

COMMON SENSE

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AAEM Mission Statement

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

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

Membership Information

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

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

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

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

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

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

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

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President's Message

AAEM's Commitment to Due Process: The Wanda Cruz Story

Kevin Rodgers, MD FAAEM
AAEM President

Due Process — the universal guarantee of due process is in the Fifth Amendment to the U.S. Constitution, which provides “No person shall ... be deprived of life, liberty, or property, without due process of law,” and is applied to all states by the 14th Amendment.

Recently at the Association of Academic Chairs in Emergency Medicine (AACEM) meeting in Phoenix, at the Florida AAEM Scientific Assembly in Miami, and at the EM Organization meeting at SAEM, I recounted a story that should energize AAEM's efforts to make due process an undeniable right for all EM physicians.

In Florida, an EM physician arrived for her shift to find the ED waiting room overflowing with patients with extensive wait times of several hours. In times past, this ED had some double coverage during the busy season (as commonly occurs in Florida) and even a contingency plan for on-call coverage for such situations. However the contract for this ED had recently been taken over by one of the well-known national corporate medical groups. With profit as their bottom line, the CMG had of course cut back to single coverage and done away with the on-call physician, leaving this single physician to deal with a certainly unsafe situation. Quite unfortunately, in that plethora of waiting room patients, was a mistriaged gentleman who was having a stroke. By the time he was seen, he was now outside the window for intervention and needless-to-say his outcome was less than optimal. The EM physician was devastated. The next morning at the end of her shift, she walked past the hospital CEO who noted that she wasn't her usual cheerful self and inquired how her nightshift had been. She noted what a terrible shift she had just endured and asked if they could speak the next day. Their discussion focused on patient safety and the significant cutback in coverage. The CEO called the CMG to discuss the situation. The very next day the EM physician was FIRED. No hearing. No explanation. NO DUE PROCESS. This is the Wanda Cruz Story.

Unfortunately this is not a new story. Remember the 60 Minutes episode by Steve Kroft, “The Cost of Admission,” which focused on a hospital corporation that demanded their EM physicians order unnecessary tests as well as admit a minimum percent of patients or face termination? (www.cbsnews.com/news/hospitals-the-cost-of-admission-03-12-2012)

That was 2012. In Becker's Hospital Review on May 25th, they cite a whistleblower lawsuit that the Department of Justice has intervened in alleging fraud associated with unnecessary admissions. The DOJ cited multiple witnesses who allege that the President and Chairman of the hospital corporation would criticize ED physicians and demand their termination if he decided they were passing up opportunities to admit Medicare beneficiaries to the hospitals. ED physicians who had admitted more Medicare beneficiaries were preferentially scheduled to work more hours while those with a relatively low rates of admission were cut back. (www.beckershospitalreview.com/legal-regulatory-issues/feds-join-former-executive-s-50m-false-claims-suit-against-prime-healthcare.html) Sound familiar to anyone else?

AAEM's White Paper on due process states,

“As a matter of public policy and medical ethics, all physicians require due process rights in hospitals. Physicians have a duty to advocate for their patients, even when such advocacy requires opposition to hospital interests. Due process rights protect physician autonomy, serve as a mechanism to protect patients, and assure physicians that they will not lose their practice rights for unfair reasons. Physicians denied a fair hearing, or those physicians who disagree with the outcome of a fair hearing, shall have a right of appeal and further redress through the courts. Furthermore, provisions in a contract denying due process rights to physicians **do not preempt** medical staff bylaws and have no effect because of the public policy protecting the welfare of patients.” *J Emerg Med* 2007; 33:439-440.

At the recent BOD Strategic Planning Meeting two weeks ago, the BOD reconfirmed its number one priority as working to insure workplace fairness for EM physicians, specifically due process. AAEM continues to work with both Congress and CMS to make due process an undeniable right under the Rules of Participation for Medicare that cannot be waived/signed away. This would remove the continuous threat from the CMGs and/or hospitals involved in Joint Ventures that force EM physicians to practice under their economically driven (read “money making”) guidelines or fear termination. This is not only a patient safety and quality of care issue, I believe the exploitation and abuse of EM physicians in the workplace is a significant contributor to “physician burnout.”

I encourage every member to do three things:

1. **Listen to Larry Weiss's Podcast on Due Process** located on the website under Publications/Podcasts tab.
2. **Sign the AAEM Due Process Petition located under the Advocacy/Due Process Petition tab.** Your support of this petition will back both our advocacy efforts in D.C. with Congress/CMS as well as individual legal battles in due process cases such as that facing Wanda Cruz.
3. **Consider a contribution to the AAEM Foundation or the AAEM PAC.** At the discretion of the Foundation's BOD, Foundation funds have/will be used to defray legal expenses incurred by individual EM physicians fighting termination without due process cases. PAC funds have/will be used to support congressional members backing AAEM's drive to make due process an unwaivable right for every EM physician.

As for Wanda Cruz, she has filed a lawsuit against her former employer for wrongful termination which AAEM has agreed to support in every way possible. Recognizing the lack of due process is not just an individual but a national dilemma, Wanda decided to dedicate her energies to fighting for due process for all EM physicians. To that end, she recently ran for and was elected to the Florida AAEM BOD! ■

If You Don't Do It, It Might Not Get Done

Andy Walker, MD FAAEM
Editor, *Common Sense*



I learned to keep a close eye on my state legislature several years ago, after the unexpected, desperate, last-minute, but ultimately successful battle waged by AAEM's Tennessee Chapter (TNAEM) to protect emergency physicians from restrictive covenants in employment contracts. I also learned that emergency physicians shouldn't rely on their state medical associations to do this alone. Although your state medical society's heart

may be in the right place, nobody outside our specialty — not even other physicians — truly understands our specialty. That lack of understanding is especially severe when it comes to the legal and economic issues that affect emergency medicine.

I was reminded of this truth when a bill that would effectively ban balance billing by emergency physicians and EDs was filed this year in the Tennessee legislature. (If you don't understand the significance of balance billing in EM, see my column in the last issue of *Common Sense*.) This didn't surprise me, since the insurance industry has mounted a nationwide effort to restrict or ban balance billing. In fact, I wrote my state representative (the Speaker of the House) and state senator (a physician) about this issue last December, just in case it came up when the legislature went back into session in January. What did surprise me when I saw the bill was this: the sponsors of the bill, in both the Senate and House, are physicians! How could this be? Obviously neither sponsor bears ill will towards his colleagues, and the bill didn't single out emergency physicians or care in the ED, so it wasn't an attack specifically on us or our specialty. The problem was innocent ignorance. Although both sponsors are physicians, neither had any idea of the disastrous effect their bill would have on emergency medicine if it became law. Now they do understand and are revising their bill.

Neither can you rely on your state chapter of ACEP to protect you. While AAEM and ACEP work together at both the national and state levels when our goals coincide, when the interests of corporations conflict with the interests of individual emergency physicians, it is my opinion that ACEP will sacrifice emergency physicians — even its own members — on the altar of corporate greed without a second thought. (If you doubt me on this, write a letter to the editor (www.aaem.org/publications/common-sense/letters-to-the-editor). The Academy, on the other hand, always takes the side of emergency physicians against any threat to our ability to take good care of patients and get paid fairly for that service.

What can you do to protect yourself and your livelihood from legislative threats? If there is a state chapter of AAEM in your state, one or more people in the chapter should be tasked with monitoring the state legislature, and staying in close contact with your state medical association. If you are in a big state like California, this will take more than one person. In a relatively small state like mine, one person can do it alone. If your state doesn't have its own chapter of the Academy, round up some like-minded emergency physicians and form one. It is easy: www.aaem.org/membership/chapter-divisions/form-a-chapter-division. If that

is impractical, then just do it yourself. As I said, in most states one person can watch the legislature for emergency medicine issues without help.

How do you go about keeping an eye on your state legislature? Start here: <http://www.govengine.com>. At this website you can select any branch of government in any state (or at the federal level, for that matter). For instance, I first click on *Tennessee*, then *Tennessee General Assembly*, then *Legislation*, and finally *Browse Bills by Subject*. I usually look for bills relevant to emergency physicians by using search terms like *physician*, *medicine*, *tort reform*, *health care liability*, etc. Fortunately almost every bill comes with an extremely short summary, and reading this tells me whether or not I need to read the bill itself.

If you find a bill that looks like trouble and are doing this on your own, without a state chapter of AAEM to go to for support, call or email the Academy and we will put you in touch with AAEM's Governmental Affairs Committee. You should also turn to your state medical association for help, which is why I strongly recommend that all emergency physicians join their local and state medical societies.

One last point: I can't emphasize enough how useful it is to have an **established** relationship with your state senator and representative when an issue comes up. Start building that relationship now. Write or email your legislators and offer to be a resource if they have questions about how something might affect emergency medicine. If you see in the news that they did something you agree with, write or email and tell them so. If they do something you disagree with, write or email and **gently** explain why you think it was a mistake. If you think your legislator is generally good, donate to his or her next campaign. Even a tiny donation of \$25-50 puts you on their radar. If you have a legislator who is exceptionally good for emergency physicians or actually is an emergency physician, let the Governmental Affairs Committee know — the Academy's political action committee (PAC) might want to donate to his or her next campaign. And if you don't know who your legislators are, you can find that out through www.govengine.com too.

Those who prey on us — corporate staffing companies, tort lawyers, insurance companies, etc. — are extremely active politically. And while the federal government may get most of the news coverage, most of the medical action is at the state level. So, get to know your legislators. Build a relationship with them. Join your state medical association. Join your state chapter of AAEM, or create one. Most of all, keep a close eye on your state legislature — not just your livelihood but also the quality of the care you deliver in the ED ultimately depend on it. You can't just assume someone is doing this for you. If you don't do it, it might not get done.

More on Restrictive Covenants and Grassroots Advocacy

1. <http://www.aaem.org/calendar/current-news/new---april-podcast-restrictive-covenants>
2. <http://www.aaem.org/search?cx=003334242142735534923%3Asovagp36zcy&cof=FORID%3A11&q=restrictive+covenants&sa=SEARCH>
3. <http://www.aaem.org/em-resources/position-statements/2007/restrictive-covenants>
4. <http://www.aaem.org/UserFiles/file/commonsense0706.pdf> (on page 15)
5. <http://www.aaem.org/UserFiles/file/commonsense1107.pdf> (on page 12) ■

HHS Unveils Proposed SGR Replacement Policy

Williams & Jensen, PLLC



The U.S. Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking for the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) incentive under the physician fee schedule. The proposal was issued as the agency begins to implement provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which was signed

into law last year to repeal the Medicare Sustainable Growth Rate (SGR).

HHS' release said the proposal is a "first step in an iterative implementation process" to establish a new physician payment system under MACRA. Secretary Burwell stated that HHS looks forward to "listening and learning" from stakeholders on advancing the goal of implementing MACRA and creating a system that works better for providers, patients and taxpayers.

The initial proposal focuses on changes to the physician payment system through the "Quality Payment Program," which includes MIPS and advanced APMs. According to HHS, the proposed rule would "improve the relevancy and depth of Medicare's quality-based payments and increase clinician flexibility" through MIPS. Under the program, providers will be paid for providing high value care across four performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities, and Cost. Of these four categories, HHS proposes to apply a 50 percent weight in year one to the quality category. While the new payments do not take effect until 2019, CMS would begin measuring performance through MIPS beginning in 2017.

Many providers will also have the opportunity to participate in advanced APMs, which would exempt them from the reporting requirements under MIPS and allow them to qualify for other payment bonuses. Two examples of advanced APMs specifically cited in HHS' release were the Comprehensive Primary Care Plus model and the Next Generation ACO model, both unveiled earlier this year.

Following the passage of legislation to replace the SGR, AAEM sent a letter to HHS officials asking them to work with stakeholders to design quality measures that make sense for emergency physicians, rather than imposing a one-size-fits-all model that works better for other providers. AAEM also noted the importance of providing emergency physicians with robust options to participate in APMs, so that they are not excluded from achieving bonus payments through the use of these models.

HHS also released a fact sheet that outlines some key information included in the 962-page proposed rule. The proposal was published in the Federal Register on May 9, and HHS is accepting comments on the proposal until June 27.

House, Senate Focus on Opioid Epidemic and Zika Virus

Beginning in March, the House and Senate have advanced legislation aimed at addressing the opioid crisis. The Chambers have worked in bipartisan fashion, with the Senate passing the Comprehensive Addiction and Recovery Act (CARA) with minimal opposition, despite Republicans denying efforts by Democrats to attach emergency appropriations spending to the effort. This bill, along with legislation that will likely be conferenced with the House, would authorize state and local grant programs to treat opioid addiction. Other legislation that appears likely to be included in the final agreement would address pain management and prescribing practices, seeking to encourage responsible use of opioids. Additional aspects of the bills considered in the Senate and House focus on the emergency response, including reforms to good Samaritan laws, and increased access to Naloxone and other drug overdose reversal medications.

Tackling the opioid epidemic is a high priority for Congressional leaders, and it is the top health care priority to be addressed in the remaining time in session before Congress recesses in mid-July for the party conventions and the August break. Key policymakers will use the upcoming weeks to negotiate the bills that have passed the House and Senate and work towards a product that can be sent to the President's desk.

Congress' efforts to develop a response to the Zika Virus have not been nearly as successful, as Congressional leaders and the Obama Administrations have had sharp disagreements over funding levels. While leaders in both parties have discussed the need for a funding plan to combat Zika, which experts say will spread to the United States in the coming months, the level and source of appropriated funding remains an area of contention. Congressional Republicans appear to have won the first battle, with the Administration reluctantly agreeing to use some remaining funds designated to combat Ebola to instead be used for Zika.

However, given the significant threat that Zika could pose to Gulf States this summer, it appears likely that Congress will provide some additional funding for Zika preparation and response. The Administration has requested \$1.9 billion in additional funds, and the Senate appears poised to provide about \$1.1 billion. It is unclear what level of funding the House could accept, although the number could be less than \$1 billion.

Continued on next page

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House Passes Veteran EMT Support Act

In May, the U.S. House of Representatives passed the Veteran Emergency Medical Technician (EMT) Support Act. The legislation, endorsed by AAEM, authorizes demonstration grants to states to streamline state EMT certification and licensure requirements for veterans who have completed military EMT training while serving in the Armed Forces. It aims to simplify the process by which veterans can become licensed EMTs without having to go through duplicative training. The bill was considered the same week as several other bills designed to address the opioid epidemic.

The legislation was first introduced in the last Congress by Representative Adam Kinzinger (R-IL), and was reintroduced this year by Kinzinger and Representative Lois Capps (D-CA). The bill passed the House by a vote of 415-1, and a Senate companion bill was introduced last year by Senator Bill Cassidy (R-LA). The bill has a chance to become law later this year, particularly if no Senators object to the measure. ■

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Strength in Numbers AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

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

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

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

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

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 1-1-2016 to 5-2-2016.

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

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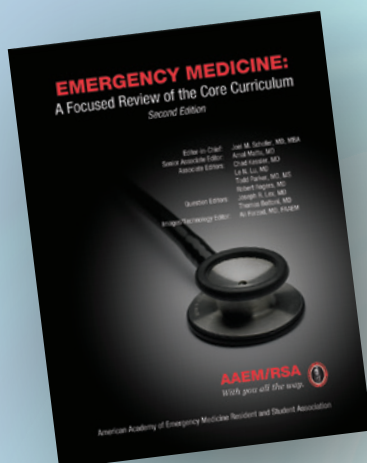
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www.aaem.org/oral-board-review

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

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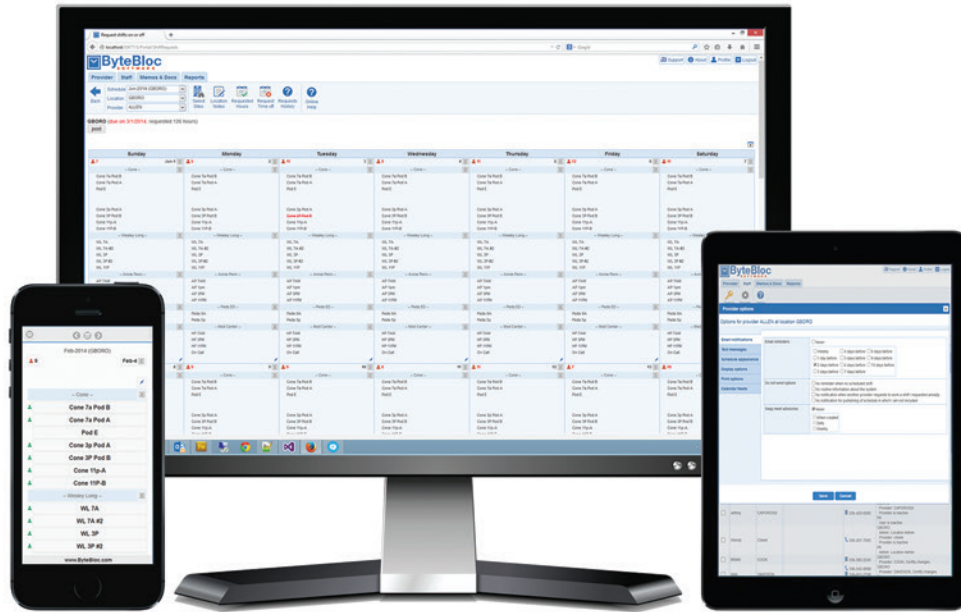
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In the last edition of *Common Sense* I wrote an article that discussed disability insurance (DI) in detail. I wanted to follow it up with a question and answer session with an expert on DI. I chose Andy Borgia, CLU, from DI4MDS.com for two reasons. First, he's my DI agent! Second, he was the only person I could find that was able to get me adequate DI as an active duty physician. Thanks

to Andy for fielding my questions, and here are his answers.

Most emergency physicians would probably assume that a large and influential medical society like the American Medical Association (AMA) would offer a top-of-the-line disability insurance policy.

What is wrong with just taking the plan offered by the AMA?

This is an association policy, and is not as comprehensive as an individual disability insurance policy.

To expand on the differences:

1. The maximum monthly benefit is lower. \$12,500 with the AMA versus \$17,000 with individual DI companies.
2. The maximum benefit period is lower. To age 65 with the AMA versus to age 67 with most individual companies.
3. The AMA plan doesn't offer a presumptive disability benefit (loss of sight, speech, hearing, or the use of two limbs). Standard (a company that offers DI), for example, will pay the monthly benefit with no elimination period for your lifetime for a presumptive disability.
4. The AMA plan can be canceled or modified by the insurance company, and rates can increase on each renewal date (either the plan anniversary date of September 1 or the insured's annual renewal date, if later). A non-cancelable, guaranteed renewable individual policy means that as long as the premium is paid by the end of the grace period, the premium rate cannot be changed for the life of the policy and the company cannot cancel or modify the contract in any way. This puts the insured in control of the policy.
5. With the AMA policy, the insured cannot work in any occupation during the waiting period before benefits begin. With a quality individual policy, the insured can satisfy the completion of the waiting period even while working part time in their own occupation.



6. The AMA policy requires that total disability benefits be paid before any partial disability benefits are payable. Quality individual policies do not have this requirement. Disability often begins with a period of partial loss of income, especially when the disability is caused by illness rather than injury. Under the AMA policy, the insured wouldn't be covered during that period.
7. The AMA's future benefit increase option isn't flexible. The AMA policy allows for only one increase, and that must be exercised within the first three years of the policy's original effective date or before the insured's 40th birthday. Future benefit increase options on quality individual policies allow increases all the way to age 55.

As you can see, the AMA plan isn't comprehensive and is not a plan we recommend to our physician clients. All association policies are similar,

and should only be utilized as a supplement to individual policies.

How do you know that a policy that says it is "own occupation" or "specialty specific" really is a high quality policy?

Based on contractual provisions and personal experience with the claim procedure.

What are the options for an emergency physician who is active duty military or in the Reserve or National Guard?

There are no limitations for Reserve/National Guard physicians, except with Berkshire/Guardian, which does not cover any military related disability. Active duty coverage is limited to Lloyd's and Mass Mutual.

Does the order in which you sign up for group, association, and personal policies really matter?

Insurance companies have issue and participation limits which determine the total amount of DI you are qualified to establish, based on your level of income. Group policies will generally issue their coverage without regard to other coverage, as do most association plans. To maximize the total amount of disability coverage it is prudent to establish individual coverage first. Otherwise the existence of group or association coverage will limit or prohibit you from obtaining an adequate level of the individual comprehensive protection you should have.

Continued on next page

Which riders do you usually recommend to emergency physicians?

The own occupation and partial residual riders are critical, and should be added if not part of the base policy. For any physician under age 45, the Future Increase Option is a must as well. The Cost of Living rider should only be added if you have maximized your coverage or are limited by the existence of group or association coverage.

Which companies usually give emergency physicians the best deal?

Taking into consideration contractual provisions, premium, and underwriting: Standard, MetLife, and Guardian, in that order.

How does the typical agent get paid when they sell a policy to a physician?

Agent commission is based on the amount of the policy premium.

Does the agent really matter if I pick the right company?

The goal is to obtain the most comprehensive policy possible. Since almost 40% of disability policies are approved other than as applied for — with waivers, benefit limitations, increased premiums, etc. — it is critical to choose an agent who will guide your application through the difficult underwriting process and be your advocate for policy approval. Don't accept a policy with an exclusion or limitation without a complete explanation. An experienced, knowledgeable agent substantially increases your chances of obtaining a fair and just approval from the insurance company.

How do I find an agent?

Reading articles like this is a good place to start. Asking friends and colleagues who they use, and if they are satisfied, is also wise. The internet can also be helpful if you have the time and know what to look for.

Does it matter where I live?

In addition to factors such as age, health, and gender, location also matters. Insurance companies offer different contractual provisions and premiums based on where you live. Usually you can't do much about it, but if you are completing your training or military service it would be worthwhile to compare the premiums in your current and future location, to determine which is more advantageous. Again, an experienced agent will be aware of the differences.

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

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

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You are invited to join committees, interest groups and task forces and become involved with the organization on a deeper level surrounding the areas of interest you care most about. New committees and interest groups include:

EM Pain and Procedural Sedation Interest Group, Freestanding Emergency Centers Interest Group, Diversity and Inclusion Task Force, Geriatric Interest Group, Palliative Care Interest Group, Quality Standards Committee, Wilderness Medicine Interest Group, Wellness Committee, Marketing Task Force, and many more available on the website. Learn more and join today!

Join the Newly Formed AAEM Marketing Task Force

During the board meeting & strategic planning at the end of May, the board elected to create this task force with goals of developing a new slogan for AAEM and investigating the development of a marketing video. The chair of this task force will be AAEM board member Dr. Megan Healy. If you are interested in serving on this task force, please contact info@aaem.org.



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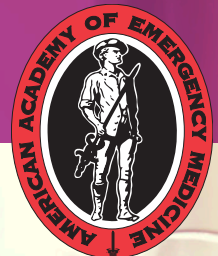
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AAEM16 Physician Assistant Challenge Bowl a Success

Gary Gaddis, MD PhD FAAEM

The Third Annual PA Fellowship Challenge Bowl was held during the morning of February 18, 2016, just before the opening sessions of the American Academy of Emergency Medicine Scientific Assembly. This year, two teams competed, one being Josiah Horneman, PA-C and Garrett Scray, PA-C, from the University of Iowa and the other being Joe B. Hamm, PA-C and Michelle C. Miller, PA-C, from the Naval Medical Center San Diego. LCDR Kishla Askins, PA, who is responsible for creating the format for the PA Challenge Bowl had prepared a number of incredible questions for the Challenge Bowl.

Lieutenant Commander Askins was unable to attend this year, so Dr. Gary Gaddis, served as quiz-master. Dr. Gentry Wilkerson and Dr. Terez

Malka served as judges and score-keepers. The University of Iowa maintained small leads both before the intermission and at the end of the contest. At the end, University of Iowa defeated Naval Medical Center San Diego by a score of 300 to 290.

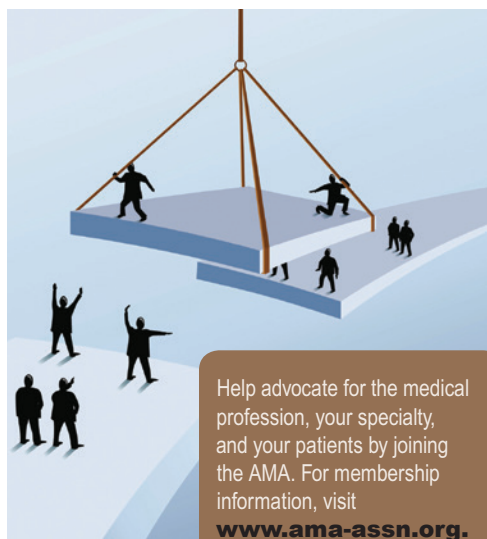
We hope to recruit more teams next year. If you are aware of any PA training programs that may wish to participate, by all means, "put a bug in their ear" for 2017. The 2017 Scientific Assembly will convene in Orlando, next spring. There is room on the PA Task Force for younger members of AAEM interested in a service opportunity in 2017. If you are interested in volunteering for the 2017 PA Challenge Bowl, please contact Emily DeVillers at the AAEM office at 800-884-2236 or edevillers@aaem.org. ■



The winning team from the University of Iowa (Garrett Scray, PA-C and Josiah Horneman, PA-C) receive their plaques from PA Bowl Judges (Gentry Wilkerson, MD FAAEM; Terez Malka, MD FAAEM; and Gary Gaddis, MD PhD FAAEM).



(L-R): Gentry Wilkerson, MD FAAEM; Terez Malka, MD FAAEM; Garrett Scray, PA-C; Josiah Horneman, PA-C; Gary Gaddis, MD PhD FAAEM; Joe B. Hamm, PA-C; and Michelle C. Miller, PA-C



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

Help advocate for the medical profession, your specialty, and your patients by joining the AMA. For membership information, visit www.ama-assn.org.

Young Physicians Section 2015-2016 Wrap Up

Terez Malka, MD FAAEM
YPS Immediate Past President



First, I'd like to thank all Young Physicians Section members, the YPS board, and the greater AAEM community for an incredible year.

Next, I'd like to look back at some of the highlights of the past year:

- **RSA/YPS Track**

The 2016 Scientific Assembly, in Las Vegas, was a great success. There was excellent turnout for the RSA/YPS track. The track expanded and diversified this year and speakers provided insight into the pros and cons of pursuing fellowship training, picking the right job out of residency, and incorporating social media and online resources into training and practice. This year's track also included a networking lunch, where students, residents, and young physicians were able to mingle with YPS and RSA board members over chips and salsa.

- **Open Mic Competition**

The YPS open mic competition provided a platform for new speakers to practice and showcase their talents. The best open mic speakers earn a formal speaker invitation to the next year's assembly. Last year's winners, Drs. Bruce Lo and Kevin King, gave excellent talks and were very well received.

- **ALiEM/YPS Social Media Fellowship**

Our ALiEM/YPS social media fellow, Matthew Zuckerman, worked throughout the year to create a digital version of *Rules of the Road for Young Emergency Physicians* by adding new audio visual and interactive components. This incredible product will be a YPS member benefit.

Finally, I look forward to the continued growth of YPS under the guidance of Dr. Kanapicki Comer, and to many more years of providing opportunities and support for young physicians! ■

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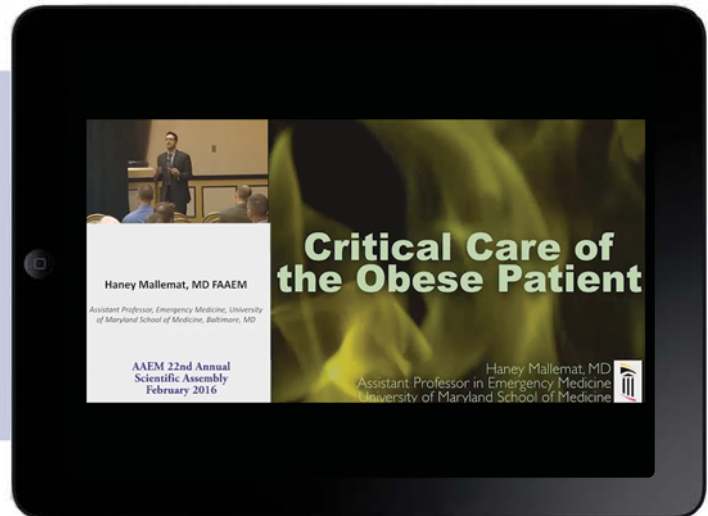


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Advocacy Committee

Committee members staff three sub-committees, focusing on patient advocacy, resident advocacy and political advocacy both at the state and national levels. Your activities include developing policy statements, outreaching to AAEM/RSA members about critical issues in emergency medicine, and collaborating with the AAEM Government Affairs Committee.

Education Committee

Committee members plan and organize the resident educational track at the AAEM Scientific Assembly, which will be held March 16-20, 2017, in Orlando, FL. You will also assist with the medical student symposia that occur around the country.

International Committee

The International Committee will have the opportunity to contribute to international medicine projects and resource development that are helpful and beneficial to students and residents.

Membership Committee

The Membership Committee promotes our mission by building AAEM/RSA membership through recruiting, developing valuable member benefits, and communicating with residency program directors and chief residents. You will be involved with one of the most critical and exciting committees within AAEM/RSA.

Social Media Committee

The newly formed Social Media Committee will concentrate efforts from the previous Communications and Publications committees. Members will contribute to the development and content of RSA's four primary media outlets: the RSA Blog Modern Resident, the AAEM/RSA website, Facebook and Twitter. The committee also oversees development and revisions of AAEM/RSA's multiple publications including clinical handbooks and board review materials. You will have numerous opportunities to edit, publish, and act as peer-reviewers, as well as work from the ground-up in developing AAEM/RSA's expansion to electronic publications.

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AAEM/RSA President's Message

Transitions

Victoria Weston, MD
AAEM/RSA President



I remember standing in a crowd of strangers, squinting into the sun, full of anticipation. It was a hot and humid August day and my new, freshly pressed white coat felt coarse and starched. Although it was a short medical student coat, and though I had no idea what an "H&P" was or even how to use a stethoscope, I still felt like I was taking my first real step toward becoming a physician, as my new classmates and I

took our first photo together.

Now, years later, I've grown into a longer white coat — one that has been intermittently stained with coffee, pen marks, and occasionally blood. It has been through long days in the ED and long nights in the ICU, and has sometimes been abandoned near the trauma bay door. I remember when I first put on my long white coat. I felt excited but also terrified at being an intern, and finally felt like a real doctor. Little did I know that I had even more to learn than during medical school.


As I transition to the next phase of my career, I find myself looking back to the beginning. It has been a long eight years. When I see myself in the mirror, I look happy but older, and maybe a bit fatigued. Sometimes it is hard for me to remember what life was like before medicine. We have a wonderful but strange job — we are there when babies are born and at the bedside when people pass away. We go from treating the critically ill to providing primary care, from the homeless patient to the CEO, from the devastatingly sad to the comical and strange, and from injustices we are powerless to change to situations where we can really make a difference.

It is hard to believe that residency is almost over, and that this first part of my clinical journey is almost at an end. I feel incredibly grateful for the opportunity to practice medicine, and fortunate to have met so many wonderful friends, teachers, and mentors along the way. I feel ready to make



“We go from treating the critically ill to providing primary care, from the homeless patient to the CEO, from the devastatingly sad to the comical and strange, and from injustices we are powerless to change to situations where we can really make a difference”

decisions and take care of my patients. I feel fortunate to have been so active in an organization that I believe in, and to have had the opportunity to lead AAEM/RSA. Most of all, I feel ready to step into my next role — a role where my white coat says “Attending Physician.” ■




Residency Graduates: Invest in Your Future

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How Do I Know If I Go Too Slow? Improving Efficiency for Residents, Part 2

Gregory K. Wanner, DO PA-C

Senior Emergency Medicine Resident, Thomas Jefferson University

Andrew W. Phillips, MD MEd

Critical Care Fellow, Stanford University, Division of Critical Care

Staff Emergency Physician, The Permanente Group

In “Improving Efficiency for Residents, Part 1” (*Common Sense*, Mar/Apr 2016), we discussed patients per hour (pt/hr), factors influencing efficiency, and the value of efficiency. In this article we will share advice on how to safely improve efficiency.

Recap of Part 1

Our review showed that PGY-1 residents average between 0.73 and 1.06 pt/hr, PGY-2 residents range from 0.85 to 1.33 pt/hr, and senior residents see between 1.05 and 1.41 pt/hr.¹ These numbers may seem a little low, but they are averages across several studies that include different shift lengths and practice environments. Some of the factors that influence efficiency are shift length (longer shifts appear to reduce productivity) and distractions (emergency physicians are interrupted every 5.8 minutes and are required to unexpectedly switch tasks every 8.7 minutes).^{2,3}

Speed versus Efficiency

Learning to be efficient is more important than learning to be fast, and there is a difference. The number of patients seen per hour, while important, does not tell the whole story. Avoiding discussions with patients, minimal documentation, and hurrying through procedures are not appropriate ways to increase patients per hour. Efficiency, however, makes use of all available resources to help move patients through the ED without cutting corners. It takes practice — lots of practice. As residents, we can all improve our efficiency.

Improving Personal Efficiency

Being productive and improving efficiency in the ED can be difficult. There are, however, several ways for residents to improve clinical efficiency.

- Start your shift by seeing as many patients as possible in the first couple of hours, while you are fresh and have few distractions. One author recommends having “two speeds in the ED: on and off” with the suggestion to avoid “slow mode” even when volume is low.⁴
- Use low volume periods to catch up on documentation or begin writing discharge paperwork. The objective should always be to “keep your plate clean” by preparing discharges or calling for admission as soon as a firm disposition decision is made. Keeping the ED clear when volumes are low will help to buffer the inevitable patient surge later.
- Discover and focus on why the patient is here early in the encounter.⁵ This may sound obvious, but we’ve all had patients who, after a full workup, ask during the discharge conversation, “Well, aren’t you going to look for X? That’s why I’m here.” Focusing on the true reason for the visit rather than just the chief complaint makes for a more efficient evaluation. In the same vein, ask about work notes up front — that may be the entire reason for the ED visit.

Personal Efficiency Tips

- Keep the same fast pace regardless of census.
- Anticipate discharge paperwork.
- Discover and address the main reason the patient presented.
- Start rate-limiting steps early (e.g., imaging, consults).
- Arrange your physical movements to provide parallel workflow.
- Identify the slowest step in a patient’s workup, such as the obvious imaging study or consultation. Beginning that step early can decrease a patient’s time in the ED.⁶
- Everything in parallel: be sure to do something else for the patient while your rate-limiting step is happening. Running in parallel doesn’t have to be with the same patient, either. See if your headache patient is feeling better on your way to see your new patient. Schedule bathroom trips on your way to see a patient. Make the most of your physical movements.⁷
- Communicating plans or changes in plans to nurses can help streamline the patient’s course through the ED and decrease interruptions. Try to order all necessary labs up front, but if additional labs are needed be sure to inform the nurse.⁴
- Delegate responsibilities. Having a nurse, technician, or medical student set up for a pelvic exam or irrigate a wound can save precious minutes.⁶
- Finally — and there is no reference for this other than advice from a wise attending — make a personal checklist of things you ask all patients before discharge (G.M. Garmel, MD, personal communication, July 1, 2012). Rather than waiting until just prior to discharge, ask those questions at the end of your initial encounter. This will prevent interruptions that keep the patient from leaving when you have already mentally moved on to the rest of your patient list. For example:
 - Work excuse?
 - Ride?
 - Pharmacy? (Re-sending electronic prescriptions and calling the “old” pharmacy to cancel is painful.)
 - Does the Medicaid patient need a prescription for OTC analgesics?

Continued on next page

Improving System Efficiency

Although residents may be able to improve their own efficiency, there are often systems-based issues that can slow us down. After all, ED crowding is a “complex, multifaceted” problem.⁸ Flow issues, boarding admitted patients, and computer problems can all slow down an ED. For additional information, a good review of ED crowding and flow solutions appeared in *Annals of Emergency Medicine* a few years ago.⁸ While much of that is beyond the scope of this article, some systems issues can be improved by residents. One study evaluated the changes in efficiency and teaching after modifications were made in the resident staffing model. By changing the supervisory structure and making a senior resident and intern team responsible for a geographic region of the ED, residents saw more patients per hour (an increase from 1.24 to 1.56 pt/hr), and residents also felt teaching improved.⁹ This suggests that quality teaching doesn't have to be sacrificed for the sake of efficiency — an important point since education is the main goal of residency training.

Take Away

Increasing efficiency as a resident is a progressive process — don't rush it and don't cut corners. Little by little you will notice your efficiency improving. Try incorporating our suggestions into your practice, and ask your attendings for their thoughts on efficiency as well. By the end of residency you will be amazed at how far you'll go, and how quickly you will get there.

Acknowledgments: We would like to thank the many attendings who have offered valuable advice for improving efficiency over the past several years. Several of those recommendations are incorporated into this article.

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Are Antibiograms Effective Guides for the Treatment of UTIs in the Emergency Department?

Authors: Lee Grodin, MD; Kaycie Corburn, MD; Jacqueline Shibata, MD; Raymond Beyda, MD

Editors: Kelly Maurelus, MD FAAEM and Michael Bond, MD FAAEM

Emergency physicians typically must treat urinary tract infections (UTI) without knowledge of urine culture results. Accordingly, EPs anticipate local resistance patterns to determine as appropriate antibiotic. Cost, safety, tissue penetration, and tolerability also play roles in this. The Infectious Disease Society of America (IDSA) guidelines recommend using institutional antibiograms, which are designed to reflect local resistance patterns, in treatment selection.¹ However, shortcomings exist in using the institutional antibiogram, particularly in treating less complicated UTIs in the ED. This is partially due to the fact that institutional antibiograms are often based on culture results from admitted patients, which over represents sicker and older patients. This edition of RJR reviews several articles that call into question the utility of using institutional antibiograms for ED patients.

Draper H, Farland J, Heidel R, May L, Suda K. Comparison of bacteria isolated from emergency department patients versus hospitalized patients. *American Journal of Health-System Pharmacy*. 2013; (70): 2124-2128.

ED treatment of UTIs and other Infections involves empiric treatment according to the most commonly encountered pathogens. In this article the authors seek to demonstrate that a difference exists between inpatient pathogens and those typically found among ED patients, suggesting that hospital-wide antibiograms may not be applicable to ED patients. Cultures were obtained from patients in the ED, the medical ward, and the ICU in a single suburban community hospital. Culture data such as organism identified and anti-microbial susceptibility were compared between the settings. Over 12,000 ED-specific cultures were compared to hospital-wide cultures. A higher frequency of gram negative organisms (59.7%) were identified in the ED compared to the inpatient setting (47.8%); *E. coli* was more commonly isolated in the ED, while *E. faecalis* and *P. aeruginosa* were isolated more commonly in the inpatient setting. MRSA infections were found nearly at the same rate between the two health care settings.

Antimicrobial susceptibility also differed between the ED and hospital. There was increased overall antimicrobial susceptibility in the ED compared to the wards and ICU. Accordingly, this study suggests that the utilization of hospital-wide antibiograms may lead to excessive use of broad-spectrum antibiotics with potential for harm without any added benefit. Statistically significant differences in susceptibility to antibiotics such as erythromycin were found between coagulase-negative *Staphylococcus* isolated in the ED versus the hospital (48% vs 30%, unadjusted OR 2.17 and CI 1.15-4.09). Additionally, *Enterococcus faecalis* isolates from the ED showed higher drug susceptibility to levofloxacin and MRSA isolated in the ED was more susceptible to clindamycin compared to MRSA isolated in the hospital (85% vs 60%, unadjusted OR 3.78 and CI 2.51-5.69). For gram-negative organisms, ED isolates of *E. coli* were more susceptible to ampicillin, levofloxacin, and TMP/SMX while ED isolates of *P. aeruginosa* were more susceptible to gentamicin but not to ceftazidime or levofloxacin.

These findings suggest that the setting (ED, hospital wards, or ICU) where a patient is being treated should factor into selecting an antibiotic. It suggests that utilizing an antibiogram derived from institutional data may be exposing ED patients to overly broad coverage, which increases the risks of emergence of resistant strains and of antibiotic toxicities without any added benefit. This study shows that the epidemiology of pathogenic organisms differs between the ED and the rest of the hospital, and even among the same organisms, antibiotic susceptibilities differ; therefore, it is prudent that our approach to treating patients with UTIs should be tailored accordingly.

Smith S, Bazzoli C, Chung I, Johnson A, Martin D. Antimicrobial Susceptibility of *Escherichia coli* in uncomplicated cystitis in the emergency department: is the hospital antibiogram an effective treatment guide? *Academic Emergency Medicine*. 2015; 998-1000.

This retrospective chart review examined bacterial resistance patterns in otherwise healthy women with uncomplicated cystitis in the ED as compared to the hospital-wide antibiogram. Smith and colleagues suspected that the hospital antibiogram disproportionately represented patients with more resistant pathogens. Hospital antibiograms include isolates that from non-urinary sources as well as from patients who are hospitalized.

Eligible patients for this study were non-pregnant, afebrile females treated and discharged from a large Midwestern tertiary medical center and diagnosed with cystitis with subsequent *E. coli* positive urine culture over a selected timeframe (April 1, 2009 to December 31, 2010). Patients with any complicating factor such as recent surgery, separate pelvic infection, or in-dwelling catheter were excluded. A urine culture was obtained on all patients with an abnormal UA regardless of cause. The results of 349 distinct patients were pooled into an ED-specific antibiogram. Compared to the institutional hospital-wide antibiogram, the ED-specific antibiogram showed increased susceptibility to ciprofloxacin (89.1% vs 73%), nitrofurantoin (99.3% vs. 98%), and TMP/SMX (80.2% vs 71%).

The authors concluded that the antibiograms offer prescription guidance based on a statistically different patient population. ED patients range from completely healthy to moribund. This suggests that more specific guidance for empiric antibiotic selection is warranted including using an antibiogram that is specific to isolate, tissue source, and patient health.

Hines M, Al-Salamah T, Heil E, Mallemat H, Witting M, Johnson J, Winters M, Hayes B. Resistance patterns of *Escherichia coli* in women with uncomplicated urinary tract infection do not correlate with emergency department antibiogram. *The Journal of Emergency Medicine*. 2015; 1-6.

ED physicians do not routinely obtain a urine culture on every patient who is diagnosed with a UTI. Older patients and those with comorbidities are more likely to have cultures sent which ultimately may skew even

Continued on next page

ED-specific antibiograms towards more resistant isolates. This study occurred at an institution with separate antibiograms for the ICU, ED, and for the rest of the hospital. Unlike most of the other areas of the hospital, the ED routinely sees generally healthy patients who have UTIs. Therefore, data from the ED antibiogram may be skewed towards less resistant isolates than the antibiogram derived from patients admitted to the wards or ICUs. This study analyzed how well the institution's ED-specific antibiogram performed in predicting the resistance patterns in uncomplicated cystitis.

Hines et al., prospectively enrolled healthy men and women with uncomplicated UTI or pyelonephritis in the ED. Inclusion required patients ≥ 18 years with acute urinary frequency, urgency, or dysuria and pyuria (WBC >10 per high power field). Patients who had urologic abnormalities or complications, recent Foley catheterization (within 14 days), nephrolithiasis, diabetes, CD4 count <350 , did not speak English, or pregnant were excluded. Clean-catch urine cultures were sent for all positive UAs with pyuria as above and were included if fewer than three organisms were identified. *E. coli* resistance rates were compared between the authors' sample and the hospital published ED-specific antibiogram. Compared with the institutional ED-specific antibiogram, there was a lower rate of resistance to ciprofloxacin (2% vs. 42%) and TMP/SMX (16% vs. 33%).

This study suggests that even ED-specific antibiograms overestimate urinary *E. coli* resistance to commonly prescribed antibiotics. This may encourage using fluoroquinolones and TMP/SMX as appropriate antibiotics

when nitrofurantoin is not appropriate. The authors underscore that nitrofurantoin requires a longer course of treatment, cannot be used with renal insufficiency, and is inadequate in the treatment of pyelonephritis.

Flemming V, White B, Southwood R. Resistance of *Escherichia coli* urinary isolates in ED-treated patients from a community hospital. *American Journal of Emergency Medicine* 2014; (32): 864-870.

Given that antibiograms pool data from different sources such as blood, urine and sputum, as well as from patients of differing acuity, Fleming and her colleagues investigated whether separating out patients by disposition (discharged from the ED) would reveal a significantly different antimicrobial resistance pattern than the institutional hospital-wide antibiogram. Similar to previous studies, this study focused on *E. coli* isolated from urine specimens.

This retrospective review analyzed *E. coli* isolated from urine with $>100,000$ CFUs between January 1, 2011 and July 31, 2011 in a 200-bed community hospital in Georgia. The study used only ED isolates and excluded patients: under 18, who were pregnant, or who had no documented symptoms or treatment. Duplicates were excluded. Two categories were developed: The first was community acquired UTIs (CA-UTI) and the other was health care associated UTIs (HA-UTI). To be classified as HA-UTI, patients had to: have been hospitalized for 2 or more days in the preceding 90 days, currently reside in a long term facility, or have

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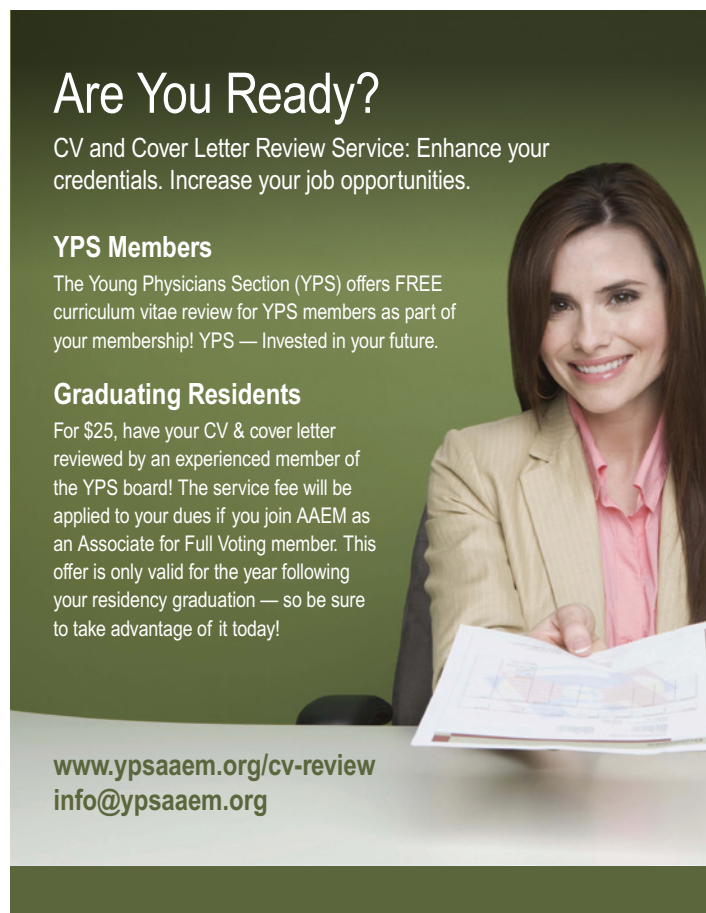
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undergone a genitourinary procedure in the preceding 30 days. Over 200 patients were included yielding 29 HA-UTI and 147 CA-UTI enrollees.

The main endpoints were susceptibility to levofloxacin and TMP/SMX. According to the institutional antibiogram at the study institution, *E. coli* resistance to levofloxacin was 27% and to TMP/SMX was 26%. The authors' data revealed that for CA-UTI, resistance to fluoroquinolones was less than 10%, and so the authors felt that this drug class was an appropriate choice.

While this was a small study, it adds to the growing body of evidence that patient care may improve if antibiograms are made based on the correct study population. This includes adjusting for the origin of the isolate (from urine alone or from all tissues), the state of the patient (admitted or discharged), relevant comorbidities and recent hospitalization.

Conclusion

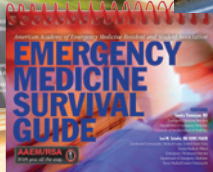
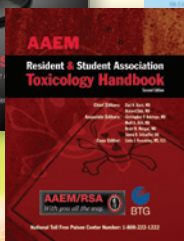
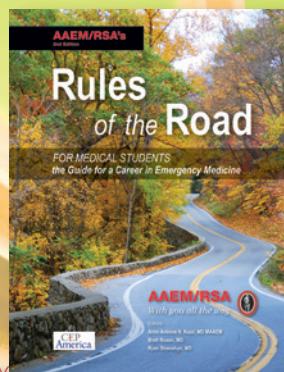
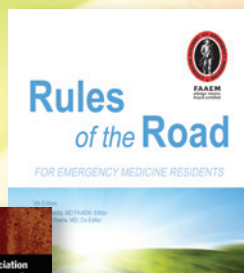
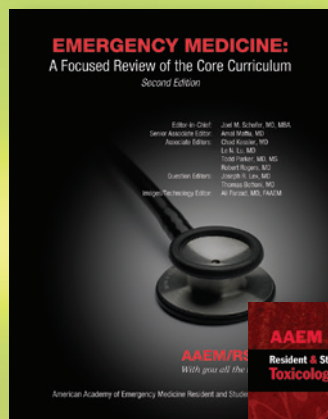
These articles are among many in a growing body of evidence that calls into question the efficacy of using institutional antibiograms to guide antibiotic selection for UTIs treated in the ED. It would be extremely helpful to ED physicians to have antibiograms that are specific to patients amenable to outpatient treatment. ED physicians need to take into account the shortcomings of antibiograms when prescribing antibiotics and call on their institutions to improve the data upon which they are asked to base their decisions.

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Lessons from the 2016 Match

Mike Wilk, MS4

AAEM/RSA Medical Student Council President



The 2016 Match in emergency medicine continued the trend of rapid growth and a bright future for our great specialty. In comparing this year's NRMP data to last year's, the number of EM programs increased from 171 to 174 and positions increased from 1,821 to 1,895. The number of applicants rose from 2,352 to 2,474 and USA senior medical student applicants rose from 1,613 to

1,693. Only one EM position in the entire country went unmatched. The match rate for American senior med students was nearly 88% (data on whether these students ranked other specialties above EM are not yet available, so the actual match rate may be higher). The number of American MD seniors filling these positions held steady at 78.4%, from 79% the previous year. Based on these data, it looks like the number of new programs and positions continues to balance consistently high demand for EM residency slots.

From sending applications to doing rotations away to Match Day, I want to share a few lessons I learned on the way to securing my own EM residency position.

Lesson 1: Applying for Away Rotations (January-March)

I planned to do my residency in the same city where I attended medical school, so when I began the process of applying for away rotations I applied only to programs in my area. I recommend doing your away rotations in the region you want to be in for residency, as this can affect whether or not you get an interview at certain programs in that region. It is not the end of the world if you don't do a rotation in a specific region though (more on that later). I ended up rotating at both a very strong community program and a very strong academic program in my area. I also recommend that you vary your experience by rotating at different types of programs — such as county, academic, and community hospitals — since they really do have different training environments and their faculties and house staffs will be populated by different kinds of personalities.

Lesson 2: Applying through ERAS (September-October)

Speak with an experienced EM adviser who can give you honest advice about the strength of your application, and tell you how many programs to apply for through ERAS. Many of my friends committed minor errors, such as not realizing interview invitations were going to the spam box and not assigning letters of recommendation to each individual program. Check and double check your ERAS applications, and please check your spam folder throughout the entire application process!

Lesson 3: Interviews (October-January)

I ultimately did fifteen interviews, which in retrospect was more than necessary. Of course this is easy to say after I have matched, but if I could go back I would do no more than 10-12 interviews. Keep in mind that your chance of matching with 12 interviews is greater than 95%. If you do not receive an interview invitation from a program you are strongly interested

in by late October or November, I recommend sending a brief email to the program director to let him or her know you are particularly interested in that program. I emailed two programs outside my region and received invitations to both the following day. Many of my classmates had similar success with this strategy as the interview season progressed. It is no



“This year 53% of U.S. senior medical students matched at their top-choice program, and nearly 80% matched in one of their top three choices, which demonstrates how truly personal rank lists really are.”

surprise that program directors would prefer to interview applicants who are truly interested in their programs, rather than only top applicants who are just checking another program off of their interview list.

I found nearly all interviews to be laid-back and conversational in nature. Remember, they are recruiting you to their program and want you to have a positive opinion of them. I found behavioral questions involving experiences with patients to be common, so have a few patient interaction stories from your EM rotations in the back of your mind and be prepared to discuss them.

Lesson 4: Rank List Time (February)

Making a rank list is highly personal and based on a variety of factors, including location, family and significant other preferences, training environment, prestige, cost of living, and “gut instinct.” This year 53% of U.S. senior medical students matched at their top-choice program, and nearly 80% matched in one of their top three choices, which demonstrates how truly personal rank lists really are.

I talked to a few of my mentors about whether or not to send “love letter” emails to the programs at the top of my list, and debated this issue with plenty of my classmates. Overwhelmingly, everyone agreed that emailing your top-choice program was advisable. Though you can email multiple programs and let them know you are ranking them highly, I decided to email only my top-choice program. Do not tell multiple programs they are your number one choice. I understand the temptation to do so, but EM is a small community and you will eventually run into the program director you lied to.

Lesson 5: Match (March)

Being surrounded by friends and family on Match Day made it one of the happiest days of my life. Congrats to all the fourth year medical students who matched, and good luck to those coming through the ranks! I wish you all the best! ■

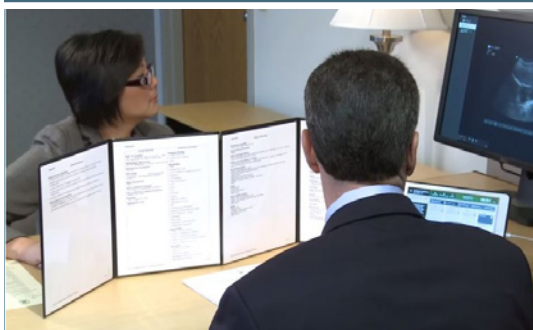
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