

COMMON SENSE



VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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COMMONSENSE

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AAEM Mission Statement

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

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

Membership Information

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

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

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

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

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Thank You for Another Successful Scientific Assembly!

David A. Farcy, MD FAAEM FCCM — President, AAEM



Premier Education from AAEM

I'd like to extend my sincere thanks to everyone who made the 25th Annual Scientific Assembly a great success! From the Scientific Assembly planning subcommittee, to every member and attendee who participated, to every speaker who volunteered their time and expertise — AAEM19 showcased the culmination of everyone's efforts. Our annual Scientific Assembly continues to offer a diverse lineup of cutting edge, focused presentations that change our practice and positively impact our patients. As always, our meeting is FREE for members! We remain committed to providing affordable high-quality continuing medical education in emergency medicine.

Thank you to our keynote speaker, Dr. Matthew Wetschler, who shared his inspiring journey from sustaining a catastrophic injury and in less than a year, making a near-complete recovery. He shared his lessons gained on his journey and about navigating our most difficult challenges with strength and grace.

Our dynamic plenary speakers filled the room with the following stand-out sessions:

- Amal Mattu, MD FAAEM: Emergency Cardiology 2019: The Articles You've Got to Know!
- Peter M.C. DeBlieux, MD FAAEM: Sepsis – New Recommendations
- Thomas M. Scalea, MD FACS MCCM: Trauma Updates
- Ilene Claudius, MD FAAEM FAAP FACEP: Efficient EM Care of the Child with Special Needs
- Corey M. Slovis, MD FAAEM FACP FACEP: Essential Resuscitation Articles 2018-2019
- Evie Marcolini, MD FAAEM FACEP FCCM: Neurology Updates
- Haney Mallema, MD FAAEM: Critical Care in Review

Watch for these sessions and more AAEM19 educational content coming to AAEM Online this summer! Selected recorded sessions will be accessible for AAEM members (an exclusive member benefit!) in the next few months. You can stream or download the audio and video files. Visit www.aaem.org/aaem-online to get started.

New pre-conference offerings this year included a two-day boot camp version of our stellar Written Board Review Course (the full four-day course is offered this August 13-16 in Orlando, FL — register today!) and a partnership with the Teaching CoOp for a full day session on presentation skills, learning theory, the struggling learner and providing feedback to empower physician educators.

Attendees of the Medication Assisted Treatment Waiver Training jointly provided by the American Academy of Addiction Psychiatry were able to apply for the Drug Enforcement Agency waiver ("X-license") to prescribe buprenorphine, one of three medications (buprenorphine, naltrexone and methadone) approved by the FDA for the treatment of opioid use disorder, a direct benefit to the communities those physicians serve.

The Uniformed Services Chapter Division educated attendees on translating military damage control resuscitation strategies into civilian practice with the hands-on Military Hemorrhage Control course.

Returning attendee favorite pre-conference courses were again well received: Resuscitation for Emergency Physicians, Ultrasound Beginner and Advanced, ECG in the ED, Medical Student Track, and the 2018 LLSA Review Course.

Wellness and Social Events

This year in Las Vegas, the AAEM Scientific Assembly continued to place special focus on our members' wellness. The AAEM Wellness Committee hosted a number of events at AAEM19 including: the inaugural Coffee Crawl; Airway at AAEM Storytelling, F³ Meals – Food, Friendship, and Fun; the Wellness Room and Mindfulness Session; and the System-Based Drivers of Burnout Focus Group.

This year at AAEM19 we also debuted:

- **First-Time Attendees Meet-Up:** New attendees and seasoned members met to connect on a personal level and learn the in's-and-out's of the AAEM and Scientific Assembly.
- **Social Media Bar:** Social Media Committee members offered their expertise and guidance to those looking to create profiles or extend their online reach.
- **Women in EM Networking Lunch:** Over 80 attendees came together for this inaugural lunch hosted by the Women in Emergency Medicine Committee. The lunch featured highlights and impact of the WiEM Committee and recognition of Women in EM by co-chairs Dr. Faith Quenzer and Dr. Vicki Norton. Thank you to everyone involved with the committee who organized such a successful event and made the space for this important networking. Stay tuned for next year's event!

Looking Forward

As we continue to move forward in 2019, AAEM has a packed calendar of advocacy and educational events for you to join. See (page 13) for a complete listing of directly and jointly sponsored conferences.

I encourage all members to stay engaged with AAEM by reading the weekly eNewsletter, AAEM Insights. This is our main weekly communication featuring important announcements, benefits, upcoming events, and committee announcements — members should take the time to read it. The Academy is a dynamic organization with many ongoing projects, advocacy initiatives, and educational opportunities all focused on you our members. Insights is the best way to quickly catch-up on our work and engage with the Academy. Remember, this is your organization and we work tirelessly to bring you the best value. Communication works both ways and I encourage you reach out to the board of directors at info@aaem.org with your ideas and feedback. ●



AAEM19 Recap

AAEM19 Wrap-Up from the Co-Chairs

Joelle Borhart, MD FAAEM, Evie Marcolini, MD FAAEM — Scientific Assembly Subcommittee Co-Chairs



The 25th Annual AAEM Scientific Assembly in Las Vegas was a celebration of 25 years of providing outstanding emergency medicine education. The Academy has come a long way since the first SA held in Philadelphia in 1994. We broke records again with 1,257 attendees — the highest registration ever!

Amal Mattu showed us how the standard of care has changed with his plenary on critical updates in emergency cardiology. More powerhouse plenaries followed from Peter DeBlieux (sepsis), Tom Scalea (trauma), Ilene Claudius (pediatrics), Corey Slovis (resuscitation), Evie Marcolini (neurology), and Haney Mallemat (critical care).

We were fortunate to feature fellow emergency physician Matthew Wetschler as our keynote speaker. Dr. Wetschler shared his inspiring story of surviving a near fatal surfing accident that resulted in him being paralyzed. Six weeks after the accident, Dr. Wetschler walked out of a rehab facility, and two weeks before Scientific Assembly he worked his first shift back in the ED. His powerful story of resilience, perseverance, and hope resonated with all who heard him.

Another highlight of SA was the first annual Women in Emergency Medicine Networking lunch attended by 84 participants — both men and women. This luncheon will hopefully be the first of many to come, and highlights the active Women in Emergency Medicine (WiEM) Committee that has grown tremendously in size and activity.

The rapid-fire Breve Dulce track (formerly known as Pecha Kucha), led again by Zack Repanshek continues to be one of the most popular sessions of SA. It was standing room only as a mix of seasoned speakers and fresh faces delivered high-yield talks covering everything from wellness to the many uses of tranexamic acid.

Gentry Wilkerson directed flawless pre-conference sessions that featured the popular recurring ultrasound, resuscitation, ECG, and LLSA courses as well as brand-new additions including MAT Waiver Training and TeachingEM. For the third year in a row, Mak Moayed organized the popular Small Group Clinics, which gave attendees hands-on practice in LVAD management, joint reduction, vaginal delivery, and more.

Jack Perkins piloted a special session this year, bringing in a cancer survivor, the wife of another cancer patient who passed away and the oncologist who treated both of these patients to the stage for a panel discussion. This unique panel reviewed some of the pathophysiology of neutropenic fever in the oncology patient, and explained to us in first person

the mindset and needs of a patient receiving chemotherapy, relating it to their experience in emergency departments. This was an eye-opening experience for us in the audience — we'd love to know how you liked it and whether it would be something to bring back with another medical issue.

The one and only Billy Mallon again hosted the 3rd Annual Airway at AAEM Storytelling session, with great attendance and participation and some heartwarming and thought provoking stories. Thank you Billy!

We had an energetic group of medical student ambassadors, who were omnipresent and ever helpful in keeping the conference going. Special educational sessions were targeted toward their benefit, and they received a warm welcome from attendees and the program subcommittee. Thank you student ambassadors!

The Open Mic Session was a great success, with seven judges (thank you) and two winners Brian Parker, MD MS with "Heavyweight Resuscitation Champion" and Diana Ladkany, MD FAAEM with "Imaging in Pregnancy." As winners of this year's competition, Drs. Parker and Ladkany are invited to speak at AAEM20 in Phoenix — we look forward to their talks!

We hope that you enjoyed the scientific content, the new modalities of learning and the young up-and-coming speakers this year. Our goal is to continue in the tradition of bringing in a combination of your perennial favorites and some new speakers to keep you educated, inspired, and coming back every year for more. Please let us know your thoughts and we hope to see you next year in Phoenix, Arizona for AAEM20 April 19-23! ●



Total Registered for AAEM19: 1,257

Total number of exhibitors: 65

Number of speakers: 147

Number of photo competition submissions: 301

Number of WestJEM competition submissions: 9

Number of JEM abstract competitions: 71

Number of YPS poster competitions: 12

Airway at AAEM attendees: ~150

Number of impressions on the #AAEM19 hashtag: 10,776,000

Tweets on the #AAEM19 hashtag: 3,367

Number of AAEM19 mobile app participants: 1,240

Passport to Prizes Participants: 98

Passport to Prize Winners: 18

Number of Women in EM Networking Lunch Participants: 84





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AAEM19 Co-Chairs

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2019 AAEM Award Winners

Master of the American Academy of Emergency Medicine – MAAEM

Mark Reiter, MD MBA MAAEM FAAEM
Daniel F. Danzl, MD MAAEM FAAEM

Amin Kazzi International Emergency Medicine Leadership Award

Zeki Atesli, MD
Jim Connolly, MBBS FRCS(Ed) FCEM
Rajat Gangahar, MBBS FRCS(Ed) FCEM
Bob Jarman, MBBS MSc FRCSE FRCCEM
Hein Lamprecht, MD PhD

David K. Wagner Award

Andy Walker, MD FAAEM

James Keaney Award

Loice A. Swisher, MD FAAEM

Joe Lex Educator of the Year Award

Joelle Borhart, MD FAAEM

Robert McNamara Award

Joel M. Schofer, MD MBA CPE FAAEM

Resident of the Year Award

MohammedMoiz Qureshi, MD

2019 AAEM/RSA Award Winners

Kevin G. Rodgers Program Director of the Year Award

Aloysius "Butch" Humbert, MD

Program Coordinator of the Year Award

Michele "Miki" Adair-Russo

Committee Member of the Year Award

Ryan DesCamp, MD MPH
Gabriel Stahl, MD MPH



2019 AAEM Competition Winners

Open Mic Competition

Brian Parker, MD MS
Diana Ladkany, MD FAAEM

AAEM/RSA and *Journal of Emergency Medicine* Resident Research Forum Winners

Joseph G. Salameh, DO	1st Place
David A. Kim, MD PhD	2nd Place
Anwar S. Ferdinand, MD	3rd Place

AAEM/RSA *WestJEM* Population Health Research Competition

Cortlyn Brown	1st Place
Anna Yang	Runner-Up
Austin T. Jones	Runner-Up

YPS Poster Competition

Michael Gottlieb, MD RDMS FAAEM	1st Place
Katharine Burns, MD FAAEM	2nd Place
Kraftin E. Schreyer, MD CMQ FAAEM	3rd Place

Photo Competition

Timmy Cheung, DO
Matthew J. Warner, MD FAAEM



Congratulations to the 2019-2020 AAEM Board of Directors!

AAEM is proud to welcome the newly elected board.

To contact the board of directors, email info@aaem.org.



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Emergency Medicine Wellness Bill of Rights

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



Sitting in an airport after leaving the latest AAEM Scientific Assembly is a place for me to reflect upon the last several days of lectures, meetings, social events, and personal interactions. Attending the Scientific Assembly, as I have mentioned in previous articles, is a “wellness event” for me. The meeting

allows me to charge my emergency medicine batteries. Listening to one of the many rock star lecturers like Amal Mattu or Peter Deblieux or a new young academic at an open mic session allows me to feel like I am part of the broader emergency medicine community. You can hear new opinions and approaches to problems we face in our practice every day. These are all great, but to me, the real magic occurs standing with a cup of coffee hearing how the rest of the country is holding up.

The tales of success and failure and how different practitioners deal with the various common stressors allow me to realize that my issues and concerns are not unique. In fact, we in the end really share most of the same issues just in different forms. Speaking to doctors in different practice settings, whether it be a huge inner city hospital to a small rural hospital, lets you consider the same problem from many perspectives. The tales of success, failure, or stress allows you to see the various emotional, intellectual, and other responses to these issues. Sometimes there is a flash of genius when you hear how someone solved what to you seemed an insurmountable task. These interactions give encouragement to those having troubles. You can hear the range of situations from great success while flourishing in a career to others who are just barely hanging on by their fingertips.

What is the difference between these two groups? This brings me to “wellness” and what it means to different people and what it should mean to you and AAEM. Wellness has many forms and strategies. Interacting with fellow emergency physicians makes me ponder what I as a colleague, partner, friend, or whoever could and should do in this regard. What is your responsibility to yourself and your emergency medicine community? The more I think about it the more I realize that whether you work for a CMG, an independent group, academic setting, locums, military, or wherever the stressors are intertwined. Your fellow emergency physicians can be feeling burned out for various reasons whether they are related to the insanity which is now modern medicine or some personal issue. Certainly, there are unique individualized causes for burnout but in my experience, they usually boil down to a lack of control at work and/or personal issues related to relationships, family, money, or substance issues.

What about writing an Emergency Medicine Wellness Bill of Rights? Could this organization with input from any interested stakeholder put together some core rights which we could promulgate and try and honor? What might these be? Could you list ten things which you feel are inalienable rights on a shift?

I was raised in a household where I was taught that success in life was “10% what happened to you and 90% what you do about it.” This may seem simplistic but there is real truth in the phrase. Being a World War II buff, I have been fortunate to live in the city where the National World War II Museum is located. I have attended many lecturers and tours and met many Holocaust survivors or other survivors of incredible ordeals. I was fortunate several years ago to be able to sit and speak with Lester Tenney who survived the Bataan Death March and was a prisoner-of-war in the Philippines and then in Japan for years. *My Hitch in Hell*, his book based on his experience is not an easy read. After surviving years of torture, he returned home to find that he had been declared dead and his wife had remarried and had a child. Somehow, he rebuilt his life, married, became a college professor, and lived until the age of 96. This

type of experience makes me wonder what is the difference between these survivors.

What makes one survivor of unspeakable horrors succeed and be content while another's spirit is broken for life. Consider reading Victor Frankl's book titled *Man's Search for Meaning*. He was a psychiatrist who survived

Auschwitz. It gives one perspective on this issue and in the end, it relates to wellness and resiliency. How does one person become self-actualized while another cannot overcome these events?

There is no intention by me to compare the challenges we face in America's emergency departments to the Holocaust or the Bataan Death March, but there are lessons to be learned and food for thought. Each emergency physician's path to wellness is different but there should be shared tools and resources which can help in this regard. We all see and hear examples of burnout in our emergency departments. When I listen to the tirade from a doctor about seeing yet another fully dressed patient with knee pain what I hear is frustration. Burnout is in the end the opposite of resiliency and is often caused by a lack of autonomy in our practice. We are daily being held responsible for things which we do not control. This is a formula for frustration and burnout.

So, what can AAEM do in this regard? I was fortunate to be able to attend several wellness events at the Scientific Assembly. The Wellness Committee is active and interested in you and helping our members with these challenges. AAEM is very fortunate to have such an incredible group of emergency physicians who are championing this cause. This group is exploring the common issues and concerns facing all of us in our practices. Certainly, AAEM cannot wave a wand and make the practice of emergency medicine self-actualizing and carefree. The violent



FROM THE EDITOR'S DESK psychiatric patient, stroke protocols, EMR, nursing shortages, and boarding issues will still be there on your next shift.

During one of the Wellness Committee's events, I attended a small group session where these groups sat around and brainstormed about ideas and solutions. This is definitely not a one solution issue which can be fixed in a quick and easy way. Sitting back, listening to those in my group I was struck by the depth of talent in this group of emergency physicians. Sadly, I do not remember the individual who made mention of the idea which is the title of this article. What about writing an Emergency Medicine Wellness Bill of Rights? Could this organization with input from any interested stakeholder put together some core rights which we could promulgate and try and honor? What might these be? Could you list ten things which you feel are inalienable rights on a shift?

Low hanging fruit in this line would simply involve having time to go to the restroom, time to have a cup of coffee, maybe be able to walk outside and see the sunshine or moonshine for a minute. I don't know about you but working in a room with no windows can be a real downer. What would you put on the list? I know that making this list will not solve the problem but maybe they would provide insight into what our profession is missing and be a place to start. *I challenge you to send in your ideas or join the Wellness Committee.* Contact info@aaem.org. ●

Introducing the AAEM Member Bulletin



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

Visit the *Common Sense* website to learn more and submit your updates for publication!

www.aaem.org/resources/publications/common-sense ●

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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 1-1-2019 to 6-5-2019.

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

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The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from 1-1-2019 to 6-5-2019.

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AAEM Conferences

August 13-16, 2019

Written Board Review Course
Orlando, FL
www.aaem.org/written-board-review

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ED Management Solutions: Principles and Practice
New Orleans, LA
www.aaem.org/education/events/ed-management-solutions

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Mediterranean Emergency Medicine Congress - MEMC19
Dubrovnik, Croatia
www.aaem.org/MEMC19

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Dallas, TX and Philadelphia, PA
www.aaem.org/oral-board-review

September 14-15, 2019

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www.aaem.org/oral-board-review

September 25-26, 2019

Las Vegas, NV
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April 19-23, 2019

26th Annual Scientific Assembly - AAEM20
Phoenix, AZ
www.aaem.org/AAEM20

AAEM Jointly Provided Conferences

July 18, 2019

Hardrock 100 Medical Symposium
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www.aaem.org/education/events/hardrock

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San Miguel de Allende, Guanajuato, Mexico
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<https://theairwaysite.com/>

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

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



Three Questions

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



As I progress in my career, I find myself getting busier and busier. Some of it is my own doing. Like many successful people, I am cursed by two things — a reluctance to say no and a propensity to have opportunities floated my way.

I also find myself financially independent. When my Navy commitment ends in September of 2022, I will have amassed enough that I no longer need to work. This is a nice problem to have, but it means that I finally have to figure out what I want to be when I grow up. If I continue to work, it won't be because I need the money.

As a regular reader of financial blogs, I recently read one on ThePhysicianPhilosopher.com titled “Living an Intentional Life: The Three Kinder Questions.”¹ The Kinder Questions were created by a financial planning guru named George Kinder. You can read about them in a Money.com article titled “3 Questions That Will Get Your Finances — and Life — on Track.”² If you're reading this on a format that won't allow you to click on hyperlinks, Google the titles of the blog posts/articles and you'll find them.

The Kinder Questions are designed to help you think about how you use your money to create the life you want. Here are the questions:

1. I want you to imagine that you are financially secure, that you have enough money to take care of your needs, now and in the future. The question is, how would you live your life? What would you do with the money? Would you change anything? Let yourself go. Don't hold back your dreams. Describe a life that is complete, that is richly yours.
2. This time, you visit your doctor who tells you that you have five to ten years left to live. The good part is that you won't ever feel sick. The bad news is that you will have no notice of the moment of your death. What will you do in the time you have remaining to live? Will you change your life, and how will you do it?
3. This time, your doctor shocks you with the news that you have only one day left to live. Notice what feelings arise as you confront your very real mortality. Ask yourself: What dreams will be left unfulfilled? What do I wish I had finished or had been? What do I wish I had done? What did I miss?

Since most reading this are emergency physicians, we can probably relate to the second and third question. Stuff happens, and you never know when or if it'll happen to you.

Not many people reach the end of their life and think “I wish I had worked more” or “I wish I had more money.” Your career and your financial resources are tools that should enable you to live the richest life you can possibly live. Reflecting on your unique answers to these three questions may help you assess whether your financial journey is getting you where you want to go or if somewhere along the way you took a wrong turn.

If you'd like to contact me, please email me at jschofer@gmail.com or check out my Navy blog for physicians, MCCareer.org.

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

References

1. <https://thephysicianphilosopher.com/2018/12/05/three-kinder-questions/>
2. <http://money.com/money/collection-post/3517318/3-questions-will-put-your-finances-life-right-track>



“Reflecting on your unique answers to these three questions may help you assess whether your financial journey is getting you where you want to go or if somewhere along the way you took a wrong turn.”

Thank You to Dr. Joel Schofer

The entire staff of *Common Sense* would like to thank Dr. Joel Schofer for his many years of dedication and commitment to this publication. His "Dollars and Sense" column has been a regular feature for years and has been very helpful to many of our members. Sadly, despite the many years of education that emergency physicians receive, many of us make poor and sometimes disastrous financial decisions. Joel's column has brought useful insight into many of the financial issues and choices facing each of us. *Common Sense* wishes only the best for Joel in his career in emergency medicine while serving in the United States Navy.

— Andy Mayer, MD FAAEM
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The Last Lecture to the Newly Graduating Emergency Medicine Residents

James Keaney, MD MPH MAAEM FAAEM — First President of AAEM



The recent Scientific Assembly in Las Vegas was our 25th anniversary and AAEM was fortunate to have our founder, Dr. Jim Keaney present a lecture entitled “The Last Lecture to the Newly Graduating Emergency Medicine Residents.” This editor had the opportunity to attend the lecture and meet our founder. I asked him if he would submit his thoughts and opinions for *Common Sense* as we continue to celebrate our 25th anniversary. Dr. Keaney was gracious enough to submit his opinions for our members

who were not able to hear him in person. Hopefully, all emergency physicians are familiar with the early history of AAEM and the role which Dr. Keaney played as an author championing many of our issues and as our founding president.

The following is from AAEM's webpage describing his role:

“*The Rape of Emergency Medicine* was first published anonymously by “The Phoenix” in 1992, as a quasi-fictional account of the physicians and patients harmed by egregious emergency medicine contract management group abuses. This engaging book was a catalyst for AAEM's formation, after the author, James Keaney, MD MPH FAAEM, revealed himself during a *60 Minutes* investigation of the abuses detailed in the book. Hundreds of emergency physicians, who had similar negative experiences and felt they were not properly represented by organized emergency medicine, contacted Dr. Keaney and began plans for what eventually became AAEM. Dr. Keaney served as the first President of AAEM.”

This editor encourages you to read and absorb this lecture and some of Dr. Keaney's spirit.

Andy Mayer, MD FAAEM
Editor, *Common Sense*

The Current Climate of EM – How Did We Get Here?

There are several recurrent phrases making their way into the vernacular of emergency medicine including transmutation, Joe the Plummer, the Leviathan Levy, and tumbleweed doctors.

The transmutation of clinically generated fees into management money is the theme of this talk revolving around the misallocation of Medicare-approved, clinically generated fees by practicing doctors into administrative wealth. The premise of the talk is this transmutation not only provides zero-point-zero real benefit to the physician, possibly even has negative effects, but also represents a public health detriment to the communities in which the hospitals are located.

Many of you will ultimately work in community hospitals. Ideally, you will find an independent group with a fair road to full partnership and equitable distribution of nights, weekends and holiday shifts. However, independent groups are rapidly losing their natural habitat meaning most of you will likely work for a large contract management group (CMG) which has scores of contracts with hospitals and then subcontracts with a hundred, or hundreds, or maybe even many hundreds of emergency physicians, most of them residency-trained like yourselves.

“These are high-stakes issues that big money is going to fight to the death but my fellow emergency physicians, this is a good fight and the issues are far from insurmountable.”

When you graduate, you will make three to five hundred thousand dollars a year give or take. For the right to work in a CMG you will be required to tithe 25% of your collected fees to the mothership receiving a prorated number of shillings in return depending on your longevity and fealty to the CULTure of the CMG.

Fifty to seventy-five grand from ten doctors staffing an ED multiplied by ten contracted hospitals adds up to some pretty serious coin. Leasing the one-eighth of an acre on the hospital's first floor, otherwise known as the emergency department (ED), makes the ED the most expensive piece of real estate in any district with many barracudas in the tank vying for these lucrative leases.

Until very recently, the three-square-yard footage of terra firma in front of the operating table occupied by the anesthesiologist was not for sale, nor the chair in front of the view box by the radiologist, only God's little acreage in the ED.

What's a CMG to do with all those Krugerands accumulating in the vault? Well, they could give it back to the clinicians who earned it, but rarely. Instead it goes to unconscionable sums distributed to directors, regional directors, COOs, CFOs, CEOs, and various well-remunerated vice



LAST LECTURE

presidents, all of them just a few years ago
fellow clinicians working in the foxhole next
to you before their rise in the management

ranks to partake of the largesse, the same boys and girls now wearing different hats, a bizarre phenomenon not existing in other medical specialties. The neurosurgeon who clips the most aneurysms and removes the most brain tumors has the highest income. In emergency medicine, unlike any other specialty, the emergency physicians seeing the fewest emergencies make the most money.

Yes, twenty grand a month is a common stipend for the director of an emergency department with an annual census of thirty-thousand visits a year. That's a quarter-of-a-million bucks before they even see a patient. Bear in mind, the chief of staff of the whole hospital has a stipend of twenty grand a year. How 'bout fifty grand a month for being a regional director, doing the hard work of taking hospital administrators to Michelin restaurants, golf courses, maybe even St. Andrews to secure a high-stakes hospital contract. As one regional director of a California CMG wrote, "you just don't know what hard work it is dealing with these administrators." It's certainly difficult to find time to do clinical work after eighteen holes. In fact, most regional directors only see patients at the point of a bayonet, and even then, just in urgent care clinics taking out a few stitches here and there. There are also fluff positions for loyal buddies, like vice presidents of education, government affairs (what surgery group-practice has their own vice president for government affairs?), leadership, and most importantly vice presidents for mergers and acquisitions where some potentially astounding salary and commission money is to be made especially if a buyout occurs or an IPO emerges. The physician CEOs and others are generously paid, "work" in opulent offices, and receive lavish golden parachutes, sometimes the golden watch worth millions of departing money for their "valuable services," all originating from the Medicare-approved, clinically generated fees of the yeomanry. Everything about emergency medicine "management" is luxuriant, and again, only in emergency medicine not the other twenty-three formally recognized medical specialties by the American Board of Medical Specialties (ABMS).

What to do with the rest of the rapidly accumulating loot? Logically, one turns to the vice president of mergers-and-acquisitions. But there are only five thousand emergency departments in the nation and more than half of these are in rural areas, or academic centers, Kaisers, VAs, or military hospitals so there is a limited quarry to excavate. After continuing efforts to torpedo the other CMG's ED contracts, the next logical prey is right in the neighborhood, the square yardage in front of the operating table. Given that, one of best ways to metabolize all the mounting cash is to acquire, mainly purchase, the nearest investable asset which would be an anesthesia group, and voila — expansion bonanza by annexation — and now on to that chair in front of the PACS machine in the radiology cave. The triple play offers the complete package, an Amazonification with the whole enchilada from one CMG, one-stop shopping for hospital administrators. Large corporations, having nothing to do with emergency medicine, have taken note of the high-profit margins by skimming off of

the fees of emergency physicians with bigger fish gobbling the barracudas purchasing ED groups creating handsome dividends for their shareholders. Unbelievably, a Moby Dick hedge fund has recently gone into the sweepstakes as well, and a neologism, "the Leviathan Levy" on emergency physicians has been created for the mega-wealthy.

It is self-evident when Joe the Plumber takes his daughter into the emergency department at 3:00am for an earache and pays his fee to the residency-trained board-certified emergency physician, Joe is unaware a portion of his fee, the Leviathan Levy is going to a well-rested investor comfortably in bed. It is equally self-evident Joe the Plumber would find displeasure with this fiscal arrangement with the moneychangers in the temple.

Emergency physicians also work in disjointedness from the internists, surgeons, and pediatricians, physicians who usually settle in one locale for a lifetime of work with continuity-of-care for their patients. These doctors have due process rights which fall within the purview of the governance of the hospital medical staff. If a dispute occurs with hospital administration, the administrator cannot single-handedly remove a physician. Administrators can request a judicial review where the medical staff doctors themselves, and only the medical staff doctors, make the final decision on staff discipline. However, CMGs make all emergency physicians sign lengthy contracts, the forty-page contracts being masterpieces of complexification also assuring the hospital administrations the CMGs will kindly handle all due process adjudications with their own in-house extrajudicial Star Chamber complete with kangaroo courts, show trials, and hanging judges. Administrators remind emergency physicians in so many words they can be removed if the color of their ties is not to their liking.

You also have gag orders other specialists don't, and this in today's world, represents a public health detriment to the community. The no-fly zones for emergency physicians are safety suggestions to administration that cost money. Do not complain about the carbon-dated ultrasound machine with a missing probe gifted from the radiology toolshed. Never criticize the hospital policy to cotton-candy the (insured) drug addicts who waste an inordinate amount of time and resources to get their daily fix. And whatever you do, don't suggest the obvious like extra nurses for the understaffed evening shift. A good CMG director will inform you ahead of time not to express such verboten thoughts at staff meetings. The director will inform you these suggestions can only be brought by the permanent cardiac or orthopedic rainmakers, not subcontractors with ninety-day no-cause termination contracts. You will soon realize the indignity of knowing all the other specialists at the table are fully aware you're the only doctor that can be here today and gone tomorrow. "Whatever happened to ...?"

You are also the community canary in the coal mine warning about unusual infectious disease patterns especially meningitis and other notifiable diseases, or messaging the public of a higher grade of heroin on the street or a local food-poisoning epidemic, and as well, unfortunately, have to act the constable for on-call doctors who don't respond appropriately. You are also the *de facto* primary care doctors to many locals especially the recently uninsured. Party loyalist regional directors have the eye of an ornithologist making sure any birds singing out of school are neutralized.



LAST LECTURE

If you are a responsible town crier but don't color within the lines you could find yourself absent on next month's schedule tumbleweeding to a new CMG located in another zip code.

The work-a-day of a national CMG begins with the daily check of a map of the country showing all existing ED contracts with red pins showing the contracts soon to expire. The situation room looks like the headquarters of NORAD with the bloodhounds on red-hot scents for any new contracts up for grabs. Next the printing presses are heated up. Thousands of beautiful, slick, Madison Avenue-designed brochures, printed on glossy, very-expensive papyrus tsunami the offices of hospital administrators. If the CEO bites, the marketing team is sent for the presentation. If you ever get the opportunity to attend a presentation, jump at it, even if it's short notice and you realize they only want to showcase a tokenized scrub like yourself. Be their preforming seal and be dazzled by the ringmaster orchestrating the men in crisp blue suits and red ties accompanied by the Saks Fifth Avenue ladies in high heels "shocking and aweing" hospital administrators with their technicolor bar graphs and pie charts demonstrating how their doctors are providers of "peer-reviewed, evidence-based, best practices to offer the highest quality emergency care at the lowest price making your institution a Center of Excellence with one-hundred per cent CUSTOMER SATISFACTION!"

Then the tyranny of the meaningless metrics, and ah yes, the metrics of productivity are the darling of the marketing departments with the MBAs from the best schools who excel with Excel. You must embrace that this side of the room sees 2.4 patients per hour but this side sees only 2.1 patients per hour. Might not seem like much except the taxi-meter runs 24-7-365 and the cash the 2.4s generate adds-up, possibly enough to buy another anesthesiology group. Now, of course, it may be the 2.1s are more meticulous with their suturing, likely to take their time sewing up a vertically oriented facial laceration in a child too deep to Dermabond. The 2.4s would rather unwrap a thick 4-0 nylon thread with a large fishhook needle and get it over with, maybe even whip out a staple gun and get themselves up to 2.5. Hedge funds only want productivity from the rapid-through-put assembly lines since insurance only pays for the length of the laceration not the final cosmetic outcome.

All CMGs will then claim they have trade secrets revealed only to the exclusivists and their Fellows. Emergency medicine is the only specialty offering a Fellowship in Management! A madrassa in "management?" Could someone please tell me what trade secrets are in emergency medicine? They're obviously pretty well-kept secrets since no stool pigeon has ever told me what they are. What about proprietary information, copyrights, trademarks? What's the secret sauce here and how come nobody's spilled it? Keeping the contract at all costs, regardless of morality is clearly the single biggest trade secret which is common knowledge to all in the sub-culture. But how far does the information warfare and nefariousness go to poach ED contracts from other CMGs? Hacking tools perhaps?

After the show's main event winds down, you will realize that you, the clinician who evaluates and treats the patients of America, are the sideshow,

the bit player, a movie extra utilized for window dressing. You may be invited to the Loch-Ness-Monster-Lobster lunch, but the magicians still do not reveal their secrets. You will not be invited to where the deals are solidified, an Area 51 where the perks are announced to the administrator. You will also not be invited to the champagne cork popping if the CMG successfully hit the mother lode by outmaneuvering and capsizing the existing contract holder, dropkicking the current emergency physicians out of town to be proselytized into a brand-new CULTure. Someday, when the curtain of contract acquisition is finally pulled back, the Wizard of Oz-like figure will appear.

Most unfortunately, the American College of Emergency Physicians (ACEP) has been dominated by the wealth and exploitation of the original founders and many past presidents who were never emergency physicians to begin with but were highly motivated by the riches of a plantation economy. Their strict radio silence disguised as *laissez-faire* has betrayed the innocent blood of newly graduated residents, willfully neglecting individual physician rights along with the community welfare, and aiding and abetting the power of the abusive corporations. The litmus test for management advancement in CMGs is active involvement in ACEP at national and state levels. Most CMGs pay the dues money of their subcontracted physicians utilizing a tax deduction to massively boost ACEP's treasure chest indirectly.

What about the general medical societies, national and local? They will not, I repeat, be of any help. Don't get me wrong, they perform their tasks extremely well, but they are not constituted in such a fashion to champion an explosive issue especially when some of their CMG-embedded dues-paying, office-holding, cocktail-party buddies are involved.

What will happen this time when reforms are proposed? There will be a perfunctory public reading of the mission statement and other pieties, "We are here to protect the health of the blah, blah, blah." Then the faux outrage will demand a committee be formed, yes of course, a committee with all the stakeholders present to hammer out a suitable solution fair to all parties for this perplexing dilemma. Committee is medical code for delay until the fuss dies down. Joe the Plummer is in no need of such head scratching. If Joe applies too much external pressure they will announce not just a committee but convene a Blue-Ribbon Commission to issue a White Paper "for the protection the public."

There's still an elephant in the room my friends in the national medical societies. When the one-eighth of an acre on the hospital's first floor is being leased for the price of Fabergé Eggs, and clinically generated physician fees are alchemized into obscene "physician-owned-and-managed" salaries and bonuses, all of medicine is losing ground. Surgeons don't pay their office managers more than themselves, and cardiology groups don't pay fifty-thousand dollars a month for managers to handle schedules, retirement plans, health insurance, and go golfing with administrators on weekends in Hawaii. There's no reason not to pay management doctors a fair hourly for his or her time that is equal to the clinicians seeing and treating the patients rather than the current tapeworms envisioning themselves as a bizarre new form of captains of industry even though they created



LAST LECTURE no industry. Other than raw exploitation there is no economic justification for excessive nonclinical, laughable bonuses ruled by the now rather visible hand of the market place, paying clinicians “whatever the market will bear” while keeping the rest for themselves.

Ossified brains sipping Grand Marnier in executive dining rooms will harrumph, “Isn’t this capitalism? What do those aparatchiks want, Bolshevism? Although Joe the Plumber never read Marx and Engels, and never siped Grand Marnier in an executive dining room, it would again be self-evident that collectivized labor in a Worker’s Paradise with a Five-Year-Plan by a Central Committee with no Glasnost or Perestroika, and with untold riches going to the politburo is not entrepreneurialism but worthy of a May Day parade.

Not to be totally exculpatory to the old guard but the embryonic specialty of emergency medicine didn’t even exist just thirty-five years ago. Most older doctors know only of serving a tour of duty in the ED as a resident or as a moonlighter, and many still say, “I used to be an ER doc.” Many physicians who were full time moonlighters were bidding their time until a dermatology residency or a gastroenterology fellowship opened up. Others had medical or substance abuse problems such as the orthopedic surgeon who developed rheumatoid arthritis. Some were just ski-and-scuba bums taking a gap year making pocket money doing shifts here and there. More than a few were post-sixties Jesus lookalikes wearing sandals and flowing robes to work. Many who attended the first emergency medicine conferences in the 1980’s looked like characters who’d just stepped out of the Old Testament or Greek Mythology with this image still persisting.

However, a new paradigm in American medicine has emerged, happening so rapidly many physicians haven’t realized the seismic shift, an epochal medical advancement as important as the CAT scan or MRI. Emergency medicine needs a new *Tabula Rasa* (clean slate). Today’s emergency departments need to have professional physicians staffing the department as integral members of the medical staff for a lifetime of continuity of community care. Organized medicine has to embrace this model rather than the current greed-based musical chair policy where whole ED staffs are replaced *en masse* by marauding CMGs with their new set of provisional physicians parachuting into town. No longer can it be ignored. If general medical societies really want new clinician members they can’t walk between the raindrops forever pretending to be the piano player in the whorehouse not knowing what’s going on upstairs.

The Solution

There’s an obvious common-sense solution. I propose the **Emergency Medicine Antiprofiting Act (EMAPA)** which includes four elements:

1. A percentage cap on management fees
2. Interdiction of the sales of emergency department contracts for any form of consideration
3. Elimination of cotermious clauses where physicians automatically lose hospital privileges when the CMG loses its contract
4. Strengthening due process rights for real-estate-based physicians.

In reality, with a simple percentage cap on management fees the rest will

fall into line with the cap being the core of the reverse engineering that needs to be done. Until there is a cap, the last rites cannot be administered to the current blight of the CMGs.

Although I’m not the greatest fan of Obamacare, one clause peaked my attention — the clause limiting the administrative costs of health insurance companies to 15% of the premiums, requiring 85% go directly to patient care. Why can’t we clinicians have a law capping the percentage any organization or individual expropriates for their so-called management? Ironically, the oligarchies justify their incomes because of the excessive amount of resources spent on the cutthroat competition fending off the other jackals for the lucrative spoils of a new contract.

We can justify a congressionally enacted federal law since so many of the payments come from government sources. Taxpayer Joe should know exactly where his fee is going. Representative Pete Stark, while in congress, would lecture us that Medicare ran on a four percent overhead while indemnity insurance ran on 35% overhead. Capping management fees to 4% excluding the hard cost of billing and malpractice would eliminate all interest in acquiring an ED contract except for those wanting to work in a hospital and live in a community for a lifetime career. The Barnum and Bailey Circus of emergency medicine would come to a screeching halt with no more avalanches of glossies to administrators, restaurants, golf, top-shelf liquors, Waterford crystal or Steuben Glass. Emergency medicine needs to codify the ancient doctrine of “Render unto Caesar.”

The second approach, and I believe the better one, is the Thurgood Marshall strategy. Who would have ever thought the little elementary schoolgirl in Topeka, Kansas would overturn the sixty-year precedent of *Plessy v. Ferguson* eliminating the charade of separate but equal? The Centers for Medicare and Medicaid are in clear violation of the original intent of the Medicare Act. The Medicare system has become the unwitting supplier of the river of money oiling the scam artists sometimes creating fast-buck millionaires overnight, essentially a federally sanctioned money laundering scheme enriching unnecessary third-party middlemen. They have been shameful stewards of the taxpayer money designated to provide healthcare to the Joe-the-Plumbers of America. Even Ginsberg and Kavanaugh would need no head scratching on that one. For that matter, even Trump and Ocasio-Cortez wouldn’t need to committee it. It’s time for the *Common Sense Emergency Physicians versus United States of America*.

Thomas Carlyle said, “No lie can live forever.” Eventually payers will catch on to this bizarre falsity existing in only one specialty. It would be far better for us emergency physicians to bring it to the public’s attention rather than an outside group doing it for us. It would be most embarrassing for a public interest group to do the dirty work because of our inaction. At a minimum, we must Paul Revere the nation. Two lanterns in the belfry and Leviathan is coming your way.

These are high-stakes issues that big money is going to fight to the death, but my fellow emergency physicians, this is a good fight and the issues are far from insurmountable. Corporations will threaten us with



LAST LECTURE what I call the three lawsuits of the last refuge of scoundrels — libel, slander, and antitrust. CMGs know they will be laughed out of open court when they say that contract management groups place patients above dividends and bonuses. District by district, state by state, we can expose them, removing the stranglehold existing in only one medical specialty. We need to fight with an organization interested in long-term career emergency physicians serving a community throughout their tenure, dedication, and offering true quality assurance for the populace. We would no longer have to choose between the Oath of Maimonides or the bottom-line dictums of Bernie Madoff.

It's best for our patients, and it's best for us. ●

James Keaney is a former president of the American Academy of Emergency Medicine (AAEM).

AAEM was formed in 1993 as the emergency physician's alternative to ACEP, and now has eight thousand members. AAEM is the only organization of board-certified emergency medicine physicians that promotes the right of every American to be served by a qualified emergency physician and the right of every physician to serve those patients with full autonomy without corporate interference, and with all the obligations, duties, and due process rights of the entire hospital medical staff.

James K. Keaney, MD MPH, a clinical emergency physician for the past 43 years, is solely responsible for the contents of this article.



A large advertisement for a course. The background is a street scene in New Orleans with a red trolley. Overlaid on the left are five white arrow-shaped boxes pointing right, containing the following text: "Clinical Redesign", "Patient Experience", "Change Management", "Revenue Cycle", and "Negotiation". In the center, the text "REGISTER TODAY!" is written in large, bold, red letters. Below it, "ED Management Solutions: Principles and Practice" is written in large, bold, black letters. A red circle highlights the text "Two Day Course". To the right, the dates "September 5-6, 2019" and the location "Hilton New Orleans/St. Charles Avenue New Orleans, LA" are listed.

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DISCLAIMER: *None of the information in this article constitutes legal advice, as all of the information is general and individual circumstances may vary. The*

only purpose of this article is for continuing medical education in the area of professional practice development.

Clinical emergency physicians have many significant professional problems and most of these problems emanate from our contracts. The days are long gone when a physician can simply sign a brief straightforward contract or letter of retention without carefully reviewing its contents. Before signing any contract, physicians should hire a contract attorney to review the contract and serve as the physician's advocate.

This article will provide brief general information about contract law as it pertains to physicians, then focus on common problems that arise in emergency physician contracts. Some of these problems could profoundly affect the balance of your career.

A contract is a legally binding agreement where parties exchange things of value. Typically, an employer or contract holder will provide a salary and benefits, while the physician provides professional services. Verbal contracts are enforceable in most states but harder to prove. Therefore, physicians almost always sign written contracts. Most written contracts have a clause near the end that states that the entire agreement is contained within the contract. Therefore, if the physician receives oral promises not contained within the contract, such promises are unenforceable. In such cases, the physician should request an amendment to the contract containing the oral promises.

A section near the beginning of most physician contracts will include a list of duties that each party must perform. Typically, the contract will specify your clinical duties. Beware, if the contract specifies that you must perform duties outside of the emergency department (ED). Make sure your malpractice insurance

Read Your Contract, It's Dangerous!

Larry D Weiss, MD JD MAAEM FAAEM — Professor of Emergency Medicine (retired)
University of Maryland School of Medicine — AAEM Past President

covers such duties. Virtually every medical malpractice insurance policy only covers you for acts performed within your specialty. Such policies may not provide coverage for practicing in the intensive care unit, inserting central lines in admitted patients, running cardiac arrests outside the ED, or writing admission orders.

Employee or Independent Contractor?

A central issue in physician contracts is the question of whether the physician will function as an employee or an independent contractor (IC). This has great importance for three major reasons. An IC may take more business related tax deductions, including far more generous tax deferrals for retirement accounts. On the other hand, an IC pays double social security taxes. On the balance, IC status confers significant tax advantages.

The second important reason to determine the status of the physician concerns benefits. Generally, employees may receive benefits and the employer will make all necessary tax deductions from the employee's paycheck. ICs do not receive benefits and must pay their own taxes. Finally, employers will always have vicarious (indirect) liability for the acts of their employees performed within the scope of their employment, but contract holders generally do not have

liability for the acts of ICs.

If the contract holder provides medical malpractice insurance for the physician but does not provide any other benefits, the Internal Revenue Service (IRS) will most likely classify the physician as an IC. However, the single most important factor is control. If a supervisor controls the work of a physician, then the physician is most likely an employee, even if the contract refers to the

physician as an "independent contractor." For simplicity, this article will refer to all parties to a contract as "employers" and "employees" regardless of the legal status of the physician.

More technically, the IRS has a list of 20 factors to determine whether an individual functions as an employee or an IC. Discussion of these factors lies beyond the scope of this article, but you may easily find a list of these factors on the IRS website or by performing a general internet search.

For many reasons, you should review the malpractice policy before you sign a contract. Not only should you review the scope of coverage, but determine the amount of coverage and whether you must pay for tail coverage after termination of the contract. Most policies in emergency medicine are "claims made"



“Clinical emergency physicians have many significant professional problems and most of these problems emanate from our contracts.”



policies that provide coverage only during the period of employment. Extending coverage beyond the term of employment requires purchase of tail coverage.

After about five years of employment, the cost of tail coverage plateaus at about 250% the cost of an annual premium. For example, if your malpractice policy costs \$40,000 per year, then the cost of the tail will be around \$100,000. Therefore, you must receive written guarantees that the employer will pay for tail coverage.

Indemnification

An important issue relating to malpractice litigation is the “indemnification clause.” These pernicious clauses began routinely appearing in physician contracts 15-20 years ago. On first glance, these clauses seem harmless. In fact, they are sometimes labeled “hold harmless” clauses. The most common form of indemnification clauses in physician contracts state that each party will indemnify the other, or hold the other party harmless, for all liability. This sounds “harmless” and reciprocal, but in practice it places the physician at huge risk for uninsurable losses.

As a general rule, an indemnification clause means that the primary actor in any alleged case of negligence must pay the attorney fees, court costs, and verdicts levied against all other defendants. For example, in a typical medical malpractice lawsuit, the plaintiff will allege that the physician committed malpractice. Therefore, the physician is the primary actor. If the plaintiff then names the hospital and the practice group as additional defendants, then the physician will have to pay all costs of the other defendants.

Malpractice insurance policies do not cover these indemnification expenses. Physicians will have to pay these expenses out of pocket. Just one case can cost several million dollars, resulting in financial ruin for the physician. No benign reason exists why a contract would saddle physicians with such a burden.

Your Practice Rights

Perhaps the most important advocacy issues in emergency medicine relate to the systematic abuse of emergency physician practice rights. These abusive practices emanate from our employment contracts. Most important are

waivers in physician contracts that deprive us of basic due process at hospitals. Due process within this setting means that adverse actions against our medical staff privileges must not occur until after a fair hearing before a panel of the physician’s peers.

We have many sources of our due process rights. At government owned or operated hospitals, our due process rights come from the U.S. Constitution, specifically the Fifth and Fourteenth Amendments. At non-government hospitals, our due process rights come from a variety of sources. The Health Care Quality Improvement Act of 1986 specifies in detail the type of hearing we must receive so that hospitals retain their protection from retaliatory lawsuits from dismissed physicians. Also, the Joint Commission requires all physicians at hospitals to have due process rights. Finally, because of the Joint Commission requirements, virtually every set of medical staff bylaws requires due process rights for every member of the organized medical staff.

Regardless, physicians may voluntarily waive these rights. A scientifically valid survey of emergency physicians published in 2013 showed that more than 60% of emergency physicians did not have due process rights at their hospitals.¹ Many reasons exist for emergency physicians to waive these rights. An individual emergency physician has little or no leverage when negotiating a contract with a large hospital or a large contract management group. Routinely, emergency physicians do not have due process rights at most community hospitals.

Since virtually all emergency physicians can have their contracts terminated under the terms of their contracts, what is the real importance of due process rights? Perhaps the most important reason to retain these rights is to end the “second class” status of most emergency physicians at community hospitals. The right to a fair hearing is perhaps the most important basic right of physicians at hospitals. Emergency physicians cannot expect to be treated as full members of the medical staff without basic practice rights.

Another important reason for emergency physicians to retain their due process rights relates to the National Practitioner Databank (NPDB). If a physician loses his medical staff

privileges due to any aspect of his performance or behavior, the hospital has a legal duty to report this action to the NPDB within 30 days. Failure to report such disciplinary actions may result in a loss of the hospital’s peer review antitrust immunity for up to three years.

If the terms of a contract force a physician to waive her due process rights, then the physician should seek legal counsel to try to protect her rights. If the other contracting party insists on depriving the physician of her due process rights, then she must make a decision whether to look elsewhere for employment. The demand for board eligible or board certified emergency physicians is currently very strong. Most emergency physicians do not realize how much bargaining power they have, so in most cases they can look elsewhere and take a job at a hospital that does not deny their practice rights.

Another contractual provision routinely used to restrict the practice rights of emergency physicians is the restrictive covenant, or “non-compete clause.” In its most common form, a post contractual restrictive covenant will prohibit the physician from working in a defined geographical location for a specific period of time. For example, a restrictive covenant may state that the physician cannot work in a 50 mile radius from the hospital for a two year period after termination of the contract.

Laws in eight states prohibit the use of restrictive covenants in physician contracts. Courts in the other 42 states use a “rule of reason” when deciding whether to uphold restrictive covenants. This rule balances an owner’s legitimate business interests against an individual’s right to practice one’s profession. Courts in these states will uphold the restrictive covenant if the geographic and time restrictions are reasonable. However, the prevention of competition is not a legitimate business interest.

What constitutes a legitimate business interest that a restrictive covenant may protect? Restrictive covenants primarily protect trade secrets. For this reason, many contracts containing restrictive covenants will also contain unintelligible language stating that the physician acknowledges that he will learn trade secrets from the employer, and these trade secrets have enormous value. I’m not aware



MASTERS OF AAEM

of any trade secrets in emergency medicine. We don't have referral lists. We keep our doors open 24/7 and patients constantly fill our waiting rooms.

For a number of other reasons, restrictive covenants are most inappropriate in emergency medicine. We don't learn our profession from employers. Almost every emergency physician learns everything they need to know during residency. Unlike physicians in many other specialties, we don't learn office management from employers. We don't have personal patients who will follow us to other hospitals. Unfortunately, restrictive covenants exist only to control and exploit emergency physicians. If a prospective employer will not remove a restrictive covenant from a contract, this creates another need for legal representation. Also, since many restrictive covenants do not protect legitimate business interests, they may not survive a challenge in court.

Conclusion

For many emergency physicians, signing a contract may constitute the most hazardous step in one's career. Most emergency physician contracts contain some exploitative provisions. In addition to understanding employment status and duties under the contract, physicians should pay close attention to conditions under which they may be terminated, whether they have access to a fair hearing prior to termination, and whether they may be subject to a restrictive covenant after termination of their contract. Finally, indemnification clauses represent a relatively new danger with potentially devastating consequences.

Physicians should secure legal counsel while navigating the process of signing a contract. An experienced contract lawyer can review almost any physician contract within three hours. Therefore, the cost of such representation will be quite modest, especially when

considering the important consequences of signing a dangerous contract.

(An abridged form of this article appeared in the December 2018 issue of Emergency Medicine News.) ●

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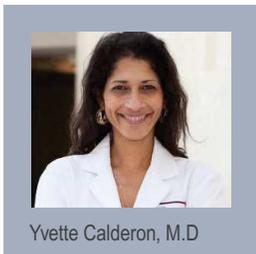
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ABEM Board of Directors Elects Two New Members

The Board of Directors of the American Board of Emergency (ABEM) recently elected two new members: Yvette Calderon, MD, and John L. Kendall, MD Both were elected by the emergency medicine community-at-large.



Yvette Calderon, M.D

Dr. Calderon is Chair of the Department of Emergency Medicine at Mount Sinai Beth Israel, and Professor of Emergency Medicine at the Icahn School of Medicine at Mount Sinai. She has been an ABEM oral examiner since 2010, and an item (question) writer for the Qualifying (written) exam since 2014. Dr. Calderon completed her emergency medicine residency training at the Jacobi Medical Center.

Dr. Kendall is Professor of Emergency Medicine and Vice Chair of Education in the Department of Emergency Medicine, and Director of Ultrasound Curriculum at University of Colorado School of Medicine. He has been an ABEM oral examiner since 2013, and a senior case reviewer since 2015. He also is a member of the MyEMCert Advisory Panel, Case Development Panel, and Modified Singles Advisory Panel, and was an item writer for the Qualifying Examination. In 2016, he was the recipient of a Lifetime Service Award from the Ultrasound Section of the American College of Emergency Physicians.



John L. Kendall, M.D.

Dr. Kendall is Professor of Emergency Medicine and Vice Chair of Education in the Department of Emergency Medicine, and Director of Ultrasound Curriculum at University of Colorado School of Medicine. He has been an ABEM oral examiner since 2013, and a senior case reviewer since 2015. He also is a member of the MyEMCert Advisory Panel, Case Development Panel, and Modified Singles Advisory Panel, and was an item writer for the Qualifying Examination. In 2016, he was the recipient of a Lifetime Service Award from the Ultrasound Section of the American College of Emergency Physicians.

Dr. Calderon and Dr. Kendall will begin their terms as ABEM directors at the close of the summer Board meeting.

The ABEM Board of Directors is comprised solely of volunteer, board-certified, clinically active emergency physicians who are actively participating in ABEM Maintenance of Certification, a program of continuous learning and periodic assessment.

About ABEM

Founded in 1976, the American Board of Emergency Medicine (ABEM) is an independent nonprofit that develops and administers Emergency Medicine certification examinations to physicians who have met all ABEM credentialing requirements. Once certified, ABEM-certified physicians must complete continuing education and assessment activities.

The ABEM Its mission is to uphold the highest standards in the specialty of Emergency Medicine. It has over 37,000 emergency physicians currently certified. ABEM is one of 24 Member Boards of the American Board of Medical Specialties. ●

Congratulations to the 2019 Recipients of ABEM 30-Year Certificate

To maintain certification for 30 years, ABEM-certified physicians must participate in a program of continuous professional development and learning in the specialty.

AAEM joins ABEM in saluting these physicians for their dedication to the specialty, their recognition of the value of board certification, and their commitment to caring for acutely ill and injured patients.

In 2019, 697 physicians who have reached this milestone — AAEM members receiving this distinction are listed below.

Eric William Brader, MD FAAEM
Kris R. Brickman, MD FAAEM
Brian Joseph Browne, MD FAAEM
Thomas Buckley, MD FAAEM
James Melvin Cade, MD FAAEM

Thomas James Calvert, MD FAAEM
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Jeffrey Alan Rey, MD FAAEM
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Melanie Richman, MD FAAEM ●

Dr. David Farcy Honored at Miami Beach Chamber of Commerce Annual Heroes Breakfast

Remarks presented at the award ceremony are as follows:

“Dr. Farcy has been a part of the Mount Sinai family for 13 years and continues to be a tremendous asset to the medical center and to the Miami Beach community. Pulling from his experience as a paramedic with the U.S. Air Force, he has the ability to think quickly and take action, while exuding compassion for patients and their families. He is an exemplary leader and a team player, and was instrumental in expanding our high quality emergency services to other communities with the opening of our freestanding emergency centers in Aventura and Hialeah.

Over the years he has worked closely with City of Miami Beach police officers, firefighters, and ocean rescue first responders to ensure seamless emergency care for our residents and visitors. He has also gone above and beyond the call of duty countless times over the course of his professional career. Passionate about emergency and disaster medicine, he assisted in the aftermath of Hurricane Andrew, the Mexico City and Haiti earthquakes, Hurricane Mitch, and September 11th. We are also very proud to say that Dr. Farcy was recently named President of the American Academy of Emergency Medicine. His passion for caring for those in our community, across the country and abroad in times of need, has made him a true hero for countless patients over the years, and I am honored to present him with this award today.”

— Steven D. Sonenreich, President & CEO of Mount Sinai Medical Center, Miami Beach



Photo Credit: Al Ricketts Photography

AAEM president, David A. Farcy, MD FAAEM FCCM was recognized at the Miami Beach Chamber of Commerce Annual Heroes Breakfast on February 15, 2019.



Photo Credit: Al Ricketts Photography

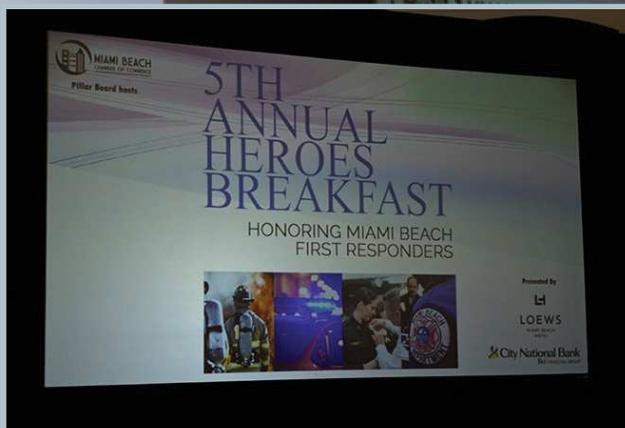


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Dip, Chew, and Snuff: A Case of Nicotine Toxicity

Tim Montrief, MD MPH and Mehruba Anwar Parris, MD FAAEM

Case

A 25-year-old Caucasian male with no significant known past medical history presented to a community emergency department via EMS with palpitations and altered mental status while on vacation at a friend's bachelor party. Per the patient's friend, he had been drinking alcohol all day and accidentally ingested a large amount of smokeless tobacco one hour prior to arrival, with subsequent nausea, vomiting, and excessive salivation. His friend denied any co-ingestions or drug use. The patient was found to be somnolent but arousable to voice, without any focal neurologic deficits and normal point of care blood glucose. The initial physical exam was remarkable for new-onset atrial fibrillation with a heart rate in the 160's, blood pressure of 102/56 mmHg, respiratory rate of 16 breaths per minute, and saturating 100% on room air. Aside from atrial fibrillation with rapid ventricular response, the electrocardiogram was unremarkable (Figure 1). Additionally, the chest X-ray showed no evidence of cardiopulmonary pathology. Further testing revealed normal troponin, T4, and TSH levels. He had an elevated serum alcohol level of 191 mg/dL, and a negative urine drug screen. Initial cotinine and nicotine levels were not available. The patient was given a diltiazem bolus and drip, as well as four liters of lactated ringers, with subsequent heart rates in the low 100's, with corresponding blood pressures in the 120's/80's. The patient was admitted to the ICU, and spontaneously converted back to a normal sinus rhythm within 24 hours of his initial presentation. The patient was discharged the next day with close outpatient follow-up.

What do we know about smokeless tobacco and nicotine toxicity?

Smokeless tobacco products contain either air- or fire-cured tobacco that is powdered or ground for use as nasal or oral snuff, cut and grated for use as oral snuff, or stripped and compacted for use as chewing tobacco. These products routinely include formaldehyde, various sugars (most commonly sucrose, fructose, sorbitol, molasses, or dried fruit), water,

sodium chloride, ammonium chloride, licorice, menthol, paraffin oil, and glycerol, in addition to tobacco-specific nitrosamines.¹ Tobacco also contains nicotine, which acts on both the parasympathetic and sympathetic nervous systems by binding to acetylcholine receptors. Nicotine is readily absorbed through the lungs, skin, GI tract, and mucous membranes. While ingestion is the most common route of exposure for accidental overdoses, exposure can also occur through the dermal, ocular, and inhalational routes. Compared to smoked tobacco, smokeless tobacco produces a much slower onset and much lower peak concentration of nicotine in the blood with the same total daily dose of nicotine.² However, studies comparing the use of smokeless versus smoked tobacco have demonstrated qualitatively similar magnitude of effects on the sympathetic nervous system from nicotine.²

Although nicotine toxicity is not a new phenomenon, the recent emergence of electronic cigarettes has spawned a market for highly concentrated liquid nicotine, resulting in unprecedented access to potentially toxic doses of nicotine and other harmful compounds in the home. Calls to Poison Centers regarding tobacco products have rapidly increased since 2010, resulting in an average of 200 calls per day in early 2014.³

A recent comprehensive review by Mayer suggests an LD50 of 6.5-13 mg/kg (approximately 500-1000 mg for adults), which is more consistent with reported values in case reports of actual fatalities.⁴ However, clinically significant symptoms of nicotine toxicity can occur in children with doses as low as 1 mg and in adults with doses as low as 2-5 mg.⁴ For comparison, one cigarette has about 20-30 mg of nicotine, and the typical systemic dose from a single exposure to a cigarette, snuff or chewing tobacco is estimated to be 2 to 3 mg.⁵

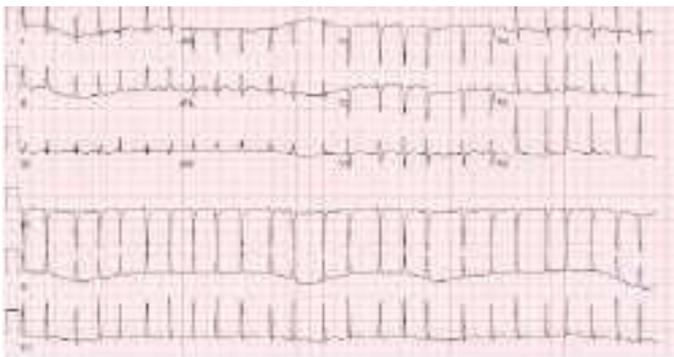


Figure 1. Initial ECG, showing atrial fibrillation with rapid ventricular response at a rate of 150 beats per minute, and normal PR/QT/QRS intervals.

Clinical Effects of Nicotine Toxicity		
Organ System	Early phase (<1 hour after ingestion)	Late phase (>1 hour after ingestion)
Gastrointestinal	Hypersalivation Nausea and vomiting Abdominal pain	Diarrhea
Cardiovascular	Hypertension Arrhythmias Tachycardia	Arrhythmias Bradycardia Hypotension
Neurologic	Tremor Headache Ataxia Fasciculations Miosis	Hypotonia Seizures Coma
Respiratory	Bronchorrhea Tachypnea	Dyspnea Apnea Respiratory depression

Figure 2. The clinical features of nicotine toxicity by organ system, in the early (<1 hour after ingestion) and delayed (>1 hour after ingestion) phases.



What are the clinical features of nicotine toxicity?

Acute nicotine poisoning has a strongly biphasic pattern, owing to its short half life of one to four hours (Figure 2). The early clinical phase occurs most commonly within the first hour of exposure, and is characterized by excessive nicotinic stimulation. Patients may present with nausea, vomiting, pallor, abdominal pain, salivation, bronchorrhea, tachypnea, hypertension, tachycardia, miosis, ataxia, tremor, fasciculations, arrhythmias (including atrial fibrillation), and seizures.⁶ The delayed phase consists of central nervous system, as well as respiratory depression, and most commonly occurs greater than one hour after ingestion. These patients present with severe dyspnea, bradycardia, hypotension, shock, mydriasis, weakness, muscle paralysis, coma, and death. Signs and symptoms after ingestion of nicotine appear to be dose related, with lower doses stimulating the neural and cardiovascular systems, while higher doses suppress the central nervous and respiratory systems.

Treatment of Nicotine Toxicity	
Clinical Manifestation	Intervention
Nausea, Vomiting Gastritis	Antiemetics Proton pump inhibitors
Tremor Seizures	Benzodiazepines
Hypotension Bradycardia	Fluid resuscitation, Vasopressors Atropine
Hypoventilation Hypersalivation	Intubation and mechanical ventilation Atropine, Glycopyrrolate
Nicotine Withdrawal	Nicotine replacement therapy

Figure 3. Treatments for nicotine toxicity by clinical manifestation.

What treatments are available for nicotine toxicity?

Treatment of nicotine poisoning is usually supportive (Figure 3). The patient should have cardiorespiratory monitoring, intravenous access, and be observed closely. Immediate treatment should be initiated whenever nicotine toxicity is suspected, primarily focusing on resuscitating the patient and correcting any life-threatening symptoms, including respiratory support with mechanical ventilation if necessary. Anticholinergic drugs such as atropine can be given to counteract bradycardia, bronchorrhea, excessive salivation, and wheezing.⁶ Benzodiazepines may be given for seizures, and antiemetics may be given for nausea or vomiting. Decontamination by washing the skin and removing clothes is necessary for dermal exposures. Use of activated charcoal is an option for patients who present within an hour of ingestion, but it is infrequently used, and close consultation with your local Poison Control Center is recommended. Multi-dose activate charcoal may be beneficial to remove

it from enterohepatic circulation. Likewise, gastric decontamination may be initiated if recommended by poison control experts. Although nicotinic stimulation, including hypertension and tachycardia, is usually treated with adrenergic antagonists during the early phase, this treatment is not recommended, as this may exacerbate any hypotension during the delayed phase.⁷ Hemodialysis may also theoretically enhance elimination due to its low protein binding and small volume of distribution but evidence supporting its use is sparse. While nicotine toxicity is commonly a clinical diagnosis, blood tests may be indicated, particularly if the patient is unstable, has an unclear history, ingestion was an attempted suicide, or if the toxidrome is inconsistent. Serum nicotine and cotinine (a nicotine metabolite) levels are not generally available and may not result in a timeframe that is practical in the ED. It may be useful to confirm exposure and toxicity.⁸ Generally, a minimum observation time after oral or dermal exposure is four to six hours, although longer observation periods may be warranted for large ingestions involving intact nicotine patches or plant material.

Conclusion

As tobacco delivery devices, particularly e-cigarettes, are becoming more widespread in the United States, more patients are presenting with sequelae of their toxicity. While most providers already know the classic presentation of nicotine toxicity, it is important for us to be aware of the other complications, including dysrhythmias, and their appropriate treatment.

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Why We Shouldn't Teach Doctors to be Well

Arlene Chung, MD MACM FAAEM



My nightmare is waking up to a phone call in the middle of the night with a frantic chief resident telling me that one of our residents is dead.

We shouldn't be teaching our doctors how to be well. Teaching the individual resident or physician is the easy way out, and as an educator, I do not say that lightly. Culture change is harder, but critical to protecting the wellness of our residents and physicians. Individual wellness education has a place, but increasingly our focus needs to be turned outward toward the places where we can make the greatest impact for both the individual and the system. We must be proactive, not reactive. Once a resident or physician is dead, no amount of after-the-fact education or policy change will bring her back.

I am a lifelong educator and advocate for physician wellness. But I no longer believe that any amount of classroom teaching about mindfulness or resilience will make my residents "more well." I have watched the number of wellness lectures given to our residents rise, but our burnout rates have yet to fall. I have been part of a residency program that provides excellent food, retreats, and a robust wellness committee, yet I still receive texts from residents who feel overwhelming anxiety, shame, and sadness. With the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements now mandating residency programs to provide greater emphasis on resident and faculty well-being¹, I worry that many institutions across the country will expend valuable time, money, and resources toward educational interventions that do not work.¹

Teaching residents and physicians about wellness presumes the underlying assumption that un-wellness is due to a lack of knowledge. It assumes that individuals eat poorly, drink too much coffee, and suppress their feelings because they don't know any better. Traditional wellness topics have focused heavily on physical interventions, such as healthy weight loss, smoking cessation, and nutrition. Although we now understand wellness to be a much broader concept, this also makes it a more nebulous topic. Knowledge is not sufficient for behavioral change and certainly not enough for cultural change. My resident may know that exercise is good for her, but that fact alone is not going to be enough to get her to the gym regularly.

I argue that teaching residents and physicians about wellness rarely makes an impact by giving them NEW knowledge. Instead, carving out the time and space for a wellness activity demonstrates to them *indirectly* that wellness is valued by the leaders in the residency program, department, or institution. It is the value demonstrated by their teachers, not knowledge that makes the impact. It is not difficult to convince the residents on our wellness committee to attend a lecture on resilience. The challenge lies in transferring that value to the residents and faculty who don't grasp the necessity of training for wellness, until they find themselves "unwell." In the eyes of many, wellness does not have the same value as reimbursement, multi-center research trials, or cutting-edge patent technology. It is often perceived as a "soft skill" and a less essential one. Sadly, physician wellness only seems to receive mainstream attention once doctors start dying. We may understand cognitively that wellness is important, but it is not until we feel it emotionally that we begin to take action. I do believe that we have at least succeeded in

creating a sense of urgency, however, due in large part to the efforts of Dr. Tait Shanafelt and colleagues, who have published extensive research



Individual wellness education has a place, but increasingly our focus needs to be turned outward toward the places where we can make the greatest impact for both the individual and the system. ””



WOMEN IN EMERGENCY MEDICINE on the prevalence of physician burnout, and Dr. Pamela Wible, who brought physician suicide to the public eye.^{2,3}

A hierarchy exists for wellness interventions. At the most basic level, we can teach knowledge, which may change the values of individual residents and inspire them to engage in self-care. We can teach skills, such as critical incident stress debriefing or peer-to-peer counseling, which will allow physicians to go on to help others. We can create a local support network by engaging our colleagues in shared experiences. We can enact policies at the institutional level that encourage maternity and paternity leave, protect against workplace violence, and promote opt-out programs for mental health services. We can work with national accrediting bodies, such as the ACGME, to develop standards for physician wellness. Finally, we can lobby at the level of the federal government to change how health care organizations are reimbursed, in order to reward hospitals, clinics, and physician groups that demonstrate low turnover and other potential quality markers of wellness. Assuredly, interventions at the highest level have the greatest impact and that is where we should ultimately be directing our efforts.

I can hear you ask, "But if we focus solely on large scale interventions, won't some residents and physicians become lost in the shuffle? Surely some would benefit from knowing more about sleep hygiene or mindfulness-based stress reduction?" The answer is, yes, of course. I am not arguing for complete elimination of classroom wellness teaching. But there is a danger to focusing too much on individual interventions that assume that burnout or alcoholism or mental illness is the fault of the individual.

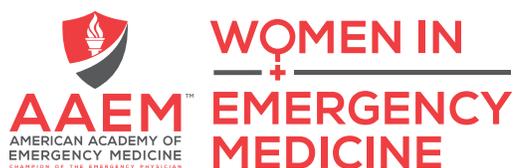
Large scale change can be leveraged to the tremendous benefit of the individual. For example, shift work scheduling policies can have a much greater impact on a physician's sleep habits than trying to teach him to reduce his daily coffee consumption. Also, large scale interventions often result in ways to improve our health care environments such that we can find joy in medicine again — for example, by reducing the burden of electronic charting to allow for more time to engage in meaningful conversations with patients and families.

Thankfully, I have never been woken up in the middle of the night by a phone call from a frantic resident bearing terrible news. And I have hope in my heart that, if we all work together with the right focus and dedication, it will stay that way for a long time.

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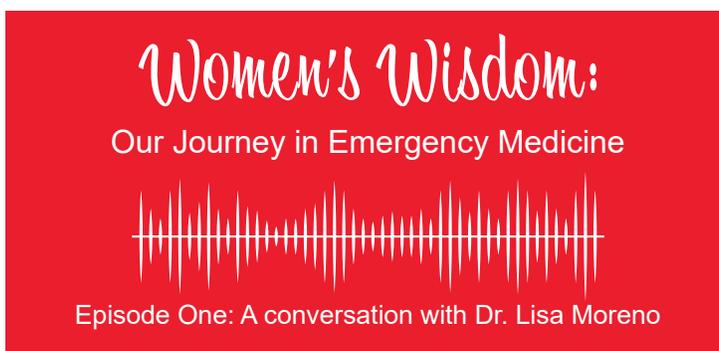
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Emergency Medicine Ultrasound Merit Badges ... There's No Need

Ryan C. Gibbons, MD FAAEM — AAEM Emergency Ultrasound Section

Emergency medicine ultrasound is among the latest targets for opportunistic companies, like Inteleos. In 2016, Inteleos was founded as the parent company for the Alliance for Physician Certification & Advancement™ (APCA™) and the American Registry for Diagnostic Medical Sonography® (ARDMS®). The ARDMS was originally founded to standardize sonographer training, assessment, and continued education. As the use of ultrasound expanded across medical specialties, ARDMS began to target physicians looking to legitimize their training in the burgeoning subspecialty of point of care ultrasound. ARDMS offers multiple certifications in various ultrasound applications. Each has a significant financial burden to the provider and not surprisingly the requirement to maintain accreditation at an additional cost every few years. Hoping to capitalize on ultrasound's continued expansion into multiple fields of medicine, Inteleos founded the Alliance for Physician Certification & Advancement™ (APCA™) to focus on physicians exclusively. As their website states, the APCA is a physician-centric certification council founded to meet the needs of physicians.

The numerous certifications offered by the APCA and ARDMS are equivalent to the myriad of medical merit badges, including ACLS, PALS, and ATLS, recommended by organizations, such as the American Heart Association and the American College of Surgeons, which try not only to exert influence over the practice of emergency medicine but to profit from it as well. Emergency medicine is among the youngest specialties in medicine having achieved recognition by the American Board of Medical Specialties in 1979 but with the caveat of having other medical specialties represented on its board. It would take nearly a decade for this to change. Throughout the development of our specialty, outside influences would attempt to exercise control over the practice of emergency

medicine. For nearly two decades, the American Academy of Emergency Medicine has openly opposed these unnecessary merit badges.² More recently, the Coalition to Oppose Medical Merit Badges, an association of ten national emergency medicine organizations, released a position statement in March 2017 opposing the requirement for medical merit badges.¹

Emergency ultrasound is no different. As emergency medicine providers, we have a proud tradition in the field of point of care ultrasound. In fact, there is emergency ultrasound literature dating back to 1988 and policy statements regarding emergency bedside ultrasound from the Society of Academic Emergency Medicine and the American College of Physicians as early as 1991.⁶ As a specialty, emergency providers have been at the forefront of developing point of care ultrasound and pushing the boundaries of its use. In the early years, RDMS certification represented the only means to validate ultrasound proficiency. However, with the release of ACEP's policy statement, Ultrasound Guidelines: Emergency, Point-of-care, and Clinical Ultrasound Guidelines in Medicine in 2001, we as emergency physicians set our own standards of training and assessment. The American Medical Association's Resolution 802 affirmed that "ultrasound imaging is within the scope of practice of appropriately trained physicians and that the recommended training and education standards be developed by each physician's respective specialty society."⁵

As a subspecialty, emergency ultrasound has come a long way since its introduction into emergency medicine. Presently, the Accreditation Council for Graduate Medical Education (ACGME) mandates ultrasound training as a core competency for emergency medicine residencies and according to the 2013 Model of the Clinical Practice of Emergency



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EMERGENCY MEDICINE ULTRASOUND MERIT BADGES

Medicine, it is an integral skill for emergency providers.^{3,4} We have developed over 100 emergency ultrasound fellowships

nationwide and have an integral role introducing ultrasound training into medical school curricula across the country as well.

Given our expertise in point of care ultrasound, organizations such as the APCA specifically target emergency medicine physicians. The recent development of the Point-of-Care Ultrasound (POCUS) Academy by the APCA explicitly aims to exploit emergency providers charging several hundreds of dollars for the unnecessary Emergency Medicine POCUS Certification, as well as several additional clinical ultrasound credentials. As the APCA plans to expand their specialty certifications to other fields of medicine, we as emergency medicine physicians must continue to dictate how we develop and practice emergency medicine without the intrusion of outside entities which hope to manipulate our colleagues and demean our American Board of Emergency Medicine Certification.

If you would like further information, please contact our section. We encourage all emergency providers who are interested in ultrasound to join us as well.

Check out the section website and learn more about membership at: www.aaem.org/EUS.

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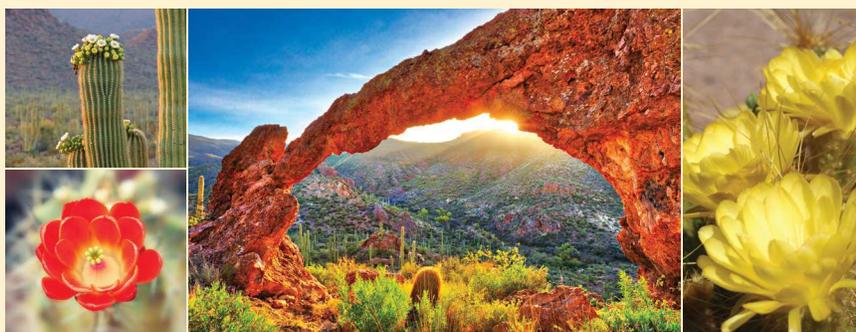
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From MCAT Failure to Emergency Physician: My Journey through International Medical School

Kimberly M. Brown, MD MPH



After completing residency almost one year ago, I have been extremely reflective over my journey to becoming an attending emergency physician. Growing up, I always knew that I wanted to become a physician, but my journey here has not been easy. Looking back, I did not expect that I would

have to leave the United States for twenty months in order to become a physician. After taking the MCAT several times with a poor score and being rejected from American medical school during two separate application cycles, Ross University School of Medicine gave me the opportunity to fulfill a lifelong goal.

During my application process to medical school, I heard many negative things about students that chose to attend medical school outside of the United States. International medical graduates (IMGs) were lazy, dumb, spoke English poorly, and were horrible physicians — just a few of the things I heard. I internalized the rhetoric, and avoided applying, even while I received rejections from American medical schools daily.

While completing my master's degree in public health and applying for the third time to medical school, I had a friend encourage me to apply to a Caribbean school.

He had multiple other friends that had successfully completed medical school internationally, matched into and

completed a residency in the United States. By this time, I also had several friends that were at Ross that were doing well. I decided that my passion to become a physician was greater than any stereotype of a Caribbean school. I applied to, interviewed and was accepted at Ross University School of Medicine in Dominica, West Indies.

I flew to Dominica on January 1, 2011, and was nervous, excited, and scared all at the same time. Living and studying in Dominica changed me for the rest of my life. Dominica is an island in the Eastern Caribbean. She boasts 290 square miles and with a population of a little less than 75,000 people. Although beautiful, Dominica suffers from the second lowest gross domestic product (GDP) in the Caribbean and 29% of Dominicans live below poverty level. Most Dominicans are of African descent, but I also had the amazing privilege of serving the Carib people, a group of pre-Columbian natives to the island. Studying in Dominica exposed me to patients from different cultures and languages. Beginning my medical career serving a diverse and culturally rich population is a rarity that I appreciated even more as I transitioned back into the United States for clinical rotations.

In 2014, I embarked on my endeavors to match into an emergency medicine residency. I knew the road would be difficult. Even though I had good board scores and clinical grades, most program directors would see my medical school as a blemish on my application, instead of an asset. I found it difficult to find sub-internships in emergency medicine because many medical schools would not allow international medical students to rotate. However, I worked diligently, remained tenacious, and applied broadly. I received multiple rejections from programs, even though my



Beginning my medical career serving a diverse and culturally rich population is a rarity that I appreciated even more as I transitioned back into the United States for clinical rotations.



DIVERSITY AND INCLUSION

scores were on par with American medical students. Match Day 2015, my hard work and dedication was rewarded by matching into my first choice program.

Although my time in Dominica is in my rearview, my passion for seeing other IMGs complete emergency medicine residency is more heightened than ever before. Our emergency departments are filled with patients of diverse backgrounds, educational levels and levels of health literacy. IMGs, through their experiences in offshore medical schools, are uniquely qualified to see, treat and serve a rapidly changing patient population. Those of us in academia need to work diligently and purposefully to remove the barriers for IMGs to pursuing and matching into emergency medicine here in the United States. International medical schools produce graduates with invaluable experiences that make them incredible physicians and contribute to the landscape of diversity and inclusion. ●

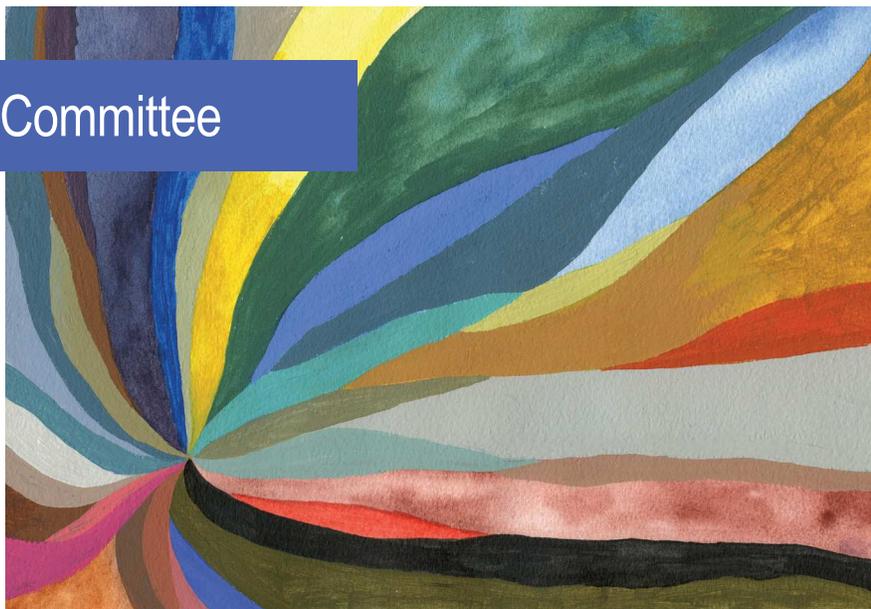
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Getting Off the Ground: Developing an ED Patient and Family Advocacy Council to Improve Patient Experience

Jonathan D. Sonis, MD; Maryfran Hughes, RN MSN NE-BC; Cassie Kraus; Robin Lipkis-Orlando, RN MS NE-BC; Linda Kane, MSW LCSW; Benjamin White, MD FAAEM

Patient experience continues to be a growing area of focus for hospital and emergency department (ED) leaders across the United States.^{1,2} Despite this, existing avenues of obtaining accurate data regarding the most critical drivers of ED patient experience are limited and, importantly, largely missing the perspective of patients and family members themselves.³ While many U.S. EDs employ a post-visit survey tool (i.e., Press Ganey, Healthstream, QDM, and others), survey data may be limited by poor response rates, non-response bias, and restricted by the scope of the responses reported.⁴

To address the critical need for patient and family member input in improving patient experience, Patient and Family Advocacy Councils (PFACs), which include both invited patients and family members and selected staff, have been employed at the hospital and specialty level with increasing frequency over the past decade. In early 2018, recognizing a void of the patient's voice in our own ED patient experience improvement efforts, we set out to create the first-ever ED PFAC at Massachusetts General Hospital.

Planning and Staff Recruitment

The first step in developing the ED PFAC was ensuring that stakeholders from all branches of the department's leadership were supportive of the concept and would be willing to devote time and resources to the project. Early on, the ED Nursing Director, ED Clinical Director, and Executive Director all recognized the value in forming such a council and agreed to participate. Given the need for experience with PFAC formation, we also reached out to and gained the support of the director of our hospital's Office of Patient Advocacy (OPA), who provided not only invaluable expertise and support, but also a source of potential participants.

To create balance within the group, it was decided that the PFAC would be co-chaired by a nurse (ED Nursing Director) and a physician (ED Administrative Fellow) with plans to also include a representative from ED Administration (Administrative Manager for Quality and Process Improvement) and the OPA (Advocacy Representative), as well as the ED Clinical Director.

Patient and Family Recruitment

Based on recommendations from the OPA, we sought to have an approximate one-to-one ratio of patients and family participants to staff participants in our PFAC. Therefore, five patient and family participants were sought out. Three participants were identified by the OPA as they



“To address the critical need for patient and family member input in improving patient experience, Patient and Family Advocacy Councils (PFACs) ... have been employed at the hospital and specialty level with increasing frequency over the past decade.”

had expressed interest in joining a PFAC and had experienced several episodes of care in the ED. Another two participants were identified directly by the PFAC co-chairs through communication following ED visits. Finally, a sixth patient participant who had already expressed long-term interest in supporting ED patient experience improvement efforts was asked to join the group. All participants were interviewed prior to being selected to participate on the council.

First Meeting Logistics

An initial meeting was scheduled for January 2019 after consulting the schedules of each participant. The agenda for the initial PFAC meeting was developed by the co-chairs with assistance and feedback from the OPA with the goal of introducing all participants and providing a general “lay of the land” of the major challenges facing our ED as well as existing solutions. This included a brief explanation of the PFAC's



OPERATIONS MANAGEMENT

development and the importance of patient and family perspective in improving ED patient experience followed by participant

introductions, a brief summary of ED statistics and a demonstration of previous and current patient experience improvement efforts. While a formal agenda was utilized, extensive discussion among participants occurred throughout the meeting.

“ International medical graduates, through their experiences in offshore medical schools, are uniquely qualified to see, treat and serve a rapidly changing patient population. ”

Challenges

A key challenge throughout the planning and recruitment process was ensuring that the resulting group was diverse and as representative as possible of the population served by our ED. In particular, we found it more difficult to recruit younger participants than retirees, who often expressed increased time flexibility compared to their working counterparts. Ongoing recruitment efforts will focus particularly on underrepresented groups.

An additional challenge revolved around management of the meeting itself. Because all participants were eager to share their experiences and personal interests, some group members were more vocal throughout, at times making it challenging for others' voices to be expressed. Moving forward, each meeting will begin with a summary of meeting expectations, including adhering to time limits and avoiding interruption.

Lastly, maintaining momentum and enthusiasm throughout the PFAC group will continue to be a challenge, both for patient and family participants and for staff. We plan to schedule meetings quarterly for the first year in order to continue to build momentum, with the option of decreasing frequency to three times annually in the second year.

While it is too early to determine whether the formation of the ED PFAC will lead to quantitative improvement in ED patient experience, initial feedback has been universally positive, with patients, family members, staff, and departmental leadership enthusiastic about the promise of gaining the patient and family member perspective in our ongoing patient experience efforts. Despite the challenges in providing excellence in patient experience in the ED, this relatively low-effort, low-resource project has the potential to bring significant and longstanding improvement for our patients and their families.⁶⁻⁸ ●

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CCMS-AAEM Updates

Ashika Jain, MD RDMS FAAEM — President, AAEM Critical Care Section



We started the AAEM Critical Care section in 2017, and have grown exponentially since, not just in membership, but also in involvement in AAEM as a whole. We are ecstatic with how far the section has come in the last two years.

Where We've Been

2018 was an exciting year. We kicked off the year at the 2018 Scientific Assembly (AAEM18) in San Diego, CA. We had a productive section meeting, and after a hearty discussion, the section decided to support the subspecialty certification in Neurocritical Care. There was a thoughtful and robust discussion about this topic and in the end, we recognized the need to establish a formal ABMS pathway for subspecialty certification in neurocritical care medicine.

Our section has been busy with educational content. Dr. David Farcy recorded two episodes for AAEM's critical care podcast series, which is AAEM's most downloaded podcast. He talked about balanced fluid resuscitation with Dr. Michael Winters and treatment algorithms for emergency invasive cardiac procedures with Dr. Amal Mattu.

Multiple members published in AAEM's member magazine, *Common Sense*.

- March/April: Why Play the Waiting Game? A Discussion on Chest Radiography and Ultrasound for Central Line Placement, Ashika Jain, MD FAAEM
- May/June: Mechanical Ventilation in the Difficult Patient and Ventilator Cycling, Joseph Levine, MD and Ashika Jain, MD FAAEM
- July/August: CCMS Update, Joseph Shiber, MD FAAEM
- September/October: The Most Stable Pulseless Patient You'll Ever Meet! A Clinical Update on LVADs in the ED, Gage Alexander Stuntz and Andrew Phillips, MD MEd FAAEM
- November/December: Immunotherapy Complications in the Emergency Department: Be on the Lookout for the Checkpoints!, Adarsh Srivastava, MD FAAEM

Read all of the articles from the CCMS at www.aaem.org/get-involved/sections/ccms/resources/common-sense.

If you would like to contribute to *Common Sense* in our critical care section, please contact Michael L. Martino, MD FAAEM, our new Secretary-Treasurer.

Along the lines of education, multiple Critical Care Section members presented at AAEM19, in fact 12 of our members presented in various forms.

Where We are Going

As a section, we are grateful for our current members and are excited that membership is on the rise, and we want to continue to grow. We elected a new board, and Joseph Shiber has moved to the role of Immediate Past President. He has been an amazing leader and mentor as the section grew its legs. Ashika Jain moved into the role of President with a few plans up her sleeve for the section, with Andrew Phillips as President-Elect. Michael Martino was elected Secretary-Treasurer. The at-large board now includes Alexandra June Gordon, who was the previous RSA representative, we are excited that she decided to join the at-large board now that she has graduated residency and is in fellowship. Hector Peniston-Feliciano also stayed on as an At-Large Director. We welcome Alex Flaxman, Skylar Lentz, and Douglas Schiller to our at-large board as well. Dr. Leena Ramadan is the new RSA Representative.

We have a few great projects that we kicked off at AAEM19. We initiated Critical Care Hacks, a social media based compendium of the little things that we do in the ED to help our critically ill patients.

We will be posting short videos and topic summary on various modes of social media. We invite all of our members to join us in this fun and innovative project. If you have a hack, let us know. At the section meeting, we decided that it was important for this project to be open source. We believe that this compendium will be a resource for all of our members, of the section and of AAEM as a whole, alike.

We want to do more for our members and want to provide resources and support, more specifically, mentorship. We recognize the importance of mentorship, both for the mentor and mentee. We will be sending out a call for both, with a hope to pair section members up.

As we continue to grow within, we want to ensure that we support our fellow AAEM chapters. We have reached out to local chapters to offer our support for chapter division conferences, providing critical care speakers, or helping to identify speakers in their areas.

The next year of AAEM-CCMS is going to be the greatest yet. We remind AAEM members that the Critical Care Section is not just for critical care trained members. We all provide critical care to our patients, we support you, the emergency physician, which wants to be a part of the critical care dialogue. We look forward to providing our members with knowledge, mentorship, and resources. We hope you will join us on this journey. ●

AMERICAN ACADEMY OF EMERGENCY MEDICINE



Connecting to Purpose and Restoring Meaning

Mary Jane Brown, MD FAAEM and Larisa Coldebella, MD



Life in emergency medicine can be challenging, draining, and at times insufferable. It's easy to lose sight of our purpose in the face of difficult patients, striving to meet non-patient centered metrics and the fear of litigation. How does one restore meaning in our working lives? At the individual level, finding

this meaning calls for self-awareness and an ability to reflect on what is most impactful to us personally.

Dr. Bryan Sexton at the Duke Patient Safety Center has developed the Web Based Intervention for the Science of Enhancing Resilience (WISER) program specifically to treat burnout in health care workers.^{1,3} With programs like WISER, we can hope to rebuild self-awareness and view both the doctor-patient relationship and the workplace in new and positive ways. Dr. Sexton notes as a species we are trained to focus on the negative, which was necessary for survival. The skills Dr. Sexton presents are evidence based, simply done, and portable. These skills include “three good things,” random acts of kindness, and an openness to awe and wonder.

on three good things each day for fourteen consecutive days has been shown to cause a significant drop in burnout, increase subjective well-being, work life balance and surprisingly, depression was ‘cut in half’ for people with at least mild depression.¹

Dr. Sexton offers this exercise as one to close out the day, typically within two hours of bedtime. He suggests recalling three good things that happened that day and reflecting on our feelings and what role we had in these good things. As participants, we can log and share these good things with others (anonymously) or simply keep the good things private to ourselves. Reading other peoples ‘good things’ can be transformative and inspiring.

For example, good things can be as simple as camaraderie in the workplace. My longtime paramedic colleague confessed to me a few years back of her struggle with PTSD and what now we would call Second Victim Syndrome. She is my mentor for a good chat and seeing good things. At the end of a patient handover prehospital to ED, we exchange “How are you?” and “How is your shift going?” “Sunshine and no rain”



“How does one restore meaning in our working lives? At the individual level, finding this meaning calls for self-awareness and an ability to reflect on what is most impactful to us personally.”

Three Good Things

Good things range from the personal or professional, ordinary or extraordinary. Good things abound even in the emergency department. The good things leave us with emotions — feelings of joy, peace, inspiration, and amusement to name a few. The good things deserve our notice and may hold the key for restoring meaning in our working lives. Reflecting

she says. While it may not always have been that way, she has knack for seeing good things and sharing her positivity with others. Even in the middle of the night, we can share a laugh together and gratitude and joy for our work and our friendship.



COMMITTEE REPORT
WELLNESS

Acts of Kindness

As for random acts of kindness in the emergency department, I have one colleague who never fails to bring me a bottle of water when he comes back from the Doctor's Lounge (I stay much more hydrated when he is working!). He recently shared with me that his kindness should not be considered altruistic, but seen for the self-serving act of keeping me from wandering off to find my own water. Nursing colleagues often assist caregivers with coffee or additional warm blankets for a cold patient. Techs and paramedics give directions to family members and may walk with them to rooms, often checking in to see if they need anything else. For the physician, kindness is important to see and promote, as patients important to receive, and as humans kindness is good for our heart. So, with Dr. Sexton's encouragement, these small acts are important connections to meaning; as he notes they remind us to tend and befriend and build relationships in medicine.⁴

Awe and Wonder

The last skill is the development of openness to awe and wonder. Through an "awe intervention," Dr. Sexton notes that you can create a sense of slowed down time, which offers a calming sensation and feeling of having more time available.^{2,7} These need not be necessarily "extraordinary," but just a memorable time or incident that reminds us of who and what we are and fosters connection to our sense of purpose or meaning. Dr. Sexton considers these skills important to emotional thriving.

One may ask where to find awe and wonder? Certainly in nature or listening to Neil DeGrasse Tyson discuss astrophysics. Other times it comes in the form of witnessing a colleague's accomplishment or great save. Recently upon arriving for my shift the overnight resident shared a great save with a patient who complained of chest pain with EKG changes and had an urgent cath with recognition of a coronary artery aneurysm. Awe started my day — much nicer than the "turn around while you have the chance" greeting, which I hear all too frequently and find emotionally draining.⁶

In summary, finding connection and staying connected to purpose is not static. The practice of looking for good things, performing, or recognizing random acts of kindness, and experiencing awe and wonder requires intention.^{3,5,8} As a group, we should begin to treat these skills like any other skill that we practice in the emergency department, a Continuing Medical Education for meaning in medicine, if you will. With the help of Dr. Sexton's tools and the support of ourselves and our colleagues in this pursuit, we can rekindle the flame that set us on the tumultuous path of becoming a physician in the first place. ●

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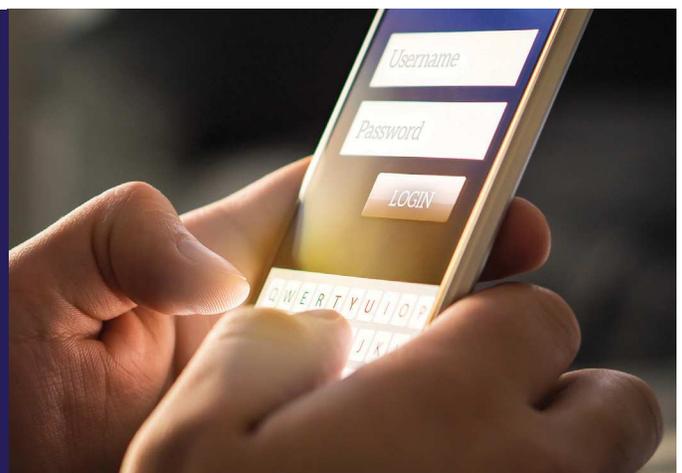
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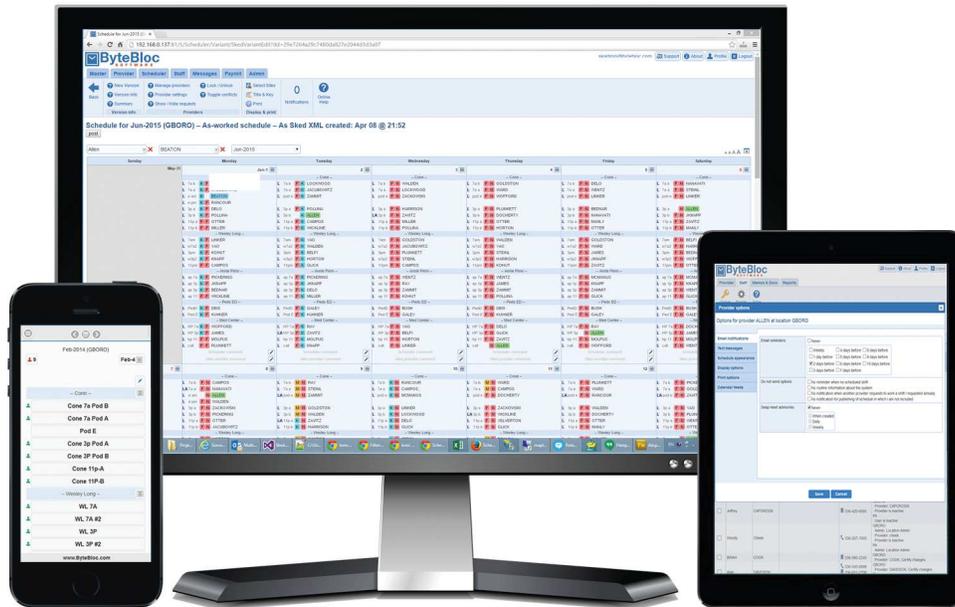
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Palliative Care in the ED: How Do We Bill Appropriately?

Ray Isenburg, DO and Deniece Boothe, DO



Billing and coding can be confusing; think of any provider picking from the seemingly endless “pedestrian struck” codes. Perhaps this holds truer for specialties like emergency medicine where chart review and coding are often completed by a third party agency. Billing may not be the most interesting

aspect of our jobs or why we decided to pursue medicine, but it is essential to being reimbursed for the services we render. This article is targeted at educating how to bill for palliative care services you may already be providing and what exactly constitutes palliative care in the emergency department.

Palliative care is a broad term and under current CMS guidelines any specialty may bill for palliative care services. There are two general routes on billing for palliative care in the emergency department. The first is integrating palliative care into critical care and the other involves advanced care planning discussions with non-critical care patients.

Critical Care Billing Route

Critical care time may be billed on any patient requiring high complexity decisions that are aimed at preventing vital organ failure or life threatening deterioration. Most patients who meet criteria for critical care billing would benefit from incorporating palliative care. In this setting, palliative care is implemented with a discussion regarding patient care preferences and overall goals. Time devoted to this discussion is then added to the overall critical care time.

Two components of palliative care that can be easily integrated with critical care patients include:

1. Patient preferences regarding treatment options
2. Decisions on how a patient would like distressing symptoms managed

With either example a discussion can be carried out directly with the patient or under certain circumstances with their family.

A direct discussion with a patient can be attempted and accomplished with any patient who is competent and aware of their condition. A family discussion may be attempted if the patient cannot participate either due to instability or lack of capacity. If a provider does speak with family instead of the patient they must document: 1) Why the patient cannot participate; 2) Need for the discussion (patient instability and some form of organ failure).

In either situation the conversation should cover medically necessary treatment decisions and how the patient would like distressing symptoms managed. Examples of treatment decisions include: preferences on cardiopulmonary resuscitation, mechanical ventilation, initiation of vasoactive medications, dialysis, invasive procedures (enteral feeding tube / tracheostomy/chest thoracotomy), and artificial hydration and nutrition. Examples of distressing symptoms include pain management strategies, treatment of dyspnea, and delirium.

When you discuss these types of goals with a patient you are providing a palliative care service and the time spent during discussion may be added to your critical care billing time. To bill for this service add together: 1) Time spent preparing for the discussion; 2) Total actual discussion time. After tabulating this time you may add it directly to your existing critical care billing time.

Example: You perform 60 minutes of critical care time resuscitating a patient. After resuscitation you have a discussion with family regarding patient care preferences lasting 15 minutes.

Total critical care time = 75 minutes.

Advanced Care Planning Billing Route

Advanced care planning (ACP) is another route that we as emergency department providers can integrate and bill for palliative care. Advanced care planning refers to having a direct discussion with a patient, family member, or surrogate regarding advanced directives. This discussion may be billed independently of an E/M code and does not require the completion of any official advanced directive documentation.



There are two general routes on billing for palliative care in the emergency department. The first is integrating palliative care into critical care and the other involves advanced care planning discussions with non-critical care patients.



PALLIATIVE CARE An emergency department provider can have an advanced care planning discussion with essentially any patient. The requirement is that this planning must involve an advance directive type discussion which records the wishes of a patient pertaining to his or her medical treatment. The purpose of the discussion is to develop a plan for future care if the patient lacks decisional capacity.

There are not specific CMS requirements as to what must be discussed during an ACP session, however some recommended aspects include:

- Identifying who the discussion was with
 - Patient, family, or other health care surrogate
- Describing the existence of any current legal documentation regarding health care decisions
 - POLST, MOLST, durable power of attorney, health care proxy, living will, etc.
- Medical care preferences
 - Patient priorities, goals, and values
- Advance directive choices and designation of a health care decision maker

Similar to discussing treatment choices and options within critical care if you perform an ACP discussion you are providing a palliative care service and the time spent during discussion is billable. The appropriate code is the “first 30 minutes” ACP code which is 99497 and reimburses at 1.5 RVUs. One important note in with billing for ACP is that you must spend 16 minutes face-to-face with patient or family.

Example: You care for a CHF exacerbation patient who is complex and requires admission. While in the emergency department you also enter into an ACP conversation with the patient.

Billing= Level 5 E/M code + ACP code.

Appropriate Documentation for All Palliative Care Services

An important aspect of integrating palliative care is the requirement of proper documentation. For both the critical care and ACP methods there are certain documentation requirements which must be met. This includes:

1. Start time of discussions
2. End time of discussions
3. Total ACP or critical care time
4. Summary of what was discussed

*For critical care you must also list time preparing for discussions (which can be added to total time)

Finally, one additional caveat is that the ACP code can be billed with an E/M code however you cannot bill for ACP and critical care time together. Although documenting these requirements may seem daunting; a small macro in your local EMR can make it as quick as clicking on a few boxes.

Palliative Care is of great benefit to patients and families facing serious or life limiting illness. It allows for the individual or family members to be an active participant in the medical care being provided. It ensures that the treatments and care are consistent with their values. Please consider implementing more of these practices for your patients and when you do, now you know how to bill for it! ●

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

www.aaem.org/get-involved/committees/interest-groups/palliative-care

Three Small Documentation Changes to Improve Your Billing

Brian K. Parker, MD MS



One of the biggest surprises for me after graduating residency was the amount I had to learn regarding billing and coding. It was always something that was in the back of my mind during residency, but like many of us, I focused on patient care more so than the documenta-

tion.¹ Thankfully, I had several good billers and coders in my department willing to give me a few tips on how to maximize my charting.

The first thing I learned was how to document a level V bill.²

Someone may assume it's intuitive to checkmark a series of boxes. In actuality, the process is a bit complex. My understanding when I came out of residency, was that I only needed to cover 10 points in the review of systems, two out of three for social history, and nine systems in my physical exam.

In reality, the biller develops a score based on your diagnosis and treatment documentation, your data reviewed, and risk the patient's presentation represents.³ The actual calculations of these are outside the scope of this article. One important tip is that you can increase your data "points" based on ordering and reviewing laboratory studies, imaging, ECG and echocardiograms. You can "earn" additional points by independently interpreting the ECGs and images in real time. If you obtain outside records, or if you review and summarize older records, this also increases the data portion of your score. In most patient encounters, laboratory studies are ordered, and you review them during the patient encounter, so adding one sentence to your chart referencing this should be fairly easy to implement. You are also interpreting EKGs on patients many times during a shift, so it also should become routine to document your interpretation into the chart. Most electronic medical records will allow smart phrases or text expansion to cover these two very actions. The interpretation of radiographic imaging is a little bit more complicated, and may vary based on your hospital and the hospital's arrangement with the radiology department.

Some encounters, no matter how much documentation you provide, will never be complex enough to warrant a level V bill. The patient who presents for medication refill will most likely not be able to generate enough data "points" to bill at level V. Knowing this, you should focus on making this chart as streamlined and brief as possible, to minimize your time away from patient care.

As a resident, I could not generate critical care billing time, and so I was unfamiliar with the exact definition of critical care time. However, I was made aware that a critically ill patient quickly qualifies for critical care time. CMS defines critical care time as treating a condition which impairs at least one organ system with a high probability of imminent deterioration which may be life-threatening.¹ The first 29 minutes of treatment are included in the initial ED bill, so your critical care time must be at least 30



minutes. This time is cumulative during your care of the patient, so any ECG, chest X-ray, or blood gas interpretations, adjusting the ventilator, obtaining vascular access, calling consultations, discussing the patient's case with the family or the patient, or even documentation are included in this time.

When I met with my billing company, they pulled five random charts of mine and walked me through the scoring system. This helped me to better understand the process. The review meeting lasted longer than the time I spent learning about coding and reimbursement during residency.⁴ These three tips, along with continued coaching from my coders and billers, have helped me to document the services I had been providing. I would recommend for you to contact the billing company to ask if they have any suggestions they could offer you in regard to billing and documentation. ●

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Let's Recap

Mohammed Moiz Qureshi, MD — RSA Immediate Past President



As another academic year comes to a close, I am thrilled to share about the progress RSA has made as an organization this past year. There are too many individual and group performances to list them all, but I would like to take the time to discuss and share some of the proudest moments RSA has had over the year.

through the medical student council and requested every state chapter to include medical students on their boards hope to create more opportunities for leadership and mentorship through AAEM. Most exciting however, RSA published a new resource to use for bedside ultrasound! The guide, developed by faculty at Temple, is a quick and easy reference for all things ultrasound and RSA was proudly able to distribute them at the last Scientific Assembly!

Advocacy

In the 2018-2019 academic year, RSA has continued to fight the good fight on behalf of its resident and student members. After supporting the AAMC pilot program in the past years regarding standardized video interviews for EM applicants, we took a stand this year and firmly opposed the continuance of this program, citing concerns of increased stress and monetary limitations of our students. We tried to be open minded and collaborate however when the evidence wasn't there, we made protecting our students' interest our utmost responsibility. Along those lines, RSA was one of the emboldening forces behind the updated AAEM policy regarding midlevel independent practice. Knowing that as residents, after over 10 years of education and training, it is imperative to protect our right to safe and reliable working conditions to provide the highest quality of care to our patients.

Wellbeing

RSA has also been at the forefronts of resident and student wellness. Remembering to celebrate times of happiness and comforting in times of tragedy, we have made it our priority to support the mental and physical wellbeing of our constituency. As such this year, RSA joined AFFIRM, which is a research organization that works on gun research, and to clarify not gun control, but rather research what are safer ways to own guns and what aspects of the process are leading to the mass casualties we are all too accustomed to hearing. We also put three board members on the multi organizational collaborative working group discussing resident maternal/paternal leave advocating for more flexibility in accrued time away so that we too can be present for life's precious moments. We welcomed storytelling at not one, but two airway events over the year and turnouts were outstanding!

Education

As a board, RSA also continued our commitment to our educational objectives by again providing an exceptional resident track at the annual Scientific Assembly in Las Vegas, supporting the resident educational program at CORD, the annual medical student track at AAEM19, and then also went above and beyond to attempt to defend our program leadership's need for protected time for our education that has been threatened by new ACGME guidelines. We also found new opportunities



Yet of all these successes, the one most groundbreaking of all this year for RSA has to be the addition of the organization to participate in the EM Model Review Task Force. Initially proposed years ago, and despite years of adversity and hurdles, RSA was finally admitted to participate in the continued molding of this critical document pertaining to EM residency education. This year's board had made achieving this invitation one of its primary objectives and worked hard to rally support from the other voting organizations. With this opportunity, RSA is thankful to be included and recognized as a contributing member to the overall specialty of emergency medicine and welcomes the prospect to continue to grow and collaborate with other organizations on this critical document pertaining to residency training! All this would not be possible without the longstanding work of past RSA boards for helping build these relationships with the other organizations.

Challenges and Opportunities

With all these successes, the year has not gone without its challenges either. We said goodbye to our long-time executive director, Janet Wilson, who after 13 years with AAEM and RSA transitioned into retirement. She will surely be missed in the years to come. Janet was heavily involved from RSA's early days and we thank her for all of the wisdom and experience she shared with the organization.



AAEM/RSA
PRESIDENT'S MESSAGE

Retaining our veteran RSA members in AAEM in the YPS section has been a challenge and has created a void where we are working to bridge that gap and guarantee earlier connections for graduating seniors and encourage that graduated transition of leadership. It was with this gap in mind that we created the Legacy Assembly to create more direct lines of communication between RSA past and present leaders, and encourage all former RSA board members to join and impart their experiences.

It has been an honor to serve RSA this past year. If anyone has any questions about any of the work RSA has done over the past year I'd be more than happy to indulge further details and welcome everyone to get involved on our various committees and projects. As immediate past president, I'm excited to see RSA continue to advocate for its members, provide educational opportunities and promote resources for overall wellness! ●

Congratulations to the 2019-2020 RSA Board of Directors

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Cancer Sucks

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Cancer sucks! This is the proverbial phrase that unites all cancer survivors, cancer fighters, and cancer victims. It allows unity among the terrifying cancer experience, allowing us to bond and empathize over the seriousness that is a cancer diagnosis. Clinical experience suggests that cancer is

frequently diagnosed in the emergency department (ED). Anecdotally, in three years of residency I have seen a whopping two STEMI's between my two large academic EDs, whereas, maybe monthly I worry about a new cancer diagnosis.

Some studies have demonstrated that patients diagnosed with cancer in the ED have more advanced disease and poorer outcomes when compared to outpatient diagnoses. Of the estimated 105,000,000 emergency department (ED) visits annually, almost 4,000,000 (3.8%) are that of cancer patients. Knowing the impact of cancer-related illnesses is research that is ongoing, but little is known about the rate of new-onset cancer diagnoses in the ED.

Compared to non-cancer patients, ED patients are older, experience longer ED length of stay, undergo radiological testing (including CT scans), more likely to be septic, have higher thrombosis rates, and are more likely to be admitted to the hospital. Thus, the ED presents as a unique interface for the large number of potentially sick cancer patients. Of the cancer visits, ED providers frequently see oncological emergencies such as febrile neutropenia, acute pain, shortness of breath, and spinal cord compression. Further, as patients get closer to the end of their life, ED utilization increases. How do we identify patients with malignancy sooner as to prevent some of the significant downstream complications of more advanced disease states?

Further, some recent, but limited work has shown patients diagnosed in the ED with some sort of suspected malignancy suffer worse outcomes, theoretically due to more advanced disease states. Seemingly this is a vulnerable patient population and by accomplishing this preliminary work we can impact a large population of patients. A lot of these patients visit the ED before they are diagnosed with cancer, and by identifying which types of malignancies most commonly are diagnosed in the ED, and in which subset of patients present with these malignancies, protocols can be made to identify these patients earlier. For better or for worse the ED is the safety net for a large population, and while the ED isn't designed for primary care for many hospitals the ED is the entrance to the hospital but more importantly the health care system.

There is certainly little evidence about who and why we diagnosis with cancer but it happens. It happens everyday in all EDs across the nation. CNN highlighted this idea in that we are seeing cancer diagnosis made in younger and younger patients, further emphasizing that cancer sucks, and even more ED physicians need to be on the look out for malignancy.

We are trained in emergent diagnoses, hyperkalemia, stroke, STEMI, and septic shock, but in reality we do more than that. I would argue we practice as much primary care and non-emergent care as we do emergent, and appreciating the impact of one single cancer diagnosis has on a patient, a family, a community is of tremendous importance.

Rather than scuff off at the opportunity to be a patient's doctor, don't just say "they can follow up with their PCP" but instead tell the patient what you are worried about. Use the word cancer. Be honest, be fair, and be there for your patients. Remember, cancer sucks and we need to be there for our patients. ●



Some studies have demonstrated that patients diagnosed with cancer in the ED have more advanced disease and poorer outcomes when compared to outpatient diagnoses.



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The Role of High Sensitivity Troponin Pathways in the Emergency Department

Akilesh Honasoge, MD MA; Robert Brown, MD; Sharleen Yuan, MD PhD MA
Editors: Kami M. Hu, MD FAAEM and Kelly Maurelus, MD FAAEM

Clinical Question:

Can high sensitivity troponin meaningfully contribute to an acute coronary syndrome evaluation?

Introduction:

Traditional 4th-generation troponin assays are part of the standard cardiac evaluation when there is suspicion of acute coronary syndrome (ACS). Patients presenting to emergency departments with chest pain are typically risk stratified using a combination of historical risk factors, electrocardiogram (ECG) findings, troponin testing, and clinical suspicion. Patients are discharged from the emergency department if their risk is determined to be low while higher risk patients are usually admitted for further observation or testing. Recent data suggests, however, that high sensitivity troponin (hsTrop) testing could supplement or even replace current methods such as clinical risk scores when used in specific protocolized serial testing pathways. High sensitivity troponins first became available in the United States in 2017, but their use has not yet reached widespread acceptance. The test offers detection of cardiac troponin approximately 1000 times more sensitive than standard 4th-generation cardiac troponin testing. With this higher sensitivity come questions regarding reliability and specificity in certain comorbidities such as chronic kidney disease and underlying coronary artery disease. Some studies also explore the use of computed tomography (CT) coronary angiography when used in conjunction with hsTrop. Here we explore a few studies that evaluate the role of hsTrop in the evaluation of potential ACS.

Chapman A, Hesse K, Andrews J et al. High-Sensitivity Cardiac Troponin I and Clinical Risk Scores in Patients with Suspected Acute Coronary Syndrome. *Circulation*. 2018;138:1654-65.

The authors of this study sought to determine whether the addition of hsTrop to previously developed clinical risk scores would alter their negative predictive value (NPV) for ruling out ACS in low-risk patients. They evaluated two hsTrop ACS rule-out protocols: the European Society of Cardiology 3-hour pathway (ESC) and the High-Sensitivity Troponin in the Evaluations of patients with Acute Coronary Syndrome (High-STEACS) pathway. For both pathways, myocardial infarction is ruled in if the hsTrop concentration rises above the 99th percentile.

The ESC pathway rules out ACS in patients with symptoms lasting longer than six hours and a non-ischemic ECG if the initial hsTrop level is below the 99th percentile. For patients with symptoms lasting less than six hours, a second hsTrop is collected three hours after presentation, and if it remains below the 99th percentile and changes by less than half the threshold for the 99th percentile, ACS is ruled out.

By comparison, the High-STEACS pathway rules out ACS in patients with symptoms lasting two or more hours, without ischemic changes on ECG, with a hsTrop < 5ng/L at presentation. If the patient is within two hours of symptom onset a second hsTrop is collected at three hours after presentation and if it remains below the 99th percentile and there is no change (Δ < 3ng/L), ACS is ruled out. For patients with a presenting hsTrop > 5ng/L but below the 99th percentile, a re-test is performed three hours later and if there is no change (Δ < 3ng/L) then the patient is considered ruled out for ACS. Of note, the 5ng/dL threshold to rule out ACS at presentation was derived and then validated using consecutive suspected ACS cases at hospitals in Scotland.

The authors compared the sensitivity and negative predictive value for ACS of these protocols both with and without the following additional clinical risk scores: Thrombolysis in Myocardial Infarction (TIMI), Global Registry of Acute Coronary Events (GRACE), Emergency Department Assessment of Chest Pain Score (EDACS), and the History, ECG, Age, Risk Factors, Troponin (HEART) score.

This was a prospective observational cohort study of 1,935 consecutive suspected ACS cases at a tertiary care center in Scotland. The primary outcome was the composite outcome of myocardial infarction (MI) due to ACS or death due to MI, dysrhythmia, or heart failure at either presentation or 30 days later. Diagnoses were adjudicated by 2 independent cardiologists. The authors achieved 100% follow up via individual patient calls as well as regional and national registries.

The primary outcome occurred in 276 patients (14.3%). The ESC 3-hour pathway NPV was 97.9% (95% CI: 97.1-98.6) but with a sensitivity of only 89.9% (95% CI: 86.3-93.4), corresponding to a pathway-based rule-out of 70% of patients, with 27 missed events. When combined with clinical decision rules there was a significant ($p < 0.001$) improvement of the NPV (99% or greater in each case) but the proportion of patients characterized as "low risk" decreased dramatically to 25% with the addition of the HEART score, 42% with EDACS, 43% with TIMI, and 49% with GRACE.

The High-STEACS pathway ruled out a similar proportion of patients (65%) but with a better NPV (99.7% CI: 99.4-99.9) and sensitivity (98.7%, CI: 97.4-99.8), corresponding to 3 missed events. When combined with clinical decision tools there was no significant improvement in the NPV but the proportion of patients able to be categorized as low-risk fell significantly to 24.3% for the HEART score, 41% for EDACS, 44% for TIMI, and 47% for GRACE with $p < 0.001$ for each.

Although the High-STEACS protocol outperformed the ESC pathway, there are important limitations to this data. The actual High-STEACS pathway was derived from the first 1,218 patients used for this study, which derived its patients from a single large academic center. Therefore,



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it is without broad multi-centered validation. The study also notes that there is a high coefficient of variance surrounding the reference limits of the hsTrop testing of about 12.6% across 33 devices. This study also requires replication to ensure the generalizability of using a 5ng/L cutoff for hsTrop.

The High-STEACS highly sensitive troponin pathway appears to offer an effective method of ACS evaluation that is not significantly improved when combined with clinical risk score such as the HEART score. However, hsTrop pathways require more studies with different study populations, further specification of reference limits, and actual data on the effects of utilizing said pathways before there can be widespread adoption.

Kraus D, von Jeinsen B, Tzikas S, et al. Cardiac Troponins for the Diagnosis of Acute Myocardial Infarction in Chronic Kidney Disease. *J Am Heart Assoc.* 2018;7:e008032.

Chronic kidney disease (CKD) is associated with an increased risk for myocardial infarction, but the utility of cardiac troponins in evaluating for ACS is hindered by the fact that patients with CKD often have elevations in troponin even in the absence of myocardial ischemia. In this study, the authors hypothesized that although the performance of high sensitivity troponins I and T (hereby referred to only as “hsTrop”) to diagnose ACS is confounded by the presence of CKD, dynamic changes in hsTrop may outperform static cutoffs in the diagnosis of NSTEMIs in CKD patients. The authors proposed an algorithm using hsTrop levels to increase specificity in CKD patients.

The authors included two patient cohorts including over 8,500 patients in their analysis. The first was a prospective cohort that enrolled 1,818 patients with suspected ACS. They excluded dialysis-dependent patients but included 280 with CKD. The second was a retrospective cohort of patients with hsTrop testing in clinically-suspected ACS. Dialysis patients were again excluded, and it was narrowed to 5,478 patients without CKD and 1,581 patients with CKD after exclusion criteria. Important exclusion criteria included dialysis dependence, pregnancy, recent surgery, IV drug abuse, and anemia. The authors used this data to calculate the appropriate initial and 3-hour hsTrop level that would optimize both positive predictive value (PPV) and negative predictive value (NPV) for ACS in patients with CKD. The final diagnosis of ACS was made by two independent cardiologists after thorough chart review.

For the prospective cohort, the average GFR of patients with CKD was 46 mL/min/1.73 m², while in patients without CKD the GFR was 85 mL/min/1.73 m². The prospective cohort resulted in an NSTEMI rate of 17% (without CKD: 15%, with CKD: 26%). The retrospective cohort had a similar 19% overall rate of NSTEMI (without CKD: 17%, with CKD: 28%). The high sensitivity troponin levels were overall higher in patients with CKD (measured in ng/L). In the prospective cohort, for example, the initial hsTrop on average was 5.6 (CI: 3.0-18.2) in patients without CKD and 14.7 (CI: 6.5-76.9) in patients with CKD.

The authors derived optimized cutoffs for both absolute and relative changes for their hsTrop algorithms. The two main thresholds used were the 99th percentile and another “very high” level. This “very high” hsTrop

level was calculated to reach an equivalent specificity for ACS in CKD patients when compared to an initial hsTrop in a patient without CKD based on the 99th percentile cutoff. This “very high” level maintains the sensitivity of hsTrop I while dropping the sensitivity of hsTrop T. Based on these cutoffs, the authors established three different algorithmic criteria upon which to rule ACS in or out, making the following statements:

If the initial hsTrop level at presentation falls below the 99th percentile with no more than a 2.8x increase in hsTrop after three hours, ACS in patients with CKD can be ruled out (NPV=98%, CI=94-100%). Any increases past this level should prompt at least inpatient observation.

If the initial hsTrop is above the 99th percentile and increases more than 2.8x for hsTrop I after three hours, ACS is ruled in (PPV=89%, CI=65-99%). If they increase after three hours, but do not exceed the 2.8x cutoff, ACS is still possible, and the patient should be observed.

If the initial hsTrop level is above the very high level, ACS is ruled in without need for further troponin measurement in the emergency department (PPV=74%, CI not given).

Based on these cutoffs, when applied to the two cohorts being studied, the authors found the rule out approach described above had a sensitivity of 100% (CI=94-100%) for the diagnosis of ACS.

Limitations of the study include its use of initial serum creatinine at time of measurement of hsTrop rather than evaluation of the patient’s baseline creatinine clearance, which may damage the inherent validity of this study, as conditions like acute kidney injury offer a different pathophysiology and inherent ACS risk than chronic disease. The determination of final diagnosis of ACS was made by independent cardiologists in the prospective cohort, however the retrospective cohort established the final diagnosis of ACS from the patient’s evaluating provider. The study cohorts also excluded patients on dialysis, limiting the generalizability to that population.

Using a cutoff for hsTrop change, rather than absolute values, in the ACS evaluation of patients with CKD may have a place at some point in the future, however there is not enough data to make an adequate assessment on the validity of this approach at this time.

Ferencik M, Liu T, Mayrhofer T, et al. hs-Troponin I Followed by CT Angiography Improves Acute Coronary Syndrome Risk Stratification Accuracy and Work-Up in Acute Chest Pain Patients: Results from ROMICAT II Trial. *JACC Cardiovasc Imaging.* 2015;8(11):1272-81.

The ROMICAT II trial (Rule Out Myocardial Infarction/Ischemia using Computer Assisted Tomography) explored the effects of supplementing standard troponin testing with standard coronary computed tomography angiogram (CTA) to reduce hospital admissions and further testing. This study is a nested observational cohort of the larger ROMICAT II trial that evaluates the outcomes of combining hsTrop testing with advanced coronary CTA.

The study population included patients aged 40-75 years with at least two cardiac risk factors, in sinus rhythm, who presented to the ED with at least five minutes of chest pain or an anginal equivalent concerning



for ACS. Notable exclusion criteria include a positive initial standard troponin, serum creatinine >1.5mg/dL, or an ECG with diagnostic ischemic changes such as ST elevations or depressions >1mm or T wave inversions >4 mm in two anatomically adjacent leads. This study narrowed the 501 members of the CTA arm of the ROMICAT II trial to those who also had hsTrop testing, which lead to a total study population of 160 patients.

The patients were divided into three main categories based on their initial hsTrop: low risk (below the level of detection, <0.5pg/mL), intermediate risk (0.5-0.49pg/mL), and high risk (above the 99th percentile, >0.49pg/mL). Coronary CTA findings stratified levels of coronary stenosis to define presence of coronary artery disease (CAD) defined as: no CAD (0%), non-obstructive CAD (1-49%), and obstructive CAD (>50%). Advanced evaluation of coronary CTA analyzed high-risk features of coronary artery plaque (remodeling index >1.1, plaque with low CT attenuation <30 HU, napkin-ring sign, and spotty calcium) independently of the level of underlying coronary artery stenosis. The eventual diagnosis of ACS was based on an independent committee review of the patient's hospital or after-discharge course.

The overall presence of ACS in this cohort was 11.9%. In patients stratified by hsTrop level, 5.6% were deemed to be low risk and 7.5% were deemed to be high risk, with a 0% and 58.3% rate of diagnosed ACS respectively, independent of CTA testing. The 86.9% of patients with intermediate-risk hsTrop levels had an ACS rate of 8.6%. All patients with an eventual diagnosis of ACS had at least one high-risk feature on advanced CTA independent of the presence of obstructive CAD. No patient with an absolutely negative CTA (no CAD and no high-risk plaque) developed ACS, while patients with both obstructive CAD and high-risk plaque had an ACS rate of 69.2%.

The authors proposed an ACS evaluation algorithm that first stratifies patients based on initial hsTrop and associated rate of ACS (noted in parentheses): see Figure 1.

Patients with low-risk hsTrop levels (ACS=0%) would be deemed appropriate for ED discharge without a need for a coronary CTA.

Patients with intermediate-risk hsTrop levels (ACS=8.6%) would subsequently receive an advanced coronary CTA for further risk stratification. If no obstructive CAD and no high-risk plaques are found (ACS=0%), the patient is low risk. If either CAD or high-risk plaque is found, they are defined as intermediate risk (ACS=7.7%). If both are found the patient is deemed to be high risk (ACS=69.2%).

Patients with high-risk levels (ACS=58.3%) would go on to further inpatient evaluation without need for additional ED risk stratification with coronary CTA.

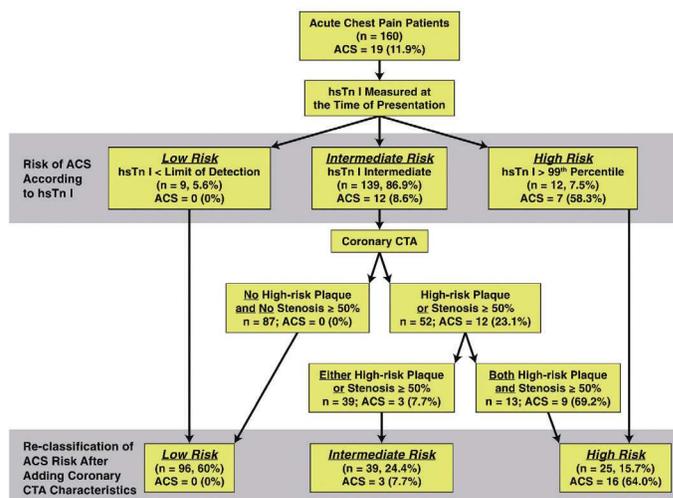


Figure 1: Combined hsTrop and Advanced Coronary CTA algorithm for ED evaluation of ACS derived from the ROMICAT II Trial

The author's overall conclusion is that use of hsTrop and advanced coronary CTA maintains the 100% (95% CI: 82.4-100.0%) sensitivity of ACS when compared to standard troponin and standard coronary CTA. However, it improves the specificity from 48.2% (95% CI: 39.7-56.8%) to 68.1% (95% CI: 59.7-75.7%).

This study is a small study (n=160) with no direct control or comparison group. Its generalizability is limited by excluding patients not in sinus rhythm and with chronic kidney disease, which may confound the hsTrop level determinations, even if it is sensible that physicians are not likely obtaining coronary CTAs in patients with CKD.

The use of sequential high sensitivity troponin and coronary CTA with assessment of advanced plaque features has potential to be an improved objective tool for stratifying ACS risk, potentially allowing discharge of patients who would otherwise fall into the intermediate risk category. Evaluation of high-risk plaque features on coronary CTA has the potential to change our approach to ischemia evaluation via stress testing and potentially even invasive angiography. Additional studies are required, however, to validate this proposal, and physicians will need to keep in mind the cohort of patients excluded due to limitations in the use of coronary CTA.

Shah ASV, Anand A, Strachan FE, et al. High-sensitivity troponin in the evaluation of patients with suspected acute coronary syndrome: a stepped-wedge, cluster-randomised controlled trial. *Lancet*. 2018; 392(10151):918-28.

The High-STEACS investigators sought to determine whether utilization of a hsTrop assay with a sex-specific threshold above the 99th percentile would decrease the rate of subsequent MI or cardiac death in patients with suspected ACS. A cluster-randomized, stepped-wedge trial across ten hospitals in Scotland over three years, the study included patients presenting to the ED with suspected ACS, collecting both a standard and high-sensitivity troponin at initial presentation and again at six or 12 hours after the onset of symptoms, at the attending physician's discretion. The study was broken up into a six-month validation phase during which treating physicians were blinded to the hsTrop level, and an



implementation phase during which the hsTrop level was known but the standard troponin level was masked to

treating physicians.

The primary outcome was subsequent MI (type 1 or 4b) or cardiovascular death within a year of initial presentation to the hospital. Secondary outcomes were duration of hospital stay, type 1 or 4b MI, unplanned coronary revascularization, hospital admission for heart failure, ischemic stroke, major hemorrhage, unplanned hospital admission, and all-cause death. Diagnosis of MI was made by two physicians blinded to the study phase who determined that there was myocardial injury (hsTrop level above the 99th percentile) in the context of suspected ACS with consistent symptoms or signs on ECG or stent thrombosis at angiography.

A total of 48,282 patients were enrolled, with 10,360 (21%) having hsTrop concentrations above the 99th percentile and meeting criteria for myocardial injury at presentation. 1,771 (17%) patients had not been initially identified by the standard troponin assay and were reclassified based on the hsTrop. At one year, 2,586 (5%) patients overall had MI or cardiovascular death. Patients who demonstrated myocardial injury by troponin level were more likely to meet the primary outcome, although there was no difference in rate of primary outcome between implementation or validation phase. Of the 1,771 patients reclassified with myocardial injury by hsTrop, only a third were diagnosed with subsequent myocardial infarction, but these patients were more likely to undergo coronary angiography (11 vs 4%) without increase in percutaneous coronary intervention, be prescribed additional anti-platelet therapy, ace inhibitors, statins, and/or beta-blockers, and had a longer hospital stay. In patients without evidence of myocardial injury, the duration of hospital stay was decreased from a median of seven to four hours.

Some caveats to the study findings include its before-and-after study design, which may include inherent confounding from changes in practice or treating physicians at the various locations over time. Also, some argue that the benefits of additional medical therapy may not be seen within a year's follow-up, leading to premature acceptance that there was no decrease in primary outcome. The authors also comment that they did not make adjustments to the threshold for renal dysfunction. Identification of higher risk patients with positive hsTrops did not translate to improved outcomes in this study, but the data leaves room to speculate on improved ability to discharge from the ED.

Conclusion:

The use of high sensitivity troponin pathways or protocols appear to circumvent some of the pitfalls of isolated hsTrop testing. The current data suggests a higher number of patients may be able to be discharged safely from the emergency department which may be able to lower health care costs, but the high sensitivity of the test puts physicians and patients at risk of increased testing, medication, and cost without apparent benefit. Research suggests that a result below the level of detection can effectively rule out ACS in emergency department visits regardless of underlying historical risk factors, however the small percentage of patients in which these levels occur limit the test's utility in busy EDs, where confounding factors such as the presence of chronic kidney disease

lead to an elevated level of high sensitivity troponin regardless of the patient's underlying cardiac pathology. A variety of testing algorithms appear to suggest that serial testing in the emergency department with a high sensitivity troponin or use in conjunction with other cardiac testing such as advanced coronary CTA can lead to even better specificity than traditional methods while maintaining tremendous sensitivity for acute coronary syndrome. Serial testing algorithms may allow EM physicians to eliminate the subjectivity of currently accepted clinical risk stratification scores, such as the HEART score while combined use with coronary CTA may be able to recategorize intermediate risk patients to allow for discharge from the emergency department rather than admission. For the moment, however, the lack of an established laboratory standard, limited prospective data, and current ease of use and widespread acceptance of the HEART score limit the current implementation of the high sensitivity troponin.

Answer:

Current data on high sensitivity troponin pathways suggest they may be able to offer a more simplified and objective approach to ACS evaluation. However, due to the confounding factors of hsTrop, these pathways are not ready for general use and much more data is needed before widespread adoption can be considered. ●

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An Interview with the Creators of Medicus Podcast

Shea Boles



As members of AAEM/RSA already know, podcasts are a great way to keep up with interesting topics in EM and are proven to be popular resources for medical students, residents, and physicians. Earlier this year, I had the opportunity to participate in an episode for Medicus, a newer medical podcast run

by students at Loyola University. The topic was an MS4's perspective of emergency medicine. After a pre-med student who listened to the podcast reached out to me with some questions I realized the vast reach that podcasts can have. I decided to interview the Medicus team- Alek, Neal, Nate, Josh, and Mara, all MS2's at Loyola. Here is the interview below.

Me: What kind of topics are covered, and how do you come up with new topics?

Medicus team: Our goal is to cover a wide variety of topics. The only criterion is that it be applicable to the medical field and interesting for medical professionals and students. The ideas seem to create themselves from people and topics that we come across! So far we've covered topics ranging from the theory behind medical admissions to the challenges of starting a family during medical school and residency. We have a huge list of topics that we are excited about for future episodes, such as understanding the gender wage gap for physicians or the role of alternative and complementary medicine. We're always looking for guests, suggestions, and episode ideas. We would love to hear from anyone at medicuspodcast@gmail.com.

Me: Is your audience mostly pre-med, medical students, or physicians?

Medicus team: We cover topics that anyone who is interested in medicine will enjoy, regardless of their training level. Since we are just starting out, our audience mostly consists of groups we have affiliations or experience with, so mainly pre-med students at various universities, and medical students and faculty in the Loyola community. However, we try and make it as accessible as possible to anyone who is interested and hope to grow our audience in numbers and diversity.

Me: What inspired you to create Medicus, and why podcasting vs other forms of information distribution?

Medicus team: This was really the brainchild of all of us. Independently, most of our group at one time or another had had the idea to do a podcast related to medicine. And I mean, why not? Medicine is such

an evolving and nuanced field, filled with complex problems and difficult discussions. Furthermore, many of the topics we want to explore are not formally taught in the standard medical school/residency curriculum — so we can use this podcast as an opportunity to fill gaps in our own knowledge and share with others.

With respect to using a “podcast”: We all love podcasts and think they are a great way to learn and add value to time spent in a car or while cooking, etc. Podcasting is definitely trending, so most people nowadays know

what a podcast is when you mention it to them. There are a lot of reasons that make it the perfect platform for us:

It is personalized: Listeners can access episodes on their own time, at their own pace. They can choose to listen to episodes seem interesting to them.

Accessibility: It's extremely accessible. Podcast apps are free and can be downloaded on one's smartphone and computer. People commuting

to or from work, running errands, etc. can pop a podcast on and make the time go by while learning something new.

Ease of production: Producing a podcast is fairly easy once you have the right equipment (and the right teammates!). We have found that having one to two hosts per episode is perfect, so we can split the episodes up between the five of us and we aren't all pressed to edit something every week. So far it has let us release episodes weekly while still being busy medical students.

Me: What sets Medicus apart from other medical podcasts?

Medicus team: There actually aren't very many podcasts made with a medical audience in mind. The few that exist typically will focus on a specific aspect of medicine, such as case reports or specialty choice for medical students, or they will try to appeal to a wider non-medical audience and talk about health topics in layman's terms. Our approach is to highlight a wide range of topics that would interest anyone in the medical field. So rather than focusing on one goal such as teaching people medical facts or telling pre-meds how to get accepted into medical school, we are bringing on a variety of guests to talk about their unique interests and discuss hot topics in the medical field.



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Me: What has been your favorite episode to create and why?

Medicus team: All episodes are fun for different reasons! It can be great to sit down and talk with peers or mentors that we already know, but also exciting when we have the chance to get to know new guests. Everyone we invite on the podcast is there to talk about something they are passionate about, so overall it is just awesome to have them share their knowledge and interests with us. We love the episodes that are on topics we don't really know a whole lot about, because it challenges us to consider things we hadn't thought of before and we are happy to share that with our audience too.

Me: Is this a project you see continuing beyond medical school?

Medicus team: We want to make sure that Medicus can continue as long as there are more topics to explore and people to listen- so we anticipate that being for a long time! We know it is unrealistic that the five of us can continue being the only creators indefinitely, so we have talked about ways to bring new people on board. We have some novel ideas for expansion too, but it is a work in progress. In the end, we will all be able to contribute to Medicus in both the near and distant future.

How to listen: Apple Podcasts, Spotify, Google Podcasts, Anchor, Stitcher, Pocket Casts, RadioPublic, PodBean, Breaker

How to donate (any little bit helps!): <https://medicuspodcast.com/support-us/>

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Episode Highlight — Myths, Bias, and Lies My Medical School Taught Me

In this episode, Kenneth Chang and Richard Byrne, MD FAAEM, discuss Dr. Byrne's AAEM18 talk, Myths, Bias, and Lies My Medical School Taught Me. Mr. Chang is a medical student at Western University of Health Sciences and AAEM/RSA Education Committee Member. Dr. Byrne is an Assistant Professor of Emergency Medicine at Cooper University Hospital.

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