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# COMMON SENSE

VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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## Musings of a Master: How I Came to Embrace AAEM

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David Lawhorn, MD MAAEM FAAEM

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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)

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## President's Message

# What Ever Happened to “How May I Help You”?

David A. Farcy, MD FCCM FAAEM  
AAEM President-Elect



“We need your brain power, your expertise, your service, your involvement, and your infectious energy. Two heads are better than one, and three better than two. This is your opportunity to ‘pay it forward’ and improve the services AAEM members enjoy!”

— Kevin Rodgers, MD FAAEM

We are living in strange times. The medical field is being challenged on all sides. I am about to show my age with an analogy comparing the Millennial generation with our beloved specialty of emergency medicine. Let me preface this by saying I am in no way attacking Millennials, but merely illustrating a problem affecting our specialty. Millennials are often described as lazy, entitled, selfish, and shallow — the “what about ME, ME, and ME” mentality. It would be unfair to say that the Millennials are the only ones who think like this, as the philosophy of “what can you do for me” carries through Generation X, Y and yes even Baby Boomers as well.

We can see this inward-focused attitude increasing in recent years. According to the National Institutes of Health, 58% more college students scored higher on a narcissism scale in 2009 than in 1982.<sup>1</sup> *TIME Magazine* in 2013 noted that Millennials “believe in being recognized with award or trophy and study showed that 40% believe they should be promoted every two years, regardless of performance.”<sup>2</sup>

*Managing the New Workforce: International Perspectives on the Millennial Generation* co-author Mr. Lyons writes that “this generation has the highest likelihood of having unmet expectations with respect to their careers and the lowest level of satisfaction with their careers at the stage they’re at.”<sup>3</sup>

Does this sound familiar to you?

When I think of emergency physicians, there are several personality traits that come to mind — positive traits that describe the vast majority of us: energetic, resourceful, efficient, creative, and caring. On the other end of the spectrum the negative traits commonly seen are: fear, greed, anxiety, and submission. All these negative flaws contribute to our increasing rate of burn out. By identifying problems in our profession and making changes, we can improve both patient care and our practice environment.

**1. Fear:** We live in a litigious society. Ask any emergency physician his or her primary concern — it is usually a lawsuit. I’m currently reviewing the corroborating affidavit served in a malpractice claim against me. The opposing expert has been practicing for 20 years and only practices cruise ship medicine, but listed 19 points alleging that I deviated from the standard of care. What if doctors, as a profession, only did the right thing and only agreed to review and provide expert testimony based on the merits of the case rather than simply rubber stamping an attorney’s affidavit for a large sum of money? A trial lawyer once told me, “It is an easy \$5,000,

just read the affidavit and sign it.” I told him that this issue could affect someone’s life and had the potential to destroy a doctor — both professionally and personally. He quickly replied, “Don’t worry about this, they will settle, again a quick \$5,000.” I replied that the settlement would be on his record for five years. The point is “money” seems to be the common denominator for many of our problems and negative traits — make a quick buck at any cost, even if it is unethical and uncaring.



“By identifying problems in our profession and making changes, we can improve both patient care and our practice environment.”

**2. Greed:** We all need to work together to support the profession. One major problem facing our specialty is CMGs (Contract Management Groups). Some people will do whatever they can for more money, without thinking of the repercussions or effects on their peers. Recently while traveling, I ran into one of my former residents. During our talk, when I asked him how his wife and kids were doing, and he responded, “Fantastic, I just bought a Ferrari.” I was dumbfounded; I asked, “Did you win the lottery?” He said no, he had a great new gig. I asked him to explain. He said, “I have a new position with my contract management group. I cover shifts that are not filled on that day and I get \$500-\$800 and sometime more. I am credentialed with several of their hospitals.” As some of you may suspect, he got an earful from me. When I asked him, “Have you ever wondered who and why you were covering?” The answer was “no.”

Continued on next page

Imagine if everyone in our specialty had a commitment to advocate for basic practice rights instead of selling our services to unethical corporate contract holders. If we as physicians stand together and protect each other, we can improve our profession. The CMGs are not evil, but they are for-profit companies that have a duty to maximize profits for their shareholders. Contract management groups and internal locums give CMGs the ability to terminate emergency physicians on the spot without a fair hearing or due process. But, if their supply of physicians was more limited, they would need to adjust their business model and provide a fair hearing and due process for their physicians. We work in a difficult industry amid massive change. We, as physicians, need to steer the changing system to make it work for us.

One recent example that has received lots of media attention was the Summa Health events in early 2017. The entire group at Summa Health stood together and made personal sacrifices to counter US Acute Care Solutions takeover of their contract. USACS had to offer exuberant rates —near \$800 per hour to fill their shifts. The former staff members lost their jobs and USACS could not meet the ACGME requirements for faculty. Sadly, Summa lost its residency program and all of their residents had to scramble and find another residency. It is time for us to all work together toward a common goal. Do not let personal greed be your driving force — work to provide protections to all doctors practicing at a hospital.

**3. Anxiety:** I am anxious even while writing this column — my deadline, this lawsuit, and about the potential negative outcomes. As a result of our own actions, we create our own anxiety. Many emergency physicians work at a hospital, but simply show up, work the shift, and go home, and the cycle continues. You may have worked in your hospital for five years, but have never met the CEO, CFO, CMO, or CNO. Most do not sit on any hospital committees and are not involved in the hospital or community. In response, I hear, “You need to pay me.” Pay you for what? Your own job protection? Why do you think CMGs don't allow you to talk to your C-suite: indifference or are they concerned you might take over their contract? I would encourage you to get involved in your hospital, meet your entire C-suite, join a few committees, go to the medical staff meetings and participate. Sure, you're not getting paid, but the return on your time investment is exponential. The next time the CEO gets a letter of complaint about an ER doctor, instead of calling HR and asking, “Who is this doctor?,” he or she may think, “Oh, that is the emergency doctor I know, a standup individual who is involved in our hospital,” rather than simply asking the regional director of the CMG to remove this individual.

**4. Submission:** Well after reading this, many of you will shake your head and say, “What do you expect us to do, nothing will change; I work too much; I have no time” ... and there you have it. The circle completes, we lose all of our voices, and we go home and complain and complain but do nothing to change the situation.

So you might ask yourself, “How does this compare with the Millennial? This is about me making more money, me being freer, me being able to afford more ... me, me, me.”

We know the science. We are on the front lines providing medical care to the critically ill. Every day we deal with the unexpected. We are America's safety net, but we do not take the time to invest in our profession. I always hear, “Why should I do this, nothing will change.” Change starts with us, one person at a time.

The Academy's mission is to support fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care including provisions for due process and the absence of restrictive covenants. By upholding the AAEM mission statement, many of our members working in democratic groups have successfully overcome these traits by making personal sacrifices for the greater good of the group — leading to better career satisfaction, longevity, happiness, and less burnout.

I encourage you **to stop asking what we the Academy can do for you, but instead say, “What can I do for the Academy?”** We are YOUR voice, the voice for each of you that does not speak. We are your voice in D.C., we are your voice with regulatory bodies like CMS, TJC, etc. We are your voice working with ABEM on board certification issues. We are your advocate.

Get involved! I urge you to join a committee and join our Advocacy Day, our Scientific Assembly; and if you are too busy, then just keep your membership active, renew it yearly, and donate money. Donate the proceeds of one shift a year — you don't really have any excuses not to, especially if you have been out of residency for more than two years. Why? Because AAEM is the ONLY VOICE you have for fighting for you: your due process, your board certification, your wellness, and that's just the beginning.

In the past few weeks, I have received several calls from members asking for help from the Academy regarding threats to their practices. Unfortunately, by the time AAEM is contacted, it is often too late. So I hope it is clear by now, that it is never too early to get involved. I challenge you to make a personal pledge that now is the time to invest in your future and career.

Alone we are a single voice, together we are stronger ... here's to a brighter tomorrow.

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3. Ng E, Lyons S, Schweitzer L. *Managing a New Workforce: International Perspectives on the Millennial Generation*. Northampton, MA: Edward Elgar Publishing, Inc; 2012. ●

#### AAEM Antitrust Compliance Plan:

As part of AAEM's antitrust compliance plan, we invite all readers of *Common Sense* to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at [info@aaem.org](mailto:info@aaem.org) or by calling 800-884-AAEM.

From the Editor's Desk

# What is ACEP Thinking?

Andy Mayer, MD FAAEM  
Editor, *Common Sense*



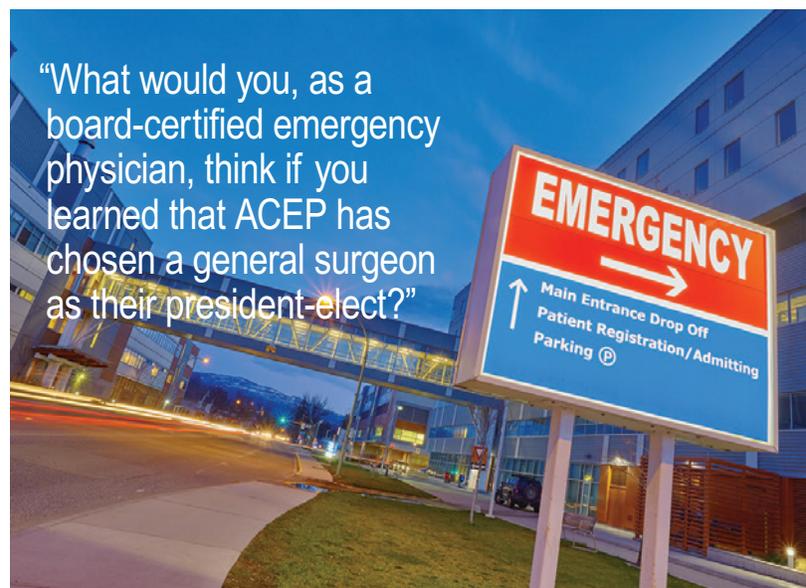
An emergency physician who grew up in the 21<sup>st</sup> century may not know or appreciate the complex history of emergency medicine. Emergency medicine is still much younger than internal medicine, surgery, or pediatrics — but it is no longer an infant either. The days of the “ER” as a place for older or lost physicians who can't work anywhere else are gone. Emergency medicine is now a respected and competitive specialty. The early founders and supporters of our specialty were not residency trained in emergency medicine, of course, and did not have the mentors and role models available to budding emergency physicians now. Those pioneering physicians blazed a path which has blossomed into the specialty of emergency medicine. All of us owe a debt of gratitude for their service and dedication to our specialty. It is now accepted that emergency medicine involves a unique and specific set of knowledge and skills, which are embodied by being certified by ABEM or AOBEM as a specialist in emergency medicine.

A knowledge of our history is required to understand where we came from and where we are headed. The American College of Emergency Physicians was formed in 1968. The first resident in emergency medicine was Bruce Janiak, who entered residency in 1970 at the University of Cincinnati. Other residents and residencies soon developed, but the American Board of Emergency Medicine (ABEM) did not administer its first board examination until 1980. ABEM recognized that there were physicians who had been working in emergency rooms (this is long before they were departments) who did not have the opportunity to complete an emergency medicine residency, and were often the faculty of the original emergency medicine residencies. A “practice track” with a ten-year grace period was established, to allow these pioneers of our specialty the opportunity to become board certified by ABEM/AOBEM. This practice track to board certification closed — with ample, ten-year, advance notice — in 1988. Thereafter, any physician who desired to sit for the ABEM or AOBEM board exams would be required to complete an approved emergency medicine residency. In recognition of our development as a specialty, the American Board of Medical Specialists (ABMS) in 1989 designated emergency medicine as a primary board. I was a third year resident at the time, and remember proudly when my chosen specialty finally made it.

Assaults on the value of residency training and board certification soon started. The Board of Certification in Emergency Medicine (BCEM) (which is now recognized by the American Board of Physician Specialties) initially allowed physicians who had never completed **any** residency to become “board certified” in emergency medicine, and even now will certify physicians who have never completed a residency in emergency medicine. The Daniels lawsuit began when a general surgeon who practiced emergency medicine (along with many others) sued ABEM (and others), claiming that ABEM's closure of the practice track was an illegal conspiracy to enhance the economic status of ABEM-certified

emergency physicians. Dr. Daniels and some of his co-plaintiffs formed the Association of Emergency Physicians. I had just graduated from a four-year emergency medicine residency, and was shocked and dismayed to read about this attempt to trivialize the sacrifices my family and I made to complete a residency and become board certified.

I still remember the day in 1992 when a colleague at an EmCare ED, where I was working part-time, handed me a copy of Jim Keaney's *The Rape of Emergency Medicine*. I went home and read it cover to cover, and had a eureka moment. Suddenly, I realized there were doctors and corporations who had decided to profit off of my labor. I felt belittled and exploited. The idea that I was being used and abused was a shock. Dropping what I once thought of as my hard-earned and impeccable FACEP designation clearly seemed to be the right thing to do, and I joined AAEM and have been a proud member since its early days.



Fast forward to 2017: we are now a mature specialty, graduating thousands of expertly trained residents chosen from the top of their medical school classes. Our specialty is a highly sought-after Match spot for graduating medical students. You may not think so, but it really is a sign of respect for our specialty that patients are sent to virtually every emergency department in our nation by their physicians, so we can figure out what is wrong and decide on a course of treatment.

If you are under 40, you may be rolling your eyes as the old guy bemoans the bad old days of our specialty, and think we are past the infighting and divisive discourse between AAEM and ACEP. The issues dividing our two professional organizations are in the past, right? The thought that one of our specialty's professional societies could be led by an individual who is not a board-certified emergency physician is unthinkable, isn't it?

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What would you, as a board-certified emergency physician, think if you learned that ACEP has chosen a general surgeon as their president-elect? You might think that must be some sort of mistake or tasteless joke. What message does this send to tens of thousands of board-certified emergency physicians? I guess this resurrects the question of just who is an emergency physician. Does any physician who works in an emergency department automatically become one? I know what I think about that, but decided to see what ACEP thinks. Their website provides the answer:

**“Definition of an Emergency Physician  
Reaffirmed April 2017  
Originally approved June 2011**

An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.”<sup>1</sup>

Please read that definition carefully, with emphasis on the end of the sentence. A quick reading sounds good and makes you think, “Well, okay.” However, it is the “...or who is eligible for active membership in the American College of Emergency Physicians” that is the important part to me. Again looking at ACEP’s website, the criteria for membership include “...or eligible for active or international membership in the College at any time prior to the close of business December 31, 1999.” Why was this last phrase added and who wrote it? I am not sure, but the candidate material Dr. John Rogers submitted for the recent election might shed some light. In his list of accomplishments, number six is:

*“Helped to write ACEP’s current definition of an emergency physician.”<sup>2</sup>*

Discovering that a physician who is not and never has been eligible for the ABEM or AOBEM exams helped ACEP define *emergency physician* gives me pause. I do not discount the years of service which Dr. John Rogers provided to ACEP. He may even be the finest clinician in the world, but does that matter? The president-elect of ACEP, who is listed as a fellow (FACEP) and who will be to many the face of emergency medicine in 2019, is not a board-certified specialist in emergency medicine. In my opinion, he is not an emergency physician. He is a surgeon who has worked in emergency departments for a long time. I do not think a doctor who does something for a long time transforms into something he is not. However, according to the ACEP definition of what an emergency physician is, Dr. John Rogers, FACEP is one. What do you think?

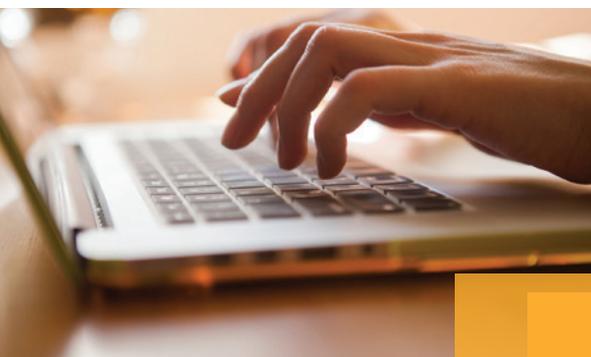
Does emergency medicine want to tell the house of medicine it is not a real specialty? Can just any surgeon or internist safely step into your shoes? The message ACEP sends to the emergency medicine community and medicine in general with this election is something I hope each and every one of you will carefully consider. The value of becoming a fellow of the College loses value when board certification is not required. This is not 1980. ACEP has many fine physicians who took the painful and arduous task of completing an emergency medicine residency and then passing the ABEM or AOBEM board exams. Why did ACEP decide to elect someone who did not? Did the fact that ACEP’s elections are not directly democratic come into play? Would this have happened with a direct, “one member-one vote” election like AAEM’s? Did the councilors know that Dr. Rogers was not board-certified, and simply decide he had earned the presidency as a reward for long years of service?

In closing, I ask each of you to reflect on this issue. I had hoped, and still do, that AAEM and ACEP could grow closer and work together on common goals and interests. This act makes that idea less appealing. I am an emergency physician — a board-certified specialist in emergency medicine — and I want to be led by those with the same training, knowledge base, and values.

#### References

1. <https://www.acep.org/Clinical---Practice-Management/Definition-of-an-Emergency-Physician/#sm.0008xf81z1b56cu1q4x2ri7paz95n>

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## Response to an Article? Write to Us!

We encourage all readers of *Common Sense* to respond to articles you find interesting, entertaining, educational, or provocative. Help us stimulate a conversation among AAEM members.

[www.aaem.org/publications/common-sense](http://www.aaem.org/publications/common-sense)

**Editor's Note**

This is a response which I received from Dr. Paul Kivela, the ACEP president, related to my article "What is ACEP Thinking?" The two of us had a lengthy conversation about the issue of ACEP electing a non-boarded physician and the importance of this decision. We certainly disagree as to the importance of this issue but do agree that AAEM and ACEP should try and work together whenever possible on issues on which we do agree.

— The Editor

**Response from Dr. Paul Kivela**

Dear Dr. Mayer

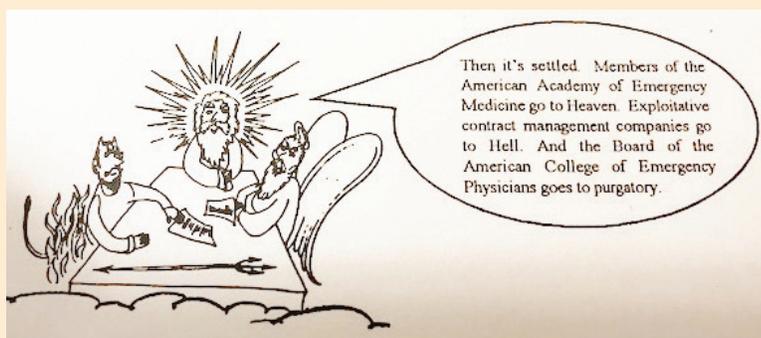
Thank you for reaching out to me. I understand your concerns that the current ACEP president-elect is not boarded in emergency medicine. There are several issues you raise which I think should be addressed. First of all, there is more that unites emergency physicians than divides us and I hope that ACEP and AAEM members and both organizations will stay united on the issues upon which all emergency physicians can agree. I doubt any emergency physician nor any patient will benefit from fighting each other. We need to work together where we can and concentrate on common goals and interests. Secondly, I have spent the past six years on the board with Dr.

Rogers and I know him to be an honest, knowledgeable and thoughtful emergency physician and I believe he will be an excellent spokesperson for our specialty. Third, I cannot speak for Dr. Rogers and I encouraged you to reach out and speak to him directly. What I can say is that in the time I have known him, he has always been committed to ABEM/AOBEM as the gold standard in emergency medicine. It is my understanding that Dr. Rogers narrowly missed the ABEM window and serves in an area of the country where there are still very few emergency medicine residency trained individuals. Most importantly, Dr. Rogers has a long history of successfully advocating for emergency physicians and continues to fight for the best interests of emergency medicine and the patients we serve.

We may not agree on this issue. I hope that we can put this issue behind us and unite and work together on the important issues that face our specialty where we do agree including upholding the prudent layperson standard, ensuring fair payment for our services, defining scope of practice, reinforcing the importance of emergency physician led teams, resolving the opiate crisis, improving psychiatric care, decreasing boarding, and combating burnout by improving the emergency physician work environment. Let's not get distracted and lose sight of what improves the lives of our patients and emergency physicians.

Paul Kivela, MD MBA FAAEM FACEP  
President, ACEP ●

## Call for Cartoon Submissions



**"Humor is just another defense against the universe." — Mel Brooks**

Here's a comic from the premiere issue of *Common Sense* in 1994. Emergency medicine is moving forward, but issues remain. Maybe some humor would help? Are there any aspiring artists out there who would like to submit cartoons for publication in *Common Sense*?

Send your submission to [lburns@aaem.org](mailto:lburns@aaem.org).

## Washington Watch

# Federal Health Policy: The Role of Congress, Agencies, and the Impact on Medicine

Williams and Jensen, PLLC

The purpose of this article is to give some context to how major health care policy decisions are made, and to explain the always evolving role of Congress and the Administration in these priorities.

The big questions lingering around federal health care policy in 2018 revolve around the reauthorization of the now-expired Children's Health Insurance Program (CHIP), and the potential for Republicans to make "one last attempt" at repealing or making significant changes to the Affordable Care Act (ACA). The chances of a bipartisan deal on the former are high, given what is at stake for children across the country. The prospects of an ACA fix are lower than in 2017, particularly given the

is taking a similar approach on the Deferred Action for Childhood Arrivals (DACA) program. This philosophy towards legislation has taken some by surprise, particularly given the widely perceived increased concentration of power within the executive branch over the past several decades.

However, key agencies are still expected to play a big role on a variety of issues that will have a large impact on the health care sector. For example, the replacement policy for the Medicare Sustainable Growth Rate (SGR) — which will determine quality measures, incentive payments, and a variety of other elements of physician payments under Medicare — will continue to be tweaked by HHS and CMS. The Administration continues to play a key role on insurance markets under the ACA, including cost sharing reduction (CSR) payments (or lack thereof) for low-income consumers.

But even for other bureaucratic rules proposed by federal agencies — such as updates to payment policies and rates under the Medicare Physician Fee Schedule, or changes to Medicare Conditions of Participation for hospitals — Congress can wield influence. As an example, a Medicare Rule proposed by the Centers for Medicare and Medicaid Services (CMS), could draw the attention of the House Ways & Means Committee, the House Energy & Commerce Committee, the Senate Finance Committee, and the Senate Health, Education, Labor and Pensions (HELP) Committee. These committees share jurisdiction over the Medicare program.

A further reason that these Committees and its Members are relevant to federal agencies is that their top leadership is subject to Senate confirmation. CMS Administrator Seema Verma's nomination was referred to the Senate Finance Committee, which held a hear-

now slimmer Republican Senate majority following the December special election in Alabama. Any changes to the ACA in 2018 are more likely to be made at the regulatory level — without the involvement of Congress — or bipartisan, and thus not likely to "unravel" the law. Of course, there are many other impactful health policy considerations in 2018, including the setting of a budget for the Department of Health and Human Services (HHS) and its subagencies.

In his first year in office, President Trump has heavily relied upon Republican Congressional leaders to develop solutions to major issues. In an unsuccessful 2017 attempt to repeal and replace the ACA, he suggested he would be willing to sign whatever Congress sent him. In the tax reform legislation signed into law at the end of the year, he again indicated that he was relying on Congress to come up with the details. In both cases, he took a much more hands off approach and instructed Congress to provide the details. At this juncture, it appears that the Administration

ing followed by a vote to report her nomination to the full Senate. She was then confirmed by the Senate prior to assuming her role.

The Senate is currently contemplating the nomination of Alex Azar to serve as the Secretary of HHS. If confirmed, he would succeed Tom Price, who served as President Trump's first HHS Secretary. Azar's path to confirmation includes votes in both the Senate HELP and Senate Finance Committees, followed by a vote of the full Senate. After confirmation, these officials travel frequently to the Hill to provide updates and testify on key issues.

Another very significant role by Congress is filled by the House and Senate Appropriations Committees. These Committees control the purse strings for these agencies, setting an overall topline number, as well as funding levels for salaries and expenses, and for subagencies. Congressional appropriators and agency leaders sometimes find

Continued on next page



themselves at odds over spending decisions, particularly when appropriators feel that agencies are ignoring their “report language” or instructions that accompany spending bills on how money should be spent.

With the new year, Congress will once again start the annual budget process. The process begins with the president submitting a budget proposal to Congress in February. The president’s budget proposal is often ignored by Congress, but can signal what the Administration’s spending priorities will be. A concurrent resolution on the budget is then passed by both chambers by April 15. These deadlines are statutory, but rarely met. Once the budget resolution is passed, the appropriations process begins. Over the summer, lots of work in both chambers is done in an attempt to pass twelve separate appropriations bills and then reconcile the differences. In recent years, this work is not concluded by September 30, which marks the end of the fiscal year. Failure to pass the appropriation measures by that date results in a government shutdown, or a continuing resolution (CR) that provides short-term funding to the government. Often the final appropriations are combined into a single large “omnibus” bill that contains funding for many different agencies. The CR and omnibus process represents a broken budget system which results in waste, continued funding of outdated priorities, and lack of investment in new programs. In particular, the military has suffered from the effects of short-term CRs on planning and readiness.

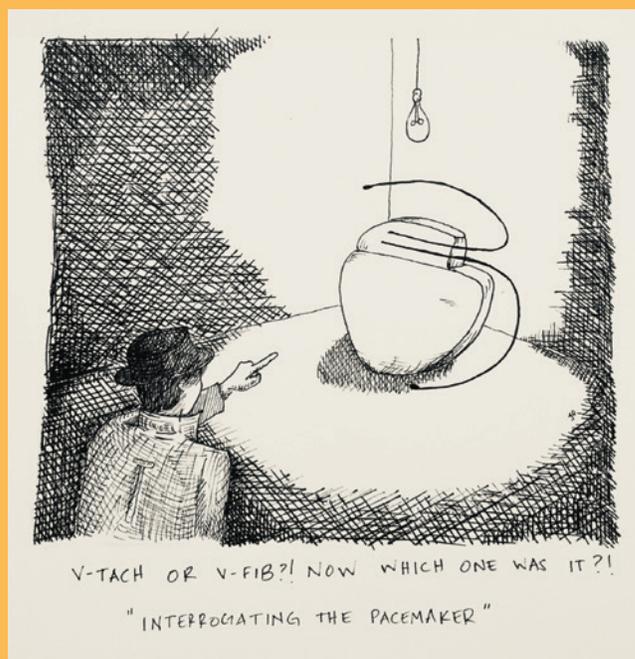
Congress’ failure thus far to enact legislation to reauthorize the expired CHIP program represents another challenge for Presidential and Congressional leadership. While Members of both parties stress the importance of the program, which helps insure over 9 million children, they have yet to devise a bipartisan funding solution that will allow the federal government to match state funds. While the issue is likely to be resolved as a result of continued political pressure, some states are beginning to face budgetary constraints as a result of Washington’s failure to act.

Federal policy making is a complicated process, with competing goals and visions of how to achieve those goals. This in part forms the very essence of politics. As James Madison wrote in the Federalist Papers, “Ambition must be made to counteract ambition.” In the coming year, it is possible that Congress and the Administration work in a bipartisan way to fix key issues facing our health care system. It is also possible that partisanship and election year politics roil the chances of CHIP reauthorization, and legislative and regulatory enhancements involving access to health care. One prediction we can confidently make for 2018 is that all three branches of government will continue to play an important role, but no single branch will control all the levers of power. And a system that has endured 250 years will endure past this election, and probably many more after that. ●

## “Conceived on a night shift.”

Jenna Otter, MD  
PGY3 Temple University Hospital

Interested in submitting your own? See page 7 for details.



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### Submit your story!

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## AAEM Conferences

### March 24-25, 2018

Spring Pearls of Wisdom Oral Board Review Course  
Philadelphia and Dallas  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### April 7-11, 2018

24th Annual AAEM Scientific Assembly – AAEM18  
San Diego Marriott Marquis & Marina  
[www.aaem.org/AAEM18](http://www.aaem.org/AAEM18)

### AAEM18 Pre-Conference Courses

#### April 7, 2018

Resuscitation for Emergency Physicians (Two Day Course)  
Ultrasound – Beginner  
Special DelivERies – Managing Births in the Emergency Setting  
(Jointly provided by *Special DelivERies*)  
Tactical Combat Casualty Care for the Civilian Emergency Physician (Jointly provided by *USAAEM*)  
Think You Can Interpret An EKG?

#### April 8, 2018

State of the Art Pain Management in Emergency Medicine  
Emergency Neurological Life Support (ENLS)  
(Jointly provided by the *Neurocritical Care Society*)  
Ultrasound – Advanced  
2017 LLSA Review Course  
2018 Medical Student Track  
[www.aaem.org/AAEM18](http://www.aaem.org/AAEM18)

#### April 21-22, 2018

Spring Pearls of Wisdom Oral Board Review Course  
Chicago and Orlando  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### April 25-26, 2018

Spring Pearls of Wisdom Oral Board Review Course  
Las Vegas  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### September 15-16, 2018

Fall Pearls of Wisdom Oral Board Review Course  
Philadelphia and Chicago  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### September 22-23, 2018

Fall Pearls of Wisdom Oral Board Review Course  
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### October 3-4, 2018

Fall Pearls of Wisdom Oral Board Review Course  
Las Vegas  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

## AAEM Jointly Provided Conferences

### February 10-11, 2018

7th Annual Florida Chapter Division Scientific Assembly – FLAAEM18  
Miami Beach, FL  
<http://www.flaaem.org/events/scientific-assembly>

### March 8, 2018

Delaware Valley Chapter Division Resident's Day & Meeting - DVAAEM18  
Philadelphia, PA  
[www.aaem.org/membership/chapter-divisions/dv-residents-day](http://www.aaem.org/membership/chapter-divisions/dv-residents-day)

## AAEM Recommended Conferences

### April 6-8, 2018

American College of Medical Toxicology 2018 Annual Meeting  
Washington, D.C.  
[http://www.acmt.net/2018\\_Annual\\_Scientific\\_Meeting.html](http://www.acmt.net/2018_Annual_Scientific_Meeting.html)

### April 20-22, 2018

The Difficult Airway Course: Emergency™  
Boston, MA  
[www.theairwaysite.com](http://www.theairwaysite.com)

### May 4-6, 2018

The Difficult Airway Course: Emergency™  
Denver, CO  
[www.theairwaysite.com](http://www.theairwaysite.com)

### May 15-18, 2018

SAEM18  
Indianapolis, IN  
[www.saem.org/annual-meeting](http://www.saem.org/annual-meeting)

### June 5-9, 2018

ICEM 2018 Conference  
Mexico City, Mexico  
[www.pr-medicaevents.com/congress/icem-2018/](http://www.pr-medicaevents.com/congress/icem-2018/)

### September 5-7, 2018

ACMT's Total Tox Course: Cutting-Edge Toxicology for Emergency Providers  
Chicago, IL  
[http://www.acmt.net/Total\\_Tox\\_Course.html](http://www.acmt.net/Total_Tox_Course.html)

### September 21-23, 2018

The Difficult Airway Course: Emergency™  
Baltimore, MD  
[www.theairwaysite.com](http://www.theairwaysite.com)

### October 26-28, 2018

The Difficult Airway Course: Emergency™  
New Orleans, LA  
[www.theairwaysite.com](http://www.theairwaysite.com)

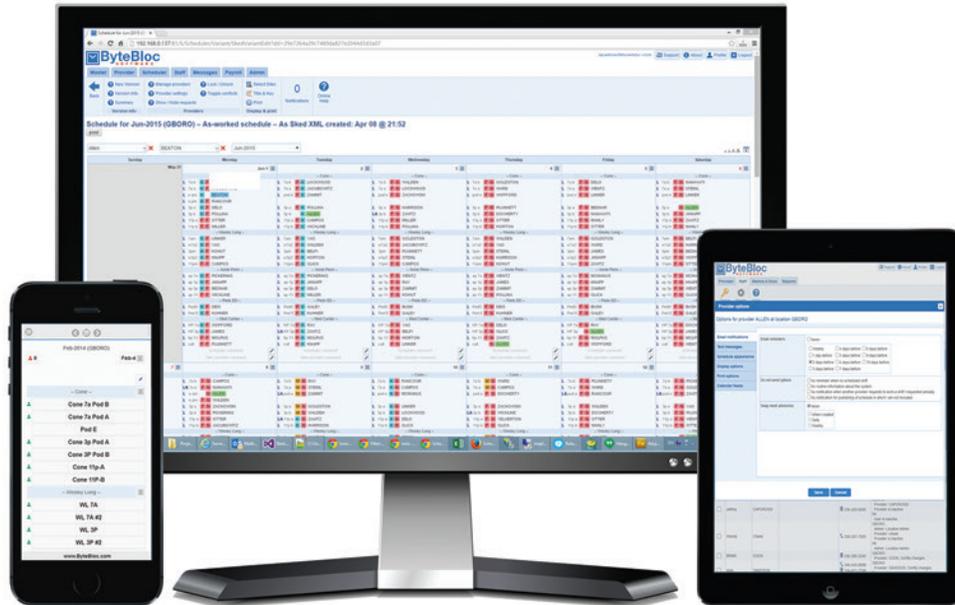
### November 9-11, 2018

The Difficult Airway Course: Emergency™  
San Francisco, CA  
[www.theairwaysite.com](http://www.theairwaysite.com) ●

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Rebecca Sommer to learn more about the AAEM approval process: [rsommer@aaem.org](mailto:rsommer@aaem.org). All jointly provided and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

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As AAEM enters its 25th anniversary year, enjoy this "Blast from the Past" issue of *Common Sense* from 1993.



*when minutes count*

The Voice of the Specialist in Emergency Medicine

Premiere Edition

# COMMON SENSE

## Why "Common Sense"?

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

When the then thirty-seven year old Thomas Paine arrived in America late in 1774, the newcomer from England saw with fresh eyes the promise of America. Within six months he began to argue that the issues for America were far more than simply the catalyst for anger i.e. taxation without representation.

He began to write from his perspective and insight about the larger issues which made true independence from England necessary for America to grow and prosper. The first pamphlet dealing wholly with this issue was published in January, 1776 (a little more than a year after he arrived in America).

The pamphlet "COMMON SENSE" was literally an overnight sensation and became the talk of the colonies, selling more than half a million copies within a few months. "COMMON SENSE" allowed the general public of the time to see and understand the broader issues and is widely believed to be the major writing to influence and pave the way for the Declaration of Independence which was signed six months later.

From the perspective of AAEM, our "COMMON SENSE" will bring to Emergency Physicians a broader understanding of the issues underlying the need for a new organization — a revolution in Emergency Medicine. It is not just the taxation without representation at ACEP. It is not just the exploitation of emergency physicians and Emergency Medicine sanctioned by the American College of Emergency Physicians. It is the broader failure of ACEP to address the concerns and desires of the majority of its membership and instead to embark upon a destructive short and long-term strategy. An organization no

longer responsive to its members becomes a tyrant to them.

"COMMON SENSE" is the newsletter voice of the AAEM, the organization of the specialist in Emergency Medicine. We have formed because ACEP has failed to guard the quality of Emergency

Medicine we offer to the public as well as to disregard the well-being and desires of its membership. "COMMON SENSE" will bring to Emergency Physicians the information and reasoning which can serve as the underpinning to the Declaration of Independence from ACEP (= tyranny).

**"There comes a time when silence is betrayal."**

*Dr. Martin Luther King, Jr.*

### This is Your Newsletter!

This is the premiere issue of Common Sense, the periodic official newsletter of the American Academy of Emergency Medicine (AAEM). Its purpose is to further the goals of the Academy — democracy, quality care at a reasonable cost, universal emergency medical care and equitable work arrangements — by communication amongst members through articles, letters, responsible criticisms and appropriate praises. Humor will also have its place! Contributions are encouraged, be they letters, articles, nominations for awards, or humor.

The Academy has high standards regarding ethics, fairness and honesty and it is expected that all contributions meet these standards. Although the editor will make every attempt to maintain these standards, it is understood that the views expressed are those of the authors and do not necessarily represent those of the academy.

Other considerations suggested by supporters are a matching system for physicians and hospitals desiring democratic groups, a legal column and a legal referral system for those members who have

exhausted all other measures to resolve their grievances. Other ideas you have would be gratefully considered.

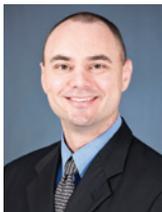
Please be aware that enormous thought and deliberation as well as some frank disagreement transpired amongst the governing members of the academy concerning the contents of this newsletter. The aforementioned journalistic standards being assumed, we realize we walk a fine line in exposing the outrageous state of affairs in Emergency Medicine while trying to maintain the confidence of the overwhelming majority of emergency physicians who are honest hard-working professionals. It is a difficult balance. Your comments would be appreciated!

Please send newsletter contributions and any comments to the address below. We will gladly print articles and withhold the submitter's name. However, for purposes of editing and responsible journalism, the editor must know the contributor's identity. Hope to hear from you soon!

**COMMON SENSE**  
Drew E. Fenton, M.D., Editor

# Dollars & Sense: Saving for College

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



Only a small percentage of students get enough financial aid to cover their tuition, housing, books, and fees. As a result, saving for college is a major financial goal for many people. Luckily, it is as easy as three numbers ... 5-2-9, as in using a 529 plan. 529 plans allow parents or grandparents to put money aside in a tax advantaged way that can later be used for college.

As of 2017, you can contribute as much as \$14,000/year to each child without incurring the federal gift tax. In addition, you can pre-fund up to five years of these contributions, or \$70,000 in one year. Couples can give \$140,000.

Sound too good to be true? Well, it is true, which is why 529 plans have come to dominate the college saving game.

## Downsides of a 529 Plan

If you don't use the proceeds of your 529 plan for educational expenses, your gains are subject to income tax and a 10% penalty. In addition, colleges will consider 529 assets when determining need-based financial aid. If you believe you'll be eligible for financial aid, you might be better off keeping the assets in your name or the names of the grandparents.

That said, the amount you've saved for college has much less of an impact on your financial aid than your overall income does. In other words, physicians with high incomes will be expected to pay for at least part of college regardless of whether they saved for college.

## As Usual, Taxes and Costs Matter

Not all 529 plans are perfect. Each state offers a plan, and you can use the plan from any state. You are not limited to the one you live in.

There may be some state tax benefits if you use your state's plan, but just like with all investments you have to see if those tax benefits outweigh the other features of the plan. Some states have high fees and expenses or have less than optimal investment options. Some states give you tax benefits no matter which states' plan you use.

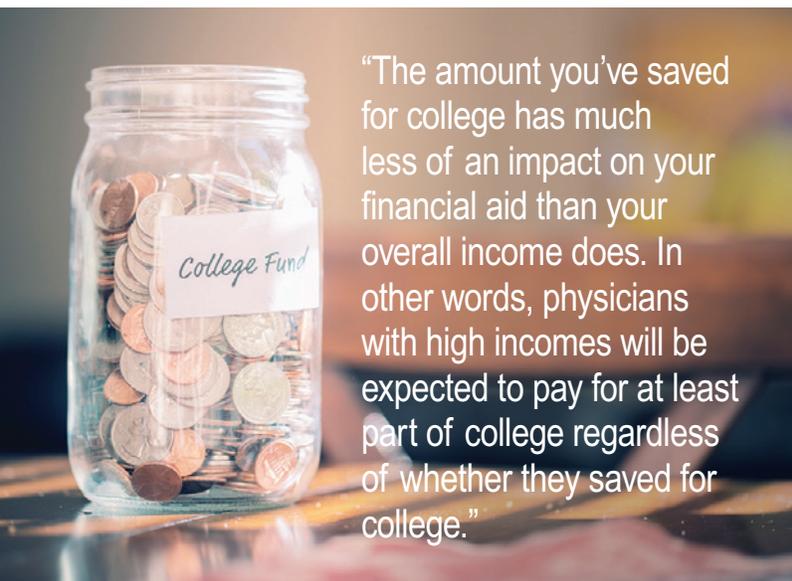
Which 529 plan do I use? Regular readers would guess that I use whichever state's plan is run by Vanguard, and they'd be correct! Vanguard administers the Nevada plan, which is what I use. They also provide management and services in the Colorado, Iowa, Missouri, and New York plans. Many states, though, offer Vanguard and other low cost investment options.

You find a lot of good information on 529 plans at: <http://www.saving-forcollege.com/>

## Other Types of Accounts

Table 1 is a great table from the Vanguard website that compares benefits offered by 529 plans against various other types of accounts people use to save for college (see next page).

As you can see, while there are other options, the 529 offers the most benefits. Some people advocate using Roth IRAs, whole life insurance, or ultra-conservative investments like certificates of deposit (CDs) or savings accounts, but this is generally a bad idea.



## How Expensive is College?

In 2014, the average family paid \$13,461 for college, which was only 64% of the total cost of tuition, room and board, and other expenses. For the 2014-15 school year, the average public college cost \$18,943 while a private institution cost \$42,419. If that wasn't enough, educational costs are increasing at a 6% rate annually.

## How Can You Limit Costs?

You can join the military and transfer your GI Bill benefits to your kids. That is my plan ... two kids ... two GI Bills ... done.

If you don't look that great in camouflage and don't want government funded vacations to warzones, one other consideration is to get your kids to go to a state school. You've gone to college and medical school. Do any of your patients or colleagues really care where you went? Mine don't. State schools are just fine.

## 529 Plans

The money in 529 plans can be invested in stock and bond funds. As long as the withdrawals are used for qualified higher educational expenses, the investment gains are free from federal taxation.

Continued on next page

Table 1

	529 Plan	Uniform Gifts/ Transfers to Minors Act (UGMA/UTMA)	General Investment Account	Education Savings Account (ESA)
State tax breaks	X			
Federal tax breaks	X			X
Low financial aid impact	X		X	X
High contribution limits	X	X	X	
Earning potential	X	X	X	X
Access to your money	X		X	X
Age-based options	X			
Total flexibility		X	X	
Account control	X		X	X

(Source: <https://investor.vanguard.com/college-savings-plans/which-account>)

You need your IRAs to save for retirement, not college. Saving for retirement is your top priority, even over funding the college education of your children. You can borrow money to pay for college, but you can't borrow money to retire.

Life insurance is expensive and generally offers very low investment returns. CDs and savings accounts aren't expensive, but their investment returns are just as anemic. With educational inflation at 6% annually, it will be hard enough for stocks and bonds to keep up let alone life insurance or CDs/savings accounts.

### What's the Bottom Line?

529 plans have become the go-to account for most people saving for college. Go to [SavingForCollege.com](http://SavingForCollege.com) to find out which state's plan is right for you. If you'd rather just use your GI Bill, let me know. The Navy's hiring.

*If you'd like to contact me, please e-mail me at [jschofer@gmail.com](mailto:jschofer@gmail.com) or check out the two blogs I write for, [MCCareer.org](http://MCCareer.org) and [MilitaryMillions.com](http://MilitaryMillions.com).*

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



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# Musings of a Master: How I Came to Embrace AAEM

David Lawhorn, MD MAEM FAAEM



*"I would hope that in four years you would become so accustomed to the first-rate, so imbued with the 'habitual vision of greatness' that you will never in your life be satisfied with less. I would hope that you would come so much to love good books, good conversation,*

*good friends, and good deeds that nothing will diminish your commitment or lessen your enthusiasm. "The life so short, the craft so long to learn." I would hope that your minds and spirits would be so touched with imaginative fire that you would happily acknowledge that these years are only the beginning on your education, that your search for knowledge and touch are only the beginning on your education, that your search for knowledge and beauty would be, quite literally, the task of a life-time."*

From *The Craft So Long to Learn*, an address delivered to students of the University of Chattanooga in 1964, by Guerry Professor of English George C. Connor.

In 1992, I had just returned to the United States after several years of active duty as a medical officer in the U.S. Army. My wife and I settled in North Carolina and I began working in various emergency departments, as an eager but untrained emergency physician, through a company called Coastal Emergency Services. Due to a twisting and adventurous career path that included a life-changing detour through a war, I was well into my mid-thirties by then. Though experienced in life, I was naïve about the world of emergency medicine. I was working mostly in small towns, while applying for a residency in emergency medicine and hoping to get back on the track I had envisioned as my career path.

During my time as an untrained, fly-by-the-seat-of-your-pants doctor — and making mistakes every day — I was faced with Coastal wanting to change my contract every few months. It was an odd thing to me at the time, and illustrates just how little I knew about the business of emergency medicine. Despite my innocence, I negotiated reasonably well and began to learn something about contracts and bargaining. I recall a conversation with my wife at the time in which I said something like, "I don't know who this company really is or how they work, but if they continue doing what I think they are doing, they are going out of business soon." I learned later that my statement coincided with a newsmagazine cover story that described Coastal as essentially the best opportunity for investors since the invention of ice cream. It wasn't long, however, before they did indeed file for bankruptcy.

As fortune would have it, I was offered a residency position in a brand new emergency medicine program at Vanderbilt. Corey Slovis had assembled a remarkable faculty of the best and brightest, including one outspoken young renegade by the name of Andy Walker. Andy introduced me to a new, activist voice in emergency medicine that was standing



up for individual, practicing physicians and shining a light on what is now called *the corporate practice of medicine*. Having some practice experience prior to residency, the principles and vision of this fresh organization hit home with me. The passion of Dr. Bob McNamara, who happened to be exactly my age, was also convincing and contagious. It was a turning point for me.

In case you have forgotten or never read AAEM's Vision Statement, here it is:

A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference.

We aspire to a future in which all patients have access to board certified emergency physicians.

## The Principles

1. The ideal practice situation in emergency medicine affords each physician an equitable ownership stake in the practice. Such ownership entails responsibility to the practice beyond clinical services.
2. Emergency physicians should have control over their professional fees and should not engage in fee-splitting.
3. The role of emergency medicine management companies should be to help physicians manage their practice. The practice should be owned by and controlled by its physicians and not by a management company.
4. Medical societies should actively encourage the creation and enforcement of statutes prohibiting the corporate practice of medicine.
5. Medical societies should not accept financial support from entities that do not adhere to the above principles.
6. Emergency medicine specialty societies should work towards the goal of establishing a workforce sufficient to ensure that all emergency departments in the United States and its territories are staffed by emergency physicians certified by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

After four years of residency, plus a prior internship year and four years of military service, I finally entered practice as a fully trained emergency physician. I had grown up in East Tennessee and wanted to return to the beautiful mountains of home. I learned quickly that almost all the emergency departments in East Tennessee were staffed by a company called Team Health, headquartered in Knoxville, TN and largely run by a few family practice doctors. I later learned that the CEO, Dr. Lynn Massengale, had never completed a residency in any area of medicine. Instead he found it much more rewarding to take a significant part of

Continued on next page

the money earned by the physicians who actually worked in an ED. In 1999, financial reports posted on the SEC website recorded compensation of around \$2,000,000 a year to Dr. Massengale.

A few of my colleagues saw the business model and wanted to follow the trail blazed by Lynn Massengale and others. It made me a bit uncomfortable, but I thought I would give this contract management company a chance to prove they were the good guys they said they were. Then I witnessed a series of egregious business arrangements, the firing of good doctors, and threats to enforce restrictive covenants. I could not conscientiously continue in any capacity that would support what I came to view as an extremely unethical business. I resigned. I fulfilled my contract obligations, including the restrictive covenant clause, without challenge. I had to sell my home, pack up my family, and move away from East Tennessee. This was another turning point. With no job and no income stream, but a great future as an emergency physician who took the arduous path of residency training and ABEM certification, I went to a board meeting at the AAEM Scientific Assembly and pledged a large sum of money to support the new AAEM Foundation, so that no board-certified emergency physician would have to worry about bankruptcy because of fighting the unethical business practices of lay-owned corporate staffing companies.

Eventually several of my former Vanderbilt colleagues and I established one of the finest democratic, independent, emergency medicine groups in the country. In the subsequent years of exciting and fulfilling practice in a community hospital, I became an expert on the business of emergency medicine. I was encouraged by some great friends within AAEM, ended up on the Academy's board of directors, and helped lead a task force through the complex process of forming a new entity that helps

Now I find myself standing on the shoulders of giants, looking out over the future of emergency medicine. I hope that future will be determined by emergency physicians who remember what we have been through and where we ought to be going.



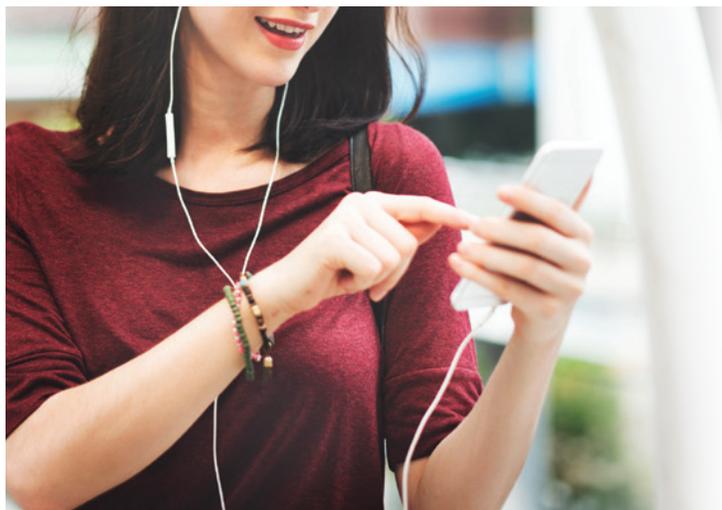
emergency physicians create and maintain their own democratic groups, the AAEM Physician Group.

Now I find myself standing on the shoulders of giants, looking out over the future of emergency medicine. I hope that future will be determined by emergency physicians who remember what we have been through and where we ought to be going. I hope to retire in the not too distant future, but I will remain a staunch advocate and vocal supporter of those leading our specialty in the right direction, like AAEM. There will be no end of challenges in our chosen field, emergency medicine.

#### References

1. (<http://digital-collections.library.utc.edu/digital/collection/p16877coll13>) ●

## AAEM/RSA Podcasts – Subscribe Today!



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FemInEM

American Board of Emergency Medicine (ABEM)

How to Match in EM

How to Excel on your EM Clerkship

**TOPICS  
INCLUDE:**

# 9th Mediterranean Emergency Medicine Congress a Wonderful Success

Lisa Moreno-Walton, MD MS MSCR FAAEM, AAEM Secretary-Treasurer; MEMC Executive Chair



The Academy successfully sponsored the Ninth Mediterranean Emergency Medicine Congress in Lisbon, Portugal on October 6-10, 2017 in collaboration with Global Research on Acute Conditions Team (GREAT) led by Prof. Salvatore DiSomma and the Mediterranean Academy of Emergency Medicine (MAEM; an international chapter of AAEM) led by Prof. Amin Antoine Kazzi, a former AAEM President.

Prof. Lisa Moreno-Walton served as the Executive Chair of the Congress and led the AAEM team on the Executive Committee. The Congress was attended by 653 people from 45 countries. About 160 AAEM members attended, along with 27 members of MAEM, and 20 members of GREAT. Apart from the U.S., Australia had the greatest number of registrants, totaling 45. Under the leadership of Dr. Terry Mulligan, MEMC offered three pre-conference courses: Advanced and Beginner Ultrasound, Advanced EKG, and Resuscitation and Critical Care. Dr. Ziad Kazzi collaborated with the Portuguese Ministry of Health to create a course with faculty from both countries on Hospital Management of Chemical and Radiation Incidents.

We were honored to have Prof. Lee A. Wallis as our keynote speaker at the Opening Ceremony. Prof. Wallis is the current president of the International Federation of Emergency Medicine (IFEM) and the immediate past president of the African Federation of Emergency Medicine. He focused on the substantial differences between emergency medicine and emergency care, stressing the fact that most people in the world have access only to emergency care and this is not likely to change in our lifetime. There is a great need for those of us who are privileged to be trained in emergency medicine to engage in culturally competent and resource sensitive partnerships with those struggling to provide emergency care to the vast majority of the world's patients, and he issued a challenge to us to consider meeting this need in at least some small way.

The Opening Ceremony was distinguished by the presence of several dignitaries. In addition to the President of IFEM, the President-Elect, Prof. Jim Ducharme was in attendance, along with representatives of the Portuguese Ministry of Health and the Portuguese National Institute of Medical Emergencies (INEM)'s Director, the Honorable Dr. Luis Meira. The UK was represented by the Honorable Mr. Robin Roop, Director of the National Health-Wales; Editors in Chief Drs. Steve Hayden (*Journal of Emergency Medicine*), Jim Ducharme (*Canadian Journal of Emergency Medicine*), and Mark Langdorf (*Western Journal of Emergency Medicine*); President of GREAT Italy Prof. Sal DiSomma; advisor the Minister of Health-Lebanon Prof. Amin Kazzi; and the entire Executive Board of AAEM.

AAEM President Dr. Kevin Rodgers focused his plenary on "The Business of Emergency Medicine." He made our international audience aware of the threats presented to US EM by the corporate practice of medicine, restrictive covenants and certain government regulations, and advised how to avoid some of these issues as EM is developed internationally. Prof. Jim Ducharme, the president-elect of the IFEM and editor of the *Canadian Journal of Emergency Medicine* is a world recognized expert on pain management. He provided a provocative plenary on "Pain Relief, Patient Satisfaction and Addiction," candidly addressing the opioid crisis that has become the pandemic that all of us are struggling to manage. Dr. Eveline Hitti, the Chair of Emergency Medicine at the American University of Beirut brought us into new territory with her illuminating presentation on "Leaning Out: Gender, Medicine and Tethered Potential." As the glass ceiling cracks, we are finding that women are still not being promoted to advanced positions at the same rate as their male counterparts. Dr. Hitti looked at overwhelming evidence that women bear the greatest burden for care of children and home, and postulated that the unequal burden of domestic work tethers women's career potential. MEMC's own Prof. Antoine Kazzi examined the many aspect of "Standards to be Required to be Designated Specialist in EM," a topic that is part of the AAEM mission



MEMC17 attendees enjoying the Gala Dinner at the Xabregas Palace.



(L-R) Lisa Moreno-Walton, MD MS MSCR FAAEM and Antoine Kazzi, MD MAAEM FAAEM present the Cristina Costin International Emergency Medicine award to Eveline Hitti, MD MBA FAAEM.



Lisa Moreno-Walton, MD MS MSCR FAAEM presents the MEMC Founders Award to Juliusz Jakubaszko, MD PhD.

Continued on next page



Prof. Lee A. Wallis, president of IFEM, delivers the Keynote Address at MEMC17.



Attendees enjoy the view at the Faculty Appreciation Dinner at Casa do Leão.



and is being widely discussed globally. Dr. Frank Peacock's plenary, "Hit the Road Jack! What the High Sensitive Troponins Mean for Your ED" brought us home to the practical applications of biomarkers in our home ED's, and the ever popular Dr. Amal Mattu spoke to a standing room only crowd on "Groundbreaking Cardiology Articles that Should Influence or Change Your Practice."

The Scientific Program received unprecedented praise for the quality of the presentations and the timeliness of the topics. Scientific Chair Prof. Gary Gaddis coordinated our team's efforts to bring our attendees two main tracks and a Pecha Kucha track daily. Our standard offerings were particularly strong, especially in the areas of (track organizers) toxicology (Dr. Ziad Kazzi), education (Dr. Marianne Haughey), critical care (Dr. David Farcy), and pediatrics (Dr. Isabel Barrata). In addition, we offered more edgy topics that have been increasing in popularity: conflict medicine (Drs. Mazen El-Sayed and Lorenzo Paladino), pain (Dr. Sergey Motov), tactical medicine (Dr. Jeff Elder); and workshops on the successful development of EM systems world-wide (Profs. Lisa Moreno and Judith Tintinalli) and sustainable international programs (Profs. Lisa Moreno and Lee Wallis). The Abstract Committee reviewed over 400 abstracts under the leadership of Drs. Mark Langdorf and Ed Panacek, offering two tracks of oral abstract presentations and a poster area daily. Editor Steve Hayden and the *Journal of Emergency Medicine* provided cash awards for three top scoring abstracts, which were also presented during the Opening Ceremony, and GREAT provided awards to the best posters.

The MEMC Founders' Award went this year to Prof. Juliusz Jakubaszko for his role as the father and sustainer of emergency medicine in Poland, for the significant personal and professional risks that he undertook to

bring EM to the level of a recognized, board certified specialty. The Dr. Cristina Costin Memorial Award was a new award inaugurated this year by AAEM to honor the memory of one of the early graduates of EM residency in Romania, who founded the first Urgent Care Center in Lebanon. Her spouse, Prof. Antoine Kazzi, requested that the award be given to a woman emergency physician, and AAEM determined that this physician must be one who has made outstanding, sustained contributions to the development of EM either in her country or globally. Dr. Eveline Hitti was the inaugural awardee for her work in building the first academic ED in Lebanon and in developing one of the only three ACGME-I certified emergency medicine residencies in the world.

MEMC Lisbon continued our tradition of great parties with a Faculty Appreciation Dinner held at the magnificent Casa de Leao in the Castelo Sao Jorge, a Moorish castle located high above the city of Lisbon. Cocktails were enjoyed on the fortress, as we watched the sun set over the River Tagus and a panoramic view of the city, and were treated to a meal of typical Portuguese foods and traditional Fado music. The Gala Dinner took place at the Palacio de Xabregas, built for members of the royal family in the 16th century and containing the largest collection of antique Portuguese painted panels in the world. Following cocktail hour in the formal rooms, an elegant, chef-prepared meal was served in the courtyard and then the palace walls rocked as guests danced and sang the night away to a DJ and karaoke.

Thank you to those of you who were part of the 9th MEMC! Votes are being tallied for the location of the 10th MEMC, and we want to see you there, learning from the best speakers, teaching as a speaker yourself, touring a new-to-you city, and enjoying the Mediterranean evenings with food, music and friendships new and old. ●

Wellness and Burnout Prevention Committee

# Work-Life Balance and the Search for Bigfoot

Annahieta Kalantari, DO FAAEM  
AAEM Wellness and Burnout Prevention Committee



There is a ton of internet chatter in regard to work-life balance. In fact, a simple Google search of “work-life balance” reveals 98,600,000 results in 1.19 seconds. With all the resources available, why do we still struggle to find work-life balance? For the same reason we struggle to find Bigfoot (whose Google search revealed 130,000,000 in 0.74 seconds), it does not exist. The very term “work-life balance” implies that work is not part of our lives; as if, work is a separate entity from our lives. This idea is preposterous. When we enter the work place, we do not spontaneously morph into a separate being just as the reverse does not occur when leaving the work place to head home.

To further explain my point, let’s look at my household first-aid kit. As a mother of two young boys, our first-aid kit is equipped with Dermabond®, a suture kit along with suture and lidocaine, a pediatric laryngoscope with a set of Magill’s forceps, and then the normal first-aid accouterment such as bandages, tweezers, and antibiotic ointments. As an already paranoid human, being an EM physician adds another layer of paranoia based on what I see at work every day. This comes home.

Another example is how I interact with parents or gravid females who present to the ED with various concerns and complaints. The fact that I carried two children and am now raising them gives me an increased “street cred” when I treat these patients. Because I am able to sit down and share personal experiences with these patients, they find more confidence and comfort in the medical advice I offer. Work and life are not separate.

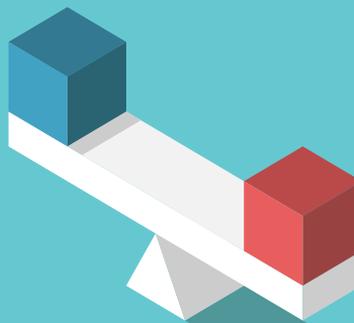
One major key in finding balance is to first remove the term work-life balance from our lexicon and replace it with life balance. Next we must do a personal

inventory about what makes us happy and unhappy at work and at home. I have found that after working three to four days in a row, I am done with all things work related. When I attempt to push past that, I am not happy and decompensate. The same goes for home life. On day one of being at home with the kids, I am thrilled to cook for and craft with my family. Beyond day four at home, I am begging to get back to work. Since this revelation, I am a much happier person in general and feel balanced.

The next step in finding life balance is to balance what we put out with what we take in. By this I mean, we can only give so much to others until our personal giving tanks are empty and we decompensate. We chose a profession in which the giving often exceeds the receiving. We must do another self-assessment to evaluate what we can do to maintain our generosity. I approached this by simply writing a list of all things I find relaxing and replenishing. My list includes items such as sleep, exercise, and healthy eating. Sometimes one or two items on my list may take a hit and I can feel it physically and mentally. Every Saturday, I sit down with my husband to analyze the upcoming week and work in two hours a week where I can get in some form of exercise whether that be a spin class, yoga or Pilates. That’s literally two hours of time dedicated to myself out of 168 possible hours.

The journey to finding life balance is not an easy road. It is laden with some obstacles and one should expect a few fails. Do not be discouraged by these. With practice and time, we can all become masters of finding balance and share our personal victories with one another. Good luck. I am looking forward to seeing you on the path with me. ●

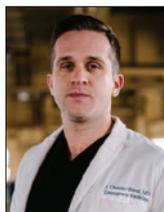
“With all the resources available, why do we still struggle to find work-life balance? For the same reason we struggle to find Bigfoot ... it does not exist.”



## Emergency Ultrasound Section

## What is the Point ... of Care?

Jordan Chanler-Berat, MD FAAEM  
Emergency Ultrasound Section (EUS-AAEM)



I tell my residents often that 80% of what we do in emergency medicine is bread and butter, the routine hum-drum of the ED. Those of us who practice, probably any specialty, know that about 15% can be utter frustration and demoralizing. It's that remaining 5%, and the randomness of its appearance in our day, week, or

month that drives us. It is the point ... of care. In emergency medicine, it can be that needle (aortic dissection) you just picked up in a haystack (of chest pain patients) or an invigorating successful protection of an anaphylactic patient's airway. For many, this 5% is the point of care. It's why they care about their job, their specialty and the importance of the practice of medicine.

For me, an emergency physician fellowship-trained in ultrasound, I tend to agree. However, given the name of my sub-specialty "Point-of-Care Ultrasound," there is a duality in the significance of the "point." To me the point of care is both figurative and literal. Placing my hands and a diagnostic tool on the patient's body, inspecting and probing his or her innards with my magical wand creates a connection long missing in the doctor-patient relationship. A relationship that has been shattered and distorted, truncated, and separated by technology.

The electronic medical record and the house of medicine's reliance on diagnostic machines — far away from the point-of-care — to tell us all that ails our patient has been a disservice to what many of them need the most. Patients need to be palpated, listened to, attended to, and to have their doctors spend some reasonable time at the bedside. This point — the physical contact and time spent pursuing concerning ultrasound findings — allows me to develop a bond of trust with my patients. Some studies are beginning to show the development of the patient's trust and fulfillment when physicians use the ultrasound at the bedside.<sup>1</sup> For those of us who practice this daily, we don't need much peer-reviewed literature to know that it augments our holistic understanding of the patient and provides a nidus for the development of trust in what is normally a brief emergency department interaction.

Aside from improving our interactions with patients, using a diagnostic tool at the point-of-care opens doors to rapid diagnosis. Not by a digital robot, nor by a hard working radiologist tucked away in a dark room. For example, pressing on a firm rigid abdomen of a young woman who was



**“Patients need to be palpated, listened to, attended to, and to have their doctors spend some reasonable time at the bedside.”**

just wheeled into your ED, unconscious, alerts you as a physician to a broad array of potential diagnoses. We see cases like this often in the ED, and right after that physical exam I wheel over my ultrasound machine, as I ask the nurse for a stat IV and pregnancy test. Within minutes I have found a belly full of fluid, likely blood, and no evidence of an intra-uterine pregnancy. I have narrowed down what was a broad differential within minutes without this sick young girl leaving my ED.

With my mouth I ask a history, with my hands I perform my physical exam, and with my probe I make critical diagnoses right then and there at the point-of-care. That, I presume, is the point ... of care.

Jordan Chanler-Berat, MD is Director of Emergency Ultrasound at The Brooklyn Hospital Center. ●

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Women in Emergency Medicine Committee

## FIX Celebrates Its First Annual Conference

Kristen Kent, MD FAAEM

Twitter: @KristenKentMD

AAEM Women in Emergency Medicine Committee



FIX, the acronym for **FemInEM Idea EXchange**, was held this October 4-6, 2017, in New York, New York. FemInEM, is an open access community that was founded by Dara Kass, MD (@darakass) in September 2015. The community is committed to **FEMales working IN Emergency Medicine** and aims to address and correct gender disparities in a way that empowers both women and men physicians.

The sold-out conference consisted of two days of speakers followed by a day of workshops, along with networking, dinners, and storytelling. Participants were mostly women, mostly physicians, mostly working in emergency medicine, and mostly Americans, but also included paramedics, nurses, medical students, physician assistants, and nurse practitioners. Participants also traveled from five other countries, and included at least three medical specialties.

Resa Lewis, MD (@ultrasoundREL), FemInEM advisory board member, explained that the conference helps to create a “more equal and easier path for the future and affect change in the present.” The conference called for collective action to recognize and improve the biases and challenges that women and minorities face in medicine, elevating and amplifying that objective, and advocating for patients in the community and beyond. Speakers discussed tools for resiliency, efficiency, inspiration, mentorship, and leadership.

Mindy Naliboff, DO (@TorpedoinToledo), a second year emergency medicine resident, explained why she attended. “I wanted to see female physicians in positions of power and learn from their examples and their resilience. The attendings and residents at my program are

predominately male, and we (females) learn, treat, and see things differently.” The conference served that purpose. Speakers told of successful endeavors in areas of advocacy, business, and leadership in the emergency department and beyond. For example, Marina Del Rios, MD (@DraCoquiMD) discussed how her efforts with community engagement have increased neurologically intact survival of out of hospital cardiac arrest in Illinois. Mizuho Spangler, DO (@mizspangler) discussed starting her own business, Three Mommy Doctors, with two friends from residency. Esther Choo, MD MPH (@choo\_ek) coordinated conference-goers with the #ENOUGH campaign which aims to end the gun violence epidemic in the United States.

Workshops on the third day continued the theme for the conference in a smaller group setting and focused on strengthening speaking, writing, and leadership skills.

AAEM/RSA sponsored two resident attendees to FIX2017. The scholarship application called on the residents to write about a personal situation or important issue surrounding women in emergency medicine. The scholarships were awarded to Trisha Morshed, MD and Kimberly Brown, MD, their essays were published on the AAEM/RSA blog: <http://aaemrsa.blogspot.com/>.

The vibe of the conference was positive and empowering. Dara Kass, MD (@darakass) commented that it was “everything I wanted to hear in a conference.” Participants overwhelmingly agreed, writing that it was an “inspirational, meaningful conference” (@UBemSono), “paradigm changing” (@amyfaithho), and a “transformative experience” (@KariSampsel).

If you missed FIX or want to find out more, please search #FIX17 on twitter, view [feminem.org](http://feminem.org), and plan to come to FIX18 next fall in New York! ●

## Delaware Valley Chapter Division (DVAAEM) Residents' Day and Meeting

Thursday, March 8, 2018

7:30am-4:00pm

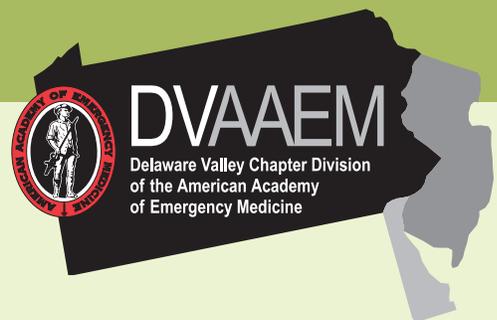
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[www.aaem.org/membership/chapter-divisions/dv-residents-day](http://www.aaem.org/membership/chapter-divisions/dv-residents-day)





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## Young Physicians Section

## Killing Burnout with Exercise and Nutrition

Daniel Migliaccio, MD

Young Physicians Section Board of Directors



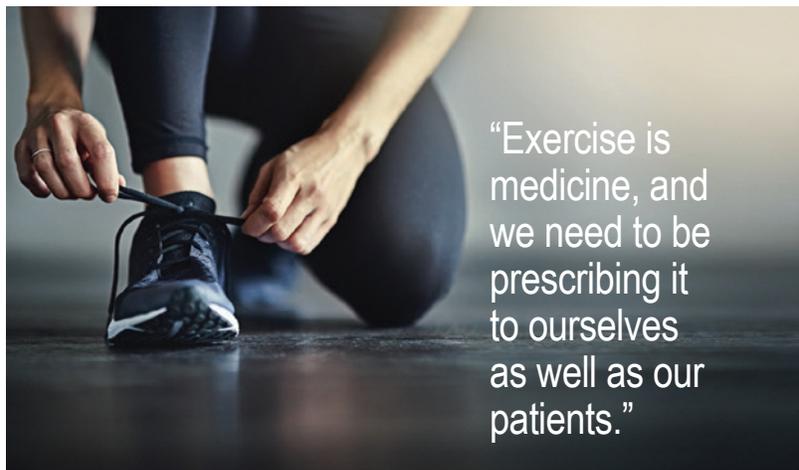
The concept of “burnout” has recently surfaced and is starting to receive its much needed attention and concern. Burnout is described as a maladaptive response to job stressors as defined by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment.<sup>1</sup> The rate of burnout amongst emergency physicians (EPs) is incredibly high, reaching up to 75%.<sup>2</sup> Burnout is associated

with negative outcomes for EPs, including poor decision making at work, increased medical errors and negative attitudes towards patients and colleagues. Outside of the emergency department, burnout is associated with poor health and chronic illness.<sup>3</sup>

In surveying physicians, exercise is one of the key factors in building resilience, maintaining wellness, and decreasing burnout.<sup>4</sup> While it may not be the panacea for the prevention of physician burnout, exercise can serve as an avenue to obtain and maintain wellness. In addition, exercise and proper nutrition decreases the likelihood of EPs developing chronic disease such as diabetes, hypertension, and even dementia.

During clinical training, when work free time is minimal, residents often succumb to physical inactivity and poor diets. Dietary staples for the emergency resident include energy or “protein” bars, sandwiches and/or packaged foods. These foods tend to be fast, easy to prepare and satisfy (at least temporarily) hunger. However, they usually contain refined, processed carbohydrates and fats. Consumption of these refined carbohydrates leads to large fluctuations in blood sugar and eventually insulin resistance. Insulin resistance! That’s right, the very basis of diabetes and its long-term negative sequelae on health. The consumption of high sugar foods also decreases the endogenous production of growth hormone. Growth hormone serves as our fountain of youth; it promotes lean body weight, joint health, muscle mass, and the production of collagen to maintain our skin and hair. Without our supply of growth hormone, insulin resistance, obesity and its chronic health problems are accelerated.

In addition to diet/growth hormone, EPs become even more prone to insulin resistance from the high stress environment in which we work and because of shift work. Stress causes perpetually elevated levels of cortisol and a blunting of the normal diurnal cortisol curve, which in turn has been associated with insulin resistance.<sup>5</sup> Shiftwork also causes a disruption in the hypothalamic-pituitary-adrenal axis. In fact, one night of sleep deprivation can cause as much insulin resistance as six months of being on a junk food diet.<sup>6</sup> Insulin resistance, high cortisol levels combined with physical inactivity creates a pro-inflammatory milieu within our bodies. This inflammation has been attributed to obesity, diabetes, and depression. I believe that this pro-inflammatory lifestyle is leading to an increase rate of burnout in EPs.



Frequently, unhealthy habits that are developed during residency become engraved into the lives of EPs as they transition into practice. However, we are not destined to a life of stress, chronic disease and burnout. Our environment is loading the gun but we pull the trigger. We need to change our environment to work for us, not against us. How can we do this? To start, remove all the unhealthy options out of the equation by not keeping them in your house and/or your work environment. This might seem extreme but it can help kick start someone into making nutritious food selections including plenty of vegetables, lean proteins and complex carbohydrates. Healthy eating in this manner becomes the default and not the exception. In a similar light, preparing food ahead of time for the week (or for a few shifts) also helps to budget smart food options. Practical on shift habits includes scheduling hydration breaks and small breaks for nutritious snacks, which will facilitate steady blood glucose levels. By avoiding large fluctuations in blood sugar, you are lessening the likelihood of excessive “hangry” caloric intake post-shift.

Moreover, we cannot afford to not exercise. Exercise is medicine, and we need to be prescribing it to ourselves as well as our patients. We can decrease and even reverse insulin resistance with a combination of aerobic (cardiovascular) and anaerobic (strength training, high intensity intervals) exercise. We need to set realistic goals about exercise and attempt to schedule it in advance as you would schedule a meeting, or a shift. An impactful exercise program will combine the above modalities at least three to six times per week for at least 30 minutes. Ideally, exercise should be performed in a setting that is enjoyable for you as an individual so that it is maintainable. Options to choose from are vast and include group fitness classes, outdoor activities like hiking, dancing and weightlifting. Exercise and nutrition can serve to fuel your wellness tank. In this manner, your tank is full when the daily stressors we encounter try to empty it.

Continued on next page

Exercise is key in mitigating this insulin resistance and improving mental wellness and burnout. By using exercise as a tool to fight burnout, we can promote healthy lifestyles amongst EPs. Additionally, we as doctors have the responsibility of promoting healthy behaviors in our patients. How, though, can we preach ideologies that we don't practice and expect our patients to follow. In fact, it has been shown that sharing personal nutrition/exercise behaviors with patients improves our credibility and gives our patients more motivation. We need to empower ourselves, exercise, and eat nutritious foods. In doing so, we can prevent burnout, improve our own health, improve the health of our patients and the health of the world.

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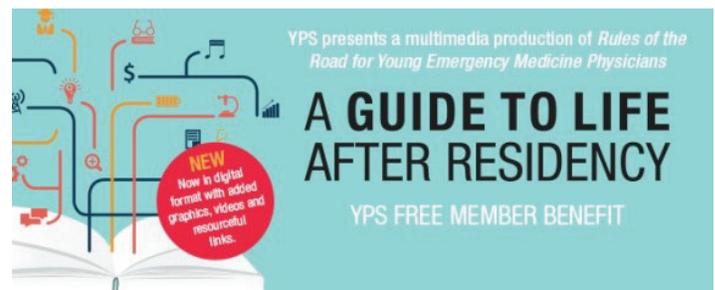
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AAEM/RSA President

# Remembering a Titan: Kevin Rodgers, MD FAAEM

Ashely Alker, MD MSc, PGY-3  
AAEM/RSA President



On November 20<sup>th</sup>, 2017 the medical community lost a great physician, leader, and mentor, Dr. Kevin Rodgers. When I set out to write this tribute article to Dr. Rodgers, there was an outpouring of students and residents who wanted to be involved, which is so much more meaningful than once voice. I am honored to share the voices of residents and medical students who worked with Dr. Rodgers. This article is

a testament to an educator physician who clearly impacted the future of medicine and the lives of countless many.

## Introduction by Elaine H. Brown, MD, RSA Board of Directors, Social Media Committee Board Liaison

The life of Dr. Rodgers was a life well lived, and at sixty-one years of age, Dr. Rodgers had achieved nothing short of the extraordinary. His footprint began in Baltimore, MD, December 1955. He attended the University of Virginia for undergrad, where he received his bachelor's degree in 1977. After college, Dr. Rodgers earned his physician's associate degree at Emory University in 1981. In 1982, he enrolled into the United States Army where he served at Brooke Army Medical Center, Fort Sam Houston in San Antonio, Texas. A few short years later, Dr. Rodgers went on to earn his medical doctorate at the Medical College of Virginia in 1986. He returned to Texas to complete a residency in emergency medicine at San Antonio Uniformed Services Health Education Consortium. Dr. Rodgers was honorably discharged from the U.S. Army at the rank of Lt. Colonel in 1998, and accepted a staff position in the Department of Emergency Medicine at Indiana University. In 2002, he assumed the role of Co-Residency Director for Indiana University Emergency Medicine, and later became Residency Director Emeritus in 2013. He was an active member and leader of American Academy of Emergency Medicine (AAEM), and in 2016, he was elected president of AAEM. Outside of his professional accomplishments, Dr. Rodgers spent time as a volunteer physician on several medical mission trips to Haiti, served as a parishioner for his church, and was the assistant coach for the Cathedral High School lacrosse team. As a leader, educator, physician, mentor, and friend, he has influenced the lives of thousands, and left a legacy in the field of emergency medicine.

## Ryan DesCamp, Medical Student at Indiana University, RSA Wellness Committee Vice-Chair

As a second-year medical student at Indiana University, I had only met Dr. Rodgers briefly, however, I knew I wanted to get more involved with the field of EM and attend Scientific Assembly 2017. However, the dean of my campus was unsure about allowing a three-day absence during

the rigorous pre-clinical years. I reached out to Dr. Rodgers who, the very next day, wrote a personal letter to my dean outlining everything I would gain from attending AAEM17 as a medical student. I then had the pleasure of getting to know Dr. Rodgers more during AAEM17. It was there that his passion for emergency medicine, teaching, and mentoring became apparent to me. Dr. Rodgers is the reason I became more involved with AAEM/RSA and I cannot thank him enough for that and for teaching me that whatever it is you do, always be passionate about it.

## Lauren Falvo, MD, EM Resident Indiana University, RSA Wellness Committee Chair

As a second-year resident, I only had the opportunity to work with Dr. Rodgers (or KRodg, as he was often referred to by his residents) for a short period, but his influence on our education was undeniable and unparalleled. KRodg was a giant. He was larger than life and approached everything he did with infectious enthusiasm. He opened his home to us on countless occasions, and encouraged us to not only grow as physicians, but also as people. We will always remember his delicious cooking, his humbling Viz Quizzes (basically medical trivia hour during lectures), and the way his voice echoed across the emergency department when he worked.

In the weeks following his death, we at IUEM have taken solace in sharing our favorite memories with KRodg. I've included a few brief excerpts from fellow residents:

*"Once on shift after a difficult consult, KRodg wrote out the serenity prayer and handed it to me, saying [it had] helped him." — Maura Walsh, IU Resident*

*"KRodg was a fantastic chef. For our R2 retreat, he would cook a huge feast for the residents, drive home to Indianapolis, then get back at 7:00am and drive back to Bloomington by himself to make breakfast for the residents again." — Jen Lommel, IU Resident*

Dr. Rodgers was a selfless man. Be it our education, or spirits, or our stomachs, he always made certain his residents were being fed. He was an advocate for his patients and a father to his residents. He will forever be missed. Thank you, KRodg, for all you've done for us.

*The AAEM/RSA program director of the year award will now be known as the Dr. Kevin Rodgers Program Director of the Year Award. RSA and AAEM are planning additional ways to honor Dr. Rodgers at the AAEM Scientific Assembly April 7-11, 2018 in San Diego. During this time of loss please reach out to others. If you would like to join in any of the planning of activities to honor Dr. Rodgers, please reach out to the RSA Wellness Committee ([info@aaemrsa.org](mailto:info@aaemrsa.org)). ●*

AAEM/RSA Editor

# The Opioid Epidemic: Where Are We Now?

Aaron C. Tyagi, MD  
AAEM/RSA Editor



We have seen the rate of overdose mortality in general and mortality of overdoses related to opioids continue to rise.<sup>1,2</sup> As a society, we were slow to recognize this problem, for a number of reasons. Now it is incumbent upon us to respond appropriately and in a timely manner. But our opportunity in which to do that in is quickly shrinking. It seems the executive branch and President Trump have recognized this.<sup>3</sup>

But let's actually take a closer look at what we've done and what we're doing currently.

Drug overdose and opioid overdose continues to be a problem in the United States. According to a 2016 report by the CDC, of the 47,055 deaths from drug overdoses that occurred in 2014, 28,647 (60.9%) involved an opioid. The following year (2015), the number of deaths from overdoses rose to 52,404 with 33,091 (63.1%) from opioids.<sup>4</sup> We are constantly exposed to this in the ED. We (the ED and our EMS colleagues in the field) are the frontlines when these patients come in dead or near-dead and need to be resuscitated. We know first-hand the potentially devastating effects of these medications.

It's not hard to see why we were so blind to the problem this was going to pose and currently is causing. When opioids first came on the market, they were advertised as a quick-fix for pain, with a minimal side-effect profile. Profits for pharmaceutical companies sky-rocketed as physicians thought they had a great solution to pain that was "safe" and non-habit forming. This quickly proved to be untrue. However, we were slow to recognize this.

Now we are in the midst of an epidemic of our own making. It is on us to find solutions to this problem.

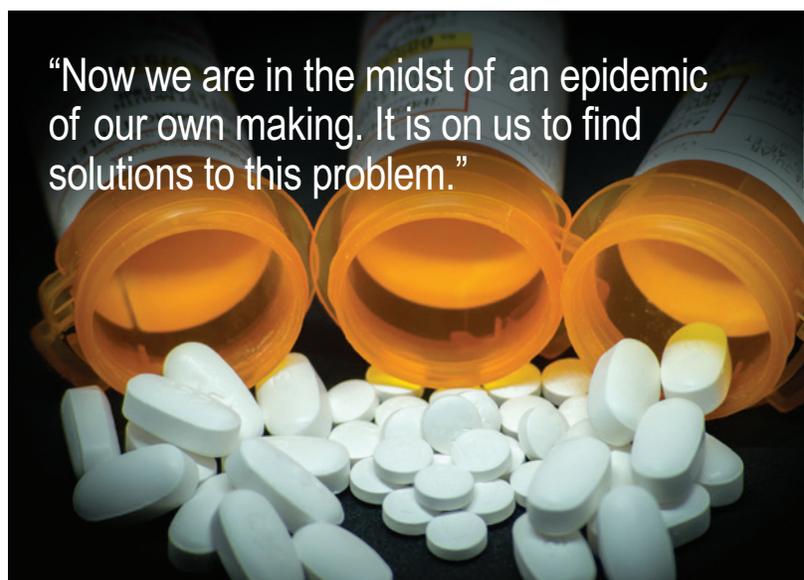
The first step is recognizing and acknowledging that the opioid addiction crisis is something that needs treatment. In Washington, things such as the Comprehensive Addiction and Recovery Act (CARA) 2016 (P.L. 114-198), Addiction Treatment Access Improvement Act of 2017 (H.R. 3692), and Stem the Tide of Overdose Prevalence from Opiate Drugs (STOP OD) Act of 2017 (H.R. 664) have been or are on the table as broad-stroke solutions. It is this process that has allowed more and more states to prescribe naloxone. Some states now have it available over-the-counter at local Walgreens or CVS stores.<sup>5</sup>

Additionally, approaching addiction from a multi-faceted view has some momentum. A recent trial was published in *JAMA Internal Medicine* detailing collaborative care vs. usual care and showed a collaborative approach was associated with increased access to treatment and abstinence from alcohol and opioids at six months.<sup>6</sup>

While we are moving in the right direction, we still have ways to go. We have done better by recognizing pain and addiction as a problem that requires a multi-disciplinary approach to treatment. But still more advocacy needs to be done by us as physicians, both locally and nationally.

For example, the current administration's recent attempts to repeal and replace the Affordable Care Act (ACA) would have resulted in significant cuts to the Centers for Medicaid and Medicare Services (CMS). This is a key way by which most recovery centers are funded.

By getting more involved with our local and national policy-makers, we as physicians have a powerful voice in making sure that this iatrogenic disease gets addressed and hopefully cured correctly. ●



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## Resident Journal Review

# Evaluation of Syncope in the Emergency Department

Authors: Theodore Segarra, MD; Lee Grodin, MD; Taylor Conrad, MD; Raymond Beyda, MD  
 Editors: Michael C. Bond, MD FAAEM and Kelly Maurelus, MD

As syncope is a common yet nebulous complaint, evaluation of the patient with syncope presents a unique challenge. Syncope is defined as a brief loss of consciousness and postural tone with rapid return to baseline mentation. Yet, rather than having a single underlying cause, syncope itself is a syndrome with many potential etiologies. Some identified causes are arrhythmia, myocardial infarction (MI), cerebrovascular accident (CVA), hemorrhage, and pulmonary embolism (PE).<sup>1</sup> In this edition of RJR, we review the potential etiologies of syncope, the utility of risk stratification tools in the workup of syncope, and the prevalence of atypical causes of syncope.

## **S Safari, et al. Comparison of Different Risk Stratification Systems in Predicting Short Term Serious Outcomes of Syncope Patients. *J Res Med Sci.* 2016 Aug 1;21:57. eCollection 2016.**

Given the potential for serious underlying cause in syncope, EPs must quickly assess, risk stratify patients, and determine appropriate disposition. To this end, several risk stratification scores were developed to identify patients at moderate and high risk of serious negative outcomes. Yet there exists significant variability between these rules regarding their criteria, outcomes, and applicability in various populations. Safari and colleagues address this issue in their study by comparing the short term (one week) diagnostic accuracy of four of the most well-known predictive models for patients with syncope. These models included the San Francisco Syncope Rule (SFSR), the Osservatorio Epidemiologico sulla Sincope nel Lazio (OSEIL) model, the Boston model, and the Risk Stratification of Syncope in the Emergency Department (ROSE) score.

The authors conducted a prospective, non-blinded, observational diagnostic accuracy study involving 187 patients chosen by convenience sampling and screened by EM residents and attendings at teaching hospitals in Tehran, Iran from October 2013 to October 2014. Exclusion criteria were age less than 18 years, pregnancy, drug/alcohol/substance abuse, and known underlying cause of syncope. Mean age of participants was 64.2 +/- 17.2 years, and 64% were male. Patients were screened for all potential risk stratifying criteria based on a pre-designed checklist and were followed for one week to determine rates of three primary outcomes: mortality, MI, and CVA. Models were compared using receiver operator curve (ROC) analysis for relative diagnostic accuracy in predicting the primary outcomes.

The one-week incidences of mortality, MI, and CVA were 19 (10.2%), 12 (6.4%), and 36 (19.2%), respectively. The authors determined the area under the ROC curve for each outcome. The authors found there was extremely low accuracy for all four models in predicting mortality, MI, and CVA. Further, they found no significant difference between the four models in their predictive accuracy for any of the three outcomes. The authors then combined all criteria in a single pooled model, and found similarly poor predictive capability. The authors concluded that all four models, as well as the pooled model, are unable to accurately predict one-week mortality, MI, or CVA in syncope patients.

Unfortunately, several critical flaws plague this study. Though the choice of a one-week time point is useful for the EM provider by providing a unified and short time frame for comparison, the problem is that each model was designed and powered to predict different outcomes over different time frames (SFSR: serious outcomes at 1 week to 1 month; OSEIL: mortality at 1 year; Boston: serious outcomes at 1 month; ROSE: serious outcomes at 1 month).<sup>1,6-9</sup> Therefore, it is not surprising that models like OESIL, Boston, and ROSE may not be useful in predicting short term risk. Moreover, models like the SFSR were designed to be applied to patients with no obvious cause of syncope after full evaluation in the ED. However, in this study, the criteria were applied to all patients prior to an initial evaluation. Furthermore, prior validation studies revealed that the most commonly identified cause of syncope after initial evaluation was arrhythmia, which was not assessed by the current study.<sup>6</sup>

The study's design leads to significant bias due to its observational, non-blinded (Hawthorne effect) nature. In addition, the small sample size, with less than a 30% incidence of each negative outcome, results in a study that is underpowered to identify differences between the four models. Also, the use of convenience sampling leads to significant sampling bias, particularly given the small sample size and unblinded nature. Furthermore, as a diagnostic accuracy study, the authors failed to include controls and to describe their methods for determining true positive rate and false positive rate. As a result, it remains unclear how they determined the true diagnostic accuracy of each model. Due to these significant flaws, the study's results should not alter current practice.

## **V Thiruganasambandamoorthy, et al. Predicting Short-Term Risk of Arrhythmia Among Patients with Syncope: The Canadian Syncope Arrhythmia Risk Score. *Academic Emergency Medicine.* 2017 Nov;24(11):1315-1326.**

In patients with no identifiable cause of syncope, the possibility of paroxysmal arrhythmias which may not be detectable on initial evaluation should be considered. As a result, newer clinical decision rules have focused increasingly on identifying patients at risk of arrhythmia. Thiruganasambandamoorthy and colleagues recently conducted a multicenter prospective cohort study in order to identify variables from the clinical evaluation and ED testing to derive a prediction model for clinically important arrhythmias related to syncope, the Canadian Syncope Arrhythmia Risk Score (CSARS). The outcomes evaluated were death due to arrhythmia or unknown cause, arrhythmia, and procedural interventions to treat arrhythmias within 30 days of the ED evaluation and disposition. Patients with pre-existing arrhythmias or other serious conditions were excluded in the study. Thirty-nine predictor variables were identified from statistical analysis of the cohort, and from that initial group eight predictors were selected to be included in the risk score: vasovagal predisposition, history of heart disease, ED systolic pressure >180 or <90mmHg, troponin elevation (>99th percentile), QRS duration >130ms,

Continued on next page

QTc >480ms, ED diagnosis of vasovagal syncope, and ED diagnosis of cardiac syncope. The score ranges from -2 to +8, (vasovagal predisposition and ED diagnosis of vasovagal syncope confer -1 point). It is important to note the authors mention the troponin value, although included in the score, was not present for the majority of patients, and further, values could not be compared across sites due to differing laboratory tests. As such, the >99th percentile cutoff was chosen, and a missing troponin was assumed to be below that percentile.

Of the 5,010 patients included in the final analysis, 106 (2.1%) patients experienced a study outcome with 0.9% of the outcomes occurring outside of the hospital. No subsequent analysis was performed on this sub-grouping. After analyzing the sensitivity, specificity, and positive and negative predictive values for each score, the authors assigned an estimated 30-day risk percentage with a score of  $\leq 0$  associated with <1% risk of outcome. Scores of 1-3 are associated with a 1.9-7.5% risk and scores 4-8 associated with a 14.3-22.2% risk. Not calculated in the paper, the negative likelihood ratio for a score  $\leq 0$  is 0 to 0.054 and the positive likelihood ratio for a score  $> 0$  is 4.2 to 24.5. As the prevalence for death due to unknown cause and arrhythmia in the population is low, the greatest utility may be that a low score ( $\leq 0$ ) has a very good negative predictive value.

The authors discuss that this analysis represents a unique reporting of predictors for short-term arrhythmia or death following initial evaluation in the ED for syncope. These predictors are also consistent with past studies evaluating one-year outcomes. Interestingly, two predictors not included in the final CSARS mode (advanced age and absence of a prodrome) did show significant association with outcomes but when adjusted for other variables were not included in the final score calculation. A major strength that this score provides is that it parses out abnormalities in ECG, specifically QRS prolongation and QTc prolongation, rather than grouping the characteristic as "abnormal EKG" as most other prospective studies have done.<sup>10-12</sup> A major limitation was that one fifth of eligible study participants were not enrolled as the providers did not complete study forms during their evaluation. With regards to the large number of missing troponin values and assumption of normal results, the authors argue that the populations missing these values were substantially younger with fewer comorbidities and that the presumed normal value was reasonable even though this data was not specifically reported. Lastly, it is important to note that the score does include two, arguably subjective, predictors (final ED diagnosis of cardiac or vasovagal syncope). The predictor with the highest odds ratio was ED diagnosis of cardiac syncope (4.29) and the lowest odds ratio was ED diagnosis of vasovagal syncope (0.27). The investigators address this point noting that many currently used decision-making tools for venous thromboembolism and chest pain contain similar predictors and that when removed from the score, the remaining predictors provide sufficient risk stratification.

While CSARS still needs validation from other studies, it could offer additional information by providing estimated risks for patients. However, one can argue that some of the most important predictors remain the result of a provider's clinical examination and history taking to differentiate vasovagal syncope from cardiac syncope which can be challenging.

## **P Prandoni, et al. Prevalence of Pulmonary Embolism Among Patients Hospitalized for Syncope. *N Engl J Med.* 2016 Oct 20;375(16):1524-1531.**

This study sparked significant controversy and received attention last year when it was published in the *New England Journal of Medicine*. In this paper, the authors attempted to study the prevalence of PE in patients admitted to the hospital for syncope. Their main conclusion was that nearly 1 in 6 (approximately 17.3%) patients admitted for syncope had a PE. This figure is astounding as it goes against much of what many EM providers likely encounter in actual clinical practice.

This study was a cross sectional study which took place in 11 participating Italian hospitals. Importantly, the participating hospitals screened 2584 patients presenting with syncope during the study period. Of this original study population, 1867 were discharged, and 717 were admitted. Of the 717 admitted 157 were excluded for various reasons, leaving a final group of 560 admitted syncope patients for analysis. All 560 patients were evaluated with the simplified Wells Score to assess the pretest probability of PE, using dichotomous unlikely (if less than or equal to 4) versus likely (greater than 4) results to drive further testing. All patients underwent D-dimer testing as part of their initial syncope workup. Of the 560 patients evaluated, 330 had low pretest likelihood and negative D-dimers, and 230 had either a high likelihood, positive D-dimer, or both.

Of the 230 patients with a positive D-dimer or high likelihood of PE, one died and was found at autopsy to have a PE (proximal and bilateral), 180 had a CT scan, and 49 had a VQ scan. Out of the initial 229 patients who underwent advanced pulmonary imaging, 97 PEs were found. When compared to the initial number of patients who presented to the ED for syncope and were screened, this is a prevalence of PE in the undifferentiated syncope population of 3.8% (97/2584). A significant selection bias, selecting only admitted patients to run the tests, is contributing to the conclusions that were found. The rate of PE in the patients that were discharged is not known, and they were excluded from the final data set.

Why was the prevalence of PE so high in the admitted patients? The average age of these patients was 76 with no significant difference between those with or those without PE. But there were some very important key differences between those diagnosed with PE compared to those with negative imaging. Those diagnosed with PE had significantly higher rates of previous venous thromboembolism (VTE) (11.3% vs 4.3%), higher respiratory rates (45.4% vs 7.1%), more tachycardia (33% vs 16.2%), higher rates of having a blood pressure less than 110 mmHg (36.1% vs 22.9%), more clinical evidence of DVT (40.2% vs 4.5%), and a higher rate of active cancer (19.6% vs 9.9%). Basically, patients found to have PEs also had many other worrisome signs and symptoms to suggest they may indeed have a PE, and likely would have been worked up to exclude PE. The very fact that they were admitted suggests that their presentation was more worrisome to the EM provider.

What about the PEs that were found? Of the 180 patients who underwent CT, 72 were detected, with 30 in the main pulmonary artery, 18 in a lobar artery, 19 in a segmental artery, and 5 were sub-segmental. Of the 49 patients who underwent VQ scanning, 24 PEs were diagnosed with 4 involving more than 50% of the area of both lungs, 8 involving 26 to 50%

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of the area of both lungs, and 12 involving 1 to 25% of the area of both lungs.

While this study did follow a systematic protocol-based approach to exclude PE based on assessment of pretest probability, it did so for a subset of very high-risk syncope patients. Many had other risk factors and clinical features concerning for PE. Applying nonspecific clinical prediction scores and blood tests can lead to over-diagnosis and over-estimation of the prevalence of disease, which likely accounts for the high rate reported in this study. As the authors correctly note, PE should be on the differential diagnosis of patients presenting with syncope; however, testing in the undifferentiated syncope patient can lead to misdiagnosis and medical misadventures. Therefore, evaluating for VTE or PE should be driven by the history, physical examination, risk factors, and validated clinical prediction scores applied to appropriately selected patients.

**A Frizell, et al. Prevalence of Pulmonary Embolism in Patients Presenting to the Emergency Department with Syncope. *Am J Emerg Med.* 2017 Jul 31. pii: S0735-6757(17)30639-3.**

The authors performed a retrospective, secondary analysis of prospectively gathered data from patients presenting with syncope to an academic ED from July 2010 to December 2015. Prospective subjects were asked, "Have you passed out in the last 24 hours?" A total of 778 patients were screened, with 348 eligible for inclusion. Of these, two were excluded because they were diagnosed with PE in the ED. Researchers calculated the PERC score for all enrollees. The patients were followed for 30 days after the visit. Telephone outreach successfully reached 68.4% of patients. Of the remainder, the electronic medical record system was reviewed for subsequent health care encounters. The end point was diagnosis of PE in any setting in the 30 days following enrollment. Data was analyzed using descriptive statistics and presented as percentages for categorical variable and means for continuous variables. Pearson's chi-square test and Student's t-test were used.

Demographic and historical attributes were collected including the prevalence of VTE (15.8%, CI:12.3-20). Patients reported symptoms of shortness of breath (54.3% CI: 49-59.5), chest pain (49.1%, CI:43.9-54.4), and calf pain/swelling (17%, CI:13.4-21.3). While in the ED, 22.7% of patients underwent PE testing by D-dimer, V/Q testing, or CTPA. In the study patients, 50.1% underwent further hospital evaluation (23.9% placed in observation unit). None of the patients who remained in the hospital were diagnosed with PE outside of the two patients diagnosed in the ED. By telephone follow-up, three patients (0.9% CI: 0.3-2.5) reported a diagnosis of PE in the follow up period. Overall the rate of PE in patients presenting to the ED with syncope was 1.4% (95% CI: 0.6-3.3).

The authors discuss that their findings differ significantly from those of Prandoni, et al. Significant differences between the two studies help explain this. The Prandoni study did not include all patients with syncope as it excluded those who had syncope attributed to vasovagal events, pharmacologic iatrogenesis, situational provocation, or hypovolemia. Therefore, the Prandoni study evaluated the prevalence of PE in only a subset of patients with syncope. This work up was done on the inpatient units. In contrast the study by Frizell, et al., relied largely on the discretion of the providers for work up, and telephone and EMR review for follow-up.

While it is convenient to partially disregard the high prevalence of PE in patients presenting with syncope found by Prandoni, we must do so with caution. It is perhaps more palatable to the ED provider to accept a lower incidence given the commonality of syncope as a chief complaint, but must remember that patients that are sick enough to warrant an admission are likely to have more risk factors that should put a PE on the list of possible causes for the syncope.

### Conclusion

Syncope is a complex and difficult chief complaint for the EM physician to evaluate, mainly due to the multitude of potential underlying etiologies and the lack of any single well-validated risk-stratification tool. Though several risk scoring criteria have been shown to be helpful, at the end of the day, clinical judgment and maintaining a broad differential remain the key components to appropriately managing these patients. In the patient with no obvious cause of syncope after thorough evaluation, it appears that arrhythmia is the most common cause of syncope symptoms, and that PE is likely not as prevalent a cause for syncope as was reported by Prandoni. As EM providers, we must continue to strive to both protect our patients while simultaneously utilizing our resources appropriately and avoiding unnecessary admissions and undue burdens on the health care system.

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# The SVI from a Student's Perspective

Chris Ryba, MS4

AAEM/RSA Medical Student Council President



As I write this, I must begin by mentioning that this piece by no means represents the view of some or all students. This is a brief collection of talking points from my experience alone. Everyone's experience or opinion on this matter may vary greatly, but I wanted to take a moment to offer some insight from a student's perspective of someone who took the SVI.

By now, many of you have had exposure to, or at least heard mention of, the AAMC's pilot Standardized Video Interview program first rolled out as an optional component in 2016 and made mandatory for all students applying to an ACGME accredited emergency medicine residency in 2017. I'll spare you my paraphrase and will just copy over the description straight from the AAMC website, "The Standardized Video Interview is an innovative tool that enables applicants to share objective, performance-based information about themselves, beyond academic metrics, to add breadth and depth to their application, as well as to provide residency program directors with additional information to assess applicants."

Each applicant receives six randomly assigned standardized questions comprising two ACGME competencies: knowledge of professional behaviors and interpersonal and communication skills. The applicant has thirty seconds to read the question and develop a response and then three minutes to answer the question as they see fit. Once the timer begins, applicants can pause between interview questions, however they cannot pause mid response. I have listed two sample questions from the AAMC below:

- One of your patients refuses treatment because it is incompatible with the patient's religious beliefs. How would you handle the situation?
- Give an example of a time when you were successful in communicating a difficult message. What was the message? How did you communicate it? What was the outcome?

Overall the experience was not too difficult. Once over the discomfort of the set-up, the questions were very straight forward. I prepared by setting aside some broad stories and examples using the question examples from the AAMC website that could be loosely used across many questions. Twenty-one minutes went fairly quick and then my SVI was submitted.

As a student piloting the program, the set up was the most difficult and stressful part of the entire process. Since the interview could be done on any platform wherever you had access to internet and a webcam, there

was a lot of subtle unknowns to take into account. Components like: what type of back drop to use, what to do if your internet connection drops, external noise, dress code, and posture were all factors that previously were out of our control in the formal interview setting that had to be accounted for in the SVI. Another difficulty that was hard to prepare for was maintaining eye contact with the webcam and not your own face while answering the questions as the platform used displayed your image as if you were speaking to yourself.

Several weeks later, around the time of ERAS submission, came the score report. Trained third-party graders scored the six questions on a scale of 1 to 5 giving a total score of 6 to 30. As a student, and I am willing to guess the same holds true for the program directors, there are still a lot of questions about how these scores equate to performance and the metrics the AAMC hopes to develop with this assessment tool down the road. It sounds as if the AAMC is at-

tempting to add an assessment tool which scores the applicant on a more personal basis that can be used in combination with USMLE scores.

The hopes on the student side are that this may give some students who may not test well a better opportunity at receiving interviews from more schools. The most common counter argument that I have come across is that in the emergency medicine field, the personal side is well assessed through SLOE's which are already a well vetted standardized process of evaluation. More will come on this as the data begins to be released.

I believe the greatest concern that I am hearing across the board for students is that this will become another expensive mandatory assessment tool on top of an already expensive interview trail. Right now, the AAMC is assuring students that this will not become a cost burden for the time being, however the future remains open ended as the data continues to be gathered and there is no definite answer to what direction this assessment tool will take. So long as the SVI is in pilot, there will be no cost for the students, but that is no guarantee as the project moves forward.

The SVI, in my opinion, is still in too early of a pilot to say whether or not this is going to be a benefit for students or residency programs moving forward. I see promise in the tool if data shows a unique benefit to applicants but I have major concerns that this may just become another cost to students down the road. I look forward to the data collected from the AAMC following one complete year of mandatory compliance for EM applicants.

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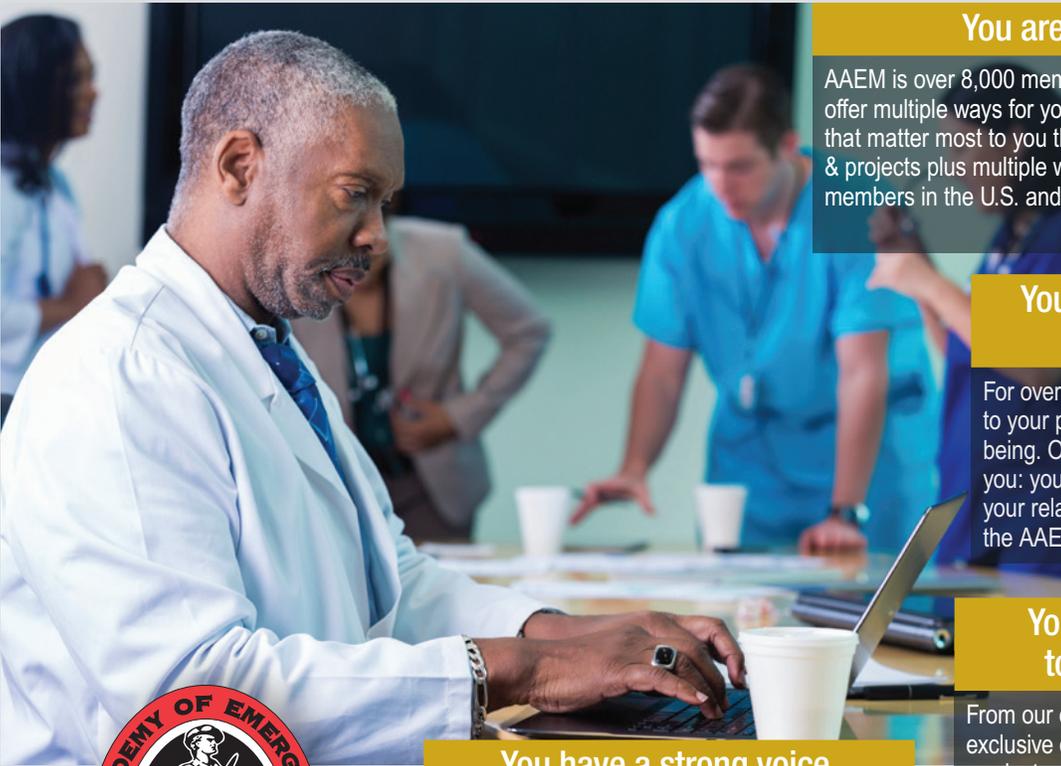
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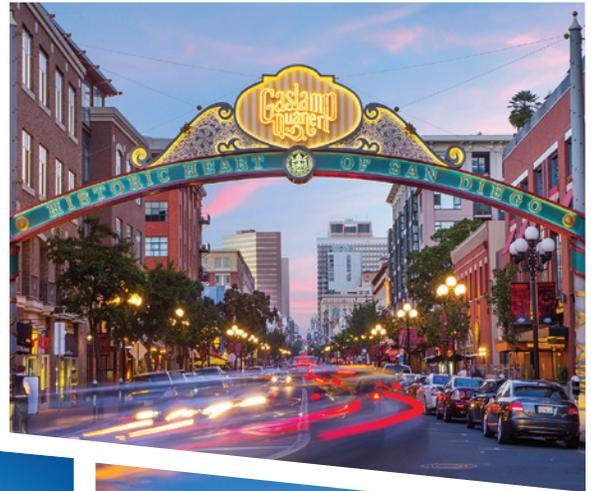


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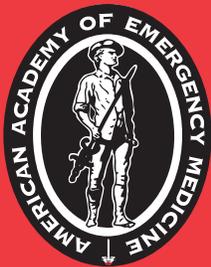
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