

COMMONSENSE

VOLUME 20, ISSUE 3
MAY/JUNE 2013



WWW.AAEM.ORG

INSIDE

President's Message

From the Editor's Desk

Washington Watch

Foundation Donations

AAEM News

Upcoming Conferences

YPS News

AAEM/RSA News

Job Bank



William Durkin, Jr., MD MBA
President



Mark Reiter, MD MBA
Vice President



Kevin Rodgers, MD
Secretary-Treasurer



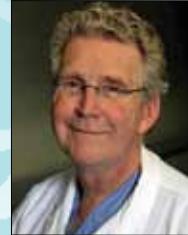
Howard Blumstein, MD
Past President



Robert McNamara, MD
Past Presidents Council
Representative



Kevin Beier, MD
Board Member



John Christensen, MD
Board Member



Mark Foppe, DO
Board Member



David Lawhorn, MD
Board Member



Robert Suter, DO MHA
Board Member



David Vega, MD
Board Member



Andy Walker, MD
Board Member



Leslie Zun, MD MBA
Board Member



Michael Pulia, MD
YPS Director



Meaghan Mercer, DO
RSA President



Stephen Hayden, MD
Editor, *JEM*—Ex-Officio
Board Member

AAEM PEARLS of WISDOM

ORAL BOARD REVIEW COURSE

Sept. 18-19 and 21-22
2013

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

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

2013
BOARD OF DIRECTORS



Officers

President

William T. Durkin, Jr., MD MBA

Vice President

Mark Reiter, MD MBA

Secretary-Treasurer

Kevin Rodgers, MD

Immediate Past President

Howard Blumstein, MD

Past Presidents Council Representative

Robert M. McNamara, MD

Board Of Directors

Kevin Beier, MD

John Christensen, MD

Mark Foppe, DO

David Lawhorn, MD

Robert E. Suter, DO MHA

David D. Vega, MD

Andy Walker, MD

Leslie Zun, MD MBA

YPS Director

Michael Pulia, MD

AAEM/RSA President

Meaghan Mercer, DO

Editor, JEM

Ex-Officio Board Member

Stephen R. Hayden, MD

Executive Director

Kay Whalen, MBA CAE

Associate Executive Director

Janet Wilson, CAE

Common Sense Editors

Andy Walker, MD, Editor

Mark Patrick Doran, DO, Assistant Editor

Edward Siegel, MD, Resident Editor

Laura Burns, Managing Editor

COMMONSENSE

Table of Contents

President's Message	3
From the Editor's Desk	4
Letter to the Editor	6
Washington Watch	7
Foundation Donations	10
Blast from the Past – New!	11
Upcoming Conferences: AAEM Sponsored and Recommended	16
AAEM News	
The Business of Emergency Medicine	18
Higher-Complexity ED Billing Codes	19
PEMC Update	22
Committee Reports	24
State Chapter Reports	27
Young Physicians Section News	
YPS President's Message	28
There is More Than One Way to Care for a Patient	29
AAEM/RSA News	
AAEM/RSA President's Message	33
Resident Journal Review: Assessing Fluid Responsiveness in Resuscitation	35
Medical Student Council President's Message	37
Job Bank	39

AAEM Mission Statement

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

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

Membership Information

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

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

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

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

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

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

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

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

International Resident Member: \$25 (voting in AAEM/RSA elections only)

Student Member: \$25 or \$55 (voting in AAEM/RSA elections only)

International Student Member: \$25 (voting in AAEM/RSA elections only)

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

Pay dues online at www.aaem.org or send check or money order to:

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

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

AAEM is a non-profit, professional organization.

Our mailing list is private.



President's Message

Stress and Burnout

William T. Durkin, Jr., MD MBA FAAEM

While coming back from a recent residency visit, I was catching up on some reading. I came across two articles back-to-back referencing surveys, which listed emergency medicine as the most stressful specialty. The next article detailed a survey where "burnout" was highest amongst emergency docs. It was surprising to me that ours was the most stressful specialty, but not at all surprising to see we had the highest rate of burnout.

We see the gamut of medical problems, most are not life-threatening. Many of us pride ourselves on being able to respond quickly and decisively to those situations where our expertise and training come into play to truly save a life. We find that a very rewarding experience; that is why we chose EM. I have heard many remark that they wish they had those kinds of cases more frequently, rather than the run of the mill belly pains and the like. Family and friends usually remark that our job must be stressful, but I think most of us would admit that, most days, it is fairly routine. The stressors are not what the lay public thinks they are.

Many of the things creating the most stress are extrinsic to the practice of medicine itself. One of the biggest stressors for younger physicians is the crushing debt many have. In my informal survey among the programs where I have spoken, the average resident has a debt of around \$225,000. Essentially, starting out with a mortgage. Because of this, many seek the highest paying job rather than a job that may start them out at a lower rate for a couple of years but offer an ownership opportunity. Some CMGs offer a stipend during the final year of training in exchange for a commitment post-grad. In many instances, the jobs are in understaffed facilities where it is unusually stressful. I know of other physicians who work extraordinary hours in order to get a jump on debt. Over time, this will definitely be stressful and contribute to burn out. I have talked with three physicians since the beginning of the year that have only been out of residency for four years or less and have already had a bad experience with such groups. Unfortunately, they have now soured on the specialty itself.

Other sources of "stress" are all of the extraneous issues we are all forced to deal with on a daily basis: social issues, drug seekers, lack of back up support, keeping satisfaction scores up, keeping wait times down. I often think that a rotation through social services should be a mandatory part of any training program, as it seems that is all I have been dealing with some days. Some expect the ED to handle all of society's ills. Those cases are definitely time consuming and take up considerable resources. Our volumes are forecasted to increase as the ACA takes effect. In most businesses, an increase in traffic would be a quality problem. In ours it can be a mixed blessing as many of these patients will pay at Medicaid rates that, in many states, do not cover the cost of seeing them. So, we will need to become more efficient, which can be stressful.

So, while we may not be able to control all of the "stressors," what can we do to prevent the high rate of burn out? I have a few suggestions.

First, live on less than you bring home. Maximize your retirement contributions and savings plans. I recently read an article by a physician who continued to live as he did while a student and squirreled away a considerable sum over a few years, enabling him to retire at age 40. Not so sure many of us would be willing to go to that extreme but he does make a good point: live on less and save as much as you can. That way, you have options in 10 or 20 years.

Next, understanding that our job entails working nights, holidays, and weekends; value your free time. Do things with your spouse, family, and friends. Get out there and enjoy your hobbies and those who are close to you. If it helps, schedule the time and do not cancel that "appointment." Be there for the important events in your child's life. They should not consider you a stranger. Make that day off count!

Do not work for those that will take advantage of or treat you as a "cog in the wheel." Ideally, you should be in a group where you have ownership in the practice or have an opportunity to be recognized for your contributions to the medical group or institution. Of course, this means that you have to be willing to contribute and help make that institution a better place. Avoid employment situations where they take all you have to give yet give nothing back.

Try to minimize the external stressors, be smart with your finances, contribute to your institution and/or make your specialty better, and make your days off count. Those are a few guidelines that have helped me during my career and kept me interested. I hope that many of you find them helpful so that you have long and fruitful careers and don't get too stressed or burnt out!

Coming to your ED ... a pediatrician?

As this goes to press, we have been made aware of the fact that there is a provision in the ACA that allows for a pediatrician who sees a child in the ED to be paid more than the EP who sees the same child. A few hospitals are now trying to capture those funds by hiring a pediatrician to work in the ED. We have been working with Williams and Jennings, our lobbyist, on a congressional fix for this issue. Since it is already written in the regulations, Congress will need to pass a law if we are to overturn this. I am also reaching out to the other organizations within our specialty. Stay tuned! ■

Contact the President: president@aaem.org

Zen and the Scientific Assembly

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



I have been going to emergency medicine meetings for well over 20 years. AAEM Scientific Assemblies, ACEP Scientific Assemblies, board review courses, literature updates, lawsuit avoidance courses, Mediterranean and Pan-Pacific Emergency Medicine Congresses, and even courses on how to be a better expert witness. Roughly 15 years ago I realized that the AAEM Scientific Assembly was the best emergency

medicine meeting in the world. Even knowing that, I was amazed at the quality of the Academy's 2013 Scientific Assembly in February. It went beyond technical quality. It was the most inspirational meeting I have ever attended.

The conference opened with a keynote address by James Keaney and comments from Scott Plantz, the founders of AAEM, in celebration of the Academy's 20th year. Dr. Keaney may still be better known by the pen name under which he wrote *The Rape of Emergency Medicine*, The Phoenix. They made me realize that, despite the threats our specialty and those who practice it face, we have indeed made progress over the last 20 years — there is reason for hope.

Dr. Durkin's state of the Academy update, during the business meeting on the last full day of the conference, gave me additional confidence in the future of AAEM, emergency medicine, and those emergency physicians who want to control their own practices and be treated fairly. I encourage more of you to attend the annual business meeting. You will be briefed on the membership, finances, and activities of AAEM; hear from the candidates for office; vote on those candidates; and come away with a greater sense of involvement in our Academy. One of the important differences between AAEM and ACEP is the Academy's simple, clear, direct system for choosing its leaders: one member, one vote. Direct democracy that puts all the power, and the responsibility that goes with it, completely in the hands of the members. When you come to the annual business meeting, hear the candidates speak, question them, and then immediately choose which of them will lead AAEM — with the results announced the very next day — you can see and feel just how important you are to the Academy.

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.

As if meeting and speaking with Jim Keaney wasn't enough, I got to meet another of my medical heroes, Stephen Bergman. Who? Yeah, I didn't know his real name either. Dr. Bergman is better known by his pen name, Samuel Shem, author of *The House of God*. He too gave a keynote address, "Staying Human in Medicine." Although it wasn't planned to do so, it tied in beautifully with Dr. Plantz's talk and Dr. Keaney's speech, "The Past is Prologue: 20 Years After The Rape of Emergency Medicine."

One thing I took away from that address was how healing, real healing, depends on a connection between doctor and patient. Especially in emergency medicine, that connection will be brief, but for the patient to feel cared for — and for the physician to find deep satisfaction in rendering that care — a connection must be made. Think about how dissatisfying, even aggravating or maddening, those encounters are when you can't connect with a patient. All of us suffer through those every day. Sometimes it's our fault. We are focused on screening for acute injuries and real emergencies, getting the trivial crap out of the ED as fast as possible, and generally "moving the meat" rather than healing. When we do find someone who actually needs the services of an emergency physician, we often become focused on meeting our "quality metrics" rather than on the human being with the disease. Time benchmarks for stroke and MI patients, documentation requirements for every patient, pre-procedure sedation forms for patients with fractures or dislocations, etc. — all these things distract us from where our attention should lie. Largely because of outside interference from bureaucrats and administrators, the chart has become more important than the patient. Remember when it was primarily a way to communicate with other physicians who were caring for the patient? Often it is the patient's fault. It's almost impossible to connect with a drug abuser who doesn't want to face his own problem and will leave in a rage unless he gets more hydrocodone or alprazolam. Equally difficult is the malignantly neurotic patient who desperately needs to be in a psychiatrist's office, but instead comes to the ED 30-40 times a year for an endless variety of physical complaints and refuses to consider that those symptoms may be psychosomatic. There are many other examples. I don't have to recite them for you, you see them every day.

As he spoke about the importance of connecting, how to do it and the obstacles we face in trying to do it, Dr. Bergman mentioned the newest barrier to connecting with patients: the electronic medical record (EMR). I found that personally gratifying, since I have been a vocal critic of the EMR for many reasons.

Listening to Dr. Bergman inspired me to buy his most recent book, published in 2008, *The Spirit of the Place*. I just finished it, and recommend it highly. I think it is going to be as important to me in the last phase of my career as *The House of God* was at the beginning. Dr. Bergman has obviously studied Buddhism. He injects several Buddhist

Continued on next page

ideas into the story through the protagonist's girlfriend, who teaches Buddhism. The protagonist becomes a Marcus Welby-style primary care doctor in his small hometown in upstate New York, taking the place of his old friend and mentor, Bill. The passage in which Bill dies is one of the most moving and instructional scenes I have ever read. I challenge you to read it without tears. There isn't a Buddhist word in it, but it's all about how to be open to the brokenness in ourselves and others, how to be fully present with someone else — with their pain and yours, and how to let go and quit grasping. It's about being connected and loving,

forgiveness, and healing. It is a reminder that profound healing can occur even at death. With all due respect to the author (and apologies to Robert Pirsig), the book should have been called *Zen and the Art of Medicine*. I urge you to read it, especially if you are feeling burned out. It is magnificent. And although I don't see how it could beat this year's, I look forward to seeing you in New York at next year's Scientific Assembly — if not this September at the Mediterranean Emergency Medicine Congress in Marseille. ■



NEW: AAEM PODCASTS

AAEM is proud to unveil a new podcast series titled

Emergency Physician Advocates: Medical-Legal Issues in Emergency Medicine

In this podcast series, Larry Weiss, MD JD FAAEM, and Joseph Wood, MD JD FAAEM, discuss timely advocacy issues for the emergency physician. Both contributors are emergency physicians, attorneys, and past-presidents of the American Academy of Emergency Medicine (AAEM). Join them each month as they discuss issues of importance to emergency physicians.

May: Asset Protection for EPs

June: EP Advocacy Issues in the ACA

Other series coming soon!

- Critical Care topics
- Operations Management topics



AAEM Podcasts are available as part of AAEM Connect and on iTunes

AAEM Connect
www.aaem.org/connect



Get the AAEM Fact of the Day and other AAEM Updates.



Letter to the Editor

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

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

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

— The Editor

Andy,

Just finished reading your column in the recent *Common Sense*. As always, fantastic article. This one in particular hit a great note; it echoed exactly why I love AAEM — no matter people's opinions and projects, everyone is genuinely a good person. I'm looking forward to another SA. I was pleased to see you on the ballot again, too — did someone twist your arm? ;)

Also, outstanding reply to the Letter-to-the-Editor. I hope we continue to have strong conversation with readers. It really is great.

— Teresa M Ross, MD

Dear Dr. Walker,

I read your editorial regarding a "Personal View on Burnout" and wanted you to know that it has been reassuring that I was not the only one out there with the same feelings and experiences. I left full time practice of EM in July of 2012 after nineteen years as an "ER doc." I was in academics for seventeen years. I worked the past two years for a great bunch of ER doctors, a fourth of which I had trained with or trained them during their EM residency. After leaving EM, I worked from home for a private audit company on the East Coast for three months and decided it was too mundane for me. I have since worked in an Urgent Care, working four to eight shifts a month. Thank you for putting this into words as I hope other physicians will read it and perhaps find a way to salvage their future with the help of their colleagues and family.

Best Regards,
— Norberto Adame, MD FAAEM

Dr. Adame:

I am glad my editorial helped. Rest assured that you are far from alone. It frightens me that colleagues twenty years younger than you and me feel the same way we do. It is time emergency physicians and hospital administrators realized that most burnout isn't due to a flaw in the physician. It is because of a badly flawed system in which the doctors and nurses, who work in the ED and know best how it ought to work, have the least authority to affect how it does work. Burnout is the inevitable result when good people who aspire to excellence are working in a system that actively pushes them away from excellence, and then blames them for not achieving it.

On a more optimistic note, I seem to have recovered from my burnout and now look forward to going to work again. I am working just 72 hours a month, which helps by itself. More importantly, I believe, I am working in an ED with much better EMR and CPOE software than previously, and with much lower patient volume. I now have time to relax and talk to patients, concentrating on them rather than charting, without feeling crushing pressure to "move the meat" because patients are getting backed up. The majority of my patients still don't have acute injuries or serious medical problems, and many of them are still substance abusers, but that doesn't bother me as much now that I can take the time to see them as human beings, rather than a problem to be checked off my to do list. ■

— The Editor



COMMONSENSE

SUBMIT
YOUR
LETTER



Update on the Congressional Landscape

Williams and Jensen, PLLC

March 1st marked the official beginning of life under sequestration and, generally speaking, Congress is thus far not facing significant pressure from back home to reverse the across-the-board spending cuts. Congress recently completed an agreement to fund the government for the remainder of fiscal year 2013 (September 30th), and these bills factored in the cuts from sequestration. As a result, it appears that sequestration is here to stay, at least for the near-term.

After completing work on funding for the remainder of the current fiscal year, the House and Senate have now begun work on the fiscal year 2014 spending bills. The next big "cliff" is the expiration of the current debt limit agreement, which is set for May 18th. However, legislation to increase the debt ceiling can be put off until July or August once the U.S. Treasury deploys "extraordinary measures" to continue servicing the nation's debt.

Meanwhile, a bipartisan group of senators and representatives are working on immigration reform, and Congress is carefully watching the implementation of major provisions of the Affordable Care Act that are set to take effect in 2013 and 2014. In particular, there is a focus on the health insurance exchanges which are set to begin enrolling individuals on October 1st.

House Ways & Means Committee Chairman, Dave Camp (R-MI), continues to work on tax reform, releasing in March a third discussion draft which focused on small business tax reform. The previous drafts covered the international tax system and financial products. Senate Finance Committee Chairman, Max Baucus (D-MT), has maintained his support for comprehensive tax reform. Overall, prospects for major reform in 2013 remain uncertain.

During the next several months, Congress is expected to devote time to fiscal year 2014 appropriations bills, ACA oversight and reforms, and continued dialogue on areas of bipartisan interest such as tax reform, immigration reform, and cybersecurity. There is still work being done to forge a "grand bargain" agreement that would include entitlement reform and revenues, but such a deal remains elusive due to a fundamental disagreement between the parties on whether or not new revenues should be included as part of the package.

Physicians Take Two Percent Medicare Pay Cut; Congress Weighs Permanent "Doc Fix"

A two percent Medicare pay cut to physicians took effect on April 1st. The cut is a result of sequestration, which did not fully exempt Medicare but instead capped cuts to the program at two percent. The cuts will also impact other payments to Medicare providers, including incentive payments for "meaningful use" of electronic health records (EHRs). Medical groups have cautioned that the cuts may have an outsized impact on their community, because the industry is already contending with other recently enacted spending reductions.

The cut comes at a time when lawmakers are trying to secure a deal on permanent repeal of the Medicare Sustainable Growth Rate (SGR) formula, which will require a roughly 25 percent reimbursement cut in 2014. Current proposals in Congress would offset the cost of a fix with long-term structural payment reforms rather than provider cuts. House Energy & Commerce Chairman, Fred Upton (R-MI), has said he would like to see a permanent repeal bill on the House floor by the end of this summer.

In February, the House Energy & Commerce Committee republicans (jurisdiction over health issues) and the House Ways & Means Committee republicans (jurisdiction over tax/revenue issues) issued a release outlining their efforts to develop the principles of a permanent "doc fix" and physician payment reform. Rep. Michael Burgess, MD, (R-TX), who introduced temporary "doc fix" legislation in the last Congress, called the proposal a "serious step" towards repealing SGR and replacing it with a payment system that preserves access to care. The committees jointly endorsed a three phase process to achieve payment reform: "(1) Repeal the SGR and provide certainty for physicians through 'predictable, statutorily-defined physician payment rates'; (2) Reform Medicare's FFS system to a model that rewards quality of care; and (3) Use the new model to reward physicians who deliver efficient care."

According to the principles set forth by the authors, reform must also:

- "Not increase the deficit;
- Involve the physician community and other stakeholders;
- Foster clinically meaningful (not government determined) care for patients;
- Encourage achievable improvements in quality, efficiency, and patient outcomes based on physician-endorsed measures;
- Be applicable to all specialties, practice arrangements, and geographic locations;
- Reward the value rather than the volume of services;
- Motivate all stakeholders to adopt reforms; and
- Strengthen Medicare for seniors."

Proponents of permanent repeal argue that the cost of this measure was most recently estimated by the Congressional Budget Office (CBO) at \$138 billion, which represents a steep discount from the previous score which came in at \$245 billion. However, there is acknowledgement on both sides of the Capitol that an agreement on how to offset the full cost of repeal may be difficult to achieve by the end of the year.

Government Funding Measure Passes Congress with Senate Modifications

On March 21st, the House gave final approval to the six-month continuing resolution (CR) to fund the government through the end of FY 2013, sending the bill to the President for his signature. Last week, the Senate

Continued on next page

took up H.R. 933, the Department of Defense, Military Construction, and Veterans Affairs and Full-Year Continuing Appropriations Act, 2013. Senate Appropriations Chairwoman, Barbara Mikulski (D-MD), and Ranking Member, Richard Shelby (R-AL), offered a substitute amendment that added three additional appropriations bills, including the FY 2013 Agriculture, Rural Development, FDA, and Related Agencies and FY 2013 Commerce, Justice, Science, and Related Agencies bills.

The Senate considered over a dozen amendments to the legislation, including an amendment that would have increased funding for certain agencies within HHS, but not altered the overall cost of the bill. Among other provisions, the amendment would have provided \$140 million in additional funding for the National Institutes of Health (NIH) over the CR proposed level. The amendment was defeated by a vote of 54-45, with 60 votes required for adoption. An amendment to defund the Affordable Care Act was defeated 45-52.

Many Senators expressed a desire to provide additional flexibility for agencies to deal with across the board cuts resulting from the sequester, but most of these amendments were defeated or not offered out of concern that it would poison the bill's chances in the House.

The Senate approved the legislation by a vote of 73-26, and the House followed by approving the final Senate-passed bill by a vote of 318-109.

HHS Grants Additional Approvals of State Insurance Exchanges; Releases Essential Health Benefits Final Rule

In March, HHS gave conditional approvals to proposed insurance exchanges in Iowa, Michigan, New Hampshire, and West Virginia. According to HHS, the Agency has now conditionally approved of "some form of exchange marketplace" in 24 states and the District of Columbia. Exchanges in the remaining 26 states are expected to be run by the federal government.

Continued on next page

AAEM Written Board Review Course

Unmatched Preparation for the Qualifying Exam and ConCert Exam
August 21-23, 2013 • Hyatt Regency Grand Cypress • Orlando, FL

Comments from Course Participants:

"I feel more prepared than ever before for a board exam."

"It's perfect for busy practicing MDs."

"Excellent, organized approach tips regarding specific test questions."

Course Features:

- Up to 27 hours of intense review of EM board materials.
- Taught by experienced emergency medicine faculty.
- Exceptional value — Includes lunch all three course days.
- Great review of emergency medicine even if you aren't taking your boards.



Named as one of EMRA's Top Written Qualifying Examination Preparation Courses



For more information,
visit www.aaem.org/education/written-board-review-course
or call 800-884-2236

AAEM-0113-714

However, a number of Affordable Care Act proponents in Congress have raised concerns that the six-month spending bill that was signed into law could delay implementation of the exchanges because of the decreased funding levels resulting from sequestration. HHS continues to express optimism that it will meet the October 1st open enrollment deadline for the exchanges.

On February 20th, HHS released a final rule on essential health benefits (EHBs), that health insurers are required to cover under the Affordable Care Act. The rule addresses essential benefits for 10 categories, including emergency services. According to the rule, as part of coverage of EHBs, a health plan must "(1) provide coverage for emergency department services provided out-of-network without imposing any requirement under the plan for prior authorization of services or any limitation on coverage for the provision of services that is more restrictive than the requirements or limitations that apply to emergency department services received from network providers, and (2) apply the same cost sharing in the form of a copayment or coinsurance for emergency department services for an out-of-network provider — as would apply to an in-network provider."

Senate, House Pass Competing Budget Resolutions

On March 23rd, the Senate completed work on the Fiscal Year 2014 Budget Resolution offered by Senate Budget Committee Chair, Patty Murray (D-WA). The resolution was agreed to by a vote of 50-49, with four Democrats joining all 45 Republicans in opposition to the measure. During the "vote-o-rama" that lasted over 12 hours, the Senate called up a total of 101 amendments, and roughly one-fourth were healthcare related amendments.

Notably, the Senate approved: (1) an amendment to repeal the 2.3 percent excise tax on medical devices that was included in the Affordable Care Act; (2) an amendment to fully fund the Biomedical Advanced Research and Development Authority (BARDA) and the BioShield Special Reserve Fund; and (3) an amendment to raise the eligibility age of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) from 23 years to 26 years. Senator Murray offered the Fiscal Year 2014 House Budget authored by Representative Paul Ryan (R-WI) as a substitute amendment, and it failed by a vote of 40-59.

The repeal of the medical device tax, which was offered by Senate Finance Committee Ranking Member, Orrin Hatch (R-UT), and Senator Amy Klobuchar (D-MN), was passed by a vote of 79-20, with 34 Democrats joining all Republicans in support of the amendment.

The underlying budget resolution is non-binding, but proponents of the repeal argue that the vote demonstrates bipartisan support for repeal. The Medical Device Access and Innovation Protection Act (S. 232), which would repeal the tax, currently has 29 Senate co-sponsors. Companion legislation in the House current has 212 co-sponsors. Neither bill specifies how the \$30 billion cost of repeal would be offset.

Meanwhile, on March 21st, the House approved the Fiscal Year 2014 Budget Resolution authored by House Budget Committee Chairman, Paul Ryan (R-WI). The measure was approved by a vote of 221-207, with 10 Republicans joining all Democrats in opposition. In his floor remarks, Chairman Ryan said that the proposal represented a "responsible, balanced budget." He said that Republicans were committed to strengthening Medicare. House Budget Committee Ranking Member, Chris Van Hollen (D-MD), stated that the Ryan Budget "violates important commitments we've made to our seniors." He said that the budget would turn Medicare into a "voucher program."

Overall, Chairman Ryan indicated that his budget would balance in 10 years, reducing the federal deficit by \$4.6 trillion over this time period and preserving sequestration. Chair Murray said that the Senate plan would reduce the deficit by \$1.85 trillion over 10 years, and would undo sequestration using a mix of revenue increases and spending cuts. The House and Senate are not expected to be able to successfully reconcile their budget resolutions.

PAHPA Reauthorization Bill Signed Into Law

In March, President Obama signed into law H.R. 307, the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPA). The legislation reauthorizes several key programs relating to medical countermeasures and public health preparedness. Notably, it provides authorization for the Project Bioshield Special Reserve Fund at \$2.8 billion between fiscal years 2014-2018. Since the program's creation in 2004, funding has been used to help develop vaccines and other medical technologies to enhance public emergency preparedness.

Senator Thune Introduces Emergency Services Bill

In February, Senator John Thune (R-SD) introduced S. 328, the Strengthening Rural Access to Emergency Services Act. The legislation would amend EMTALA to "allow certain critical access hospitals and sole community hospitals to use interactive telecommunications systems to satisfy requirements with respect to having a physician available to stabilize an individual with an emergency medical condition under the Medicare program."

Under the proposal, the federal emergency room staffing requirement is considered satisfied if (1) the physician available by an interactive telecommunications system is board certified in emergency medicine or pediatric emergency medicine and (2) a nurse practitioner or physician assistant is onsite in the emergency department.

House Lawmakers Propose Medicaid Expansion Repeal

On March 25, Representative Matt Salmon (R-AZ) introduced H.R. 1404, the Medicaid Expansion Repeal and State Flexibility Act. The legislation would repeal the Medicaid expansion included in the ACA, and would also repeal ACA's minimum essential coverage requirement for Medicaid "benchmark" benefits. The legislation was introduced with five co-sponsors: Representatives Diane Black (R-TN), Trent Franks (R-AZ), Duncan Hunter (R-CA), Doug LaMalfa (R-CA), and David Schweikert (R-AZ). ■

Recognition Given to Foundation Donors



Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1-1-13 to 3-14-13.

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

Donor

Rebecca K. Carney-Calisch, MD FAAEM
Crystal Cassidy, MD FAAEM
William T. Durkin, Jr., MD MBA FAAEM
Mark Reiter, MD MBA FAAEM

Contributor

Ademola Adewale, MD FAAEM
Paul Ahlers, MD FAAEM
Mobarak A. Al Mulhim, MD MBA FRCPC
FAAEM
Todd Alter, MD FAAEM
Aditya Arora, MD FAAEM
Jonathan D. Auten, DO FAAEM
Garo Balkian, MD FAAEM
Jennifer W. Bellows, MD MPH FAAEM
Brent A. Bills, MD FAAEM
Thomas D. Black, MD FAAEM
Michael L. Blakesley, MD FAAEM
Michael A. Bohrn, MD FAAEM
Peter D. Bosco, MD FAAEM
James K. Bouzoukis, MD FACS FAAEM
Eric W. Brader, MD FAAEM
Antonio L. Brandt, MD FAAEM
Richard D. Brantner, MD FAAEM
J. Allen Britvan, MD FAAEM
David P. Bryant, DO FAAEM
Leo W. Burns, MD FAAEM
Michael R. Burton, MD FAAEM
Bruce R. Bush, MD FAAEM
Anthony J. Callisto, MD FAAEM
John W. Cartier, MD FAAEM
Philip D. Chadwick, MD FAAEM
David C. Chapman, MD FAAEM
Brian Charity, DO FAAEM
Jeanne M. Charnas, MD FAAEM
Frank L. Christopher, MD FAAEM
Steve C. Christos, DO FAAEM
Garrett Clanton, II, MD FAAEM
Justin D. Coomes, MD
Peter B. Cridge, MD FAAEM
Jerry E. Davis, MD FAAEM
Justin B. Davis, MD FAAEM

Anthony J. Dean, MD FAAEM
Francis X. Del Vecchio, MD FAAEM
Manuel J. Delarosa, MD FAAEM
Scot M. DePue, MD FAAEM
Michael M. Dickerson, MD FAAEM
Steven E. Diebold, MD FAAEM
California R. Do, MD FAAEM
Christopher I. Doty, MD FAAEM
Christopher R Dutra, MD FAAEM
Michael S. Euwema, MD FACEP FAAEM
Richard G. Faller, MD FAAEM
Mark A. Foppe, DO FAAEM
Robert J. French, DO FAAEM
Robert A. Frolichstein, MD FAAEM
Paul W. Gabriel, MD FAAEM
Gary M. Gaddis, MD PhD FAAEM
Frank Gaudio, MD FAAEM
Alan M. Gelb, MD FAAEM
Christopher Gerst, MD FAAEM
Kathryn Getzewich, MD FAAEM
Matt Gratton, MD FAAEM
Mary Margaret Green, MD FAAEM
Steven E. Guillen, MD FAAEM
Elizabeth C. Hall, MD FAAEM
Dennis P. Hanlon, MD FAAEM
Carson R. Harris, MD FAAEM
Thomas Heniff, MD FAAEM
Eric Herbert, MD FAAEM
Ronald G. Himmelman, MD FAAEM
Victor S. Ho, MD FAAEM
Kenlyn J. Hobley, MD FAAEM
Robert A. Hoogstra, MD FAAEM
Elizabeth J. Hull, MD FAAEM
Michael T. Imperato, MD FAAEM
Sandra L. Indermuhle, MD FAAEM
Tapiro O. Innamaa, MD
Leland J. Irwin, MD FAAEM
Ralf Joffe, DO FAAEM
Carroll Don Johnson, MD FAAEM
Heath A. Jolliff, DO FAAEM
Shammi R. Kataria, MD FAAEM
Ziad N. Kazzi, MD FAAEM
Gabe D. Kelen, MD FAAEM

John H. Kelsey, MD FAAEM
Kevin P. Kooiker, MD FAAEM
Erik Kulstad, MD FAAEM
Chaiyi Laoteppitaks, MD FAAEM
Stanley L. Lawson, MD FAAEM
Liza Lê, MD FAAEM
Tracy Leigh LeGros, MD PhD FAAEM
Benjamin Lerman, MD FAAEM
Bruce E. Lohman, MD FAAEM
Richard C. Lotsch, DO FAAEM
Ann Loudermilk, MD FAAEM
Eric Lubliner, MD FAAEM
William K. Mallon, MD FAAEM
Christopher K. Marcuzzo, MD FAAEM
Scott P. Marquis, MD FAAEM
John R. Matjucha, MD FAAEM
Andrew P. Mayer, MD FAAEM
Gregory S. McCarty, MD FAAEM
Reagann McCreary, DO FAAEM
Rick A. McPheeters, DO FAAEM
David E. Meacher, MD FAAEM
Carl A. Mealie, MD FAAEM
Sarah Meister, MD
Heather Mezzadra, MD
Gregory R. Micklow, MD FAAEM
Usamah Mossallam, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Sassan Naderi, MD FAAEM FACEP
Vicki Norton, MD FAAEM
Joshua S. Obak, MD FAAEM
Paul D. O'Brien, MD FAAEM
Isaac Odudu, MD
Lillian Oshva, MD FAAEM
Diane M. Paratore, DO FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Jeffery M. Pinnow, MD FAAEM
Matthew W. Porter, MD FAAEM
Brian R. Potts, MD MBA FAAEM
Robert H. Potts, Jr., MD FAAEM
Scott A. Ramming, MD FAAEM
Kevin C. Reed, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Melissa Rice, MD

Howard M. Rigg, III, MD FAAEM
Alberto R. Rivera, MD FACEP FAAEM
Conal Roche, MD
Marc N. Roy, MD FAAEM
Stephen P. Scherr, MD FAAEM
Sarah B. Serafini, MD FAAEM
Richard D. Shih, MD FAAEM
Lee W. Shockley, MD MBA FAAEM
Thomas M. Short, MD FAAEM
Jonathan F. Shultz, MD FAAEM
Robert Sigillito, MD FAAEM
Michael E. Silverman, MD FAAEM FACP
Mark J. Singsank, MD FAAEM
Michael Slater, MD FAAEM
Robert D. Slay, MD FAAEM
Craig A. Smith, MD FAAEM
Marc D. Squillante, DO FAAEM
Robert E. Stambaugh, MD FAAEM
Keith D. Stamler, MD FAAEM
Everett G. Stephens, MD FAAEM
Kenneth C. Stewart, DO FAAEM FACEP
B. Richard Stiles, DO FAAEM
James B. Stowell, MD FAAEM
Robert M. Stuntz, MD RDMS FAAEM
Khanh H. Thai, MD FAAEM
Sarah Todd, MD MPH FAAEM
Mary Ann H. Trephan, MD FAAEM
Thomas C. Van Der Heyden, MD FAAEM
Rex Villanueva, DO
Christopher P. Visser, MD FAAEM
Julie K. Wachtel, DO MPH FAAEM
Roland S. Waguespack, III, MD FAAEM
Kay Whalen
William David Wilcox, Sr., MD FAAEM
Joanne Williams, MD FAAEM
Janet Wilson
Richard Clarke Winters, MD MBA FAAEM
Andrea L. Wolff, MD FAAEM
Emily Wolff, MD FAAEM
Robert W. Wolford, MD FAAEM
Regan Wylie, MD FAAEM
Jorge M. Zeballos, MD FAAEM ■



Donate to the AAEM Foundation!

Visit www.aaem.org or call 800-884-AAEM to make your donation.

Blast from the Past

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



This edition of "Blast from the Past" includes the second issue of *Common Sense*, reprinted on the following pages. It reports two important milestones in the history of the Academy: AAEM's first annual meeting and its first mission statement. Compare that first mission statement with the current one, found on page two of this and every issue of *Common Sense*. It has expanded a bit but changed very little.

In reading the second issue of *Common Sense*, I was struck by the quality of the speakers at the very first annual meeting. This gathering was already on its way to being the best emergency medicine meeting in the world, AAEM's Annual Scientific Assembly. The other things that stand out are how active the Academy was, even then, meeting with the U.S. Surgeon General as well as ACEP and the AMA; how cheap the Academy's dues were, and still are; and the fact that Coastal sued Dr. George Schwartz, AAEM's secretary, for libel. We will watch that lawsuit play out as we continue to republish old issues of *Common Sense* in "Blast from the Past."

I would love to have been in that meeting between AAEM, ACEP, and the AMA. It was obviously another attempt to bring ACEP into the fight against the unfair treatment and exploitation of emergency physicians in the workplace. Read about it for yourself. It is the first story on the next page. ■

— The Editor

Celebrating 20 years as the specialty society of EM



Visit www.aaem.org/about-AAEM/celebrating-20-years.



when minutes count

The Voice of the Specialist in Emergency Medicine

September, 1994

Volume 1, Number 2

COMMON SENSE

AAEM PRESENTS CRITICAL ISSUES AT THE AMA

by George Schwartz, M.D., F.A.A.E.M., Secretary, American Academy of Emergency Medicine

(DH) In June 2, 1994 a historic meeting was held at the AMA headquarters in Chicago. Representatives of AAEM met with those of the AMA and of ACEP and key issues were laid on the table and discussed. Participants included AAEM President Dr. James Keaney, Vice President Dr. Scott Plantz, Dr. Robert McNamara, and Dr. Marcus Pittman, as well as AAEM Secretary Dr. George Schwartz who attended by speakerphone after an early morning flight was cancelled. The AMA was represented by Nancy Dickey, M.D., Kirk Johnson, Counsel, and Irv Bomberger. ACEP was represented by President John McCabe, M.D., Executive Director Colin Rorrie, Ph.d., and Micheal Gallery, Ph.d.

Key issues discussed included the growth of large multi-hospital groups and the unethical conditions which often are related to these groups including lack of due process in physician termination, non-compete clauses, and the subsequent effect on the quality of care to the public. Dr. McNamara raised concerns about cuts in residency training positions which are being proposed in the face of a shortage of specialists in our field. The apparent role of ACEP in fostering the large exploitative groups was discussed which is illustrated by the deep involvement of many of ACEP's previous presidents and board members in many of these groups. Also aired was the concern that many of the critical issues facing Emergency Medicine could not be discussed at appropriate forums, e.g. the ACEP Scientific Assembly, due to pressure from attorneys who delivered opinions which were not only unwritten, but also unsubstantiated in case law. In fact these opinions concerning restraint of trade touted by ACEP are contrary to the opinions of other experts in the field of associations, leading one to the conclusion that they may be self-serving.

The issue of representation of Emergency Medicine at the AMA was raised, but not resolved. AAEM's position that it speaks for the specialist was countered by ACEP's argument that its numbers are greater, and will

remain so as its criterion for membership is "significant interest" in Emergency Medicine, not board certification.

In summary, I was pleased that such a high level meeting occurred in which the critical issues of the Mission Statement of AAEM were brought to the table. The AMA seemed to be seriously concerned with the

issues, however was reluctant to intervene. They perceived the issues as more of an internal debate within the specialty. This beginning of serious dialogue is vastly important in that it represents the perceived importance of the issues raised by AAEM as well as the key role that AAEM will play in the future as the specialty society of Emergency Medicine.

AAEM Holds First Annual Meeting in Las Vegas

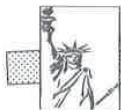


From left, Drs. Bob McNamara, George Schwartz, Chris Minas, Phyllis Troia, Drew Fenton, Howard Freed (representing the White House), Rick Key, and Jim Keaney

The First Annual Meeting of AAEM got *The Renaissance in Emergency Medicine* off to a good start with a stimulating agenda and a line-up of diverse speakers who deliberated topics heretofore not discussed in an Emergency Medicine meeting, such as wellness, universal health care, the impact of certain multihospital groups on the specialty, and how to protect one's rights through legal remedies when all others have been

exhausted. The *Excalibur Hotel* set the mood for this most unconventional of conventions which was highlighted by the Saturday evening banquet entitled *The Whiskey Rebellion Hootenanny*, with active spousal attendance. First Lady Hillary Rodham Clinton sent Dr. Howard Freed to represent the White House. The 700 Club was on hand to film the event.

And to think that the United States also had such a brash and humble beginning!



AAEM DELEGATION MEETS SURGEON GENERAL DURING SAEM MEETING IN WASHINGTON

by James K. Keaney, M.D., M.P.H., F.A.A.E.M., President, A.A.E.M.

WHY WE WILL PREVAIL

Ralph Nader gave a keynote address at the recent Society for Academic Emergency Medicine meeting. He spoke of how one goes from the research lab to a true movement. First the "citizen jolt" has to occur. The second event in any viable movement is the *formation of a critical mass of members*. He suggested 500 as the number needed to organize a national movement. AAEM on the strength of a single nationwide mailing got 600 members. Nader then spoke of *passion*. The 500 had to be passionate about their effort. *Passion was the key, and passion, will topple any amount of money and power.*

I know Nader is right about the passion. At the SAEM meeting AAEM took advantage of Washington's locale and met with several people. I, Lewis Goldfrank, Bob McNamara, and Phyllis Troia first had a private meeting with Surgeon General Jocelyn Elders, MD,

Undersecretary of Health and Human Services Phil Lee, MD, and the chief administrative aide to Representative Pete Stark, Doneg McDounagh. We divided our time equally among the Anti-profiteering Act and the COGME issue of residency positions in Emergency Medicine.

When I came back to our AAEM booth at the SAEM conference, we were asked by many of the participants, "How did you get in to see these people privately?" The answer is simple: **the passion of our members**. All these meetings were set up by our membership, right down to the times for us simply to show up. Good thing we had enough passionate members who offered to staff our booth while we were off to Capitol Hill. By the way, potential members were three deep at our booth during break times.

No one should mistake AAEM as an organization of disgruntled, whiny victims. Goodness no! AAEM is a collection of

frontiersmen with the vision and courage to give this nation the finest Emergency Medical care system in the world. And to accomplish that goal, we have many members working at local and national levels, all passionate, and this is

WHY WE WILL PREVAIL

QUALITY THROUGH JUSTICE!

AAEM Vice President Scott Plantz, already the author of several Emergency Medicine books, plans to write a manual on how to acquire and set up your own ED practice. He seeks contributing authors, and can be reached at 800 S. Wells, Suite 746, Chicago, IL 60607. Telephone: (312) 341-1176

AN ATTACK AT THE HEART OF AAEM?

Alibel suit filed by Coastal this spring against AAEM's secretary and guiding force Dr. George Schwartz alleges that the well-known professor of Emergency Medicine "maliciously intended to subject Coastal to ridicule, contempt, and disgrace..." with an article entitled "*SOUNDING AN ALARM AGAINST UNSCRUPULOUS CONTRACT MANAGEMENT*" published in *EMERGENCY MEDICINE NEWS*, February 1994. Although conceding Coastal was not mentioned by name, the action seeks compensatory and punitive damages, and furthermore demands a trial by jury. Dr. Schwartz in a counterclaim argues that Coastal engages in "exploitation of Emergency Physicians" and "unfair and deceptive practices" and that the suit seeks only to use its "raw economic power and the unjustified threat of expensive litigation to muzzle Dr. Schwartz" and thereby to destroy AAEM.

AAEM SECRETARY DR. GEORGE SCHWARTZ SUED FOR LIBEL BY COASTAL

When initially asked to comment in early July, Coastal spokesperson David Singley stated he had not seen the complaint or countercomplaint and therefore had no comment on the actions. Dr. Schwartz who was reached in Florida where he was visiting his mother stated that he had "spoken the truth. Let the chips fall where they may, and I'm perfectly prepared to prove the truth in any forum whatsoever."

At the first Board of Directors meeting in Las Vegas the leadership of AAEM agreed to wholeheartedly support Dr. Schwartz, agreeing that the suit was an attack at the heart of AAEM.



WELLNESS

Wellness! The word is starting to come up in the most unlikely places from the most unlikely sources. It is now an "in" word, prompting articles, books, seminars, and workshops—the focus of the nineties and hopefully beyond. The search for wellness is as old as the human species. We instinctively know what it is *not*. We know it is *not* about staying healthy and living to be as old as Methuselah. It is *not* about making a lot of money and having the "good life." These things certainly make life palatable and may be consequences of wellness but they don't constitute it. Wellness exists within the framework of birth, life, living, dying, and death. Somehow, somewhere there exists a way of being in relationship to this paradigm that produces wellness.

The science of medicine, as distinct from its art, has traditionally been focused on body health, with the spiritual and mental dimensions addressed in other disciplines and institutions, e.g. psychiatry, religions, and spiritual practices. Everything has been neatly separated to the point that even patients are referred to as "the tibia in room 4." When presented with this evidence we smile and say that we don't really mean *that!* The reality is, consciously or not,

this separation of mind and body has fragmented our lives to the point that we may live with relationships that lack integration and inspiration. That integrating and inspiring essence is the Holy Grail of Wellness. What it is for each person is a unique lifelong discovery process. Some never start, others are awakened to its presence by the pain of unexpected change while others take on the challenge with passion and excitement.

"People don't grow old. When they stop growing they age."

Chopra's quote captures the essence of the odyssey to wellness. Growth is usually seeded in the challenging and sometimes painful experience of change. The change could be the personal loss of job, family, security, or a loved one. It can be the challenge of taking on something new, doing things in a different way, or going the extra mile. In all cases there is a change in the status of an existing relationship or set of relationships. One thing becomes obvious to anyone involved in change: when one relationship changes, everything changes. You cannot break the pretzel in one spot! One aspect of wellness is the relationship we have to ourselves. This relationship is the cornerstone of

any work in the arena of wellness. This personal growth and development is the most important of all relationships and the one that may be the least nourished. It requires great honesty, and many times can be most difficult. *The AAEM meeting in Las Vegas was a moving experience. It was an expression of wellness at an individual and group level.* There was the necessary "kvetching", the commonality of shared experiences, the intimacy of shared pain, the excitement of shared vision, and the identification of a mission that would reflect the values of our lives as committed human beings and physicians. It was a great start for wellness at a group and institutional level. The building blocks for this success is the individual commitment we make to our personal health and well-being. *"Physician, heal thyself."*

Be well!

WANTED: ALIVE & WELL

Volunteers to serve on AAEM Committees. For the Education Committee contact John Kealy, MD at (201) 971-5044 or (914) 423-7890. Other committee assignments are currently being worked out and will soon be publicized.

An Invitation to Participate in the American Academy of Emergency Medicine

Full Voting Member:	\$195
(Board-certified in Emergency Medicine or Pediatric Emergency Medicine)	
Resident or Fellow:	\$50
Associate Member:	\$100
(Nonvoting status)	
Lifetime Member:	\$2,500

Send check to:

American Academy of Emergency Medicine
P.O. Box 1968
Santa Fe, NM 87504
1-800-884-AAEM (2236)

The American Academy of Emergency Medicine is a non-profit professional organization

Our Mailing List is Private

AAEM MISSION STATEMENT

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

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in Emergency Medicine.
2. A specialist in Emergency Medicine is a physician who has achieved, through personal dedication and sacrifice, certification by the American Board of Emergency Medicine.
3. The practice of Emergency Medicine is best conducted by a specialist in Emergency Medicine.
4. The Academy supports the growth of residency programs and graduate medical education, which are essential to the continued enrichment of Emergency Medicine, and to ensure a high quality of care for the patient.
5. The personal and professional welfare of the individual specialist of Emergency Medicine is a primary concern to the AAEM.
6. 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.

Adopted April 30, 1994 by the Board of Directors in Las Vegas, Nevada



ANNOUNCING THE FIRST ANNUAL AAEM SCIENTIFIC ASSEMBLY!

This conference, co-sponsored by the *Medical College of Pennsylvania*, is directed at the board-certified specialist in Emergency Medicine. It will provide an advanced-level overview of new developments and the latest recommendations regarding major clinical topics in Emergency Medicine. Basic reviews will *not* be presented. It will be held in historic Philadelphia at the Society Hill Sheraton from Friday, October 14th through Sunday, October 16, 1994. Fifteen Category I AMA credits will be provided. The cost is \$300 (\$275 Early Bird), \$150 for residents (\$125 Early Bird).

The panel of prominent Emergency Physicians presenting advanced level talks in adult and pediatric care will include:

Adrienne Buffaloe, M.D.
Daniel F. Danzl, M.D.
Daniel Dire, M.D.
Glen Freas, M.D.
Lewis Goldfrank, M.D.
Micheal B. Heller, M.D.
Robert Hoffman, M.D.
David Jaffe, M.D.
John Kealy, M.D.
Brent King, M.D.
John Loiselle, M.D.
Robert M. McNamara, M.D.
Edward A. Panacek, M.D.
James Roberts, M.D.
David K. Wagner, M.D.
Donald M. Yealy, M.D.

**For brochure and registration
contact the CME office at (215) 762-
8263 or AAEM (800) 884-2236.**

*Don't miss the most advanced
Emergency Medicine meeting
of the year!*



American Academy of Emergency Medicine
P.O. Box 1968
Santa Fe, NM 87504
1-800-884-AAEM Fax: 505-983-1383

when minutes count

THE OPINIONS EXPRESSED IN
THIS MESSAGE ARE THOSE
OF THE AUTHOR AND
DO NOT REPRESENT
NAEM POLICY UNLESS STATED.



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

Upcoming Conferences: AAEM Sponsored and Recommended

AAEM is featuring the following upcoming endorsed, sponsored and recommended conferences and activities for your consideration.

For a complete listing of upcoming endorsed conferences and other meetings, please log onto <http://www.aaem.org/education/aaem-recommended-conferences-and-activities>.

August 21-23, 2013

- AAEM Written Board Review Course
Orlando, FL
<http://www.aaem.org/education/written-board-review-course>

September 18-19, 2013

- AAEM Pearls of Wisdom Oral Board Review Course
Las Vegas, NV
<http://www.aaem.org/education/oral-board-review-course>

September 21-22, 2013

- AAEM Pearls of Wisdom Oral Board Review Course
Chicago, IL
Dallas, TX
Los Angeles, CA
Orlando, FL
Philadelphia, PA
<http://www.aaem.org/education/oral-board-review-course>

September 8-11, 2013

- VIIth Mediterranean Emergency Medicine Congress
Marseille, France
www.memc2013.org

February 11-15, 2014

- 20th Annual Scientific Assembly
New York, NY
<http://www.aaem.org/education/scientific-assembly>

AAEM-RECOMMENDED CONFERENCES

June 7-9, 2013

- The Difficult Airway Course: Emergency™
New Orleans, LA
www.theairwaysite.com

August 2-3, 2013

- 1st Annual AAEM/RSA International Emergency, Trauma & Critical Care Conference
Barceló Punta Cana, DR

September 27-29, 2013

- The Difficult Airway Course: Emergency™
Baltimore, MD
www.theairwaysite.com

November 22-24, 2013

- The Difficult Airway Course: Emergency™
Las Vegas, NV
www.theairwaysite.com

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

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



Train Non-Anesthesiologists on Moderate Sedation and Analgesia

Train staff in the competencies needed to administer and monitor moderate sedation with ASA's Sedation and Analgesia by Non-Anesthesiologists video backed by the Authority in Anesthesia – The American Society of Anesthesiologists.

This educational video provides the latest guidelines on the safe administration of sedative and analgesic drugs used to establish a moderate level of sedation. CO₂ basic monitoring and advanced life support information is also covered.

Formats Available Include:



<http://goo.gl/TvJvT>

For more information and to order visit
www.asahq.org/Sedative and use promo code: EM2013
or call ASA at (847) 825-5586.

American Society of
Anesthesiologists® 

SCHEDULE GENERATION THAT **WORKS**

Find out what over 8,000 providers already know...

- ✓ The most advanced scheduling algorithm available
- ✓ Customizable to meet your needs
- ✓ User-friendly interface and unbeatable tech support

... this is scheduling as it should be.



The Business of Emergency Medicine

We Are All In This Together

Craig Norquist, MD FAAEM
Chair, Practice Management Committee

Emergency physicians face a new threat. Like past threats, I believe we will come through this stronger than when we began. History gives me reason for optimism.

Since the birth of emergency medicine we have faced many different types of threats. Early on it was the threat of the robber-barons who held contracts and made their profits off of those who worked the shifts. In the '80s the threat was the birth of contract management groups (CMGs), which also made tremendous profits from the labor of working clinicians. In the '90s the threat of managed care affected everyone in medicine, including emergency physicians.

Today, the Patient Protection and Affordable Care Act (PPACA) threatens us. The current threat comes with a considerable amount of FUD: Fear, Uncertainty, and Doubt. Because of this we have been holding our collective breath, looking for someone to help us out. First, we waited for the Supreme Court to strike it down, then for a new party to be elected and repeal it, then for state or local governments to come up with a better plan. With each passing failure, we continued to look for help or answers.

Through PPACA, physicians and hospitals are allowed to band together and form Accountable Care Organizations. ACOs, while led by physicians, potentially pose a threat because there does not seem to be a place in them for emergency medicine. In fact, utilization of the emergency department will be considered a system failure in many quality measures being proposed by ACOs.

At the recent Scientific Assembly our past president, Larry Weiss, while speaking eloquently about PPACA and ACOs, mentioned that most of us will be employed by hospitals in the near future. Not surprisingly, at the ACEP conference its current president reasoned similarly — that we would have to join forces with large groups in order to survive. Neither of these conclusions seems far-fetched, as FUD seems to be growing faster than understanding of PPACA and ACOs. Hospital administrators, not understanding how to include emergency physicians in the new healthcare delivery model, are employing more doctors — thinking it will be easier to employ them and put them on salary instead of allowing their independent practice.

When you have seen one ACO, you have seen one ACO. Each is unique. They do share many tactics in trying to achieve savings and improve care; however, in some places emergency physicians have been instrumental in developing the ACO.

We have considerable power and influence in the hospital, which should put us in a prime position in the ACO. We control the decision to admit or discharge patients, which is the single biggest cost decision made in the care of the patient. Every day we work with all the different specialties, from primary care to surgical subspecialties. No specialty is better prepared than ours to bring all facets of medicine together, to achieve an organization that is caring, effective, and accountable. In the past we had to argue this point to hospitals and insurance carriers only. Now, with accountable care organizations, we have to continue that discussion with other physicians in the network or ACO.

As more small groups get swallowed up by larger groups and CMGs, or become employed, it makes those groups that survive an even bigger target. Strong democratic emergency medicine groups are our best weapon to survive the latest threat. Groups that survive stand as proof to hospitals and ACOs that emergency medicine, in its current form, has a role in the future of medicine, with hard-working entrepreneur doctors doing whatever it takes to be able to practice the way that they want, not the way others want.

It takes knowledge to combat FUD. Our best source of knowledge has been and always will be our colleagues. We need to share information on the successful integration of emergency medicine into ACOs. Please share any strategies that have worked with your hospital or ACO and your emergency medicine group. Contact me personally, the Practice Management Committee, or reach out to *Common Sense* with thoughts, ideas, strategies, and questions. The Practice Management Committee will organize these and make them available to Academy members, as tested and successful strategies to maintain your contract in the face of health care reform.

We need each other in order for each of us to succeed. We are all in this together, and only together we can get through this, just as we have before.

Craig Norquist, MD FAAEM
craignorquist@post.harvard.edu ■

Current news and updates

can now be found on the AAEM website

WWW.aaem.org

new!

Procedural Sedation and Advanced Resuscitation Expertise Card

The Advanced Resuscitation Expertise Card now includes procedural sedation.

Access and download your card from your AAEM member account
www.aaem.org/myaaem

Higher-Complexity ED Billing Codes — Sicker Patients, More Intensive Practice, or Improper Payments?

Stephen R. Pitts, MD MPH

Department of Emergency Medicine

Emory University School of Medicine, Atlanta

If you subscribe to the New England Journal of Medicine you may have seen the article below, but it is worth reading again. Last September the feds warned hospitals of escalating efforts to prevent fraudulent upcoding associated with the electronic health record (EHR). The emergency department was mentioned specifically in that letter. I believe this thinly veiled allegation is completely unfair, and many factors other than fraud have led to higher levels of coding in the ED.

First is the EHR itself. It was forced on us by the feds to begin with, despite all its serious clinical drawbacks. These include dramatically slowing patient throughput; taking emergency physicians away from the bedside and forcing them to spend the majority of their time entering data into computers; and generating a medical record that fails to capture the uniqueness of each individual patient encounter, fails to accurately reflect medical reality, fails to tell a coherent story, fails to protect physicians in the event of a bad outcome, and is difficult to decipher by the physicians who care for patients after they leave the ED. The EHR does do one thing well — it codes well and captures all possible charges. In fact, as far as I can tell, those who wrote the software behind the EHRs I have used couldn't care less about speed, clinical accuracy, or medical quality. They care about coding, billing, and maximizing reimbursement. The EHR isn't leading emergency physicians to commit fraud by dishonest upcoding; it is leading us to more accurate coding, so that we are now being paid more of the money we were owed all along. The feds created this game, wrote the rules, and made us play — and now they are complaining about the outcome! And, of course, they never mention the huge public service that emergency physicians provide the country through the unfunded EMTALA mandate.

In his article Dr. Pitts mentions several other reasons for higher coding in EDs. These seem to boil down to emergency physicians trying to protect themselves from unfair allegations of negligence, and stepping in to fill the gaps left by other parts of our health care system — as we always have. And for this we are accused of fraud. I urge you to read the article carefully. If you remember nothing else from it, remember this:

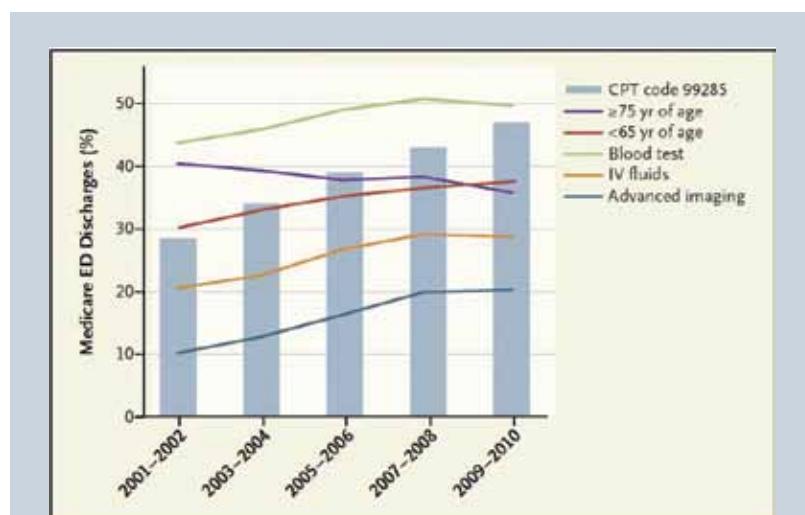
"Although ED physicians are increasingly employed by hospitals, hospital chains, or contract groups with productivity-based compensation, the OIG holds individual physicians accountable for billing done in their name, regardless of who directly manages the billing operations."

— The Editor

A recent analysis of Medicare billing data for evaluation-and-management services, conducted by the Office of Inspector General (OIG) of the Department of Health and Human Services, showed that between 2001 and 2010, the proportion of claims for lower reimbursement categories decreased while the use of higher-paid categories increased across all visit types.¹ The largest increase reported was in level 5 emergency department (ED) visits

(Current Procedural Terminology [CPT] code 99285; average reimbursement, \$173) — from 27% to 48% of Medicare discharges (see graph).

Although the report didn't assess the reasons for higher billing levels, its findings have been amplified by investigative reports in the media suggesting that fraud is the cause. On September 24, 2012, a formal letter from the U.S. Departments of Justice and Health and Human Services to hospital leaders warned of an escalated effort to prevent fraud and abuse and explicitly linked higher bills to "gaming" made possible by new electronic health record (EHR) technology. The OIG report addressed only physician billing, not hospital billing, and the office has initiated further study into usage of all CPT codes. Although it's possible that "up-coding" facilitated by increasing use of EHRs has contributed to the trend, other causes such as changing demographics, shifting practice patterns, and the ED's evolving role in



Changes in Use of the Billing Code for Level 5 ED Visits, in the Age Range of Medicare Patients Discharged from the ED, and in the Use of Diagnostic Technology and IV Fluids, 2001–2010.

Lines represent estimates from the public-use files of the National Hospital Ambulatory Medical Care Survey, excluding the 2010 estimates, which were not available. The average sample of Medicare discharges was 3747. All slopes are statistically nonzero at $P<0.01$ in logistic-regression models, with survey years defined as a continuous variable. CPT denotes Current Procedural Terminology.

Continued on next page

the health care system must also be considered.

To explore these potential contributors, I analyzed a nationally representative sample of Medicare ED discharges in the National Hospital Ambulatory Medical Care Surveys, using methods described previously and detailed in the Supplementary Appendix (available with the full text of this article at NEJM.org).² Like the OIG report, my analysis excludes the 35% of Medicare ED visits that lead to hospitalization or transfer.

Between 2001 and 2009, the average age among all patients discharged from the ED increased by 0.18 years annually, but among Medicare patients discharged from the ED, the mean age trended downward (see graph). In 2006, 38% of these Medicare patients were younger than 65 years, whereas only 19% of the total Medicare population was in that age group. The disposition of Medicare patients under 65 after an ED visit is often more difficult than that of older Medicare patients, because on average, such patients have worse self-reported health status and are more likely to be disabled, poor, or cognitively impaired.³ In 2006, 33% of Medicare patients under 65 who were discharged from the ED were in the costly “dual eligible” category also covered by Medicaid, whereas only 21% of all Medicare beneficiaries were dual eligibles.

Along with demographic changes in the Medicare ED population, the overall health care system and the ED's role in medical care changed sharply during the decade of the OIG study. The marked increase in use of new diagnostic technology in U.S. medicine was magnified in the ED, with its ready access to hospital-based advanced imaging: computed tomography (CT), magnetic resonance imaging, and ultrasonography (see graph). In the past decade, an increasingly strained primary care infrastructure for adults has resulted in greater use of the ED for first-contact care.⁴ Lack of stable “medical homes” encourages ED physicians to seek greater diagnostic certainty before discharging a patient. The three most common symptoms reported by Medicare patients who are

ultimately discharged from the ED are abdominal pain, chest pain, and shortness of breath — all challenging diagnostic problems that often necessitate testing that's unavailable in office settings in order to diagnose serious conditions. For example, technological innovations have revolutionized care for abdominal pain. Whereas surgical consultation and hospitalization were once standard, multidetector CT now permits rapid risk stratification in the ED, often averting the need for admission or consultation for patients with negative tests. The diagnostic precision afforded by these technologies is increasingly expected by patients, physicians, and the public. Failure to diagnose patients' conditions carries heavy penalties for ED physicians and hospitals, whereas “overuse” of technology is ill defined, and penalties for it are less direct.

The ED has also been affected by another major trend: hospitals' reduced inpatient capacity has led to widespread boarding of inpatients in ED hallways. This trend contributes to shifting of work formerly done in inpatient wards to the ED, encouraging EDs to discharge patients with borderline health status (who might have been admitted in the past) in order to reduce crowding and prolonged waits.

The result of these changes is an increasingly interventionist ED practice style, illustrated not only by increased imaging, but also by increased laboratory testing and initiation of IV fluids (see graph). Whether this trend has truly improved patient safety and quality of care is unknown, but it has certainly increased the complexity of the medical decision-making component of documentation, which translates into higher physician billing.

Finally, the culture of billing for medical services changed with the implementation of evaluation-and-management guidelines in the late 1990s. Physicians have adapted: some have become students of the coding procedures, but many have outsourced billing to professional coders trained to search for keywords. Although many ED physicians don't know exactly what is billed in their name, physicians commonly

Continued on next page



www.aaem.org/connect

AAEM Connect is a new centralized dashboard on the AAEM website that brings together all of our social media and interactive elements into one convenient location for you.

Connect with us to...

- Access our Facebook, Twitter, and LinkedIn streams and interact with other members
- Read the latest AAEM blog posts
- Tune in to AAEM Podcasts. Featured topics include: legal issues, critical care, and more!
- Voice your questions and opinions on “Letters to the Editor” and “Curbside Consult”
- Catch-up on all of AAEM's interactive features on one central website

With live-updates from all of our social media outlets — AAEM Connect is an easy, one-stop source for the busy emergency physician.



AAEM-0213-022

receive regular feedback on their average billing performance through automated reports.

Early adoption of electronic records by the ED may in part explain the sharper billing increases in emergency medicine than in other clinical specialties. The EHR facilitates billing by presenting clickable checkboxes that easily satisfy coding-complexity criteria, and some EHRs even issue notifications when documentation needed for certain billing levels has not been achieved. These changes ensure that no billable action goes unnoticed and have reduced undercoding. In fact, EHR vendors tout this effect to justify the cost of their products. In other ways, however, the HER has become a double-edged sword, potentially undermining its intended goal of reducing medical errors. Throughput suffers when time that could be better spent with patients is wasted on elaborate documentation. The EHR may also facilitate improper behavior, such as clicking multiple items in the “review of systems” that patients were not directly asked about. Of even greater concern is the possibility of deliberate, systematic use of easily selected templates designed to ensure billing at the highest possible level, rather than promoting validated clinical decision rules and protocols designed to improve efficiency and quality. Although ED physicians are increasingly employed by hospitals, hospital chains, or contract groups with productivity-based compensation,⁵ the OIG holds individual physicians accountable for billing done in their name, regardless of who directly manages the billing operations.

What should be done about the trend in billing? A first step is to do what the OIG report proposes: educate physicians about the importance of proper billing, review billing records to ensure that results match performance, and scrutinize physicians who consistently bill at higher levels than their peers.¹ From a broader perspective, the science of ED operations should be advanced to facilitate timely care. These advances should include the development of a more effective business model for the digital era that allows ED practitioners to get away from the computer and back to the bedside of sick and injured patients.

The EHR is one reason behind increased ED billing, and fraud may be facilitated by these new systems. However, this simple explanation does not capture the broader story of what happened in U.S. EDs during the decade the OIG examined. While the ED has remained the social safety net, it has also gradually inherited roles previously handled by office-based physicians. EDs have become a central staging area for acutely ill patients, for the use of diagnostic technology, and for decisions about hospital admission, all of which makes ED care increasingly complex.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

References

1. Department of Health and Human Services, Office of Inspector General. Coding trends of Medicare Evaluation and Management Services. May 2012 (<http://oig.hhs.gov/oei/reports/cei-04-10-00180.pdf>).
2. Pitts SR, Pines JM, Handigan MT, Kellermann AL. National trends in emergency department occupancy, 2001 to 2008: effect of inpatient admissions versus emergency department practice intensity. *Ann Emerg Med* 2012;60:679-86.
3. Cubanski J, Huang J, D'Amico A, Jacobsen G, Neuman T. Medicare chartbook. 4th ed. Washington, DC: Kaiser Family Foundation, 2010 (<http://www.kff.org/medicare/8103.cfm>).
4. Pitts SR, Carrier ER, Rich EC, Kellermann AL. Where Americans get acute care: increasingly, it's not at their doctor's office. *Health Aff (Millwood)* 2010;29:1620-9.
5. O'Malley AS, Bond AM, Berenson RA. Issue brief no. 136: rising hospital employment of physicians: better quality, higher costs? Washington, DC: Center for Studying Health System Change, August 2011:1-4 (<http://www.hschange.com/CONTENT/1230>).

From New England Journal of Medicine, Steven Pitts MD MPH, Higher-Complexity ED Billing Codes — Sicker Patients, More Intensive Practice, or Improper Payments?, 367;26, 2465-2467. Copyright © 2012 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society. ■

AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

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

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

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

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

Pan-Pacific Emergency Medicine Congress Recap

Christopher Lee, MD FAAEM



A former member of AAEM's board of directors, Chris Lee is more responsible than any other individual for last October's incredibly successful Pan-Pacific Emergency Medicine Congress (PEMC) in Seoul. It was a great meeting, but I'll let him tell you about that below. What I want to tell you about is what a magnificent city I found Seoul to be. While huge, with a population of over 20 million, it is modern, clean, safe, and very easy to get around in — even for those who don't speak Korean. In fact, I think it is the easiest city in which not to speak the native language of any place I have visited — even Barcelona, which is also particularly easy for foreigners. Perhaps hosting the Olympics contributes to that.

Seoul's subway was easy to navigate, with signs and announcements in English, and the people were uniformly friendly and helpful. Several times, when I must have looked confused during my sightseeing, Koreans offered to help. More than once while I was visiting cultural or historic sites, school children engaged me in conversation to practice their already excellent English. They are apparently taught to

compliment English-speakers appropriately based on gender, because more than one child said, "You are a very handsome man." I was quite flattered until the same compliment was paid to Dr. David Lawhorn!

The convention center and hotel where the Congress was held were among the best I have seen, easily rivaling the best of Las Vegas. The hotel even gave us smartphones to use while in Korea, preprogrammed so that pressing "1" would connect us with the concierge if we ever needed help. And the food — wow! All kinds of cuisine at all levels of expense can be easily found in the city, but my favorite was the native Korean food. After decades of diligent searching I finally found food spicy enough for my taste ... and then some. If you ever get a chance to visit Seoul, do it! I certainly hope to see more of Korea, and look forward to visiting Hong Kong in two years for the next PEMC. Thank you Dr. Lee!

— The Editor

I would like to thank everyone who supported the first Pan-Pacific Emergency Medicine Congress (PEMC), held October 26-28, 2012, in Seoul, Korea. The conference was a huge success, attended by 1,400 emergency physicians from all over the world. The conference was organized jointly by the American Academy of Emergency Medicine (AAEM) and the Korean Society of Emergency Medicine (KSEM), with the support of the Asian Society of Emergency Medicine (ASEM). My thanks to all those who helped put this together, especially Dr. William Durkin, Dr. Joe Lex, and the leaders of the Korean Society of Emergency Medicine.

Having witnessed the tremendous growth of emergency medicine in Korea and across Asia, I thought the time was right for a pan-pacific meeting combining the accumulated knowledge, experience, and enthusiasm of emergency physicians from around the world. The collaboration between AAEM, with its strong commitment to education and global perspective, and KSEM was especially successful and fruitful — leading to one of the largest international emergency medicine conferences to date.

The Korean Society of Emergency Medicine, the host organization, put a tremendous amount of effort into the creation of the PEMC — also supported by the Asian Society of Emergency Medicine. Both would like to continue to celebrate our specialty and work together to advance emergency medical care across the globe. I am confident that the collaboration between AAEM and KSEM will continue to promote the specialty of emergency medicine and offer a wonderful opportunity for academic and scientific exchange.

I clearly remember when I first put forth the idea of creating a PEMC three years ago during a strategic planning session of the AAEM board of directors in Phoenix. Many board members were hesitant to take on this new project. Thankfully the idea was enthusiastically supported by Drs. Larry Weiss, Joe Wood, Stephen Hayden, William Durkin, and Joanne Williams. The AAEM board of directors eventually approved the idea, and I had the privilege of bringing all the necessary resources

Dive into Resuscitation

at Great Wolf Lodge powered by Virginia-AAEM

July 20-21, 2013
Williamsburg, VA
Great Wolf Lodge

Special hotel rates available! Book by June 19, 2013

Registration Open!

Bring the family and jump in!

VAAEM
A Chapter of the American Academy of Emergency Physicians

GREAT WOLF LODGE

<http://www.va-aem.org/events/dive-in-to-resuscitation>

8 Hours of Lecture Time
Morning Sessions = Family time for the rest of the day!

Continued on next page

together to make the conference a success. My thanks again to Dr. Joe Lex, who was instrumental in arranging CME accreditation. Thanks also to all the speakers, moderators, and presenters from around the world. A special thanks goes out to the keynote speaker, Dr. Judith Titinnalli, and the plenary speakers, Drs. Mark Henry and Mark Langdorf, all of whom helped make this conference so memorable.

Many conference participants commented on the high scientific quality of the presentations. Over 600 abstracts were submitted, and the top 100 were published in the official journal of AAEM, the *Journal of Emergency Medicine*. I thank Dr. Steve Hayden, *JEM*'s editor, for making that happen.

Participants obviously enjoyed the variety of tracks, and I was overwhelmed by the enthusiasm and quality of the speakers. I also enjoyed seeing the many residents and young physicians who came from all over

the world to present the results of their hard work and research. I hope to make this conference an ongoing part of AAEM's educational mission and envision holding it every other year, similar to the Mediterranean Emergency Medicine Congress (MEMC). I believe the PEMC can serve as a benchmark for international conferences in emergency medicine.

Finally, I thank my mentors, Drs. Mark Henry and Adam Singer, who gave me their wisdom and support; as well as my family, who believed in me and supported me throughout the long planning process and the conference itself — especially my children Joshua (10) and Esther (8), who gave me the tremendous energy and courage needed to take on such a huge project.

Please join me and many more of your AAEM colleagues at the second PEMC, in the fall of 2014 in Hong Kong! ■

Preserve Your Independent Practice



Visit info.cep.com/independent
for more information

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



- Local site autonomy
- A transparent practice structure
- A full time recruiting staff
- Above average compensation rates
- Comprehensive practice management support
- Access to best practices developed and shared by CEP America's 100+ hospital sites

COMMITTEE UPDATE: Academic Affairs

We would like to provide an update on the projects the committee has been working on over the last year or so. Members of the Academic Affairs Committee have written a white paper, *The Value of Board Certification and Residency Training in Emergency Medicine*. A press release and an announcement to the membership in *Common Sense* were sent regarding the white paper's publication. In response to the publication, the American Board of Emergency Medicine (ABEM) sent a letter of thanks and support. The letter of support has been used as a resource in AAEM's ongoing effort to promote board certification and emergency medicine residency training.

The Academic Affairs Committee has been developing a means, with the assistance of the Resident and Student Association (RSA), to monitor state medical boards on board certification activities. The goal is to monitor all state medical board meeting agendas on a monthly basis, as well as any activities that raise concern regarding board certification in state legislatures. Issues will be brought to the attention of the Academy's board of directors. This system paid off in late February, when we were alerted to a troubling bill making its way through Arizona's legislature. At the time this committee update was submitted on March 1, it appeared that the threat had been successfully averted.

A request was made to the committee that we assist in providing articles to ABEM, for the Lifelong Learning and Self Assessment (LLSA) exams. A request for interested committee members has been sent and a follow up conference call will be scheduled to establish procedures and assignments.

Finally, the Academic Affairs Committee, with the assistance of the board of directors, is studying the following issues as potential projects for the committee in the near future:

- Proactive advocacy for board certification.
- Funding for academic emergency medicine.
- Policy on residents moonlighting in a non-resident capacity.
- ACGME accreditation of osteopathic emergency medicine residency programs.

If you are interested in academic emergency medicine issues, please join the Academic Affairs Committee. Submit a brief online application at <http://www.aaem.org/about-AAEM/leadership/committees>. Thank you.

Heatherlee Bailey, MD FAAEM
Chair, Academic Affairs Committee ■

COMMITTEE UPDATE: Finance

The purpose of AAEM's Finance Committee is to invest the assets that AAEM does not expect to use in the short term, while minimizing risk, thus growing the Academy's funds while preserving capital, and to provide financial guidance to its board of directors. During the past year, the committee reviewed the Academy's asset allocation and made appropriate recommendations to its board. The committee also recently drafted a proposal on increasing the limit on expenditures the executive committee can make without full board approval, as well as the president's spending limit, which we submitted to the AAEM board for consideration. These were approved by the Academy's board of directors during their

recent meeting in Las Vegas. The committee is currently reviewing proposals by outside financial managers to oversee AAEM's investments. The Academy is a very efficient operation, with extremely low dues compared to other medical societies, especially in emergency medicine. We intend to keep it that way!

Kevin Rodgers, MD FAAEM
AAEM Secretary-Treasurer ■

JOIN A Committee!

AAEM is currently seeking committee members to assist in carrying out the work of the association. Each committee is made up of members interested in that committee's area of focus and is led by a committee chair. AAEM members interested in serving on a particular committee should complete the committee application.

The following committees are actively recruiting:

- Membership Committee
- ACCME Subcommittee
- Operations Management Committee (OMC)

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

COMMITTEE UPDATE: International

In pursuit of our mission to promote International EM and the role of AAEM abroad, the International Committee has spent the last year expanding the Academy's international relations, pursuing international opportunities for AAEM members, and creating a forum for international updates and education for AAEM members.

Since our last update in *Common Sense*, we have continued to expand our international horizons. The recent Scientific Assembly in Las Vegas was a particularly interesting and productive meeting. During this meeting we discussed the continuing partnership between AAEM and the European Society for Emergency Medicine (EuSEM), and the upcoming Mediterranean EM Congress (MEMC) to be held in Marseilles, France, September 8-11; the growing relationship between AAEM and the Sociedad Argentina Emergencias and the InterAmerican EM Congress in Buenos Aires in May of 2014; and the productive partnership between AAEM and the Korean Society of Emergency Medicine, which resulted in last October's very successful Pan-Pacific Emergency Medicine Congress (PEMC) in Seoul. Our committee also considered the possibility of future relationships between AAEM and several other EM societies, including the African Federation for Emergency Medicine (AFEM) and the International Federation for Emergency Medicine (IFEM).

In addition to nurturing our connections abroad, we have been promoting international EM inside AAEM. This is an effort to bring the skills and expertise of other committees into the international arena, and to increase interest in our committee among Academy members in general. We invited and will continue to invite AAEM members and the leaders of our sibling committees to share their skills and ideas with us. We plan to

produce a report for the AAEM board of directors on a comprehensive international EM strategy, in order to best serve Academy members who want to be involved in international EM, promote AAEM and its many excellent educational programs to the growing international EM community, and involve even more emergency physicians from other countries in the Academy.

Finally, after months of planning, the International Committee was proud to present a mini-symposium on International Emergency Medicine in Las Vegas. This was the first such IEM symposium held at AAEM's Scientific Assembly. This four-hour educational session focused on the state of EM around the world, and featured emergency physicians from around the world as speakers. Emergency physicians from Argentina, Japan, South Korea, France, and Hong Kong spoke on how EM has developed in their countries.

The symposium concluded with an update on the International Emergency Medicine Fellowship Consortium, a recently created umbrella organization working to unite and strengthen the 38+ U.S. and 5+ foreign International EM Fellowship programs. More information on the IEMFC and IEM Fellowships can be found at www.iemfellowships.com.

We conclude with an invitation to AAEM members to join the International Committee, bringing your knowledge and skill to emergency physicians abroad and expanding your horizons, while promoting EM globally through clinical, administrative, or educational activities.

Sassan Naderi, MD FAAEM
Chair, International Committee ■

Let's Be Social

Follow @AAEMinfo on Twitter for up-to-the-minute information



COMMITTEE UPDATE: Operations Management

The AAEM 19th Annual Scientific Assembly was a huge success, and in talking with Dr. Bill Durkin, AAEM president, attendance was at an all-time high. In everyone's opinion it was one of the best scientific assemblies ever. The Operations Management Committee hosted a two-day workshop February 9-10. Thirty-five people attended an incredible opportunity to hear from the best in the field of ED operations. Speakers included Tom Scaletta, MD, Jody Crane, MD, Chris DeFlitch, MD, Mark Graban, Joe Swartz, Mike Russell, MD, Marc Jaben, MD, and Joe Guarisco, MD. Unfortunately Dr. Peter Viccellio was snowed in on Long Island and missed the meeting.

Following the workshop, the Operations Management Committee held its Annual Scientific Assembly meeting to review the committee's accomplishments and plan for the future. The committee holds a virtual meeting monthly, but this was a great opportunity to meet in person and talk directly. It was an honor to have Dr. Bill Durkin attend this meeting, and contribute to the discussion and planning for the upcoming year. Also in attendance were AAEM board members Drs. John Christensen, Mark Reiter, and Leslie Zun; along with Drs. Mark Foppe, Frank Gaudio, and Prentice Tom; plus Academy staffers Janet Wilson and Lauren Johnson (our new liaison).

An enormous amount of work and planning went into the operations management workshop, and it was felt to be a huge success by all those who attended. In addition to planning for this workshop, the Operations Management Committee published two articles in *Common Sense* in 2012.

In planning for next year the committee felt that, in light of the success of the 2013 workshop, another workshop at the 2014 Scientific

Assembly would be popular. Expanding the workshop and partnering with other organizations, such as the Emergency Nurses Association, to present the workshop outside the Scientific Assembly was also considered. The committee also supported the goal of submitting at least one article to each issue of *Common Sense*. Additionally, there was significant support for increasing the visibility of the committee's work, by becoming more integrated into the social media platform being developed by AAEM. Part of this would be the initiation of podcasts highlighting both individuals and their contributions to operations management in emergency medicine. The OMC will work with Laura Burns, AAEM Communications Manager, on this initiative. Furthermore, there was great support for creating a link for Academy members, through www.AAEM.org, to best practice experts and related resource materials.

The committee thought one of the biggest threats to independent, equitable practice groups was loss of the contract due to performance issues, and that the Operations Management Committee could be a valuable resource to these groups in improving performance and weathering these challenges.

Finally, in addition to the goals above for the next year, there was strong support for restructuring the committee, from its original large size with open membership, to a smaller group of individuals more tightly focused and organized. Individuals with a strong interest in operations management are encouraged to join this group by contacting me at jguarisco@oschner.org.

Joseph Guarisco, MD FAAEM
Chair, Operations Management Committee ■

PEARLS of WISDOM ORAL BOARD REVIEW COURSE



SEPTEMBER 18-19,
2013
Las Vegas, NV

SEPTEMBER 21-22,
2013
Chicago Orlando
Dallas Philadelphia
Los Angeles

FALL COURSE DATES

ANNOUNCING: New Benefit for TNAEAM Members!



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



Check your mail boxes for the May issue!

COMMITTEE REPORT: State Chapter

Since becoming the State Chapter Committee chair last year, we have made significant progress towards the committee's two primary goals of developing new state chapters and providing support to existing chapters. During the last few months, the New York chapter has been reinvigorated through the leadership of Eric Lubliner. After a number of conference calls and a working group meeting in Las Vegas, Michael Walters has taken the lead in starting a new Great Lakes Chapter. The Great Lakes Chapter will include Minnesota, Wisconsin, Iowa, Illinois, Indiana, Michigan, and Ohio. If individual states eventually have enough active members, the Great Lakes Chapter can start spinning off individual state chapters. This will be AAEM's second regional chapter, after the long-standing and successful Delaware Valley Chapter. We are considering a plan to replicate this strategy of pooling membership, resources, and leadership to form regional chapters in other parts of the country where state chapters are lacking.

The AAEM board has agreed to provide a "start-up loan" to new chapters, to support chapter communication, benefits, and activities during the chapter's development phase. The money can be used by chapter leadership to finance early activities and set up the chapter for long-term growth.

During the Annual Scientific Assembly in February, a meeting of the State Chapter Committee was held that included chapter representatives from California, Tennessee, Delaware Valley, Florida, and the forming New York and Great Lakes chapters. Each presented their chapter reports to the committee. We discussed activity over the last few months, as well as chapter development and membership growth strategies. Following that meeting, we held our first ever "State Chapter

Start-up Workshop," to review the tasks required in the creation of a chapter as well as strategic planning to facilitate chapter growth and success. We reviewed existing chapters' activities/benefits and brainstormed other ideas to promote an active and dynamic chapter, such as:

- Monthly/bimonthly board conference calls
- Distributing tasks and responsibilities amongst chapter leadership
- Communication and recruitment with local EP groups, residency programs, & medical school interest groups
- Annual/biannual meeting, conference, lecture series, or networking event
- Resident's Day
- Online presence through a chapter website on www.AAEM.org
- Chapter newsletters
- State/local legislative and lobbying activities

I encourage AAEM members to get involved in their state chapter, and if you don't have a state chapter, get involved to help form one. You are not alone and the AAEM office and I can help you through this easy process. As someone who held previous YPS and RSA leadership roles, I especially encourage other past YPS & RSA leaders to get re-involved with AAEM by joining your state chapter leadership or starting a new chapter. We would also like to find faculty members, who are AAEM supporters, who could serve as residency program liaisons with their local state chapters. If you are an AAEM member and interested in becoming involved in a state chapter, please contact me at brianpottsmd@gmail.com.

Brian Potts, MD MBA FAAEM
Chair, State Chapter Committee ■

CHAPTER REPORT: Tennessee AAEM

Since our legislature is back in session, we are once again pushing real tort reform, the kind that would completely free emergency physicians and others who provide EMTALA-mandated care from the fear of unfair lawsuits. HB 272/SB 475 would change the definition of medical malpractice for emergency care from simple to gross negligence. We make a bit of progress on this each year, but honestly, it is unlikely to pass this year. TNAAEM will keep hammering away at Tennessee legislators; however, until they see the light. On a brighter note, we are likely to stop HB 66/SB 868, which would lengthen Tennessee's statute of limitations from one year to two. This horrible bill would force physicians to live under the threat of a lawsuit for two years instead of one after every bad outcome.

Despite its small size, our chapter contributed significantly to AAEM's Scientific Assembly in February, with four TNAAEM members giving lectures: David Lawhorn, our chapter president; Andy Walker, our vice-president; Corey Slovis, Chairman of Emergency Medicine at Vanderbilt; and Mark Reiter, Program Director at the University of Tennessee College of Medicine's second emergency medicine residency, at Middle Tennessee Medical Center in Murfreesboro.

Several TNAAEM members also serve AAEM at the national level. David Lawhorn is in his second year on the board of directors; and at

the 2013 Scientific Assembly, Kevin Beier, TNAAEM's past president, was elected to the board while Andy Walker was re-elected. Dr. Beier also serves as treasurer of AAEM's Political Action Committee, and Dr. Walker is editor of *Common Sense*. Since Dr. Reiter, AAEM's treasurer, moved from Pennsylvania to Tennessee to start a new emergency medicine residency, this gives Tennesseans four seats on the Academy's board of directors. They don't call us the Volunteer State for nothing.

Finally, while Tennessee has several equitable, democratic emergency medicine groups that I wouldn't hesitate to recommend to job-seekers, it has one that has earned the Academy's Certificate of Excellence in Workplace Fairness and also has 100% of its physicians enrolled as members of AAEM. That is emergency physicians at Sumner, PLLC, which staffs the very busy ED at Sumner Regional Medical Center in Gallatin, about 45 minutes from Nashville.

Congratulations and thanks to EPAS! We hope to have more 100% AAEM member groups in Tennessee soon, along with more groups that have earned the Certificate of Excellence in Workplace Fairness. C'mon Tennesseans, rise to the challenge!

Andy Walker, MD FAAEM
Vice President, Tennessee Chapter ■

A&O x 3?

Jennifer Kanapicki, MD FFAEM
YPS President



You've just graduated from residency, now what? Before, things were so streamlined and simple. Go to college, get into medical school, survive residency, but what's next? The opportunities are endless, but the burden of responsibility is multiplied. This is a challenging and disorienting time. A community or an academic job? How do you survive your first night shift of single coverage? What tools will you use to pass the EM boards? It can be overwhelming.

Let AAEM/YPS orient you — you know, make you A&O x 4. We are here to support you and guide you through the transition from residency to the real world. Trust me, it's an exciting and amazing time. You're making decisions on your own, you're working less and re-entering this thing called life. Let me tell you a few ways we can help.

New Projects

YPS EM Flash Facts

We are in the final stages of launching an educational flashcard app for your iPhone/iPad that allows you to review EM questions on the go. This application is a fun, interactive way to help you prepare for the boards, teach EM topics to students (perfect for new faculty), and keep you fresh on EM pearls. Look for this new benefit coming out soon. Of course, it will be free for our members!

Networking Opportunities During Board Review

It is important to network at all stages of your career, but never more important than when starting out. During our recent board meeting at Scientific Assembly, we discussed having networking opportunities (aka social events) at the AAEM Oral Board Review Courses. So, after a day of learning you can have fun with your colleagues, start new friendships, vent, and learn from each other. Stay tuned for more information on these events.

Oldies But Goodies

Common Sense & Open Mic

Do you like to write? Do you have something to say? Take advantage of the opportunity to publish in *Common Sense*. Want to break into the national lecture circuit? Sign up for Open Mic at Scientific Assembly. The winner gets to give a formal presentation at the next Scientific Assembly.

Mentoring Program

Remember all those questions I started with? After residency it can be difficult to choose among career paths. There is the standard academic vs. community-based practice question — but there is so much more. How to advance in the practice you choose? How to read a contract, how to prepare for the boards, group vs. hospital employee? You need advice from someone who has been there. That's where our Mentoring Program comes in. You will be paired with an experienced emergency physician who has already navigated the journey on which you are embarking. We have a variety of mentors in a variety of clinical settings, and you will be matched with the mentor that fits your needs.

CV Review Service

You are entering the job market and want to obtain a high quality job, so you're going to need a stellar CV. Let YPS help. One of our board members will personally review your CV and give you detailed feedback to make it shine.

Insert Your Idea

YPS is your voice. We are here to support you. We would love to hear your ideas for how to make us better and fulfill your needs. Tell us what you're thinking. Better yet, join one of our committees that interests you — whether it's education, membership, editorial, or government affairs. Email us at info@ypsaaem.org for more information.

It is now my sixth year of service in RSA and YPS. I can't tell you how honored and proud I am to be the new YPS President. I am 100% committed to continuing to advance YPS, increase membership, provide new benefits for our members, and ultimately support emergency physicians in any way possible as they start their careers. I have a strong team behind me to help accomplish that. Vice President Michael Ybarra; Secretary/Treasurer Heather Jimenez; Directors Jonathon Jones, Jeff Pinnow, Meghan Schott, and Michael Tang; and of course, Betsy Hall, our outgoing president. She left big shoes to fill, but will assist me as she continues to serve on the board as past-president.

So let YPS orient you. Use us to guide you through the transition from resident to attending physician. Use your member benefits, and let us know if there are new ones you would like to see. Lean on us, and get involved so others can lean on you. We are here to make you A&O x 4. ■

INTRODUCING EM FLASH FACTS

FREE YPS Member Benefit Coming Soon!

An iPhone and iPad application of emergency medicine questions for learning on the go.

1,000
Questions



AAEM
Young Physicians Section
Invested in your future.

**JOIN YPS
TODAY**

Walk This Way, Doc This Way — There is More Than One Way to Care for a Patient. This Month: Chest Pain

Teresa Ross, MD



A man walks into a bar. He's had a long day. While competing with other patrons for the bartender's attention, he gets frustrated and his chest starts to tighten. "What are you waiting for?" his friend says, "Go to the ER, man!"

We've met this guy before — late fifties, we'll say, maybe 10 pounds overweight. One quick look at his ECG, and we see normal sinus rhythm without abnormalities. His vital signs are normal. We ask some quick questions. In one scenario, we learn that George is a regular smoker and drinker with high cholesterol, borderline hypertension, and diabetes. This chest pain (CP) isn't his first to accompany physical and emotional stress, and it's been happening more often, including twice today. In another scenario, Wallace is a rare drinker without comorbidities who doesn't smoke and has never felt like this before. For both it's tight, left-sided CP without radiation, associated with some mild shortness of breath. It's been slowly resolving since onset one hour ago. While we're at it, let's say the young chain-smoking girlfriend with the fast-food diet, Gina, has come along too. She's annoyed and short of breath.

Now what? CP is one of the most litigious chief complaints in our field. What literature is out there to support our management of possible angina? There's old stuff and some new literature, and beyond that, there's physician preference and comfort level. Clock's ticking — let's get moving.

"Low Risk" Chest Pain: TIMI and Vancouver

In the first scenario, although George's CP is resolving spontaneously, he seems a decent candidate for that-which-we-seek: Coronary Artery Disease (CAD). We send his one hour troponin, and it's negative. However, negative cardiac enzymes will not rule out unstable angina, and this guy fits the picture. Plus, his TIMI score is two — for CAD risk factors and recurrent CP — which gives him an 8% risk of morbidity or mortality in 14 days. As a conservative doc, I'm calling George unstable angina with more than low risk. I'm admitting him to pursue further supervised diagnostic testing.

What if he had a negative stress test last year? Too bad. HPI dictates disposition in the ED. Studies show that fly-below-the-radar, non-occlusive plaques do rupture and cause ACS. In one chart review, 20.7% of CP patients presenting to the ED with a negative stress test, within three years still had significant CAD, including myocardial infarction or a positive stress test within 30 days.¹

Wallace is trickier. He's an otherwise healthy guy who had a bad day. His CP could easily be non-cardiac. How long until I can send him home? As a conservative doc, I'm still working him up for CAD, but I'm running the numbers that brand him as low risk. Current recommendations suggest several options for low risk CP: The Vancouver Chest Pain Rule would send him home; the TIMI score would admit him. If I'm thinking home, there's a negative two-hour delta CK-MB and Troponin (or single negative value after eight hours),² and then home to follow up for a stress test within 72 hours.³ These recommendations follow the Vancouver Chest Pain Rule, originally derived in 2006 to identify a cohort of very low risk CP patients who CAN go home — all while missing <2% of AMI or unstable angina. Basically, as long as your baseline ECG has nothing more concerning than flattened T waves and you've never had an MI, angina, or used nitrates (OK, that excluded 60% of their patients already — including George), you can go home with a 1.2% chance of events IF you meet these criteria too: a) you're under age 40 (28% of their remaining patients), or b) you're over 40 with a negative first CK-MB or negative delta cardiac enzymes at two hours.⁴

The two issues with this rule? The incidence of CAD in your region really does make a difference in the miss rate. In Canada,⁴ where there's more CAD, (21% of CP patients had AMI/unstable angina), miss rates were 1.2% (Sens 98%, Spec 32%), but external validation of the same rule in Iran this year (where only 15% of CP patients develop AMI/UA) showed miss rates of 1.4% (Sens 95%, Spec 56%).⁵ Perhaps more importantly, some EDs don't use CK-MB anymore — mine doesn't. So I'm only "pseudo-following" this rule, with a presumed acceptable miss rate.

Back to Wallace, another approach would admit him. His TIMI score of zero marks him low risk, with only 1.8% chance of adverse event in 14 days. That said, remember the TIMI score does NOT tell us who can go

Continued on next page

TIME RISK SCORE for UA/NSTEMI

HISTORICAL	POINTS	RISK OF CARDIAC EVENTS (%) BY 14 DAYS IN TIMI 11B*		
		RISK SCORE	DEATH OR MI	DEATH, MI, OR URGENT REVASC
Age ≥ 65	1	0/1	3	5
≥ 3 CAD risk factors (FXx, HTN, ↑ Chol, DM, active smoker)	1	2	3	8
Known CAD (stenosis ≥ 50%)	1	3	5	13
ASA use in past 7 days	1	4	7	20
PRESENTATION				
Recent (\leq 24H) severe angina	1	5	12	26
↑ cardiac markers	1	6/7	19	41
ST deviation ≥ 0.5 mm				
RISK SCORE =Total Points (0 - 7)				

*Entry criteria UA or NSTEMI defined as ischemic pain at rest within past 24H, with evidence CAD (ST segment deviation or +marker)

For more info go to www.ti.mi.org

Antman et al JAMA 2000: 284: 835 - 842

home. It was originally developed to anticipate the morbidity of patients ADMITTED for CP — and receiving anticoagulants for unstable angina at that. Its appropriate use is to risk-stratify patients to the appropriate hospital unit — not risk-stratify for discharge. A 2010 meta-analysis of ED patients admitted for CP shows strong external validity for the low morbidity rates of TIMI 0 patients: about a 1.5% risk of acute coronary event in 30 days (Sens 97%, Spec 25%). However, 97% of TIMI 0 patients in these studies were admitted to the hospital.⁶

New Possibilities: ADAPT and the 30-Day Follow Up

The recent ADAPT trial proposes a promising new decision tree to define low risk CP: it uses delta troponin I as the only biomarker and offers the best miss rate yet — 0.25% chance of a major acute coronary event (MACE) at 30 days.⁶ The algorithm is this: a) TIMI score zero, b) NEGATIVE delta Trop I at 1 and 2 hours, and c) NO new ischemic changes on initial ECG (including T inversions and Q waves). In the study 20% of enrolled patients qualified as low risk, and although most were still admitted for observation, 0.25% had adverse events within 30 days (Sens 99.7%, Spec 23%, NPV 99.7%).⁷

Even more impressive is the authors' commitment to polishing their decision tree. Their first trial, ASPECT, enrolled 3,582 patients in 14 EDs in nine countries and tested the delta of all cardiac enzymes.⁸ The next study tested the logistics of using only delta Trop I or delta Trop T.⁹ The final ADAPT study of 1,975 patients tested delta Trop I alone. Specifically, they noted that including the TIMI score for risk stratification helped decrease MACE events in the cohort from 3% to 0.25%, and using delta troponin alone rather than all cardiac enzymes improves specificity (23% vs 11%) while maintaining sensitivity (99%), likely because it works best for both early and late presenting CP.⁷

Although 74% of low risk ADAPT patients had follow-up cardiac testing within 30 days, 88% of which was during admission, it certainly suggests that these patients could be GREAT candidates for discharge and close follow up — and perhaps candidates for safe follow up far beyond 72 hours.

Remember that patients with an uninterpretable ECG — LBBB, pre-excitation, electronically paced rhythms, resting ST segment depressions <1mm at rest, and digoxin use — CANNOT use a standard exercise treadmill test to evaluate for ischemic changes.¹⁰ They require pharmacologic testing with imaging, using drugs such as regadenoson or dobutamine with Sestamibi (a radioactive tracer of coronary perfusion).

Silent MI: Women Are Higher Risk Than We Thought

Last but not least, in our brief review of bar-side stressors is a discussion of who might NOT be so low risk: Gina. In short, beware of young females with vague symptoms, vague ECGs ... and positive troponins. A JAMA study last year suggests females are more likely to have silent MI's than men by a margin of 40% vs 30% — especially when younger

(OR 1.3 for women <45yo compared to men, vs OR 1.1 as they age) — and they show increased mortality compared to men with similar symptoms (14% vs 11%), although again these differences grow less pronounced with age (OR 1.1 at age <45yo vs 0.81 when >85yo).¹¹

Take Home Messages

I don't change my practice based on one article, but I do start paying attention a bit more to the trends in my patient outcomes. We've all heard the adage that you don't want to be the first or last doc to do anything, and as a young doc I'm all the less likely to be trying brave new strategies without the input of my partners and consultants. Keeping your eyes and ears open will ensure you're staying with the pack, and within your personal comfort zone.

Dr. Ross is a former AAEM/RSA President and currently works in private practice in Virginia — a job she loves. As a young doc, she's learning to balance the thrill of attending life with the responsibilities of staying well-read, thoughtful, and efficient in the ED. She welcomes your feedback at tmrossmd@gmail.com.

References

1. Walker J, Galuska M, Vega D. Coronary Disease in Emergency Department Chest Pain Patients With Recent Negative Stress Test. *West J Emerg Med* 2010; 11(4):384-388.
2. Fesmire FM, Decker WW, et al. Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients with Non-ST-Segment Elevation Acute Coronary Syndromes. *Ann Emerg Med*. Sept 2006;48(3):270-301.
3. OConner RE, Brady W, et al. Part 10: Acute Coronary Syndromes. 2010 AHA Guidelines for SPR and Emergency Cardiovascular Care Science. *Circulation*. 2010;122: 5787-5817.
4. Christenson J, Innes G, et al. A clinical prediction rule for early discharge of patients with chest pain. *Ann Emerg Med*. 2006 Jan;47(1):1-10.
5. Jalili M, Hejripour Z, et al. Validation of the Vancouver Chest Pain Rule: a prospective cohort study. *Acad Emerg Med*. 2012 Jul;19(7):837-42.
6. Hess EP, Agarwal D, et al. Diagnostic Accuracy of the TIMI risk score in patients with chest pain in the emergency department: a meta-analysis. *CMAJ* 2010. Jul; 182(10), 1039-44.
7. Than M, Cullen L, et al. 2-hour accelerated diagnostic protocol to assess patients with chest pain symptoms using contemporary troponins as the only biomarker: the ADAPT trial. *J Am Coll Cardiol*. 2012; 59(23):2091-8.
8. Than M, Cullen L, et al. A 2-h diagnostic protocol to assess patients with chest pain symptoms in the Asia-Pacific region (ASPECT): a prospective observational validation study. *Lancet*. 2011 Mar 26;377(9771):1077-84.
9. Aldous S, Richards M, et al. A new improved accelerated diagnostic protocol safely identifies low-risk patients with chest pain in the emergency department. *Acad Emerg Med*. 2012 May;19(5):510-6.
10. Gibbons RJ, Balady GJ, et al. ACC/AHA Guidelines for Exercise Testing: Executive Summary. *Circulation*. 1997;96:345-54.
11. Canto JG, Rogers WJ, et al. Association of age and sex with myocardial infarction symptom presentation and in-hospital mortality. *JAMA* 2012; 307(8):813-22. ■

YPS 2013-2014 Board of Directors

President

Jennifer Lynn Kanapicki, MD FAAEM

Vice President

Michael Ybarra, MD FAAEM

Secretary-Treasurer

Heather K. Jiménez, MD FAAEM

Immediate Past-President

Elizabeth Hall, MD FAAEM

At-Large Board Members

Jeff Pinnow, MD FAAEM

Jonathan Jones, MD FAAEM

Meghan Schott, MD

Michael Tang, MD FAAEM

YPS Director

Michael Pulia, MD FAAEM

RSA Director

Stephanie Gardner, MD



AAEM/RSA 2013-2014 Board of Directors & Medical Student Council

Board of Directors

President

Meaghan Mercer, DO

Vice President

Rachael Engle, DO

Secretary-Treasurer

S.Terez Malka, MD

Immediate Past President

Leana Wen, MD MSc

At-Large Board Members

Michael Gottlieb, MD

Calvin Hwang, MD

Sean Kivlehan, MD

Nicole Piela, MD

Edward Siegel, MD

Victoria Weston, MD



Medical Student Council

President

Mary Calderone

Vice President

Faith Quenzer

Regional Representative – South

Ross Everett

Regional Representative – West

Melanie Pollack

Regional Representative – Midwest

Nathan Haas

Regional Representative – Northeast

Kari Gorder

International Ex Officio Representative

Alexander Simakov

Attention YPS and Graduating Resident Members

CV & Cover Letter Review

Are you ready?

Enhance your credentials.

Increase your job opportunities.

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

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

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



For more information about YPS or the CV Review service, please visit us at www.ypsaaem.org or contact us at info@ypsaaem.org.



The Ultimate EMR Plugin



Mirror your practice, improve document quality, and most importantly, deliver your message.

The PeerCharts Online™ Platform Delivers:

- Concierge Customer Care
- Personalized Content to Mirror Your Practice
- Simple and Convenient EMR/EDIS Interoperability
- Flexible Click, Talk, Type™ Input
- Single-Click Clinical History
- Maximum Efficiency at Minimum Cost
- SaaS Platform Simplicity (no installation; low initial cost; secure anywhere access)

**Emergency Medicine Documentation
Integrated Dictation
Bedside Paper Templates**

EvolveMed

175 West 200 South #4004, Salt Lake City, UT 84101 • 800.301.4901

www.peercharts.com

AAEM/RSA President's Message

Four Years Later: Reflections from a Graduating Emergency Medicine Resident

Leana S. Wen, MD MSc
AAEM/RSA President



On the first of July, four years ago, I walked through Mass General and Brigham & Women's Hospitals with an odd mixture of fear, relief, and excitement. Now, as I approach the end of my residency training, I am filled with a similar hodgepodge of emotions. It seems fitting that for my last column as your AAEM/RSA president, I record my five reflections from residency.

1. "You were terrified of being a doctor!" I mentioned this article to the attending who oversaw my first shift as a newly-minted doctor. That day is forever etched in my mind; did he remember it? Much to my great embarrassment, he chuckled and said, "Of course, I kept telling you not to worry if you didn't know something, but you were scared of everything!"

Though I knew I was there to learn, it took me a while to get over my insecurities about not knowing so that I could focus on learning. And the learning was everywhere. On every single shift I learned from great clinicians, not just about diagnosis and treatment, but also important lessons on how to help people feel better, how to teach, and how to lead. As my mentors say, it is called the practice of medicine for a reason, and we should embrace rather than fear the learning.

2. "Mistakes will happen." Every doctor has made a mistake sometime in her life. Whether it's a technical error (inserting a central line into the carotid), a systems error (ordering a medication for the wrong patient), or a communication error (angering a patient or colleague), all of us graduating residents have made some kind of error. I myself made all three of these errors, and more.

With the volume of patients we will see throughout our careers, being a source of medical error and interpersonal conflict is a terrifying and humbling thought. A wise EP told me that just as residency is the time to learn how to practice medicine right, it's also the time to learn things like how to disclose mistakes to patients, and how to deal with conflict. "Don't shy away from difficult situations," he told me, "Put yourself in the middle of them to see what others do, and then develop your own style."

3. "That man has a name, and it's not 'the chest pain in room 8.'" As busy residents with long to-do lists, we often resort to dehumanizing our patients and branding them as chief complaints to quickly decide their disposition. On the surface this might appear to save time, but dig a little deeper and such algorithmic, depersonalized medicine results in unnecessary tests, misdiagnosis, and a poorer patient experience.

Practicing cookbook medicine is not why we chose to become doctors. My work became much more meaningful when I made a commitment to connect with each patient, no matter how busy I was. I learned that

the "old guy with dementia" was a world-renowned philosopher, and that the "onc patient with fever and neutropenia" had ten children with her preschool sweetheart. As physicians we are privileged to hear so many stories from so many people. Cherish this gift we're given to share in our patients' rich lives.

4. "Residency is hard, and you have to take care of yourself." My best friend from medical school, who had just completed his pediatric residency, warned me of this before I started my internship. How right he was. Work hours may have improved since our forefathers trained, but residents still work a lot and are exposed to high-stress situations with life-and-death consequences. Studies have shown that rates of depression and burnout increase sharply during training, yet the "hidden curriculum" of medical training still favors bravado over openness. Residents are taught to "suck it up" instead of talking about difficult situations and taking care of ourselves.

Continued on next page

Now Being Accepted!

2013-2014 AAEM/RSA Membership Applications

Join or renew your membership online at aaemrsa.org/joinrsa or call our office at 800-884-2236 to renew over the phone.

Have You Moved?

If you are a graduating resident or medical student and your email address will be changing, we recommend you use an email address outside of your institution once you've logged into the RSA members only section. You may update your email address on file at any time. This will ensure your member benefits will continue without interruption.

Please include any changes to

- Last Name (include maiden name if applicable)
- Mailing Address (including city, state and ZIP)
- Email Address
- Telephone Number

To update your contact information, please login to your members only account at aaemrsa.org/myrsa or contact us at info@aaemrsa.org or (800) 884-2236.

This is not the way it has to be! I learned this lesson the hard way during my second year of residency, when my mother died. I suppressed my emotions rather than seeking help, and saw how easy it is to become isolated. Fight this impulse and stay connected. Find peers you can reflect with and openly speak with about your experiences. Nourish the other people in your life and recognize their critical role in helping you through this process. For me, it was my wonderfully supportive husband and my friends who sustained me and kept me grounded. Make time for these people in your life. I cannot think of anyone who regrets the time spent with loved ones and laments, "If only I had spent that day reading Rosen's!"

5. "Emergency medicine is a phenomenal field." The first grand rounds lecture I heard as an intern was by Dr. Larry Weiss, then President of AAEM. He spoke about how EM is an ideal specialty for advocacy: on the front line of medical care, interacting with every aspect of the health-care system, we are in the best position to be advocates for our patients, our communities, and our society. EM also provides a platform for you to follow your passion — whatever it happens to be.

As I finish my training and enter the career I've always envisioned, one that combines patient care, narrative writing, and health policy, I can very much attest to EM being a versatile and fantastic specialty. We have the incredible opportunity to use our training to do what we love, while making a difference to transform our health care system and to improve care for our patients.

What else can I say about these last four years? It's been a roller coaster ride, and now that I'm about to embark on the next stage of my journey, as an attending in the George Washington University EM Residency in D.C., I am filled with exactly the same emotions of fear, relief, and excitement that I came to Boston with. I have learned so much from so many incredible people along the way. Finally, I have been extremely fortunate to be exposed to AAEM and AAEM/RSA early in my training, and to serve the organizations that really fight for our specialty and our patients.

Now, what will the next four years bring?

For more reflections on EM and medical care, please read my new book, When Doctors Don't Listen: How to Avoid Misdiagnoses and Unnecessary Tests. I welcome your comments, @DrLeanaWen, and www.drleanawen.com. ■

Get the AAEM Fact of the Day and other AAEM Updates.

 Find us on Facebook

 twitter

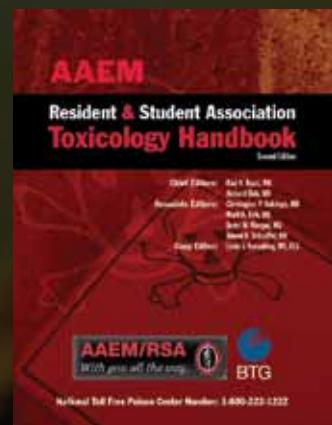
AAEM Resident & Student Association Toxicology Handbook

The *Toxicology Handbook* is an easily accessible reference of common toxicological emergencies. It is authored primarily by toxicologists from a wide range of academic programs and backgrounds, who focused on the clinical aspects of common ingestions, with a special emphasis on the "tricks of the trade" that specialists in the field acquire with time and experience. We hope that you will find it useful in the care of poisoned patients.

All new RSA resident members receive one FREE copy!

For all other orders:
Member Price: \$25
Nonmember Price: \$40
Plus Shipping & Handling

Get your copy today at aaem.org/bookstore



Chief Editors:
Ziad Kazzi, MD FAAEM
Richard Shih, MD FAAEM

Editors:
Christopher Holstege, MD FAAEM
Mark Kirk, MD
Brent Morgan, MD FAAEM
Tammi Schaeffer, DO FAAEM

Resident Journal Review

Assessing Volume Status and Fluid Responsiveness in Resuscitation

Authors: Allison Regan, MD; Eli Brown, MD; Jonathan Yeo, MD; Susan Cheng, MD MPH

Edited by: Jay Khadpe, MD FAAEM; Michael C. Bond, MD FAAEM

Fluid loading is the first step in the resuscitation of hemodynamically unstable patients. Adequate tissue or organ perfusion is the goal because under-resuscitation results in inadequate organ perfusion, while over-resuscitation increases the morbidity and mortality in critically ill patients. The traditional measurements used to assess resuscitation were based on cardiac filling pressures. They were static measurements such as central venous pressure (CVP) and pulmonary artery occlusion pressure. However, these measures are very invasive and have not been shown to predict fluid responsiveness. There are newer, dynamic tests of volume responsiveness based on the principles of the Frank-Starling curve. Each test uses a maneuver that changes the venous return (preload) and then measures the corresponding change in stroke volume as a marker of fluid responsiveness. Tests that assess changes in pulse pressure, stroke volume, and oximetric waveform are used in mechanically ventilated patients, while passive leg raise maneuvers are done in the spontaneously breathing patient. The role of ultrasound in determining fluid responsiveness has also been studied. In the end, the ultimate goal is to assess whether a critically ill patient's stroke volume will be increased by the administration of a fluid bolus.

Marik PE, Baram M, Vahid B: Does the central venous pressure predict fluid responsiveness? A systematic review of the literature and the tale of seven mares. *Chest* 2008, 134:172-178.

Central venous pressure measurements are utilized in many intensive care units (ICUs), emergency departments, and operating rooms throughout the world. It is used to assess the fluid status of patients and to aid in decisions regarding administration of fluids or diuretics.

This review addressed CVP monitoring and its ability to predict fluid responsiveness. Clinical trials that reported either of the following were included in the study: (1) the correlation between CVP and measured blood volume, or (2) the correlation between CVP or change in CVP and change in stroke index/cardiac output following a fluid challenge.

Five of the studies compared CVP with measured blood volume and 19 of the studies assessed changes in CVP and cardiac performance following a fluid challenge. Of the five trials that addressed CVP and its relation to the measured blood volume, the pooled correlation coefficient was 0.16. The pooled correlation coefficient between change in CVP and change in cardiac index (CI) following a fluid challenge was 0.11.

Based on the findings above, Marik et al. concluded that there was no association between CVP and blood volume, and that CVP did not predict fluid responsiveness.

Marik PE, Monnet X, and Teboul JL. Hemodynamic parameters to guide fluid therapy. *Annals of Intensive Care* 2011, 1:1.

Clinical studies demonstrated that only 50% of hemodynamically unstable critically ill patients are volume-responsive. So, how do we determine which patients should receive fluids? Using the Frank-Starling Principle, as the preload increases, left ventricular stroke volume increases until the optimal preload is achieved at which point the stroke volume remains relatively constant.

In the mechanically ventilated patients, the pulse pressure variation (PPV) using the arterial waveform, the stroke volume variation (SVV) from pulse contour analysis, and the variation of the amplitude of the pulse oximeter plethysmographic waveform have been shown to be HIGHLY PREDICTIVE of fluid responsiveness. These techniques are based on the simple physiology of positive pressure ventilations. Insufflation decreases RV preload, increases RV afterload and these leads to a decreased RV stroke volume, which are at the minimum at end inspiration. The LV stroke volume is at the minimum at end expiration. The cyclic changes in RV and LV stroke volume are greater

Continued on next page

**ENGINEERING DEGREE?
LOOKING FOR A CAREER CHANGE?**




STAFFING@BRCONLINE.COM

Use Medical and Engineering Training

Analyzing Injuries and Mechanism of Injuries

Full Time Positions

No Patient Care



WWW.BRCONLINE.COM

210.691.0281

when the ventricles are on the sloped portion of the Frank-Starling curve. A variation of greater than 12% is highly predictive of volume responsiveness.

The "Pleth Variability Index" (PVI) is an automated measurement of the "Perfusion Index" (PI) which reflects the amplitude of the pulse oximeter waveform. The PVI correlates with the respiratory induced variation and can be used to predict fluid responsiveness noninvasively in mechanically ventilated patients. There are limitations on PVV and PVI, such that tidal volume needs to be at least 8ml/kg (which is the higher end of standard lung protective tidal volumes of 6-8ml/kg) and it cannot be accurately used in patients with arrhythmias or spontaneously breathing.

In ventilated patients, mechanical insufflation with end inspiratory occlusion for 15 seconds can increase arterial pulse pressure and pulse contour cardiac output. An increase of more than 5% accurately predicts fluid responsiveness.

In spontaneously breathing patients, passive leg raise (PLR) is the technique of choice. Blood transferred to the heart during PLR increases cardiac preload and is considered a reversible "autotransfusion," it serves as a test of preload responsiveness. The response of aortic blood flow measured by esophageal Doppler, velocity time integral measured by transthoracic echocardiography, and femoral artery flow measured by arterial Doppler to PLR, are helpful in predicting the response to volume administration.

Marik PE. Noninvasive Cardiac Output Monitors: A State-of the-Art Review. *Journal of Cardiothoracic and Vascular Anesthesia* 2013; 28 (1): 121-34.

Bolus thermodilution has historically been the gold standard for determining cardiac output; however, it is invasive as it requires a pulmonary artery catheter. A technique for estimating cardiac output is the esophageal Doppler technique. A Doppler transducer probe is placed in the esophagus and the cardiac output is calculated based on the diameter of the descending aorta and the aortic blood velocity signal. However, there are several limitations: there is a significant learning curve, poor positioning of the probe tends to underestimate the cardiac output, and it does not allow for continuous monitoring.

Cardiac output can also be estimated using the concept of pulse contour analysis. This method can calculate stroke volume from the arterial pressure waveform as long as both arterial compliance and systemic vascular resistance are known. It does not, however, correct for discrepancies between central and peripheral blood pressures, which can be large in conditions of intense vasoconstriction and can therefore result in a falsely low cardiac output value. Examples of two pulse contour analysis systems are the LiDCO and the PiCCO Systems. Both of these systems have been shown to be at least as reliable as intermittent pulmonary artery catheter thermodilution. The FloTrac System is an example of a pulse contour analysis that does not require calibration, but instead estimates a patient's vascular compliance based on variables such as sex, age, height, and weight. The system is operator independent and only requires a peripheral arterial catheter. Unfortunately, it has shown poor agreement when compared to intermittent thermodilution and has not been shown to accurately trend changes in stroke volume after a volume challenge or with vasopressors.

Thoracic Electrical Bioimpedance (TEB) has also been used to calculate stroke volume. A high-frequency electric current of known amplitude and frequency is applied across the thorax and the voltage of the returning signal is measured and compared to that of the injected signal. The ratio between voltage and current amplitudes is a measure of transthoracic impedance, which varies in proportion to the amount of fluid in the thorax. These bioimpedance values have shown poor agreement and are sensitive to placement of electrodes, lung edema, and body size, so are not ready for prime-time use.

Another noninvasive example is the NICOM device, which estimates stroke volume by measuring the bioreactance across the thorax. Bioreactance refers to a phase shift in voltage, which can only occur from pulsatile flow. In the thorax, the overwhelming majority of pulsatile flow is from the aorta. Therefore, the NICOM device can estimate CO by measuring bioreactance. Multiple studies have shown a high correlation between CO measured by bioreactance to that measured by thermodilution and pulse contour analysis. In fact, one study by Raval et al. showed the NICOM system to be more precise than thermodilution in accurately tracking changes in CO.

Conclusion

Fluid administration has been a key component in the resuscitation of critically ill, hemodynamically unstable patients. Various methods for assessing volume status and fluid responsiveness have developed over time.

Static measures to predict fluid responsiveness include CVP, PAOP, RVEDVI, LVEDA, and GEDV; which have had poor to moderate accuracy in determining fluid responsiveness.

In contrast to static preload measures, which rely on hemodynamic values at a given point in time, dynamic predictors have increasingly gained favor for predicting fluid responsiveness. PPV and SPV have been found to be superior to several static measures of fluid responsiveness such as LVEDA and PAOP.

Other dynamic measures include peak aortic blood flow velocity variation (which is measured by TEE), measurement of respiratory variation in IVC diameter, and PLR, which have all shown to be good predictors of fluid responsiveness.

Cardiac output can be estimated using the concept of pulse contour analysis. These devices include the LiDCO system, the PiCCO system, the FloTrac System, and the MostCare system.

The NICOM device is noninvasive and estimates the SV by measuring the bioreactance across the thorax. In the thorax, the majority of pulsatile flow is from the aorta which allows the device to estimate the CO.

Additional References:

- Rivers E, Nguyen B, Havstad S, et al: Early goal-directed therapy in the treatment of sepsis and septic shock. *New England Journal of Medicine* 2001; 345, 1368-1377.
- Raval NY, Squara P, Cleman M, et al: Multicenter evaluation of noninvasive cardiac output measurement by bioreactance technique. *J Clin Monit Comput* 2008; 22:113-119. ■

Medical Student Council President's Message

Patience, Young Grasshopper

Mary Calderone, MS3

AAEM/RSA Medical Student Council President



Although the excitement of finally taking part in an emergency medicine clerkship at the beginning of my fourth year continues to build, my third year core clerkships have partially prepared me for emergency medicine in their own unique and valuable ways.

I long anticipated my internal medicine rotation to further develop my skills. Although I started the rotation with an understanding of the key differences

between internal medicine and emergency medicine, I looked forward to the opportunity to become proficient in the areas in which they overlap: the basic skills of performing an H&P, the interpretation of laboratory values, the integrated assessment of all systems, the application of medical knowledge to a wide differential, and the understanding of basic management strategies for common medical problems.

Indeed, my internal medicine rotation provided a truly enriching experience, both the most demanding and rewarding one thus far. I returned home every night with utter physical, emotional, and intellectual exhaustion that in a paradoxically, exciting and gratifying way signified how rapidly I was evolving into a physician. While working clinically, I didn't pass a waking minute without learning something from my patients and my team members. However, amidst all of this intense personal and professional growth, I eventually acknowledged an underlying angst.

I often found myself torn between goals on my internal medicine rotation. On one hand, I felt the need to know every detail about my patients. I wanted to perform the most thorough and complete H&P to present the widest and best thought-out differential, and to address every problem in my plan. On the other hand, as someone preparing to enter the field of emergency medicine, this approach concerned me. I reflected on my understanding of the skills required of an emergency physician (EP) — the ability to efficiently obtain, prioritize, and act upon patient data. These two approaches seemed to compete. I was learning and striving to be detail-oriented, rather than to grasp the big picture and take the practical, efficient approach required of EPs. I feared that when I finally reached my emergency medicine rotation, I would need to completely shift my clinical thought process. I wanted to avoid this and begin learning how to think like an EP now.

In late January, our EM interest group held an advising session for third years interested in emergency medicine, which happened to fall in the middle of my internal medicine rotation. After we covered advice about visiting rotations and fourth year planning, I raised my hand and asked the question I had pondered all month: "How can medical students planning to pursue emergency medicine balance being as thorough and detail-oriented as medical students should be, while also learning to think like emergency physicians?"

The response I got from our panel of dedicated emergency medicine faculty at the advising session reassured me. My frustration is a common one for third year students who know early on that they plan to seek a career in emergency medicine. Indeed, the approach we are expected to take in order to be successful medical students doesn't necessarily equate with the approach required of a successful EP. I realized I was getting ahead of myself. Sometimes, we need to crawl before we walk. Taking a detail-oriented approach in our training allows us to ultimately develop the ability to prioritize the most critical information for managing a patient. The process of obtaining and sifting through data and observing how different details ultimately weigh out in a patient's treatment course nourishes our clinical gestalt, allowing us to gradually build a sense of what is important based on experience. In fact, a seemingly irrelevant fact from the patient's history may ultimately have critical implications. Third year, and perhaps not even fourth year, will prepare us to think like experienced EPs — that's the goal of residency training and the life-long learning as an attending that we will ultimately undertake.

A faculty member at the advising session, Dr. Matt Pirotte, also referred us to a video of a lecture entitled, "How to Think Like an Emergency Physician" by Dr. Reuben Strayer, which offered an enlightening perspective on my dilemma. As medical students we learn the "bottom-up approach" to patient care — we start with a chief complaint, perform a detailed history and physical, and then focus on navigating a wide differential diagnosis to ultimately answer the question, "What does this patient have?" Experienced EPs, however, take a "top-down approach" in order to answer the question, "What does this patient need?" The first point in the algorithm is to determine if the patient requires resuscitation. If not, the EP proceeds with a H&P that focuses on the most critical and dangerous diagnoses, while still conceptualizing the patient's complaint in the context of his or her past medical history, medications, and social history.

The lecture inspired and excited me for the approach that I will ultimately build with experience. However, it also reminded me of the need to remain patient during training. As I finish up this year, I will continue to aim to know as much as I can about my patients and stay detail-oriented, given that I have the luxury of time, a rarity in the ED. However, I will still take the opportunity to think like an EM physician whenever possible. The most effective way I've found to practice this skill is to utilize my oral H&P presentation as an opportunity to critically analyze and distill the most important information, and to focus on ruling out the high acuity diagnoses in my assessment and plan.

In summation, if you find yourself in my boat check out the video of Dr. Strayer's lecture, and remind yourself of Master Po's advice to young Caine in the 1970's TV series Kung Fu: "Patience, young grasshopper." ■



**Now Hiring Emergency Medicine Physicians
To provide services at**

Naval Hospital Pensacola, Florida

Catalyst is a Service Disabled, Veteran Owned small business that provides medical services at U.S. Department of Defense hospitals and clinics throughout the nation.

Emergency Room Physician opportunities currently exist at Naval Hospital Pensacola. Full or half time positions are available. These positions are offered with full benefits or you can take a higher pay rate and waive benefits.

Enjoy a great work environment.

Pensacola offers gorgeous white sand beaches, unlimited outdoor recreation and a wide range of metropolitan attractions.

Malpractice protection is provided and any state license is accepted. If you are interested in enhancing your career by working with the men and women who serve our country, please contact us now!

www.catalystpsi.com

For more information contact:

Lisa Layton
571-299-8766

Megan Heath
301-518-3490



VIITH MEDITERRANEAN EMERGENCY MEDICINE CONGRESS

8–11 September 2013
Marseille, France



AAEM-0113-021