COMMON SENSE

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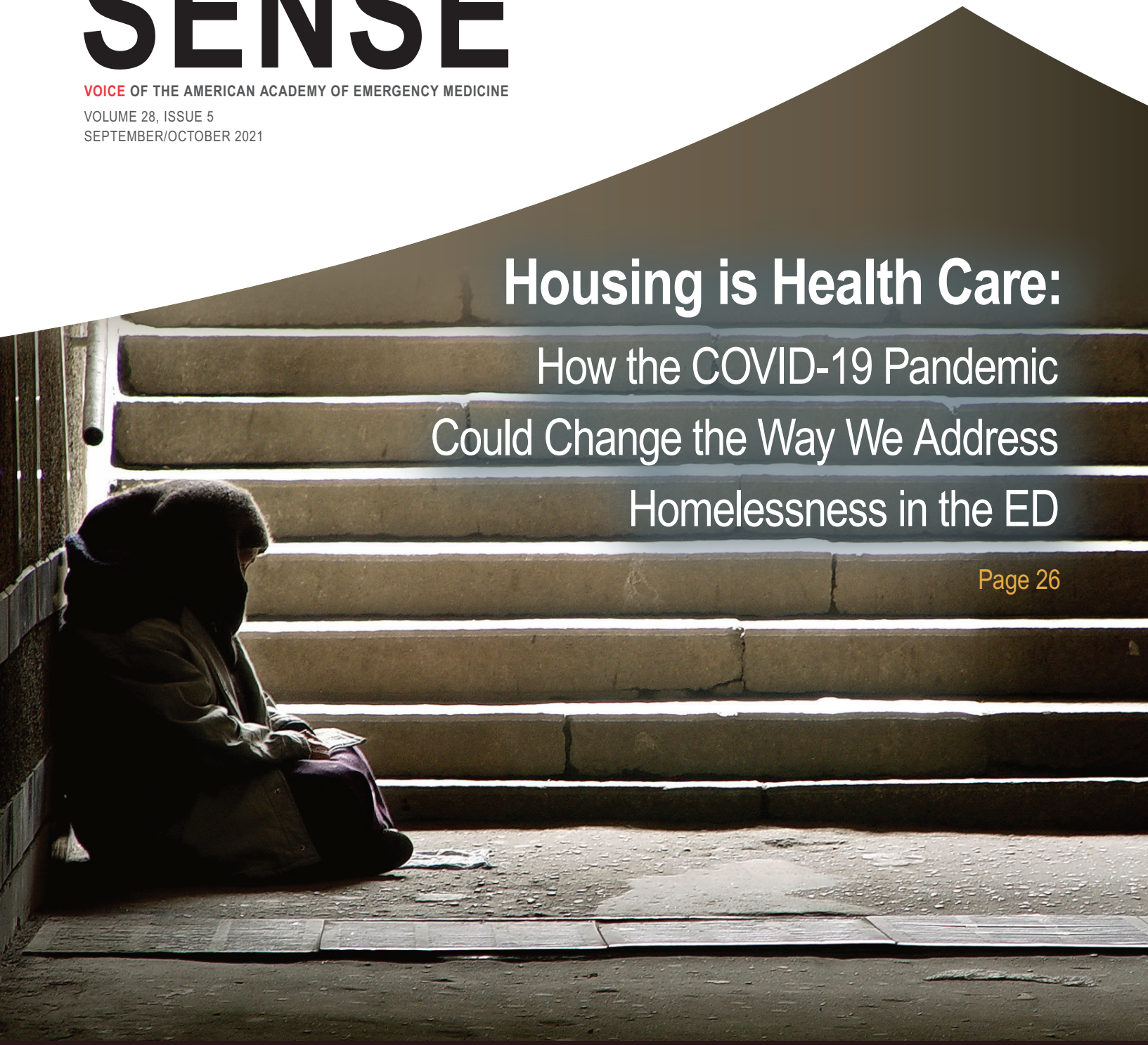
AAEM™
AMERICAN ACADEMY OF EMERGENCY MEDICINE
CHAMPION OF THE EMERGENCY PHYSICIAN



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

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

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Perception is Everything

Lisa A. Moreno, MD MS MSCR FAAEM FIFEM — President, AAEM

One of the principles I learned when, prior to medical school, I trained to be a psychotherapist is that when individuals are relating events, there is no objective truth. Each person will tell what happened through the lens of his own experience, based on her own perception, from his own vantage point, and may even see things differently years later when new life events have been experienced. How we experience things IS our reality, and throughout history, outside influences have impacted how we create our reality. As early as the 1920s Edward L. Bernays, "the father of public relations," began what we now refer to as "spin." His most nefarious campaigns included convincing women that smoking equates with female liberation and as history altering as working with the notorious United Fruit Company to coopt the CIA into taking down the democratically elected president of Guatemala based on an allegation that he had communist leanings and was a threat to Christian morals. In his book *Propaganda* (1928), Bernays stated that the public is composed of irrational individuals who follow "herd instinct" so that "crowd psychology" can be used to control their behavior in ways that governments, advertisers, and manufacturers find advantageous. While the characterization of the public is insulting and simplistic, the principles of propaganda have been shown to be effective. Over decades, propaganda and spin have changed little, except that in the era of social media, we say things more succinctly. AAEM member Dr. Andrew Pickens, who holds an MD, a JD, and an MBA, told me how they say it in MBA programs: **Perception is Everything.** It is how we perceive things, or how we are led to perceive things by how they are spun, that creates our reality.

But while objective truth may not be accessible in our experiences, there is objective truth in the universe. Smoking causes cancer. Nations have the right to a democratically elected government of their choosing. Genocide is evil. Nurse practitioners have far less classroom education in pathology, physiology, and pharmacology, and far less clinical training than physicians. Vaccines prevent disease. While we all know these facts to be objective truth, we have watched the "experts" and the media spin these facts in such a way as to make acceptable to the public that which is sensational, sells news, or elicits the response that the messenger desires. In many cases, the perceptions that are created do not match reality. "Oh, what a tangled web we weave, when first we practice to deceive!" (Sir Walter Scott, in his poem *Marmion*, 1808) And the web is so tangled that the American public cannot find its way out. The American public is suffering because of false perceptions. Let's consider the issue of masks. Masks prevent disease. It has been well proven and it makes perfect sense. A barrier that prevents the exchange of body fluids protects against diseases transmitted by exposure to body fluids. Yet some of our government officials and media pundits have convinced citizens

> "HOW WE EXPERIENCE THINGS IS OUR REALITY, AND THROUGHOUT HISTORY, OUTSIDE INFLUENCES HAVE IMPACTED HOW WE CREATE OUR REALITY."

that masking is a violation of civil rights or constitutional freedoms, and that masking should be related to our political affiliation. Similar spins have been put on vaccines: vaccines are not actually FDA approved and they don't actually prevent disease since many people who were vaccinated have contracted COVID.[1] So, if the vaccine isn't even approved and it doesn't prevent the disease it was designed to prevent, why should I get the vaccine? What is not being put out there is the fact that we are seeing a second wave pandemic that is a pandemic of the unvaccinated. These are the people we are intubating, hospitalizing, coding, and pronouncing. A small percentage of the vaccinated, less than 1% according to an August 2 CNN report of a study by the Kaiser Family Foundation, do get COVID, but they don't get intubated and they don't die. For most of them, having COVID means staying home feeling miserable and exhausted, coughing and quarantining, and then going on with their lives.

Another popular perception put out to the American public is that of "providers" as a group of health care professionals who are equally capable and knowledgeable to care for them. Nurse practitioners (NPs) spin themselves as having "the heart of a nurse and brain of a doctor." First of all, doctors have a lot of heart, especially emergency physicians. But perception is everything and we don't make the public aware of the amount of advocacy we do, the extent to which we practice social medicine, and the factors we consider when deciding who gets admitted and who goes home or who gets an injectable antibiotic and who gets the prescription. Second, no one is questioning the quality of a nurse's brain. What we question is the degree of education and clinical training that brain gets. When I recently lobbied legislators regarding the bills for independent practice of NPs and physician assistants (PAs) in Louisiana, I was disturbed by the lack of knowledge that legislators have about the education and training of NPs and PAs compared to physicians. These legislators are responsible for deciding who will care for America's patient population and in what roles and yet, they do not know the facts. Instead, they respond to spin about NPs needing independent practice so that they can go into rural areas and care for those who physicians allegedly choose not to care for (and we know that they are as unlikely as physicians to choose to go to rural areas) and spin about how they have the heart of a nurse and the brain of a doctor. PAs put forth that they are not endorsing independent practice but rather "Optimal Team Practice."

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They hold that expecting an individual physician to supervise an individual PA is "not being a good team member," and put out this spin on their website:

> *The reality is that, in today's healthcare environment, there is no such thing as "independent practice." Gone are the days of the solo practitioner, working completely alone. Just like physicians, PAs will continue to collaborate with, consult with, and refer patients to other healthcare providers whenever the patient's condition falls outside of their education, training, and experience. The PA profession's commitment to team practice is powerful. The PA and physician who work together get to keep all the benefits of the team without the legal risks and administrative burdens that agreements entail. In addition, employers will have access to a wider range of providers and won't have to file unnecessary administrative burden. Everyone wins.*[2]

Nice spin to say that "Everyone wins." The fact is that the health care disparities that we know exist today and that were deemed "unacceptable" by the Institute of Medicine Report in 2003 will only worsen when those who are Black, Brown, poor, rural, uninsured, underinsured, don't speak English, don't have a choice of "provider," or don't know the difference between a physician and an NP or PA are forced to receive substandard care. So, no, everyone does not win. Corporations may win. PAs and NPs may win. Hospital administrators may win. And MILLIONS of patients will not win. Why do I use the term "substandard care"? Because by AAEM's definition, a specialist in EM is a physician certified by ABEM or ABOEM, and, according to AAEM's Mission Statement, EVERY PATIENT with an emergency condition should have access to the care of a specialist in EM. We do not support a system where any patient receives less than optimal care.

The corporate practice of medicine is another area where spin is used to alter perception. In a recent *Emergency Physicians Monthly* article, a Missouri court ruled against EmCare in a wrongful termination lawsuitand explained their spin:

> EmCare *is a subsidiary of* Envision Healthcare*, which is owned by venture capital group KKR. According to the appellate court opinion, EmCare creates different legal entities for each state and/or location it provides emergency medical services so that it can comply with laws prohibiting for-profit corporations or publicly traded companies from owning physician practice groups. EmCare then assigns a physician "owner" to these legal entities that manage many day-to-day operations and staffing issues.*[3]

So, perceptions are created that a physician owns the group. This makes it all good for EmCare to practice medicine. The article was telling. It highlighted statements of a hospital CEO stating that a physician was taken off the schedule "because he wasn't being supportive" of hospital policy. It went on to state that the appellate court detailed evidence "showing how EmCare admitted that its staffing decisions were 'financially motivated.'" *EP Monthly* is a publication for physicians. Why is this article not in the *New York Times* or being broadcast on CNN? The American public believes in private equity, startups, and the sleek image of brands. Brands have money. Advertising agencies have money. CMGs have money. AAEM does not. Despite this, I am hopeful that what is right will prevail but it cannot do so in a vacuum. We need to change the nation's perception.

If perception is everything, we need to take advantage of the American public's perception of emergency physicians. They see us as their heroes and this is NOT the result of spin. This is the result of the fact

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> "LEGISLATORS ARE RESPONSIBLE FOR DECIDING WHO WILL CARE FOR AMERICA'S PATIENT POPULATION AND IN WHAT ROLES AND YET, THEY DO NOT KNOW THE FACTS. INSTEAD, THEY RESPOND TO SPIN."

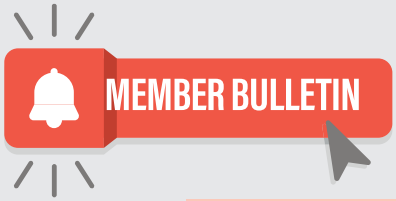
that we stand for our patients. When other doctors closed their clinics and offices, we changed nothing. We are there for every patient, every time, 24/7/365. Before the COVID vaccine existed, before anyone even knew what we were dealing with in SARS-CoV-2, we showed up for our patients. We were there, we diagnosed them, reassured the mildly ill, admitted the moderately ill, intubated the severely ill. We comforted their relatives. We taught them how to prevent the spread. We lobbied for free and wide-spread testing. We helped legislators understand that testing patients without requiring ID was a public health necessity. We showed up at testing sites. We educated the public using every form of media available. We got shots in arms, and now, even when it jeopardizes our own health and that of our families, we continue to diagnose, treat, and intubate those who refuse to be vaccinated and who refuse to wear masks. We have changed nothing. We still don't judge our patients for their smoking, excessive alcohol use, gun violence, inappropriate drug use, failure to wear seatbelts, failure to wear masks or be vaccinated. We still fight for patient safety, the right of every patient with an emergency to be cared for by a board certified emergency physician, and the right of every patient to have a physician whose only concern is doing the right thing for the patient, not whether a corporation will fire him for doing the right thing for the patient. If perception is everything, we must step up and align perception with fact. The Board of Directors is putting our energy behind marketing the message of AAEM to the American public and to gaining access to the legislators who can impact how health care is practiced in this country. We have issued an RFP for a company skilled in revising our website and our social media presence. We are interviewing for a staff member who will be highly skilled in media communications and web management. Perception is everything. We are the Champion of the Emergency Physician and that makes us the Champion of the Emergency Patient. The country needs to know who we are, and that we stand for optimal and equitable treatment for all people at all times. To do this, the EP must have workplace fairness so that she can concern herself only with providing the very best medical care for every patient. I am challenging you to join your Board in Washington DC on October 19-20th to educate our legislators and advocate for workplace fairness and patient safety. I am challenging you to join your Board in altering the perception of the American public about CMGs and non-physician health care professionals. I am challenging you to bring your ideas, suggestions, and strategies to your Board and to your President. PERCEPTION IS EVERYTHING. We must alter perception to align with fact. ●

References

1. As of writing, none of the available COVID-19 vaccines were fully FDA approved.
2. Optimal Team Practice: What Is Optimal Team Practice?" Available online at: https://www.aapa.org/advocacy-central/optimal-team-practice/#accordion__panel--5--is-optimal-team-practice-the-same-as-independent-practice
3. "$26M Judgment Against EmCare in Wrongful Termination Lawsuit." Available online at: https://epmonthly.com/article/26m-judgment-against-emcare-in-wrongful-termination-lawsuit/

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.



In an effort to keep our members connected, *Common Sense* began a column of member updates submitted by our members. We ask you to submit brief updates related to your career.
We will also publish the unfortunate news of the passing of current or former members.

Visit the *Common Sense* website to learn more and submit your updates for publication!
www.aaem.org/resources/publications/common-sense

The Emergency Physician as Plaintiff

Andy Mayer, MD FAAEM — Editor, *Common Sense*

Political activism in support of emergency medicine can take many forms. Traditionally, political activism by physicians has taken the form of membership in county, state, and national medical societies who lobby various branches of state and national governments related to specific issues and bills, which are pending. Some more involved physicians write or call their state and national elected officials asking for their support or opposition to bills pending in the respective state legislatures or in our nation's capital. The most active emergency physicians actually donate money directly to candidates and elected officials. They also try and develop a personal relationship with them and hope to become a trusted source of information and opinion related to upcoming health care related issues.

AAEM and other medical societies have asked, pleaded, and begged each of you to become involved with frankly a very limited amount of success. This editor's column in the last issue, for example, implored you to act now to get involved in an effort to stem the loss of standing by our profession in the many issues facing us. These issues include but are not limited to the increased power of corporate management groups and insurance companies and the ever-expanding role of the various forms of Non-Physician Providers (NPPs) in our emergency departments. I understand that it is easy to be discouraged and fatalistic about the prospects for the future for the entire medical profession. The truth is that very few of you will ever be willing to go visit with a state representative or visit D.C. to lobby for AAEM or ACEP. Let's be honest and ask how many of you read the candidate positions for the latest AAEM election or even took the time to vote?

It's not all doom and gloom. There may be some signs of movement related to physician activism and we still have a little time to change the future of medicine for the better if we act. Think of the issue of global warming. When will be the tipping point when disaster is inevitable? Do we still have some time to change the course of what is coming? There does seem to be a rising sense of anger in the emergency medicine community, which might actually produce some increased activism and produce positive effects. The recent town hall meeting held by AAEM discussing workforce issues in emergency medicine had a significant attendance. Medical societies around the country are currently engaged in their state legislatures fighting independent practice for non-physician providers. Certainly, we need to try and continue using our regular channels for political activism, but now may be the time to change tactics before it is too late.

We have had limited success dealing directly with corporate management groups. Trying to convince a hospital administrator or corporate management group or other forces in our lives of the dangers facing the average

> "These issues include but are not limited to the increased power of corporate management groups and insurance companies and the ever-expanding role of the various forms of Non-Physician Providers (NPPs) in our emergency departments."

emergency physician is difficult at best. The bottom line is their deciding factor. The financial bottom line should be important to us as we all live in the real world, but if you are working for a publically traded corporate management group the rate of return for the investor is the real bottom line. The interest of the emergency physician is practically irrelevant despite the fact that all of the income for the company comes from the medical professional services, which you provided while the shareholders were home in bed. The line item on these corporation's budgets for the salary of the emergency physician is seen as an expensive loss of potential profit. Reducing coverage and increasing the use of non-physician providers makes sense for their bottom line and the safety of the patient takes a secondary priority to the shareholder's rate of return.

Maybe we need to try a different way of making a difference. Remember when we are dealing with elected officials, regulatory agencies, or other entities we are usually dealing with a bunch of lawyers. It might be time to try a more aggressive method of fighting back by using the legal system against these same lawyers as they use it against us. I know that when we even hear about lawyers our fear factor increases and we run

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for cover, but there are always lawyers who will help you fight other lawyers. We just need to be smart about our tactics.

I ask you to take a look at a possible tactic which we as individuals or as a profession might consider. I do not know Dr. Raymond Brovont but he took a different path which I am sure was difficult. Fighting the swarm of lawyers who defend these multi-billion dollar corporate management groups may seem like David vs Goliath. This emergency physician tried it and won. Consider looking at a legal case called Raymond Brovont, MD v. KS-1 Medical Services, P.A. and MO-1 Medical Services, LLC. The Missouri Court of Appeal's Western District ruling can be easily found on the internet, as it is a public record at Missouri Court of Appeals – Missouri Courts: https://www.courts.mo.gov/file.jsp?id=167435.

This is a legal document which is 48 pages long but just read the first few pages and you will understand the essence of the case and the clarity in which the appeal court judges saw through the legal veil hiding the corporate practice of medicine. This emergency physician was the medical director of the emergency department of a Level 2 Trauma Center, which had both an adult and pediatric side. This facility was even stating that they had a "24 hour" dedicated pediatric ER while the single physician was also covering the adult side and responsible for trauma activations and floor codes. The emergency department and hospital expanded but the hours of single coverage remained. The emergency physicians became increasingly concerned about possibly having to be multiple places at the same time and the fact that trauma system criteria required that an emergency physician be physically present 24 hours a day. The medical director expressed this concern to the management of the corporate management group. In the end, he was terminated and also not allowed to work at any of the CMG's other local contracts.

This courageous emergency physician filed a claim for damages related to "wrongful discharge in violation of public policy." He went to court and in 2018; a jury awarded him a verdict of $28.8 million. The trial judge decreased the verdict to $13.1 million. Both sides appealed the ruling and eventually the court of appeals in Missouri ruled in the physician's favor and the award was changed to $23 million, which after judicial interest ended up being $26 million. Recently, the Supreme Court of Missouri refused to review the case so the verdict and $26 million award has stood. Much of the money will go into Missouri's Crime Victims Compensation Fund. Of course, the lawyers will get a cut but still the emergency physicians will receive a significant amount of compensation for this incident but also the satisfaction that he took a stand and beat Goliath.

Reading the appeals court opinion is refreshing as it states many of the points which AAEM has been screaming from the rooftops. The judges were able to see through the veil put up by corporate management groups in their effort to avoid anti-corporate practice of medicine statutes. Below is a quote from pages two and three of the appeal court's ruling which speaks for itself:

"Because regulations prohibit publicly traded companies or for-profit corporations from owning physician practice groups, EmCare's business model is to create a separate subsidiary legal entity for each state and in some circumstances for each location at which it supplies physicians to provide emergency medical services. KS-I and MO-I are examples of such subsidiary legal entities. EmCare then makes a physician the owner of these subsidiaries to comply with the regulations, which prohibit a publicly traded company from providing medical services. Dr. Brovont was, at the relevant times of this lawsuit, employed by two of these subsidiaries, KS-I and MO-I.2 All rule references are to MISSOURI COURT RULES – STATE 2020.3 The facts are viewed in the light most favorable to the jury's verdict. Wynn v. BNSF Ry. Co., 588 S.W.3d 907, 909 n.2 (Mo. App. W.D. 2019).3 EmCare has hundreds, if not thousands, of such subsidiaries across the United States. Gregory Byrne, M.D., a Dallas-based physician employed by EmCare, is the sole owner of KS-I. At any given period of time he also owns between 275 and 300 other EmCare subsidiaries in at least 20 different states. The exact number of EmCare subsidiaries he owns changes every month, and he does not keep track of them or take any management role in any of them. The number does not matter to him because all the profits of the subsidiaries flow to EmCare. The owners of the subsidiaries are simply paid a salary by EmCare. The payroll, human resources, legal, physician recruiting, and operation of each subsidiary was controlled by EmCare, and they would forward operational documents for the physician "owner" of the subsidiary to sign. Though EmCare is careful to maintain corporate formalities between itself and its various subsidiaries, the subsidiaries are managed and operated by persons who are agents of the subsidiaries but who are also directly connected to the parent corporation, EmCare. Dr. Patrick McHugh ("Dr. McHugh") was, at all relevant times, both the Executive Vice President of EmCare and directly responsible for all hospital subsidiary contracts in the Kansas City metropolitan area on both sides of the state line, including MO-I and KS-I. Dr. McHugh, as an agent of both companies, had complete authority to hire or terminate a physician and directly influence the ability of any such physician to work for MO-I or KSI or any other hospitals in the Kansas City area that had contracts with one of EmCare's subsidiaries."

How many more cases like this are out there? Will brave emergency physicians step forward when their careers and their patient's safety is endangered by the greed of corporations? Hitting these corporate entities in their pocketbook looks like a viable way to fight for the rights of our profession. Maybe you can help our profession and try to take back control of emergency medicine by becoming a plaintiff or whistleblower. Dealing with the legal system is typically the last place a physician wants to be but consider that now may be the time to act before the last glacier which represents our profession is melted away and the rising sea level of corporate medicine washes over us forever! ●

An Interview with Representative Troy A. Carter, Sr.

Lisa Moreno, MD MS MSCR FAAEM FIFEM — President, American Academy of Emergency Medicine

Welcome to the next installment of *Common Sense's* Legislators in the News column. This column is designed to help you get to know your legislators, understand the legislative process and how you can influence it, and strengthen the Academy's relationship with our lawmakers for the purpose of improving the working conditions of physicians and the health care of the nation.

In this issue, we interview Congressman Troy A. Carter, Sr. (D-LA). Rep. Carter is serving in his first term as the Congressman from Louisiana's 2nd Congressional District and currently serves on two House Committees, the Transportation and Infrastructure Committee and the Small Business Committee. His brief bio follows this article.

Dr. Moreno: You have a long history of serving New Orleans as a city councilman, Louisiana State Representative, and Louisiana State Senator. What factors prompted you to make the move to the federal government?

Rep. Carter: It's been an honor and a privilege to serve my community on essentially every level of government. From each experience I've learned so much and gained a better understanding of what public service is.

Public service is so many things. It's making sure the garbage gets picked up. It's fighting to get healthcare to cover more essential medical procedures. Public service is listening to the people, and being in the community, then taking action on their behalf. After all of this public service at the local and state level, I wanted to be of service in a new way. After decades of debating how to spend federal dollars, I was ready to be the one fighting to bring those dollars into Louisiana and the 2nd District.

Dr. Moreno: What do you consider the most important health related issues that Congress will address this year?

Rep. Carter: The top issues for me are recovering from COVID-19, combating racial health disparities, prescription drug affordability, and expanding eligibility for Medicare.

Dr. Moreno: You have a strong record of opposition to expanding gun rights. This is a major issue for AAEM. We are one of the founding organizations of the American Foundation for Firearm Injury Reduction in Medicine. The immediate past president, Dr. David Farcy, and I recently published our research on how Emergency Physicians can improve our role in the prevention of firearm injury.1 As a native New Yorker living in NOLA, and as an EP in these cities, I am acutely aware of the devastating toll of firearm injury and the disproportionate burden borne by young males of color. Please share with me how you came to have such a strong position on the expansion of gun rights and tell me what you believe physicians can do to support your position in Congress.

Rep. Carter: Communities of color in my district are hit hardest by gun violence, and it's clear something has to change. As a policymaker, as a neighbor of yours in New Orleans, and as a Black father of two Black sons, we are in full agreement on that.

I am open to discussing strategies to comprehensively address this scourge of violence, and I think a wide coalition could help make this discussion more effective. If this nation is going to see less gun violence we have to change policy and we have to change culture – they go hand in hand. As a group trusted by way more people than Congress is, I think emergency physicians can be an incredible voice to policymakers and to members of the community. As physicians, you have seen the damage guns can cause and tried to repair it within people's bodies. That must be devastating. It's time for everyone to step up and join you in repairing the damage they cause within our communities. I look forward to being a partner in this effort.

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"Congress should explore how to make it easier for physicians to open and run their own businesses, and support your efforts to make healthcare more affordable, accessible, and culturally competent."

"As a group trusted by way more people than Congress is, I think emergency physicians can be an incredible voice to policymakers and to members of the community."

Dr. Moreno: **One of your appointments is to the Committee on Small Business. AAEM supports physician ownership of democratic medical professional groups as opposed to the control of physician practice by large corporations. We share the view you expressed in a recent interview that corporations wake up each morning thinking about how to make a profit, while governments need to focus on service. We hold that while large corporations have a fiduciary duty to make a profit for shareholders, physicians have a fiduciary duty to provide the best medical care to every patient, regardless of race, ethnicity, religion, sexual preference, gender identity, age, ability to pay, or any other human condition. We feel physicians should control our medical practices so that we can put the patient first. Do you see a role for physicians who hold these ethical standards to collaborate with the Committee on Small Business to control our medical practices so that we can keep patients before profits?**

Rep. Carter: I think emergency medical physicians should tell their stories fully in both their roles: as a physician and as a business owner. That's a unique perspective that needs to be heard more. Congress should explore how to make it easier for physicians to open and run their own businesses, and support your efforts to make healthcare more affordable, accessible, and culturally competent. There are a lot of federal services available to small businesses but we need to improve ease of access to these programs. My office is open to help all small business owners in my district in this difficult time and beyond.

Dr. Moreno: **One of the ways in which the physician's commitment to put the patient first can be protected is to ensure that we have the right to due process so that our employment cannot be terminated when we raise concerns about patient safety in the emergency department. Emergency physicians who often are forced to waive their due process rights in their employment contracts have been fired during the COVID pandemic for fighting for adequate PPE and standing up for patients and other emergency personnel. Would you support legislation, such as H.R. 6910 introduced last Congress by Representative Raul Ruiz, which would provide critical protections for emergency physicians to advocate for their patients?**

"Public service is listening to the people, and being in the community, then taking action on their behalf."

Rep. Carter: I am a proud and strong supporter of unions and the right to organize in general, in large part because of the worker protections they provide. I do think all workers should have full due process rights and I look forward to finding ways to improve protections for all workers throughout my time in Congress. I would be happy to consider the bill further and to sit down with my colleague Dr. Raul Ruiz to learn more.

Dr. Moreno: **Congressman Carter, I want to thank you for taking the time to talk with us about issues that are important to emergency physicians and to lawmakers. I am looking forward to seeing you when we come to Washington, D.C., for our AAEM Advocacy Day on October 19 and to possibly visiting your office on October 20. Collaboration between doctors and lawmakers will go a long way to protecting the health of the public, so thank you for collaborating with us on this interview and going forward.**

1. Farcy DA, Doria N, Moreno-Walton L, Gordon H, Sánchez J, Cubeddu LX, Ranney ML. "Emergency Physician Survey on Firearm Injury Prevention: Where Can We Improve?" *Western Journal of Emergency Medicine*, (22.2): 257-265. Available online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7972360/

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Representative Troy A. Carter, Sr. Bio

The Honorable Troy A. Carter, Sr. is serving in his first term as the Congressman from Louisiana's 2nd Congressional District, encompassing most of New Orleans East & West Bank, Jefferson Parish, and River Parishes including St Charles, St. James, St John the Baptist, Ascension, Assumption, Iberville, as well as portions of East Baton Rouge and West Baton Rouge Parish.

Congressman Carter currently serves on two House Committees, the Transportation and Infrastructure Committee, one of the largest committees in Congress that has jurisdiction over all modes of transportation, and the Small Business Committee, which has direct oversight and consideration over all matters affecting America's backbone, small businesses.

The youngest of six children, Congressman Carter was raised in Algiers. He is a product of Orleans Parish Public Schools and went on to graduate from Xavier University, earning a Bachelor of Arts in Political Science and Business Administration. Additionally, Congressman Carter earned his MBA graduating Summa Cum Laude from Holy Cross University.

Soon after graduating from Xavier University, Congressman Carter served for six years as the Executive Assistant to Mayor Sidney Barthelemy. In 1991, Congressman Carter became the first African American to be elected to the Louisiana House of Representatives from the 102nd District in Algiers, where he served as the youngest ever floor leader representing the City of New Orleans.

In 1994, Congressman Carter was elected to the New Orleans City Council, representing District 'C', which includes Algiers, and the historic French Quarter, again becoming the first African American elected to the position. After a hiatus from public office, Congressman Carter was elected to the State Senate for Louisiana's 7th District, where he served as the Senate Minority Leader for the Democratic Caucus. During his time as a Legislator, Congressman Carter authored and co-sponsored hundreds of bills.

As a Louisiana Legislator, Congressman Carter championed large-scale infrastructure projects, economic development, and efforts to decrease homelessness drastically. He has also worked as a staunch advocate for criminal justice reform, women's health care, and civil rights and equality on behalf of the LGBTQI community. As Congressman, he actively continues his work to address the issues above and several others, including COVID-19 relief for individuals and small businesses, environmental justice reform, and reducing student debt.

Congressman Carter is a proud husband to wife, Brigadier General Andreé Navarro-Carter of the United States Army, and father to sons Troy Jr. and Joshua. They live on the Westbank of New Orleans, where Congressman Carter was born and raised.

The Honorable Congressman Troy A. Carter, Sr. has enjoyed a series of historic firsts including:

- 1st African American elected to the Louisiana State House from District 102
- 1st African American elected to the New Orleans City Council representing District C
- 1st African American elected to the Louisiana State Senate from District 7
- 1st Congressman elected to Louisiana's 2nd Congressional District from the Westbank
- 1st Congressman whose spouse is a General Officer in the United States Army ●

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The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from **1-1-2021 to 6-15-2021.**

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Winners Take All: The Elite Charade of Changing the World by Anand Giridharadas

Anthony B. DeMond, MD MAAEM FAAEM

This is one of the most important books I have read in years. It has helped put my misgivings about using business dogma to tackle societal problems into a real structure. Read Anand Giridharadas' book! It is topnotch, and his work needs to be disseminated.

Let me describe how Anand Giridharadas' analysis has organized my thoughts on income inequality.

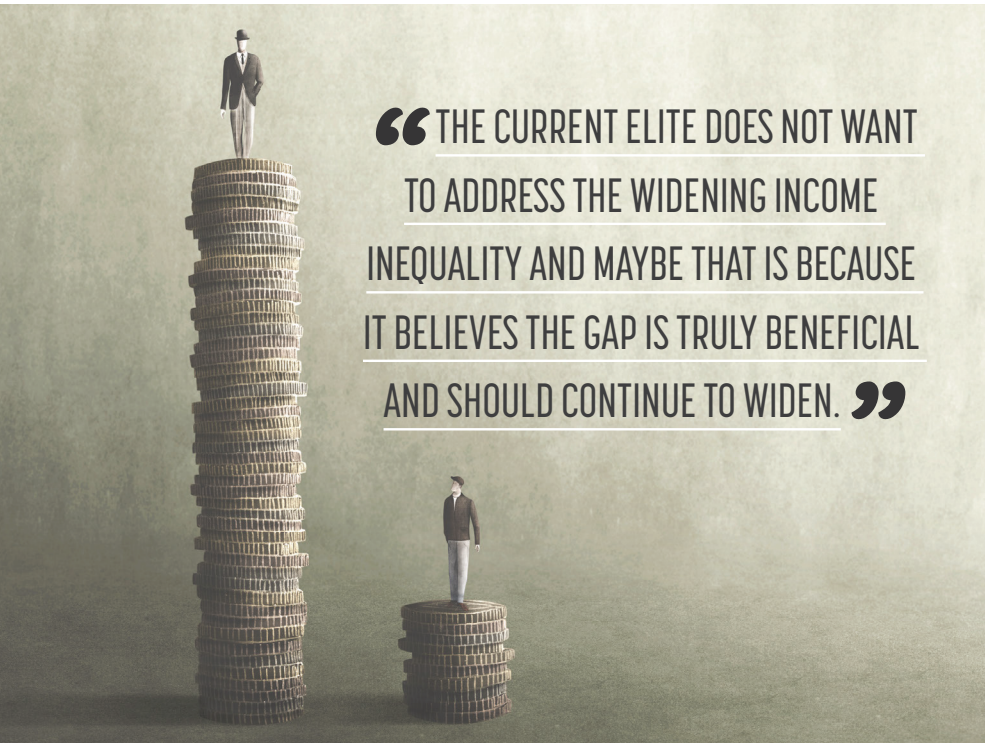
Begin with Andrew Carnegie. He famously wrote that inequality was inevitable, the price of progress, and likely beneficial. Why beneficial? Because it concentrated money in an elite class that was better suited to directing how the amassed amount of money should be redistributed. Andrew Carnegie built and endowed libraries across the country. Don't raise wages because the common man will spend the increased income on frivolous pursuits (alcohol, circuses) and not on bettering himself. Besides keeping wages as low as possible, Carnegie kept the working day long. When were you going to enjoy going to the library? Carnegie also got to decide what books his libraries would not stock. Libraries weren't meant to create revolutionaries.

Now the USA is looking at ever widening income inequality between the elite and the rest of us. Most of us are not of the communist persuasion so we will have to agree that income inequality is inevitable. But no one has studied what degree of income inequality is "acceptable." As the gap has accelerated there have been grumblings, but when is enough is enough? Andrew Carnegie believed the gap was highly beneficial. And he never thought about a ceiling. The elite should continue to acquire more and more because it was the only instrument that could intelligently decide how much and where to redistribute the money.

The current elite does not want to address the widening income inequality and maybe that is because it believes the gap is truly beneficial and should continue to widen. What the current elite is willing to address is opportunity inequality but on its own terms. The elite is not going to give up legacy admissions to top tiered universities. The elite is not going to give up its tax advantages, its housing advantages, its finance and banking advantages, its bail-outs.

What is causing this acceleration in income inequality? In 1970, there was a robust middle class. My father had a steady source of income and actually worked for one company for 20 years. There was middle class subsidized housing he was able to apply for and gain entry to because he had a steady income. My mother worked in a part time capacity and so we had a car and all the trappings of the middle class. I had all the advantages of growing up in the middle class. Move to 2020. Had my father been working now, he would not have a steady income. He would not be able to qualify for middle class subsidized housing even if he could have found it. The work environment has changed and the housing environment has changed. I would not have been raised in the middle class. I would now have to rely on the redistribution largesse of the elite.

Why is steady work at a middle class wage so hard to find now? Military and government work may be the last bastions. Of course the government employer needs to have an adequate tax base and this base is threatened by tax breaks and tax dodgers. From 1970 to 2020 business has moved away from a sense of community in spending on its local resources to being completely beholden to its shareholders and to its optimization of profit. The work force must be on call. It must be paid only when needed and not given hours when not needed. Hours must be limited so that benefits don't have to be paid. Overtime work should be demanded when you know you can avoid paying time and a half. If employees don't come in when called because they are working their second job, fire them and bring in someone else. In lean times, lay them off. In fat times, rehire them at lower salaries. Accrued seniority is lost. Unions? Oh the elite persuaded the employees that unions hurt their right to work. The elite persuaded employees that they are all individual entrepreneurs and wouldn't it actually be better if they worked as independent contractors? When your job no longer provides you with steady hours, no longer provides you with a steady income, income inequality accelerates and the middle class dwindles.



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So when do we say the income gap has reached its ceiling? When do we say this is unconscionable? Andrew Carnegie did not think there was a ceiling. What does the current elite think because it is running the country? What does the common citizenry think because it can revolt? Does voting for Donald Trump constitute a revolt? No, it is an elite co-optation. Donald Trump, a member of the elite, persuaded many a disgruntled citizen that the elite is not the source of income inequality but that immigration is the source; that minority voters who tend to vote for the Democratic Party are the source; that Asian entrepreneurs are the source; that Jews in Hollywood and other media are the source; that George Soros is the source. Donald Trump did not offer government solutions because he did not believe in the role of government for social improvement. He said he would offer business solutions because government could not be trusted. Don't blame the elite. It is making jobs and therefore needs all the tax breaks it can get and all the deregulation it wants.

> "A GOVERNMENT FUNDED PROGRAM SAYS NO CHILD LEFT BEHIND. THE ELITE FUNDED PROGRAM DISTILLS FOR A 'DESERVING' CHILD."

But what kind of job market is it making? It is making a job market that furthers income inequality. As long as the elite control both the Democratic Party and the Republican Party, this income inequity will continue to widen. The citizenry has to find politicians not co-opted by the elite, not beholden to the elite. These new politicians must not have bought into the business dogma that says the tricks of business optimization can be used to solve social problems… especially when these tricks are what has caused the social problems to begin with. Too many politicians believe that business techniques can solve social problems. They lap up this dogma as the elite finance their campaigns.

The way the elite redistribute its amassed wealth is disruptive to democratic governance because it bypasses public institutions and makes them appear to be not worthy of respect or, even worse, untrustworthy. One example would be public schools. Instead of contributing to the public sector to make public K-12 better, the elite funds alternatives such as charter schools. Projects put forward by the elite have not been voted on by the citizenry let alone vetted by the citizenry. The elite can portray itself as the savior from government missteps. But this "savior" has no accountability that a government would have. This "savior" can work around legislative restraints that government projects have. Are you having difficulty in firing teachers in the public schools? No problem in the charter schools. Due process? Excuse me, but you're fired.

If the elite does not want to address income inequality, what does it want to address with its method of money redistribution? It wants to address opportunity inequality by, you guessed it, optimizing opportunity. It wants to apply the same tricks it used to optimize business to optimize opportunity. I see this optimization as finding the best and the brightest and co-opting them into foot soldiers for the elite and possibly, one day, part of the elite. The elite can begin "mining" these students for its schools, internships, and scholarship programs. A government funded program says no child left behind. The elite funded program distills for a "deserving" child.

Why won't the elite share its good fortune (some fortunes however may actually be "bad," see the marketers of cigarettes and opiates) by raising wages? Why won't politicians pass laws to protect employees? Why has government ignored looking for social solutions to income inequality? Why won't employees band together for bargaining power (unionize has become a dirty verb)? You likely have your own answers and don't have to use mine. But we are in this societal destruction together and I hope we will in fact band together, unionize or otherwise, and correct how our society functions. ●

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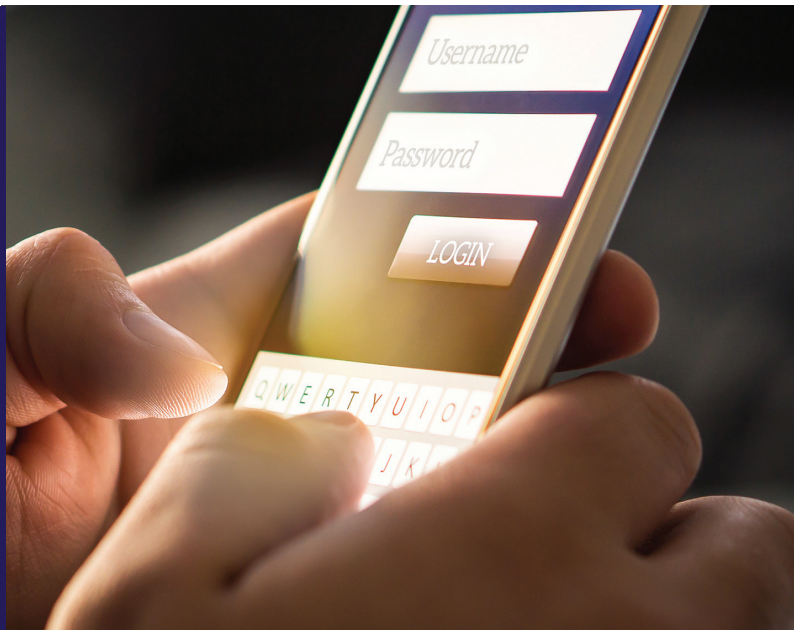

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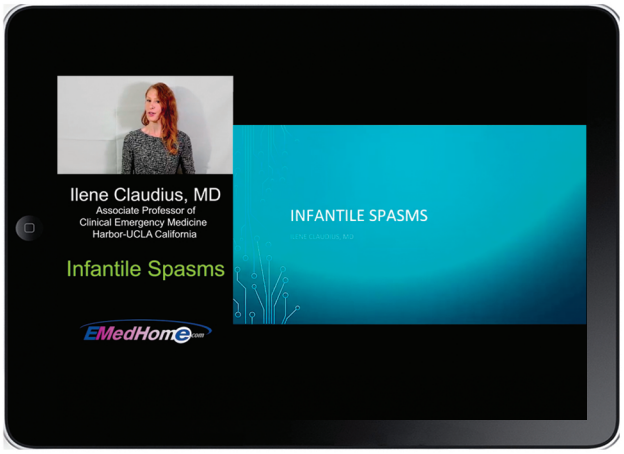

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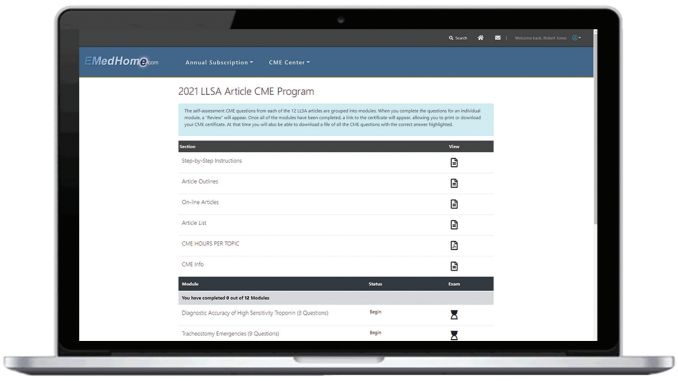

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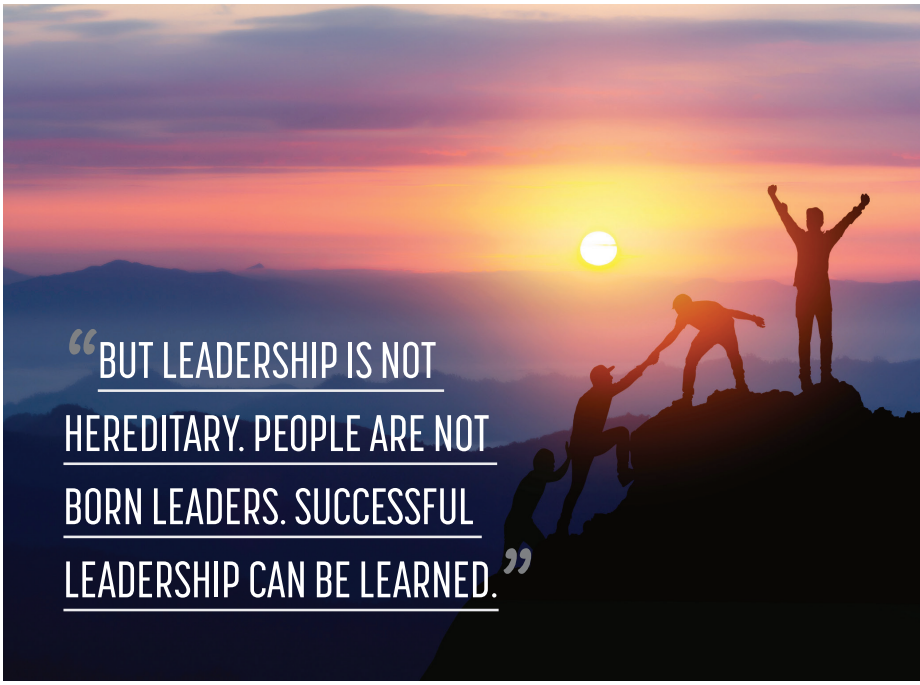
Leadership Lessons for Emergency Physicians

Mary Claire O'Brien, MD FAAEM

One of my favorite hobbies is genealogy. Who Do You Think You Are? Ancestry.com! I'm fascinated with people's stories and how they are all connected. Once I spent a whole year building an elaborate family tree on a laptop… only to have the hard drive crash, without backup. Ouch!

"Don't worry," my husband said, "they're all still dead."

Unfortunately, years of laborious research have proven that I'm not connected to anyone noteworthy; however, it seems that I am 4% Viking. The Vikings fascinate me. How did they get all the way across the Atlantic Ocean – and back? They had no nautical charts or navigation instruments. It would be romantic to think my ability to sail the stormy professional seas comes genetically from my Norse ancestors, whose leaders relied on sea creatures, celestial bodies, and oral histories.



But leadership is NOT hereditary. People are not BORN leaders. Successful leadership can be LEARNED.

Why is leadership important for emergency physicians? Being a good leader will help you get the best performance out of your team. It will help you get the best outcomes for your patients. It will save you emotional distress. And, it will prepare your team members to assume sustainable leadership after you are no longer at the helm.

What do leaders do? Leaders solve problems and resolve conflicts. What kinds of conflicts will you face? Conflicts with your hospital administration, conflicts with your peers, conflicts with the people you supervise, conflicts with your patients, and finally, conflicts within yourself, when you need to make hard decisions, about the right things to do—or not to do. **Leaders solve problems and resolve conflicts.** They also do something else that is even more important: **Leaders "inspire others—to dream more, learn more, do more, and become more."** (John Quincy Adams). This article offers 10 leadership principles for resilient emergency physicians. It ends with an appeal for gratitude.

PRINCIPLE #1: A good leader must be technically competent.

For physicians, our careers are about strangers. People who never met us before *trust us*: with their strokes, their heart attacks, their childbirth, their infections, their joint replacements, their diabetes, their car wrecks, their cancer, their LIVES. They trust us with their parents, their spouses, even their children. So all the stuff we have to learn, that's really important. It's a given. You have to Know Your Stuff, whether you are an emergency physician, or a neurologist, or a trauma surgeon, or a You Name It.

You study hard to master the competencies of our chosen profession: emergency medicine. You also work to develop a steady guarded confidence, the ability to engender trust. A look in your eyes that tells patients, "We're in this together. I will do my best for you. I got it. And I will be there for you, however it turns out. We're in this together."

The same is true with your ability to lead a team. By your actions and your demeanor, your team members must know that *you know your stuff*. For them to trust you, you must first be technically competent, solidly rooted in scholarship but open to persuasion as the science of medicine evolves and your own experience develops over time. People won't let you lead them if they think you don't know what the heck you are doing.

PRINCIPLE #2: Leaders look ahead. They also ask directions.

You might think you could become a good leader by reading about leadership, but that would be like learning how to intubate by reading Tintinalli. How do you "become" a leader? It starts with a vision. A leader begins by imagining the destination.

When was the last time you sat down and assessed your long-term vision for yourself and your team? Your "one year, five year, and ten year" plans? To reach your objectives you need to spend time carefully observing your environment, studying the people around you and how they interact, and learning institutional politics. Along the way, you must make realistic assessments of your evolving leadership skill set and what it will take for you and your team from "here" to "there." Ask someone who's been "there" for directions. Your paths don't need to be identical, because clinical or academic, the navigation skills are the same.

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"AS A LEADER, YOU HAVE TO BE WILLING TO STAND ON THE TABLE—PREFERABLY METAPHORICALLY—AND DO THE RIGHT THINGS."

PRINCIPLE # 3: A manager is not the same as a leader.

How do you know if what you are doing is *managing*, or *leading*?

Warren Bennis was a pioneer of contemporary leadership studies, a scholar, an organizational consultant, and a best-selling author. His 1989 book On Becoming a Leader is a classic, covering the qualities that define leadership, the people who exemplify it, and the strategies that anyone can apply to achieve it.1 One of Bennis's central tenets was this: a manager is not the same as a leader. Bennis insisted: A manager asks "how" and "when;" a leader asks "what" and "why."

A manager focuses on systems and structures. She administers. She maintains the status quo. She watches the bottom line. She "does things RIGHT." A leader, on the other hand, is an innovator. A leader focuses on people – not systems. She challenges the status quo. She has her eye on the horizon. She "does the right THINGS."

Years ago the Carolina Classic Fair was in town and right before it opened the carnival workers were testing out the rides. One of them, the Scrambler, has eight little compartments that whisk around like a crazed eggbeater. The workers were up in the seats, soaring around… when the whole thing came flying off the center spoke. The Scrambler went way up in the air, along with all the workers. Then, smash! Hard.

That made for instant chaos in the ED, four or five carnival workers, each of them a "Levelled Trauma," all arriving at the same time. It was epic! We were single coverage for attendings back then. I opened all the sliding doors between six and ten on the front. I hollered directions this way and that. I knew how to "manage" – this guy needs a femur X-ray, that guy has a belly injury, hey, that guy, who's got his airway? It was so chaotic, so noisy, so crazy, that finally I stood on a chair – legend has it, a table, but it was a chair – and yelled, "Everyone who doesn't need to be here needs to GET OUT! And everyone who DOES need to be here needs to BE QUIET!" With that direction, each team slipped back into the natural focused rhythm of running a trauma code.

A manager sees the minutiae, but it is impossible to have a 40 thousand foot view when you are absorbed with details. A leader sees the big picture. As a leader, you have to be willing to stand on the table – preferably metaphorically – and do the right things.

PRINCIPLE #4: Leadership is not a personality trait; it is a toolkit.

My leadership heroes include some people you would identify immediately: Abraham Lincoln, Nelson Mandela, Winston Churchill, Harriet Tubman, Martin Luther King, Jr. There are others whose names might not be as familiar: Herb Brooks. Gene Krantz, Ida B. Wells. Each of these leaders had a distinctive voice: a purpose, a self-confidence, an authentic sense of their individual abilities. Each of them was able to create shared meaning. Their diversity is proof that different circumstances call for different leadership skills. General Patton could not have established the Missionaries of Charity in over 40 countries. Mother Teresa could not have commanded the 7th Army in the invasion of Sicily.

When we consider these famous people we think they had very strong, almost immutable personalities. They had a FIXED leadership style. But I would argue, it wasn't their core characters but rather the dynamic choices they made – to use flexible leadership styles according to their circumstances – that made them great.

Think of leadership not as a personality trait you are born with, but as a toolkit of different leadership styles. In Primal Leadership, Daniel Goleman and colleagues argue that, "a leader's primary task is an emotional one – to articulate a message that resonates with their follower's emotional reality, with their sense of purpose – and so to move people in a positive direction."2 Goleman describes six leadership styles. Each style has its place. Of the six, he cautions that leaders should limit the rigid pacesetting and commanding styles.

Pacesetting – insisting on perfection – wears people out.

Being bossy – demanding compliance – makes people resentful.

The best leaders have adaptive capacity. They assess each context for its unique challenges and opportunities.

Remember, the Vikings had no maps! Maps are only helpful in the known world. When you are not sure where you are and only have a general idea of your direction, adaptive capacity will allow you to act and then to evaluate the results of your actions. This is a huge part of being a successful emergency physician. We do not always have the luxury of traditional decision-making models that call for collecting and analyzing data and then acting. Adaptive capacity is a kind of creativity. It is about identifying and seizing opportunities. Think about your Difficult Airway Algorithm. Good leaders, good emergency physicians, are ADAPTIVE. As Winston Churchill said, "Never let a good crisis go to waste."

PRINCIPLE #5: A good leader assembles a team that is better than she is.

Some years ago, I was asked to be the senior dean of health care education. We were trying to turn a decrepit tobacco warehouse into a state-of-the-art medical school and were under pressure to break ground in time to get a historic tax cut. Meanwhile, the entire curriculum needed to be overhauled, something that hadn't been done in more than 10 years, in the context of an accreditation visit from LCME.

Gene Kranz was my inspiration. He was the flight director on Apollo 13. The week after I agreed to accept the responsibility I watched that movie

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five times (the other two nights I watched Patton). I kept thinking, what do we have on the spacecraft that's good? The people, I finally realized. The faculty, the staff, the students. The people were good.

What I understood was the need for a team that was better than me, people whose unique gifts would complement my own. People who would get on the boat with me, knowing we didn't have a map, understanding that failure was not an option. People who would disagree with me as Patton said, "If everyone is thinking alike, then somebody isn't thinking." A leader sees value in diversity.

It is a credit to those people and their extraordinary work that we succeeded with the new building, the new curriculum, and the LCME site visit. And got $1.5 million in external funding for educational support, including a four-year undergraduate ultrasound curriculum.

A good leader capitalizes on the competencies of her team. She trusts their expertise and lets them do their jobs. You experience this every time you're running a code – with X-ray, respiratory, pharmacy, nursing. You're the flight director! You trust, but verify. You inspire hope. With one caveat. In the big picture, a leader inspires hope. She believes, and because of that, so do those around her, that failure is not an option. But paradoxically, to inspire growth, a good leader must encourage failure.

THAT IS PRINCIPLE #6: A good leader gives the credit, but accepts the blame.

She makes herself vulnerable by accepting responsibility for the individual actions of her followers and for the collective outcomes of the team.

Leaders "at the top" who expect perfection kill creativity and destroy morale. Why would you swing at any pitches if you were expected to bat 1,000? Why would you even step up to the plate? The goal is NOT to be perfect. It is to find solutions to the team's problems and to inspire hope.

A good leader makes it safe to fail. She's at your side, not over your head…or up your tail. No one should be ashamed of an honest mistake, as long as they learn from it. A leader shouldn't incinerate learners who fail – they'll never want to learn anything ever again!

PRINCIPLE #7: A good leader has the courage to *do* the hard thing and *say* the hard thing.

In the emergency department this is so true – you need courage to tell the truth to your colleagues, your co-workers, your students, your patients, your patient's families. You must be brave and confident in explaining to them what is, and what is not, possible. As a leader, I have had to say some very difficult things, often to people who did not appreciate my frankness. Candor can get you in trouble.

But at the end of the day it is the leader's job to communicate difficult news in a manner that is both effective and courteous. This can be extremely difficult in the emergency department, especially when you are tired and being provoked. A good leader is polite. I'd argue, however, that gentleness is "optional," because you can't be gentle with a bully. But it is possible, no, I believe it is necessary, always to be courteous. That skill that can be acquired.

Trust me, I'm from Philadelphia.

PRINCIPLE #8: A good leader seeks mutual gain.

We tend to think that negotiation is the purview of corporate bigwigs or sketchy politicians – that you need natural talent to be a great negotiator. Alternatively, if you weren't born with the gift of compromise, you just have to stick with the game long enough to develop grey hair and battle scars. You learn how to get your way by exerting power or getting angry or getting even. In this worldview, negotiation is a contest of wills, a matter of advocating and WINNING. Like it or not, as an emergency physician you are a negotiator. Think about the last time you tried to get a patient admitted to the IMC.

The problem is, when there is a contest of wills, there are only two ways to behave: you can be soft, or you can be hard. A soft negotiator wants to avoid personal conflict. She makes concessions to cultivate the relationship, but ends up feeling exploited and bitter. She is "soft" on the people and on the problem. A hard negotiator sees any situation as a conflict of wills in which the side that takes the extreme position and holds out the longest will win. The hard negotiator runs the risk of producing an equally hard response, which exhausts her and her resources and harms her relationship with the other side. She is "hard" on the problem and the people.

Good news! There is a third way. In principled negotiation, the participants are not adversaries. Their goal is neither agreement nor victory; their goal is: a wise outcome reached efficiently and amicably. Roger Fisher and William Ury describe this strategy in a classic leadership book that every emergency physician should read Getting to Yes.3 A good leader seeks mutual gain.

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Let's apply this to emergency medicine. When you are speaking with consultants you know they need patient information that is specific to their service and to the established practice guidelines of the institution. It is essential for you to be prepared. It's not ok to say, "Oh, I just picked up this patient at 3 o'clock, I haven't really examined him yet or looked at his labs, but, you know, they were worried he has peritonitis and is septic… I don't know, I just got here." #partyfoul.

Tell the truth and be worthy of trust. Don't exaggerate or downplay the facts to get your way – whether that is admission or discharge or a change in service or whatever it is you think you want. Apologize and own your contribution if you make a mistake or if you don't know something. Look for opportunities to give extra: "Sure, I'd be happy to order an extra set of blood cultures and an iron panel. What else can I do to facilitate the admission?"

Remember, skillful negotiators are building relationships.

WHICH BRINGS US TO PRINCIPLE #9: A good leader keeps her cool.

I'm going to give you two phrases to write down, to make your emergency medicine practice better. Commit these to memory!

First phrase, eight words: "I'm sorry, I can't help you with that."

Suppose a patient is very aggressive about asking for an inappropriate medication. "Hey Doc, the only thing that works for me is that D-D-duh-I don't know but I think it starts with a D…" Don't get upset. Don't be logical. Yes, you are a doctor but this is no time for rationality! Just say, "I'm sorry, I can't help you with that." Occasionally a resident will fuss back at this suggestion: "Hey, that patient was RUDE! He wants 10 pounds of dilaudid and he called me a #badword when I refused. I'm not giving him the dilaudid AND I'M NOT SORRY!"

At this point security has been called to "de-escalate," the patient is screaming obscenities, the other patients are hiding under their blankets (wait a minute – what blankets?), the nurses are scrambling in the Omnicell for haloperidol.

"I'm NOT sorry!" the resident will insist.

"Really?" I answer. "I'm sorry. Look how upset everyone is!"

Say to the patient, "I'm sorry, I can't help you with that." If they continue to argue, repeat the phrase. Don't tilt your head! That will be seen as mocking. Just the same polite phrase, same calm tone, same firm but soothing eye contact, keeping your head straight, and repeating the phrase. You are not arguing, you are stating a fact.

Second phrase, 14 words: "Doctor, I'm sure we both want to do the right thing for the patient."

"Doctor, I'm sure we both want to do the right thing for the patient."

This phrase is MAGIC when the on-call consultant is being a #badword on the telephone. You want to say, "What?! You're 'on call'" but you don't want to come see the patient!? You "accepted" a surgical train wreck to the ED but think it should "go to Medicine?!"

Take a deep breath and say, "Doctor, I'm sure we both want to do the right thing for the patient."

What are they going to do, argue that they are not a doctor and don't want to do the right thing for the patient? Please. If they fight, repeat the phrase, but calmly! Be nice.

PRINCIPLE #10: A good leader is genuinely appreciative.

Thank yous are few and far between in emergency medicine, as well you know. In 36 years my collective loot is: one tube of avocado-scented hand cream, one order of take-out shrimp scampi (easy on the garlic), one set of cheap disposable headphones, one plate of chocolate chip cookies, and one enormous fruit basket. The fruit basket came from a constipated fellow who very much appreciated our lengthy discussion on the value of high fiber diets and plenty of water.

It is SO IMPORTANT to say thank you, all the more so in a specialty as demanding as emergency medicine. The trick is, first you have to understand what makes each person feel appreciated.

I have been married for 36 wonderful years. My husband is a prince, but early in our marriage, he drove me absolutely crazy. He would say, "It's a short drive." We were interns at the same time, so when we were home together, which was rare, I wanted to sit and talk. OK, I wanted me to talk, and him to listen, but mostly I just wanted to spend time together. What did Fran do? Wash the dishes. Take out the trash. Fold the laundry.

"Will you pay attention to me?!" I'd grumble.

"I'm washing the dishes," he would say, placidly.

"I can SEE that!" I'd bark. "What about me?"

My husband was bewildered when I got upset. How could I be annoyed, when he so obviously was showing that he cared? We were functionally illiterate in each other's primary language of appreciation.

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"EACH OF THESE LEADERS HAD A DISTINCTIVE VOICE: A PURPOSE, A SELF-CONFIDENCE, AN AUTHENTIC SENSE OF THEIR INDIVIDUAL ABILITIES…THEIR DIVERSITY IS PROOF THAT DIFFERENT CIRCUMSTANCES CALL FOR DIFFERENT LEADERSHIP SKILLS."

GRATITUDE IS LIKE GLUE TO A TEAM, particularly when the going gets tough. Read Chapman and White on The 5 Languages of Appreciation in the Workplace.[3] Authentic appreciation is not "one size fits all!" If you are unsure what "language" one of your co-workers speaks, watch how they show appreciation to others. Thank people the way THEY want to be thanked. Your team will be stronger for it.

There is a quote from The Rookie that I repeat to myself when facing a crazy shift – eight ambulances on the ramp and nurses greeting me with, "RUN! Dr. O'Brien! RUN!" There are 15 boarders, no beds anywhere, and 35 sick people in the waiting room. I remember: any day I am on the correct side of the stethoscope is a good day. And I think: "You know what we get to do today, Brooks? We get to play baseball."

I am deeply grateful for my medical expertise, for my colleagues, for my health, and for my sense of humor. I wish you fair winds and following seas on your leadership journey.

#gophillies ●

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The Elderly ED Patient Who Falls, are We Making STRIDEs in Their Treatment?

Richard D. Shih, MD, Elizabeth M. Goldberg, MD, Shan W. Liu, MD, and Christopher R. Carpenter, MD



How often do you see a geriatric ED patient with a chief complaint of a fall? We have all been warned about the coming "Silver Tsunami;" predictions that the geriatric population will more than double over the next couple decades. That means more geriatric patients presenting to your ED. These patients are sicker, more difficult to care for and stay in EDs longer.[1]

ED patients with falls, in particular, are common and need more care than they currently receive. More than 30% of adults 65 and older fall every year.[2] Of these, about 25% have moderate to severe injuries that result in 3 million ED visits, 800,000 hospitalizations, and 30,000 deaths each year.[2] Falls are the leading cause of injury-related morbidity and mortality in this patient population and fall rates are increasing.[1]

Recently, the high-profile randomized fall intervention, Strategies to Reduce Injuries and Develop Confidence in Elders (STRIDE) study was published in the *New England Journal of Medicine*.[2] This 86 site multi-centered study, funded by the Patient-Centered Outcomes Research Institute (PCORI) looked at whether individually tailored interventions in older individuals at high risk of falling prevented subsequent falls and injuries. The STRIDE study results, unfortunately, did not show encouraging results in the prevention of serious fall injuries. Far worse, the "take home message" for many was that preventing fall-related injuries in older adults is extremely difficult or impossible.

This overall message from STRIDE overshadows the epidemic of fall-related injuries that are seen in the ED. The majority of these patients (~70%) who fall are evaluated and discharged from the ED. Despite not sustaining significant injury, these individuals are at high risk for subsequent fall with approximately 50% falling again or revisiting an ED within six months.[3] These ED presentations likely represent sentinel events that offer an opportunity to assess, intervene and potentially prevent subsequent injury.

Unfortunately, ED assessment for guideline recommended modifiable fall risk factors are rarely discovered during an ED fall presentation and evaluation.[4] The Geriatric ED Guidelines published in 2014 for patients who have fallen recommend a complete history and physical examination related to the fall (e.g. exam for peripheral neuropathy, vision, lower extremity strength), medication assessment, orthostatic blood pressure measurement, and neurological assessment focusing on neuropathy and strength.[5] Additional assessments include a gait evaluation, home safety assessment, and referral to community resources for fall prevention. Finally, patients discharged from the ED after a fall should also be referred for appropriate medical follow-up (see figure).

Although the Geriatric ED Guideline recommendations make sense given the poor prognosis of geriatric ED fall patients and their high-risk for subsequent repeat fall and injury, the current standard of practice is a trauma assessment only and does not come close to providing recommended care in the vast majority of cases. In our view, when a geriatric patient falls and presents to the ED, this represents an important sentinel event. If an ED patient presents with a new "thunderclap" headache, this individual will have a complete work-up to rule-out a subarachnoid bleed. Unfortunately, a geriatric ED fall patient has a greater 6-month mortality than the "thunderclap" headache patient and the Geriatric ED Guideline recommendations are almost never completed in our current health care system.[3,6] These guideline recommendations have been published for several years, yet remain aspirational for almost all US EDs (see table).[6]

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"We have all been warned about the coming "Silver Tsunami"."

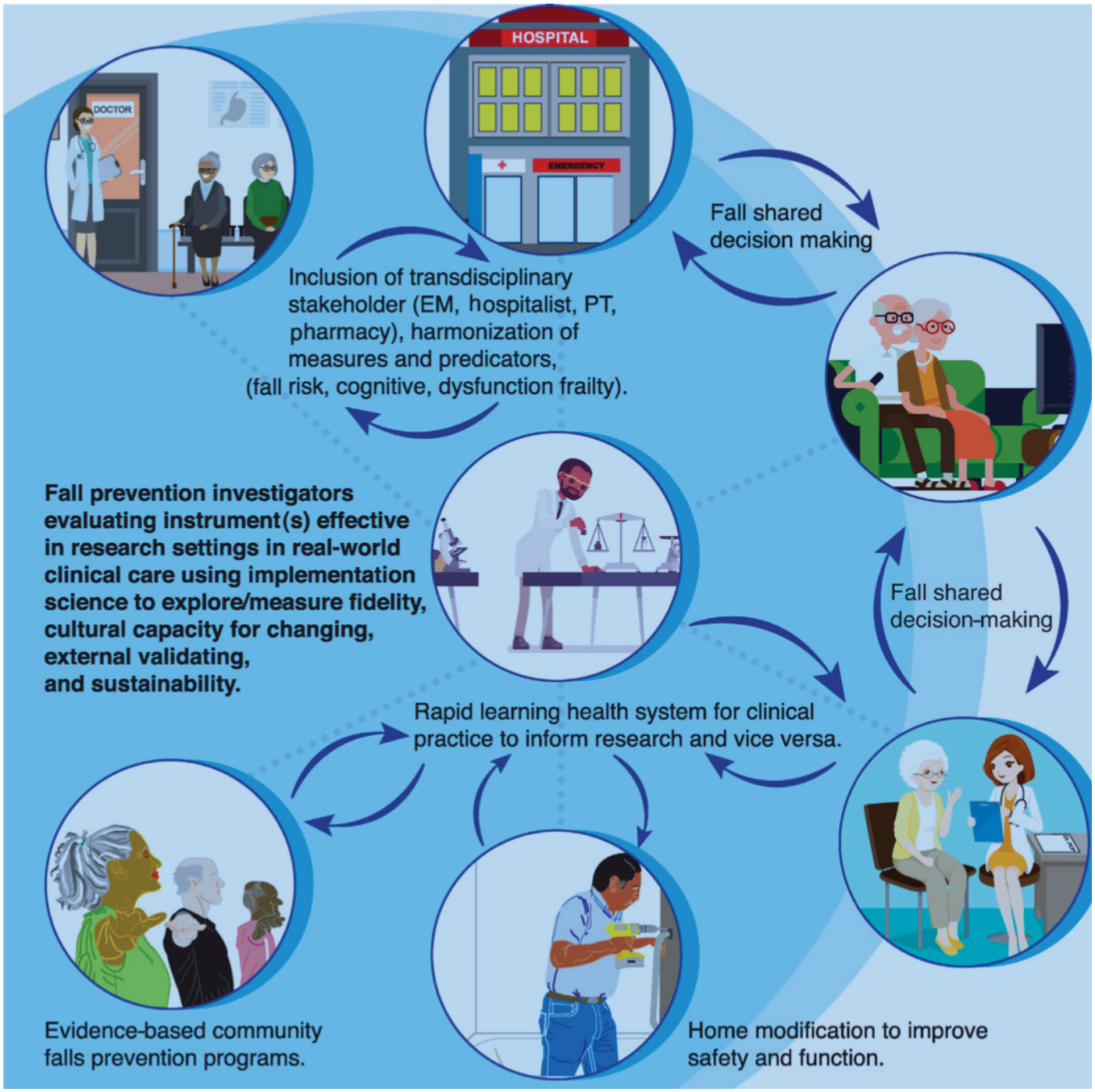

Figure: This illustrates the complex, multi-level recommendations from the Geriatric Emergency Medicine Guidelines that are involved in managing ED fall patients (Figure reproduced with permission).[11]

Not to continue the "doom and gloom" related to this topic, several ED based studies utilizing resources such as ED initiated physical therapy or pharmacology consultations have shown that targeting these extremely high-risk patients can decrease rates of injury in this patient population.[7-9] These ED based fall-intervention programs require a systems-based approach with the addition of resources to bring them to fruition. The current state of emergency medicine practice is, unfortunately, extremely fast paced and focused on increased productivity and patient throughput. Adding to the evaluation and treatment of geriatric ED patients that have fallen appear unrealistic unless there is significant recognition of this epidemic and the provision of major new resources and funding.[10]

ED fall-related presentations in the geriatric patient with significant morbidity and mortality are extremely common and are at epidemic levels. Unfortunately, as our general population ages, this problem will likely worsen. The recent *New England Journal of Medicine* STRIDE study may be viewed as discouraging. However, others view this as a call to reassess how to care for and manage this extremely common ED presentation. Our personal view is that we have yet to hit our "STRIDE" in the assessment and treatment of these patients. The first step is to recognize that guideline recommend care is needed to adequately assess and manage these patients. This will hopefully lead to system changes that provide the level of care needed for this devastating medical presentation.

Reasons That Geriatric ED Guidelines Are Aspirational

- The vast majority of US EDs have not obtained geriatric ED accreditation
- Most US EDs do not to adhere to the Geriatric ED Guideline recommendations of level care
- Lack of available resources
- Poor understanding of polypharmacy issues
- Lack of recognition of geriatric ED disease issues
- Competing ED priorities
- Poor implementation of guideline recommendations
- Poor coordination within health care system for geriatric patients ●

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Housing is Health Care: How the COVID-19 Pandemic Could Change the Way We Address Homelessness in the ED

Victor Cisneros, MD MPH, Shashank Somasundaram, BS, and Sara Urquhart, MA RN



Even before the COVID-19 pandemic, emergency physicians served as de facto primary care providers and safety nets for people experiencing homelessness. The COVID-19 pandemic has highlighted the glaring need for innovation in emergency care and a structured approach to mitigate homelessness.

Medico-social Safety Net

Emergency departments (EDs) have long served as our nation's health safety net for vulnerable populations. Recent data showed that from 2015-2018, annual average ED visits were 203 per 100 homeless persons compared to 42 per 100 among the general population. Amidst the economic downturn caused by the COVID-19 pandemic, the permanent closure of many businesses caused an estimated 45% surge in the number of unhomed people in the U.S. A report in 2020 in the U.S. found that 400,000 new shelter beds were needed in addition to the 291,837 existing temporary shelter beds with an estimated annual cost of $11.5 billion to adequately meet the needs of the growing number of people experiencing homelessness.

Many people experiencing homelessness are unable to access or maintain a consistent primary care provider and rely heavily on the ED for social resources and management of chronic medical conditions, such as diabetes, hypertension, end-stage renal disease, and HIV. For ED physicians, it is often challenging to facilitate safe discharge from the ED, leading to a lower threshold for hospitalization and longer ED stays, further increasing the health care burden of homelessness. Though the complex medico-social needs and dearth of clinical care guidelines make this a challenging population to serve, research shows that ED screening and intervention could reduce ED visits and improve housing stability.

Impact of the COVID-19 Pandemic

During times of public health emergency, the unhomed are some of the most physically, socially, and medically vulnerable populations. The structural housing deficits along racial and socioeconomic lines predispose marginalized communities to suffer most. During the pandemic, the inability to shelter in place or self-isolate put homeless people at high risk for contracting and transmitting the virus. This population's skew towards older adults and propensity for medical and psychiatric comorbidities put them at further risk for severe disease and higher mortality.

It is believed that 20% of the estimated 550,000 unhomed individuals in the U.S. are children who are dependent on public resources such as school lunches and public libraries. With pandemic restrictions, many children experienced hunger and were unable to keep up with virtual school plans.

Public health measures such as social distancing, business closures, and shelter-in-place orders severely limited access to critical social and medical resources and services as well. This disruption in access to care was worse for homeless individuals, who rely on spaces like restaurants and libraries for food and hygiene. This left them largely unable to follow public health recommendations such as surface disinfection and regular handwashing. With social distancing requiring a reduction in bed volume at shelters and hospitals, these facilities were largely unable to meet the rapidly growing needs of their communities.

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> "EMERGENCY DEPARTMENTS HAVE LONG SERVED AS OUR NATION'S HEALTH SAFETY NET FOR VULNERABLE POPULATIONS."

> "Research should focus on understanding how case workers and community health workers can collaborate with emergency department teams to manage homeless patients more effectively."

Response

The CDC issued a nationwide moratorium on certain residential evictions, but with months of mounting back-rent, this provided no real relief to many renters and contributed to widespread housing instability.

In response to the colliding crises of homelessness and COVID-19, there has been swift policy action and public health guidance at the federal, state, and local levels. The federal government passed the CARES Act waiving regulatory requirements on shelters and allocating $4 billion to temporarily house homeless individuals. A broad range of state-level efforts were initiated, such as hotel rooms in states such as California and North Carolina. Community-level interventions have been most prolific and effective in mobilizing to address the crisis of people experiencing homelessness, however these programs are sporadic and often insufficient.

The vaccine deployment focused on vaccinating health care personnel and residents of long-term care facilities followed by organized programs that reached out to individuals with addresses and medical homes, leaving unhomed people to fend for themselves for vaccine access.

Though professional organizations such as the American College of Emergency Physicians and the American Society of Addiction Medicine issued guidelines for emergency physicians noting the importance of safe discharge plans and thorough assessment of unhomed patients' needs, there has been a lack of a systemic approach to addressing homelessness during COVID-19 in the Emergency Medicine field.

Housing is Health Care

Barriers to addressing homelessness that existed prior to the onset of COVID-19 continue to persist. Stigma surrounding patients experiencing homelessness remains among the general public, most recently with 'not in my backyard-ism' (NIMBYism) in response to temporary hotel placements. Even among emergency physicians, although stigma has decreased, one recent study found that emergency residents identified homeless patients using stereotypes of poverty. Though some may see issues such as racism, substance use, and housing instability as outside the purview of medicine, these are all critical social determinants of health that need to be actively assessed and addressed in clinical care–now more than ever. Many hospitals and institutions that do recognize that housing is health care face bureaucratic obstacles such as a lack of community partners or sufficient funding. Many of these issues have taken a backseat due to the realignment of national priorities with the declaration of a public health emergency. We hope that COVID-19 may force us as a nation to reckon with the roots of homelessness. A cohesive emergency medicine approach is part of this effort.

Structural changes are needed to address these issues. Though many medical schools and residency programs recognize the importance of social determinants of health (SDOH) in clinical instruction, there remains a lack of any formal, evidence-based curricula addressing patients experiencing homelessness in the emergency department. There are few professional emergency medicine guidelines, and even less literature, on clinical management of unhomed patients. Research should focus on understanding how case workers and community health workers can collaborate with emergency department teams to manage homeless patients more effectively. Consistent and systematic ED screening for SDOH and referral to appropriate resources is critical. Lastly, political and administrative champions must advocate for these changes and for funding in state legislatures, hospital leadership, and community organizations.

Future Recommendations

1. A multi-agency, public-private strategy should be developed to ensure equitable access to vaccines in populations experiencing homelessness.
2. Emergency medicine organizations should develop evidence-based systemic approaches to addressing homelessness, both during pandemic and non-pandemic times.
3. Emergency medicine education should create a formal evidence-based curriculum for recognizing and addressing the needs of people experiencing homelessness through emergency care.
4. Emergency departments should improve care coordination for vulnerable populations through use of case managers, systematic screening, referrals for housing stability, and developing partnerships with community organizations and shelters. ●

Resources

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Stop Stigmatizing Suicide

Loice A. Swisher, MD MAAEM FAAEM

Commit suicide.

I finch with these words. It takes great effort to contain a wince as those words hit my ear. There is a visceral pain like a punch to the gut. No matter my prior personal sense of comfort, it falters. I'm sure the feeling is common for so many who have had friends or family who have killed themselves or who have had personal thoughts of suicide.

My pained mind wanders….

- I wonder if the person saying these words realizes often the immediate subliminal message of a crime or sin to those who have suffered with suicide loss or suicidal ideation.
- I wonder if the person saying these words actually believe that suicide is a crime or a sin.
- I wonder if the person saying these words is aware they are dividing suicide from all other causes of death. After all, there is no other committed death. Commit makes suicide different; perhaps subtlety implying suicide is unchangeable.
- I wonder if the words tumble out of their mouth without thought—as automatic as 'peanut butter and jelly' or 'black and white.'
- I wonder if the person just doesn't know another way or does and continues to say 'commit suicide' anyway.

I wonder if they know it hurts.

There are other ways to say this. The words are less automatic. They may sound strange to the ear. However, it is easy, and it is free. Instead, use the same terms that are used with cancer, car accident, and heart attacks: died by (or from) suicide.

When Anthony Bourdain and Kate Spade died by suicide in 2018 the media was widely watched on how the news was covered. Since then, the media guidelines are widely employed. Once made aware, one can now see that the use of 'commit suicide' is less used in the headlines.

As emergency physicians, we tend to believe we can talk about and treat all emergencies. However, this is much less true of the American suicide health crisis. We can start by choosing other words-less divisive language. For National Physician Suicide Awareness Day commit to ending stigmatizing language with suicide.

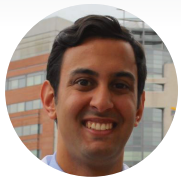
Commit to 'died by suicide'. ●

"Commit suicide. I flinch with these words."

"We can start by choosing other words-less divisive language."

My First Press Conference

Gregory Jasani, MD



In April, I had the honor of speaking at a Capitol Hill press conference. The occasion was the House's passage of HR 1195: The Workplace Violence Prevention for Health Care and Social Services Workers Act. I had been invited by Congressman Joe Courtney (D-CT) to give brief remarks about my experience with the issue and what the passage of this bill meant to me.

HR 1195, if passed, would require every hospital to develop a workplace violence prevention plan in line with current Occupational Safety and Health Administration standards. This issue is personal for me as I am sure it is for many of us; we in health care experience disproportionately high rates of workplace violence. I genuinely believe that HR 1195 would help keep us safer while at work.

Being asked to speak and share my experiences at the press conference after the passage of this important legislation in the House of Representatives was an incredible honor. My first involvement with this legislation was a little over a year ago when I wrote an op-ed to support it that was published in the Baltimore Sun (my local paper). Somehow, my op-ed found its way to Congressman Courtney. He invited me down to his office on Capitol Hill and since then I have worked with his office to promote the legislation.

As with many things this year, this press conference was virtual. That meant that I had to plan for things like lighting, background, and camera positioning. Fortunately, accounting for these factors is now almost second nature to me thanks to the pandemic and this was not too difficult.

What was more of a challenge, and this would have been the case if the press conference was in person too, was preparing my remarks. The Congressman's office provided me with two minutes to make my remarks. Two minutes initially seemed like a long time to talk but as I prepared my talking points I soon realized just how short of a time it really was. Workplace violence is a topic that I feel very strongly about and there was a lot I wanted to say. However, I had to balance my desire to hit multiple points against my allotted time. Crafting remarks that were concise yet hit all of the points I wanted to was more of a challenge that I initially anticipated. Yet, I was ultimately able to write a short speech that I felt conveyed everything I wanted to within my two minutes.

> "I think it goes to show how incredibly powerful and valued our voices as physicians are in these conversations."

The event went incredibly well I think. The Congressman and his staff were effusive in their thanks for my words and participation. When I first began advocating for this bill, I never imagined I'd get to speak at a Capitol Hill press conference for it. I think it goes to show how incredibly powerful and valued our voices as physicians are in these conversations. I hope my experience encourages you to lend your voice to this topic as well: we will need all of them as this bill moves to the Senate. ●

> "This issue is personal for me as I am sure it is for many of us; we in health care experience disproportionately high rates of workplace violence."

Mind the Gap – Utilizing the pCO_2 Gap in Shock Resuscitation

Gerard Heath, MD and Gina Hurst, MD


Abstract

The successful management of acute circulatory shock relies upon the correction of several hemodynamic and O_2-derived parameters informed by our understanding of oxygen delivery (DO_2). These metrics, while important, have limitations, and O_2-derived parameters may be confounded by physiologic derangements in the shock state. In this review, we hope to discuss how the observation of the partial pressure of carbon dioxide (pCO_2) within the cardiovascular system may be incorporated into resuscitative assessment. In the setting of otherwise normalized hemodynamics and $ScvO_2$, an elevated pCO_2 gap, which is the difference between central venous and arterial pCO_2, offers prognostic insight and has the potential to identify under-resuscitated patients who may benefit from an increase in cardiac output to achieve effective resuscitation.

Shock Resuscitation

Early-Goal Directed Therapy (EGDT) established the importance of a methodical approach to septic shock management, with ongoing monitoring of resuscitation efforts and the restoration of identifiable hemodynamic endpoints.[1] This protocolized approach highlighted several important physiologic parameters to optimize including central venous pressure, mean arterial pressure, and central venous oxygen saturation. Of these parameters, the central venous oxygen saturation ($ScvO^2$), is of particular importance as many patients in shock have reduced ScvO2 levels. This abnormality indicates a derangement in oxygen delivery or consumption correlating with an increased risk of mortality.[2-5] As with all resuscitative endpoints, contextual interpretation is key. In the setting of shock, underlying tissue damage and microcirculatory derangements may cause oxygenated arterial blood to shunt to the venous system with little oxygen extraction, leading to normal $ScvO_2$ levels despite ongoing, or worsening, tissue hypoxia.[6,7] This clinical scenario may be associated with either a normal or elevated lactate as an ongoing measure of hypoperfusion. Determining additional opportunity for resuscitative intervention in these cases can be clinically challenging. Throughout this article we hope to explore the utility of "the pCO_2 gap" in evaluation of shock resuscitation, where the pCO_2 gap is identified as the difference between arterial and central venous partial pressure of carbon dioxide.

CO_2 Biochemistry Refresher

To understand the application and limitations of the pCO_2 gap in shock resuscitation, it is important to have a basic understanding of carbon dioxide production and elimination within the human body. Under oxygen-rich conditions, the tissues in the body produce high-energy molecules, namely ATP, through oxidative phosphorylation, leaving behind CO_2 as a waste product. Under conditions of tissue hypoxia, the production of ATP results in the creation of lactate and also generates hydrogen ions which are then buffered by bicarbonate to produce CO_2. In a shock state, anerobic metabolism predominates leading to an increase in CO_2 production which then is transported to the lungs and expelled in the process of respiration.

Note: Differences exist beyond the scope of this article between the partial pressure of CO2 and concentration of CO2 in the bloodstream, as well as between central venous pCO2 and mixed venous pCO2, but the use of central venous pCO2 for calculation of the pCO2 gap has been established as valid experimentally and the relationship of pCO_2 and cCO_2 is roughly linear over the physiologic range (Markota).

Understanding Venous vs Arterial pCO_2 and the pCO_2 Gap

Arterial pCO_2 is primarily driven by gas exchange while venous pCO_2 is driven by both tissue CO_2 production, determined by the respiratory quotient, and venous outflow. Venous outflow can be thought of as directly related to cardiac output, or the blood flow supplied to physically move the CO_2 from the periphery to the lungs where it is then expelled. The relationship of venous pCO_2 and cardiac output has been established experimentally and the two are inversely related according to the Fick equation.[4] In essence, when cardiac output is not adequately matched to metabolic demand, CO_2 tends to accumulate in the venous system, while arterial pCO_2 remains primarily determined by respiration, thus increasing the pCO_2 gap between venous and arterial measurements.[8] Under normal conditions, the pCO_2 gap is rarely greater than six and this number has been established as a clinically significant alerting the clinician to the possible need for further cardiac output augmentation.[9-11] An increased pCO_2 gap has also shown to exist in all forms of shock and is not specific to septic shock or any single phenotype.[4,10,12-16]

Evidence for the pCO_2 Gap in Clinical Practice

Two questions remain to be established for the utilization of the pCO_2 gap in shock resuscitation. The questions are as follows:

How can we be sure that an elevated pCO2 gap primarily indicates inadequate cardiac output? What impact can its implementation make in the care of critically ill patients?

While the focus thus far has been on venous hypercarbia being related to poor venous outflow, one could imagine an accumulation of CO_2 in the venous system being a direct result of increased anerobic metabolism and hypoxia at the tissue level. However, animals subjected to hypoxia without ischemia did not develop

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> "Throughout this article we hope to explore the utility of 'the pCO2 gap' in evaluation of shock resuscitation, where the pCO2 gap is identified as the difference between arterial and central venous partial pressure of carbon dioxide."

venous hypercarbia in physiologic models and studies in sheep identified that despite a physiologic increase in CO_2 production, adequate cardiac output results in a normal pCO_2 gap (< 6).[17] This reflects the high diffusion capacity of carbon dioxide which is roughly 20 times that of oxygen. Both in human studies and animal models, elevated pCO_2 gap has been shown to be correlated with adverse outcomes, including greater in-hospital and 28-day mortality, longer ICU stay, more days on mechanical ventilation, and poor tissue perfusion (Hurst PPT). In combination with more commonly used parameters, an elevated pCO_2 gap adds sensitivity to lactate elevations and has been shown to indicate a poor prognosis when $ScvO_2$ is greater than 70%.[18-20]

pCO_2 Gap Indexed to O_2-derived Parameters

The pCO_2 gap has been found useful in detecting shock, guiding ongoing resuscitation, and identifying patients at increased risk for adverse outcomes. Despite this utility, there are several limitations. The primary limitation is driven by the observation that the pCO_2 can be influenced by O_2-derived parameters, often due to the Haldane effect, which allows for efficient loading and unloading of CO2 from hemoglobin molecules in the oxygenated lungs and deoxygenated periphery. In order to correct for oxygenation status, indexing the pCO_2 gap to the arterial-venous oxygen content difference ($P_{cva}CO_2/C_{av}O_2$) might be superior to the pCO_2 gap alone in reflecting global anerobic metabolism,[21,22] for elevated lactate detection,[21] for predicting lactate clearance,[22-24] and for prognosticating septic shock outcome.[22,25] A $P_{cva}CO_2/C_{av}O_2$ ratio above 1.4 mmHg/mL should be considered as a marker of global anaerobic metabolism.[21,22]

Utilizing the pCO^2 Gap in Clinical Practice

As described above, the pCO_2 gap not only provides diagnostic and prognostic information, but it also can be a helpful tool to identify under-resuscitated shock and may guide further treatment alongside current established parameters. One method of incorporating the pCO_2 gap into clinical practice is adapted

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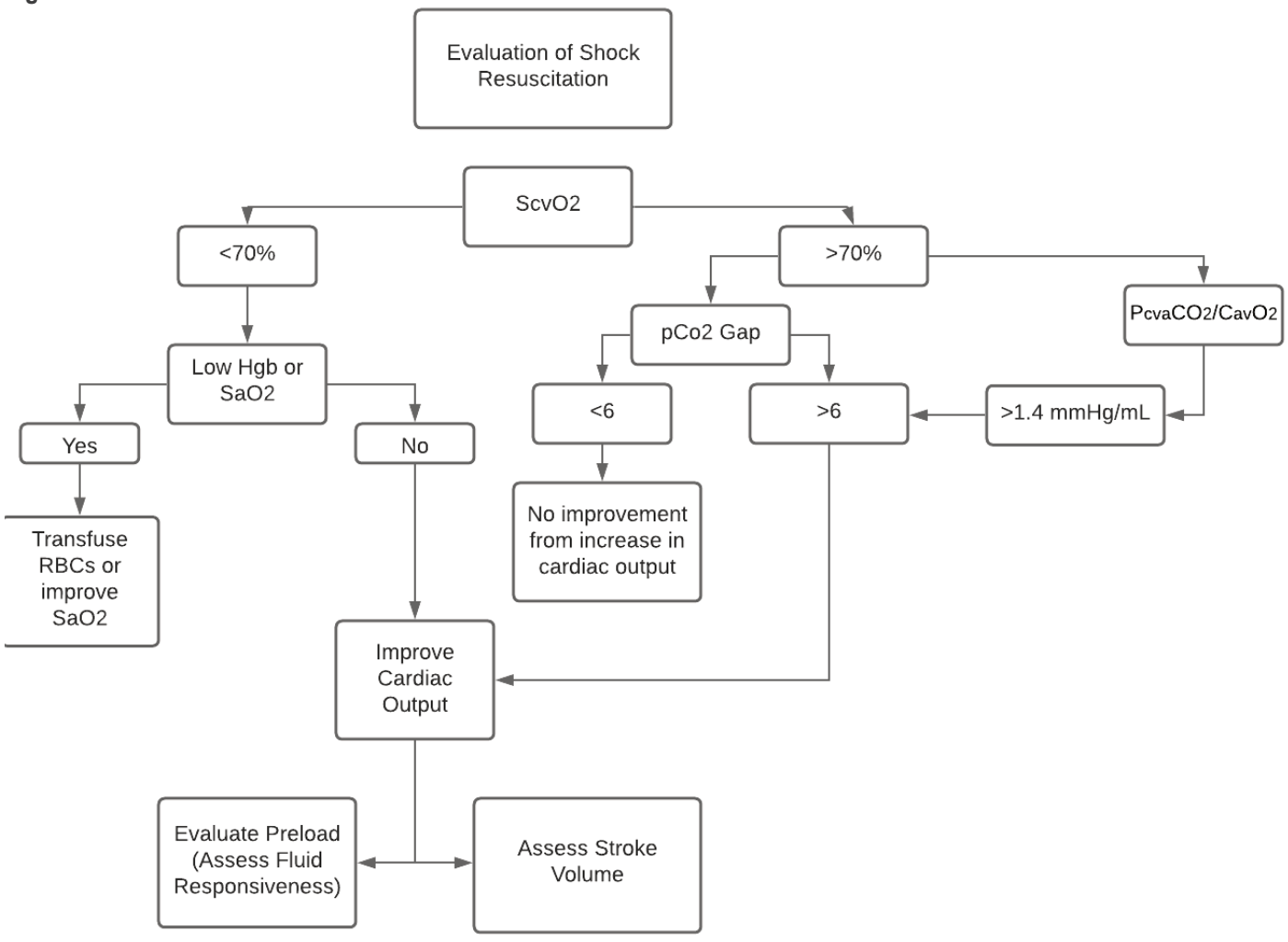
Figure 1.



from Gavelli et al.[26] When shock resuscitation is underway, evaluation of resuscitative efforts is key. An assessment of ScvO2 may determine if an improvement in DO_2 will treat shock state. A low $ScvO_2$ (less than 70%) suggests inadequate oxygen delivery or increased oxygen consumption. Normalization of $ScvO_2$ may occur by increasing DO_2 with blood transfusion, improvement in oxygen saturation, or increasing cardiac output by fluid resuscitation or inotropic support. In the setting of a normal $ScvO_2$ (>70%), we must identify if resuscitation end points have been met or if further resuscitative efforts are required. As previously stated, capillary shunting may lead to a normal $ScvO_2$ despite ongoing shock. This is often accompanied by an elevated lactate and may reflect ongoing need for improvement in oxygen delivery. To elucidate this information, we can evaluate the pCO_2 gap or $P_{cva}CO_2/C_{av}O_2$ ratio. If the pCO_2 gap is > 6 mmHg, or when the $P_{cva}CO_2/C_{av}O_2$ ratio is ≥ 1.4 mmHg/mL, attempts at improving oxygen delivery via cardiac output should continue. This will include assessment of preload and contractility and may suggest need for ongoing intervention despite normalization of $ScvO_2$.

Conclusion

With long boarding times of critically ill patients increasingly prevalent in the ER, physicians can consider utilizing the pCO_2 gap in conjunction with current resuscitative parameters to identify high-risk patients, assess the adequacy of their resuscitation, and guide further cardiac output augmentation. ●

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WiEM Awards

Loice Swisher, MD MAAEM FAAEM

The History:

Carrying my backpack on the plane to St. Louis, I could barely contain my excitement. I was transporting three awards, the new Women in Emergency Section awards, fully expecting a transformative moment at the Scientific Assembly WiEM Luncheon. Everything came together quickly and the stars aligned to make this possible. Only a handful of people were "in the know."

This journey started three and a half years ago in New York City. Sitting in the audience for the inaugural FIX conference, stunning graphs flashed across the screen showing appalling gender differences in SAEM award recipients. Apparently, this difference of men winning most of the national awards is common across medicine. I feared it would be true for AAEM too…and it was.

The FIX speakers had a fix for this:

1. Encourage women to self-nominate and nominate others for awards (which women traditionally do not do and you can't win unless you are nominated).
2. Create section specific awards more geared towards the professional interests of women.

The WiEM Committee immediately instituted an awards nominating task force in 2018 with the expressed purpose of identifying qualified women and nominating these women for AAEM awards. This approach has been successful.

Last year when Women in EM went from committee to section, I charged the leadership working group to attend to AAEM awards issues. Drs. Krafin Schreyer and Kristyn Smith submitted three new awards to the WiEM Council in May.

In reflecting on the AAEM awards, all the named awards were for men, primarily white men. These men have been significant to creating our organization, however we wanted to recognize the importance of women to our specialty as well. With AAEM, there was no doubt that this award should be named after Dr. Joanne Williams, a founding member of AAEM and the first woman Master of AAEM. She continues to be active in the WiEM Section, the DEI Committee and the CAL/AAEM Chapter Division.

The GEMs:

Now that we had award descriptions, we actually needed awards. We wanted these to be special to reflect the uniqueness of our section members. Someone asked if we were going to call these awards something like the Oscars or the Emmys. We were charged with the responsibility of creating a brand, a legacy.

Finding the glass jewel awards, a lightbulb went on. These would be the GEMs: the Gender in Emergency Medicine Awards. It was perfect. Our winners were all treasures who sparkled with a brilliance from within, each unique with a common bond.

The Emerald
Young Leader Award

This award recognizes an individual who has made an outstanding contribution to AAEM in leadership. Nominees for this award must have 10 or fewer years' experience in an EM leadership position and must be AAEM Women in Emergency Medicine Section members.

Awardee: Molly Estes, MD FAAEM FACEP

Dr. Molly Estes is a Stanford EM residency graduate where she also completed a medical education fellowship. Since 2017 she has been clinical faculty and EM clerkship director at Loma Linda since 2019. She has been a long-time member of AAEM having been involved with RSA and YPS. In 2017, Dr. Estes was a co-winner of the Open Mic competition and a Scientific Assembly speaker ever since. She is a member of the AAEM Education Committee and SA Subcommittee, chair of the Learning Management System Committee learning and the WiEM Education Working Group lead. She continues to develop our Women's Wisdom podcast.

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"THESE WOULD BE THE GEMS: THE GENDER IN EMERGENCY MEDICINE AWARDS. IT WAS PERFECT."

The Ruby
Gender Diversity Award

This award recognizes an emergency medicine physician who has advanced gender diversity in the field. Nominees for this award have served as an ally to women, gender non-binary, and transgender physicians and advocated for their promotion within AAEM. Nominees must be AAEM members.

Awardee: Megan Healy, MD FAAEM

Dr. Megan Healy is a Temple EM residency graduate where she continues as the Associate Program Director. Her interests include social emergency medicine, healthcare disparities, and physician wellbeing. Dr. Healy wrote the 2014 *Common Sense* article spotlighting the lack of women on the AAEM Board. This article was the catalyst for Dr. Mark Reiter, then AAEM President, to form the Women in EM Committee. Through our section's AMWA benefit, she applied for, and was accepted into, the Women's Wellness through Equity & Leadership (WEL) Project.

> "Apparently, this difference of men winning most of the national awards is common across medicine. I feared it would be true for AAEM too...and it was."

The Diamond
Joanne Williams Award

This award honors individuals who uphold the legacy of Dr. Joanne Williams, the only female founding member of AAEM and first female Master of AAEM. The purpose of this award is to honor trailblazers within the field. Nominees for this award must have supported efforts to add gender equity and diversity to AAEM and/or the field of emergency medicine. Nominees must be AAEM members.

Awardee: Lisa Moreno, MD MS MSCR FAAEM FIFEM

Dr. Moreno is a Professor of Emergency Medicine, Director of Research, and Director of Diversity for Emergency Medicine at LSU Health New Orleans School of Medicine. In addition, she is the Director of Latino Scholars for the LSU School of Medicine. Without a doubt, she is a trailblazer becoming the first woman president of AAEM. During her time on the board and as president, she has made substantial effort to increase gender equity and diversity within AAEM.

The Women in Emergency Medicine section would like to recognize and thank Dr. David Farcy for his generous donation to make these awards possible. ●

AAEM Wellness Resources

AAEM recognizes the burnout that emergency physicians can feel. Our jobs are demanding under normal conditions, and COVID has just increased that demand and feeling of burnout. The AAEM Wellness Committee works on resources and efforts to decrease burnout and increase well-being. Examples of Wellness Committee projects include:

- Wellness activities at the Annual Scientific Assembly
- AAEM Position Statement on Interruptions in the Emergency Department
- Suicide Prevention and Awareness Efforts
- Articles in the AAEM member magazine, *Common Sense*

To access these wellness resources, please visit:
www.aaem.org/get-involved/committees/committee-groups/wellness

"…And I took the road [far too much] traveled."

Emily Dawra (MS3) and Sarah Jacobs (MS2)

Why does emergency medicine draw us? So many choices...the puzzle of the undifferentiated patient, the endless variety of care to be offered, the small procedures that provide a big impact, the wild histories with tangled webs of both useless and critical information, the requirement to trust your well-honed instincts, and maybe most importantly the formation of immediate but sincere connections with patients when they are at their most afraid and vulnerable. These are just some of the reasons why we love emergency medicine. As students the draw is undeniable, and we want this to be our future.

"Don't go into emergency medicine unless it is the ONLY thing you can envision yourself doing." The words of my attending rang loud in my ears as I re-read ACEP's report on the future of emergency medicine for the third time. The first time, I cried. The second time, I was numb. The third time, I was looking for loopholes. Is it really possible that I could leave medical school in two years bound for a jobless future? It was supposed to be safe…

When I knew that I wanted to be a doctor, being an emergency physician was the only thing I envisioned. In fact, I knew no other form of doctor. Vaccines had been given to me by nurses as a child, and I never saw a family doctor until my sports physical for the swim team in high school – and that was over the phone. On the other hand, I had frequented emergency rooms with an ill family member perhaps 1-2 dozen times in my senior year alone. Emergency physicians are the doctors I had come to know and hold with great regard. They were my emblems of safety. They were, without any doubt, who I wanted to become.

> "WE KNEW WE COULD NOT REST SUCH A PRECIOUS DECISION AS OUR CLINICAL FUTURE ON A SINGLE WRITTEN REPORT. WE NEEDED TO HEAR FROM THE PEOPLE IT AFFECTED."

"I wouldn't recommend emergency medicine to any medical student at this point." The whispers about the EM job market concerns had become loud conversations, but I was still shocked when an emergency medicine attending told me that I should no longer consider EM an option. I couldn't dismiss his opinion outright – many of my classmates interested in EM were expressing concerns, I currently owe the federal government a significant sum, and I didn't want my future employment options to be either unemployment or somewhere far from family (which is how many framed the near-future status of EM employment). One classmate who had been a scribe in the ED originally told me he was interested in EM, but a couple of months later, he said that he was now interested in radiology. When I asked him what had changed, he asked if I had seen the report.

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I couldn't wrap my head around that reasoning. I did my first shift in the ED when I was eighteen, completing my clinical hours for my EMT license, and seven years later, it's still my favorite place in the hospital. I loved the pace, the variety, and the teamwork required. I'd written EM love letters in my medical school application essays, and every experience I've had so far in medical school has solidified my desire to pursue a career in emergency medicine.

Over the last two months since ACEP's report, we have tried countless times to talk ourselves out of walking down the path of dark uncertainty that is emergency medicine. Many friends, physicians, and peers have attempted to help in this regard too. But the further we stray from this heavily trodden path, the more we ask each other, "but then what was the point of all this?"

Last week, the two of us returned from AAEM's Scientific Assembly in St.

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"DON'T GO INTO EMERGENCY MEDICINE UNLESS IT IS THE ONLY THING YOU CAN ENVISION YOURSELF DOING."

Louis, Missouri. We came for connection, mentorship, and understanding of what was happening in the frontlines of the field. We knew we could not rest such a precious decision as our clinical future on a single written report. We needed to hear from the people it affected. Even at the medical student track, a session with program directors explaining the characteristics of good candidates morphed into anxious questions by students about whether or not they should even be entering the field.

What we found was optimists and realists - people who thought the report was "no big deal" and people who reemphasized the dire warning. But, in everyone, we found support for going forward. Everyone had their own reason for understanding why we ultimately could not deviate our paths away from emergency medicine.

As medical students still mapping out our course along this road far too much travelled, we want to thank this community for giving us endless guidance, strength, and encouragement. Through AAEM, we found resiliency and fighting spirit. We found people bushwhacking new roads and opening doors of possibility for those of us who still wish to take this broadening path towards emergency medicine. We appreciate this community for speaking truth in uncomfortable situations, researching ways to protect the field, and guiding us to join the team. ●

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Perspective: Escaping Our Burnout Crisis

David Nykin, MD

It's no secret that physicians are sustaining ever rising rates of burnout. Even prior to the pandemic, emergency medicine ranked near the top in surveys of physician burnout and that was before the added pressures of the COVID crisis. When I think about the myriad pressures of practicing medicine in our country's increasingly complex medical system, I often wonder what it was like for the physicians working before us and whether they experienced the same stresses as today. Specifically, I think about the experiences of my grandparents, who practiced medicine in the post-WWII USSR.

> "I often wonder what it was like for the physicians working before us and whether they experienced the same stresses as today."

When I was in medical school, I would complain to my grandmother about everything: the long hours, the numerous tests, the ornery attendings. She would lovingly listen and then would share about her time in medical school. After her preclinical years studying in Odessa, she had to take a break from school to travel across the country to escape the Nazis. She finished school in distant Tashkent, capital of present day Uzbekistan. After graduation when the war had ended, she was assigned to serve as the sole doctor in a remote Ukrainian village. It was the start of a grueling stint of her career, serving a war-torn population, with 7-day work weeks, nightly call, and no clinical support. Still, my grandmother looked back at those days fondly and spoke of the honor she felt working as a physician at that time.

She later petitioned for transfer to the regional hospital to train in ophthalmology, where she would meet my grandfather, another physician. His early years practicing medicine had also been interrupted by the war, and while he survived as soldier, every other member of his immediate family perished in the holocaust. He found purpose in his practice and eventually became the chair of radiology at the regional hospital. Despite their esteemed careers, their salaries did not cover basic necessities of life. Like all citizens in the USSR, my grandparents lived in poverty, depending on food rations from the government to survive. They had little control over where they would be assigned to practice, let alone their work daily schedule.

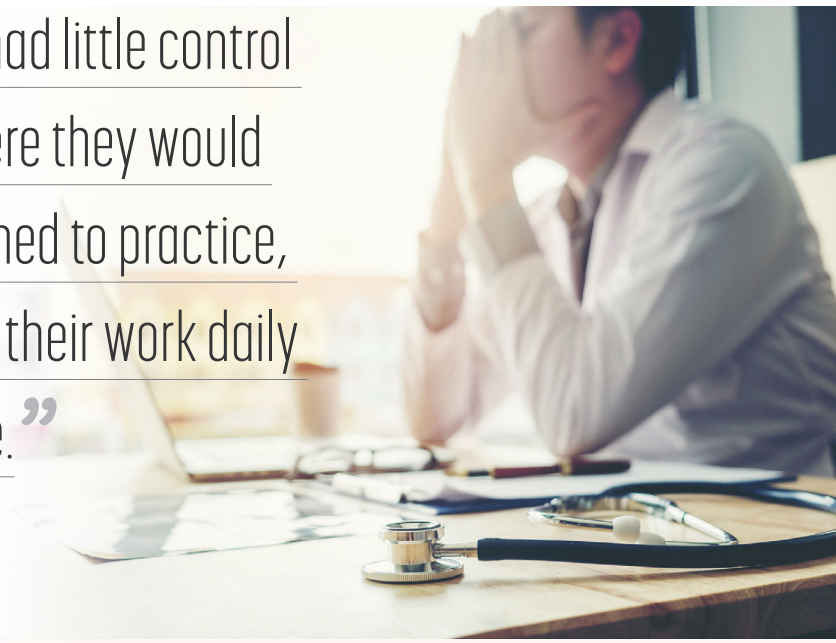
Still my grandparents loved their work and took immense pride in being physicians. They spent all of their clinical time at the bedside, talking with their patients. They did not have copious documentation burdens, nor did they have arbitrary metrics dictate their care. However, they did have the constant worry of being transferred to Siberian work camps as part of the anti-Semitic "doctors' plot" that Stalin fabricated to persecute Jewish physicians. Luckily for them and countless others, Stalin died and the plot fizzled, but not before countless lives were torn asunder. Twenty years later, my grandparents made the decision to leave the USSR and were able to immigrate to the USA as refugees. While my grandmother moved into a research career in ophthalmology, my grandfather went back to residency in his 50s. Despite being in a new country with a new language, he finished residency, passed the necessary licensing exams, and continued to practice as a radiologist.

My grandfather died when I was an infant and before my memory developed, and my grandmother died before I completed medical school. I was never able to speak about the pressures of residency or the burdens of working in the modern US medical system. However, I do wonder how they would feel about our current burnout crisis. Surely, they could empathize with the long hours and financial challenges of becoming a physician. They also worked insanely hard and had significantly less financial freedom afforded to them. Perhaps they could also relate to frustrations of working in bureaucratic systems led by non-clinicians. However, I imagine they would be bewildered by the amount of time we spend sitting behind a screen and away from our patients and would be equally surprised by increasing "protocolization" of medical practice.

For my grandpa rents, and countless other physicians from previous generations, their >>

dedication and connection to their patients and communities provided the fulfilment they needed to flourish in their careers. In today's emergency medicine climate, we have many issues at hand to advocate for. Work-force issues such as erosion of scope of practice and due-process standards are important and doubtlessly contribute to our high levels of burnout. Nonetheless, after reflecting on my grandparents' careers, I believe the depersonalization of medical care, driven largely by profit-driven corporatization of medicine, has had the most significant impact on our burnout. It has stripped us of the pride that previous generations of physicians could take in their care of patients.

It will take much more than wellness courses and mindfulness to fix our burnout crisis. And while adequate work-life balance is necessary to decrease burnout, it is not nearly sufficient. For the sake of our patients as well as our profession, we need to advocate for individualized medical care, independent from profit driven metrics and stringent medicolegal documentation standards. We need to restore the pride in medical practice that fueled my grandparents, and so many others, to love their careers. ●



> "They had little control over where they would be assigned to practice, let alone their work daily schedule."

> "Nonetheless, after reflecting on my grandparents' careers, I believe the depersonalization of medical care...has stripped us of the pride that previous generations of physicians could take in their care of patients."

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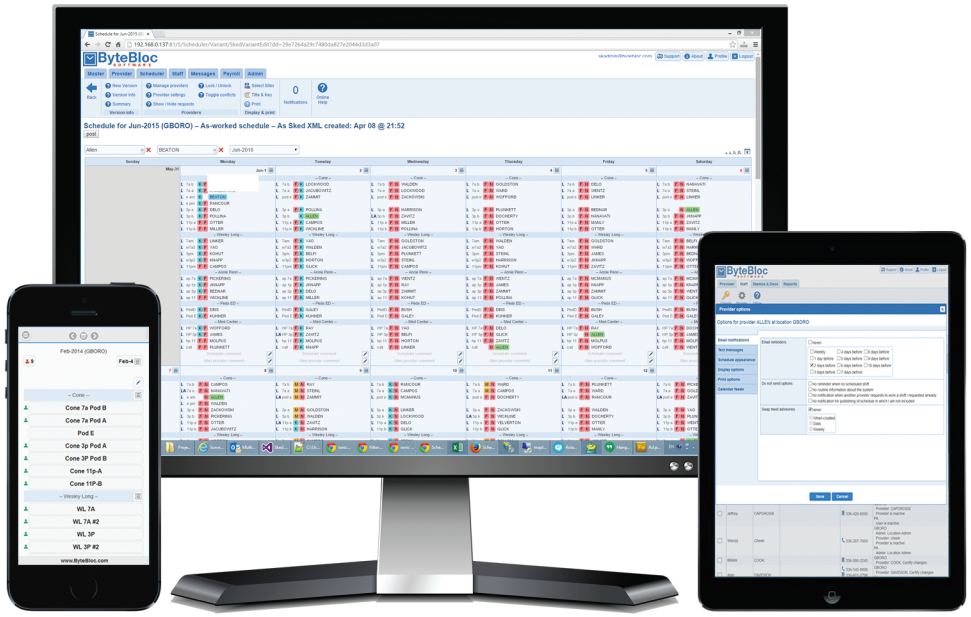

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Hello Everyone!

Lauren Lamparter, MD

Thank you so much for coming to the AAEM/RSA President's corner of *Common Sense*. I am very grateful to have been involved with AAEM/RSA for the past four years, and it is my honor to be serving you as the current AAEM/RSA President for 2021-2022. I know there are many concerns about the future of our specialty given the new light that has been shed on workforce data, reiterating the disheartening statistics AAEM has been cautioning against for years.

As a new resident and the new President of AAEM/RSA, I want you to know, I hear your concerns. I have spent most of my adult life working toward becoming an emergency physician, and as a new member of the field, I am committed to protecting our patients and our role as EM physicians. It is my goal to help educate you about the issues we are facing and what you can do to help protect our specialty. I am working with this year's AAEM/RSA Board of Directors to improve our website to make our quality resources more accessible to you and also to create new resources for advocacy, education, and wellness. We want to be your source for advocacy and understanding of key issues. It is my hope that we can also promote resident and medical student wellness as we work together to preserve our beloved specialty. Emergency medicine has always been a team initiative, and now more than ever we need to come together, as physicians, to advocate for job preservation, resident and student wellness, and, most importantly, patient protection.

> "AS A NEW RESIDENT AND THE NEW PRESIDENT OF AAEM/RSA, I WANT YOU TO KNOW, I HEAR YOUR CONCERNS."

I have a great team to lead you with this year, so I'd like to introduce them to you. Returning to the AAEM/RSA Board of Directors as our Vice President and liaison to the Representative Council is Dr. Ryan DesCamp, a resident at the University of Chicago. Our Treasurer and liaison to the Publications and Social Media Committee is Dr. Corey McNeilly, resident at the University of Tennessee Nashville. Returning to the board after two years of Presidency as the Immediate Past President, Dr. Haig Aintablian, resident at UCLA-Olive View, will be the liaison to YPS and the Workforce Committee. Other returning board members include Dr. Anika Turkiewicz, resident at Temple University and the liaison to Membership and Awards Committee, and Dr. Jordan Vaughn, resident at Louisiana State University-New Orleans and liaison to the Diversity and Inclusion Committee. Dr. Alexandra Reed, resident at Jefferson Northeast, is our International Committee liaison. Dr. Loren Touma, resident at Jefferson Northeast, is our Education Committee liaison. Dr. Megan Daniels, resident at Temple University, is our Advocacy Committee liaison. Lastly, our Medical Student Council Chair and liaison to AEROS, Ms. Ashley Iannatone, will continue to advocate for the EM bound medical students.

> "EMERGENCY MEDICINE HAS ALWAYS BEEN A TEAM INITIATIVE, AND NOW MORE THAN EVER WE NEED TO COME TOGETHER."

If you have any questions or concerns or are interested in learning more from AAEM/RSA, please let us know and we would be more than happy to help. Looking forward to a great year! ●

Sincerely,

Lauren Lamparter, MD
AAEM/RSA President 2021-2022

AAEM/RSA Chair Introduction

Kasha Bornstein, MD MPH MSC Pharm EMT-P

> "We see many of the direct effects of structural violence as they are lived and experienced by our patients on a daily basis…This presents us with a wonderful but complex set of responsibilities: how to make our practice spaces not only accessible but genuinely safe and meaningful for the patients we are tasked to treat."

Hello! I'm Kasha Bornstein, the incoming Chair of AAEM/RSA's Publications & Social Media Committee. I'm an intern at Louisiana State University's combined Internal Medicine and Emergency Medicine program in New Orleans, LA. Prior to residency I completed medical school at the University of Miami MD/MPH program. During my time as a medical student, I was honored to have the opportunity to become the AAEM/RSA Modern Resident Blog Copy Editor, where I reviewed articles submitted by residents and medical students and worked with writers to get them ready for publication by cleaning up prose, clarifying concepts, and ensuring information presented was useful, timely, and up to date. I also workshopped article concepts with new writers exploring the world of research, gave presentations on how to get involved with free open access medical education, and collaborated with students and activists across multiple fields, utilizing data to advocate for legislative policy change around harm reduction services in Florida.

My goal for my time as the Chair of the Publications & Social Media Committee is to focus our efforts on orienting our work ever more in the efforts of social justice and equity.

It's my strong belief that as physicians and medical students in emergency medicine we see many of the direct effects of structural violence as they are lived and experienced by our patients on a daily basis. Whether it's coming to the emergency department for needs as simple as medication refills or meals, or presenting with early onset of cardiovascular disease, delayed end-of-life care, trauma inflicted by needless gun violence, sequelae of unsafe drug use, or preventable complications of chronic health problems, our patients in emergency medicine come to us for medical attention in some of the lowest barrier environments for accessing health care resources in the United States. This presents us with a wonderful but complex set of responsibilities: how to make our practice spaces not only accessible but genuinely safe and meaningful for the patients we are tasked to treat.

I plan on working to make our Publications and Social Media Committee a resource for students and residents beginning or continuing their research, particularly those whose efforts explore the structural and social phenomena that make our patients vulnerable, and meaningful tools we can implement to ameliorate these problems. I look forward to assisting budding researchers strengthen their writing, clarify their research aims, and help their ideas reach a larger audience capable of adapting actionable ideas where they live and work. I look forward to this opportunity and welcome collaboration!

Sincerely,

Kasha Bornstein, MD MPH MSc Pharm EMT-P
Chair, AAEM/RSA Publications & Social Media Committee ●

Phenobarbital for the Management of Alcohol Withdrawal Syndrome

Cody Couperus, MD, Akilesh Honasoge, MD, Samantha Yarmis, MD, and Hannah Goldberg, MD
Editors: Kami M. Hu, MD FAAEM FACEP and Kelly Maurelus, MD FAAEM FACEP

Introduction

Alcohol withdrawal syndrome (AWS) is a common presenting complaint in the emergency department (ED).[1] Most patients with AWS have mild symptoms such as tachycardia, hypertension, agitation, tremors, or diaphoresis, while some progress to develop severe AWS characterized by seizures, hallucinosis, or delirium tremens. Prompt identification and treatment of severe AWS has led to large reductions in mortality from this condition.[2]

Chronic alcohol abuse causes tolerance via down-regulation of the γ-aminobutyric acid (GABA) receptor and up-regulation of N-Methyl-D-aspartic acid (NMDA) and non-NMDA glutamate receptors.[3–5] The treatment of AWS is to increase and gradually taper GABA receptor stimulation—commonly done with benzodiazepines. Chronic ethanol exposure has been shown in some to alter the GABA receptor to exclude the benzodiazepine binding site, a likely mechanism for the development of what has been termed "benzodiazepine-resistant" AWS.[5-6] Phenobarbital is another therapeutic option with multiple potential advantages over benzodiazepines including predictable pharmacokinetics, measurable drug levels, self-tapering due to long half-life, and demonstrated utility in benzodiazepine-resistant AWS.[7,8] The ability of phenobarbital to treat benzodiazepine-resistant AWS is likely due to its inhibition of non-NMDA glutamate receptors and synergy with benzodiazepines at the GABA receptor.[9,10] Yet despite the benefits of phenobarbital, benzodiazepines still remain widely accepted as the first-line treatment for AWS due to concern for barbiturate-induced respiratory depression and sedation.

Question: Is phenobarbital a safe and effective treatment option for alcohol withdrawal syndrome in the ED?

Hendey GW, Dery RA, Barnes RL et al. A prospective, randomized, trial of phenobarbital versus benzodiazepines for acute alcohol withdrawal. *Am J Emerg Med*. 2011;29(4):382-5.

This study was a double-blinded randomized controlled trial comparing intravenous phenobarbital to intravenous lorazepam and oral chlordiazepoxide for treatment of acute alcohol withdrawal. Patients were from two community hospitals with university affiliation in Fresno, CA, with a change in site halfway through due to closure of one hospital. Included patients had known or suspected alcohol withdrawal, which was defined as "tremulousness, nausea and vomiting, and hyperadrenergic manifestations occurring in a habitual alcohol user in the setting of abstinence from ethanol, without any other probable cause." Exclusion criteria were age < 18 years, severe symptoms or intoxication precluding informed consent, pregnancy, significant comorbid medical illness, and allergy to study medications. Clinical Institute Withdrawal Assessment (CIWA) scores were recorded at baseline and every 30 minutes thereafter until patients were either admitted or discharged. Patients were randomized to receive lorazepam as needed in 2 mg doses, or phenobarbital with an initial 260 mg dose and 130 mg doses as needed thereafter. Number and timing of doses were decided by the treating physician. Discharged patients in the lorazepam group were given chlordiazepoxide on discharge, whereas those in the phenobarbital group were given placebo pills on discharge. Discharged patients were asked to return at 48 hours to assess symptoms, compliance, and relapse. Outcome measures were efficacy during ED visit and at 48 hours, length of ED stay, final disposition, and relapse rate.

Baseline characteristics (specifically age, sex, and baseline CIWA) were similar between groups. Twenty-five patients were randomized to receive phenobarbital and 19 patients to receive lorazepam; an additional four patients were excluded due to lack of recorded CIWA scores after initial measurement. A mean number of 2.9 doses were received in the phenobarbital group, for a mean total dose of 509 mg. In the lorazepam group, there was a mean of 2.1 doses for a mean total dose of 4.2 mg, with the difference in number of doses between groups reaching statistical significance (p=0.03). Both medications resulted in a significant decrease in CIWA score from baseline to ED discharge, with no significant difference between the groups. There was no significant difference in rates of admission to the hospital or in ED length of stay. Eighteen patients completed the 48-hour follow-up, with no significant difference in relapse rate, compliance, or CIWA scores.

A limitation of this study was the small sample size, which did not meet the a priori power analysis performed requiring 23 patients in each group and likely limited the ability to find differences between the two treatment groups. Another major limitation was the exclusion of severely ill or altered patients; while understandably difficult to include given inability to provide informed consent, this omission limited information about treatment efficacy in an important demographic. Exclusion of patients with "significant comorbid medical illness," which was not defined by the study authors, could also have significantly impacted the results. Low follow-up rates, while not surprising in this patient population, may have biased the results, and the authors do not describe any attempts made to encourage follow-up such as phone calls to patients. Lastly, the decision to defer the number and timing of doses to the treating physician, rather than following a standardized protocol, e.g. one based on CIWA scores, may have led to increased variability in treatment and low reproducibility of results.

In conclusion, this study provides evidence that phenobarbital is an effective treatment for alcohol withdrawal in the emergency department. The authors note that usual practice at their institution is to provide

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chlordiazepoxide on discharge, a practice deemed unnecessary in the phenobarbital group due to longer phenobarbital half-life; similar symptom control was demonstrated between groups at 48 hours. For mild alcohol withdrawal in patients discharged from the emergency department, phenobarbital alone while in the ED without an outpatient taper may be sufficient.

Rosenson J, Clements C, Simon B, et al. Phenobarbital for acute alcohol withdrawal: a prospective randomized double-blind placebo-controlled study. *J Emerg Med.* 2013;44(3), 592-8.

This single-center prospective, randomized, double-blind, placebo-controlled study sought to evaluate the efficacy and safety of a treatment protocol utilizing a single initial dose of phenobarbital prior to symptom-based treatment with lorazepam. The investigators included any nonpregnant adult being admitted to the hospital with the primary diagnosis of acute alcohol withdrawal requiring inpatient management. Major exclusion criteria were previously known severe hepatic impairment, allergy to necessary medications, and inability to obtain IV access. Patients with altered mental status were included with an initial waiver of study consent and written consent was obtained later once the patient regained decision-making capacity. The study was blinded to all providers and randomization was performed at the pharmacy. The intervention group received a single dose of IV phenobarbital at a dose of 10 mg/kg in a 100 mL normal saline bag while the control group received a single dose of 100mL normal saline. Both interventions were infused over 30 minutes and visually identical to the providers. All patients were monitored on cardiac telemetry and continuous pulse ox while in the ED but were subsequently admitted to either the ICU, telemetry unit, or non-telemetry floor wards.

A total of 198 patients were initially enrolled (100 receiving phenobarbital, 98 receiving normal saline), although 96 total patients were excluded after enrollment due to a combination of declining consent, not being admitted, not having AWS as primary diagnosis, or having incomplete data. In the end, 51 patients receiving phenobarbital and 51 control patients were included in the final analysis. The final study population was similar between both groups. They were largely male (90% phenobarbital vs 88% control) and middle aged (46 vs 48 years old). Most patients were tachycardic with tremors and an assortment of other symptoms were similar between the groups. There was more altered mental status in the control group (58 vs 68%). The median time to initial lorazepam administration was 84 minutes in both groups, while time to intervention was similar (144 minutes vs 150 minutes).

The phenobarbital group had a significantly fewer ICU admissions (8% vs 25%, ARR 17%; 95% CI 4-32), less total lorazepam given (26 vs 49mg, 95% CI 7-40), and fewer continuous lorazepam infusions required (four vs 31, 95% CI 14-41). There were no differences in adverse event rates including need for intubation (2% in both groups), seizures (2% vs 4%), or need for bedside sitter (28% vs 22%). In the phenobarbital group there were trends towards lower restraint need (29 vs 45%) and decreased total length of stay (76 vs 118 hours) but these did not meet statistical significance.

The study is limited by its small size, which may have contributed to the lack of statistical significance in the decreased restraint and length of stay findings. In addition, the study's enrollment criteria only allowed inclusion of approximately a quarter of the total number of patients who presented to the ED with symptoms of alcohol withdrawal (n=460), limiting the validity and generalizability of the results.

Overall, the results suggest that a single dose of phenobarbital early on in a patient's hospitalization for acute alcohol withdrawal is not only effective at reducing ICU admissions, but also reduces benzodiazepine requirement without increasing adverse events.

Oks M, Cleven KL, Healy L. et al. The safety and utility of phenobarbital use for the treatment of severe alcohol withdrawal syndrome in the medical intensive care unit. *J Intensive Care Med*. 2020;35(9), 844-50.

This was a retrospective single-center study evaluating the efficacy and safety of an institutional protocol utilizing phenobarbital in the treatment of severe AWS. It included patients treated for severe AWS, defined as a Clinical Institute Withdrawal Assessment (CIWA) score >15, in the medical intensive care unit (MICU) between 2011 to 2015. Patients were admitted from both the general medicine floor and the emergency department; management in those units prior to MICU admission was with benzodiazepines. The MICU protocol for phenobarbital use during the study period was 130 mg IV every 15 minutes until effective, which was defined as a Richmond Agitation Sedation Scale (RASS) score of 0 to -1. The primary endpoint for safety was rate of phenobarbital-related respiratory failure requiring mechanical ventilation.

In total, data was collected for 86 patient encounters in 81 different patients; two patients accounted for multiple encounters. No phenobarbital was administered prior to MICU admission. In 74/86 of the patient encounters, patients initially requiring benzodiazepines did not require additional doses after MICU admission. In 17/86 (19.8%) encounters the patient required mechanical ventilation, although none were reported to be solely due to phenobarbital-induced respiratory depression. Reported reasons for intubation included obtundation prior to phenobarbital administration, need for airway protection in the setting of upper GI bleed, seizure, aspiration pneumonia prior to MICU admission, cardiac arrest, hypercarbic respiratory failure from chronic obstructive pulmonary disease, and hepatic encephalopathy. There was no statistically significant difference between the quantity of phenobarbital provided to patients who required mechanical ventilation compared to the patients who did not (2075 +/- 2185 mg vs. 1954 +/- 1344 mg respectively, P <0.97). The study authors reported 100% effective management of AWS utilizing phenobarbital while in the MICU, with a mean duration of therapy of 5.2 days (+/- 2.9). Specific data for RASS were not reported.

The retrospective, observational nature of the study inherently limits the ability to fully evaluate safety, as does the lack of a control group.

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The authors concluded that because the quantity of phenobarbital administered to patients who required mechanical ventilation did not differ significantly from those who did not, phenobarbital did not play a role in the need for mechanical ventilation. There was no information provided, however, on timing of phenobarbital administration in relation to benzodiazepines already given, data that would be useful to have as it is widely accepted that phenobarbital and benzodiazepine combination therapy without dose adjustment may increase risk of respiratory depression. It is also unclear how much of the phenobarbital administered in the intubated group was given before or after intubation, and serum phenobarbital levels were not obtained. Additionally, the study evaluated only the need for mechanical ventilation, a very important clinical endpoint but one that limits the ability to comment on other less severe levels of respiratory depression.

The authors conclude that IV phenobarbital can safely and effectively be used to manage severe AWS in the ICU. The data provided in the study suggest safety specifically regarding risk of intubation but further prospective controlled studies are required to better assess optimal dosing strategies and overall safety.

Discussion

Current evidence supports the use of phenobarbital as an alternative, rescue, or adjunctive therapy to benzodiazepines for the management of acute alcohol withdrawal. There is currently no clinical data to support the use of one over the other, but emergency providers should consider reaching for the phenobarbital in benzodiazepine-resistant AWS. Although the optimal dosing regimen has not been identified for AWS, the trials included here suggest the safety of a monotherapy dosing strategy employing a 260 mg IV loading dose followed by 130 mg IV to effect or adjunctive strategy of 130 mg IV every 15-30 minutes to effect with or without a 10 mg/kg loading dose. These regimens are only two of the several studied, and other existing studies suggest phenobarbital doses up to 20-30 mg/kg of ideal body weight do not result in sedation or respiratory depression that would require intubation,[11,12] although more cautious dosing is advised when combining barbiturate and benzodiazepine therapies to avoid compounded respiratory depression. Physicians should also keep in mind phenobarbital's cytochrome p450 induction effects, which can lead to increased clearance of various antimicrobials, antiretrovirals, and other medications. Additional prospective data for phenobarbital use are needed, and we await the results of the ongoing PARTI (Phenobarbital vs Ativan for Alcohol Withdrawal in the Intensive Care Unit) trial.

Question: Is phenobarbital a safe and effective treatment option for alcohol withdrawal syndrome in the ED?

Answer: Yes. The available evidence supports the efficacy and safety of phenobarbital for the management of acute alcohol withdrawal, with demonstrated benefits for patients with severe symptoms or benzodiazepine-resistant alcohol withdrawal and no increase in adverse events such as excessive sedation or intubation. Further studies are warranted to suggest optimal dosing regimens. ●

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How to Become an Expert in Marketing Just in Time for Application and Interview Season

Ashley Iannantone, MA

September marks a special, incredibly stressful milestone in the journey of fourth year medical students. This month we will submit our ERAS applications to be reviewed by residency programs across the country. For the past three years, we have tackled both pre-clinical and clinical training in medical school—first becoming experts in studying anatomy and pathophysiology and later becoming experts in patient care. Now, however, we must become experts in a completely new field: Marketing.

Application and interview season is all about finding your target audience and marketing yourself to it. Dr. Miko Rose (an Assistant Professor in the Department of Psychiatry at Michigan State University) has a great webinar called "Getting into the Residency of Your Dreams," in which she talks about this exact topic. She uses a metaphor comparing medical students applying to residency as different items that one might be trying to sell—her example is a "pair of bright red patent leather shoes." She notes that not everyone in the world is going to want this pair of shoes, but there are definitely people out there who will. The same holds true for medical students in search of residency programs—some programs are looking for exactly the type of applicant that you are. The question then becomes: How do I find these specific residency programs (my target audience) and how do I then market myself to them?

FIRST, DO YOUR RESEARCH

This is where you really get to know your target audience. You should know the culture of the programs you're applying to and what is most important to them: Is it research? Or compassionate care for underserved populations? Or advances and innovations in medical technology? You should also know the people who make up the program: the program director, assistant program directors, program coordinator, etc. Knowing these details will help you show how you're a good fit for that specific program. Which brings us to the second point:

ESTABLISH YOUR PERSONAL BRAND

Many fields, but especially emergency medicine, have experienced a significant increase in the number of applicants and subsequent increase in competitiveness over the past few years. It can be very easy for applications to blend together when everyone has similar board scores, participates in largely the same activities, and receives comparable clerkship grades. Identifying your own personal signature strength and bringing that to the forefront of your application helps you remain unique and memorable. Some examples are bravery, kindness, loyalty, creativity, curiosity, humor, leadership, spirituality, and hope; but regardless of which applies to you, make it the theme of your application. Highlight that strength in the stories you tell in your personal statement, let your experiences show how this strength changed or grown throughout medical school, and let it shine through in your hobbies/activities section. If you build your application on this foundation, you will set yourself up for a meaningful interview season. Then there's just one last thing to remember:

ABOVE ALL ELSE, BE AUTHENTIC TO YOURSELF

Go through your application line by line and ensure you can genuinely and passionately speak about each item, whether it be an experience, hobby, or award. Before each interview, take a deep breath and remind yourself that you are where you are for a reason. Then walk into the room with your best foot forward and just be yourself. This is how you can guarantee you'll end up at a program that will best serve you.

Good luck to all my fellow EM applicants—my future colleagues—in the upcoming application and interview cycle. I wish you all the best of luck! ●

A Look at Our Tribe

Andy Walker, MD MAAEM

Ethnology (noun): a branch of cultural anthropology dealing chiefly with the comparative and analytical study of cultures. broadly : cultural anthropology.[1]

Many months ago a close friend and fellow bibliophile gifted me with a book called *Unintended Consequences of Electronic Medical Records: an Emergency Room Ethnography*, **by Barbara Cook Overton (Lexington Books, 2020). For years he had listened to me complain about the EMR, calling it the worst thing ever to happen to American medicine. I suppose he thought that a rigorous look at EMRs that validated my feelings would ease my pain.**

I was in no hurry to read a book with such a boring title, and besides, I didn't need anyone to tell me about the damage EMRs had done to physicians – especially emergency physicians – as well as patients. I wish now I had read it sooner and I highly recommend it to all those who work in America's emergency departments, whether physician, nurse, or midlevel provider. I really wish every hospital administrator in the country would read it too but they are a lost cause.

What makes the book so interesting is not its detailed and accurate accounting of how EMRs have damaged those who work in our nation's emergency departments and endangered, injured, and even killed patients, but the author's approach to studying the doctors, nurses, and midlevels who work in EDs. Overton is the wife of an emergency physician and what turned into the book started as her PhD thesis in ethnology. She wound up spending several years studying urban, suburban, and rural EDs in Louisiana. Or more accurately, she studied the people who work in those EDs as though they were members of an exotic, newly discovered tribe. Seeing ourselves that way – through sympathetic eyes but as members of a foreign culture with its own language, customs, and beliefs – is fascinating and makes for an entertaining read. That is the main reason I recommend the book to emergency physicians. There are also some lively interviews with prominent emergency physicians such as Peter Viccellio and Rick Bukata, who gave Overton the title for her book's introduction when he called EMRs "inventions of the devil."

The book has value for other reasons too, though. It teaches important lessons for both patient care and hospital finances. In fact, the last chapter before the brief conclusion is "Implications and Suggestions," with separate sections specifically directed at patients, physicians, EMR designer/vendors, and most importantly, hospital administrators. I also think that someday this book will be an important work of history. Even now, some of you reading this are too young to remember what practicing emergency medicine was like before the HITECH Act of 2009 forced EMRs on us before the technology was ready, and perhaps even worse, took all concern for customer (end-user) satisfaction out of the equation at the same time. You have no idea just how fast and easy it was to dictate an ED chart and write orders on paper, and can't begin to imagine what EDs were like then. It is like looking at an expansive grassland in Nebraska and trying to imagine what it was like 200 years ago, covered with buffalo, or looking **at the southern** Appalachians in the spring and trying to imagine how they looked a century ago, when one third of the trees were chestnuts and all were in bloom. The EMR completely changed how doctors and nurses interact and work in the ED and this book shows you how.

Finally, a personal note. In reading this book, especially its section on scribes, and reflecting on my own experiences with a variety of EMRs, I have a suggestion Overton missed for reversing the damage done by EMRs. There is one simple, cheap, easy thing hospital administrators could do that would allow physicians to spend more time at the patient's bedside, increase patient satisfaction along with physician wellness, increase physician productivity as well as patient flow and revenue, and cut costs by

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> "I was in no hurry to read a book with such a boring title, and besides, I didn't need anyone to tell me about the damage EMRs had done to physicians – especially emergency physicians."

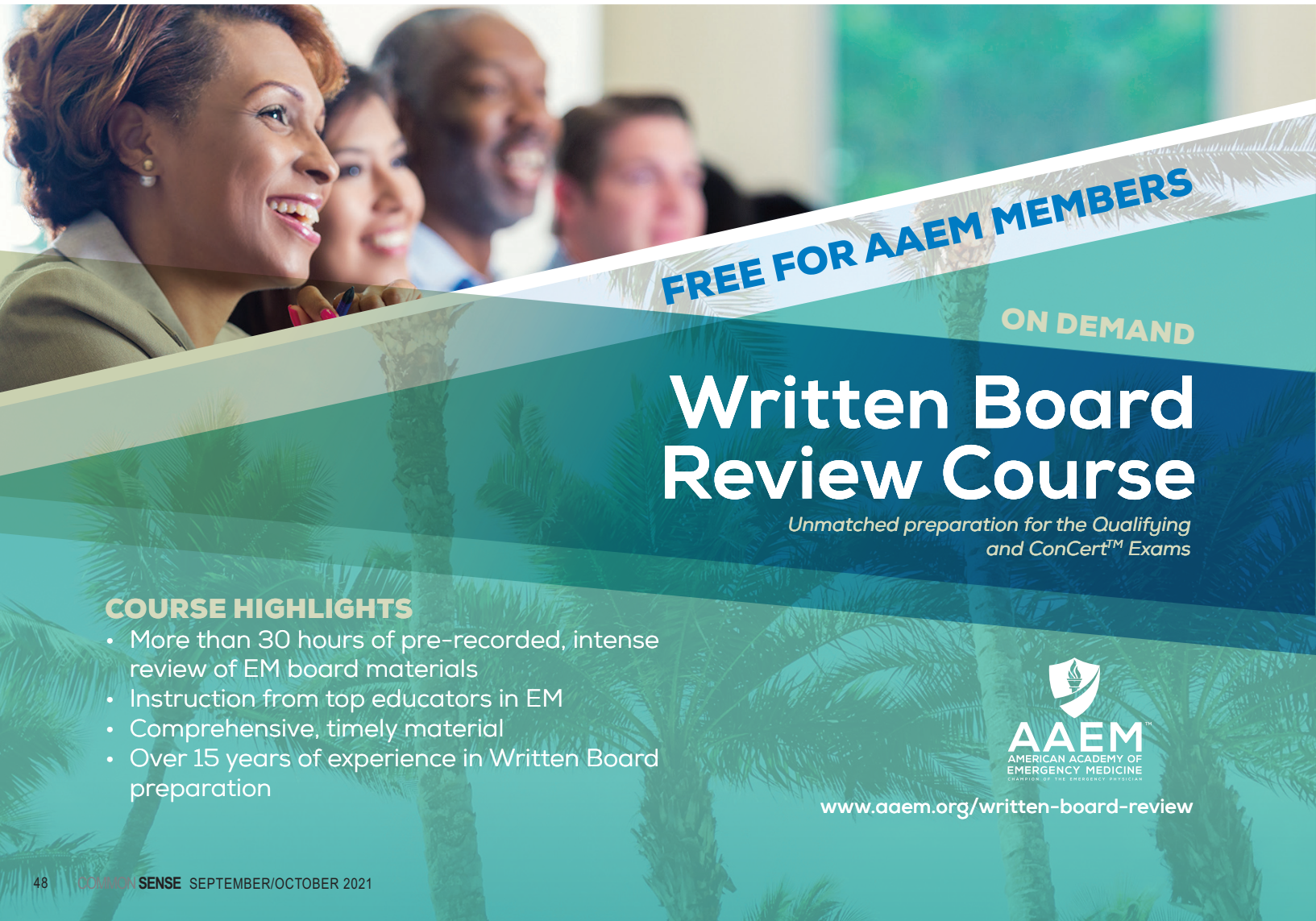
eliminating the need for scribes: resurrect the unit clerk. The unit clerk or secretary was essentially a scribe who did no charting at all but entered all physician orders into the computer. He or she was a true expert in physician order entry – far faster and more efficient than "computerized physician order entry" (CPOE). After all, the charting part of the EMR isn't so bad or time consuming, especially if the EMR has voice recognition capability and customizable templates. It is the CPOE function that is so dangerous, slow, and infuriating. Using paper, I can write all the orders I need (IV fluids, drugs, lab tests, radiology studies) in literally seconds. Using CPOE those same orders take several minutes, and when multiplied over 20-30 patients in a shift that difference becomes huge. And that assumes the computer will even let me order what I want. Sometimes what I want cannot be done via CPOE and I have to call the lab or pharmacy or radiology to arrange a work-around. With paper orders the unit clerk handles that and I am through in seconds and moving on to the next patient. Turning the most expensive person in the ED (the emergency physician) into a data entry clerk was always an insane idea and by far the worst part of the EMR. And why have a scribe for every physician when one (or maybe two) for the entire ED will work even better if they can enter orders? The increased physician productivity will more than pay for the position.

BRING BACK THE UNIT CLERK! ●

Reference

1. Definition of Ethnology by Merriam-Webster

"Seeing ourselves that way – through sympathetic eyes but as members of a foreign culture with its own language, customs, and beliefs – is fascinating and makes for an entertaining read."



September Board of Directors Meeting Summary

2021-2022 Elected Board of Directors

September Board of Directors Meeting Summary

The members of the AAEM Board of Directors met in-person at the AAEM National Office in Milwaukee, WI on September 16, 2021, to discuss current and future activities. The members of the Board of Directors appreciate and value the work of AAEM committee, section, interest group, and chapter division members and chairs as they strive toward the AAEM mission and to be the specialty society of emergency medicine. Over the course of the meeting, a number of significant decisions and actions were made. Here are the highlights:

Presentations

President Lisa A. Moreno, MD MS MSCR FAAEM FIFEM presented her President's report which highlighted the many activities that she and other leaders have been involved in. Highlights of the report included leadership meetings with other emergency medicine organizations, residency visits, and the launch of "Stop the Stigma EM." This coalition of emergency medicine organizations have come together to form an EM Mental Health Collaborative to stimulate education, awareness, advocacy, and policy action related to breaking down barriers to mental health care in EM.

Treasurer Robert Frolichstein, MD FAAEM reported on AAEM and AAEM subsidiaries financial performance through July 31, 2021. He reported that while expenses are still being finalized from AAEM21 Scientific Assembly, membership is doing well and other expenses have been controlled. Overall, AAEM is in a very good financial situation.

Approvals

A number of approvals took place during the meeting including:

- a 25% discount on annual full-voting membership fees for active-duty military members
- the formation of a Simulation Interest Group
- the Diversity, Equity, and Inclusion (DEI) Committee transition to Section status becoming the Justice, Equity, Diversity, and Inclusion Section (JEDI)
- a new CPC Statement on Palliative Care in the ED
- a MOU (project collaboration) between AAEM and the American Society of Regional Anesthesia (ASRA)

Miscellaneous

In addition, the board approved a new "Take Action Now" advocacy program which includes a new advocacy action center on aaem.org which will allow members to more easily advocate themselves. Check it out now and visit: https://aaem.quorum.us/home/ ●

The Next Board of Directors Meeting

When

November 10, 2021

Where

Newark, NJ

AAEM Job Bank Service

Promote Your Open Position

To place an ad in the Job Bank:

Equitable positions consistent with the Mission Statement of the American Academy of Emergency Medicine and absent of restrictive covenants, will be published (upon approval). All ads run for a six month period or until canceled and will appear in the AAEM member magazine *Common Sense* and online. For pricing and more information visit www.aaem.org/membership/benefits/job-bank.

Complete a Job Bank registration form, along with the Criteria for Advertising Section, and submit payment. If you are an outside recruiting agent, the Job Bank Criteria for Advertising must be downloaded and completed by a representative from the recruiting hospital/group.

Direct all inquiries to: www.aaem.org/membership/benefits/job-bank or email info@aaem.org.

Positions Available

For further information on a particular listing, please use the contact information listed.

Section I: Positions in full compliance with AAEM's job bank advertising criteria, meaning the practice is wholly-owned by its physicians, with no lay shareholders; the practice is equitable and democratic; due process is guaranteed after a probationary period of no more than one year; there are no post-employment restrictive covenants; and board certified emergency physicians are treated equally, whether they achieved ABEM/AOBEM/RCPSC certification via residency training or the practice track.

Section II: Positions that cannot be in full compliance with AAEM's job bank criteria, because they are employee positions with hospitals or medical schools and the practice is not owned by its emergency physicians. Thus there may not be financial transparency or political equity.

Section III: Positions that cannot be in full compliance with AAEM's job bank criteria, because they are government or military employee positions. The practice is not owned by its emergency physicians, and there may not be financial transparency or political equity.

Section IV: Position listings that are independent contractor positions rather than owner-partner or employee positions.

SECTION I: POSITIONS RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA

INDIANA

South Bend Emergency Physicians, Inc. is a stable, democratic, 30 member group seeking additional BC/BE Emergency Physicians. 60K visits, Level II Trauma Center, double, triple and quad physician coverage at Memorial Hospital of South Bend. We also have single coverage at a 10K visits suburban branch small, acute-care hospital, as well as single coverage at a 4.5K visits critical access hospital about 20 miles from Memorial Hospital. Equal pay, schedule and your voice is heard from day one. Over 450K total package with qualified retirement plan; group health plan and disability insurance, CME reimbursement, etc. Favorable Indiana malpractice environment. University town, low cost of living, good schools, 90 minutes to Chicago, 40 minutes to Lake Michigan. Teaching opportunities at four year medical school and with the hospital FP residency program. Contact Jennifer Burks, Practice Manager, jburks2@r1rcm.com (PA 1859)

SECTION II: POSITIONS NOT RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA

(Below are hospitals, non-profit or medical school employed positions.)

ILLINOIS

The University of Illinois College of Medicine Rockford is seeking an innovative educator for a 12-month, full-time faculty position. The selected individual will be responsible for teaching and directing the Doctoring and Clinical Skills course, a fundamental course on history-taking, physical examination, clinical reasoning, and professionalism, which extends throughout the first 2 years of medical school. To apply please visit https://jobs.uic.edu/Rockford. For fullest consideration, please apply by 3/16/2021. Applications will be accepted until 4/16/2021. The ideal applicant will have an MD/DO or its foreign equivalent in primary or emergency care specialty. (PA 1848)
Email: mquinte3@uic.edu
Website: https://rockford.medicine.uic.edu

KENTUCKY

NEW EMERGENCY MEDICINE PHYSICIAN OPPORTUNITY IN OWENSBORO, KY Owensboro Health Medical Group is seeking additional Board-Certified/Board-Eligible Emergency Medicine (ABEM, AOBEM) physicians. Join our team of 12 physicians and 6 NPs/PAs who welcome an average of 50,000-55,000 annual ED visits. Our 40 bed, level 3 trauma unit is located in a cutting edge facility licensed for 477 beds where patient experience and quality care drive every decision for the 500,000 population we serve. • $385,000 Guaranteed Base Compensation • $50,000 Potential Engagement Bonus Compensation • $35,000 Upfront Bonus • $25,000 Student Loan Forgiveness annually (total of $50,000) • 186 Nine hour shifts annually (PA 1850)
Email: jerry.price@owensborohealth.org

LOUISIANA

Emergency Medicine Physicians The Department of Emergency Medicine at Ochsner Medical Center in New Orleans, Louisiana is a well-established department that sees 75,000+ visits/year as a tertiary referral center for the larger Ochsner Health System. The department welcomed its first class of Emergency Medicine Residents in 2020 and also has seen continued rapid growth in the clinical enterprise. The department is in search of American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine certified/eligible physicians, preferably with fellowship/additional niche training, who can further grow the diversity of excellence within the academic department. Interested applicants should send Cover Letter / Curriculum Vitae to the Department Chair, Nicole McCoin, MD, at nicole.mccoin@ochsner.org. (PA 1863)
Email: morgan.aymond@ochsner.org
Website: https://ochsner.wd1.myworkdayjobs.com/en-US/OchsnerPhysician/job/New-Orleans---New-Orleans-Region---Louisiana/Physician--Emergency-Medicine--All-Regions_REQ_00022121

NORTH CAROLINA

Wake Forest Emergency Providers is currently seeking to add to our team of exceptional patient-centered emergency physicians due to expansion and growth resulting from our joining together with Atrium Health as a single enterprise. Opportunities exist in Central/Western NC, as well as Charlotte, NC, beginning as early as November 2021. We are open to experienced emergency medicine residency trained physicians as well as recent graduates for these positions. Wake Forest Emergency Providers offers a unique employment model inclusive of comprehensive benefits, local influence on practice decisions, and a strong provider voice in care delivery. (PA 1866)
Email: michael.ginsberg@wakehealth.edu
Website: http://www.wakehealth.edu

NORTH CAROLINA

Wake Forest School of Medicine's Department of Emergency Medicine has a rare opportunity to join our academic faculty team as an Assistant or Associate Professor in a position with a scholarly focus on Emergency Medicine Diversity, Equity, and Inclusion. This position will be an integral part of our ongoing EM departmental diversity and inclusion initiatives and the successful candidate will take over leadership of our active DEI committee. There are additional opportunities to participate and lead new and ongoing initiatives that will impact patient care in our local community and throughout our learning healthcare system with Atrium Health. (PA 1867)
Email: michael.ginsberg@wakehealth.edu
Website: http://www.wakehealth.edu

WEST VIRGINIA

The Charleston Area Medical Center, Department of Emergency Medicine is seeking a pediatric emergency medicine physician to work at Women and Children's Hospital located in Charleston, WV. This 120-bed dedicated Women and Children's Hospital is a part of a large university-affiliated regional referral center with a drawing population of 562,000. We have in-house Neonatologist with 24/7 coverage in Level III NICU as well as a PICU with pediatric intensivists. Job Requirements by the time of appointment: • MD, DO degree or foreign equivalent degree from an accredited pediatric emergency medicine fellowship program • Board Certification by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine • Eligible for WV Medical License. Benefits include: • Excellent benefits package with generous PTO • Vibrant community • Superb family environment • Unsurpassed recreational activities • Outstanding school systems. To apply, send your CV to carol.wamsley@camc.org. (PA 1860)
Email: carol.wamsley@camc.org
Website: http://www.camc.or_g

SECTION III: **POSITIONS NOT RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA** *(Below are military/government employed positions.)* Non Available at this time.

SECTION IV: **RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA** *(Below are independent contractor positions.)* Non Available at this time.

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AAEM is *the* leader within our field in preserving the integrity of the physician-patient relationship by fighting for a future in which all patients have access to board certified emergency physicians and physician rights are protected.

Member Benefits

Publications
Free subscriptions to the *Journal of Emergency Medicine* and *Common Sense*

Education
Free registration to the Annual Scientific Assembly with refundable deposit and discounted registration for other AAEM events

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Access the AAEM Job Bank, your Advanced Resuscitation Expertise Card (for Full Voting members), and other academic and career-based benefits

Learn more about these and other member benefits at www.aaem.org/membership/benefits

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Membership Categories

Fellow and Full Voting – FAAEM
Dues: $525 Board certified in emergency medicine or pediatric emergency medicine

Associate
Dues: $250 Graduate of an ACGME or AOA approved emergency medicine training program and not yet taken or passed your EM board

Save $100 your first year out of residency!

Fellow-in-Training
Dues: $75 Graduate of an ACGME or AOA approved emergency medicine training program and currently enrolled in a fellowship

International Member
Dues: $150 Physicians with an interest in emergency medicine who practice outside of the United States or Canada

Emeritus Member
Dues: $250 Full voting member who has practiced emergency medicine for 30 or more years and has been a full voting member for a minimum of 10 years -or- at least 65 years of age and have been a full voting member for a minimum of 10 years

Special circumstances may lead to a request for emeritus membership and will be reviewed on a case-by-case basis. See www.aaem.org/membership for more information.

Learn more and join today at: www.aaem.org/membership

Group Membership

AAEM offers group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified & board eligible physicians.

100% ED Group Membership
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ED Group Membership
Criteria: Two-thirds of all board certified and board eligible physicians at your hospital/group must be members

Discount: 5% discount on membership dues

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

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AAEM is the leader within our field in preserving the integrity of the physician-patient relationship by fighting for a future in which all patients have access to board certified emergency physicians and physician rights are protected.

It's a challenging time for emergency physicians - AAEM recognizes that and were doing something about it.

- We've continued to fight for your due process rights — AAEM worked closely with the sponsors of newly introduced legislation.
- We've had your back during COVID-19 — Read our position statements and letters to government officials advocating for you during this pandemic.
- We protect your practice rights — We're actively working to address APP independent practice to create a balanced workforce through both position and policy statements.
- We're advocating for a solid future for our specialty - we're working with the newly formed EM Workforce Committee for a future with a balanced work force.
- We're committed to diversity, equity, and inclusion – The AAEM Diversity, Equity, and Inclusion Committee is working hard to bring members resources and awareness, including statement on the Death of George Floyd and the Statement Against Federal Regulation.
- We joined the clear message being sent that #ThisIsOurLane. We are the front line providers, and we will be at the forefront of the solution, which is why we signed on to support AFFIRM.

Learn more at www.aaem.org/whyaaem
Join/renew today: www.aaem.org/membership