



President's Message

Tenet Health Update & Opportunities with AAEM

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Tenet Health Update

I recently participated in several media interviews in which I raised AAEM's concerns regarding Tenet Health's plan to replace its independent emergency medicine, hospitalist, and anesthesiology groups in California with a national physician staffing company. AAEM feels this would be highly disruptive to those hospitals and could compromise quality of care. These media interviews had much exposure in the local press and helped Tenet and the community better understand our concerns. On September 5th, I participated in a conference call with Tenet Health leadership, an attorney for the Coalition for Quality Hospital Care, and California ACEP President Dr. Osmundson. During the call, Tenet's leadership informed us they were no longer considering using one national physician staffing company for all of the involved California practices. In addition, Tenet committed to begin contract renewal negotiations with the independent emergency medicine groups staffing its California hospitals and to partner with them to achieve its goal of better coordinated care across services. We are encouraged by these positive developments. We will continue to work closely with the involved independent emergency medicine groups and monitor this evolving process.

During the call, a position supported by California ACEP — that it does not favor any physician group practice model over others — was erroneously attributed to AAEM as well in a follow-up letter from Tenet. AAEM has always endorsed practice models based on fairness, transparency,

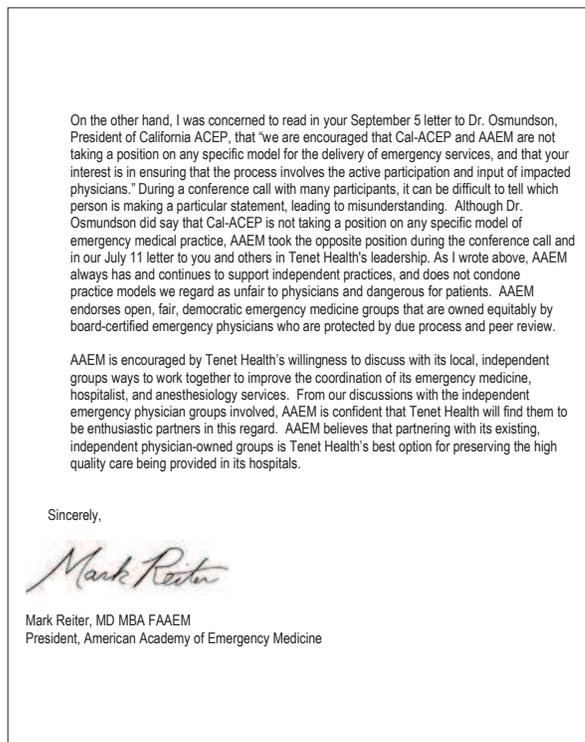
financial equity, physician autonomy, and the best possible care of patients — qualities that we believe are exemplified by independent, local, democratic, physician-owned medical groups. AAEM responded with a follow-up letter to Tenet Health's Western Region CEO, in order to clear up this misunderstanding (see below).

Opportunities with AAEM

We're fast approaching time for AAEM elections. Nominations for elections and awards close December 1st. AAEM is committed to a democratic, transparent election process — any AAEM member can run for the board of directors, and board members are elected directly by our full voting members. My time on the AAEM board has been incredibly gratifying, and I highly encourage interested leaders to consider running for the board. In particular, I feel our board would be stronger if we had more representation from our female physicians and underrepresented minorities. We have many very effective female and minority physicians active within the Academy, but none ran for election last year. If you are interested in learning more about running for the board, feel free to contact me or any other board member.

We are also in the process of updating AAEM committees. We are looking for new blood — new committee members and new committee chairs. We recently put committee information on our website at: www.aaem.org/

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[about-aaem/leadership/committees](#). Join a committee — it is a great way to play a larger role in our organization and interact with many of the top leaders in our field. New committees include the Women in Emergency Medicine Interest Group, the Minority Affairs Interest Group, and the AAEM Physician Group Task Force.

There are lots of other opportunities. AAEM members interested in publishing can contribute to our newsletter *Common Sense*, the *Journal of Emergency Medicine*, as well as AAEM collaborations with PEPID and Medscape. There are speaking opportunities at the AAEM Scientific Assembly and other AAEM-sponsored conferences. Several of our AAEM committees are releasing regular podcasts and are looking for

contributors. And, we are always looking for volunteers for our popular AAEM Oral Board courses, which take place twice a year in Chicago, Dallas, Las Vegas, Los Angeles, Orlando, and Philadelphia.

As a member-driven organization, the Academy is always looking for more ways to serve its membership. If you have an idea for a new initiative, let us know. ■



Mark Reiter, MD MBA FAAEM
President, American Academy of Emergency Medicine

AAEM Submits Written Testimony on Ebola Outbreak to House Subcommittee

Written Testimony of Mark Reiter, MD MBA FAAEM, president, American Academy of Emergency Medicine submitted for the record to U.S. House Energy and Commerce Subcommittee on Oversight and Investigations, October 16, 2014.

Chairman Murphy, Ranking Member DeGette and members of the Committee, thank you for the opportunity to provide comments on your hearing focusing on the Ebola outbreak and efforts by the U.S. Government and our healthcare system to identify, treat, and protect the public health from this infectious disease.

The American Academy of Emergency Medicine (AAEM) is the specialty society of board certified emergency physicians, representing 8,000 members across the country. Whether it is an athlete suffering from a broken bone, an infant struggling to breathe, a victim struggling to survive a gunshot wound, or a patient dealing with debilitating symptoms from an infectious disease, our emergency physicians serve on the front lines everyday combating life threatening conditions. Our emergency physicians, nurses, and medical support teams provide this type of care in often overcrowded, underfunded, and overburdened systems. A typical emergency department (ED) could see 100 patients a day while a more populated one could see 300. According to the CDC, in 2010 the number of visits to an ED was 129.8 million. This number continues to increase. Despite the well-intended efforts of the Affordable Care Act to direct non-critical and non-emergency patients to primary care providers, Americans frequently still choose EDs as their first option for care. EDs are, in particular, a first point of care for many immigrants and travelers who seek treatment in the United States.

Like many Americans, we are saddened by the toll Ebola has taken on the lives of many in West Africa and other countries and now the United States. We share in the concern for our fellow caregivers who appear to have contracted the disease from their efforts to save a now deceased patient. We are proud of our physician colleagues who are battling against Ebola in West Africa under challenging conditions in an effort to save lives and prevent further infections. Unfortunately, this disease poses significant challenges not only to the global health system but to our health system as evidenced recently in Texas, Georgia, and Nebraska.

In the case of Ebola or any other infectious disease like EVD-68, it is critically important that our health system provide emergency physicians and the critical care community with the resources, protocols, best evidenced-based practices, and expert personnel needed to diagnosis, treat the sick and protect our care-givers and the public from further harm. First, given its recent introduction to the United States, new protocols and best practices to identify and treat Ebola are still being learned “on the job” and will need further education and clarification. Secondly, some EDs do not have sufficient isolation rooms to deal with infectious disease patients given the limited space they already have to treat more common emergency cases. Thirdly, policy makers must understand EDs are often understaffed and overwhelmed, so staff must continue to treat the life threatening conditions facing other ED patients while treating an Ebola patient. If an ED had to partially or temporarily shut down due to limitations in staffing capacity to treat an Ebola patient, there could be serious health consequences for other emergency patients in the community.

Congress working with HHS, CDC, NIH, the FDA, and other public health agencies could play a critical role in helping to combat the further spread of Ebola. We understand that Congress may for example consider increased funding to help the U.S. health system better prepare and prevent the spread of Ebola. If so, we would encourage policy makers to ensure resources are prioritized to EDs and critical care facilities who are in need of training, protective gear and most importantly, additional expert medical personnel in the event of an Ebola diagnosis. Furthermore, while some hospitals may be better prepared to treat Ebola patients, others may simply lack the personnel and resources and need additional support to transition care to a more appropriate treatment facility or “dedicated hospital.”

AAEM stands ready to work with Congress and public health departments to ensure our health system is prepared to meet the challenges and risks posed by Ebola and other infectious diseases. We look forward to serving as a resource to your Committee as you seek ways to better protect the public from Ebola and ultimately, eradicate this deadly disease. ■

