a three year statute of limitations,⁸ no limits on attorney fees,³ premiums that are through the roof,¹ a high average malpractice award payment (\$575,000 in 2011), and the highest number of attorneys per capita (276 per 10,000 residents) in the country.¹⁵

Assessment: The highest number of attorneys per capita. Need I say more? High premiums, high awards, no caps, and no reform whatsoever. Grade: 0 stars out of 5.

Florida ★★★★★ 1.5 stars out of 5

Caps: \$500,000 cap on non-economic damages for physicians, \$750,000 cap on non-economic damages for hospitals (soft caps).³

Average 2012 premiums: \$20,000 to \$48,000 for IM, \$57,000 to \$190,000 for GS.¹

Liability environment for emergency physicians: Despite comprehensive reform in 2003 that included legislation geared towards emergency physicians,¹⁶ Florida will probably always be a relatively dangerous state for EPs. There is immense variation throughout the state regarding risk, with Dade and Broward counties being two of the most litigious counties in the country.¹⁷ General surgeons, OB-GYNs, and other specialists can expect to pay close to \$200,000 in annual premiums.¹ A soft \$500,000 cap on non-economic damages was instituted in 2003, but the cap can be raised to \$1 million if negligence resulted in wrongful death, a permanent vegetative state, or any type of "catastrophic injury."¹⁶ For emergency physicians and others providing care in the emergency setting, these caps are lowered to \$150,000, and \$300,000 in the case of catastrophic injury.¹⁶ On the negative side, South Florida has a lot of lawyers¹⁵ and a lot of ATRA-reported "judicial hellholes."¹⁷ On the bright side, Florida does have joint and several liability reform,³ limits on attorney fees,³ a two year statute of limitations,⁸ expert witness reform,⁸ and two patient compensation funds.⁸ In March 2013, legislation (Senate Bill 1134/House Bill 897) was introduced to transform the Florida medical malpractice system into something similar to a no-fault workers compensation model, in an attempt to reduce healthcare costs and decrease defensive medicine. Not surprisingly, surveys reveal that 93% of physicians support the bill while trial attorneys remain intensely opposed.²¹

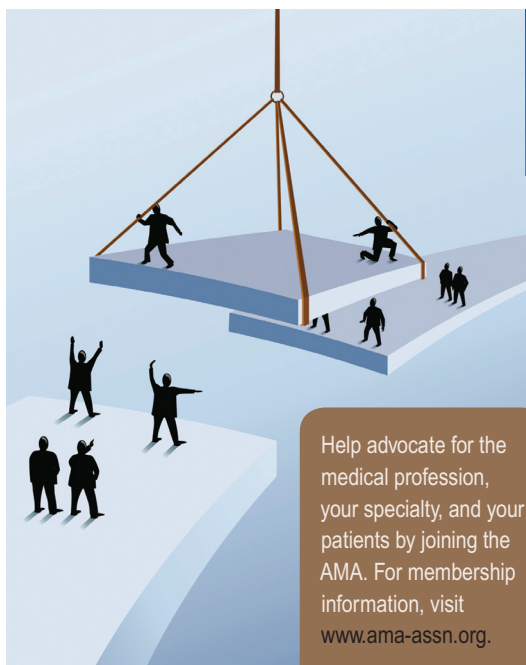
Assessment: Special caps on non-economic damages for emergency providers have failed to significantly improve this high risk environment. Grade: 1.5 stars out of 5.

Look for this series to continue in future issues!

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Warning Sounded on Demoralized Health Care Work Force

Kevin B. O'Reilly
American Medical News, staff
www.amednews.com

From the response it generated, my editorial on burnout in the March/April issue of Common Sense must have struck a chord. As you can see in the article below from American Medical News and the two graphs taken from an article on Medscape (Emergency Medicine Lifestyles -- Linking to Burnout: Medscape Survey), the problem is becoming obvious to everyone and other voices are joining in the chorus of warning. That makes me optimistic about conditions improving in the long run.

—The Editor

Many medical work environments are unsafe for health professionals, adding stress and distraction that can expose patients to harm.

The experience of working in American health care is being drained of joy and meaning amid a rising rate of occupational injuries, episodes of verbal abuse and physical assaults from colleagues, and a seemingly relentless drive to provide more care in less time.

This toxic blend is setting back the effort to improve the quality of care and prevent patient harm, according to a recently published report produced by some of the most distinguished names in the field of patient safety.

"Production and cost pressures have reduced complex, intimate, caregiving relationships into a series of demanding tasks performed under severe time constraints," said the report, released by the National Patient Safety Foundation's Lucian Leape Institute.

The institute is named for its chair, Lucian L. Leape, MD, a preeminent patient safety researcher. He said all health professionals deserve to be treated with respect, given the resources they need to do their jobs well, and be recognized for the work they do. Health care organizations where those basic needs are not met are impeding progress in patient safety.

"To the extent that people are unhappy in their work, or feel unappreciated or disrespected, they are less likely to be focusing entirely on patients and on making sure they do everything correctly, following the safe procedures and not cutting corners," said Dr. Leape, adjunct professor of health policy at the Harvard School of Public Health in Boston.

The injury rate in health care is 5.6 per 100 full-time employees, 33% higher than the rate for all of private industry, said the institute's March report, "Through the Eyes of the Workforce." Musculoskeletal injuries related to lifting and moving patients are the leading culprits. Many health professionals also are improperly exposed to infected patients and bloodborne pathogens.

"One of the ways you show respect for people working health care is by paying attention to the basic safety of the workplace," Dr. Leape said. "It's really horrendous that the delivery of health care, in hospitals specifically, is one of the most hazardous places to work in the country."

What Causes Disruptive Behavior

The institute's report says health care organizations should track worker injuries carefully, find out what is causing them and aim to eliminate them. The report also highlights the lingering problem of disruptive behavior in health care, which can create a culture of fear and intimidation that inhibits safe, high-quality care.

Seven in 10 doctors see disruptive behavior at their institutions at least once a month, and 11% said such outbursts happen daily, according to a May 2011 survey released by the American College of Physician Executives and QuantiaMD, an online physician education provider. The physician respondents said the leading cause of disruptive behavior is a heavy workload, one of several recent examples illustrating how severe time constraints in health care are harming collegiality, quality, and safety.

For example, a February 25 study in *JAMA Internal Medicine*, formerly *Archives of Internal Medicine*, found that about 80% of misdiagnoses at five primary care clinics were related to problems in the patient encounter, such as errors during the physical exam and medical history-taking. The study's lead author said shorter office visits are a principal contributor to diagnostic errors.

Meanwhile, a May 2012 Agency for Health Care Research and Quality report found that more than 70% of doctors and others working in medical offices feel rushed when taking care of patients. Nearly half of physicians report experiencing at least one symptom of burnout, said a nationwide survey of 7,288 doctors in the August 20, 2012, *JAMA Internal Medicine*.

Creating a Culture of Civility

Health care organizations hoping to prevent disruptive behavior, reduce physician stress and improve care quality should target heavy workloads and time-constrained care, said Alan H. Rosenstein, MD, who was not involved in the Leape Institute report.

"Over the years, physicians and nurses have worked harder and harder and nobody thought much about it, because they were able to do it without breaking. Now they're starting to break," said Dr. Rosenstein, a leading researcher on disruptive behavior and medical director of Physician Wellness Services, a firm that provides employee-assistance programs to hospitals and health systems.

Health care leaders should offer extra help in the form of clerical assistance, nurse practitioners, and physician assistants to stressed physicians, he said.

The Leape Institute report recommends that health care organizations commit to creating a culture that values civility and transparency. That includes using evidence-based management skills that improve an

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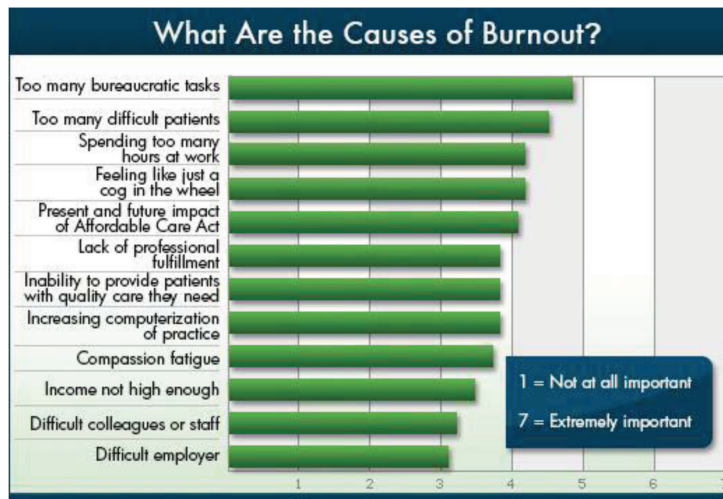
organization's reliability, communication, and teamwork; offering wellness and peer-support programs; and sharing quality and safety data to encourage problem-solving instead of finger-pointing.

Some health systems are on the right track, the report said. Seattle's Virginia Mason Medical Center has employed car manufacturer Toyota's lean production model to cut waste that makes health professionals' jobs harder and distracts from patient care. Process changes cut steps walked per day from 10,000 to about 1,200 and increased the share of time nurses spend with patients from 35% to more than 95%. In 2012, Virginia Mason implemented a tool to track and quantify the costs related to health worker injuries.

"We have the means to create a positive work environment that then becomes a milieu where people can do their very best work on behalf of our patients," said Gary Kaplan, MD, Virginia Mason's CEO and a member of the Leape Institute's board. "If we have staff including physicians and nurses feeling overwhelmed, burned out, beaten down, I think the ability to deliver what we aspire to — zero-defect care — becomes very, very problematic."

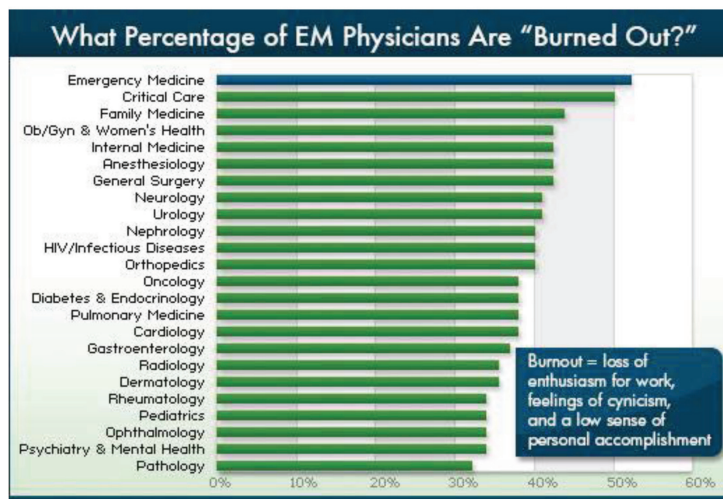
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Medscape Emergency Medicine Physician Lifestyle Report 2013



From [Emergency Medicine Lifestyles -- Linking to Burnout: Medscape Survey](#)
Marrecca Fiore; Carol Peckham
March 28, 2013

Medscape Emergency Medicine Physician Lifestyle Report 2013



From [Emergency Medicine Lifestyles -- Linking to Burnout: Medscape Survey](#)
Marrecca Fiore; Carol Peckham
March 28, 2013

Dr. Peter Rosen Receives Honorary Doctor of Science

Peter Rosen, MD FACS FAAEM, a 1960 graduate of Washington University School of Medicine in St. Louis, is an international leader in emergency medicine and one of the pioneers and founding fathers of the specialty.

He serves as senior lecturer at Harvard Medical School and visiting professor in the Department of Emergency Medicine at the University of Arizona College of Medicine, Tucson. He also is professor emeritus at the University of California, San Diego, School of Medicine.

"It is very humbling to consider the changes in the field of emergency medicine and how much of an impact it has had on the care of patients around the world and to think that I was lucky enough to have had something to do with that evolution," Dr. Rosen says.

Asked what he's most proud of in his career, he points to the students and residents who have trained in programs he started, many of whom have become departmental chairs and succeeded in other notable endeavors.

Some are even family. A great niece in Tucson recently was accepted into the emergency medicine residency there, and one of his former residents is a nephew, making for three generations of emergency physicians in Dr. Rosen's family.

His nephew, Dr. Richard Wolfe — chair of the Department of Emergency Medicine at Boston's Beth Israel Deaconess Medical Center and one of the physicians who treated the wounded in last month's tragic bombings in Boston — refers to Dr. Rosen as his "personal hero and mentor."

Dr. Wolfe says his uncle had a clear vision of emergency medicine as an academic specialty at a time when most failed to see it as anything more than a dysfunctional part of the health care delivery system.

"He was able to communicate and teach an ethical model of practice based on intellectual honesty, equal access to care, and compassion for the needy that was transformative for our specialty."

The bombings deeply saddened Dr. Rosen — but brought home the great need for sound emergency medical training and care. "It's at times like this, even though emotionally depressing, that I feel a sense of fulfillment for all the work and preparation in making the field of emergency medicine competent to help deal with the scene and the wounded," he says.

Dr. Rosen has written hundreds of articles, editorials and chapters to advance the literature of emergency medicine. He was founding editor of *Rosen's Emergency Management: Concepts and Clinical Practice*, the field's highly regarded flagship textbook, soon in its seventh edition.

He is also the founding editor of the *Journal of Emergency Medicine*, the official journal of the American Academy of Emergency Medicine, and remains on its editorial board.

He has been a prolific speaker, presenting on all matters involving emergency medicine, including medical ethics, the history of emergency medicine and even legends in the field, of which he arguably is one.

In 1990, he received the Leadership Award from the Society for Academic Emergency Medicine. He also was elected to the Institute of Medicine of the National Academy of Sciences in 1993.

AAEM presents an award named after Dr. Rosen, which recognizes individuals who have made an outstanding contribution to AAEM in the area of academic leadership. AAEM has been presenting this award at the Annual Scientific Assembly since 2001. To date, 16 individuals have been honored.

A native of Brooklyn, New York, Dr. Rosen earned a bachelor's degree from the University of Chicago. After earning his medical degree from Washington University, he completed an internship at the University of Chicago Hospitals

and Clinics and a residency at Highland General Hospital in Oakland, California, before becoming a general surgeon and a burn unit physician in the U.S. Army Medical Corps.

Dr. Rosen has taught and counseled generations of physicians. He served as director of the emergency medicine residencies at Denver General Hospital/St. Anthony Hospital Systems from 1977-1988 and at the University of Chicago from 1971-1977. He joined the University of California, San Diego, faculty in 1989, where he is residency director emeritus of the emergency medicine residency program.

He has held offices in numerous academic societies and was a founding member of the American Trauma Society.

Dr. Rosen and his wife, Ann, have four sons and two grandchildren and split their time between Tucson, AZ. and Newton, MA. ■



Peter Rosen, MD FACS FAAEM, (left) receives an honorary Doctor of Medicine from Chancellor Mark S. Wrighton (right) during the 152nd commencement ceremonies of Washington University in St. Louis on May 17, 2013.

Photo Credit: James Byard/WUSTL Photos

COMMITTEE REPORT: Accreditation Council on Continuing Medical Education (ACCME) Subcommittee

The American Academy of Emergency Medicine's CME Program offers educational activities that stimulate, maintain, develop, and enhance the study and practice of emergency medicine. To maintain accreditation as a CME provider, AAEM must meet certain criteria and adhere to many guidelines. This could not be done without the work of the ACCME Subcommittee of the Education Committee. Its members take time from their busy schedules to review numerous applications for recommended or jointly sponsored CME activities. In 2012 alone, 15 conferences sought the subcommittee's approval, so that they could advertise themselves as approved or jointly sponsored by AAEM. These conferences were at both the national and international level. The subcommittee also reviews faculty disclosures and presentations for both Academy and

jointly sponsored CME activities, to ensure compliance with all ACCME guidelines.

We look forward to another year of screening and recommending CME activities from organizations whose goals are compatible with our mission statement, to enhance the education of emergency medicine specialists. Should you be interested in obtaining AAEM's recommendation for a conference or applying for a Jointly Sponsored Activity designation, please contact Stephanie Schreiner, CME and Program Manager at sschreiner@aaem.org.

Michael Klevens, MD FAAEM
ACCME Subcommittee Chair ■

COMMITTEE UPDATE: Clinical Practice

The Clinical Practice Committee has had a very exciting year, with a great deal of activity since our last update in *Common Sense* just six months ago. Three of our reviews have been published in *The Journal of Emergency Medicine (JEM)* since last fall. Drs. Jack and Karen Perkins were lead authors on an article addressing the use of urine dipstick tests in febrile patients. This paper was published in the most recent edition of *JEM*, although the paper was completed years ago when our committee was the Practice Guidelines Committee. Drs. Will Meurer, Richard Shih, and myself were authors of a paper on the use of TPA in stroke that was published this winter. The third paper, published last fall, was on the management of ACE inhibitor angioedema in the ED, by Dr. Michael Winters and myself with editorial assistance from Dr. Gary Vilke and his fellow, Dr. Faisal Y. Almazroua.

Drs. Mike McMurdy and Jack Perkins, again with editorial help from Gary Vilke, recently submitted a paper to *JEM* offering guidance on the use of telemetry beds for low risk chest pain patients. We also have some exciting papers in the pipeline, including two addressing the use of ultrasound in the diagnosis of appendicitis. A paper by Drs. Lisa Mills and Zach Soucy, on the use of ultrasound in children, was submitted to the AAEM board of directors for review at its May meeting; and was approved. A paper on ultrasound in adults, by Drs. Ashley Bean and Henry Kim, will be submitted shortly, after the authors make some revisions suggested; by the committee. A paper addressing the safety of droperidol use in the ED is now under committee review, and should be ready

for board review by early summer. The authors of this paper are Drs. Jeff Ho and Jack Perkins. Drs. Brian Walsh and Will Meurer will soon finish a paper on CT angiography vs. lumbar puncture in the work-up of headache patients whose initial CT is normal.

Finally, a paper addressing the new ED pain management policy is in its early stages. At the Scientific Assembly in February, a policy statement on pain management was submitted to AAEM's board of directors by Dr. Bob McNamara. The board gave its approval due to the importance and timeliness of the topic, but subsequently asked our committee to revise the statement using our regular, rigorous, peer review process. That paper is now being prepared by Drs. David Cheng and Nima Majlesi. Completion is expected in early summer. It will then be submitted to the board for review.

All in all, I am proud to report that this has been a very productive year for our committee. If any AAEM member is interested in joining the Clinical Practice Committee, please apply by sending a letter of interest to either Tom Derenne (tderenne@aaem.org) or me (steve5sail@aol.com). We would love to have more members who are interested in making an impact on the practice of emergency medicine. Have a great summer!

Steven Rosenbaum, MD FAAEM
Chair, Clinical Practice Committee ■

Member Benefit Highlight — Discounted Registration for all AAEM Meetings!

AAEM members can attend the Annual Scientific Assembly for free, with a refundable deposit.

SAVE THE DATE:

FEBRUARY 11-15, 2014

New York Hilton Midtown
New York City, NY

COMMITTEE UPDATE: Emergency Medical Services (EMS)

The EMS Committee was pleased to organize the track, Prehospital Care: From the Field to the ED, at the 19th Annual AAEM Scientific Assembly in Las Vegas. The committee would like to thank Drs. Beck, Goldstein, Wayne, and Weber for speaking. Agenda items for the committee's next conference call include early plans for topics on the EM/EMS interface, for the curriculum of the 2014 Scientific Assembly in New York City.

Thanks to the efforts of our board liaison, Dr. Robert Suter, *The Journal of Emergency Medicine (JEM)* is considering the publication of "Appropriate and Safe Utilization of Helicopter Emergency Medical Services," a joint statement from NAEMSP, AAEM, AMPA, and ACEP. Meanwhile, a position statement drafted by our committee, "Due Process and Compensation for EMS Oversight," is being routed to NAEMSP for its review and consideration for approval as a joint statement.

Committee members Drs. Anthony DeMond and Eric Beck have been named as AAEM/EMS Committee representatives to the Stakeholders Work Group, to review and update the National Association of State EMS Officials (NASEMSO) Model EMS Guidelines. A candidate for AAEM liaison to NASEMSO itself will be vetted by the committee shortly, and then considered at the next EMS Committee conference call before presentation to Dr. Durkin. Finally, our warmest thanks are extended to our outgoing board liaison, Dr. Suter, as he transitions to new responsibilities on the board of directors, and we welcome our new liaison, Dr. Kevin Beier, as he joins us in that role.

Roger Stone, MD FAAEM
Chair, EMS Committee ■

COMMITTEE UPDATE: Government Affairs

The first half of 2013 has been an exciting time for the Government Affairs Committee. At the turn of the year, AAEM brought on Williams & Jensen to aid our advocacy efforts in Washington, DC. The new team, led by experienced lobbyists Susan Hirschmann and Matthew Hoekstra, has helped the committee stay on top of an ever changing policy and regulatory landscape, and be aware of opportunities for change.

One opportunity is a permanent solution to the Medicare Sustainable Growth Rate (SGR), also known as a "permanent doc fix." The SGR is a flawed formula enacted in the mid-1990s that has pushed physician payments downwards ever since. Congress has patched the SGR with temporary fixes, but a permanent fix is needed to end the constant prospect of huge cuts in Medicare reimbursement. Our lobbyists at Williams & Jensen have helped ensure AAEM's voice is heard in this process, as well as aided in the development of strategies to incorporate issues such as due process in draft legislation.

The committee has also been pursuing ways to address complex regulatory issues that have arisen from the Affordable Care Act. One example is incentive payments for primary care providers and pediatricians to see Medicaid patients. Medicaid reimbursement has traditionally been significantly lower than Medicare and private insurance, and the goal of this new incentive is to encourage primary care providers to accept Medicaid patients. However, the final regulations include emergency department E&M codes that pay primary care physicians working in the ED more for Medicaid patients than emergency physicians receive for those same patients. The committee and AAEM's board believe this incentive is improper, unfair, and harmful to emergency medicine.

Finally, a team of committee members recently met with leaders at the Centers for Medicare and Medicaid Services, to incorporate due process language in future regulations. This has long been an issue important to AAEM members, and our hope is to have it addressed on a national level in 2013.

Mike Yabarra, MD FAAEM
Chair, Government and National Affairs Committee ■

JOIN A Committee!

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

Subcommittee activities include:

- Ensuring that each educational activity meets the criteria set forth by the Accreditation Council for Continuing Medical Education (ACCME)
- Reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly sponsored activities to ensure all ACCME guidelines are met and the appropriate number of CME credits are determined

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

COMMITTEE UPDATE: Social Media

The AAEM Social Media Committee has been busy at work over the past year, and I hope all of you have seen the results! Scientific Assembly in Las Vegas was a great social media success. We have had a tremendous increase in the number of followers on our Twitter account, and we have a number of projects in the works over the next year to better connect with you, our members. Content presented at the Scientific Assembly was the talk of emergency medicine all over the world! I encourage you to follow us on Twitter (@AAEMinfo) as we broadcast messages regularly, and even include highlights from the upcoming edition of the *Journal of Emergency Medicine (JEM)*. My thanks to the *JEM* staff for assisting us with this, and especially to Robert Stuntz, MD FAAEM, and Robert Cooney, MD FAAEM, for their work in creating content.

I want to encourage all of you to head to the website and get in touch with AAEM through AAEM Connect. It is easy to submit a Letter to the Editor or obtain a Curbside Consult from *Common Sense*, all through this single page. You can also follow the AAEM Twitter feed and Facebook page, connect with us on LinkedIn, listen to podcasts, and view the AAEM Blog. Did you know *Common Sense* is online? Look out for increased activity on the blog in the near future.

As always, if you are interested in joining the ever-growing and exciting world of social media, don't hesitate to apply to the Social Media Committee. Contact us at info@aaem.org or through Facebook, Twitter, LinkedIn, or Letters to the Editor with any questions you have!

Brett Rosen, MD
Chair, Social Media Committee ■

COMMITTEE UPDATE: Practice Management

First of all, I would like to thank everyone who helped create a successful practice management track at this year's Scientific Assembly in Las Vegas. We hope that everyone enjoyed the new addition, and we are excited to continue to share ideas that make independent groups strong.

We are heading into this year with much trepidation as to what will become of medicine in general, and emergency medicine in particular. The ACA is still a big unknown for us, and seems to confuse and alarm even those who voted for it. The latest event is a move in Congress to exempt senators, representatives, and their staffs from having to participate in the insurance exchanges. It will be interesting to hear them explain that one to constituents! States are debating whether to participate in Medicaid expansion, as they will be on the hook for significant costs after the first two years, which are fully funded by the federal government.

In the meantime, work must go on in emergency departments across the country. We continue to give extraordinary care to the millions of patients who arrive every day, regardless of their ability or willingness to pay for that care. We work to satisfy patient needs, along with the needs and desires of hospital administrators, and now — through ACOs and clinical integration projects — the desires of our colleagues in these ventures and of additional administrators. The role of physicians in these projects remains nebulous, aside from primary care physicians being penalized when their patients come to the ED, and many of us continue to look for any benefits for emergency physicians in ACOs.

I recently wrote a commentary suggesting that we share ideas on how to involve emergency medicine in ACOs, and strategize on how to continue to practice medicine in our own groups rather than become employees or get swallowed up by corporate contract management groups. Any information that we gather will be shared with members, either in *Common Sense* or on the AAEM website.

We are starting to establish a database of hospitals that have independent democratic groups, those that directly employ emergency physicians, and those that are run by contract management groups. This task is enormous and we ask for help from all of you who are reading this. There will be instructions on the AAEM website on how to update the hospital database, once we have it up and running. A better understanding of where independent groups are located will help us become more proactive in supporting those groups and helping them to thrive.

In order for one democratic group to thrive, there must be other successful democratic groups around. The sharing of ideas and strategies can enable smaller groups to compete with the larger, better-funded CMGs that are always looking to take over contracts.

We are always looking for enthusiastic members to participate in the Practice Management Committee. Please contact me or AAEM staff if you are interested in participating.

Craig Norquist, MD FAAEM
Chair, Practice Management Committee ■

CHAPTER REPORT: **California AAEM**

The CAL/AAEM educational endeavors continue to thrive. Our chapter sponsored the very successful San Francisco Speakers Series last fall, the pediatric preconference course at the Scientific Assembly in Vegas, and the Orange County Speaker's Series in April. The OC Speakers Series brought together community and academic EPs in southern California, and included networking opportunities along with three amazing speakers: Ghazala Sharieff, MD MBA FAAEM FACEP, Professor of Pediatric Emergency Medicine at the University of California, San Diego; J. Christian Fox, MD RDMS FAAEM, Professor of Clinical Emergency Medicine at the University of California, Irvine; and Michael Menchine, MD MPH, Associate Professor at the University of Southern California. The event was held on April 18, 2013, at the Orange County Medical Association Center. For state chapter members that couldn't make our educational events in person, we continued our online LLSA training modules, available on the calaaem.org website.

The CAL/AAEM Chapter continues to support the independent emergency physician. Along with statewide legislative initiatives, we also offer introductory legal advice for EPs in the area of workplace fairness.

Our state chapter membership is at an all-time high. This includes full voting members, associate members (those who have just matriculated from an EM residency, but not yet taken the boards), resident members, and student members. At the last CAL/AAEM board meeting we voted to extend the duration of associate membership, thus allowing recent grads to get a price break and extended membership. We have also had an increase in the number of "all in" California EM residency programs, and due to the diligence of our resident representatives, Deena Ibrahim and Randy Woo, we now have many medical students involved in CAL/AAEM activities.

California EM programs with 100% resident membership in CAL/AAEM:

- David Geffen School of Medicine at UCLA
LAC + USC Medical Center
Stanford University Hospital
University of California San Diego
University of California San Francisco
University of California Irvine

This being the great state of California, we would be remiss if we were not a leader in social media. Please check out our revamped CAL/AAEM website. Here members can interact with the board and other CAL/AAEM members, tweet using the CAL/AAEM Twitter account, or like us on Facebook. As always, Brian Potts, MD MBA FAAEM, past president of CAL/AAEM, does a great job keeping everyone up to date with our news service. Membership forms, Speakers Series registration, news service archives, president's messages, and newsletters are also available on the chapter web page.

Email: info@calaaem.org

Web: www.calaaem.org

Facebook: www.facebook.com/CALAAEM

Twitter: www.twitter.com/CALAAEM

Trevor Mills, MD MPH FAAEM

Chief of Emergency Medicine Services for the Northern California VA Health Care System

President, CAL/AAEM ■

CHAPTER UPDATE: **Florida AAEM**

The Florida Chapter is pleased to report a productive start to 2013. Our second annual Scientific Assembly in Orlando was well attended by both chapter members and out-of-state visitors seeking a mid-winter educational opportunity in the Sunshine State. In addition, we strengthened our political advocacy for emergency physicians during the 2013 legislative session in Tallahassee. For the first time FLAAEM was a sponsor of EM Days, a collaborative effort by EPs across the state, defending emergency medicine in the legislature. As our resources grow, we look forward to providing even more advocacy and a louder voice for our members.

Dave Rosenthal, MD FAAEM

Director, Florida Chapter ■

ANNOUNCING: **New Benefit for TNAAEM Members!**



The Tennessee Chapter has just added a subscription to the *Western Journal of Emergency Medicine* to the other great member benefits. *WestJEM* focuses on integrating emergency care with population health.



Check your mail boxes for the latest issue!

CHAPTER UPDATE: Virginia AAEM

The Virginia Chapter of AAEM has a number of updates to provide on its activities:

New Liaison with Virginia ACEP

The VA-AAEM board of directors recently voted to establish a liaison position with the Virginia Chapter of ACEP. Dr. Rob Stambaugh will be serving as our liaison. It is our hope that this new relationship will allow us to work together on issues where we share common ground with VA-ACEP.

Virginia Medicaid Payments

VA-AAEM continues to work with its members from Chesapeake Emergency Physicians to address triage-level Medicaid payments to emergency physicians. VA-AAEM and members from Chesapeake Emergency Physicians held a meeting with U.S. Rep. Randy Forbes, on April 29th and are also attempting to schedule another meeting with VA Delegate Chris Stolle, to discuss strategy as we move forward on this issue.

(The views expressed in this article are those of the author(s) and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government. I am a military service member. This work was prepared as part of my official duties. Title 17 U.S.C. 105 provides that 'Copyright protection under this title is not available for any work of the United States Government.' Title 17 U.S.C. 101 defines a United States Government work as a work prepared by a military service member or employee of the United States Government as part of that person's official duties.)

Joel Schofer, MD RDMS FAAEM FACEP
LCDR, MC, USN
NMC Portsmouth
President, VA-AAEM
jschofer@gmail.com ■

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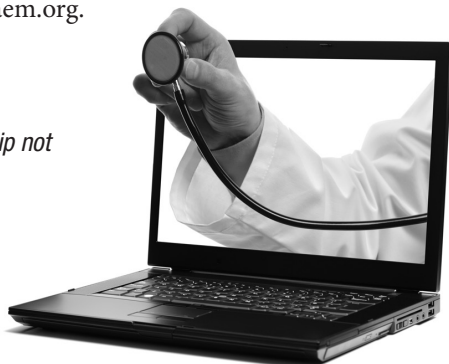
Call for Mentors

Interested in shaping the future of emergency medicine? YPS is looking for established AAEM members to serve as volunteers for our virtual mentor program.

For more information, visit

<http://www.ypsaaem.org/mentors/> or contact us at info@ypsaaem.org.

YPS membership not required.



AAEM-0911-239

AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

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

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

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

For a complete listing of 2013 100% ED Group members, go to www.aaem.org/membership/aaem-ed-group-membership.

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(Un-)Advice for the New Graduate

Jonathan Jones, MD FAAEM
YPS Board of Directors

To all the new graduates out there, congratulations! Emergency medicine is not easy. Residency is not easy. What you will do for the rest of your life is not easy. But you are ready. You are prepared.

Over the next several weeks, months, and years you will receive a lot of advice. Most of it will be generic, feel-good, and worthless. So why should you read this article on advice? Easy — because I won't give you any advice. If you want advice on what to do with the rest of your life, stop reading now. What I will relate are some of the dumb things I did when I first graduated. So why read about my mistakes? Well, learning from other's idiocy is better than learning from your own.

Six years ago this July 1, I happily started what I considered my first real job. July 1 was also when I started making my first real mistakes. My mistakes fell into two broad categories: those that involved the clinical practice of emergency medicine, and those that didn't. We've all benefited from well organized and robust EM residency training programs and are clearly prepared to provide high-quality care, so thankfully fewer of my mistakes fell into the first category. Below are four of the many mistakes I made, but at least recognized.

Mistake #1: Believing that it was just "practice variation" when a new hospital wanted me to practice medicine differently.

While there are practice variations between institutions and most of this is appropriate, I was a little too quick to assume that all of the differences were appropriate local variations. In reality, some of these differences were just bad medicine. As a young staff member I was a prime target for hospital and ED directors who cared more about patient throughput and admissions than about quality of care. I quickly, but not immediately, learned that good medicine is good medicine and does not vary much between locations. I then pushed back and ... it didn't work. The advertised culture and mission of the institution, "To provide the best and most efficient care," was not reality. Reality was closer to, "To provide the quickest care." I stopped working there and am infinitely happier for it.

Mistake #2: Using "I need to study for my boards" as an excuse not to get involved.

Wow, did I use this for all it was worth. While preparing for boards is important, I used this excuse repeatedly when asked to get more involved in teaching residents, joining hospital committees, and getting involved in the state medical association. Almost all committees and organizations refresh themselves and somewhat start anew each July. Missing the opportunity to get involved immediately after residency cost me some choice assignments and delayed my professional development. I also wasted the opportunity to be new and inexperienced. The first year out

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The AAEM Young Physicians Section (YPS) is excited to offer a new curriculum vitae review service to YPS members and graduating residents.

The service is complimentary to all YPS members. If you are not a YPS member, visit us at www.ypsaaem.org to join and learn about the additional membership benefits.

For graduating residents, a \$25 Service Fee is required, which will be applied to your YPS dues if you join AAEM as an Associate or Full Voting Member. This offer is only valid for the year following your residency graduation.

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of residency is a little like being an intern — except the hours and pay are better. No one expects an intern to know much of anything in July. As long as interns work hard and are interested, it's OK if they make a mistake or seven. I missed the opportunity to be the "intern" on committees, and therefore when I joined the following year, people actually expected me to know what I was doing — which I didn't.

Mistake #3: Thinking I was too inexperienced to make suggestions or share opinions.

No one likes the new guy who knows everything. That said, there is a reason my group hired me. They wanted me to contribute. They wanted to learn from me. Many current emergency physicians were never trained in the procedures and techniques that we were, such as ultrasound or video-guided laryngoscopy. And sometimes a situation just needs to be viewed from a new perspective. At first I was too concerned with not upsetting the status quo. Once I got over this, my department chair finally started to take notice.

Mistake #4: Not finding a mentor.

Most places have a mentor system set up, and most don't work. I waited too long to set up a system that would work for me. While there were many faculty members whom I respected and could learn from, there was really only one whose interests, career plans, and personality all matched mine. However, she was getting less involved in the day-to-day

affairs of the department and most people thought she was too busy and too important to have a mentee. It took me a few years to work up the courage to approach her on my own, but it was one of the best decisions I've made. She was thrilled with being asked and the advice she has given has been invaluable.

So congratulations, good luck, have fun — and don't make my mistakes. ■

Current news and updates

can now be found on the AAEM website

www.aaem.org

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FOAM- This is not the future of medicine, it is medical education NOW!

Meaghan Mercer, DO
AAEM/RSA President



Like many great ideas in medicine, the concept of FOAM (Free Open Access Meducation) project was born in a pub over a pint of Guinness. Doctors Mike Cadogan and Chris Nickson, from lifeinthefastlane.com (LITFL), recognized that social media has changed how we communicate and educate. Ideas now traverse the globe in hours, allowing an open

and interactive approach to how we learn and practice medicine. As one of the fathers of AAEM and greatest teachers of our specialty, Dr. Joe Lex, stated, "If you want to know how we practiced medicine five years ago, read a textbook. If you want to know how we practiced medicine two years ago, read a journal.

If you want to know how we practice medicine now, go to a (good) conference.

If you want to know how we will practice medicine in the future, listen in the hallways and use FOAM." FOAM is the concept, enacted via the Internet. #FOAMed is the conversation, enacted via Twitter.

Twitter, blogs, podcasts, and online videos are all part of the FOAM medium that is comprised of free, high quality medical education that all of us can use — or should be using. This is not just for medical students and residents. As Chris Nickson put it, "This is a movement where the hierarchy is flat. There are no leaders; everyone is a leader. A nurse can teach a doctor, a medical student can teach an attending. When it comes to FOAM, quality cannot be stopped from bubbling to the top." FOAM is a true convergence of ideas and reflects that we are in this together.

With any new idea comes criticism and concern, the biggest being the "lack of peer review." As all FOAM supporters will attest, this is not necessarily a weakness, but could be one of the greatest strengths of this movement. Peer review happens in real time. Medical knowledge can advance at an accelerated pace and even those not inclined to traditional research can share their experience or expertise. Also, many of the tweets contain links to journal articles and other formally peer reviewed evidence. Another concern is that FOAM leads to information overload or "trying to drink from a fire hose." But isn't that how medical education has always felt? Per the LITFL website, one of the biggest ways to prevent that is through good filters. Start by following the innovators in the FOAM community and high quality information will be passed to you effortlessly.

Other concepts that are embraced by FOAM are the flipped classroom and asynchronous learning. The flipped classroom is an idea that education should evolve into an open discussion, and that unidirectional teaching is, in some ways, outdated. As adult learners we can target

our weaknesses and can digest the videos, podcasts, or even tweets at a self directed pace using learning styles that are suited to our strengths. This is asynchronous learning. Formal classroom time can then be spent discussing, clarifying, and brainstorming with the teacher. #FOAMed provides a platform where we can learn and ask questions in real time — even without a classroom.

FOAM is contagious, it is a revolution, it is a community of educators who want to collaborate and freely share ideas for the betterment of all. Joining in is easy; one great resource is <http://lifeinthefastlane.com/foam/>, which directs you to other great resources and can become your filter as you dip your feet into the ocean of FOAM.

A big thank you to my attending, Dr. Cleveland, @NathanCleveland, who introduced me to #FOAMed, the LifeintheFastLane.com crew, Dr. Lex, @JoeLex5, Michelle Lin @M_Lin, Cliff Reid @cliffreid, emcrit.org, blog.ercast.org, emlitofnote.com and all the FOAM and #FOAMed participants whose open access information provided the content for this article. ■



Helpful Documents to Navigate Your Career!

AAEM/RSA has organized some free resources that will help you as you go forward with you career in emergency medicine.

Helpful Documents for Students

- How to Ace Your Emergency Medicine Residency Interview
- Online Emergency Medicine Resources for Medical Students and Residents

Helpful Documents for Residents

- The "Perfect" Job: What to Look For — And Watch Out For — In a Future Employer
- Types of Practice Opportunities in Emergency Medicine
- Senior Timeline
- Sample Interview Questions
- The Business of Emergency Medicine - Part 1: From Care to Compensation
- Key Contract Issues for Emergency Physicians

Visit www.aaemrsa.org/resources, to access these helpful documents and much more!

Haney Mallemat on Technology's Role in EM Education and Training

Ali Farzad, MD

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This article marks the last of a series that has aimed to highlight how you can use simple technology to make your learning more efficient and effective. In previous interviews with leaders in emergency medicine (EM) education — Drs. Mel Herbert, Amal Mattu, and Scott Weingart — we learned the value using free websites, blogs, podcasts, and ECG

videos to stay current with medical information and save more lives. Continuing that theme, I recently had the pleasure of interviewing Haney Mallemat, MD FAAEM (@criticalcarenow), an EM/IM-trained critical care specialist who works in the adult emergency department at the University of Maryland Medical Center as well as the critical care ICUs in the R Adams Cowley Shock Trauma Center in Baltimore, Maryland.

Dr. Mallemat is a rising star among EM educators. His simple and effective teaching methods have made him very popular on the lecture circuit at an international level. As one of his current residents, I can tell you that he is highly regarded by his colleagues as a stellar clinician and passionate teacher. Aside from his multiple board certifications, he has phenomenal ultrasound skills and is always willing to teach and discuss interesting cases. He has won multiple teaching awards and, most importantly, has been using technology to provide a forum in which cutting-edge EM education is disseminated for free to an audience of thousands of international followers. In this interview, we gave him more than the 140 characters he is used to on Twitter, and he dropped knowledge. He lists his favorite blogs and people you should be following on Twitter to keep up with the wonderful world of free open-access medical education (FOAMed). Whether you are a medical student new to EM or a seasoned attending physician looking to keep up with new literature and best practices, check out Haney's suggestions to improve your learning.

AF: Tell us a little about your educational background and how you chose to practice emergency medicine and critical care.

Dr. Mallemat: During medical school at SUNY Downstate in Brooklyn, New York, I realized I really liked critical care and decided to stay there and do a combined EM/IM residency. After completing that, I did a critical care fellowship at Dartmouth-Hitchcock Hospital in New Hampshire. It was a two-year internal-medicine based fellowship, but focused on multi-disciplinary care; and allowed me to work closely with anesthesia, surgery, and internal medicine attendings. So, I was fortunate to get a really interesting blend of critical care teaching.

During my years there, I spent a significant amount of time working with cardiologists, learning how to do trans-thoracic and trans-esophageal echocardiography. I liked it so much that I took the echo boards and continue to use ultrasound frequently in my practice. After training, I found myself at the University of Maryland, where I split my time between the emergency department and the ICUs. I also dedicate a significant amount of my time to teaching ultrasound.



Haney Mallemat, MD
FAAEM

AF: What are your thoughts on the role of technology in medical education? How do you use it to help you learn, teach, and simplify your academic life?

Dr. Mallemat: There's so much good stuff out there! When I was in residency, it was all about getting a textbook and trying to read it cover to cover. Now, it's rare that I open a textbook. By the time the textbook comes out, it's likely three or four years old, right? So, I'm really embracing technology, to stay on top of the latest literature and information. I regularly read blogs and learn from audio/video podcasts that discuss the most up-to-date clinical information available. The traditional publications process takes a long time and the information is dated by the time it is printed in many cases. Instead, I can seek information straight from the experts and find out what they're doing in their practice to help make my learning more efficient.

I use a RSS feeder to aggregate my favorite blogs and educational resources, and I read when I can to stay current. To reciprocate, I use Twitter and social media to disseminate information to other people who may not have discovered it yet. It promotes discussion and active learning. When used correctly, technology can be a powerful tool that helps us collectively sift through all the stuff out there and extract the information that matters.

It's also an opportunity for me to reach out to people when I have questions or want to learn more about a controversial topic. There was recently a debate with two very smart guys on Twitter about the use of cricoid pressure during intubation. I learned a lot just by listening to them go at it. Sometimes when I am in a bind, I will just throw out a question to my followers on Twitter to see what I get. Usually within just a few minutes, people write back from across the globe, sharing their practice, complete with references and reasoning. There will be discussion and we'll get on to Skype or Google Hangouts and start debating it live. It's amazing.

Just a few years ago, you would have to wait to go to an annual conference to get a chance to hear the opinion of experts in the field and ask them questions. Today they are tweeting their opinions for free! I can interact with my colleagues from all over the globe from the comfort of my bed ... it's crazy!

AF: What advice are you giving to your students and residents who are looking to use technology to make their learning more effective and efficient?

Dr. Mallemat: This can turn into a double-edged sword. I think the incorporation of technology for the purposes of medical education is still in its infancy. Currently it favors those who have finished their formal

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training and are looking to stay up to date, purely because they already have a strong medical knowledge foundation. The problem right now is that there's a lot of dialogue on the Internet, and people who don't have a good educational foundation can easily take the information out of context. Just because two experts debate a topic on Twitter, does not mean interns should pick a side and start treating their patients with experimental therapies the next day.

Advanced learners have an advantage in that they can put these discussions into context, but new learners must be cautious not to take short cuts to avoid confusion. Many of the blogs are in their infancy and not "peer reviewed" in the traditional sense, so it is important to have the basics down before you engage the experts. Junior learners should start with their assigned textbooks and curriculum, but not be limited by that, and actively use technology to supplement their education.

AF: What are your top five recommendations for people new to FOAMed and online learning?

Dr. Mallemat:

- To learn about open access resources, the best place to start is lifeinthefastlane.com/foam. Life in the Fast Lane is an amazing website where you can find just about anything FOAM related.
- Use your institutional access to gain access to online textbooks. Access Emergency Medicine has all the main EM textbooks online. Take advantage of resources that are free while you are in school or residency, because they are much more expensive afterwards.
- As your knowledge base improves, start with sites like EMedHome.com to watch video lectures from experts and national conferences. Again, several residencies offer free subscriptions, so make sure you are taking advantage of it.
- Use Medscape or an equivalent resource with an app that you can use for rapid drug and disease information on the go.
- Join Twitter! Start by following @FOAMstarter for 25 of the most popular #FOAMed tweeters.

AF: How about for more advanced learners? What are your favorite top 10 blogs or people you are following on Twitter?

Dr. Mallemat: That is tough because there is so much good stuff out there. Off the top of my head and in no particular order ...

- Life in the Fast Lane is also great for advanced learners. That site has great weekly reviews that spotlight the best and brightest from the entire blogosphere.
- EMCast by Amal Mattu (@amalmattu) hosted on EMedhome.com, a podcast that has great case-based panel discussions with lots of practical clinical pearls. He also puts out weekly ECG videos that are a must watch at ekgumem.tumblr.com.
- EMCrit (emcrit.org) with Scott Weingart (@emcrit) is a must read for anyone interested in critical care. It's definitely an advanced forum, mostly senior resident or fellow to attending-level discussions.

- Resus.Me by Cliff Reid (@cliffreid) is another fantastic one. He's on top of the resuscitation literature and does a good job of reviewing it.
- EMRes blog by Bob Stuntz (@BobStuntz) for ultrasound and general EM topics.
- ERCast by Rob Orman (@emergencypdx). Great literature reviews.
- Critical Care Perspectives in EM (@critcareguys) is an awesome podcast hosted by some heavy hitters in the critical care world.
- [EM:RAP](http://EMRAP) hosted by Mel Herbert (@EmrapEssentials) has several experts covering a wide range of EM topics. This can be costly when you are done with training, but RSA members have free access.
- Ultrasoundpodcast.com hosted by Matt and Mike (@ultrasoundpod) is awesome. Check them out and practice.
- Sonospot.com by Laleh Gharabaghian (@Sonospot) is another fantastic ultrasound resource.

AF: EM in particular has been quick to accept FOAMed and use social media for education. Why do you think that is? Are you optimistic about the direction the field is taking? What do expect from the future of FOAMed?

Dr. Mallemat: Because we're amazing people, that's why. I mean, honestly, if you look at the landscape of how emergency medicine does things, you'll notice we are a pretty progressive specialty. We are a young group of talented and capable folks who really had to fight to prove ourselves. The result is that we push things forward.

In regard to the future, I think it's just a matter of time before the classroom is completely dead. We use the classroom to get together and to discuss things, but you and I are talking right now over the Internet. There should be no reason that we should have to meet in person, other than to high-five or just to pound it. The classroom will die, and I think that's the next level for FOAMed, so rather than residencies doing things in isolation, I expect a more collaborative approach.

Emergency physicians as a community will start to teach one another, and there will be this new type of digital classroom where ever we unite to educate ourselves much more efficiently. The best lectures will be crowd sourced and we will work together to be better doctors, avoiding the redundancy and inefficiencies of our current methods.

Editor's Note: It has been a pleasure interviewing these amazing leaders in EM, and I hope you have enjoyed and benefited from the series. I welcome and appreciate your feedback on and thoughts on the advancing role of technology in EM education. Please send comments and suggestions for future articles about technology and emergency medicine to alifarzadmd@gmail.com and follow me on Twitter @alifarzadmd. ■

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Resident Journal Review

Resident Journal Review: Updates in Emergency Room Management of Trauma Patients

Authors: David Wacker, MD PhD; Kami Hu, MD; Phillip Magidson, MD MPH; David Bostick, MD MPH; Michael Allison, MD

Editors: Michael C. Bond, MD FAAEM; Jay Khadpe, MD FAAEM

Early hospital management of trauma patients is a daily activity for most emergency physicians. This issue of "Resident Journal Review" focuses on selected updates in the trauma literature. We specifically review new developments in trauma pharmacology, biomarkers in trauma, modalities of trauma diagnostics, and management of head trauma in anticoagulated patients. For a detailed discussion of the individual articles please see the full review published on MedScape and the AAEM website.

Presented here is a listing of the articles reviewed and a brief synopsis of each.

Trauma Pharmacology: Early Administration of Tranexamic Acid

Tranexamic acid is an amino-acid derivative, which binds to plasminogen and inhibits conversion to its fibrinolytic form, plasmin. Initially used to minimize bleeding during surgical cases, tranexamic acid is now becoming more widely used in management of trauma patients. The CRASH-2 trial¹ was a randomized controlled, multi-center trial which demonstrated reduced risk of death from bleeding if tranexamic acid was administered within eight hours of injury. More recently, this data has been examined to maximize the benefit of tranexamic acid as well as to quell apprehension about possible adverse events.

The CRASH-2 collaborators. The importance of early treatment with tranexamic acid in bleeding trauma patients: an exploratory analysis of the CRASH-2 randomized controlled trial. *Lancet* 2011; 377(9771), 1096-101.

In this study, the CRASH-2 collaborators looked to optimize the use of tranexamic acid in trauma patients with hemorrhage, specifically to examine the effects of early administration on morbidity and mortality. Toward this end, they analyzed the CRASH-2 data set (20,211 trauma patients randomized to receive tranexamic acid or placebo) by stratifying subjects based on time of tranexamic acid administration after injury (<1hr, 1-3hr, or >3hr). The primary outcome examined was death secondary to hemorrhage. Patients receiving tranexamic acid within one hour showed a significant reduction in the risk of death secondary to bleeding relative to those in the placebo group, 5.3% [tranexamic group] versus 7.7% [placebo], RR 0.68, CI 0.57-0.82, $p < 0.0001$. This trend continued between hours one and three, 4.8% [tranexamic group] versus 6.1% [placebo], RR 0.79, CI 0.64-0.97, $p = 0.03$. These benefits were found to not exist after three hours, and in fact, after three hours there was an increased risk of death due to bleeding 4.4% [tranexamic group] versus 3.1% [placebo], RR 1.44, CI 1.12-1.84, $p = 0.004$.

It was concluded that if tranexamic acid was given immediately after injury the estimated odds ratio (OR) for survival was 0.61 (95% CI 0.50-0.74). This OR is multiplied by 1.15 (95% CI 1.08-1.23) for each hour after injury that passes.

Roberts I, Perel P, Prieto-Merino D, Shakur H, Coats T, Hunt BJ, Lecky F, Brohi K, Willett K. Effect of tranexamic acid on mortality in patients with traumatic bleeding: prespecified analysis of data from randomized controlled trial. *BMJ* 2012; 345, e5839.

Roberts, et al., attempted to demonstrate that tranexamic acid provides beneficial effect regardless of injury severity, and does not increase the risk of thrombotic events. The authors stratified the CRASH-2 subjects receiving tranexamic acid within three hours into four groups according to risk of mortality (<6%, 6-20%, 21-50%, and >50%). Those treated demonstrated fewer overall deaths and deaths from bleeding than those not treated in all strata except the lowest strata (<6%). In patients treated with tranexamic acid there was also a significant reduction in risk of thrombotic events overall (OR 0.69, CI 0.53-0.89, $p = 0.005$).

In each of the risk strata, except those in the lowest strata, there was a 30% reduction in the odds of death from bleeding and thrombotic events. This, according to the authors, suggests that tranexamic acid can be administered safely to a wide variety of patients and not only to those with severe hemorrhage. The authors' analysis also demonstrated reduction in overall thrombotic events, arterial thrombotic events, and death due to bleeding, providing reassurance that there is no increased risk in use of tranexamic acid in the bleeding trauma patient.

Trauma Biomarkers: Monitoring of End Tidal CO₂ and Lactate Clearance

Rapid and accurate triage is imperative to optimizing outcomes for trauma patients. Primary and secondary surveys as well as information about mechanism and circumstances of injury provide important prognostic information. Additionally, early lactic acid levels have been shown to predict outcomes for trauma patients, including risk of mortality.² Two recent studies now expand on this with further identification of prognostic factors in trauma patients.

Caputo ND, Fraser RM, Paliga A, Matario J, Kanter M, Hosford K, Madlinger R. Nasal cannula end-tidal CO₂ correlates with serum lactate levels and odds of operative intervention in penetrating trauma patients: A prospective cohort study. *J Trauma Acute Care Surg*, 73 (5), 1202-7.

Caputo, et al., explored the use of end tidal carbon dioxide (ETCO₂) measurements as a surrogate for lactate levels and predictor of need for surgery in penetrating trauma patients. In a prospective cohort study, they enrolled 105 patients with penetrating trauma who underwent measurement of ETCO₂ by nasal cannula and arterial serum lactate on arrival to the hospital. The authors used this data to determine the degree of correlation between ETCO₂ level and 1) serum lactate level, and 2) need for surgical intervention.

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Of the 105 subjects, 58 had a depressed ETCO_2 and 43 had an elevated serum lactate. The authors found a strong inverse correlation between measured ETCO_2 and serum lactate ($R=-0.86$, $p=0.74$; $0.63-0.81$ for 95% CI, $p=0.0001$). Of the 105 subjects, 61 required operative intervention, and of those 54% had elevated serum lactate and 82% had depressed ETCO_2 . The odds ratio of requiring surgical intervention for those having depressed ETCO_2 was 20.4 (7.47-55.96 for 95% CI). The sensitivity and specificity of depressed ETCO_2 for predicting need for surgery were 0.82 (0.69-0.9 for 95% CI) and 0.82 (0.66-0.91 for 95% CI) respectively.

This study suggests a role for end tidal CO_2 measurement by nasal cannula as a fast and easily-obtainable surrogate for serum lactate level in penetrating trauma patients. Additionally, the ETCO_2 measurement has a strong predictive value for patients requiring surgical intervention.

Régnier M-A, Raux M, Le Manach Y, Asencio Y, Gaillard J, Devilliers C, Langeron O, Riou B. Prognostic significance of blood lactate and lactate clearance in trauma patients. *Anesthesiology* 2012; 117(6), 1276-88.

Régnier, et al., expand on the use of serum lactate as a marker of outcome in trauma patients by exploring trends in lactate clearance. In an observational study, they measured serum lactate on hospital arrival, and again at two and four hour time intervals for 586 patients of blunt and penetrating trauma at a single level I trauma center. The primary end point was 30-day survival, which was examined both for the

study population as a whole, and for the subgroup of patients with high ($>5\text{mM/L}$) initial lactate.

The strongest conclusions of this study were made in the subgroup of patients with initially elevated serum lactate. In this group, initial blood lactate, lactate clearance, and Trauma Related Injury Severity Score (TRISS) were each independent predictors of mortality (area under ROC curve 0.77, 0.60-0.87 for 95% CI; 0.67, 0.51-0.78 for 95% CI; and 0.90, 0.79-0.95 for 95% CI, respectively).

This study demonstrates that lactic acid clearance over four hours can add prognostic information in the evaluation of trauma patients.

Trauma Diagnostics: Streamlining Use of Computed Tomography (CT) Scans and Surgery

Balancing the risk of a missed injury with efforts to reduce unnecessary radiation exposure and exploratory surgery remains a challenge to emergency providers. Two recent studies suggest effectiveness of a conservative approach to CT use in trauma patients and mandatory exploration of neck injuries.

Mahoney E, Agarwal S, Li B, et al. Evidence-based guidelines are equivalent to a liberal computed tomography scan protocol for initial patient evaluation but are associated with decreased computed tomography scan use, cost, and radiation exposure. *J Trauma Acute Care Surg* 2012; 73(3), 573-9.

The risk/benefit profile of the whole-body or "liberal" CT in trauma

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patients has long been contested.^{3,4} Some physicians argue that a more conservative approach, with targeted scans and serial examinations, lessens the radiation exposure to patients without sacrificing diagnostic accuracy or delaying time to intervention. Mahoney, et al., attempted to determine whether or not institution of limited-CT protocol practice guidelines would affect patient outcomes.

This pseudo-prospective case-control study compared 612 patients liberally scanned according to the conventional treatment (CONV) in place in 2008 to 611 patients treated according to "evidence-based treatment guidelines" (EBG) — algorithms involving selective CTs with serial examinations — instituted in 2010. At baseline, patients in the EBG group had a higher Injury Severity Score (ISS) (11.93 v. 8.77, $p < 0.001$) but the groups were otherwise similar. There were reportedly no missed injuries in either group. As would be expected, there were fewer CTs and a reduction in estimated radiation exposure per patient in the EBG group. There was no difference in average mortality or length of stay in ICU or hospital, but there were significantly more complications and 30-day readmissions in the EBG group.

This article provides evidence that an evidence-based approach to trauma patients emphasizing selective CT scanning and serial re-examination can decrease CT use and radiation exposure without jeopardizing diagnostic sensitivity. The study would have been strengthened by discussion of the EBG algorithms themselves, how well the serial exam protocols (which are time-intensive and subjective to the examiners performing them) were followed, and how complications occurred and were diagnosed, whether by serial exam or CT scan. Also, this study enrolled only admitted patients, so may not generalize to management of patients who might be appropriate for discharge.

Inaba K, Branco BC, Menaker J, Scalea TM, Crane S, DuBose JJ, Tung L, Reddy S, Demetriades D. Evaluation of multidetector computed tomography for penetrating neck injury: a prospective multicenter study. *J Trauma* 2011; 72(3), 576-584.

The benefit of mandatory surgical exploration for penetrating neck injuries has been called into question due to a large number of negative explorations.^{5,6}

This prospective study included 453 patients with penetrating neck trauma who were classified into one of three groups with respect to possible vascular or aerodigestive injury. Patients with "hard signs" (active hemorrhage, pulsatile hematoma, bruit or thrill adjacent to injury, shock, massive hemoptysis, hematemesis, or air bubbling at the injury site) were taken for immediate surgical exploration. Asymptomatic patients were observed for a minimum of 24 hours. All other patients were considered to have "soft signs" (venous bleeding, nonexpanding hematomas, or subcutaneous emphysema) and underwent evaluation with multidetector computed tomographic angiography (MDCTA) for further injury.

About 9% of subjects had hard signs with nearly 90% of these having at least one significant vascular or aerodigestive injury. An additional 41% were asymptomatic, and no injuries were identified during 24 hours of observation or on follow up visit. The remaining 50% of patients had soft signs. In these patients, MDCTA detected vascular or aerodigestive injury with sensitivity and specificity of 100% and 97.5%, respectively.

The authors concluded that an initial physical exam can safely and effectively triage penetrating neck injury patients to immediate surgery, non-invasive imaging, or observation. This is in support of a new paradigm for management of neck injuries, focusing on exam findings of aerodigestive injury, rather than simply identification of injured zones.

Trauma Management: Minor Head Injury in Anticoagulated Patients

Anticoagulated patients have increased tendency toward bleeding, and impaired ability to mount a coagulation response at sites of hemorrhage. This is particularly dangerous for victims of head trauma, who may harbor small but steadily growing intracranial hematomas in the absence of outward signs. Two recent articles address this problem, and propose a protocol for managing minor head trauma in anticoagulated patients.

Nishijima DK, Offerman SR, Ballard DW, Vinson DR, Chettipally UK, Rauchwerger AS, Reed ME, Holmes JF. Immediate and delayed traumatic intracranial hemorrhage in patients with head trauma and preinjury warfarin or clopidogrel use. *Ann Emerg Med* 2012; 59(6), 460-8.

This is an observational cohort study that evaluated patients suffering a head injury while taking either clopidogrel or warfarin. The study's aim was to identify the prevalence of immediate intracranial hemorrhage from each of these groups and evaluate the incidence of delayed intracranial hemorrhage up to two weeks after the original injury.

Of the 1,064 patients included in the cohort analysis, 768 patients used warfarin and 296 used clopidogrel. The mechanism of injury was a

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ground level fall in 83%, a direct blow to the head in 6%, and a motor vehicle crash in 5%. Eighty-eight percent of patients had an initial GCS of 15.

The prevalence of immediate traumatic intracranial hemorrhage was higher in patients receiving clopidogrel (33/276; 12.0%; 95% CI 8.4% to 16.4%) than warfarin (37/724, 5.1%, 95% CI 3.6% to 7.0%; relative risk 2.31, 95% CI 1.48 to 3.63; $p < 0.001$). Delayed traumatic intracranial hemorrhage was identified in four of 687 patients receiving warfarin (0.6%; 95% CI 0.2% to 1.5%) and zero of 243 patients receiving clopidogrel (0%; 95% CI 0% to 1.5%).

The study is helpful in estimating the prevalence and incidence of immediate and delayed intracranial hemorrhage. There is a high rate of hemorrhage among users of both groups, suggesting that a noncontrasted head CT should be strongly considered in all such patients.

Menditto VG, Lucci M, Polonara S, Pomponio G, Gabrielli A. Management of minor head injury in patients receiving oral anticoagulation therapy: A prospective study of a 24-hour observation protocol. *Ann Emerg Med* 2012; 59(6), 451-5.

The authors of this study used a prospective observational cohort study to look at whether a 24-hour observation protocol followed by repeat head CT improved the recognition of delayed intracranial bleeding in anticoagulated patients suffering minor head trauma.

Ninety-seven consecutive patients on warfarin were enrolled after an initial negative head CT. Ten patients abstained from the repeat head CT leaving 87 patients with repeat imaging. Five patients developed a

delayed intracranial hemorrhage on the second CT; three required hospitalization and one required surgery. Two additional patients presented two and eight days after finishing the observation protocol with symptomatic intracranial hemorrhage. Analysis of patient variables collected on a structured data form at the time of enrollment indicates that an INR greater than 3.0 confers a relative risk of 14 (95% CI: 4 to 49) for delayed intracranial hemorrhage.

This study sets the stage for establishing ED-based observation protocols for minor head trauma in patients on anticoagulation. Of note, none of the patients enrolled had a GCS less than 15.

Conclusions

Tranexamic acid is most effective in reducing risk of death due to hemorrhage in trauma patients if used within three hours of the injury, after this time period it may cause harm. The benefits of tranexamic acid were noted in trauma patients of all injury severities except the most benign, and its use was not associated with increased risk of thrombotic event.

ETCO₂ monitoring is inversely correlated with serum lactate level, and is an accurate predictor of need for surgical intervention in penetrating trauma patients.

Though the merits of injury detection by serial examination versus whole-body CT scan continue to be debated, protocolized use of serial exams can lead to decreased radiation-exposure without sacrificing diagnostic sensitivity.

Penetrating neck injury patients with hard signs of aerodigestive or vascular injury should continue to receive immediate surgical intervention. Those with soft signs can be evaluated by MDCTA, and those without symptoms can safely be observed for 24 hours.

Patients taking clopidogrel or warfarin have an elevated risk of immediate or delayed intracranial bleed. A protocolized approach involving an immediate head CT followed by a repeat scan after 24 hours of observation will improve sensitivity of detection.

Additional Resources

1. CRASH-2-trial Collaborators. Effects of tranexamic acid on death, vascular occlusive events and blood transfusion in trauma patients with significant haemorrhage (CRASH-2): a randomised placebo-controlled trial. *Lancet* 2010; 376, 23-32.
2. Vitek V, Cowley RA. Blood lactate in the prognosis of various forms of shock. *Ann Surg* 1971; 173, 308-313.
3. Gupta M, Schriger DL, Hiatt JR, et al. Selective use of computed tomography compared with routine whole body imaging in patients with blunt trauma. *Ann Emerg Med* 2011; 58(5), 407-16.
4. Yeguiayan JM, Yap A, Freysz M, et al. The FIRST Study Group. Impact of whole-body computed tomography on mortality and surgical management of severe blunt trauma. *Crit Care* 2012; 16, R101.
5. Shiroff AM, Gale CS, Martin ND, Marchalik D, Petrov D, Ahmed HM, Rotondo MF, Gracias VH. Penetrating neck trauma: a review of management strategies and discussion of the "no zone" approach. *Am Surg* 2013; 79(1), 23-29.
6. Woo K, Magner DP, Wilson MT, Margulies DR. CT angiography in penetrating neck trauma reduces the need for operative neck exploration. *Am Surg* 2005; 71(9), 754-758. ■

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Medical Student Council President's Message

FOAM & the Era of Online Medical Education

Mary Calderone, MS3

AAEM/RSA Medical Student Council President



"How did medical students survive before the internet?" As a physician in training, you have likely contemplated this question. Your professors, on the other hand, may grimace at the mention of Wikipedia. They may cringe if you speak of this mysterious "Twitter" phenomenon. "What happened to textbooks?" They ask, reflecting nostalgically on simpler times.

Like it or not, the world of online learning in medical education has exploded in recent years. Not surprisingly, the young, dynamic field of emergency medicine has provided the perfect setting for such a remarkable expansion of high-quality, accessible resources. The movement is best encompassed by the concept of "FOAM," which stands for "Free Open Access Meducation." The term, coined by Life in the Fast Lane blogger, Dr. Mike Cadogan, refers to a personalized, continually expanding database of resources for medical education: podcasts, blogs, videos, modules, Facebook groups and Twitter feeds. Dr. Cadogan and his fellow Life in the Fast Lane co-author, Dr. Chris Nickson, have fueled the movement through collating these online resources for their eager audience of students, residents, and attending physicians.

Many aspects of FOAM differ from traditional learning resources. For one, unlike heavy textbooks, online resources are accessible from any device with internet capability. If you find yourself with some downtime, you can simply open up your phone browser, log on to one of many blogs and instantly have high-yield content directly at your fingertips. Even a few minutes can provide enough time to briefly review a concise blog post that reminds you of some clinical concept you may have forgotten. Stuck in a long commute home? Load some podcasts on your phone and utilize the time for learning. The ease of accessing these resources allows them to transcend the boundaries of location or setting. Learning no longer requires a classroom, as long as you've got intellectual curiosity and a cell phone handy. Furthermore, the majority of these resources are free!

FOAM, unlike many other traditional forms of learning, also provides a forum for ongoing conversation. Blog posts allow individuals to comment on the presented material. Discussions and debates about a given topic among individuals around the world can occur over Twitter, similar in concept to an online journal club. FOAM encourages one not only to learn the data, but also to have an opinion and the capacity to justify it. Learning through FOAM is also an active, personalized, and

learner-driven process. Of course, as with any new method of learning, FOAM faces its critiques, challenges, and unanswered questions. Should there be a process of validating content? What are the best online venues through which to provide learning? How can these novel forms of medical education best be integrated into more traditional curriculums, and do they actually differ in terms of knowledge retention and improved clinical practice?

Perhaps the most exciting aspect of the FOAM movement is that medical students can participate in the discussion and contribute to its evolution. I encountered one particularly inspiring blog entitled "The Short Coat," started by Canadian medical student, Lauren Westafer, as an opportunity to explore and analyze various topics in clinical medicine and thereby solidify her learning as a medical student. The blog has since developed into a major contributor to the FOAM movement.

Ultimately, FOAM encourages the active, self-driven pursuit of knowledge required of life-long learners. It reminds us that our motivation should extend beyond grades and board scores. Rather, we must passionately strive to maintain and expand our clinical knowledge with the goal of providing the best care for our patients. Recall the old adage: "You can't diagnose what you don't know." ■

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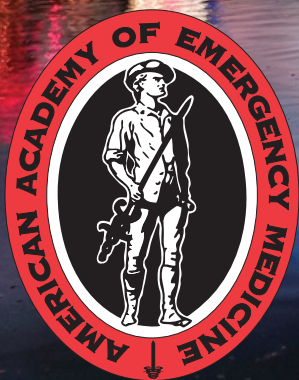
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