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COMMON SENSE

VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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Professionalism and its Implications on our Health Care System — 16

Robert Frolichstein, MD FAAEM

“We need to be involved in our organizations and devote the time and energy to engage in discussions that will improve our organizations and allow them to impact changes within our system.”

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COMMONSENSE

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AAEM Mission Statement

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

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

Membership Information

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

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

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President's Message

Due Process: Why It Is So Important

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



I just finished reading a very stimulating article that drew an interesting comparison between the airline industry and emergency medicine titled, "Why 'Be More Like Pilots' Just Doesn't Fly in Emergency Medicine" written by Dr. McGowan.¹ The article highlights what the book "Why Hospitals Should Fly" completely misses about why the airline industry and

emergency medicine cannot be compared. Building on this discussion, I'd like to address one key problem that the article failed to cite, and one of the key problems that no one really wants to mention: lack of due process protections.

The Academy's mission statement is clear, with Principle #5 of our mission stating, "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."

The author outlined some key points about how different the airline industry and emergency medicine are. Let's start by focusing on one point. The airline industry is all about safety. Imagine if an Airbus 380 with 550 persons on board crashed every day of the year ... what would happen? In reality, this would not be tolerated as the airline industry is heavily regulated to promote a culture of safety and the airline industry would quickly change forever. When we compare numbers, the airline industry in the U.S. alone carried more than 895.5 million people in 2015 compared to 141.4 million ED visits that same year. Nearly six times more people fly per year with estimated deaths to be less than 20 for that year, and mostly due to medical conditions or from smaller planes and human error. On the other hand, in our health care industry, according to the Institute of Medicine (IOM) report entitled "To Err is Human" at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented.² I would state that the figures from both publications have serious methodological errors, but this is not the point — more an example to illustrate that there is a problem.

So, let's look at some of the major differences between the two industries:

In the world of the airlines, pilots can delay or cancel the flight if there is not sufficient crew, a mechanical issue, weather problems, or weight problems. A passenger may wait hours, and sometimes are put up in a hotel for a flight the next day. Anyone can speak-up if they feel it is unsafe or have concerns. A disruptive passenger could even be arrested for non-compliance with a flight attendant or air marshal. Are you all shaking your heads?

In the ED, we are faced with a myriad of problems, yet we don't stop. For example: a nurse or tech will call out for the day and we work short staffed — that does not stop us, the CT scan is down — that does not stop us, we are at twice the capacity — that does not stop us, medication shortage — that does not stop us, the violent, scary, and cursing patient or family members we are made to apologize to and do customer recovery — that does not stop us.

We are faced with all of these challenges, yet the single biggest challenge we are faced with is our lack of due process. Without due process, if you speak up, you potentially could lose your job. Many doctors fear reprisal if they speak up — they fear that their job is on the line. Many emergency physicians work in a culture that does not allow for people to



"AAEM feels this issue is not simply about physician practice rights, but is a core driver of patient safety. If all physicians had due process and the right to a fair hearing then maybe we would not be afraid to speak up."

come forward and say "doctor stop!!!" without the doctor belittling them, or the threat of them being fired. A survey published in May 2013 in the *Journal of Emergency Medicine*, showed that 20% of emergency physicians would not call attention to a quality issue because of lack of due process rights.³ They were afraid of termination if they did so!

Continued on next page

Pilots are mandated to not fly more than 30 hours in one week. In just these past five days I worked 70 hours in direct patient care. Contract management groups will track your patients seen per hour and if they feel you are missing their target, may push for more productivity, and perhaps by also reducing coverage, all in the quest for larger profits.

Now go and try to speak up!

Oh wait, did you waive your due process? Or did you sign a non-compete (restrictive covenant) clause? For the many emergency physicians, working for a contract management group, at any moment, and for any given reason, we could be asked to leave.

As a pilot, before even going to the airport, I check the weather, ceiling visibility, and fill a flight plan. At the airport, I do a pre-flight check list, then an engine start-up check list, etc., etc. I've flown plenty of Cessna 172s or Cherokee Pipers and the checklist is fairly easy. The fuel check valve for water is in the same place on every Cessna, the command the same on each and every Cessna 172. Every patient we see has a unique history with subtle but important differences in presentation. Medication lists of patients are almost always different. Add in past surgeries, genetics, alcohol and drug use and every single patient we see will be different than the next. A checklist simply does not work in the emergency department.

The Academy has been advocating for due process and will continue to do so. AAEM feels this issue is not simply about physician practice rights, but is a core driver of patient safety. If all physicians had due process and the right to a fair hearing then maybe we would not be afraid to speak up. We could say, "Stop, we cannot take it," "This nurse is caring for six critical patients," "We cannot or do not have all the monitors we need."

The American Academy of Emergency Medicine (AAEM) is greatly concerned with physicians' due process rights. Unfortunately some hospitals and physician staffing companies attempt to limit them. This practice is a threat to physician autonomy and patient safety. This is the most important first step necessary to move towards minimizing medical errors.

When a physician makes the right clinical choice for a patient, which may go against the financial interest of a hospital or contract management group, the physician should have basic protections, just like an airline pilot does. Until then, stop comparing apples with oranges... ●

References

1. McGowan T. Why "Be More Like Pilots" just doesn't fly in emergency medicine. *Emergency Medicine Monthly*, December 22, 2017.
2. Kohn LT, Corrigan JM, Donaldson MS, eds. To err is human: Building a safer health system. Washington, D.C.: National Academy Press, 2000.
3. McNamara et al. *J Emerg Med* 2013; 45:111-116.

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



Attention Members – What Does AAEM Mean to You?

AAEM is approaching our 25th anniversary and *Common Sense* is soliciting AAEM member articles related to, "What does AAEM mean to me?" Do you have a story to tell? We invite you to share it with your fellow AAEM members. Please remember that we are in this together and your story could help another emergency physician. Submit articles to cseeditor@aaem.org or lburns@aaem.org.

Submit your story!

From the Editor's Desk

The Hamster Wheel

Andy Mayer, MD FAAEM
Editor, *Common Sense*



Do you ever feel like a hamster running endlessly on a wheel while you are working a shift in the emergency department? What should you do next? Should you rush to the stroke activation on the 25-year-old with tingling? Should you rush to see another new patient first, to keep your door-to-doctor time down? Did you remember to add the lactate level on that dialysis patient with a fever? I hope you didn't forget to chart

the TIMI score on that rule out MI who is heading upstairs.

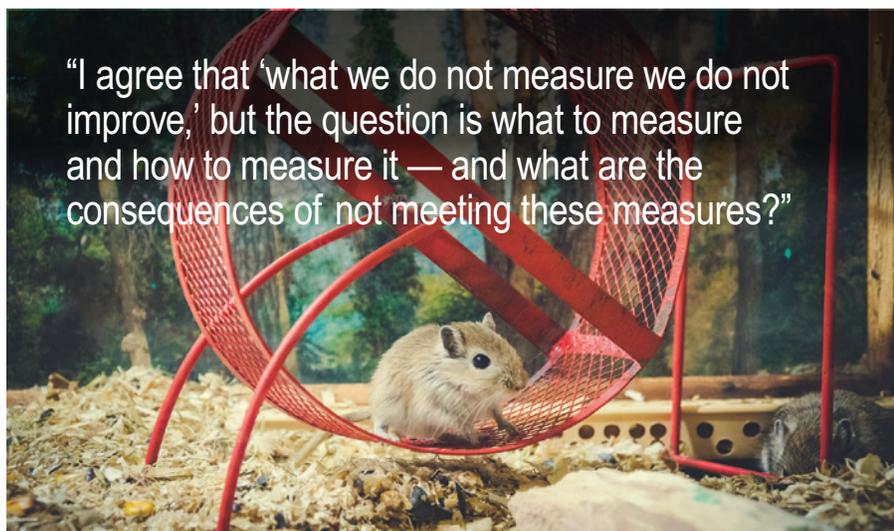
Sadly, while trying to decide on your next move the tech shoves two more triage EKGs into your face, so you can write "NO STEMI" on them while you try to talk to the nurse practitioner at a local urgent care about another patient they are sending over "because he needs to see a doctor." Emergency physicians are highly trained to handle multiple sick patients at once, but is the next action you decide to take the "right" one in relation to metrics?

Each emergency medicine practice setting has its own unique set of obstacles, but sometimes it seems that the game is rigged against us. Should we accept the fact that metrics are here to stay? I agree that "what we do not measure we do not improve," but the question is what to measure and how to measure it — and what are the consequences of not meeting these measures? Adding more and more metrics in order to monitor an emergency physician's "quality" can lead to feelings of helplessness and burnout. It is not the hamster's fault if he or she has to keep running faster and faster on the wheel to nowhere, suddenly falls off, and then gets a threatening email from deep in the bowels of the hospital. It sometimes seems that the rapidly enlarging team of "clipboard nurses" is the new military-industrial complex.

I recently became the medical director of my independent group, and the members of my group are my partners. All quality issue emails now come to me. Now I see not only my own falls off of the wheel but also those of my partners. There is certainly frustration in having to defend the clinical decisions of one of my partners when they were working alone at 4:00am. Why didn't they give the 30 cc/kg fluid bolus to the volume-overloaded dialysis patient with pneumonia and a mildly elevated lactate? This metric transgression occurred when all the quality reviewers were safely tucked into their beds at home, and discovered on Monday morning. Discussing these cases with the tired emergency physician brings out the "rage against the machine" eyes. There is that sullen quiet or loudly angry response to questioning their care, when their only crime was to decide on a course of action, which was medically correct but did not "meet the measure."

I had a partner several years ago, when "metrics" were in their infancy, who never let these measures of quality bother him. When confronted

by a reported lapse of quality he expressed a nonchalant attitude. His explanation was that he was just trying to do the right thing and that was enough. In the early days of metric-driven medicine this may have worked, but no longer. The idea that it is enough to use your best medical judgment to do what you think is right may be gone. Now we go to national meetings where we are told to order the 30 cc/kg bolus but then quickly cancel it, as this will meet the metric while still preventing harm to the patient. How did we come to this and where do we go from here?



In the age of patient satisfaction scores and metrics, I think a major reason for burnout is that the emergency physician is seemingly responsible for everything but has authority for nothing. Did anyone ask you if the stroke team measures were useful, helped patient care, or if you wanted to participate in them? These measures and metrics add layers of anxiety and frustration to the emergency physician's day, in return for highly questionable patient benefit.

What should we do? How do we prevent burnout in this new environment? This is a key question which we as a specialty need to address, so that each of us can survive and try to craft a fulfilling career. There are many activities that do not involve organized medicine, which I wholeheartedly encourage. I fish and talk about fishing. Travel with my wife and family and seeing other cultures is also one of my ways of staying sane. I would, however, like to emphasize the role which organized emergency medical organizations can play in supporting individual emergency physicians.

The idea that an organization can keep you sane or protect your career is not realistic, but the values and ideals which an organization projects and the personal support it gives to its members can be of important help. AAEM's president and board are willing to advocate directly for a

Continued on next page

member or a group, clearly illustrating AAEM's mission. The happiness and security of the "pit doctor" have always been a fundamental goal of the Academy.

Organized medicine, including AAEM, has a duty to advocate for physicians and the patients we treat. AAEM certainly does this at an individual and group level, but also on a national level. Our executive committee and board members advocate on your behalf. Our president-elect, Dr. David Farcy, has been trying to educate our federal regulators on more rational clinical requirements for sepsis care. AAEM has a strong lobbying presence on capitol hill. The latest advocacy day was an excellent experience and one I recommend for all of you. Do I think speaking to a congressional staffer will suddenly change American health care? No, but seeing the process and having a personal sense of trying to make things better might make you feel better about your career and personal well-being, while doing good for the country in the long run.

I also encourage each of you to attend the Scientific Assembly. The content is first-rate and the locations are great. However, one of the main reasons I think you should go is the sense of community you will feel. Seeing such a gathering of "pit docs" in one place, and realizing that we all face similar challenges and metrics, might restore the sense of professionalism and community that you lost in your metric-driven ED. Everyone attending walks in your shoes and is there to refresh, learn, and reconnect with old friends, partners, and residency classmates. I always head home feeling a renewed sense of having a profession instead of a job. You might remember what drew you to emergency medicine in the first place. Will this make your first shift back easier, dealing with the frequent-flyer complaining about his dose of Dilaudid? I really do hope so.

AAEM now has a Wellness Committee, which wants to help you flourish in our profession. This committee held several events in Orlando, which

were very well received. *Common Sense* is starting a regular column from our Wellness Committee named "Resuscitating Resilience." I hope you will find it a useful resource in our quest to prevent burnout and promote wellness.

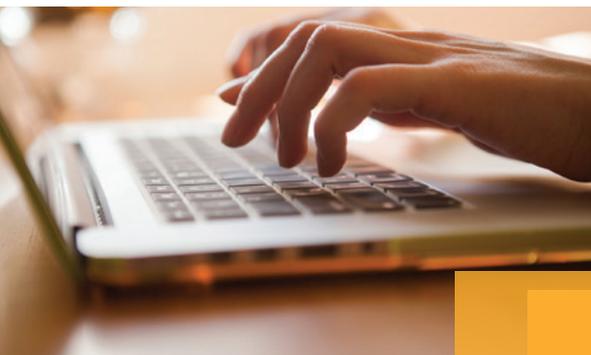
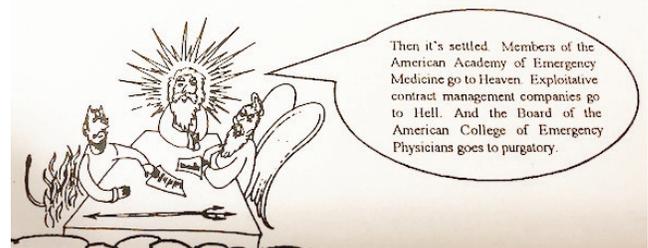
Finally, I ask you to engage in this process. Please let AAEM and *Common Sense* know your thoughts and ideas. The free flow of ideas in the pursuit of improving our professional lives might be a way to help. Letters to the editor on your ideas about the hamster wheel, or any other issue on your mind, will be appreciated. ●

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.



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

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

A Public Resignation

On a balmy day in late September I received my annual "MEMBERSHIP STATEMENT" from ACEP. In reviewing the quasi-tax deductible document I at first beamed with pride seeing the "AMOUNT BILLED" for being a fellow, an honor bestowed upon me last year for doing what I assumed any doctor would do — become competent in his specialty, join hospital committees, be proactive in local events, and have a commitment to health care in his community. And the "F" of my F.A.C.E.P. had cost only one hundred additional dollars.

Now the "AMOUNT BILLED" for fellowship renewal was only \$435 and the California Chapter "DUES" only \$185, which I considered a bargain when compared to the \$500 I spent to meet U.S. Senator Barbara Boxer, and to my surprise the ACEP California Chapter President and President-elect at a fund-raiser last summer (Please don't tell Barbara, but I'm a closeted Republican!) Then there were the other "DONATIONS" (how generous they are with our money!).

While in the midst of writing my check for \$745 Janet Jackson ironically came on my stereo singing "What have you done for me lately?" The song somehow prompted a vertiginous blur of memories of contract holders in expensive Italian suits and tasseled Gucci shoes lobbying legislators for their personal gain. (Thank God Hillary chose not to attend the ACEP convention!)

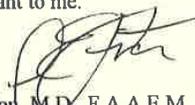
Words of the Phoenix rang in my ears - that it's hard for "us" to give up letters after our names (after all M.D. and D.O. cost 4 years and untold dollars.) And the "F" of F.A.C.E.P. was only a one time payment of \$100 and included an additional four letters free (that's ten years worth of letters!) What else would I get for my \$745 other than the *Annals* (available directly from the publisher for \$65) and a "discount" at the ACEP

convention? The only answer I could come up with after sitting through the ACEP Council meeting in Chicago was that I got a very expensive, swift kick in the rear!

As I considered how many members of the "GROUP MANAGEMENT" section of ACEP would gladly do the above free of charge, sanity prevailed and I tore up the check.

ACEP, please accept my resignation from fellowship in your college. I'll gladly rejoin when I have a vote and can discuss issues important to me.

Sincerely,


Drew E. Fenton, M.D., F.A.A.E.M.
Editor, "COMMON SENSE"



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

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AAEM PAC is the political action committee of the American Academy of Emergency Medicine. Through AAEM PAC, the Academy is able to support legislation and effect change on behalf of its members and with consideration to their unique concerns. Our dedicated efforts will help to improve the overall quality of health care in our country and to improve the lot of all emergency physicians.

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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

April 7-11, 2018

24th Annual AAEM Scientific Assembly – AAEM18
San Diego Marriott Marquis & Marina
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Written Board Review Course
August 14-17, 2018
Orlando, FL
www.aaem.org/education/written-board-review-course

September 15-16, 2018

Fall Pearls of Wisdom Oral Board Review Course
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September 22-23, 2018

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October 3-4, 2018

Fall Pearls of Wisdom Oral Board Review Course
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Jointly Provided Conferences

May 11, 2018

Tennessee Chapter Division – 2018 Updates in EM
Murfreesboro, TN
Jointly provided by TNAAEM
www.aaem.org/membership/chapter-divisions/tnaaem

AAEM Recommended Conferences

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American College of Medical Toxicology 2018 Annual Meeting
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http://www.acmt.net/2018_Annual_Scientific_Meeting.html

April 20-22, 2018

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May 4-6, 2018

The Difficult Airway Course: Emergency™
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May 15-18, 2018

SAEM18
Indianapolis, IN
www.saem.org/annual-meeting

June 5-9, 2018

ICEM 2018 Conference
Mexico City, Mexico
www.pr-medicaevents.com/congress/icem-2018/

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ACMT's Total Tox Course: Cutting-Edge Toxicology for Emergency Providers
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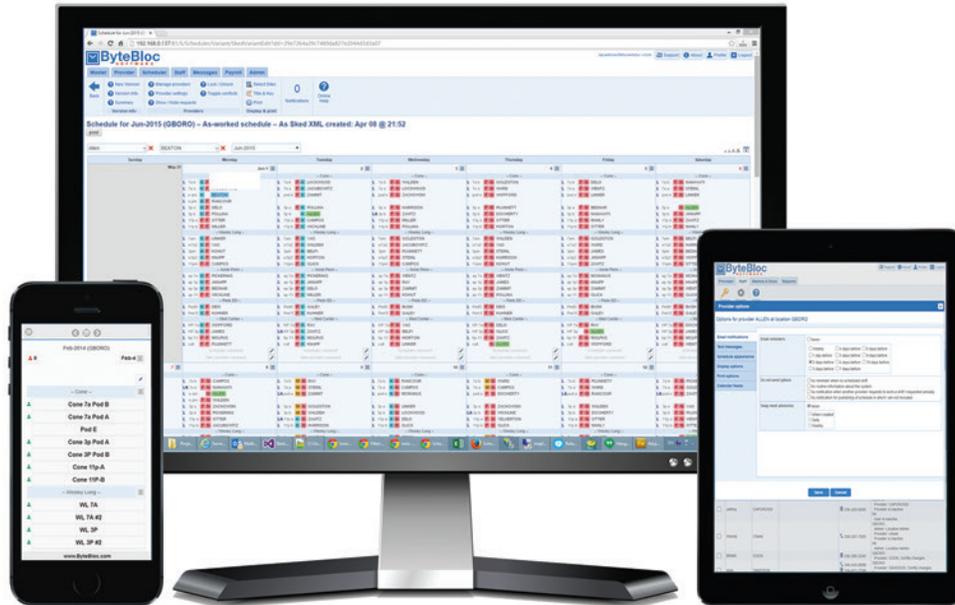
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Thoughts on the Election of a Surgeon to the Presidency of ACEP

Lisa Moreno-Walton, MD MS MSCR FAAEM
AAEM Secretary-Treasurer



In early November, I read with interest the following announcement: "WASHINGTON, Nov. 1, 2017, PRNewswire-USNewswire — The American College of Emergency Physicians (ACEP) today announced that John Rogers, MD FACEP, of Macon, Georgia, was elected president-elect during the organization's annual meeting in Washington, D.C.

He was elected by ACEP's Council to serve a one-year term and will assume ACEP's presidency at next year's meeting in San Diego, California."¹ A few paragraphs down, information about Dr. John Rogers' training was highlighted, followed by a description of ACEP: "Dr. Rogers completed his medical degree at the University of Iowa. He did his residency in the Department of Surgery at Medical Center of Central Georgia (now Mercer University) in Macon ... ACEP is the national medical specialty society representing emergency medicine."¹

Reading the announcement brought back a rush of memories. You see, Dr. Rogers is a surgeon. By AAEM's definition, he is not an emergency physician. When I was a surgeon, I had never heard of AAEM. But the work that went

on in the emergency department was some the work I most liked doing as part of surgery training. When I decided that surgery was not the right fit for me and my family, I took a couple shifts in our hospital's ED. I quickly realized three things. First, I still loved what was going on with surgical patients in the ED. Second, in EM, a doctor is able to use all the skills she learned in medical school: pediatrics, geriatrics, obstetrics, rheumatology, psychiatry; the works. It was stimulating, fun and exciting. You all already know this. But the third thing I realized may not be so obvious. I realized that there was a lot about EM that my surgery residency had not trained me to manage. I found I was presenting many of my medical patients to the EM trained attending, and at one point during the night, she told me, "Lisa, you don't have to present your cases to me. You're here as an attending." But I told her, "I'm not up on the latest literature on how to treat asthma, and I've never thrombolysed anyone. And my idea of reading an EKG is either normal, post-op MI, or call a cardiology consult. I don't know this stuff and I'm not feeling that it's very ethical to learn on the job when patients' lives are at stake." The EP laughed. "Okay," she said. "I'll

help you. Actually, a lot of people think any doctor can do what we do. I'm glad you recognize the fact that we're specialists."

During the following year, I became re-acquainted with the ERAS and the residency interview process. Many interviewers asked me how I thought I would manage with a resident's schedule and a resident's paycheck. I told them that after the 140 hour work week that I put in as a surgery resident (surgery was exempt from duty hours back then), the 80 hour a week schedule would be manageable, but would keep me busy enough that I would not have time to spend much money, and so we would manage just fine. But the most important thing I told them was that I had

fallen in love with EM and that moonlighting in an ED made it very clear to me that nothing short of EM residency could prepare me to be a top notch EP, worthy of the trust that emergency patients place in their doctors. Patients come to the ED unstable and afraid, or stable and worried. For most of them, this is the worst day of their lives, and they deserve to be treated the way that I would want my mother and my children to be treated: by an expert. If I had to bring a family member to the ED, it would be unacceptable for a doctor to have never previously seen some emergency condition, or to have never been

trained to do a particular emergency procedure. I want only the best for my family, and so my patients also deserve only the best. I told my interviewers that my intent was to be one of the very best EP's ever trained, and that I planned to put my heart and soul into residency training.

On Match Day, I was delighted to discover that I had matched at the Jacobi-Montefiore Emergency Medicine Residency Program affiliated with Albert Einstein College of Medicine, my alma mater. I received some of the finest training that is available in EM, and I can confidently say that I kept my word to my interviewers. During the course of my internship year, I found out that our program was a full residency membership program in AAEM. Bob McNamara came to speak at our Wednesday conference, and I was surprised and excited to learn that there were not only other doctors, but a whole society of EP's who felt, as I did, that no one is qualified to practice a specialty that they were not trained to practice. EP's are competent in conscious sedation, but I don't want an EP doing the anesthesia for my daughter's appendectomy. EP's are great at managing

Continued on next page



"The Academy will not compromise on the definition of an emergency physician specialist, on the commitment to fair treatment of EP's, or on the commitment to the rights of our patients. We can be proud every day of standing with the Academy."

bleeding in pregnancy, but I don't want an EP following my sister through her gestation. EP's are great at caring for patients in the early stages of their myocardial infarctions, but I don't want an EP taking my dad to the cath lab. So, why would I want a dermatologist, or an internist, or a surgeon, or a radiologist to manage my family member when she comes to the ED with a medical emergency?

My first few post-residency years went smoothly. I went through those first job interview jitters, the intense learning curve of the first couple of attending years, the awkward but exciting moment of co-signing charts, seeing your name on the attending schedule, and having the residents identify you as the attending in charge. I had always loved teaching, and I had an amazing group of residents at Lincoln Medical and Mental Health Center in the South Bronx. Many, many of them are my friends and colleagues today. I had an amazing group of senior faculty, who mentored me as an educator and a researcher, and I continued to meet with my own residency faculty from Jacobi-Monte, or to seek their advice by email or phone as I grew my academic career. There was nothing I did not love about emergency medicine. I could not have been happier with my life ... until the one day when I had qualified for my FACEP and received my invitation to the ACEP gala dinner at which I would be officially inducted.

When I opened the packet from ACEP, which included a medal on a ribbon that would hang around my neck and a certificate of fellowship, I learned from the enclosed documentation that while it was definitely necessary for a candidate for fellowship to have been paying dues to ACEP for the three years prior to fellowship designation, it was not necessary to be board certified or residency trained. Since the practice track had closed in 1988, prior to my graduation from medical school, this news was shocking. I thought about the fact that doing a residency in EM had been a no-brainer for me. In my mind, it was the only ethical and moral way to become an emergency physician in the U.S. in the twenty-first century. I thought about the fact that I would be standing up to accept my fellowship alongside individuals who believed it was acceptable to treat my family and my patients without the requisite training and to hold themselves out to the public as emergency physicians equal to those of us who had completed EM residency training or had completed the practice track requirements and had met the rigorous requirements of board certification. The realization filled me with a sense of outrage, and I not only cried, I roared with rage. I threw the medal on a ribbon against the wall, breaking a drinking glass and spilling tea all over my desk in the process. I tore the fellowship certificate into shreds while I cried and screamed. I hurled the letter from ACEP into the air. My late husband would have told you that he had rarely seen me like that, and then only when someone close to us had died. He ran into the room to ask me if I was okay. "No", I screamed. "I am not. I am not okay. I sacrificed three years of my life, and so did my family; I gave up a huge amount of money for three years, in order to do the right thing, the ethical thing, the moral thing for my patients, and the College that represents me thinks that what I did has no value, and that anyone who works in an emergency room has the right to call himself an emergency physician." The words of the EP who I worked alongside of the first time I ever did a moonlighting shift in the ED came back to me: "A lot of people think any doctor can do what we do. I'm glad you recognize

the fact that we're specialists." I definitely recognized it. ACEP definitely did not.

Ultimately, my husband convinced me to attend the ACEP gala and be officially inducted. He urged me not to let ACEP steal my joy at what I had accomplished, and to be proud that I had walked the talk, despite the sacrifices that it required not only of me, but of my family. "You'll always know that you did the right thing", he assured me, "and it's important to be able to look yourself in the mirror each morning and know that." But that incident sealed my commitment to AAEM and marked the start of my very active involvement in the Academy, because really, to quote ACEP's announcement of Dr. John Rogers' election, "the national medical specialty society representing emergency medicine" is actually AAEM. The Academy would never try to convince you that a surgeon could represent emergency physicians; could understand the training that residents undergo; could know what it's like to take the ConCERT exam and to do the yearly MOC requirements; could say that he made the sacrifices necessary to do a second residency or to be a founder of the specialty and then submit to the certification process. The Academy understands what the EP said to me all those years ago when I was moonlighting in the ED without EM residency training. The Academy understands that an EP is a specialist, that EM residency training is now essential to the competent and ethical practice of EM. The Academy understands that every patient who presents with an emergency condition deserves to be treated by a specialist in EM. The Academy understands that every single patient, regardless of race, creed, skin color, sexual orientation, age, gender and gender identification, socioeconomic status, insurance status, co-morbidities, profession, family history, place of residence, or anything else you can think of deserves only the best emergency care possible, delivered by a specialty trained emergency physician. The Academy understands that every patient should get the care that each of us wants and expects for our parents, our children, our partners and ourselves. The Academy will not compromise on the definition of an emergency physician specialist, on the commitment to fair treatment of EP's, or on the commitment to the rights of our patients. We can be proud every day of standing with the Academy. While many of our colleagues in ACEP expressed surprise that their new president-elect is not nor ever has been board certified in EM; with the Academy, you get no surprises. We are transparent and we are true to our word. We walk the talk, and really, if you don't, then it's just talk.

Note: This article is dedicated to Dr. Kevin Rodgers. We were having dinner during the ACEP meeting in Washington, and I shared some of this content with him as we discussed Dr. John Rogers' election and the fact that many ACEP members were not aware that he was not board certified in EM. Kevin urged me to write this for *Common Sense*. One of our last interactions was his text to me, urging me not to neglect to do this article. Like the great educator and mentor that he was, Kevin's influence on us and our specialty will continue. ●

Reference

1. <http://newsroom.acep.org/2017-11-01-ACEP-Elects-Dr-John-Rogers-as-President-Elect>

Where Would EM be Without AAEM?

Robert McNamara, MD MAAEM FAAEM
AAEM Past President



As one of those who in 1993 helped write the AAEM mission statement in a pizza shop in Las Vegas as well as an upfront observer of the specialty since, I want to voice my opinion of where EM probably would be if AAEM had not come into existence. I believe the specialty and the bedside physician have benefited immensely from the creation of AAEM. Necessarily, one must discuss the ACEP to see where our presence made a difference as we formed because of their perceived shortcomings. Clearly, ACEP continues to do much for the specialty but this piece is to examine where EM may have gone without AAEM. Below are several items which I believe we can make a very compelling case for:

Board certification in EM would have been severely devalued and FACEP would have been routinely given to non-board certified physicians. If you look at the Council resolutions from the early '90s, ACEP was on the path to open-up FACEP to non-board physicians and the main reason it did not do so was the threat of a major membership loss to AAEM. The AAEM has been the standard bearer for EM board certification and continues to be so. Do you really think EM could trust ACEP to do this job knowing they just elected a non-certified EM physician to be their 50th president? As an academic, this was the key issue that drove me to be part of AAEM, fortunately ACEP moved in our direction.

Continued open membership in the largest EM professional society to non-certified EM physicians. Again AAEM forced this issue by the threat of membership loss. AAEM grew rapidly because we criticized ACEP's membership policies. Without us there would have been no need to shut off this revenue stream.

Unchecked corporate growth. No one would be speaking for, let alone acting to promote, physician ownership of EM practices if not for AAEM. ACEP has continued to point to its "Anti-Trust" policy as a justification for why it must remain silent (despite abundant evidence that the AMA, TMA, and CMA have no qualms about fighting corporate medicine). Yes, the wave of consolidation and growth of the big players fueled by the sell out by senior physicians of their groups has been disheartening. However, think where we would be with no AAEM for an independent group to turn to for help. Besides the new AAEM Physician Group, we have helped countless physician owned groups remain intact through direct advocacy and actions.

Large hospital systems taking over their EDs with their own contract management group and destroying independent practice in the name of profit while relegating us to employed status. You only have to look at the Catholic Healthcare West (now Dignity) matter on the west coast to realize what could have happened. AAEM took a stand while ACEP saw this as a "private business matter." If CHW got away with this it would have been open season on EM among hospital chains of all types.

A future generation of EM physicians would have had no idea of the benefits of true physician partnerships, the ideal form of practice.

No one was speaking about this to EM residents and practitioners until AAEM came into being. In fact, just the opposite message was being sent out. In the December 1997 "Future of EM" issue of the *Annals of EM* two articles by corporate types said our future was with the big groups. The entire issue had no mention of the benefit to physicians being owners. Graduating residents would have been permanently relegated to sheep status.

Individual EM physicians with nowhere to turn when fired or threatened for speaking up about the quality of care, poor staffing, ethical violations and the like. Still today the only professional society who offers direct support including financial and legal support in such matters is the AAEM.

"AAEM was founded to support the individual board certified physician and it pleases me to no end that this is still the guiding principle of the organization."



Drafters of the AAEM mission statement on April 30, 1993 at the Excalibur Hotel in Las Vegas.

Likely inclusion of advanced practice providers as ACEP members.

This was on the table in 1994-5; the executive director, Colin Rorrie, called for ACEP to reconsider its stance as a "traditional physician organization." ACEP already had and continues to have a close alliance with SEMPA (The Society of EM Physician Assistants) housing them in their TX headquarters. Today we see the AMA and all types of physicians fighting the push for independent practice by APPs. EM would have been in no position to be part of this opposition had this happened (the aforementioned cozy relationship weakens us as it is).

Higher dues and more costly meetings. Say what you want but competition is still the American way, two professional societies competing for your dues dollars is better for the bedside doc. The conferences

Continued on next page

themselves have become much better through competition which each group trying to stay a step ahead of the other group.

There is much more that can be said like AAEM's role in promoting the growth of EM in Europe and elsewhere but I will end it here with this

simple observation: AAEM was founded to support the individual board certified physician and it pleases me to no end that this is still the guiding principle of the organization. Thank you for your membership. Let us keep going forward to support our colleagues. ●

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Change Healthcare	511	PEPID	312-314
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Dollars & Sense

Highlights from 2017 Physician Compensation Reports

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



Over the last month I've looked at a few physician compensation reports from 2017. I think it is useful to examine these and reflect on two things. First, despite all of the headaches associated with our profession, we are lucky to be as well compensated as we currently are. Second, recognize that unless you really screw up you'll never be out of a job for very long. In other words, as a physician you have tremendous personal capital and earning power, which should allow you to take extra risk with your investments if you have the risk tolerance for it.

Here are the highlights of these compensation reports.

Barbara Katz's 2017-18 compensation report was published in the October ACEP newsletter and noted the following:

- In the past 10 years, emergency physician salaries have increased 31 percent while the average clinical hours worked (1,632 hours per year) have gone down 12 percent. I think most physicians would be surprised by this. Does this represent a greater focus on lifestyle by the younger generation? I would guess so.
- The national average wage is approximately \$200 per hour.
- Large sign-on bonuses are being offered, with some up to \$100,000.
- There is great variability in compensation between states and regions, with more popular areas having lower compensation.
- New physicians are not willing to pay buy-ins to join democratic groups, therefore these buy-ins are disappearing.
- Small democratic groups (which historically paid the highest salaries) are disappearing as hospitals bring in larger national groups or bringing the physicians in house as employees. Much to AAEM's dismay, this seems to be the pattern.

Doximity put out their first ever physician compensation report in 2017, based on 36,000 physician responses. I noticed:

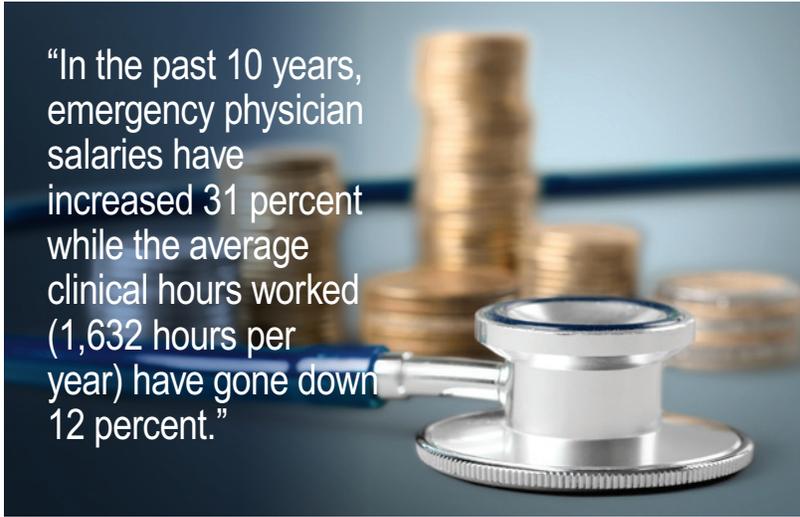
- Across all specialties, the average gender gap among physicians is 26.5 percent less per year, meaning that on average, female doctors make \$91,284 less than what the average male doctor makes. There are significant disparities in compensation between male and female physicians across specialties, metro areas, and all states.
- On average, foreign-trained doctors make 2.5% less than U.S.-trained doctors, a difference of \$8,300 a year.
- The average emergency physician's annual compensation is \$314,000 per year. Pediatric emergency physicians make \$244,000 per year.

The *Medscape EM Physician Compensation Report* is available online in slide format.¹ It is based on 19,270 physician respondents. Reading through the slides, I noticed:

- Average income was \$339,000 per year, a 5% increase from their 2016 data.
- Foreign-trained physicians make 3% less than their U.S.-trained

counterparts (\$340,000 vs. \$330,000 per year), consistent with the Doximity report.

- Self-employed physicians earn \$387,000, much more than their employed colleagues who came in at \$314,000 per year.
- Men earned \$349,000 vs. \$303,000 per year for women. Part-time work was higher among women (26%) than men (17%), which might explain the gender gap in pay.
- Emergency physicians were the highest among all specialties when it came to self-reported fairness of compensation as 68% of us felt fairly compensated. Nephrologists were the lowest at 41%.
- Eight percent of emergency physicians spent 45 hours or less per week seeing patients.
- According to Medscape, bureaucratic tasks are the #1 cause of



"In the past 10 years, emergency physician salaries have increased 31 percent while the average clinical hours worked (1,632 hours per year) have gone down 12 percent."

burnout among physicians. Approximately 56% of physicians from all specialties spent 10+ hours per week on these tasks, while emergency physicians came in well below that percentage. Only 40% reported spending 10+ hours per week on bureaucracy.

- When asked to name the most challenging part of their job, emergency physicians listed dealing with challenging patients and having so many rules/regulations (both at 26%), worrying about lawsuits (16%), and having to work with an electronic health record (15%).

If you'd like to contact me, please email me at jschofer@gmail.com or check out the two blogs I write for, MCCareer.org and 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. ●

Reference

<https://www.medscape.com/slideshow/compensation-2017-emergency-medicine-6008568>

Professionalism and its Implications on our Health Care System

Robert Frolichstein, MD FAAEM
AAEM Board of Directors



Introduction: About two or three years ago a good friend and colleague, Dr. Dale Crockett, MD, and I were talking about what it meant to be a professional. As we chatted we saw how many of the problems in our system seemingly arose from a lack of professionalism. We decided to write an article but life got in the way and we never finished. On July 27th, 2017, Dale died tragically and unexpectedly from undiagnosed coronary artery disease. I finished this article as a tribute to him. He was a professional in every way described below but more importantly Dale Crockett was a good man.

Maybe I should pick a better adjective — like great, tremendous, fantastic. But Goodness is a fruit of the Spirit. There is no better superlative. The Bible defines goodness in Micah as: “To do what is right, to love mercy, and to walk humbly with your God.”

Dale always did what he thought was the right thing. Sometimes what he thought was right was actually wrong like being a Baltimore Orioles fan, but nobody is perfect. I would frequently seek Dale’s opinion on things because of his ability to see through the tangle of circumstances and know and do the right thing. He led his department for many years and would not compromise on his obligation to do the right thing — for the patient, because they are why we are there.

If you have ever heard Dale speaking to a patient and their family, you know he loved mercy. He loved his job — no, not his job, his calling. He believed he was on this earth to help others, and he was thrilled after a shift seeing lots of really sick patients that he could help. Not even a month before he died, I came in as he was leaving, and he was telling me how he had a real emergency medicine shift. You could sense, see the excitement, the feeling of fulfillment, as he described the shift.

He was humble. I don’t ever think I heard him brag — unless it was about the Aggie’s but that wasn’t even very often lately. Sure he bragged about his kids. Don’t we all do that? But humility is more than the opposite of bragging. It is a recognition of our place in this world and yielding to the power and plan of our God. Dale knew what he was — a professional, a healer, a friend, a father, a man to love.

Dale was a good man.

What makes someone a professional? Paid athletes are referred to as professional athletes. It is not uncommon to see ads for a professional plumber or electrician. Are all professionals? Traditionally, there were three professions: divinity, law, and medicine. As society has become more complex, other professions have evolved. Understanding what it means to be a professional is crucial to the role of physicians and especially important to the physician’s role in shaping the health care system.

Definition

Professionalism defies easy definition. Profession comes from the Latin *professio*, meaning to publicly declare. We profess to have the skills and knowledge to care for patients. But we declare much more than this. We also profess to have the altruism and integrity that truly define our profession. Epstein and Humbert craft the following definition:

“Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.” The Medical Professionalism Project published a charter in 2002 that defined three principles of professionalism.

1. **Principle of Primary Patient Welfare**, which states that the medical professional is obligated to put the best interest of the patient before any personal or corporate interest despite any external administrative, financial, or societal pressures.
2. **Principle of Patient Autonomy**, which says we have an obligation to empower patients to make health care choices, and should abide by their decisions as long as they are ethical.
3. **Principle of Social Justice**, which states that physicians should work to eliminate discrimination and promote the wise use of health care resources, acknowledging they are finite. This group also outlined the responsibilities that are listed in Table 1 (next page).

“We need to be involved in our organizations and devote the time and energy to engage in discussions that will improve our organizations and allow them to impact changes within our system.”

Continued on next page



Table 1

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge journals
- Commitment to maintaining trust by managing conflicts of interest CMG
- Commitment to professional responsibilities

In exploring these definitions it becomes clear that physicians are ethically obligated to act within a defined set of values. This obligation arises from a social contract between physicians and society. The social contract between physicians and the public in the United States has largely evolved over the last 125 years. Prior to the late 1800s, while there were certainly medical professionals with state of the art skills for the times, there were also many charlatans and not enough standardization of knowledge to effectively function as a profession. In the early 1900s there was a trend to standardize medical training based on science. This led to the rise of medicine as a respected profession. What occurred over the ensuing years was the evolution of a social contract that defined how the profession would interact with society. As in any contract, each party has expectations and responsibilities. Patients expect to be given the best possible chance at survival and health. They present with an illness or injury and rely on our expertise to relieve suffering and restore health. They expect us to be competent and accountable. They expect us to behave with integrity. In turn, physicians are granted autonomy. We are allowed to see to our own governance, rules, and regulations. We are granted a monopoly, in which we regulate who can practice medicine and under what circumstances. Physicians expect to be trusted. Patients cannot have the knowledge to make good decisions about their disease or its treatment without our advice. They must trust us as we explain their treatment options. Physicians expect patients to make an effort to comply with treatment and make lifestyle choices that promote health. Physicians expect to hold a unique status in society and be compensated appropriately for the work we do. Physicians expect a system that supports our relationship with patients.

Consequences

If we agree that physicians are professionals, there are consequences for how we practice and how the system in which we practice should be designed. The heart of health care is the doctor-patient relationship. This relationship and the resulting change in the patient's health is the "widget" of the health care system. It is what is produced. The whole system should be designed to support this interaction. It is easy to agree that the professional responsibilities outlined in Table 1 should be followed. However, if we look at what is happening around us we see instances where the standards of professionalism are not met. At times, this occurs when physicians themselves make a conscious choice to disregard their responsibilities for self-gain. In many instances, however it is the system that has failed the physician causing them to choose between doing the right thing or complying with the demands of the system.

Commitment to competence. The current standard in the United States for competence is ABMS or AOA board certification in the specialty you practice. There will always be examples of providers providing excellent care without meeting the current standard of competence. In general, however, it is better to have a standard of competence that is fair and met by the vast majority of physicians. Yet, today we have alternative certification bodies developing and growing. In some instances, alternate certifications appear to be an end-around that compromises our professional obligation to competency by allowing physicians a non-standard path to certification that may be less rigorous. If the goal of board certification is to standardize the training necessary to insure competency in a field, then alternate pathways only exist for only a few potential motives. One

would be if our current pathway does not insure the competency of those it certifies. This would mean that the pathways are more rigorous which is not the case. Another reason for the existence of an alternative pathway would be to allow those that do not meet the standards of ABMS/AOA certification a way to claim board certification. Perhaps another reason for the existence of an alternative pathway is to generate profit for the certifying body. Physicians who choose an alternate pathway may be neglecting their obligation to competence but a system designed to support physicians and their pursuit of professionalism would not tolerate an alternate pathway.

Commitment to honesty. This is straightforward. Who is not honest with their patient? We hear of very few instances of dishonesty to patients. However, is it honest to prescribe antibiotics for acute bronchitis or colds? We are not being honest with our patients when we prescribe medications that have been demonstrated to serve no purpose. Our system should support us in our efforts to properly treat patients however the pressure to rapidly see patients and achieve good patient satisfaction scores make it much easier for the physician to prescribe the unnecessary medicine rather than have a meaningful conversation with the patient.

Commitment to patient confidentiality. HIPAA generally prevents physicians from violating patient confidentiality, but we still occasionally hear of social media posts containing protected health information. HIPAA regulations can be confusing, and at times lead to unnecessary restrictions on the exchange of information for patients' benefit. Physicians should embrace the fact that they have a professional responsibility to protect patient confidentiality and be expert at doing so, rather than having laws like HIPAA forced upon us.

Commitment to appropriate relations with patients. The vast majority of physicians do not struggle with inappropriate sexual relationships with patients. However, when we hear of colleagues who fail to uphold this responsibility it is devastating to our profession, as evidenced by the recent case of an academic star in emergency medicine.

Commitment to improving the quality of care. Since the famous article "To Err is Human" was published, most hospital systems have developed programs to enhance quality. Many of those programs are thrust upon us by administrators who seem more focused on meeting poorly designed benchmarks than actual patient safety. Physicians should be leading the

Continued on next page

effort to improve quality and choosing the benchmarks to measure improvement. Instead, we find ourselves frustrated by processes developed by non-physicians who lack the expertise or professional obligation to do the right thing for our patients.

The current debate about Maintenance of Certification (MOC) is justified, but may also reflect a lack of commitment by physicians to improve quality. A system to insure that physicians stay current in their knowledge will improve quality. MOC, in its current form, fails. Most attention on MOC has focused on eliminating it rather than improving it to make it meaningful and less burdensome or developing an entirely new tool to insure ongoing quality.

Commitment to improve access for all. There is much discussion about this topic in the media and political arenas. Most of it centers on access to a means of paying for medical care, rather than actual medical care. The Oregon experiment on expanding Medicaid provided benefits to a randomly selected population. What did not follow was access to health care professionals in the new Medicaid recipients. Most of the care that population received was provided in the emergency departments of Oregon. This is an example of reform led by groups that do not have the professional obligation to do what is best for patients. Physicians need to be involved and indeed lead these discussions to help produce reform that does the right thing for patients and not groups with deep pockets and/or political interest.

On a smaller scale, we ought to look at our own practices and see what we can do to improve access to care. Would patients have shorter waits in the ED if it were staffed differently, perhaps less profitably? Specialists such as ophthalmologists, gastroenterologists, and many others no longer depend upon the hospital. The result is that it is difficult to provide care to patients with emergencies requiring subspecialists. Is it upholding our professional obligation to improve access to care when unfilled call schedules require patients to be transferred, just because a physician won't take call without a stipend that far exceeds the amount of any potential uncompensated care?

Commitment to the just distribution of finite resources. The Choosing Wisely campaign is evidence that physicians have sometimes contributed to the waste that spawned this campaign. There are myriad reasons behind waste, including fear of liability, the quest for speed, and the fears and unrealistic expectations of patients. Physicians need to understand that ordering any test requires a cost/benefit analysis, and the cost side includes more than just financial considerations. Ordering unnecessary test spawns a cycle of over-testing.

Commitment to scientific knowledge. This is one area where physicians do seem to lead the way. Many physicians perform research and publish. However, we know the influence of drug companies and device manufacturers in this area. Physicians should ask the hard questions. Are the right studies being done? Are negative results published? Is it too costly to do research? We must keep in mind that we are the group that has a professional obligation to do what is best for our patients by advancing relevant and unbiased research.

Commitment to maintaining trust by managing conflicts of interests. There is nothing wrong with legitimate profit earned by providing professional medical care. There is a very fine line that has

to be rigorously maintained, however, to prevent profit from becoming the primary motive rather than the patient. Large corporations with lay shareholders employing physicians or running hospitals or clinics need be especially cognizant of this line. In theory an organization can have the welfare of patients as their primary goal and generate profit but the demands of shareholders for ever increasing profit make it unlikely, if not impossible, to continue to place the patients at the center of their organization. We as professionals have to hold them accountable when we see profit being placed above patients and should not endorse them by utilizing their facilities or working for them.

Physicians are obliged to conduct themselves in a professional manner.

“We must fight to maintain professionalism.”

Most physicians went into medicine with some combination of the desire to help people and a love of scientific knowledge. Some may have gone into medicine for the profit motive, but likely very few. Professional obligations are always difficult to uphold, but exceedingly so in a system that fails to support the professional. The current system in the United States does not support the nurses and doctors who care for patients. It has evolved to exploit the relationship between physicians and their patients to generate profit for hospitals, insurance companies, pharmaceutical companies, device manufacturers and contract management groups. The relationship between the patient and the physician must be at the center of any reform that takes place in our health care system. We have an obligation to make the physician-patient relationship and the needs of the patient the driver of all decisions made in our health care system. Many physicians feel they have no ability to promote change in our system. We need to start by understanding our professional obligations and being committed to upholding them. Everyone can do this and the impact will be significant. Our current system does not encourage physician involvement. As a whole, physician professional organizations have been inept at guiding change. Generally speaking, physicians are too independent to go “all in” in support of a single organization or individual to represent them. One thing we can all do is find the organization that is most consistent with our philosophy and support it. Financial support is critical as it takes money for our organizations to be impactful. Financial support is not enough however. We need to be involved in our organizations and devote the time and energy to engage in discussions that will improve our organizations and allow them to impact changes within our system. We must fight to maintain professionalism. In our current system, where profit seems to be the driving force, the best thing for that system would be for physicians to be not held to any standards of professionalism. The system wants us to just do as we are told so they can use us to generate more profit, in essence be highly trained technicians. If we do not stand in the way it will be devastating for our profession and most importantly our patients. Examine your practice, your group, your hospital in light of our professional obligations. Support each other through involvement in local, state and national medical societies. We can and will make a difference and preserve our beloved profession by upholding our standards of professionalism and striving to remodel the system to support rather than exploit the patient-physician relationship. ●

Operations Management Committee

Introducing: The ED Management Solutions Course

Jason Hine, MD FAAEM

Operations Management Committee



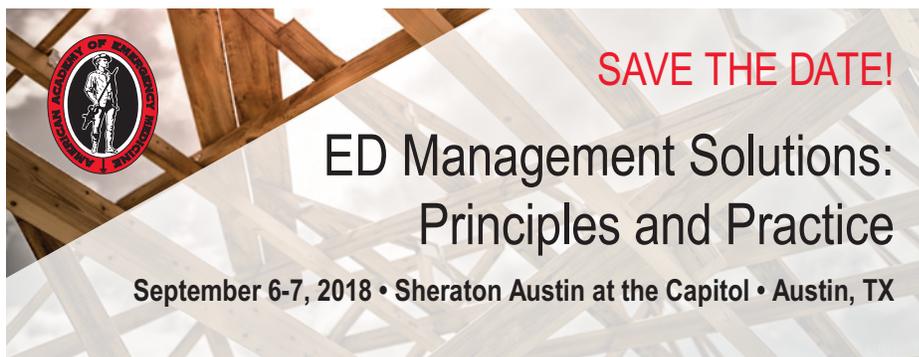
Within the arena of emergency medicine, AAEM carries some unique values, including a steadfast dedication to the clinician. Because of this, the organization has drawn to it some of the nation's most talented and independent thinking physicians. This is no more true than in the area of ED Operations. With corporate medicine and others looking to de-

value and disenfranchise the practicing clinician, the need for operational leaders could not be higher. AAEM proudly holds among its ranks some of the best. We at the Operations Management Committee (OMC) have seen this as an untapped resource. We had the realization that this in-house talent and unique perspective in ED management should be shared with all of AAEM's members. Therefore, some time ago we set out on our goal to offer our members high quality, personalized ED management education with an AAEM spin. From this the ED Management Solutions Course was born.

The ED Management Solutions course is a two-day interactive learning experience for those in the administrative trenches. We at the OMC believe there is a discreet body of knowledge related to running and managing ED's and that this information is often lacking in hospitals. We want to improve the experience of both patients and health care professionals through the dissemination of this knowledge base. That is our goal for this course. Covering topics from physician recruitment, staffing, and retention to patient experience and flow solutions, the course is intended to have something for everyone. The course will progress from a foundation of operational basics on to complex topics, allowing practitioners from a wide range of backgrounds and experiences to expand their skillset.

While the course will have AAEM's best educators leading presentations and lectures, the Operations Management Committee is aware that ED management is not all articles, theories, and formulas. Part of it is problem solving, teamwork, and having a place to turn with questions. This is why multiple modes of learning will be incorporated. With the small group discussions, our hope is the course not only offers a fantastic educational

experience but also serves as a venue for networking and finding like-minded practitioners and ED leaders. After completion, enrollees will also have at their disposal the collective mind of the Operations Management Committee, course's educators, as well as other learners through discussion boards and optional listservs. As we venture into this new area of educational offerings through AAEM, we expect further expansion of this course, planned development of graduate networks, as well as resource and reference libraries.



Where is all of this action going to happen? The great city of Austin, Texas will be our host for this first in AAEM's educational history. That's right, the city known for keeping it weird will graciously be opening her arms to embrace the ED Management Solutions course as we break new ground for AAEM. Slotted for Thursday, September 6th and Friday, September 7th, 2018; after completion, course attendees can return home to enjoy their weekend or take advantage of Austin's average temperature in the 80s to enjoy time with family or friends.

As you can see, in planning this course we started with the question "what do our members want from an ED management course?" and built things from there. We are very excited with the outcome. Most of all, we are happy to bring AAEM's powerhouse management faculty to our members. After all, we have all chosen AAEM for its morals and merits, and we at the Operations Management Committee hope this course offers its attendees the knowledge and know-how to implement operational solutions that hold true to AAEM values. ●

Wellness Committee

Late Career Resiliency: Is it Time to Make a Change?

David Lawhorn, MD MAAEM FAAEM



I always considered myself one who was born to be an “ER” physician. Throughout my career I would routinely go home energized at the end of the day rather than run down. There was something almost invigorating about the chaos. Not that there weren’t some difficult days, but I loved what I did. Then about five or six years ago, I rather suddenly realized that I somehow had gotten to be the old guy in my group — by at least eight to 10 years. I wasn’t quite able to bounce back from the shift changes. I was getting physically and mentally tired. I had helped start our democratic independent group and happily held the banner for all that AAEM stands for. That meant doing my fair share of all the shifts and nights. And I didn’t know how to comfortably say no.



I was very tired the morning I was heading into a shift. For the first time in my career I had become a little apprehensive about drinking from the fire hose onslaught of patients that was the daily experience in the ED. As I pulled into the parking lot my phone rang. I let it go

to message as I didn’t immediately recognize the number. Then I heard the voice of the son of my dearest lifelong friend who, simply said, “Call Mom, please. Something has happened to Dad.”

My friend and old college roommate, Rick, had died suddenly from complications of a surgery that I didn’t even know he was going in to have.

I am quite sure that I frightened my bright young superstar female colleague a little while later after picking up a chart, turning towards her, and breaking down in tears saying, “I don’t think I can do this today.” Like those of us who were born to do emergency medicine, I did indeed finish my shift. But that day was a turning point.

Physical fatigue and depression began to take a toll. Burnout had unexpectedly become very real for me.

I chose to embark on a journey of recovery. Here is what I did and it has made all the difference for me.

1. I took a break from work. This seems like an obvious choice. But in talking with many of my colleagues during and since this time it is not a choice that can easily be made for many. I never thought I would experience burnout — ever! Thus, I never really thought or planned for the possibility of **NEEDING** to take a break. How do you do that in EM? It does take a bit of preplanning — especially financial planning. For me, I was lucky to be able to consider being able to take off for two, three, or even six months without significant financial stress. Also fortunately for me, I was a partner in an exceptionally great independent group and could have the legitimate discussion about taking a break or sabbatical of sorts. They were very

understanding and supportive. The sabbatical concept should be incorporated into every business model of ED practice these days.

2. I visited my personal doctor. I had a routine upcoming physical exam so I looked forward to talking with my physician as a patient. At the end of our office visit I asked him if there was someone I could talk to professionally in psychiatry or psychology to help me sort through my feelings, grief, depression, burnout, whatever you want to call it. This was perhaps the best single decision I made. I would strongly encourage anyone experiencing some burnout to take the advice you often give to others — seek professional help.
3. I spent more time with good friends and good people.
4. When I felt like I wanted to test the waters of getting back into the ED environment, I eased into it. Rather than go back on the shifts at our big busy hospital, I opted to start to pick up some shifts at a small critical access hospital. I found out three things quickly. **First** I still love what I do. **Second**, decades of experience and training allowed me to provide great and needed care to a very underserved population which gave me more meaning in my work. **Third**, I enjoyed more time to be able to spend with my patients, the nurses, and everyone else who worked in the hospital.
5. I learned how to become more comfortable saying “no” in order to protect my time.
6. I quickly realized that even though my income was notably less than when I was working at the big busy community hospital ED, I was still making a good income and able to enjoy life much more.
7. Finally, my wife and I decided to take an adventure and experience more of this life while we still can. I chose to take a completely new job in a part of the world I had never spent time. It had to be beautiful. It had to be a slower pace. And it had to bring inspiration daily through doing something meaningful with my skills. My wife and I decided to commit to a three year adventure. We ended up in a very rural part of northern Idaho where I now provide care in small critical access hospital.

I definitely feel as if I have renewed my interest and found more meaning in what I do in medicine. I feel more appreciated than ever in my career in this small town. Life in general is much more fun than it was a few years ago. I recognize that not everyone experiencing fatigue or burnout is in a position **to make the choices I did**. I believe, **however**, that you can choose a pathway to extend your career. **I believe you can bring meaning and joy back into the practice of emergency medicine**, but you **might have to have the courage to embrace change.** ●

“What the caterpillar calls the end of the world, the master calls a butterfly.”

Richard David Bach

International Committee

AAEM International Scholarship Program – Recipient Highlight

AAEM has a long history of involvement in international emergency medicine through conferences, committees and the operation of the AAEM Scientific Assembly. In recent years, AAEM had partially or fully funded multiple international EM physicians for participation in AAEM Scientific Assembly through an international scholarship program. The objective of this program is to aid development of liaisons and fostering of opportunities for exchange of information, education, and ideas with international EM societies and organizations. The program is administered by the International Committee and participants are invited to apply. Applications are reviewed by committee members and applicants are ranked by several factors including the strength of their resume and potential to promote emergency medicine in their country of origin.

— Ashely Bean, MD FAAEM, Chair, International Committee

What Happened in Vegas, Didn't Stay In Vegas!

Dorota Rutkowska, MD – Poland

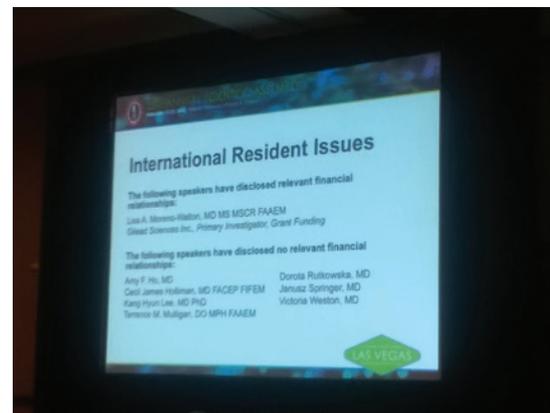
2016 AAEM International Scholarship Recipient

“What happens in Vegas, stays in Vegas”. This popular saying connected to “Sin City” does not apply to my experience in Las Vegas. I returned to Poland energized and inspired by the conference, its many dynamic lectures, and the medical professionals I had the pleasure of meeting there. What happened to me in Vegas, didn't stay in Vegas. I brought home many great experiences that I use as a source of inspiration in my professional life even to this day. As a young EM physician from a country where emergency medicine is still a relatively new and developing specialty, I am always eager to discover new professional resources. Exposure to world class teachers, establishing a dialogue with my fellow American residents, and experiencing new teaching/learning techniques are all examples of what didn't stay in Vegas, and was brought to Poland.

In 2016, as a recipient of an AAEM international scholarship, I had the opportunity to attend the 22nd Annual Scientific Assembly in Las Vegas. Together with my colleague, we actively participated as panelists in the “International Resident Issues” track of the conference. It included two panel discussions regarding “Global Emergency Medicine Residents Working Conditions” as well as “Global Emergency Medicine Student, Residents, and Trainee Associations Around the World.” The conference organizers requested that I give a presentation regarding the status and training of emergency medicine residents in Poland. My presentation

at this conference allowed me to take a big step in my professional life because this was my first opportunity to present at such a high level international conference. Although I was nervous, it was a great first step that opened a new path for me which gave me the confidence to present at further conferences that I continue to do up to this day. It was a step that I knew I had to take.

Currently, I am in my fifth and final year of the emergency medicine residency in Bydgoszcz, Poland. Although emergency medicine was established as a primary specialty in my country in 1999, there are still many issues, including organization of the specialty and quality of the educational system, that still require some serious improvements. Wanting to be an active participant in this process I joined the Polish Society for Emergency Medicine, and in 2016 I became the chair of the newly formed Young Doctors Section. Since this is a completely new section of the Polish Society for Emergency Medicine, we had to formulize our section's structure, goals and the methods of achieving them. In Las Vegas, the opportunity to attend the Resident and Student Association Board of Directors Meeting, offered me the chance to observe the operation of an established organization similar to the organization we have recently formed in Poland. Our question and answer period with our American col-



leagues proved to be very helpful, in order to further develop our section here in Poland.

Along with my emergency room duties, I am currently teaching medical students in both the Polish and the English divisions of the medical school. Many aspects of the conference inspired me to develop new approaches to teaching which are still relatively new to Poland. For example, attending the lecture of Mike Winters, MD, an internationally recognized medical educator, opened my eyes to what a lecture can be. In Poland, lectures tend to be about giving information, period. Dr. Winters showed me that a lecture should also be interesting, enjoyable, and even entertaining! Since the conference, my aim is to constantly improve my lectures. My goal is to keep my students informed, motivated, eager and

Continued on next page

involved. Dr. Winters and others at the conference made me realize the importance of being a dynamic lecturer. Another part of the conference that I want to talk about was the keynote address by Dr. Joe Lex. His history in the development of Polish emergency medicine is well known in my country. Prior to his retirement, Dr. Lex was a frequent lecturer at annual conferences organized by the Polish Society for Emergency Medicine. His history in Poland made him a role model and mentor for many in the Polish medical community. Due to his Polish connection, it was even more special for me to attend his final lecture in person.

I felt welcomed by my American colleagues at the conference as a medical professional. But let's face facts, this is America, this is Vegas ... and being in Vegas is fun! When our daily lectures ended, it was great fun to socialize with my colleagues in more informal settings. It was a pleasure to learn about their lives outside of medicine, while enjoying the entertainment offered by the city. I did even get my first taste of gambling by playing craps ... fortunately, I left the table on a positive note and with a smile!

By attending the AAEM 22nd Annual Assembly I had experiences that continue to influence me up to today, both professionally and socially. I know these influences will continue to affect me into the future. Although there have been a great many changes over the last few years, Poland is still a very conservative country. This conservatism is reflected in our medical training, teaching techniques that are used, and in the medical community in general. Exposure to this type of conference stimulates a new way of thinking, and helps to trigger discussions about further needed changes. I know from personal experience that has happen to me. I welcome new ideas which I hope to use to address the specific challenges here in Poland. I look forward to sharing these ideas with my colleagues, and especially with my students.

Dorota Rutkowska, MD
 Collegium Medicum in Bydgoszcz, Poland
 Nicolaus Copernicus University in Torun, Poland ●

AAEM/RSA Podcasts – Subscribe Today!



This podcast series presents leaders from emergency medicine speaking with residents and students to share their knowledge on a variety of topics. Don't miss an episode - subscribe today!



- Steps to Building a Career in Emergency Medicine
- Niches in EM
- Physician Suicide
- Wilderness Medicine Fellowships
- Ultrasound Fellowships
- Administration Fellowships
- Caring for the Acutely Psychotic in the ED, Psychosis or Not?
- Psychiatry in the Emergency Department
- FOAM at the Bedside
- Developing International Residency Programs
- Global Emergency Medicine Development
- Significance of Completing a Residency Rotation Abroad
- RSA Advocacy Opportunities
- RSA Advocacy
- Corporate Practice of Emergency Medicine
- FemInEM
- American Board of Emergency Medicine (ABEM)
- How to Match in EM
- How to Excel on your EM Clerkship

**TOPICS
INCLUDE:**



Dear AAEM Member,

Enclosed are the candidate statements for the 2018 AAEM board of directors election.

As you are aware, the call for nominations was sent to all voting members. Those AAEM members who appear on the enclosed ballot have indicated their willingness to serve on the AAEM board.



Statements from each of the candidates full listing of previous board service and awards, and AAEM activities dating back five years (2013 and greater) are on the following pages. Please review the enclosed information, then exercise your democratic right to vote for the representatives you would like to see serve as AAEM's leaders. Remember, we have a one member, one vote system, so your voice counts. Please follow these instructions for casting your ballot in the 2018 election.

If You Will Attend the Scientific Assembly:

- ***We recommend that you do not complete your official ballot at this time.*** There will be a Candidates' Forum held during the Scientific Assembly on April 8, 2018, 3:00pm-4:00pm where you can hear the candidates respond to direct questions from the voting membership. You will be asked to submit your ballot online at the conclusion of that Forum.
- ***If certain of your choices or unsure if you will attend the Forum,*** you may vote online at www.aaem.org/elections. Voting will remain open until April 8, 2018 at 11:59pm PT.

If You Are Unable to Attend the Scientific Assembly:

- You may complete your official ballot online at www.aaem.org/elections. Online voting will remain open until April 8, 2018 at 11:59pm PT.

Balloting Procedure for 2018:

- ***Voting ballots will only be available online.***
Please visit www.aaem.org/elections to cast your vote electronically.

Thank you for your continued support of AAEM. Please call 800-884-2236 with any questions you may have regarding the election procedure.

Sincerely,

Kay Whalen
Executive Director

www.aaem.org/elections



Lisa A. Moreno-Walton, MD MS MSCR FAAEM

Candidate for President-Elect

Nominated by: David Farcy, MD FAAEM FACEP FCCM; Mark Reiter, MD MBA FAAEM; Judith E. Tintinalli, MD MS FAAEM

Membership: 2001-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors 2015-2018
 AAEM Foundation Board of Directors 2015-2018
 Academic Affairs Committee 2013-2015
 Diversity and Inclusion Committee Board Liaison 2016-2018
 Education Committee 2010-2018
 International Conference Committee Board Liaison 2017-2018
 Learning Management System Task Force 2014-2015
 Scientific Assembly Planning Sub-Committee 2014-2015
 Women in Emergency Medicine Committee Board Liaison 2015
 Women in Emergency Medicine Committee 2014-2018
 Mediterranean Emergency Medicine Congress Executive Chair 2017
 Mediterranean Emergency Medicine Congress Scientific Committee 2015, 2017
 Mediterranean Emergency Medicine Congress Steering Committee 2015, 2017

Mediterranean Emergency Medicine Congress Speaker 2011, 2013, 2015, 2017
 Mediterranean Emergency Medicine Congress Abstract Chair 2015, Judge 2011, 2017
 Mediterranean Emergency Medicine Congress Clinical Case Competition Organizer 2015
 Scientific Assembly Speaker 2014-2018
 Scientific Assembly Abstract Judge 2014, 2015
 Scientific Assembly Diagnostic Case Competition Judge 2014
 Scientific Assembly Open Mic Judge 2014
 AAEM & AAEM/RSA Residency Visit Speaker 2015-2018
Common Sense Author 2017-2018
 AAEM and AAEM/RSA Podcast Contributor 2016, 2017

It has been my pleasure to serve the Academy in many capacities over the years I have been a member. My most recent service has been on the Board of Directors, and on the Executive Board as your Secretary-Treasurer. And I am excited to be a candidate for President-Elect.

During my years on the Board, Mark Reiter, Kevin Rodgers, David Farcy and I have established a close relationship focused on maintaining the integrity of the Academy's mission and being true to the Mission Statement while moving the Academy's brand forward to reflect the practice of emergency medicine in the 21st century. Our leadership as your Executive Board has resulted in the formation of a robust Women in EM Committee which has not only resulted in an increase in women active in the Academy, but an increase in women on the Board and an increased presence of women's issues at Scientific Assembly. More recently, we have established a Diversity and Inclusion Committee, which has resulted in new members joining AAEM, and members who lapsed because they believed we lacked relevance have re-joined. Last year, I initiated a Memorandum of Understanding with the American College of Medical Toxicology (ACMT), resulting in AAEM and RSA presenting Diversity and Inclusion activities at ACMT's annual meeting in Puerto Rico. Currently, I am collaborating with National Medical Association, the largest organization of Black physicians in the world, to develop a mentorship program at traditionally Black medical colleges, none of which have EM residency programs. As your Executive Board, we hired a full time Social Media staff person, and supported the development of a Social Media Task Force and the re-branding of our logo and slogan under the able leadership of Dr. Healy. We have added the Mediterranean Academy and AAEM-India as full chapters of the Academy, furthering our diversification and global reach. I recently served as Executive Chair of the most diverse and inclusive MEMC that AAEM ever sponsored, bringing new voices from all over the globe to share their knowledge, and experience what AAEM is about.

In the current climate of corporate practice of EM and alternative boards, when major EM organizations not only fail to take a stand against but actually support corporate practice and restrictive covenants, and elect non-EM boarded physicians to their leadership, the Academy stands alone in supporting the rights of emergency physicians and our patients. Mark, Kevin, David and I have done outstanding work together to support that Mission and insure that the Academy keeps pace with current practice issues. I ask you to support my election to the position of President-Elect. While we will miss Kevin's mentorship, I am confident that the current Executive Board can continue the incredible work that we have done together. If you honor me by electing me as the Academy's first woman and second ethnic minority President, I will serve you with dedication to the Academy's mission, passion for insuring that we remain relevant to the current practice climate, and unwavering integrity.



Jonathan S. Jones, MD FAAEM

Candidate for Secretary-Treasurer

Nominated by: David Farcy, MD FAAEM FACEP FCCM; Lisa Moreno-Walton, MD MS MSCR FAAEM; Mark Reiter, MD MBA FAAEM

Membership: 2009-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors 2016-2018
 AAEM Board of Directors YPS Director 2015-2016
 AAEM Foundation Board of Directors 2015-2018
 Young Physicians Section Vice President 2014-2015
 Young Physicians Section Board of Directors 2013-2014
 AAEM/RSA Program Director of the Year Award 2017
 AAEM/RSA Board Liaison 2017-2018
 Chapter Division Committee 2016-2018
 Content Management System Sub-Committee 2016-2017
 Education Committee 2014-2018
 Oral Board Course Sub-Committee Board Liaison 2016-2018
 Wellness Committee Board Liaison 2016-2018
 Written Board Review Course Sub-Committee Board Liaison 2016

Mediterranean Emergency Medicine Congress Speaker 2015
 Mediterranean Emergency Medicine Congress Abstract Judge 2015
 Pan-Pacific Emergency Medicine Congress Speaker 2014
 Scientific Assembly Planning Subcommittee 2016, 2018
 Scientific Assembly Speaker 2015-2018
 Scientific Assembly Abstract Judge 2015-2018
 Scientific Assembly Open Mic Judge 2013-2014
 Oral Board Review Course Examiner 2011-2017
 AAEM & AAEM/RSA Residency Visit Speaker 2015-2017
 Young Physicians Section Mentoring Program 2013-2015
Common Sense Assistant Editor 2013-2018
Common Sense Author 2013-2015
 AAEM/RSA Podcast Contributor 2017

To excel as an Emergency Physician, I must meet four needs. First, I must continually educate myself about new and better ways to care for patients. Second, I need to personally stay healthy, both physically and mentally. Third, regardless of my exact employment type, I need to work with colleagues and a group who understand, value, and support true emergency medicine and emergency physicians. Finally, I need policy makers, on the state and national level, to understand the unique challenges facing doctors and patients in the ED.

The primary purpose of professional organizations, such as AAEM should be to meet member needs. I joined AAEM because I knew the type of medicine I wanted to practice and knew that this was under threat. Specifically, what first drew my interest to the Academy wasn't due process, employment concerns, education, or any single issue. It was the first point of AAEM's mission statement: Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.

As simple as that statement sounds, it is incredibly powerful. It addresses every one of my needs as an emergency physician. I chose to be an active member and then to serve on the Board of Directors in order to help AAEM meet this mission.

I am running for Secretary-Treasurer because a strong financial foundation is essential for AAEM to continue to fulfill its mission. Thanks to previous leadership, the Academy is in good financial shape, but there are threats. One significant threat is slowing of membership growth.

Thanks to growth in the specialty, more EM physicians are in training than ever. So why has AAEM membership been mostly flat?

RSA has done an excellent job increasing resident membership and is the premiere EM resident organization. But many residents do not continue membership once they graduate. We must engage more with RSA and YPS to find ways to retain these graduating residents as members.

Despite AAEM's compelling message, it is either not reaching or not resonating with many EPs. AAEM's missions should never change, but we do need to update our message. While local, democratic groups remain the ideal working environment, the reality is that the majority of EPs work for national mega-groups or are employed by hospitals or academic centers. These physicians are in greatest need of AAEM advocacy, but are least likely to be members. The Academy should aggressively seek out these physicians and communicate why they should join the Academy.

Efforts to end the corporate practice of medicine must continue, but we also need to increase our efforts to protect physicians forced to work in difficult practice environments. We must continue to assist EPs with the formation of independent democratic groups.

I've gained valuable experience working in both academics and private practice. Working on the board, and specifically with YPS and RSA has provided insight to the needs of our members. I am dedicated to AAEM and prepared to help it succeed. Please contact me with any questions: jsjonesmd@gmail.com.



Leslie S. Zun, MD MBA FAAEM

Candidate for Secretary-Treasurer

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM and Mark Reiter, MD MBA FAAEM

Membership: 1993-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors 1998-2002, 2011-2016
 AAEM Foundation Board of Directors 2011-2016
 David K. Wagner Award 2011
 AAEM/RSA Board Liaison 2013
 Academic Affairs Committee Board Liaison 2014-2016
 Academic Affairs Committee 2013-2016
 ACCME Subcommittee 2013-2016
 Education Committee 2013-2018
 Finance Committee 2013-2016
 Independent Practice Support Committee 2013-2018
 Operations Management Committee 2013-2018

Palliative Care Interest Group 2016
 Quality Standards Committee Board Liaison 2015-2016
 Quality Standards Committee Chair 2014-2016
 Inter-American Emergency Medicine Congress Speaker 2014
 Mediterranean Emergency Medicine Congress Speaker 2013, 2015, 2017
 Mediterranean Emergency Medicine Congress Abstract Judge 2015
 Scientific Assembly Speaker 2013-2017
 AAEM & AAEM/RSA Residency Visit Speaker 2012-2015
Common Sense Author 2013-2017
 AAEM/RSA Podcast Contributor 2017

I am running for secretary treasurer of AAEM to continue to serve the members not only to improve our practice environment but also to continue AAEM's quest to raise concern about contract management companies. My desire to serve AAEM has recently been reinforced by a recent unfortunate situation. My department was recently outsourced so I have the first hand experience of being uprooted from my position after being there for many years. This event motivated me to write an article on this experience as the means to help other emergency physicians who are going or may go through the same thing.

I was present at the organizing meeting to start a new organization focused on emergency physicians, the American Academy of Emergency Medicine. I served on the board a few times in the past, participated on multiple AAEM committees and received the Wagner Award for service to emergency medicine. I am residency trained in emergency medicine at the University of Illinois and acquired a MBA from Northwestern University. I am professor and chair of Emergency Medicine at Chicago Medical School and faculty at the University of Chicago's Residency Program in Emergency Medicine. I had the experience to see the emergency department from the other side as the President and CEO of a 250 bed hospital in Chicago.

I want to bring my fervor concerning contract management companies taking over emergency medicine to the members and our board. I want to bring my experience and expertise to ensure that you are represented in the house of medicine. I want to bring my energy to wage a constant battle against unfair labor practices, non-competes and waiving of due process rights. I want to continue our excellent education programs in the US and abroad. I want to ensure that no residency program is ever again put in jeopardy because of a contract management company.

Thank you for your consideration.

Les



Kevin H. Beier, MD FAAEM
Candidate for At-Large Director

Nominated by: David A. Farcy, MD FAAEM FACEP FCCM; Lisa Moreno-Walton, MD MS MSCR FAAEM; Mark Reiter, MD MBA FAAEM

Membership: 1999-2000, 2002, 2005-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors 2009-2011, 2013-2014
AAEM Foundation Board of Directors 2009-2011, 2013-2014
Tennessee Chapter Division Immediate Past President 2008-2009
Tennessee Chapter Division President 2005-2008

Tennessee Chapter Division Board of Directors 2009-2012, 2014-2015
James Keaney Leadership Award Recipient 2008
Government and National Affairs Committee 2012-2017
Scientific Assembly Speaker 2014

I am honored to have been nominated for this position and would like to thank Drs. David Farcy and Mark Reiter for their support and confidence in considering me for the AAEM board. I have been a long-standing member of AAEM, and have previously served on the Board of AAEM, both at the National and State level. I currently serve as the Treasurer of the PAC. I am one of the founding members of the Tennessee Chapter of AAEM and served as the first TN AAEM president. As such I helped lead our Chapter to defeat the efforts to bring back restrictive covenants to the State of TN for emergency physicians. I was instrumental in spearheading the plan to establish a new emergency medicine residency program at Saint Rutherford Hospital in Murfreesboro, TN, which has the largest emergency department in Middle Tennessee and sees approximately 95,000 ED visits a year. I am serving as the Associate Program Director here and I am dedicated to GME and the training of our future generations of emergency physicians.

In my spare time I have a family with four kids, operate a 100 cow beef cattle herd and farm, and enjoy fine wine, traveling, and fishing.

I take the opportunity to serve AAEM as a board member very seriously, and if elected, I will strive to make emergency medicine better for the working emergency physician and our patients.



Ashika Jain, MD FAAEM
Candidate for At-Large Director

Nominated by: David A. Farcy, MD FAAEM FACEP FCCM

Membership: 2015-2018

Disclosure: Nothing to disclose at this time

Critical Care Medicine Section President-Elect 2017-2018
 International Committee 2017-2018
 International Conference Committee 2017-2018
 Inter-American Emergency Medicine Congress Speaker 2016, 2017
 Mediterranean Emergency Medicine Congress Speaker 2017

Mediterranean Emergency Medicine Congress Abstract Review Committee
 2017
Common Sense Author 2017-2018
 AAEM Podcast Contributor 2014

In the last few years I have become significantly more involved in AAEM, more so since becoming ABEM certified. The mission of AAEM aligns with many of my own personal beliefs in emergency care.

I have had the opportunity to travel with AAEM to various countries to participate in international education conferences in Argentina, Costa Rica and Portugal, which has significantly ignited a commitment for EM education projects. As result I have joined the International Committee as well as the International Conference Committee and look forward to becoming more involved in these conversations.

As an EM Trauma Critical Care trained physician, it has been an honor to revitalize the EMCCM section of AAEM. Creating the bylaws and coordinating a sustainable venue for AAEM members interested in critical care has been a true privilege. As President-Elect of the AAEM EM-CCM section, I look forward to fostering dialogue within AAEM and coordinating with other EM-CCM section groups.

AAEM has truly become a home for my emergency medicine interests. Being a part of the board allows me to grow my commitment on the national and international level of emergency medicine care.

Thank you for your consideration.

**Robert P. Lam, MD FAAEM****Candidate for At-Large Director**

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM and Jonathan S. Jones, MD FAAEM

Membership: 2002-2018

Disclosure: Nothing to disclose at this time

Diagnostic Case Competition Award 2016
Wellness Committee, Chair 2016-2018
Wilderness Medicine Interest Group 2015-2016
Social Media Committee 2012-2017
Mediterranean Emergency Medicine Congress Abstract Reviewer 2017

Scientific Assembly Speaker 2017
Oral Board Review Course Examiner 2012-2016
Common Sense Author 2016-2017
Wilderness Medicine Interest Group Photo Competition Winner 2017

I am honored to be nominated to the Board of Directors of AAEM. I have been a member of AAEM since 2002. What makes AAEM unique as a specialty society is the concern for the personal and professional well-being of the individual emergency physician. It is this concern that is the reason that AAEM has been, and will be the specialty society that matters the most to me. In 2016, I saw a need for specialty societies to join in the fight against physician burnout. I helped to start the AAEM Wellness Committee and continue to serve as the chair. With the support of our amazing Wellness Committee colleagues, we strive to: advocate for well-being with positions statements that aim to reduce unnecessary tasks, create experiences that invite members into community, improve resiliency education at the scientific assembly, write articles on resilience in *Common Sense* and the *EM News*, and collaborate with other specialty societies like the National Academy of Medicine that share our goal of physician well-being. If elected to the board, I hope to continue AAEM's vision of looking at the challenges we face through the lens of how every decision will affect the well-being of our colleagues. In this era of corporate medicine and consolidation of health care systems, emergency physicians have become a cog in the wheel. I hope to continue to create intentional gatherings that move us from networking to community to fill this void.

Throughout my career I have had the privilege of working in various practice settings which I believe gives me a unique perspective on the challenges we face as a specialty. My prior employment spans from a single coverage rural safety net hospital, to a member of a health professional union employed by the New Zealand government to my current practice which is a blend of academics and community practice with a democratic group. AAEM cares that corporations desire to make us their servants rather than serving us. Only AAEM stands with us when we face a crisis of losing our democratic practice unfairly. I have witnessed first-hand the depth of care and involvement of AAEM when it came to the aid of our democratic group when we found ourselves forced out by a contract management group. If elected my goal is to advocate for this support to any physician that finds themselves in similar circumstances. I believe that AAEM should also be the professional society that cares for the well-being of physicians that currently work for contract management groups who are particularly vulnerable to abuse and depersonalization that comes from the lack of control from these employment arrangements.

As long as I am given the privilege to represent you, I will continue to try to embrace the vision that AAEM cares about you.



Terrence M. Mulligan, DO MPH FAAEM FIFEM

Candidate for At-Large Director

Nominated by: Howard Blumstein, MD FAAEM; Mark Reiter, MD MBA FAAEM; Larry Weiss, MD JD MAAEM FAAEM

Membership: 2009-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors 2016-2018
 AAEM Foundation Board of Directors 2016-2018
 Amin Kazzi International Emergency Medicine Leadership Award 2015
 Government and National Affairs Committee Board Liaison 2016
 Government and National Affairs Committee 2014-2018
 International Committee Board Liaison 2016-2018
 International Committee Chair 2015-2016
 International Committee Co-Chair 2013-2014
 International Committee 2013-2018
 Inter-American Emergency Medicine Congress Pre-Conference Course
 Director 2014
 Inter-American Emergency Medicine Congress Speaker 2014, 2016, 2017
 Mediterranean Emergency Medicine Congress Executive Committee 2015,
 2017

Mediterranean Emergency Medicine Congress Pre-Conference Course
 Director 2015
 Mediterranean Emergency Medicine Congress Scientific Committee 2015,
 2017
 Mediterranean Emergency Medicine Congress Steering Committee 2015,
 2017
 Mediterranean Emergency Medicine Congress Speaker 2013, 2015, 2017
 Mediterranean Emergency Medicine Congress Abstract Judge 2015
 Pan-Pacific Emergency Medicine Congress Speaker 2014
 Scientific Assembly International Track Chair 2013-2015
 Scientific Assembly Speaker 2015-2017
 Oral Board Review Course Examiner 2015
 AAEM and AAEM/RSA Residency Visits 2017-2018
 Young Physicians Section Mentor 2013-2015
 AAEM/RSA Podcast Contributor 2017

I have had the privilege of serving on the AAEM Board of Directors since 2016, and am running for another term. I've been an active AAEM member since 2004, and have chaired, co-chaired, vice-chaired and been a member of multiple AAEM committees. Since being on the Board of Directors, I was the executive director and co-executive director of 2 highly successful MEMC conferences in Italy and in Portugal. I also developed and ran a one-day AAEM symposium on Health Policy in Washington D.C. as a prelude to our National Advocacy Day. I was instrumental in creating one of AAEM's newest international chapters: AAEM India, and have continued to represent AAEM at multiple residency visits, in Washington DC to our National legislators, and to our many EM colleagues in the USA and internationally.

I am a full clinical professor at the University of Maryland School of Medicine, and the Director of our International Emergency Medicine program. I am also a visiting professor in Cape Town, South Africa, in Kolkata, India, and in Changsha, China. I am double-residency / double-boarded in EM and in neuromusculoskeletal medicine, have completed three subspecialty fellowships in International EM, in Health Policy, and in EM Administration and Management, and have an MPH in Epidemiology and Biostatistics, and an MS in Health Economics, Policy and Law (pending).

I look forward to continuing to serve AAEM: the best organization in emergency medicine, the Champion of the Emergency Physician, and ask for your vote to remain a member-at large of the AAEM Board of Directors.



Andrew Phillips, MD Med FAAEM

Candidate for At-Large Director

Nominated by: Jeffery D. Chien, MD FAAEM; Jonathan S. Jones, MD FAAEM; Joel Schofer, MD MBA CPE FAAEM

Membership: 2011-2018

Disclosure: Nothing to disclose at this time

Critical Care Medicine Section Secretary-Treasurer 2017-2018
Critical Care Medicine Section Board of Directors 2017-2018
AAEM/RSA Board of Directors 2014-2015
Resident of the Year Award 2015
Education Committee 2016-2018
Online Comprehensive Written Board Review Task Force Chair 2016-2018
AAEM/RSA Education Committee 2013-2014
AAEM/RSA Publications Committee 2013-2015

Mediterranean Emergency Medicine Congress Speaker 2017
Mediterranean Emergency Medicine Congress Abstract Reviewer 2017
Scientific Assembly Speaker 2016-2018
Medical Student Ambassador Mentor 2017
Toxicology App Editor 2014-2016
AAEM/RSA Peer Reviewed Blog Editor-in-Chief 2014-2015
Common Sense Author 2014-2015

It's all about the family—the EM family.

I was drawn to AAEM years ago as an intern because I saw a group of people that had a genuine care for our EM community. The extraordinary contributions of individuals—giving their time and money, expecting nothing in return—is the heart of AAEM. A free annual meeting with free CME? Unheard of. A board review book, complete with high quality questions and images for \$50? Unheard of. A group that donates money to help other emergency physicians fallen victim to unjust business practices who aren't even members of their organization? Unheard of. And I jumped straight into the deep end with no regrets.

I am a former junior high teacher, turned emergency physician, intensivist, and medical education researcher. From the beginning, I was encouraged to be creative and contribute my skills to the deep reservoir of AAEM talent. I'm terrible at toxicology, but I know how to make a mobile app. One year later, the AAEM toxicology app was launched, sharing AAEM members' work in a new way that reached more people. I'm not a blogger, but I'm a decent researcher and a section editor for the *Western Journal of Emergency Medicine*. Six months later, the AAEM/RSA blog was transformed into a mentorship-driven, peer-reviewed blog whose success was established by more than tripling readership and publication in *Academic Medicine*, the #1 medical education journal in the world, garnering praise and attention for AAEM and RSA. My latest project is harnessing the RSA, YPS, and AAEM written board preparation materials in a single, evidence-based, online platform that you will hear more about at this year's Scientific Assembly. The teamwork from the more than 20 section editors has been inspiring. And it's the spirit of AAEM members—you—that makes member resources like these available.

That is why I am asking for your vote. I see the most fundamental role of the board as supporting members' ideas and talents to make all of our professional lives better. We've all seen areas for improvement in our professional lives, and we all have talents that can contribute to those areas. Maybe you have a background in art and have ideas for promotional materials. Maybe you're hooked on Facebook and think a group for EM parents and their unique challenges would be helpful. The possibilities are endless. What I do know is that none of us individually have the answers; we as a collective organization do. I am asking for your vote so I can support you, in your support of the EM family, to join ideas and talents with organizational resources.

Thank you for your vote and support.



Thomas R. Tobin, MD MBA FAAEM

Candidate for At-Large Director

Nominated by: David A. Farcy, MD FAAEM FCCM

Membership: 2002-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors 2016-2018
 AAEM Foundation Board of Directors 2016-2018
 Chapter Division Committee 2016-2017
 Independent Practice Support Committee Board Liaison 2017

Independent Practice Support Committee Chair 2015-2016
 Wilderness Medicine Interest Group Board Liaison 2016-2017
 AAEM Residency Visit Speaker 2016-2017

I currently practice clinically in Washington State. I returned to my home state after completing medical school at Albany Medical College in New York and EM Residency at University of Pittsburgh in Pennsylvania.

I have been working on the AAEM BOD for the past two years. I am seeking election to be able to continue my work with AAEM and for all of its members. Being on the BOD and working on behalf of the members has become a deep passion for me. I am driven to protect and improve our specialty and profession.

During my time on the BOD I have been involved in many projects. I have been the chairperson for the Independent Practice Support Committee. I have been working with Society of Immunotherapy for Cancer on behalf of AAEM for the past year. Partnering with them to develop and increase education for physicians on these new breakthrough cancer therapies and the potential complications that EM physicians may see in their patients.

I have done interviews and helped write articles for national publications to further advance the key issues facing AAEM and the membership. I have been very active in Advocacy for AAEM and our specialty at the national and state level; developing relationships with key members of Congress.

There is much work left to be done and I would love to be able to continue that work. These include protecting the importance of Board Certification. In addition, fighting for each of our ability to care for patients without corporate threat or interference. Protecting the ability of each of our patients to have access to emergency medicine care by board certified and trained physicians.

Your vote is important to the democratic process of AAEM. Please vote for me so I may continue to work on your behalf within AAEM.



Jennifer Kanapicki Comer, MD FAAEM

Candidate for YPS Director

Nominated by: Self Nomination

Membership: 2007-2018

Disclosure: Nothing to disclose at this time

AAEM Board of Directors YPS Director 2017-2018
AAEM Foundation Board of Directors 2017-2018
Young Physicians Section Board of Directors Immediate Past President
2015-2016, 2017-2018
Young Physicians Section Board of Directors President 2013-2015,
2016-2017
Young Physicians Section Board of Directors Vice President 2012-2013
Young Physicians Section Board of Directors Secretary-Treasurer
2011-2012
Young Physicians Section Board of Directors 2010-2011
Resident and Student Association Board of Directors 2008-2010
California Chapter Division Board of Directors Vice President 2014-2016
California Chapter Division Board of Directors Secretary 2013-2014,
2016-2017

California Chapter Division Board of Directors 2011-2013
Young Educator of the Year Award 2016
Academic Affairs Committee Board Liaison 2017-2018
Palliative Care Interest Group Board Liaison 2017-2018
Social Media Committee Board Liaison 2017-2018
Chapter Division Committee 2016
Education Committee 2013-2018
Women in Emergency Medicine Committee 2015-2018
California Chapter Division San Francisco Speaker Series, Co-Chair
2013-2015
Scientific Assembly Speaker 2015-2017
Scientific Assembly Open Mic Judge 2015-2017
Young Physicians Section Mentor 2012, 2014-2015
Common Sense Author 2013-2016

I was honored to be able to serve on the AAEM Board of Directors for the past year. During this time I have enjoyed my role as board liaison for Social Media and Academic Affairs, taking part in a very successful lobbying day on the hill and being an advocate for AAEM members. I ask to be re-elected as YPS Director, in order to continue AAEM's mission to improve physician practice environment, provide resources to its members and support to its youngest physicians.

I have been involved with AAEM since my intern year of residency almost ten years ago. Since that time I have been privileged to hold numerous leadership roles within RSA and YPS. I, with the support of AAEM/YPS, have accomplished a lot in the past few years. Our ALiEM-AAEM Social Media and Digital Scholarship produced the very popular multimedia product, AAEM/YPS Rules of the Road. We also launched AAEM/YPS EM Flash Facts, an application used to help our members prepare for the EM boards, help educators teach EM topics to students, and assist learners in reviewing important EM topics portably. On a local level, I serve as the Secretary of CAL/AAEM. This role allows me the opportunity to be the Co-Director of the San Francisco Speaker Series.

Outside of my work with AAEM, I have completed two fellowships and serve as an Assistant Professor at Stanford. I have completed fellowships in both International EM and Medical Education. I have held the title of Assistant Residency Director for the Stanford/Kaiser Residency Program for the past 5 years and am also the Co-Fellowship Director of our Medical Education Scholarship Fellowship. Given my passion for teaching and residents, I look forward to continuing to promote resident education and provide valuable AAEM resources to our young physicians as they make the transition out of residency.

I have served many roles on both RSA and YPS and would be honored to continue my role as YPS Director. If elected, I will continue my endeavor to support young physicians while instilling in them AAEM's values and mission.

Critical Care Medicine Section

Why Play the Waiting Game?

Ashika Jain, MD FAAEM

Critical Care Medicine Section, President-Elect



Let's say you have a patient in the emergency department (ED), who has been coughing and feeling ill.

You note that his triage vital signs are consistent with sepsis, the initial lactate is 4.3 and so you start giving fluids per CMS Sepsis guidelines. Despite giving the required fluids, the blood pressure continues to decline and so you decide you want to give vasoactive medications. At the same time, the nurse

informs you that the IV has infiltrated and despite multiple attempts, another peripheral IV cannot be established. What are your next options?

At the bedside of a critically ill patient, time is of the essence.

There are a few options here. The most popular would be to either use an ultrasound to get a peripheral intravenous line (PIV) and give vasoactive medications peripherally or decide to put in the central venous catheter (CVC).^{1,2,3}

Safety of peripheral vasoactive medication administration has shown to be useful in the appropriate setting, evidence to state the contrary is sparse and opinion based. Based on consensus, vasoactive medication can be administered through PIV access when a 20 gauge or larger PIV is placed in the antecubital fossa or proximal. These are policies, rather guidelines that many institutions have adopted.

Nevertheless, if the patient has poor access and needs multiple medications simultaneously or attempts at ultrasound guided PIV come with no avail, then perhaps the CVC is the optimal choice. Once the decision to place a CVC is made, focus should be on procedure completion and confirmation to minimize time to medication, time to MAP improvement and decrease mortality from persistent hypotension.⁴⁻⁸

Current practice is to place the CVC, with ultrasound guidance, await radiographic confirmation before starting mortality changing medications.⁹⁻¹² Chest radiography confirms catheter location and rules out pneumothorax. In multiple studies, radiographic confirmation can take anywhere from 20 minutes up to one hour, if not longer.

With the advent of point-of-care ultrasound, why wait?

When a CVC is placed with ultrasound guidance, wire confirmation in the vein during placement, and without complication, the use of the "Bubble Test" and anterior chest sonography should be employed for immediate confirmation and use.

Ultrasound has been shown to be more sensitive than supine chest radiography for pneumothorax.¹³⁻¹⁷ With the patient still in position for the CVC, the linear probe should be placed over the anterior surface of the chest wall to evaluate for pleural sliding. For additional confirmation, using M-mode over the pleura can be used to look for "sand on the beach" vs "bar-code" sign for normal vs lack of sliding, respectively.

CVC tip should be in or near the distal superior vena cava. This can be easily confirmed using the "Bubble Test". This can be accomplished with the patient still in position, the subxyphoid view of the heart is obtained using the phased array probe. Either 10cc normal saline flush or agitated saline should be quickly administered via the distal port of the CVC. A "snow storm" of turbulent flow should be seen in the right ventricle in under two seconds from time of administration. This confirmed adequate placement.¹⁸⁻²² Additionally, location of CVC tip may not be as significant for non-caustic infusions (chemotherapeutics, etc.) as previously thought. So long as the CVC tip is near or in the right atrium, superior vena cava, brachiocephalic veins or subclavian vein, short term infusion of medications and fluids is considered safe.²³



While many institutions require chest radiography for confirmation and documentation of CVC placement, utilizing immediate ultrasound can rule out major complications, such as pneumothorax and malposition, allowing for timely medication and fluid administration.

The radiography can still happen, but at least we are not waiting for it.

Ashika Jain, MD FAAEM, Associate Professor, Trauma Critical Care, Emergency Ultrasound. Ronald O Perelman Department of Emergency Medicine, New York University, New York, NY ●

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Women in Emergency Medicine Committee

The Emergency Physician on “Disability” (Maternity Leave)

Anumeha Singh, MD FAAEM
Women in Emergency Medicine Committee

“12 weeks! That is a *long time*.”

That was the first thought I had as my excited friend and fellow emergency physician gushed about our generous maternity benefits. She herself was a mom of two toddlers and on hearing my big announcement was full of helpful advice and upbeat news. She repeatedly said “It will fly by so fast” and I remember thinking that I am *different* and will need major projects to “utilize” this abundance of time. Now, that the end is almost here, I find myself laughing at how naive I was. They say life changes when you have a kid. Well, whoever “they” are, “they” were not kidding.

You cannot blame me for thinking it was a long time, however. What adrenaline driven, high-on-life, ADHD emergency physician would not have that thought on hearing “12 weeks off?” When in your adult life did you get 12 weeks off?

Hence, I made a long list of projects, mainly compromised of non-clinical but professional related work, like CQIS, presentations, etc., that I had been planning, but never gotten around to. You know, the last third of your “to-do” list — the part you never get to. Now all of a sudden this neglected southern section had the position of honor — a time slot dedicated specifically to tackle it. I was all excited to start my “leave” and start working on my projects. This way I would remain productive, and not drive my husband insane. Hmm, everything seemed in order. Excellent!

My upbeat mood and strong grip over my life continued through the last days of my pregnancy *and* through the delivery. My baby, like an obedient intern, was right on time — normal delivery, no complications, no issues. I went into labor right during my last shift and delivered few hours after. Brilliant time management kid! Done like a true emergency physician. So far, so good. She was born precisely at 3:35pm. As my husband likes saying — the precise time my regime ended.

To my bewilderment, the seven pounder snatched my life, days, schedules, lists, and tossed them right into the diaper genie, pretty much the moment she was born. The next two weeks passed in a haze, in a blurred continuity of diaper, feeds, burp, sleep (if you can call 60 minutes stretches that) and reset with a background noise of crying. Actually crying was the good part or else I found myself having this odd compulsion of continuously checking for her breath, *just in case*. You never know with SIDS. During those first two weeks, my tired zombie mind imagined her in all PALS scenarios. Ignorance is bliss and doctors know way too much to experience this bliss ... ever. I had always been the snotty one medically — upturning my nose at people who sought medical care for small cuts, colds, and tummy aches. Keep calm and drink green tea, would be my inner voice advice to half my ED patients for their “ridiculously silly” complaints. Thankfully I always maintained the thin veneer of outward credibility — for this very veneer reflected by my pediatrician must have protected me during my multiple calls for the non-existent “issues” that my baby experienced in my mind. I even sent her a seven minute video of my baby sleeping, while “breathing very loudly” — just to make sure that she didn’t have a congenital laryngeal stenosis, stop scorning, it is an entity — it exists.

After two weeks, she slept for five hours in a stretch! Ask any new parent, and they will tell you that this is an absolutely glorious experience. Like sun peeping out from under the cloudy sky on a “flood warning and thunderstorm” prediction day. Yes, I felt poetic and I felt energized, a little giddy. Almost invincible. I had my life back. Albeit a slightly different life. Maybe like switching to a stick shift. Yes, that’s it. It took a little getting used to but now I was back in control.



“Let us not treat going back to work as soon as you can as an accolade. Let’s not encourage our women and men to continue with their lives as if nothing has changed. For a lot changes.”

I took my list out, a sly smile on my face. I decided to start from the “easier” stuff and do some chart reviews. It felt a little silly, being so excited about chart reviews, but after doing nothing-else-but-baby, chart review seemed a nice little tease. Excited, I pulled up my laptop and opened my home access for EMR. Wait, access denied? Oh well, those silly password requirements. Undeterred, I decided it was time to reset my password to my newborn’s name, anyway. Hmm, not able to reset? Ah, well a call to IT is not as bad as it is made out to be. It’s ok. We had good IT support at our ED. Small setback. Hence, still not deterred, I called up IT, explaining them the issue. The friendly IT personnel asked me to hold on for a minute while he looked up the issue. Sometimes it’s a new trainee and they need to ask their colleagues about simple stuff like password reset. That’s alright. The answer came back, “Ma’am, your access has been denied as you are ‘disabled’.”

Hell hath no fury like a postpartum high on hormone, low on sleep, EP being called disabled. I lost it. Every fiber in me became a warrior and I entered into a high-pitched, fast-paced, angry monologue. A small rational corner of my brain told me in a subdued voice that this was not that particular person’s fault and I should have an adult conversation and find out more as to where this “mistake” is coming from. That small voice was

Continued on next page

ignored pretty much like a second year medical student and I ended my monologue by suggesting the IT person to complete his training before answering calls.

The next half an hour I vented out about the inefficiency of this world in general and that person in particular to my still asleep daughter. After which she had enough and woke up and demanded to be served, distracting me from my rage and changing me to the newly born docile mom avatar. After the next round of burp/feed/diaper I handed her over to her doting and very hands-on father. Half glad that I could not “work,” I sat down and composed a very descriptive email to my Chairman to intervene and take care of this highly preposterous situation.

The next few days went in another blur as my daughter decided that a five hour stretch of sleep was not good for my mental health. By now I was fully adjusted to my stay-at-home-mum role. I was now feeling relieved of having no access to my charts/work communication. There was no point of looking at the list and hence I was spending guilt-free doting mother time, or at times, just pampering myself. Enjoying it. Rather *loving it*. I got *the* email from my chair. I opened it, consoling myself that I had few dreamy days and now I can start some “real” work. Luckily for me God and my hospital had different plans in store. Our hospital had made a new policy where anyone on maternity leave will have no access in any official capacity and will not be allowed to do anything work related for the entire 12 weeks.

Stunned, I just laid down, internalizing the content of the email. Accepting it. Loving it. I looked at my chubster and a calmness took over. A feeling of extreme pleasure and pure joy, no guilt, no hurry-lets-complete-the-list, no strategies to “use” the time to the maximum. Just me and the baby. Just being a mother and recovering and bonding. What an absolute bliss! I cannot explain how grateful I felt. I need not compete with the “other” new moms who are back to work before you know it. I need not pretend that my life is still the same, for by far it was not. I could just enjoy the greatest blessing that life can bestow — the blessing of a new life itself.

The next eight weeks flew by. Now, it’s that time. The time to go back to the “real world.” However, I got these 12 weeks of bliss and struggles of being a new mom, pains and pleasures of breastfeeding, of sleepless nights, of hormonal rages, and maternal joys. Of being *just* a mother and *fully* a mother. To rest and recuperate, to bond and feed, to get used to a new life and my new life.

Having a kid changes your life. It is not an easy change. Don’t let anybody tell you otherwise for “they” were right. You need all the help you can get. You need to be “disabled” from work to be fully “able” in your new self and the new life dependent on you. The struggle will go on for your entire life as you are a parent now and it’s not easy being one.

I go back to work, mostly happy and excited, for emergency medicine is still one of my greatest loves. I go back with a happy soul. I wish all the parents out there get to experience these weeks. At the risk of sounding political, I do wish that we bring in a reform, at least in the emergency medicine world. Let us not treat going back to work as soon as you can as an accolade. Let’s not encourage our women *and men* to continue with their lives as if nothing has changed. For a lot changes. Let’s welcome these changes and bring in a culture of taking as much time as we possibly can. To celebrate and adjust. ●



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A Quick Solution to Finding Time to Teach During a Busy ED Shift: The One-Minute Teacher

Jennifer Kanapicki Comer, MD FAAEM
YPS Director



Finding time to teach during a busy ED shift can be tough. Yet the ED is one of the best areas for teaching. There are diverse patient encounters, you make rapid clinical decisions and then there is the multitude of hands on procedures. However, this amazing teaching environment comes with some barriers. Many educators cite lack of time as the major obstacle to teaching during a shift. We have an

increasing volume of patients (thank you, influenza!). We also have high acuity patients and are constantly getting interrupted.

But there is a solution, one that only takes a minute. The solution gives you a quick recipe for providing feedback during every ED presentation you receive. For faculty this includes presentations from residents, medical students, and APPs. Residents can also use this when supervising junior residents and medical students.

The strategy makes for countless teachable moments throughout a shift and very appreciative learners. I'd like to introduce you to the "One Minute Teacher."

Drs. Neher and Stevens introduced this concept in 1992 in the family medicine literature and now it is a widely accepted teaching model. This model assures that you teach during every patient presentation. It also allows the learner to take ownership of the clinical problem and forces them to assess and manage the patient. For the educator, it allows you to quickly identify any gaps in the learner's knowledge and focus your teaching. Lastly, it's easy to learn: five easy steps.

Step 1: Get a commitment.

The first step is used immediately after the learner has presented. This is your chance to ask a specific question or fall silent. After a learner presents you need to have patience. It's very easy to jump in and give YOUR plan. The ED is busy, you have things to do, but it's unfair to your learner. Let them take ownership of the case. After the presentation, pause. If the learner still doesn't initiate, ask an open-ended question. "What do you think is going on?" or "What do you want to do?" Help bring out their plan. Your objective is to get the learner to process the information they just have collected and apply it. Things not to do: don't take over the case. Don't do the usual: "Okay, sounds good." Let THEM manage the patient.

Step 2: Probe for supporting evidence.

Next step is to find out how the learner got where they did. Explore the learner's "mind map." Why do they think its pneumonia? Listen carefully to the learner's clinical reasoning and look for any deficits in their

knowledge base. Some potential questions might be: "What major findings led you to that conclusion?" or "What else are you considering?" By probing your learner you can lead them to the correct answer.

Sometimes it can be challenging teaching senior residents. This is a time where you might add for your senior learners an additional question: "How would you manage this patient in a rural setting without this hospital's resources? What if this patient was pregnant?" Challenge your senior learners by putting a spin on the case.

Step 3: Teach general rules.

Every case has some teaching value. Remember this is the one-minute teacher so one to two general teaching points will do. Keep it short and sweet which will help your learner remember your take home points.

These can be anything from the case. Explain what SVT looks like, why we give adenosine, how to call an effective cardiology consult, how to manage a difficult/demanding patient. Think of how many patients we see during a shift? Each patient holds at least one teaching point.

Step 4: Reinforce what they did right.

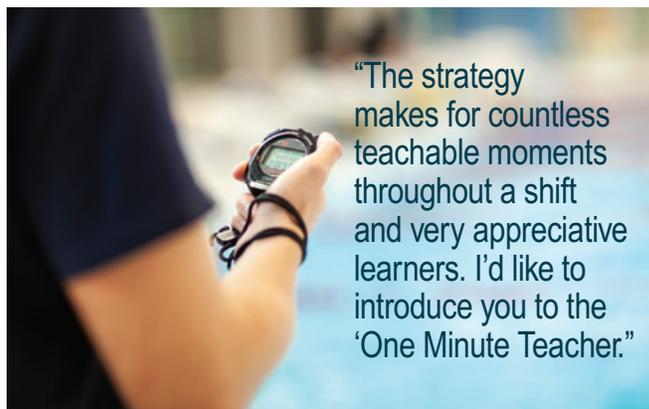
Giving some positive reinforcement builds self-esteem and reduces anxiety. Be their coach. Your goal is to reinforce positive behavior so they keep doing it. Good feedback is descriptive and specific. You don't want to simply

say "Great job" or "Sounds good." A better statement is "You had a very good differential for chest pain. You focused on the emergencies that we would want to rule out." Learners quickly discard feedback without substance.

Step 5: Correct mistakes and discuss next steps.

Now the tough part. Feedback is not always easy to hear. Remember to praise in public and perfect in private. Be well timed. Feedback in real time is often better than waiting for the end of a shift when everyone is looking to go home. Be descriptive and specific. Acknowledge your learner but also correct them. "I agree the patient likely has musculoskeletal chest pain, but we still need to do a careful H&P to rule out any emergencies like ACS." Don't be judgmental or abrasive. Discuss the next steps in care.

That's it, five easy steps to help you face the challenge of finding time to teach. Although the ED is filled with barriers to teaching, **giving feedback helps bad first efforts from becoming bad habits.** We owe it to our learners. Remember, you can make a teaching point out of every case presentation, and by using the one-minute teacher; you can do so quickly and efficiently. Try it out on your next shift. ●



AAEM/RSA President

The Wonder Women of WiEM: Why Do Female Superheroes Still Need Support Organizations?

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



Whether it is Women in EM (WiEM), AWAEM, FeminEM or Shemergency, women in emergency medicine are uniting to advance shared goals, including equal pay and access to leadership opportunities. This comes at a time when women across many disciplines, from Hollywood actors to D.C. politicians, are standing up against inequality.

Women have been undervalued since before they entered the workplace. A *Washington Post* article determined that the value of a homemaker's labor is equivalent to an annual salary of \$96,261.¹ This is not an inconsequential sum, as the United States Census Bureau quotes the median household income as \$55,322.² Meanwhile, a woman with an advanced degree earns \$65,000, which is \$30,000 less than the median income of a man with the same degree.³

Today, the reality is that despite 75% of the health care labor force being women, only 26% of hospital CEOs are women.⁴ Moreover, a 2016 survey of Fortune 500 health care companies showed women make up only 21% of executive roles and 21% of board members.⁴ Men and women are far from equal in the workplace.

It is essential to recognize and overcome the insidious sentiment that opposes true gender equality: fear. For example, one may fear that increased women in leadership roles means that men must lose leadership opportunities. And from a place of fear come falsehoods concerning men being superior leaders to women.

A recent *Critical Care Medicine* Article, "Influence of Gender on the Performance of Cardiopulmonary Rescue Teams," exemplifies this false narrative. This article concludes that female code leaders did not perform as well as male code leaders. A critical care powerhouse team across three specialties from the University of California, San Diego, including emergency medicine's Radhika Sundararajan, MD PhD, wrote a forceful rebuttal. The rebuttal evaluated the study's serious systemic flaws, including the use of medical students with no code experience as code leaders, and equating assertiveness with leadership. Cognizant of the

repercussions from bad research linking vaccines and autism, we must be critical of all research-drawn correlations, especially those which propagate negative stereotypes.

It is important to acknowledge we still live in a patriarchal society, from the simple convention of a woman taking a husband's last name to the male predominance in our leadership. We are assigned our gender roles and without realizing it, we become accustomed to sexism. However, recent events, including the social media #metoo and #dresslikeawoman campaigns, demonstrate that our society is demanding a *new normal*. The most qualified candidate should get the job, but this necessitates open

access resources and opportunities to bring forward the most competent candidates from all backgrounds. This is the philosophy of emergency medicine gender equality guru, Dara Kass, MD FAAEM.

Sceptics Guide to Emergency Medicine (SGEM) deemed 2017 the year of females in emergency medicine, with the number one slot going to Dara Kass, MD FAAEM, the driving force behind FeminEM. One of the crowning achievements of FeminEM being the FeminEM Idea Exchange (FIX conference), held October

2017 in New York City. The RSA Diversity and Inclusion Committee was excited to host the resident networking coffee hour event at FIX. The FIX conference boasted speakers from many backgrounds, enthusiastically including men. Talks highlighted overcoming imposter syndrome, leadership, finance, branding, maternity leave, and mentorship.

RSA's podcast also interviewed Dr. Kass, who stated FeminEM was created because there was, "no place to park the issues related to women in emergency medicine consistently that was not governed by an overarching organization." When Dara Kass speaks about equality, she purposefully includes both men and women in the discussion, stating that one of her worst days in academic medicine was "seeing my resident at work 24 hours after his wife gave birth and their baby was under bili lights." Dr. Kass calls for options-based solutions for both men and women. "There is no right way to be a physician. Anyone can choose to be at home or at work, but the decision should be yours." What is Dr. Kass' ultimate goal for the FeminEM organization? "For there to be no need for it to exist." *Because that means we are truly equal.*

"It is essential to recognize and overcome the insidious sentiment that opposes true gender equality: fear."



Continued on next page

RSA has many opportunities for you to support equality in emergency medicine through our Diversity And Inclusion Committee, and the Women in EM (WiEM) Committee. Or, just start by listening to our FeminEM podcast with trailblazer, Dara Kass, MD FAAEM. The next FeminEM FIX conference will take place October 16-18, 2018, in New York City. ●

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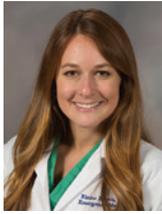
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AAEM/RSA Editor

Chief Complaint: I Feel Like I'm About to Have a Seizure

Elaine Holtzman Brown, MD
AAEM/RSA Board of Directors



Your patient is a 69-year-old female with a past medical history significant for seizure disorder, hypothyroidism, anxiety, and frequent urinary tract infections. She presents with a four-day history of generalized weakness to the point where she can no longer walk without assistance. Additionally, she has shortness of breath that worsens with exertion. She is anxious, and feels like she is about to have a seizure. You hear

her say, "I have this feeling of impending doom." And there it is. This lady has a PE. You nailed it!

When you look at your patient, you notice she has peri-oral cyanosis. Her vitals are concerning for mild tachycardia, and an oxygen saturation of 90%. How could she not have a PE?! So, you put your patient on some oxygen and begin your workup. Her EKG shows sinus tachycardia, and her chest radiograph is normal. Her CBC is significant for polycythemia; however, no elevated WBC count, no metabolic derangements, normal TSH, and ABG appears relatively unremarkable. With PE still at the top of your differential, you go straight to the scanner. But what do you find? Stone-cold normal CTA of her chest. The plot thickens. Could this be another one of her anxiety attacks? Not for four days. She's not anemic. Could it be sepsis? She has a normal lactate. Toxidrome? Time to go back to the drawing board.

Talking more with the patient, she tells you she started taking Aztreonam last week for dysuria, which she has done several times in the past. And then you realize it: could she have methemoglobinemia? She has pallor, perioral cyanosis, cyanotic nail beds, and an oxygen saturation of 90% that won't improve with supplemental oxygen. Your nurse tells you when she was drawing her blood, it was the color of chocolate. You send a sample off to the co-oximeter and the results come back with a methemoglobin level of 15.3%.

Methemoglobinemia occurs when the ferrous (Fe²⁺) irons of hemoglobin are oxidized to the ferric (Fe³⁺) state. The ferric state is unable to reversibly bind oxygen, resulting in impaired oxygen delivery to the tissues. Most cases of methemoglobinemia are acquired through the use of various exogenous agents that cause an increase in production of methemoglobinemia. These agents can include Dapsone, aniline dyes, nitrites, phenazopyridine, (compound found in Aztreonam), and topical anesthetics agents such as lidocaine and benzocaine, which are commonly added to

"Not all hypoxic patients have a PE, and don't forget to ask about potential toxins and new medications!"

street drugs like, heroin and cocaine.¹ Ever seen unexplained acquired methemoglobinemia in an illicit drug user?

Diagnostic testing should involve an ABG analyzer, as well as a co-oximeter in order to measure the concentration of methemoglobin (MetHb) as a percentage of the total hemoglobin concentration in a blood sample. In asymptomatic patients with MetHb levels <20%, no therapy other than discontinuation of the offending agent is required. Levels of MetHb >20% are associated with clinical symptoms. If patient is symptomatic in an acute acquired methemoglobinemia, use of IV methylene blue is indicated. Levels of MetHb >40% are associated with a high mortality rate, and should be managed in the ICU setting.¹

Methemoglobinemia can be easily over looked on your differential for a hypoxic patient, I've done it. One should have clinical suspicion of methemoglobinemia in any case where hypoxia does not improve with supplemental oxygen, when there is discoloration of blood, or when a patient is cyanotic with a normal PaO₂ on ABG analysis. Not all hypoxic patients have a PE, and don't forget to ask about potential toxins and new medications! ●

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Resident Journal Review: Inflammatory Bowel Disease

Authors: Erica Bates, MD and Adeolu Ogunbodede, MD
 Editors: Michael Bond, MD FAAEM and Kelly Maurelus, MD FAAEM

Introduction

Inflammatory bowel disease (IBD), which includes both Crohn's disease (CD) and ulcerative colitis (UC), is a potentially debilitating chronic inflammatory condition of the digestive tract that affects over one million Americans.¹ Individuals with IBD are at risk for a number of potentially serious complications which emergency physicians must be able to recognize and manage. Here we review several articles relevant to the care of this patient population.

Yoon SK, Park D, Hong S, Ran K, Eun K, et al. "Predictors of urgent findings on abdominopelvic CT in patients with Crohn's disease presenting to the emergency department." *Digestive Diseases and Sciences* 60, no. 4 (2015): 929-935.

Abdominal CT is a mainstay of emergency department (ED) evaluation for patients with known CD who present with gastrointestinal symptoms, but repeated CT scans expose these individuals to significant radiation over time. In this multicenter retrospective trial, the authors examined visits by patients with CD who underwent a CT abdomen/pelvis in 11 university EDs in Korea from 2002-2013. Their goal was to identify predictors of urgent CT findings that change management in this patient population.

Patients were excluded if the ED CT represented a new diagnosis of CD, if they did not present with a GI related complaint, or if there was insufficient data recorded. They identified 266 visits with a CT abdomen/pelvis for 155 patients with CD. The primary outcome was a composite of several outcomes, either related to the CD or not, requiring urgent or emergent intervention. These included new or worsening obstruction, abscess, perforation, or other diagnoses requiring intervention (such as appendicitis). One hundred and three of the 266 CTs had urgent or emergency findings (38.7%), with the most common diagnosis being abscess, followed by obstruction and perforation. Thirty-four (31.6%) CTs demonstrated evidence of worsening CD, such as inflammation, stricture, or fistula, but only 10 (3.8%) of these CTs caused a change in actual management, such as intravenous steroids. Seventy-eight (29%) of the CTs showed no change or improvement compared to prior imaging.

Statistically significant predictors of urgent or emergent findings on CT were history of stricturing/penetrating disease, heart rate >100, WBC >10,000, and CRP >2.5. Use of biologic agents was associated with reduced risk of urgent findings. Disease distribution, history of prior abscess, obstruction, or perforation, history of prior Crohn's related surgery, a prior CT abdomen/pelvis in the previous 1 or 3 months, and degree of symptoms at the time of the ED visit were not predictive of urgent CT findings.

This study did not include results for patients who underwent CT after admission. Another limitation is the lack of data on CD patients who presented to the ED with gastrointestinal symptoms but did not undergo CT. Furthermore, certain data points, such as CRP, were not available for all patients. The study also took place in Korea, which may limit

generalization of the results to a U.S. population with different baseline characteristics. Overall, the results showed that a fairly high proportion of CD patients (42%) who undergo CT in the ED have urgent findings that change management in some way, and more information is needed to allow emergency providers to reliably identify which patients with CD and gastrointestinal complaints may be able to safely forgo CT.

Mathurin F, Xiaocang C, Dauchet L, Gower-Rousseau C, Peyrin-Biroulet L, Colombel JF. "Thromboembolic events and cardiovascular mortality in inflammatory bowel diseases: A meta-analysis of observational studies." *Journal of Crohn's and Colitis* 8, no. 6 (2014): 469-479.

Inflammatory bowel disease is associated with an increased risk of venous thromboembolism (VTE), which is thought to be a result of the inflammation itself. In this article, Fumery et al performed a meta-analysis of existing studies to examine the relative risk of VTE as well as arterial thromboembolism and cardiovascular mortality for patients with IBD compared to the general population.

The authors performed a literature search and identified peer-reviewed observational controlled studies of adult patients with IBD (CD or UC) which reported risk of thrombotic events expressed as odds ratios, relative risk or a Standardized Mortality Ratio for cardiovascular disease. Thirty-three eligible studies were included, with a total of 207,814 IBD patients and 5,774,898 control patients. Weighted pooled relative risk was then calculated for each outcome.

A total of 10 studies examined the relative risk of VTE in a total of 72,205 IBD patients vs 891,840 controls. IBD patients had a greater risk of VTE (RR 1.96, 95% CI 1.67-2.3). There was no significant difference between CD vs UC patients. IBD patients showed increased risk of both deep venous thrombosis (DVT) (RR 2.42, 95% CI 1.78-3.3) and pulmonary embolism (PE) (RR 2.53, CI 1.95-3.28). Nine studies showed no increased risk of arterial thromboses (RR 1.15, 95% CI 0.91-1.45). The studies reviewed demonstrated no increased risk of stroke, peripheral artery disease, ischemic heart disease, or cardiovascular mortality when compared with controls. There were no significant differences between CD and UC subgroups. Two studies did show an increased risk of mesenteric ischemia in IBD patients (RR 3.46, 95% CI 1.78-6.71).

The authors did identify certain limitations to this review. Statistical analysis of the pooled data revealed significant heterogeneity among the studies. Certain outcomes, such as mesenteric ischemia, were supported by a relatively small number of studies and patients. The studies included also included a multitude of different clinical settings, including hospitalized and ambulatory patients, and some had relatively short follow up periods. Importantly, the data was not sufficient to examine the effect of IBD medications on the primary outcomes, and further studies are needed. Nonetheless, this review does demonstrate an increased risk of VTE

Continued on next page

in IBD patients, which emergency providers should keep in mind when evaluating these patients for possible DVT/PE.

Vavricka SR, Schoepfer A, Scharl M, Lakatos PL, Navarini A, Rogler G. "Extraintestinal manifestations of inflammatory bowel disease." *Inflammatory Bowel Diseases* 21, no. 8 (2015): 1982-1992.

IBD can be complicated by a number of extraintestinal manifestations involving multiple organ systems. In this review article, Vavricko et al highlighted common extraintestinal complications that may occur in addition to the primary intestinal disease activity. Up to 50% of patients experience at least one extraintestinal manifestation at some point, and a quarter occur before the diagnosis of IBD is established. High clinical suspicion is necessary not only for prompt diagnosis and treatment of these accompanying conditions, but also to evaluate for underlying IBD when appropriate.

Peripheral arthritis is seen in 5-10% of patients with UC and 10-20% of patients with CD. It is usually seronegative and may be pauciarticular (less than 5 large joints) or polyarticular (5 or more small joints, typically including the metacarpophalangeal joints). Pauciarticular arthritis is usually associated with IBD activity and self-limited in a matter of weeks, while polyarticular disease is not related to degree of intestinal disease activity and may persist for years. Treatments include steroid injections. Systemic NSAIDs should be avoided due to the associated risk of IBD exacerbation. Rarely, patients may also develop ankylosing spondylitis and sacroiliitis. Unlike the peripheral arthritis, which is typically nondestructive, axial arthritis can cause permanent skeletal damage and limited spinal flexion. These patients may require referral to a rheumatologist for treatment with systemic immunosuppression independent of treatment of their underlying IBD.

Up to 15% of IBD patients experience cutaneous manifestations of their disease. Erythema nodosum, characterized by tender red or purple nodules usually found on the anterior lower extremities, is associated with IBD flares and is more common in women and in CD. It usually resolves with treatment of the underlying disease and can often be treated supportively with elevation, analgesia, and compression hose. In contrast, pyoderma gangrenosum is a rare and more serious skin condition seen more frequently in UC. It usually starts as a nodule or pustule that progresses to a deep ulcer with irregular edges. The ulcers may contain sterile purulent material. Biopsy is not required, but shows neutrophilic infiltration and dermolysis. It can be treated with topical or intralesional injected steroids, treatment of the underlying IBD, and moist dressings. More serious cases may require systemic treatment such as dapsone, steroids, or immunosuppression with azathioprine, methotrexate, tacrolimus, etc. Surgical debridement may worsen pyoderma gangrenosum. Acute febrile neutrophilic dermatosis, Sweet's Syndrome, is a rare condition characterized by a tender papular rash, leukocytosis, fever, arthritis, and neutrophilic infiltration on biopsy. It is usually treated with topical or systemic steroids.

Ocular complications occur in 2-5% of IBD patients. Episcleritis is an inflammation of the tissue between the sclera and conjunctiva. It is a benign condition which causes redness of the conjunctiva and does not require therapy beyond treatment of the underlying IBD. In contrast, scleritis is a painful inflammation of deeper layers of the eye which can lead

to retinal detachment or vision loss. Patients should be referred to an ophthalmologist and often receive topical steroids in addition to treatment of the underlying disease. Uveitis, an inflammation of the middle chambers of the eye, is another vision-threatening ocular manifestation. It can be unilateral or bilateral and usually presents with eye pain, blurry vision, light sensitivity, and "cell and flare" in the anterior chamber on slit lamp exam in anterior uveitis. Treatment includes topical and systemic steroids as well as urgent ophthalmology referral.

Half of patients with IBD experience some form of hepatobiliary involvement, which can include fatty liver disease, hepatitis, cholestasis, gallstones, and autoimmune pancreatic disease. A feared biliary complication is primary sclerosing cholangitis, an inflammation of the biliary ducts which leads to irreversible fibrosis and stricturing with cholestasis and ultimately cirrhosis. It is more common in UC (2.4-7.5%) than CD. It is treated with ursodeoxycholic acid, but this has not been shown to alter the overall disease course. The ultimate treatment is liver transplant.

Tang YM and Stone, CD. "Clostridium difficile infection in inflammatory bowel disease: challenges in diagnosis and treatment." *Clinical Journal of Gastroenterology* 10, no. 2 (2017): 112-123.

Clostridium difficile Infection (CDI) is a gastrointestinal infection of growing prevalence in the United States. It is caused by a gram-positive spore-forming anaerobic bacillus which causes a disruption of the micro and macroscopic gut wall-interface leading to watery diarrhea. This diarrhea, and the associated inflammatory response, can cause marked fever, leukocytosis, sepsis, shock and even death in severe cases. CDI is recognized as the leading cause of gastrointestinal death today.

CDI is not only growing in prevalence amongst healthy individuals in the community, but is increasingly affecting the vulnerable population of individuals with inflammatory bowel disease. Those with diseases such as UC and CD are at much greater risk due to multiple factors including disruption of the gut flora, antibiotic use, repeated hospitalization, systemic immunosuppressants, and chronic inflammation which hinders the gut's ability to fight off infective processes.

Diagnosis of c.difficile infection in a patient with IBD poses a complex diagnostic challenge, requiring a high index of clinical suspicion and correct testing modalities of stool. The authors stress the importance of performing PCR analysis of unformed stool due to its higher specificity (>95%) and sensitivity (>90%) versus older modalities of testing, such as enzyme immunoassay (EIA) and nucleic acid amplification tests (NAATs). Clinical suspicion trumps test results due to the increasing prevalence of positive PCR testing for presence of c.difficile toxin colonization without the presence of active infection. This is especially true in individuals with IBD due to higher colonization rates.

Tang et al., then propose a practical algorithm for the diagnosis and treatment of individuals with IBD and diarrhea based on updated infectious disease guidelines and recent gastroenterology literature. The authors note important signs, symptoms and laboratory data required to classify a CDI as severe. These can include fever, hypotension, abdominal distension, lactic acidosis, leukocytosis or leukopenia, mental status changes or

Continued on next page

otherwise meeting admission criteria for the ICU. It is recommended that mild to moderate CDI be treated with metronidazole on first or second occurrence, and with oral vancomycin for severe disease. Severe complicated disease, which includes signs of intestinal obstruction, should be treated with oral and rectal vancomycin as well as intravenous metronidazole. Surgical consultation should be obtained early in patients with complex disease in event that colonic resection is warranted. For a third episode of recurrent CDI, a 24-day regimen of oral vancomycin is recommended. Fecal transplantation as well as fidaxomicin should be discussed in consultation with gastroenterology and infectious disease for patients with four or more occurrences.

Patients with IBD and c.difficile infection require a multidisciplinary approach to diagnosis and treatment. The authors note that high quality evidence is lacking to guide the use of antibiotics in patients who are often on chronic immunosuppressive therapy. They also caution the practitioner to consider treating an IBD patient with induction therapy if they are not improving in the face of treatment. Finally, the authors stress that continued diarrhea in a patient with underlying IBD does not necessarily signal treatment failure, and to be wary of the possibility of false positive tests in this challenging patient population.

Kucharzik T, Kannengiesser K, Petersen F. "The use of ultrasound in inflammatory bowel disease." *Annals of Gastroenterology: Quarterly Publication of the Hellenic Society of Gastroenterology* 30, no. 2 (2017): 135.

One long term risk of IBD is the high cumulative doses of radiation these patients experience over the course of their lifetime due to repeated CT scans. MRI can provide a potential alternative without the risk of ionizing radiation, but its use is sometimes limited by cost and availability. In this article, the authors review the potential role of intestinal ultrasonography (US) in the management of CD and UC.

Intestinal bowel wall thickness on ultrasonography can be used as a proxy for inflammatory activity. Bowel wall thickness greater than 2mm of the small intestine or 3-4 for large bowel is generally considered abnormal. A thickness of 3mm for large bowel has a sensitivity of 88% and specificity of 93%; increasing this to 4mm reduces sensitivity to 75% but increases specificity to 97%. Loss of clear bowel wall layers on ultrasound can also

indicate inflammation. In flares of CD, fibrofatty proliferation can also be seen on US as a hyperechoic area around actively inflamed bowel. Bedside color doppler US can be used to detect increased vascularity of the thickened bowel, which is also associated with active inflammation.

Intestinal US can be useful in detecting certain common complications of IBD, such as intestinal abscesses and fistula. Ultrasound has a sensitivity of 84% (95% CI 79-88%) and specificity of 93% (95% CI 89-95%) for abscess in CD, while it has a sensitivity of 67-87% and specificity ranging from 90-100% for fistulas. US can additionally be used to guide sampling of a suspected abscess. For perirectal fistulas, MRI and transrectal ultrasound have similar sensitivity.

There are several limitations to the use of intestinal US for IBD. Uniform standards do not exist for interpreting characteristics such as bowel vascularity, nor are there standards for the number and locations of views that should be obtained. Significant interobserver variation has been noted. Patient characteristics, such as body habitus and degree of bowel gas, may also limit US evaluation. Intestinal US is not a standard part of emergency bedside US training for many emergency providers in the US, who may not feel comfortable relying on these findings to assess for complications, and it is not universally available as a standard radiology exam. Nonetheless, intestinal US is a promising modality for the evaluation of IBD, and more study is needed on potential applications.

Conclusion

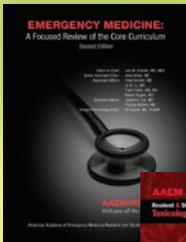
Patients with IBD are at risk for a number of potentially serious issues, from abscesses or c.difficile infections to thrombotic events and structural complications. Although CT scans frequently change management while assessing these patients, the risks of high cumulative lifetime radiation have prompted increased interest in intestinal ultrasound as a promising new modality to assess for inflammation and certain complications. Emergency providers must be familiar with the many possible presentations of this challenging condition. ●

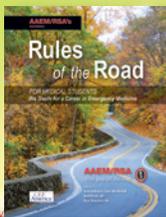
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Medical Student Council President

Top Ten Things I Have Learned Along the Interview Trail

Chris Ryba, MS4

Medical Student Council President



As my interview season comes to a close and Match Day now awaits on the horizon, I thought now would be the perfect opportunity to list the top ten things I have learned along the interview trail:

1. The Interview Trail is **TIRING**

Long days, long travel times across the country, early morning starts, and the constant goal of always

trying to look your best during months of interviews can take a major toll on the body.

My advice: Rest up and keep a good sleep schedule, maintain a healthy lifestyle, pack meals for road trips, and take advantage of hotel perks.

2. The Interview Trail **COSTS** a pretty penny

The applications themselves aren't cheap. Now factor in flights, hotels, meals, rental cars, suit cleanings, and interview clothes the bill continues to grow.

My advice: SAVE! Being prepared is number one. Other tips are to bank on credit card perks and frequent flyer miles. Using travel sites to try your best to group hotel, flights, and cars all in one became my best friend this fall. Plan your interviews out of state all near each other to avoid multiple trips. Reach out to as many friends as you can remember to couch surf.

3. The Interview Trail is **DAUNTING**

Many years of hard work is finally coming to fruition. All that stands in your way may be a twenty-minute interview with several different program staff and current residents. It's a scary notion when looking at it simplistically like that and an even scarier moment when you are actually in it.

My advice: Prepare! Research the program. Know the names and faces of the chief residents. Practice standard interview questions. Always keep a bank of stories for basic questions in your back pockets.

4. The Interview Trail can be **OVERWHELMING**

Tons of interviews ... Tons of cities ... Hundreds of faces and names, and now you have to rank where you want to train the next few years.

My advice: Keep a running list. I chose a Google Doc where I kept track of the general program info that I found important and then fun facts or program perks maybe not seen on a website. I would jot down quotes and facts on the trip home and upload it onto the computer. Then I could actively adjust my rank list as I went.

5. The Interview Trail is **HUMBLING**

You will have a bad interview. You will come across another applicant seemingly way more qualified. You will feel as if there's no way you will attend that program. And that's **TOTALLY** okay. The beauty of the interview process is it's a chance to see where YOU fit. You don't necessarily have to be the best candidate ever, you just need to be a good fit.

6. The Interview Trail allows you to **TRAVEL**

I applied to and interviewed in locations I never had thought to travel to



before and some of those places offered the most amazing experiences I have ever had.

My advice: Take that interview out of town. Who knows if you may fall in love with a city you never thought you would have.

7. The Interview Trail is **FUN** (surprisingly)

I had been told this time and time again but it wasn't until I was in the moment that I realized how right people were. I was truly amazed at how fun the resident socials were and how much I enjoyed traveling for the interviews. It was a nice change of pace after months of applications and away rotations.

My advice: Nothing really to say here other than to see for yourself.

8. The Interview Trail is **NOT AS BAD AS YOU MIGHT THINK**

Sure, there's the stress of wanting to be the best you can be, but most programs already know and like a ton about you if they are offering you the interview so just be yourself. You will be far less stressed if you think of it this way.

My advice: Be yourself!

9. The Interview Trail is to **REALLY SHOW WHO YOU ARE**

The programs have read everything about you on your application and in your letters and the jury is still out on the SVI so this is your major opportunity to really sell who you are as a person off the paper. Both parties are trying to see if you will be a good fit for the program and if the program is a good fit for you. Use this to your advantage but do not overdo it and be somebody you are not. Believe me, they will know.

My advice: Be your best self but in the end, make sure to just be yourself!

10. The Interview Trail is a **CULMINATION OF YEARS AND YEARS OF HARD WORK**

This isn't just medical school work, this is all of the experiences you have ever had that have turned you into who you are today.

My advice: ENJOY IT! You made it! ●



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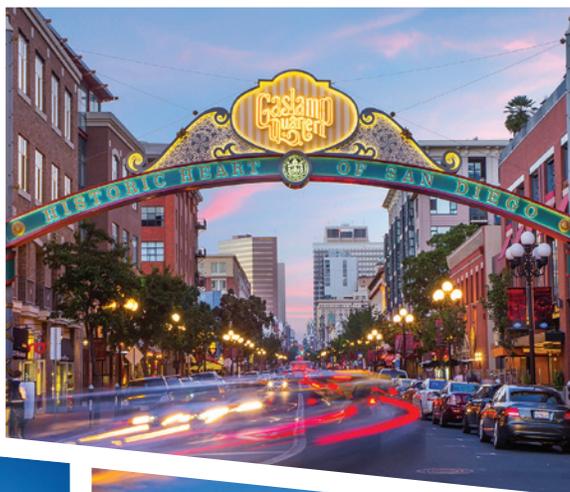
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Candidate Platform Statements

AAEM does not endorse any statement made by candidates and specifically rejects anticompetitive statements.

The nomination period for AAEM's upcoming elections has ended. All individuals running for an open seat on the board of directors have been identified, and the race has begun. Presented here for the benefit of all AAEM full voting, emeritus, and Young Physician Section (YPS) members of AAEM are the formal platform statements of each of the candidates.

AAEM's democratic election process is just one of the many things that make our organization unique among medical specialty societies. Please carefully review the information presented here, and make your arrangements to join us in San Diego for the Candidate's Forum and final elections. ●

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For the 2018 election ballots will only be available online. We encourage all members to attend the State of the Academy, Town Hall, and Candidates' Forum and all eligible members to cast their vote online. ●

Important Dates

- Attend the State of the Academy, Town Hall, & Candidates' Forum: April 8, 2018
- Online voting closes: April 8, 2018 at 11:59pm PT ●

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