COMMON SENSE

VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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AAEM™
AMERICAN ACADEMY OF EMERGENCY MEDICINE
CHAMPION OF THE EMERGENCY PHYSICIAN

New Look. Same Values. Introducing the New AAEM Logo

COMMON**SENSE**

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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 quallity of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $150 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program within their first year out of residency) or $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program more than one year out of residency)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Please visit www.aaem.org for special eligibility criteria)
International Member: $150 (Non-voting status)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
International Student Member: $30 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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AAEM-0318-197

President's Message

New Look, Same Values: Introducing the New AAEM Logo

David A. Farcy, MD FAAEM FCCM
President, AAEM

Record Attendance at AAEM18

I want to share my sincere gratitude to the membership of AAEM for another fantastic Scientific Assembly. The 24th Annual Scientific Assembly (AAEM18) in San Diego featured five days of outstanding education, seven pre-conference courses, four new themed tracks, 130 speakers, four wellness-focused events, and social events, all surrounding the theme of "Breaking Down Barriers." I'm pleased to announce we reached a record attendance of 1,279 attendees! As always, Scientific Assembly continues to be a FREE benefit for Academy members. I encourage everyone to join us next year in March 2019 in Las Vegas for our 25th anniversary year.

I would like to recognize Dr. Evie Marcolini and Dr. Joelle Borhart, the 2018 Scientific Assembly co-chairs, and the entire AAEM18 planning committee, for their dedication and devotion to education in making this year's Scientific Assembly a huge success. I would also like to thank each and every speaker for taking the time to prepare and deliver your lectures; without you, our success and high standard of education would not be possible.

I also want to recognize the un-sung heroes who work ceaselessly behind the scenes to make sure all of the puzzle pieces fit; thank you to our entire staff at EDI for your continued dedication and efforts.

Many long-time members and brand new faces participated in one of our many in-person committee, interest group, section, or chapter division meetings. I want to challenge all members to take part in the energy and enthusiasm generated in these meetings as we carry on the work of the Academy into the year ahead. Find a committee or section related to your interests and join in on their important work. www.aaem.org/get-involved.

Ruth Rodgers, Dr. Rodgers' wife, accepts the David K. Wagner Award in memory of Dr. Rodgers

Patrick Rodgers, Dr. Rodgers' son, accepts the MAAEM Award in memory of Dr. Rodgers

The Rodgers Family

Introducing the "Dr. Kevin G. Rodgers Memorial Fund" of the Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM)

In San Diego, we were honored to be joined by the family of our late president, friend, and mentor, Dr. Kevin G. Rodgers. Dr. Rodgers' wife, Ruth, three of his four sons, and his niece were in attendance to accept the Master of the American Academy of Emergency Medicine (MAAEM) and David K. Wagner awards in his memory. The MAAEM designation honors senior AAEM fellows who have demonstrated a long career of extraordinary service to AAEM and service as an exemplary clinician and/or teacher of emergency medicine. The David K. Wagner Award recognizes individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives.

LEAD-EM
PROMOTING THE LEADERSHIP DEVELOPMENT & KNOWLEDGE OF EMERGENCY PHYSICIANS
AAEM AMERICAN ACADEMY OF EMERGENCY MEDICINE

Continued on next page

Dr. Mark Reiter, joined by the AAEM Executive Committee and the Rodgers Family, announces the creation of the Kevin G. Rodgers Fund of LEAD-EM

As a continuing memorial to Dr. Rodgers' impact on emergency medicine education, AAEM has established The AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM). The Kevin G. Rodgers Fund and the Institute will "LEAD-EM" just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. If you are interested in contributing to this fund, please visit: www.aaem.org/donate/lead-em. As the president, I personally donated $500 and challenged the entire board to do the same, I would challenge each and every one of you to find it in your heart and donate whatever you feel is appropriate and that you can afford.

Dr. Megan Healy (chair) and Dr. Brian Potts of the Marketing Task Force unveil the new AAEM logo

New Look. Same Values.

One piece of the strategic plan of the Board of Directors of AAEM over the past year has been to better communicate the mission of the organization to members and non-member emergency physicians. As you know, AAEM is *the* leader within our field in preserving the integrity of the physician-patient relationship by fighting for a future in which all patients have access to board certified emergency physicians and physician rights are protected. The Board of Directors created a Marketing Task Force, with the goal of updating our logo, tagline, and website to better communicate the important work of the Academy.

At AAEM18, we made the exciting debut of the brand new AAEM logo, tagline, and the redesigned AAEM.org. I would like to thank the Marketing Task Force: Megan Healy, MD FAAEM , Brian Potts, MD FAAEM; Jason Hine, MD FAAEM; Manish Garg, MD FAAEM; for their hard work in completing this rebranding.

The shield represents the idea of advocacy, with AAEM as the defender of emergency medicine. The torch represents our role as a leader, lighting the path toward physician autonomy. We kept the continuity of colors as a nod to the proud tradition of the organization and the leaders that paved the way. The impactful new tagline "champion of the emergency physician" speaks for itself. We look forward to the continued growth of the academy and we appreciate your membership and support! Visit www.aaem.org/about-us/new-look to learn more about the story behind the new logo.

Looking Forward

Over the next two years as your president, my goal is to focus on increasing membership and increasing the academy's budget. You might ask yourself, "Why pay my dues?" When I talk to many residents in our union, I tell them it is an investment in their future. An investment: to improve your work environment, to stand up and represent yourself on issues such as due process & board certification, and to continue to receive great member benefits like the free Scientific Assembly.

My commitment is to increase our advocacy efforts, not only by our Washington representatives, but also at a grassroots level. I hope to have each and every one of our members participate in letter/email writing to their legislative representatives when a bill is presented that affects how we practice. Paying your dues on an annual or multi-year basis is a great first step, I challenge you to take the next step and invest even more in your future by becoming involved with the Academy. You do not purchase car/home/health insurance and ask what do they do, you're happy when you have to use them. Tell a friend, tell your colleagues to join. Join because we are looking for great people that want a brighter future. ●

AAEM Antitrust Compliance Plan:

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

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There are over 40 ways to get involved with AAEM

Dive deeper with AAEM by joining a committee, interest group, task force, section, or chapter division of AAEM. Network with peers from around the U.S. sharing your clinical and/or professional interests or meet-up on the local level with members in your state.

Visit the AAEM website to browse the 40+ groups you can become a part of today.

Get Started!
www.aaem.org/get-involved

From the Editor's Desk

The Real Threat?

Andy Mayer, MD FAAEM
Editor, *Common Sense*

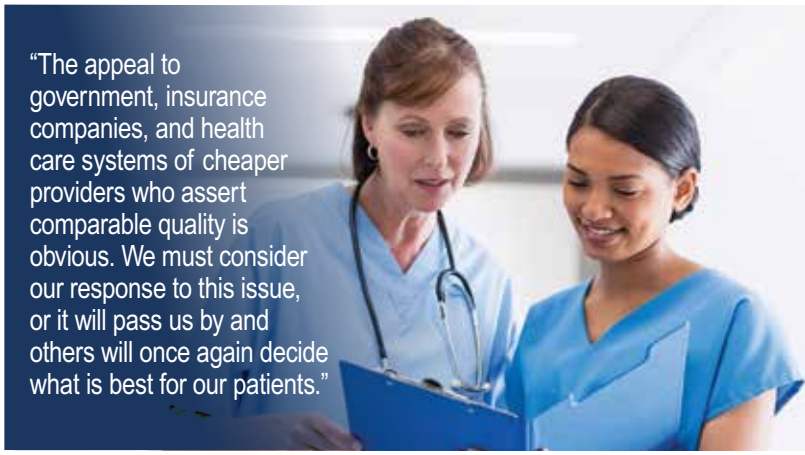
"These are the times that try men's souls"
— Thomas Paine

Emergency medicine will face many significant challenges in the coming years. Our specialty is certainly not unique in this regard. Like all medical specialties, we will need to be organized and vigilant in protecting our profession as a whole as well as our individual careers. Some of the challenges are well known and hopefully recognized by all in our field. These very issues were at the forefront of why the Academy was founded in the first place. The threat to board certification by ABEM/AOBEM for America's emergency physicians has stood the tallest among these issues. Notwithstanding the recent ACEP election of a surgeon as President-Elect, I hope that this issue is finally being put to bed forever. I would hope that ACEP will amend their election rules and hold board certification as an absolute requirement for any leadership role in their organization. However, as a specialty we must face other challenges.

The house of medicine in general, and the specialty of emergency medicine in particular, must face the increasing involvement of mid-level or advanced practice providers (APP's). Most, if not all, of us have been exposed to nurse practitioners or physician assistants in our emergency departments. Many of us have very successful and useful collaborations and interactions with them. How many of you now speak to APP's answering consults or doing history and physical exams as hospitalists? How many of you work closely with APP's on a daily basis in your emergency department? Certainly, probably all of us have interacted with APP's who are very intelligent and helpful, and can be faster and more efficient than some of the emergency physicians with whom we work. These APP's have increasingly diverse roles and responsibilities in all aspects of our health care system. The current physician shortage and the aging of the Baby Boomer generation will require us to be creative if we are to meet the health care needs of the aging population. The (hopefully) universally accepted value of board-certified emergency physicians will not mean much if your emergency department is really staffed by APP's who work as independent practitioners. What will your role be in this business model? Our health care system is being severely challenged on multiple levels. The appeal to government, insurance companies, and health care systems of cheaper providers who assert comparable quality is obvious. We must consider our response to this issue, or it will pass us by and others will once again decide what is best for our patients.

The American Association of Nurse Practitioners (AANP) has categorized nurse practitioners by their degree of independence. They can be full practice (entirely independent), reduced practice (partially independent), or have a restricted practice (non-independent). These determinations are usually made by each state, with politics involved. Many different stake holders and interest groups support the full practice rights of nurse practitioners, including the Institute of Medicine, the Robert Wood Johnson Foundation, the National Council of State Boards of Nursing, and AARP.

The variety of opinion on the ability and appropriate level of responsibility and authority of APP's is not going to generate consensus. Some will say that APP's should always be totally independent practitioners with little or no physician oversight. What should we do? The American Medical Association (AMA) has stepped into this fray with resolution 214. This resolution calls for the AMA to create a national strategy that would "effectively oppose the continual, nationwide efforts to grant independent practice to non-physician providers." This resolution is encouraging the AMA to create a strategy to oppose model legislation, and national and state-level campaigns, which would allow non-physician practitioners to practice independent of doctor supervision. Most physicians might think this is a common-sense point of view. We as individuals should reflect on this issue and decide what we individually think before we step into this fray.



Pamela F. Cipriano, PhD RN, president of the American Nurses Association (ANA), is certainly supportive of nurse practitioners having independent practice. She responded to the AMA's resolution by stating "this divisive tactic will directly impact the nation's advanced practice registered nurses, and perpetuate the dangerous and erroneous narrative that APRNs are trying to 'act' as physicians and are unqualified to provide timely, effective, and efficient care." The ANA represents the 3.6 million registered nurses in America. How did the nurse practitioners themselves respond to the AMA's resolution? In a press release, Joyce Knestrick, PhD, the president of the American Association of Nurse Practitioners stated "the American Medical Association has asserted, once again, its commitment to put the profit of its physician membership ahead of patients and their access to high-quality health care." Is this simply a financial issue? Do we fear competition or is our concern for our patients and their safety?

Continued on next page

The Veterans Administration has added its support for APP's practicing independently. In 2016, the VA granted full practice authority to their advance practice registered nurses. The Centers for Medicare and Medicaid Services had a program to spend $200 million to help train APPs, stating that it costs about $30,000 to train an APP — about one fifth the cost of training a primary care physician. CMS has also determined that nurse practitioners are paid at 85% of the amount a physician is paid under the Medicare Physician Fee Schedule. Are you getting scared yet? The government wants to train more APP's for a fifth the cost, pay them less, and let them work independently at all Veterans Administration hospitals and clinics.

What about the states? Currently about 40% of the states have adopted a full practice model for nurse practitioners. There is also something called the Advanced Practice Registered Nurse Compact, which would allow an APRN with one valid state license reciprocity to practice in other states in the compact. This compact will go into effect when ten states have passed it. Idaho, North Dakota, and Wyoming have passed it, with pending legislation in Nebraska and West Virginia. This fight is really more in our state legislatures. Can you play a role in this at the state level? The APP's will certainly be there, strongly lobbying for their cause. How much effort will be expended by organized medicine?

How about emergency medicine? There is a current proposal to amend the bylaws of the American College of Osteopathic Emergency Medicine, to add a representative from the American Academy of Emergency Nurse Practitioners (AAENP) to their board of directors. I understand this is causing some controversy. There is always a desire by medical organizations to increase their membership. Adding the legions of APP's to their rolls may seem an attractive way to add revenue and numbers.

What about the Academy? Here is AAEM's 2017 position statement:

Position Statement on Advanced Practice Providers (APPs)

1. It is the concern of AAEM that emergency patients have timely access to the most appropriate and qualified practitioners.
2. Properly trained APPs may provide emergency medical care as members of an emergency department team and should be supervised by a physician who is board certified in emergency medicine (ABEM, AOBEM).
3. On-site supervision of APPs should be provided by board certified (ABEM, AOBEM) emergency physicians. These physicians should be permitted adequate time to be directly involved in supervision of care.
4. As a member of the emergency department team, an APP should augment (not replace) the unencumbered access to quality emergency care provided by a specialist in emergency medicine as defined in the AAEM Mission Statement.

I think that emergency physicians should come together and form a consensus, and develop a unified strategy to face this challenge. APP's are here to stay, but we should play a leading role in defining the scope of practice and level of responsibility for these providers. This issue is one in which all organizations and societies in emergency medicine should have common interests and goals. ●

Letter to the Editor

Dear Dr. Mayer:

My compliments to you, Dr. Jonathan Jones, Laura Burns, and the rest of AAEM's staff on the new look of *Common Sense*. Great job! I was especially glad to see your editorials "Crossed Swords" and "What is ACEP Thinking," and Dr. Lisa Moreno-Walton's article "Thoughts on the Election of a Surgeon to the Presidency of ACEP."

Even after I became a founding fellow of AAEM, I remained a member of ACEP, thinking I would do all I could for emergency medicine as a member of the Academy while I waited for the College to come around and start looking out for the interests of individual emergency physicians — meaning board certified specialists in emergency medicine. Unfortunately ACEP never did change course, and I finally gave up and resigned in disgust over behavior that convinced me ACEP had sold its soul to corporate interests — and had sold out both its membership and our specialty at the same time. I wrote the College and explained my action too.

Nothing seems to have improved since then. In the ensuing 20 years ACEP has granted fellowship status (FACEP) to non-board certified physicians (as far as I know the only specialty society in medicine to do such a thing), continued to elect upper management from corporate staffing companies like EmCare/Envision to leadership positions, and now even elected a president-elect who isn't a board certified emergency physician at all. Does the rank and file membership not know about these things? Do they not care? Do they not see the conflict of interest? Is it the lack of direct democracy that results in such decisions? I just don't understand how this keeps happening. It's bad for our specialty and all emergency physicians, whether we are members of ACEP or not.

That is why it is important that you and others keep the spotlight on ACEP. There is no telling what they would do if the Academy wasn't around to compete with the College and criticize it when called for. Dr. Bob McNamara did a good job of pointing out how AAEM has made ACEP a better organization in the last issue of *Common Sense*, with his article "Where Would EM be Without AAEM?." Please keep up the good work. ●

Thank you,
Andy Walker, MD FAAEM

Submit a Letter to the Editor: www.aaem.org/resources/publications/common-sense

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

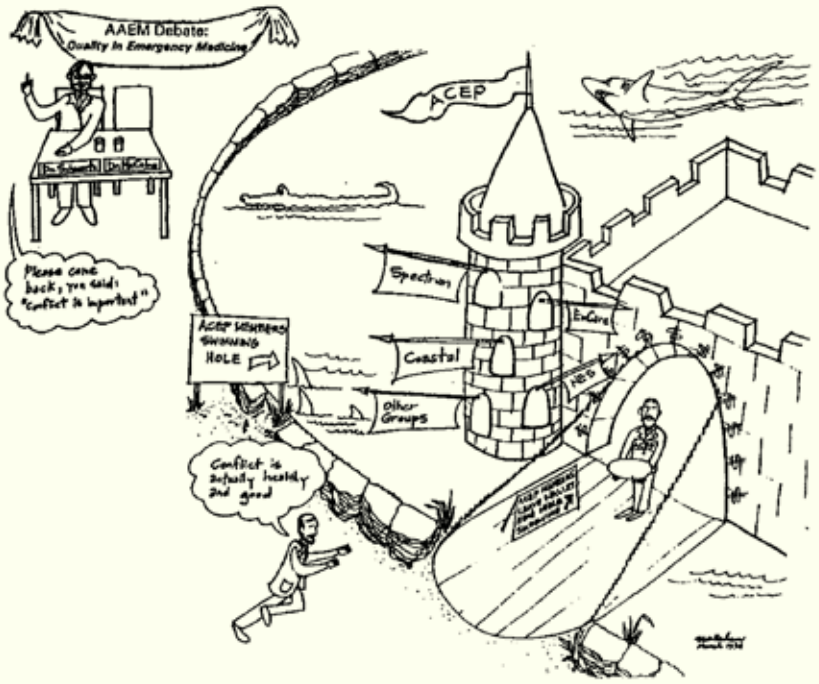
! A PROCLAMATION ! Hear Ye! Hear Ye!

Announcing the First Annual Meeting of the American Academy of Emergency Medicine in the city of Las Vegas in H.R.H.'s colony of Nevada at the Excalibur Hotel from Friday, April 29th at 12:00 pm through Sunday, May 1st at 2:00 pm in the Year of Our Lord 1994. Thine man or maid-servant should hotel provisions for Thee make by calling upon 1-800-937-7777 and asking for Contract XAAEM. Rooms are $69 per night. A paltry sum of ninety-nine King Georges are requested for meeting costs payable to AAEM, P.O. Box 1968, Santa Fe, NM 87504 (1-800-884-AAEM). A full program will be sent to registrants. 15 CME Category I credit hours have been applied for through Martin Luther King, Jr. - Drew University Medical Center whose directorship, in the tradition of it's namesake, nobly and fearlessly offered to lead the quest for justice and equality.

Invited Speaker Hillary Rodham Clinton has notified the academy that a representative will be sent to the first annual meeting.

Important topics include: the special agenda of AAEM, critical issues in Emergency Medicine, Watching Goliath Fall, Emergency Medicine health care reform, social issues, and how AAEM can lead Emergency Medicine into the future. All physician speakers are diplomats of ABEM.
The Whiskey Rebellion Hootenanny, a complimentary banquet will be served on Friday evening.

John McCabe, M.D., President of ACEP, is invited to debate the subject "Has ACEP Failed its Membership"?



Emergency Medicine
Joke of the Month.

Q: What did the ED contract holder say to his contracting physician when he gave him his pay check?

A: "Was it as good for you as it was for me?"

Heard a good one lately? Send it to our Beverly Hills address

Has ACEP failed its membership?

This cartoon commemorates Dr. John McCabe's refusal to debate the critical issues affecting the quality of Emergency Medicine and of the Emergency Care we provide the public. The moat refers to the exploitation of Emergency Medicine and of Emergency Physicians by the very organization that is accepting (and in some cases indirectly demanding through intimidation by large contract management groups) their money as dues and as contributions. Dr. McCabe's refusal to debate accentuates the destructive strategy of ACEP. Because of its non-democratic nature such wrong-mindedness is virtually impossible to change.

AAEM Foundation Contributors – Thank You!

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from **1-1-2018 to 5-8-2018**.

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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Donate to the AAEM Foundation! Visit www.aaem.org or call **800-884-2236** to make your donation.

AAEM PAC Contributors – Thank You!

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.

All contributions are voluntary and the suggested amount of contribution is only a suggestion. The amount given by the contributor, or the refusal to give, will not benefit or disadvantage the person being solicited.

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The AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM) was established after the tragic and unexpected death of AAEM president, Dr. Kevin G. Rodgers.

The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from **1-1-2018 to 5-8-2018**.

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Upcoming Conferences: AAEM Directly, Jointly Provided & Recommended

AAEM is featuring the following upcoming conferences and activities for your consideration. For a complete listing of upcoming conferences and other meetings, please visit: www.aaem.org/education/aaem-recommended-conferences-and-activities.

AAEM Conferences

August 14-17, 2018
Written Board Review Course
Orlando, FL
www.aaem.org/education/written-board-review-course

September 6-7, 2018
ED Management Solutions: Principles and Practice
Austin, TX
www.aaem.org/education/events/ed-management-solutions

September 15-16, 2018
Fall Pearls of Wisdom Oral Board Review Course
Philadelphia and Chicago
www.aaem.org/oral-board-review

September 22-23, 2018
Fall Pearls of Wisdom Oral Board Review Course
Orlando and Dallas
www.aaem.org/oral-board-review

October 3-4, 2018
Fall Pearls of Wisdom Oral Board Review Course
Las Vegas
www.aaem.org/oral-board-review

March 9-13, 2019
25th Annual Scientific Assembly – AAEM19
Caesars Palace, Las Vegas, NV
www.aaem.org/AAEM19

AAEM Jointly Provided Conferences

September 13-16, 2018
Mediterranean Academy of Emergency Medicine Congress
Beirut, Lebanon

AAEM Recommended Conferences

August 15, 2018
First Panamerican Forum on Emergency Care and ALSO Obstetrics
San Miguel de Allende, Guanajuato, Mexico
www.pacemd.org/foro2018

September 5-7, 2018
ACMT's Total Tox Course: Cutting-Edge Toxicology for Emergency Providers
Chicago, IL
http://www.acmt.net/Total_Tox_Course.html

September 21-23, 2018
The Difficult Airway Course: Emergency™
Baltimore, MD
www.theairwaysite.com

October 26-28, 2018
The Difficult Airway Course: Emergency™
New Orleans, LA
www.theairwaysite.com

November 3-4, 2018
Lao People's Democratic Republic Emergency Medicine Conference
Vientiane, Vientiane Capital, Lao PDR

November 9-11, 2018
The Difficult Airway Course: Emergency™
San Francisco, CA
www.theairwaysite.com

November 11-14, 2018
Myanmar Emergency Updates 2018
Yangon, Mynamar

December 11-12, 2018
ACMT 2017 Seminar in Forensic Toxicology, "Opioids, Toxicology, and the Law: Medical-Legal Aspects of the Opioid Epidemic"
Chemical Heritage Foundation - Philadelphia, PA
http://www.acmt.net/2017_ACMT_Seminar_in_Forensic_Toxicology.html

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

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Washington Watch

Federal Policy and the Prudent Layperson Standard

Williams and Jensen, PLLC

Over two decades ago, Congress enacted landmark patient rights' legislation as part of the Balanced Budget Act, establishing the Prudent Layperson Standard (PLS) for Medicare and Medicaid managed care plans. The PLS was seen as a key patient protection against illogical prior authorization requirements for ED visits, or the denial of claims based on retrospective review.

Advocates of the PLS argued that this would provide assurances to patients that act prudently, requiring payment for the care they receive in the ED regardless of the ultimate condition. Senator Ben Cardin (D-Maryland), one of the architects of the PLS when he was serving in the U.S. House of Representatives, explained the reasoning as follows:

"The Prudent Layperson Standard was specifically drafted to allow patients to get the services they need, when they need them. Patients should not be forced to act as their own doctors and second guess themselves when they truly believe that they are having a medical emergency."

"Despite broad patient support for the Prudent Layperson Standard, there are varied threats to its existence from both likely and unlikely sources."

Enrollment growth in health maintenance organizations (HMOs) exploded by 700 percent in the 1980s and 90s, and this rapid change left many patients feeling anxious about the healthcare delivery system. If the Emergency Medical Treatment and Active Labor Act (EMTALA) had established the ED as the nation's healthcare safety net, then the PLS was its sturdy companion, further protecting access to emergency care. The enactment of the PLS seemed to arrive at the ideal time, to acclaim from the public.

Seizing on the positive response to this measure, federal and state policymakers successfully worked to expand the PLS, giving this protection to federal employees in 1999 and further extending it to individual and small group health plans as part of the Affordable Care Act (ACA) in 2010. Meanwhile, the number of states with codified versions of the PLS more than doubled in the last 20 years, from 22 to 47.

Despite broad patient support for the PLS, there are varied threats to its existence from both likely and unlikely sources. One area where the PLS is being undermined is from insurance companies. Seeking cost savings from ED claims, several insurers have announced policies within the last year to give additional scrutiny to ED visits. Vocal opponents of these new policies assert these changes would allow the denial of ED claims even in cases where a prudent layperson with an average knowledge of medicine would believe they are having a medical emergency. These new policies are being carried out in states that have enacted statutory PLS protections in addition to federal law, so patients and providers will be paying close attention to what comes next.

Additional concern for erosion of the PLS comes from the dual aims of federal policymakers to identify savings in the healthcare system and to lower ED utilization. While overall data demonstrates the value of emergency care at around 2 percent of all health spending, recent Administrations and Congress have sought to reduce costs by advocating for policies that will steer patients away from the ED. Specifically, they have sought to target the roughly 1 in 5 patients that visit the ED who do not believe they have an emergency condition.

While the goal of reducing unnecessary ED visits is strongly shared by emergency physicians, efforts by federal and state policymakers to address this challenge through payment or reimbursement policies have not achieved the intended effect. For example, coding changes that seek to reduce the amount of money paid by states for emergency care do little to change patient behavior and merely shift more costs to EDs. Many other proposals similarly move money around rather than producing actual savings for the healthcare system.

The expansion of the PLS via the ACA also increases the chances that a massive overhaul of the law could result in a rollback of these enhancements. While Congressional Republicans will likely continue to lack the votes for proposals that repeal significant parts of the ACA, further changes to the law are possible, particularly those that have bipartisan support. The popularity of the PLS means that these provisions are safe for now, but may not be if momentum for ACA repeal strengthens at a future date.

At present, policies being carried out in the states pose the most risk to the PLS. But emergency physicians should be mindful of the potential role of federal policymakers in reaffirming and expanding the PLS. Two

Continued on next page

years prior to the enactment of the Balanced Budget Act, the *New York Times* described a time when ED personnel would be haggling over the phone with HMOs over the appropriate course of treatment and patients were advised that "failure to contact the primary care physician prior to emergency treatment may result in a denial of payment."

Fewer than one in five currently serving Members of Congress were elected before 2000, and more than half were elected after 2010, the last time Congress made significant alterations to the PLS. There may not be much institutional knowledge left from these debates, but as their constituents face the prospect of high out of pocket costs over denied claims for emergency care, they may quickly realize why the PLS was so popular in the first place. ●

Master of AAEM Series — MAAEM

Welcome to the Tribe: Thoughts on Starting Out in EM

Joe Lex, MD MAAEM FAAEM

Yesterday I received this (redacted) email:

Hello Dr Lex,

Over the past two to three years I have come across your various teachings and pearls in emergency medicine. I have had a strong passion for emergency medicine since my undergrad years at Temple and as a scribe in a Philadelphia ED. I was recently accepted into ED residency at Virginia Commonwealth University and was hoping for any advice you may offer in this new chapter.

Thank you so very much for your time.

I thought about it and came up with this. Feel free to copy, adjust, edit, add your own thoughts, and share with those whom you feel it might help.

First and foremost, welcome to EM. I am biased, but I truly feel we are the most interesting 15 minutes of every other specialty.

Second, thank you for being a member of the military. I was drafted in 1966, so I had no choice, but my medical training and experience in Vietnam made me into a totally different person than I would have been otherwise ... and I hope it was for the better.

Third, I am about 30 years removed from my residency in EM. When I trained, 90% of the attendings had trained in another specialty and they were not a 24-hour presence. On night shift, they headed off to bed about 11:00pm and reappeared to cosign charts at 6:30am. We were on our own and it was a sign of weakness to wake them up for help.

You are about to enter into one of the scariest — and most difficult — times of your life. You will start with an unconscious incompetence that you will recognize very quickly: "I know so little that I had no idea how little I know." After a few weeks, you will reach conscious incompetence, and this is probably even scarier: "I now know how much I don't know. Oh crap." By the time you graduate, you will be consciously competent. But you may not reach the peak of unconscious competence until you've been in practice a few years.

You now feel very smart and full of evidence-based medicine, although you've probably been a little rattled by working with some physicians who seemingly ignore the evidence. Get used to it. For instance, every textbook will tell you the starting dose of morphine for someone in acute pain is 0.1-0.15mg/kg; in reality, it will be 4mg, for many reasons. Every textbook will tell you that the loading dose of phenytoin for acute seizure management is 15 to 20mg/kg; in reality, it will be 1 gram. At least 15 articles over the past 30 years have shown the superiority of metered-dose inhaler albuterol over nebulized albuterol for acute asthma, but I assure you that 90% of patients who are wheezing will get the nebulizer. You will memorize the Ottawa Ankle Guidelines, and then probably ignore them. Don't question this — you are not in a position to challenge the "common wisdom" while you are inside the loop of residency. Just remember when you start practicing on your own what the right answer is. Albert Schweitzer understood this when he said, "Imitation is not the main thing in learning; it is the ONLY thing." (Although I cannot locate the source for this quote, it sounds like something Schweitzer would have said).

What do I mean by "inside the loop?" It's where a vast majority of people live their entire lives. But creativity and innovation are outside the loop. You can get there eventually, but residency is not the appropriate time or place. You will silently question decisions of your seniors more than you care to think about. You will silently question yourself when you have followed all the rules and used all your knowledge and come to a different conclusion.

Whether your mother is alive or not, you will talk to her in your mind a lot. "Mom, I decided to do X to a patient. Are you proud of me?" It's also something that will come in handy when you talk to a consultant. "Call your Mom and tell her what I told you. Then ask her if you're making the right decision and if she's proud of you."

Continued on next page

"You will need good mentors all your life. Most mentors will pat you on the back and say, "Good job." The best mentors push you past where they are and help you succeed far more than they can and not be jealous of you. Remember, "everything worth having is on the other side of fear," and a mentor is sometimes needed to push you through fear."

You will feel like an impostor for the rest of your life. "There's been a dreadful mistake ... I should NEVER have become a doctor. I'll never get it right." This is a good thing. If you recognize the limits of your knowledge, it will stimulate you to learn more. If you don't doubt what you are doing at least once a week, you are probably doing the wrong thing. And get used to reading articles and blogs and listening to podcasts. The evidence is pretty clear that to stay current and maintain competency, you will have to actively learn for an average of five hours weekly for the rest of your life. You are not and will never be infallible — the greatest learning moment in your career will be when you no longer have to pretend that you know everything.

Do NOT speak ill of patients. They are not the enemy. We are the one place that many people know they can come and be treated like a human being. We take care of some of the most unloved people in the world, and we do it because we want to. Never forget that we get to touch sick people, who has been allowed this privilege through history? Gods, prophets, kings ... and physicians.

"Welcome to EM. I am biased, but I truly feel we are the most interesting 15 minutes of every other specialty."

I recommend that as an intern, you occasionally ask your faculty member to come to the bedside with you when you present the history and physical results — maybe once every shift. It cuts down on bullshit, and a good attending can supplement what you have learned by asking an additional question or two without making you look bad. You then discuss the differential at bedside, using difficult words like "cancer" and "stroke" if appropriate, because the worst-case scenario is what the patient is worried about also. When you walk away from bedside, the attending, patient, and any family present know what you are thinking and what plan has been laid out.

The most difficult thing you will do is tell a parent that a child has died unexpectedly, but fortunately it's something you only have to do every few years. The most difficult thing you will do on a day-to-day basis is convince other doctors to take care of sick people. Get used to it. Sometimes doing the right thing will piss people off; if it is the right thing, you'll sleep fine at night.

Also get used to being second guessed. "Guess what those clowns in the ER did THIS time?" We want to be protective of our tribe, of course, but never lose sight of the patient coming first.

Remember that other specialties are trained to find out "What does this patient have?" Our goal is to determine "What does this patient need?" When a patient arrives with tachypnea in a tripod position with blue lips, do we know the diagnosis (other than the all-inclusive "respiratory failure")? Probably not, but we know exactly what to do.

You will need good mentors all your life. Most mentors will pat you on the back and say, "Good job." The best mentors push you past where they are and help you succeed far more than they can and not be jealous of you. Remember, "everything worth having is on the other side of fear," and a mentor is sometimes needed to push you through fear.

Find a copy of the ACEP Code of Ethics and read it. Then read it again. And remember that ethics is a daily destination, a daily challenge. Every shift should start by looking in a mirror and saying, "It's not about me."

Mahatma Gandhi once said, "Whatever you do will be insignificant, but it is very important that you do it." Don't lose sight of that.

Savor your successes but then move on: dwelling on them causes overconfidence (and there is nothing more dangerous than a cocky ER doc). Learn from your failures but then move on: dwelling on them causes indecision.

Half of what you are learning is wrong or will be out of date in a few years. Don't feel guilty — it's because half of what your instructors are teaching you is wrong, because half of what THEY know is wrong. It's not their fault. If they knew it was wrong, it would be unethical for them to teach it.

Emergency medicine is becoming the proceduralist by default. Currently, American Board of Internal Medicine requires five procedures for someone to become board certified: ACLS, peripheral venous access, arterial blood draw, venous blood draw, and pelvic exam, pap smear and cervical culture. If you look at the Core Content for EM, there are literally dozens of procedures in which we must show competence, both ultrasound-guided and blind. No other specialty comes close.

And never forget that "A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die, and a new generation grows up that is familiar with it." (Max Planck, Scientific Autobiography and Other Papers). In other words, science and medicine change one funeral or retirement at a time.

I don't know if you're into music, but I worship at the altar of John Coltrane. Miles Davis you probably know. What you may not know is that he literally changed the music three or four times. Bop --> cool --> hard bop --> fusion. Coltrane was a student of Miles, but also of Thelonious Monk and Coleman Hawkins, Lester Young and Eric Dolphy, Indian music and African music, Buddhism, Shintoism, Taoism, Christianity, and Judaism, always seeking, always questing. Miles may have changed music, but Coltrane changed people's expectations of what music should be. In the same way, emergency medicine borrowed from medicine and surgery, pediatrics and psychiatry, anesthesiology and obstetrics, pulmonology and cardiology, and not only changed medicine, but changed people's expectations of what medicine should be.

Welcome to the tribe.

Joe ●

Dollars & Sense

Lessons to Learn from the Early 2018 10% Stock Market Decline

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

In early 2018, the US stock market took about a 10% dive, followed by a partial recovery. What lessons can we all learn from the 10% decline?

1. The stock market is volatile.

Since 2009, the stock market has quadrupled in value. This has given many investors the impression that the stock market does nothing but go up. Those of us with more grey hair (or less hair, in my case) have invested during market declines and know that what goes up can also come down.

Here is a telling chart that shows you the volatility of a portfolio constructed of various portions of stocks and bonds (Source: Vanguard.com):

Stock/Bond Ratio	Maximum 1 Year Decline	Maximum 1 Year Increase
100% Bonds	-8%	+32%
80% Bonds/20% Stocks	-10%	+30%
50% Stocks/50% Bonds	-23%	+32%
80% Stocks/20% Bonds	-35%	+45%
100% Stocks	-43%	+54%

All investors need to take a hard look at this. Notice that a 100% stock portfolio has dropped as much as 43% in a year. In other words, the 10% drop was nothing.

2. Everyone needs a plan they can stick to during market declines.

One of the biggest mistakes investors can make is to sell low. For this reason, you need a financial plan that you can stick to during market declines.

For example, my current overall target asset allocation is 80% stocks and 20% bonds. This is based on my own risk tolerance and retirement timeframe, and I know I can stick to it.

What did I do during the stock market decline? I purchased more stocks. Why? It had nothing to do with the decline, and everything to do with my plan.

When it was time to invest, I took a look at my desired asset allocation of 80/20. I saw that I had less than 80% in stocks, so I purchased more. It was that simple.

Everyone needs a written personal financial plan so that when the seas get rough, you don't bail out. You stick to your plan. My plan was 80% stocks and 20% bonds, and I stuck to it.

What is your plan?

3. Regularly re-assess your own personal risk tolerance.

We've established that a 10% stock market decline is not a big deal. It could be much worse.

It is time for some serious introspection. How did a 10% decline make you feel? Did you sell stocks low? Did you seriously contemplate it?

Me? As I already discussed, I just marched on with my plan, which is what I'd encourage you to do, but everyone is different.

If the decline spooked you a little, you need to reassess your personal risk tolerance. My favorite way is to take the Vanguard survey (https://personal.vanguard.com/us/FundsInvQuestionnaire). There are other ways, though. It could be a conversation with your financial planner. It could be sitting down with your significant other and carefully examining the chart above and talking about it. It could be by getting a second opinion on your plan (https://www.whitecoatinvestor.com/getting-a-second-opinion-podcast-41/).

Whatever it is, you need to do it. For me, it is something I do on an annual basis.

The Bottom Line

Here are the three lessons we all need to learn from the early 2018 10% market decline:

1. The stock market is volatile.
2. Everyone needs a plan they can stick to during market declines.
3. Regularly re-assess your own personal risk tolerance.

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. ●

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AAEM18
SAN DIEGO

- **1,279** total registrants
- **130** speakers
- **276** photo competition submissions
- **8** *West*JEM competition submissions
- **69** AAEM/*JEM* abstract submissions
- **12** YPS poster competition submissions
- **10,298,000** impressions and **3,539** tweets on the #AAEM18 hashtag
- **47** Wellness 5K Fun Run and Walk participants
- **20** Early Risers Yoga participants
- **16** Tai Chi for Mind & Body participants
- **200** Airway at AAEM attendees

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2nd Place — Kraftin E. Schreyer, MD FAAEM
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Kraftin Schreyer, MD
Barriers to Performance Management

Mark Magee, MD
Syncope: A Tale of Ultrasound and Why it Matters

The winners of the 2018 Open Mic will be invited to give a formal presentation at the 2019 Scientific Assembly in Las Vegas, NV.

Photo Competition
Christopher N. Scavelli, DO
A Complicated Foreign Body Removal

AAEM/*Journal of Emergency* Medicine Resident and Student Research Competition
1st Place — Amanda Esposito, MD
2nd Place — Nancy K. Glober, MD
3rd Place — Victoria Zhou

AAEM/RSA & *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health* Research Competition
1st Place — David A. Kim, MD PhD
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Runner-Up — Luther Walls

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Remarkable Testimony: Fighting Back

Howard Blumestein, MD FAAEM
Past Presidents Council Representative

Congratulations. You have been sued for malpractice. And the fun begins.

At some point in the process, the plaintiff must produce an expert who verifies that the assertions made in the complaint are legitimate. That you failed to follow the standard of care. That your failure resulted in harm to the patient.

Many defendant physicians become outraged. They believe the self proclaimed experts are twisting the facts and the relevant standards of care. They believe the experts will say just about anything to satisfy the lawyers who pay them. And they are often right. There is lots of money to be made in court.

I know this personally, because I was once sued and had to sit in court, silently, unable to personally respond or defend myself. Ultimately the jury found in my favor. Apparently they saw through the twisted testimony. But I did not feel any better about the whole episode.

Several years ago, AAEM members clamored for the Academy to "Do Something" about the malpractice crisis. Many other medical societies were lobbying hard for tort reform. We couldn't make a meaningful impact in that arena.

In a classic example of thinking outside the box, the board decided to develop a "Remarkable Testimony" site. Members were invited to submit examples of testimony that they found remarkable because it was either very bad or very good. Among the 20 submissions we received, three met our requirements. They were written up and posted on the AAEM website. The posting included the complete text of the testimony in question and commentary. The witnesses were invited to respond, with the promise that we would post their response verbatim.

We received positive feedback from many Academy members and attention from the press. Attorneys still occasionally reach out to AAEM after finding the site in the course of their web searches.

But the site became dormant. The work involved writing the posts was considerable. We never solicited more cases. The malpractice crisis lost its immediacy. Time and attention turned elsewhere.

The board recently decided to reinvigorate the site.

We are, therefore, issuing a new call for examples of remarkable testimony. "Remarkable" testimony could be very bad, inaccurate, or biased. It could also be succinct and insightful. Submissions should include a cover letter describing the case, a copy of the full testimony itself, and a description of why the testimony is remarkable. Cases should be closed (fully resolved, including appeals).

Cases can be submitted either electronically (testimony@aaem.org) or on paper, mailed to the AAEM offices in Milwaukee.

For more information and to see the cases that were posted in the past, please explore the website at http://www.aaem.org/aaemtestimony/.

Remarkable Testimony – Call for Case Submissions

Purpose: to make known to the emergency medicine community due process cases that are notable and to highlight those physicians whose testimony in malpractice actions is remarkable for any reason.

Emergency physicians who are aware of appropriate testimony are invited to submit the cases for submission.

Visit www.aaem.org/aaemtestimony to learn more and submit.

Past AAEM Board Member Elected President-Elect of ACOEP

Robert E. (Bob) Suter, DO MHA FACOEP-D FAAEM FACEP FIFEM was re-elected to his third board term, and elected President-Elect of the American College of Osteopathic Emergency Physicians. In July, Dr. Suter returned from a Middle East deployment as a Colonel in the U.S. Army Reserve, where he served as the Commander of the medical and health care forces in the 13 nation CENTCOM region. When home in the U.S., he practices emergency medicine in a variety of settings, from small rural hospitals to major academic medical centers as a Professor of Emergency Medicine. He is a Past President of the American College of Emergency Physicians and the International Federation for Emergency Medicine, and served three terms on the Board of Directors of the American Academy of Emergency Medicine. He received his bachelor's degree from Washington University in St. Louis, and received his DO and MHA degrees from Des Moines University in Des Moines, Iowa and a Masters in strategic studies from the Army War College. He was the physician Co-Chair of the federal project EMS Agenda for the Future published in 1995. On the Board of ACOEP, he has worked hard to mentor osteopathic students, residents, and physicians across the US, always available as a coach or mentor. Dr. Suter was the first osteopathic physician to serve in an officer position in ACEP, serving as secretary-treasurer, and President in 2004-05. He was also the first osteopathic physician on the Board of the International Federation for Emergency Medicine, and served as its President in 2006. Before deploying, Dr. Suter was Vice President of Quality and Health IT for the American Heart Association, and a professor in the Department of Emergency Medicine at UT Southwestern in Dallas. In addition to being recognized as an expert clinician, he is also the author of scores of studies, papers, and textbook chapters in emergency medicine, and has given hundreds of presentations worldwide, especially in the areas of Evidenced-Based Practice, EMS, Practice Management, Quality and Health Policy. He has practiced in nearly every imaginable health care practice setting, and has extensive experience in operations and administration, including as a managing partner in a regional emergency medicine group and as the COO of a 15-hospital multi-specialty group of over 200 providers. As a Colonel in the U.S. Army Reserve he has served in Iraq and Afghanistan with the 1st Cavalry and 3rd Infantry Divisions. Dr. Suter is the Reserve Consultant to the Surgeon General for Emergency Medicine, and has commanded the 94th Combat Support Hospital, the 2d Medical Brigade, and the 3rd Medical Command-Forward. ●

AAEM Commends ABEM's Announcement of Alternative ConCert™ Exam

MILWAUKEE — The American Academy of Emergency Medicine (AAEM) commends the American Board of Emergency Medicine (ABEM) for the phased introduction of an alternative to the ConCert™ Exam.

On March 9, 2018, ABEM announced that:

"In 2020, a second way to demonstrate competencies will begin to be phased in. The alternative will consist of:

Shorter, more frequent tests: Each test will assess one or more specific content areas relevant to the clinical practice of emergency medicine, such as cardiovascular disorders or trauma. The tests will be about an hour long.

The ability to take a test again if it's not passed the first time: Additional chances will be available to retake and pass a test, which will give physicians a clearer idea of what topics need to be reviewed."

AAEM president-elect, David A. Farcy, MD FAAEM FCCM, noted that, "AAEM continues to support ABEM's mission of ensuring the highest standards in the emergency medicine specialty and will continue to work with ABEM on making the re-certification less stringent and expensive. We look forward to continued progress and changes in the future."

International Committee

Emergency Physician Working as an EM Consultant in UK and Poland

Grzegorz Waligora, MD PhD

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.

— Ashley Bean, MD MA FACEP FAAEM, Chair, AAEM International Committee

In 2017, I was granted a scholarship for the AAEM Scientific Assembly in Orlando.

As an emergency physician working in Poland and UK, I was very interested to join this conference for the first time in my life. As we all try to advance our knowledge and stay updated with everything in our field, my expectations were very high prior to arrival for this Scientific Assembly.

I have to admit that I was astonished by the positive feeling, extraordinary people, and the quality of presentations that took place during this Assembly.

I was gaining more and more each day, and I think it was a turning point in my professional career. At this conference, I realized that if you want to practice emergency medicine in the way that meets international standards you have to be at such conferences, meet these top-speakers in this field, and participate actively in this type of event.

Moreover, I realized that without strong involvement in such events like AAEM Scientific Assembly, my professionalism will be lacking something very important — it is also about knowing and meeting with people dedicated to emergency medicine, people with great values and great character, people who share similar values in life and work.

I am very proud that I had the opportunity to participate in AAEM Scientific Assembly in 2017 in Orlando and I am very grateful for granting me scientific scholarship for AAEM conference.

As a result of this involvement and participation in the Scientific Assembly I became a member of the AAEM Clinical Practice Committee, International Committee, and Quality Standards Committee. I was also inspired by AAEM to attend MEMC-GREAT 2017 in Lisbon as a speaker, conference abstract reviewer, session moderator, and participant.

In my work place, I managed to inspire my colleague to join AAEM and to actively participate in AAEM conferences ●

Palliative CORNER

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

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

Women in Emergency Medicine Committee

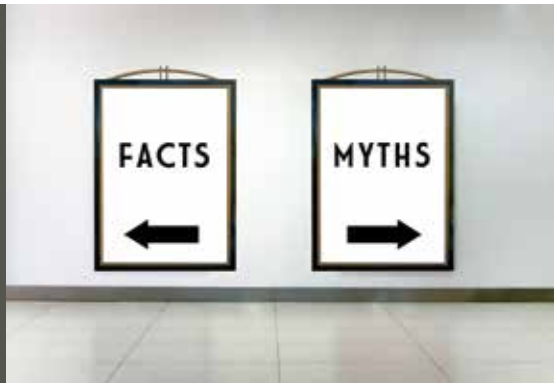
Myth Busting: Women in Emergency Medicine

Megan Healy, MD FAAEM
AAEM Board of Directors

Over the past year, I've participated in great discussion forums about women in medicine. From large conferences to local meetings and online groups, I've witnessed insightful conversation centered on the recruitment, retention and promotion of women leaders in our field. However, there are a handful of stale talking points I hear repeated over and over. These myths make me cringe every time. Men and women, to move this conversation forward, I'd like to propose we examine the evidence and put the following myths to rest, once and for all.

Myth 1: ***The lack of female physician leaders is a pipeline problem.*** According to the AAMC, women represent 50.7% of new medical school enrollees in 2017, surpassing men for the first time.[1] Emergency medicine reflects this same shift – albeit slower – with an ever-growing number of women in training. One recent study showed 38% of EM residents are women, up from 28% in 2001.[2] Yet, women account for 38% of full time faculty, only 21% of full professors, and a measly 16% of deans.[3] One clever study in *BMJ* showed that men with mustaches significantly outnumber women as leaders of U.S. medical departments. They quantified the proportion of women over the proportion of mustaches at major academic institutions and found the overall "mustache index" to be 0.72.[4] The authors set a challenge that every department should strive for an MI greater than or equal to 1 – at least one woman in a leadership position for every mustache. Scan the room at the next high level meeting you attend. We don't have a pipeline problem – we have an advancement problem. If we quit focusing on the pipeline, which has been improving on its own every year, we can focus on the barriers keeping women from climbing the ranks.

> "I'd like to propose we examine the evidence and put the following myths to rest, once and for all."



Myth 2: ***Most problems for women physicians stem from child-rearing issues.*** Across many types of settings, I have seen potentially groundbreaking discussions about how to fix the advancement problem devolve instead into a complaint session about maternity leave. I'll be the first to say, having a parental leave policy on paper is a game changer and every workplace should strive for this goal (see Myth 3). However, focusing too much on maternity leave, we alienate women who are pre- or post- family planning and those without children. There are issues that unite women at all ages and stages of their careers. For example, the problem of gender bias in evaluation of residents. One recent study demonstrated qualitative differences in the feedback that male and female residents received, from faculty of both genders.[5] There are also different rates of milestone attainment tracked for men vs. women in EM training.[6] Let's come together to closely examine the tools we use to evaluate our trainees and see whether bias may be at play during these formative years, then track performance measures across a woman's career. That's an area with potential for lasting impact.

Myth 3: ***A champion of women, whether in academics or the community, is someone who listens.*** I heard a panel in front of hundreds of physicians with two celebrated "champions of women in EM." Both panelists were men, so I was irritated from the get-go. One was a regional manager of a huge contract management group who claimed his shops were "family friendly" because he would sit down with individuals and be "extremely flexible" about their needs. Beware: this load of fluff means go ahead and take as much unpaid time as you want, we are happy to have you back at the end of it all. Keep in mind, recruitment and training of new docs is expensive. Male and female physicians should be wary of companies that claim to support families, with a modus operandi that tells a different story. Remember to carefully scan those contracts for sneaky due process waivers and restrictive covenant tricks – these are the least "family friendly" implements out there. A champion gets policies on paper and makes institutional change. One final point to keep in mind regarding finding a true champion: you'll want this type or person not only in your chair or site director, but also in the individual professional relationships you build. Mentoring is great, but what is most needed for women physicians in their early career is a person who thinks of you when a new opportunity comes up and vouches for you as the best choice. This active process distinguishes a champion from a typical mentor.

Myth 4: ***Men in primary caregiver roles do a sub-par job.*** I found it difficult to listen to one talk recently on a household with "flipped" roles from the "traditional" model, with the woman working full time in EM, and the man doing child rearing. Though a tongue in cheek talk, the physician lamented over the boxed mac and cheese being prepared and the video

Continued on next page

games being played, and learning to "let it go." What should we let go of? The tired notion that men can't, don't, or won't prepare healthy food or provide stimulating activities for children. Personally, if left to my own devices I'd choose Wawa for every meal (come to Philly, you'll understand) and would prefer to never leave the house all winter, whereas my husband crafts meals with grains I've never heard of and regularly ventures out on his bike with our toddler year-round. I'd argue these differences have much more to do with our personalities and childhood experiences than XX/XY. We can't move forward if we keep referencing the 1950s. The share of two-parent homes with two full-time working parents is 46%. It's time to think creatively about division of household duties, including caring for other family members, like aging parents.

I'm heartened that in recent years, emergency medicine has recognized the importance of all kinds of diversity in leadership. Within AAEM, I've seen tremendous growth in opportunities for women and promotion of new voices and ideas at the table. I believe we can do even better for ourselves, and in turn our patients, if we ditch the tired myths above, ask the right questions, identify the most threatening problems and work to fix them in priority order. After all, we are emergency physicians – who is better up for that task? ●

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Critical Care Medicine Section (CCMS)

Mechanical Ventilation in the Difficult Patient and Ventilator Cycling

Joseph Levin, MD
Ashika Jain, MD RDMS FAAEM FACEP, President-Elect CCMS

Mechanical ventilation, conventionally known as invasive positive pressure ventilation, is employed to partially or fully replace spontaneous breathing in patients with impaired ability to adequately oxygenation or ventilate, or both. In severe pulmonary disease or neurologic processes affecting spontaneous respiration, invasive ventilation via the insertion of an endotracheal tube is used to deliver this respiratory support. Modification of the ventilator's delivery of air volume, pressure, partial pressure of oxygen, flow, and rate of delivery should be tailored to the specific pathology afflicting the patient. These variables are sequenced to optimize gas exchange in the lungs while minimizing pulmonary trauma the ventilator itself may cause. Striking a balance between these two tenets of therapy is often challenging due to pathology that alter lung mechanics.

There is a growing body of evidence that protective lung ventilation can be beneficial in non-diseased lungs.[1] This paradigm is defined by low lung volumes (often 4-8ml/kg ideal body weight) and permissive arterial hypercapnea. Prior to this strategy, earlier models of ventilation often employed tidal volumes of 10 to 15ml/kg of body mass, which were required to yield comparable partial pressures of arterial carbon dioxide and physiologic pH values when compared to spontaneously breathing individuals, but subjected patients' lungs to substantial volutrauma and barotrauma known as ventilator-associated lung injury (VALI).[2,3] Lung protective strategy can render a mechanically ventilated patient with respiratory acidosis and decreased arterial oxygenation, yet is associated with lower risk of developing acute respiratory distress syndrome (ARDS), pulmonary infection, and atelectasis in previously uninjured lungs in surgical and ICU patients.[1,4]

In patients with ARDS, protective lung ventilation has become the standard of care, however investigators have challenged this notion.[1,5] ARDS is a constellation of lung pathologies that arise from an intense inflammatory state and increased vascular permeability. Due to decreased lung compliance arising from atelectasis and proteinaceous deposits, recruitment of alveoli to allow oxygenation is impaired. Assist control (pressure control or volume control) with low tidal volumes (6ml/cc of ideal body weight), minimum Fi02, and permissive hypercapnea, can recruit vulnerable alveoli and reduce distending volutrauma. The use of formal alveolar recruitment strategies including high peak end expiratory pressure (PEEP) and open lung ventilation is not routinely recommended due to lack of standardization and unclear benefits, in addition to potential harm associated with prolonged distending pressures.[6,7] Studies have shown, however, that employing a low tidal volume ventilation strategy is associated with lower mortality in patients with ARDS. Since the landmark ARDSNET ARMA trial showed lower mortality associated with low tidal volumes, subsequent investigations have corroborated the benefit of lung protective strategy in ARDS.[2,8,9] Airway pressure release ventilation (APRV) has challenged the ARDSnet protocol in its methodology. Nevertheless, both support open lung ventilation.

Low tidal volume is only one part of the equation. In fact it is a compensatory parameter in order to achieve open lung ventilation, which is mostly achieved by higher PEEPs. When thinking about ventilation pressures, and mechanical ventilator support, it is crucial to understand the physiology first, i.e., peak inspiratory pressure (PIP), plateau pressure and PEEP. PIP is the maximum pressure in the lungs during inhalation. Increased airway resistance will increased the PIP. Plateau pressure is the pressure in the alveoli. It is measures when there is no airflow in the system, when inspiration is complete. Lung compliance will greatly affect the plateau pressure. In order to open the alveoli, ventilator pressure must be higher than the plateau pressure. PEEP is the airway pressure above atmospheric pressure at the end of exhalation by means of mechanical impedance. It can be created intrinsically, (pursing lips during exhalation) or extrinsically (dialed in by ventilator). PEEP mitigates alveolar collapse.

Whether you believe in ARDSNET or APRV, open lung ventilation is the key to prevent atelecta-trauma and baro-trauma during this low compliance state. The ventilator will deliver the programmed amount of volume and pressure without regard for successful ventilation. Whether or not it was delivered to the alveoli is up to the parameters set. Without adequate pressure, the ventilator will continue to deliver inadequate breaths causing a spiral incomplete ventilation.

Other disease states affecting the lung at the level of the alveoli may benefit from low tidal volumes, as well. Acute pulmonary edema, pneumonia, sepsis, trauma, shock are proven risk factors for development of acute lung injury (ALI) and ARDS.[10,11] While data is limited to cohort studies and animal models, traditional ventilation strategies in critically ill subjects without previously injured lungs are associated with increased inflammatory markers in bronchial washings and are at higher risk for the development of ALI/ARDS, where utilization of lung protective measures demonstrates reduced mortality.[10,12,13,14]

During acute exacerbations of obstructive lung disease such as chronic obstructive pulmonary disease (COPD) or asthma, patients may require invasive mechanical ventilation as a result of respiratory distress refractory to medical therapy and noninvasive positive pressure ventilation. The goal of mechanical ventilation in these patients is to rest fatigued respiratory muscles, provide adequate oxygenation, and prevent dynamic hyperinflation from "air trapping." Due to increased airway resistance at the level of the large and medium airways, heightened peak airway pressures are expected. Even with non-elevated plateau pressures, however, there is speculation that due to heterogeneous obstruction patterns, high peak pressures may pose the risk for barotrauma to alveoli distal to less obstructed regions.[15]

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Mechanical ventilation strategies in patients with obstructive lung disease require a balance between airway pressures and inspiration-expiration ratio to maximize gas exchange. In patients with severe obstruction, presumed intrinsic PEEP) may lead to deterrence in applying extrinsic PEEP due to concern of worsening already increased lung volumes. In contrast, the application of external peep will allow for acceleration of expiratory phase of breathing and improved CO2 unloading.[15,16] The key to successful ventilation in this case is a prolongation of the expiratory phase, often 1:3 to 1:5. This often comes at a sacrifice of minute ventilation required to normalize the pAC02. As with ARDS, a strategy of permissive hypercapnea can be employed which has been shown to be well tolerated by patients with obstructive lung disease and reduce ventilator associated lung injury.[14,17]

Assisted and supported mechanical ventilation is intended to share the work of breathing with the patient, serving to unload fatigued respiratory muscles, facilitate ventilation and oxygenation, and coincide with the patient's own efforts. Despite employing optimized ventilator strategies, however, undesired interactions between the patient and ventilator called dissynchrony can lead to "imposed" respiratory muscle loads and impair gas exchange. These can present during any phase of the ventilator cycle: initiation, breath delivery, or the inflection point of inspiration/expiration. Most dissynchrony occurs when the ventilator does not sense patient efforts leading to missed breaths or there is a process driving excessive triggering.[18] Absent triggers are largely due to inappropriately set negative pressure (or flow) trigger thresholds that exceed a patient's ability to generate necessary inspiratory force as a result of fatigue and illness. Elevated lung volumes at end-expiration, intrinsic PEEP, can also be prohibitive by increasing the amount of negative pressure required by the patient to overcome for ventilator triggering. Inappropriately high sensitivity thresholds can induce unintended triggering (autotriggering) of the ventilator, which can in turn result in patient tachypnea, barotrauma, worsening intrinsic PEEP, and increase sedation requirements. Noxious stimuli including pain, cardiac ischemia, foreign body sensation from the endotracheal tube, among others will also stimulate the respiratory center of the CNS to cause excessive triggering.[19] Perhaps most interestingly, there is suggestion that a controlled mechanical breath itself can stimulate a subsequent spontaneous breath, a process known as entrainment.[20]

Synchrony of the patient with the ventilator relies on the interplay between respiratory mechanics (loading patterns) and the central neural drive of respiration (controller).[21] Acute illness producing acidosis, hypoxemia, and increased metabolic demands all stimulate the controller to increase minute ventilation. An inability of the ventilator to match controller demand promotes ventilator dissynchrony with ensuing imposed respiratory loads.[16]

Dissynchrony during cycling phase arises from a mismatch between anticipated breath termination by the controller and the end of the delivered mechanical breath. A mechanical breath that ends after the neural inspiratory time will promote discomfort via initiation of expiratory muscle contraction. In contrast, an inspiratory time delivered by the ventilator that terminates before the controller inspiratory time prolongs muscle contraction of the diaphragm and accessory muscles driving imposed loading. These factors can both result in dynamic hyperinflation.[19]

Patient-ventilator interactions are complex and can be difficult to manage in situations where patients have significantly altered lung mechanics and capacity for gas exchange, as in diffuse lung disease such as ARDS or obstructive processes. Ventilator strategies must be employed that optimize gas exchange while minimizing iatrogenic harm from volutrauma, atelecta-trauma, and barotrauma. Understanding pulmonary pressures as they relate to the ventilator is crucial in achieving synchrony and adequate ventilation. Without the basic understanding of the relationship of physiology and ventilator mechanics, management of complex pulmonic processes prove to be intangible. Novel ventilation strategies that respond automatically to patient-ventilator feedback such as proportional assist ventilation (PAV) and neutrally adjusted ventilator assist (NAVA) may be the next step in addressing these complex interactions, but more research is needed.[19,22]

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Board Member

Haig Aintablian, MD

Hometown: Los Angeles, CA
Undergrad: University of Southern California
Medical School: University of Arizona College of Medicine
Residency Program: UCLA Medical Center
Professional Interests: Healthcare administration & policy, disaster medicine, aerospace medicine
Hobbies: Meteorite collecting, curling, martial arts, photography, astronomy, astrophotography

Board Member

Crystal Bae, MD MSc

Liaison to the International Committee
Hometown: Baltimore, MD
Undergrad: Duke University
Medical School: University of Maryland School of Medicine
Residency Program: Temple University
Professional Interests: International EM, education
Hobbies: Traveling, board games, hiking

Board Member

Lauren Falvo, MD

Liaison to the Wellness Committee
Hometown: Sparta, NJ
Undergrad: Wake Forest University
Medical School: University of Kentucky
Residency Program: Indiana University
Professional Interests: Medical education, simulation medicine, interprofessional communication, physician wellness
Hobbies: Music, running, rock climbing

Board Member

Trisha Morshed, MD

Liaison to the Education Committee
Hometown: Portland, OR
Undergrad: Arizona State University
Medical School: University of Arizona
Residency Program: University of California
Professional Interests: Global health, wilderness medicine
Hobbies: Travel, acrobatics, weightlifting, surfing, yoga, backpacking, hiking

Board Member

Nicholas Pettit, DO PhD

Liaison to the Social Media Committee
Hometown: Columbus, OH
Undergrad: Miami University
Medical School: Ohio University
Residency Program: Indiana University
Professional Interests: Research, cancer in the ED, palliative care
Hobbies: Golf, my family, The Ohio State University sports

Board Member

Faith Quenzer, DO

Liaison to the Diversity & Inclusion Committee
Hometown: Stockton, CA
Undergrad: UC San Diego
Medical School: Western University of Health Science
Residency Program: Desert Regional Medical Center
Professional Interests: Research, women in EM, ultrasound
Hobbies: Surfing, swimming, kayaking, reading, traveling, eating good food, learning new languages

AAEM/RSA Medical Student Council President

Shea Boles

Hometown: Sonoma, CA
Undergrad: Santa Clara University
Medical School: Loyola University Stritch School of Medicine
Hobbies: Volleyball, running, cooking

AAEM/RSA Medical Student Council May 2018 – May 2019

Medical Student Council President
Shea Boles
Hometown: Sonoma, CA
Undergrad: Santa Clara University
Medical School: Loyola University Stritch School of Medicine
Hobbies: Volleyball, running, cooking

Medical Student Council Vice President
Joshua Novy, MBA MS
Hometown: Long Island, NY
Undergrad: Cornell University
Medical School: University of Miami Miller School of Medicine and Miami Business School (MD/MBA)
Professional Interests: Trauma and pre-hospital care, administration
Hobbies: Cooking! (former MasterChef casting finalist), off-roading in my Jeep, playing with dogs #dogperson

Western Regional Representative
Mitchell Zekhtser
Hometown: San Francisco, CA
Undergrad: San Francisco State University
Medical School: Western University of Health Sciences
Professional Interests: Education, critical care, ultrasound
Hobbies: Skateboarding, international travel, dancing, music festivals, eating

Midwestern Regional Representative
Henrik Galust
Hometown: Los Angeles, CA
Undergrad: UCLA
Medical School: Northeast Ohio Medical University
Professional Interests: Medical education, leadership & administration, critical care
Hobbies: Family time, reading, cooking

Southern Regional Representative
Theddy Blanc
Hometown: North Miami Beach, FL
Undergrad: University of Central Florida
Medical School: Nova Southeastern University Kiran C. Patel College of Osteopathic Medicine
Professional Interests: Wellness, ultrasound, critical care
Hobbies: Kickboxing, comic collecting, hiking

Northeastern Regional Representative
Jordan Powell
Hometown: Dallas, TX
Undergrad: Xavier University of Louisiana
Medical School: University of Rochester School of Medicine and Dentistry
Professional Interests: International medicine, public health, medical education, clinical research
Hobbies: Travel, HIIT, weight lifting, food, hiking, trying new recipes

Ex-Officio International Representative
Hannah Mezan
Hometown: Katonah, NY
Undergrad: Tulane University
Medical School: University of Queensland - Ochsner Clinical School
Professional Interests: International medicine, pediatric EM, critical care
Hobbies: Traveling, kickball, beach time with my dog

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Midwest MSS
September 22nd

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September 22nd

AAEM/RSA President's Message

A Year in Review

Ashely Alker, MD MSc
AAEM/RSA Immediate Past President

It has been my honor to serve as the president of the AAEM Resident and Student Association (RSA) for the past year. I have been so proud to work for my co-residents around the country, creating innovations to make your residency experience more fulfilling, as well as advocating for resident futures.

This was a year of many challenges including the loss of AAEM's president, Dr. Kevin Rodgers. RSA has taken many steps to honor the memory of Dr. Rodgers, including partnering with the AAEM Wellness Committee for a storytelling event that took place at the 24th Annual AAEM Scientific Assembly, and the renaming of the RSA Program Director of the Year award to the Kevin G. Rodgers Program Director of the Year Award.

The **RSA Wellness Committee** has done an outstanding job this year, dedicating much of their efforts to prevention of physician suicide, participating in the #BeThe1To and Take Five to Save Lives campaigns. The Wellness Committee also continues working to create a combined physician wellness initiative with other emergency medicine organizations.

This was the first full year for the **RSA Diversity and Inclusion Committee**, which created its mission statement. The committee supported the FemInEM FIX conference, including two resident scholarships to attend and the RSA networking event held at FIX. RSA also continues to have our recruitment booth at the Student National Medical Association (SNMA) Conference.

The **RSA International Committee** has engaged in international resident and student mentoring. The committee has also embarked on the creation of the international resident database, which would offer our international members guidance and research opportunities.

The **RSA Social Media Committee** continued to bring you relevant tweets, and the RSA blog, which continues to offer RSA members opportunities to submit articles for a peer review publication.

RSA **supported medical students** by participating in the monitoring and improvement of the AAMC Standardized Video Interview (SVI) Project, which will now have a second year of testing, after feedback from emergency medicine organizations. RSA also continues to increase funded medical student events, from our annual student symposium events in Chicago, New Orleans, and New York, to potential medical student events in Florida and California.

RSA is truly dedicated to innovations in emergency medicine resident education and advocacy.

This year RSA has focused on resident education, and the **RSA Education Committee** has done a stellar job creating the RSA track at this year's AAEM Scientific Assembly. As always, attendance to AAEM Scientific Assembly is FREE for RSA members. This RSA track educates residents on the missing curriculum of residency, including the financial, political and legal aspect of medicine. RSA also continues to contribute

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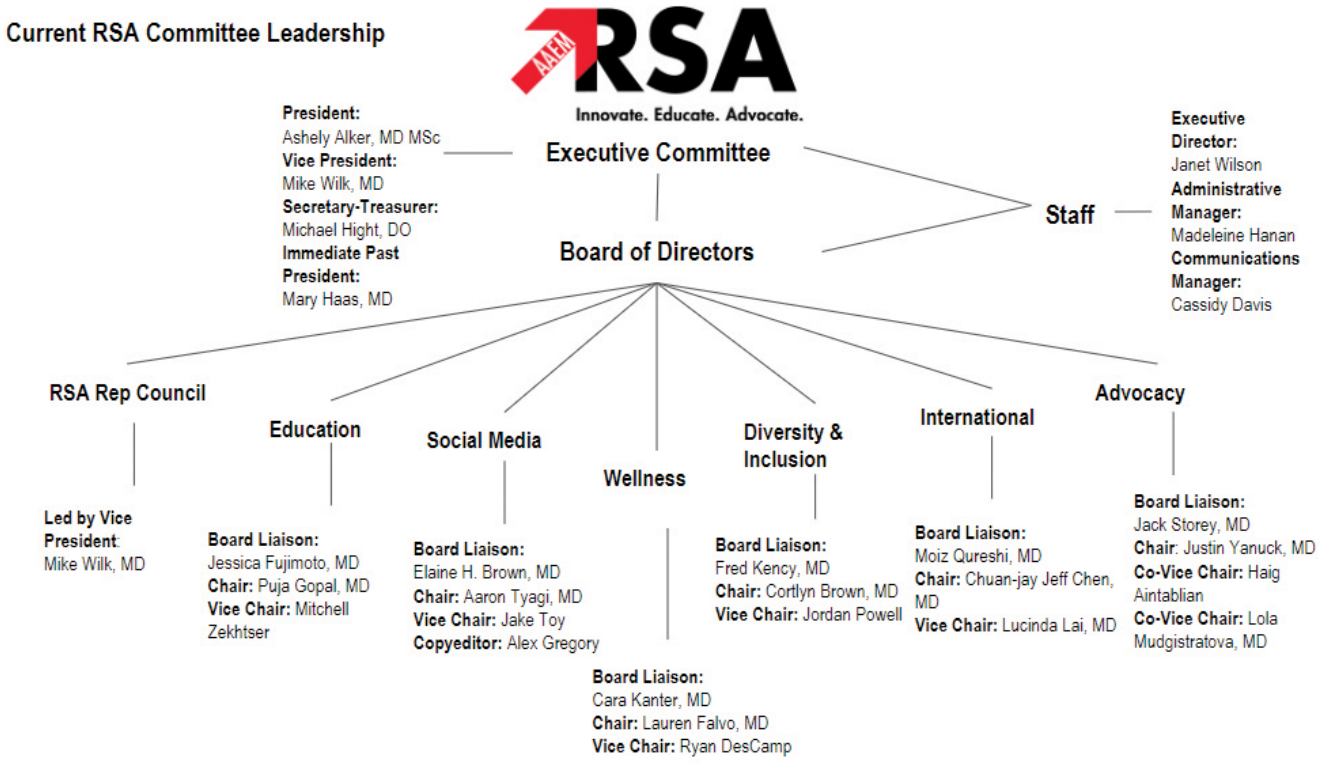

to the residents track at CORD Academic Assembly, and sponsors the resident dodgeball event at SAEM's annual meeting. Additionally, the Education Committee has produced over a dozen RSA podcasts on topics relevant for residents.

The **RSA Advocacy Committee** continues to support, as well as educate residents on health policy. RSA and AAEM are planning our second annual Health Policy in Emergency Medicine (HPEM) Conference in June 2018. This conference takes place in Washington D.C. and is free for members. We will discuss active issues in health policy. In the past HPEM hosted speakers from such governing bodies as Health and Human Services. Abutting the conference will be our AAEM and RSA Advocacy Day on Capitol Hill, where we will speak with members of Congress about issues that affect students, residents, and their patients. Historically RSA has focused on such issues as protecting the prudent laypersons laws, maintaining Public Service Loan Forgiveness with no cap on forgiveness amount, and expanding the National Health Service Core to include Emergency Medicine.

RSA also continues our **Congressional Elective with Congressman Ruiz**, where residents can spend one month working in the office of the Congressman as a health policy fellow. RSA created scholarships for the elective of up to $2,000 per awardee.

This year would not have been possible without the outstanding leadership of the RSA board members, committee chairs and vice chairs, as well as the tireless work of our Representative Council, Medical Student Council and committee members. Additionally, a very special thanks to the RSA executive staff for their support and guidance through the years. The dedication of these residents and medical students has led to the success and growth of the AAEM Resident and Student Association.

Thank you for your dedication to the future of medicine. ●

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- Significance of Completing a Residency Rotation Abroad
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Lessons from the Front Lines

AAEM/RSA Congressional Elective

Rachel Solnick, MD

From recent headlines, it seems like we live in a world of escalating incivility in Washington, D.C. From the White House being called an "adult day care center" by a Congressman, to the HHS Secretary resigning over abuse of government funds, to protesters in wheelchairs getting forcibly removed by police, the current environment does not lend itself to collaborative problem solving. In the context of the generalized vitriol it is hard to remember that buried behind the layers of gridlock, there is a busy hive of earnest civil servants, toiling under insurmountable stakes and odds, venturing into the policy weeds, and looking for real solutions.

One such beacon of light is Congressman Raul Ruiz of California. As an emergency medicine doctor with Harvard degrees in public health and public policy, Dr. Ruiz is dedicated to not only representing his constituents but in evidence-based policy with a special interest in the underserved. This real world approach is sorely missing from a dogma driven system which too readily rewards talking points and too regularly misses content. Luckily for me, one of his other interests is in developing and educating a pipeline of leaders. Through a collaboration of Dr. Ruiz's and AAEM/RSA to create the Congressional Elective, I had the opportunity to serve on the Congressman's staff as their Health Policy Fellow for one month. Getting to dive straight into a role immersed in a different work environment was a remarkably valuable and unique opportunity to learn how legislation and government works. While it is disappointing that much of the work produced by legislators gets caught in a sticky quagmire of inaction, it was enlightening for me to see the themes that influenced what gets flagged, investigated and acted on: 1) constituents as king, 2) the knowledge economy and 3) priorities as triage.

Though it may seem like big interests have gobbled up much of the D.C. agenda, representation is still firmly rooted in the constituent matters. One of my first actions in acquainting myself to the office was in learning how their constituent opinion tracking software works. Whenever someone calls their local California or D.C. office, the address is checked to confirm their district, and then their opinion is stored under an issue group. During my time there, President Trump's plans for ending the DACA program and the Graham-Cassidy health reform proposal were making the phones to ring off the hook. Daily totals on how many calls and emails we had received for trending issues were recorded and helped inform a magnitude and direction of the public opinion. Many of the people who called in had been initially contacted by an action alerts from an interest group which then forwarded the call to our office, demonstrating that a strategic nudge can amplify the impact of a specific interest. These constant reminders that real people are watching federal policy help to hold politicians accountable, and reminds them that whenever they take a vote on a bill or amendment, they must ask themselves, "If I am stopped on the street and asked about this, how do I explain in one line why I decided to do this?"

Secondly, in the land of white papers, reports, and pithy statistics that is the knowledge economy of D.C., finding evidence can be a cakewalk for second hand facts, but a much more challenging maze to drill into details. Every day in D.C. there are scores of hearings, think tank briefings, interest group or professional group informational lunches, industry seminars or receptions. Lobbyists come in droves to pass out their one-pagers giving a select sampling of facts. Other members of Congress send out "dear colleagues," that eloquently request bill co-sponsorship. Senate and House hearings invite experts to testify, which is often a soapbox for a Member to go on the record with his/her own statements. Congress commissions studies requesting investigation with party line objectives in mind. Much of the informational stew is steeped in specific agendas, making original inquiry less common. In those scenarios, Congress has its own version of a think tank, the Congressional Research Service. This group of researchers and librarians create general analysis on a myriad of governmental issues and also Member-requested reports as a nonpartisan service to Congress, and is an incredible resource for getting instant access to content experts. Though it is striking and should be thought provoking that Congress has not paid for access to pay-wall protected research journals, the CRS can help pull these articles for Members upon request. Part of the challenge to operating in D.C. is the mountain of institutional knowledge needed about how federal agencies work to even know which levers to pull. The clear reports from the CRS are a boon to a crowded arena of agenda driven information.

Lastly, I was impressed with how much of Congress's policy prioritizing is like triaging in the emergency department. ED's across the country are strained by an epidemic of boarding which slows the department flow and

Continued on next page

is a dangerous setting for unstable patients. Similarly, Congress is dealing with an epidemic of bill and appropriation boarding. So many programs requiring government funding are waiting in the purgatory of gridlock, that when the crashing patient (during my month this was hurricane funding, home visiting programs for mothers and CHIP) comes through the door, the departmental resources are already too hampered to give the best care possible or the attention it deserves. Though CHIP funding expired at the end of September, a final decision on the program still has not been made. Helping to stall the decision is the fact that most states still have enough funding for a couple of months. But it is not as if this was a surprise deadline. The problem is that with so many other issues are vying for attention, Congress is by de facto design unable to be proactive. A frustrating feature of Congressional triaging is how much of it is not related to acuity. One might think that the decision process for voting on a piece of legislation would be somewhat merit-based, perhaps influenced by the number of co-sponsors, or if it has been reintroduced and built a groundswell of support, or a bipartisan bill. However, Chairmen of Committees have no such transparent merit-based system, they can simply choose the bills they want. In the long road of obstacles for legislation to be enacted, almost all are easily thwarted in the opening round by the whims of an opposing Chairman. This frustrating truth makes me even more thankful for our triage nurses and their protocol driven approach.

During my fellowship period, Congress felt like a whirlwind with the end of the fiscal year, health reform "Hail Mary's" and a historic level of hurricane destruction. But in looking forward, recollecting the challenges that the system, Congressmen, and those who seek to influence them face, there is likely little smooth sailing ahead. With that in mind, it is heartening to know that at least for Dr. Ruiz's office, the people manning the ship are working incredibly hard to steer it in the right direction. ●

Join an AAEM/RSA Committee!

Fall committee application deadline: August 1, 2018

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Wellness Committee

Committee members will focus on resident and student wellness initiatives including taking on new initiatives like creating a wellness curriculum and identifying the unwell resident and/or student. Committee members will act as liaisons to the AAEM Wellness Committee in helping to plan activities for the annual Scientific Assembly that enhance their vision of making Scientific Assembly a rejuvenating wellness experience for EM physicians, residents, and students.

Advocacy Committee

Committee members staff three sub-committees, focusing on patient advocacy, resident advocacy and political advocacy both at the state and national levels. Your activities include developing policy statements, outreaching to AAEM/RSA members about critical issues in emergency medicine, and collaborating with the AAEM Government Affairs Committee.

Diversity & Inclusion Committee

Committee members will work with the AAEM Diversity and Inclusion Committee to plan and execute the Resident and Student Track at the annual ACMT meeting, outreach to underserved medical schools, and create resources for minority residents and students in emergency medicine.

Social Media Committee

The Social Media Committee members will contribute to the development and content of RSA's four primary media outlets: the RSA Blog Modern Resident, the AAEM/RSA website, Facebook and Twitter. The committee also oversees development and revisions of AAEM/RSA's multiple publications including clinical handbooks and board review materials. You will have numerous opportunities to edit, publish, and act as peer-reviewers, as well as work from the ground-up in developing AAEM/RSA's expansion to electronic publications.

Education Committee

Committee members plan and organize the resident educational track at the AAEM Scientific Assembly, which will be held March 9-13, 2019 in Las Vegas, NV. You will also assist with the medical student symposia that occur around the country.

International Committee

The International Committee will have the opportunity to contribute to international medicine projects and resource development that are helpful and beneficial to students and residents.

AAEM/RSA Editor

The Unfortunate Case of the Costa Rican Colles' Fracture: An Up-Close Case Study of Costa Rica's Emergency Department

Kayla King
RSA International Committee Member

Picture this: you're on a study abroad in beautiful, picturesque Costa Rica, in between your first and second year of medical school, learning about their health care system and practicing medical Spanish. You're travelling to volcanoes, beaches, national parks, and national sloth reserves, taking pictures for every social media account possible, with six classmates. Seems glorious, right? Now, imagine that you're doing all this, except you have a bright blue cast on your dominant wrist.

… What?

It's, unfortunately, a true story. We were playing pick-up soccer when an errant ball struck my classmate's wrist just the wrong way, breaking it into a nearly textbook picture of the Colles' fracture we saw in the third week of our anatomy class.

Now, picture this as well: we're quite obviously foreigners in this Latin American country and have no exposure to their health care system (or their emergency department). Our medical Spanish is subpar, at best. So how the heck are we supposed to take care of her?

Still the relaxing trip that you envisioned four paragraphs ago? Yeah, us neither.

Fortunately, our Costa Rican professor (who has no medical training) was with us and took her to the local private emergency department, where we learned an invaluable lesson about the Costa Rican health care system, it is split into two parts: public and private. The public system is the one that the Costa Ricans are most known for: a universal system that allows everyone to be seen and receive care — regardless of financial wealth or social status. It quite literally means that every Costa Rican who pays into the system will get free health care, no matter if it is a heart transplant or cough syrup. Their system means that whoever pays into the system gets seen by the same physician and receives the same care as the next person. The system that they pay into is part of a five part system, but the most similar explanation of how they pay into the system is that the government takes it out of their taxes, and that they are registered into the nationwide computer system.

Their private sector offers the same services, but the Costa Ricans have to pay for the services they receive there. Now, my question is: why even have a private sector? And the answer is simple: short waiting times. For example, in the public sector, it could take four to nine months to get a mammogram, but in the private sector it is done on the same day. So when you pay for it, you get it. Richer Costa Ricans will pay the out of pocket expenses to avoid the lines and see a doctor faster.

Additionally, medical training there is structured differently than in the United States; after a six-year medical education that begins directly following high school, newly minted doctors are eligible to apply for a residency, but residency spots are scarce. Costa Rica produces about 700 new doctors each year, but there are about 65 residency slots. That's roughly 10% becoming residents after graduation. The other 90%? They become general practitioners, working in primary care clinics in both rural and urban Costa Rica. They have other options to do non-clinical specialties as well, such as public health or administration.

So who staffs the Costa Rican Emergency Departments? Residency certified and trained attending physicians. There are also ED residents who work under those attendings, as well as 6th year medical students rotating in and out, just like our 4th year students do here. Funny enough, those same doctors who work in the public sector will also be found in the private sector.

Lucky for us, those attendings happened to be at the private ED that our professor took my classmate to. After walking into the emergency department, my classmate was registered and seen within 30 minutes. She was examined in the waiting room of the emergency department and diagnosed with a probable fracture. The physician then told her that the charge for an X-ray of her wrist would cost $300 upfront, taking time to explain the charges. Once she agreed and paid, the X-ray technician took her back and filmed her wrist. After it was filmed, she was sent back out into the waiting room (not a hospital room), until the physician returned with confirmation of the fracture. Taking her out of the waiting room a second time, he led her back into a small casting room to cast her wrist. Total cost of the entire visit? $450. Now, had our professor taken her to the public hospital, the wait would have been much longer, but it would've only cost $50-$100. He chose to take her to the private hospital because he knew she had travelers insurance and he didn't want to wait for hours on end to get her taken care of.

Another question though: why did my classmate have to pay in this universal health care system? Again, another sensible answer — she's a foreigner, she's not in their system. She has never paid into the Costa Rican health care, so she has to pay out-of-pocket for the care she receives.

Though my friend was initially disappointed to have to wear a cast for the rest of our trip, she quickly realized she was very impressed with her treatment and visit. The final price was satisfactory, but more than that, she appreciated how she was informed of the X-ray cost before agreeing to obtain the test. She felt it allowed for more transparency in her care, empowering her, as both a foreigner and a patient, to make an educated decision.

As unfortunate as it was for my friend's wrist, the personal exposure to the Costa Rican health care system was invaluable. We were learning about the health care system in our classroom, but hearing her experience fleshed things out even further. Sometimes, I guess you just have to take a soccer ball to the wrist to fully understand the lecture material! ●

Resident Journal Review

Update on Direct Oral Anticoagulants in the Emergency Department

Authors: Megan Donohue, MD MPH; Erica Bates, MD; Robert Brown, MD; Christine Carter, MD; Hannah Goldberg, MD
Editors: Kami M. Hu, MD FAAEM and Kelly Maurelus, MD FAAEM

Questions: What new information do we have regarding direct oral anticoagulants (DOACs), specifically:

1. What is the most recent safety data?
2. Do our standard coagulation assays provide an accurate measure of anticoagulant activity?
3. Where do we stand with reversal agents?

Introduction

Use of DOACs such as rivaroxaban (Xarelto®), apixaban (Eliquis®), edoxaban (Savaysa®), and dabigatran (Pradaxa®) has increased dramatically since dabigatran first hit the market in 2009. Data from four major trials (ARISTOTLE, ROCKET-AF, RE-LY, ENGAGE AF-TIMI 48) supported the safety of DOACs and promoted their FDA approval.[1,2,3,4] Their use presents some challenges in the management of the therapeutically-anticoagulated patient. This article reviews recent data on safety metrics, assessment of coagulopathy, and reversal strategies for these drugs.

Xu Y, Schulman S, Dowlatshahi D, et al. Direct Oral Anticoagulation or Warfarin-Related Major Bleeding Characteristics, Reversal Strategies, and Outcomes from a Multicenter Observational Study. *CHEST*. 2017;152(1):81-91.

Because the early trials have been criticized for limited generalizability due to relatively low rates of therapeutic INR and reversal in the warfarin groups, the authors of this study sought to determine if their findings were reproducible in a more generalizable population with a higher rate of attempted warfarin reversal. To achieve this, the Bleeding Effected by Direct Oral Anticoagulants (BLED-AC) study looked at post-market surveillance data; which is used to asses and monitor safety in the real-world setting.

The study included data from five tertiary care hospitals in Ontario, Canada, on adults over 66 years old with atrial fibrillation or flutter who were taking warfarin, rivaroxaban, apixaban, or dabigatran and were hospitalized for major bleeding. Outcomes included location of bleeding, treatment strategies, and survival rates. Patients were excluded if they had a prosthetic heart valve or if their initial presentation did not involve hemorrhage.

The data included 460 patients using DOACs and 1,542 on warfarin. The mean age was 81 years old. There were no significant differences between the two study groups in general demographics, blood pressure, or hemoglobin levels at presentation. There was an increased prevalence of chronic kidney disease (CKD) and INR elevation among the warfarin group which was expected given the contraindications to use of various DOAC in CKD and the known general lack of effect on INR. The warfarin group had more intracranial hemorrhages (19.0% vs 13.3%, $p < 0.01$) and the DOAC group had more gastrointestinal bleeds (31.1% vs 17.3%, $p < 0.01$), which translated to a higher rate of packed red blood cell transfusions in the DOAC group (52% vs 39.5%, RR 1.32, 95% CI 1.18-1.46). The warfarin group received more vitamin K, fresh frozen plasma, and prothrombin complex concentrate. Survival comparison showed lower in-hospital mortality in the DOAC group (9.8% vs 15.2%, $p<0.0001$), but no statistically significant difference in all-cause mortality at 30 days (12.6% vs 16.3%, 95% CI 0.61-1.03).

Despite inherent limitations of retrospective chart reviews, this study addressed criticisms of previous studies by comparing outcomes to a control group representative of current clinical practice. Other strengths included a large sample size and its longitudinal nature. The authors conclude that their results confirm the relative safety profile of the DOACs in comparison with warfarin.

Ebner M, Birschmann I, Peter A, et al. Emergency Coagulation Assessment During Treatment with Direct Oral Anticoagulants: Limitations and Solutions. *Stroke*. 2017;48(9):2457-63.

DOACs pose a challenge to EPs because, unlike for warfarin, there is no rapid, reliable test to determine how anticoagulated a patient is. This fact hinders decision-making in conditions such as ischemic stroke, where thrombolysis might otherwise be offered, or hemorrhagic stroke, where reversal agents may be necessary. Ebner et al. evaluated samples collected as part of a separate prospective observational study, the POCT-DOAC trial (Point-of-Care Testing of Coagulation in Patients Treated with Direct Oral Anticoagulants), which determined that point-of-care testing allows the rapid identification of clinically-significant concentrations of dabigatran and rivaroxaban (but not apixaban) in nonbleeding patients. For this investigation, they looked to see if the prothrombin time (PT), activated partial thromboplastin time (aPTT), and thrombin time (TT) could reliably screen for clinically significant concentrations of the same DOACs.

They evaluated 481 samples of blood from 96 patients taking dabigatran, rivaroxaban, and apixaban; serial blood samples were drawn after medication administration to obtain samples with different drug concentrations. Patients with baseline coagulopathy or recent use of other anticoagulants were excluded. PT, aPTT, and TT were performed for each sample and were compared to drug concentrations obtained using ultraperformance liquid chromatography-mass spectrometry, the gold standard test to determine the actual plasma concentrations of DOACs. A concentration of 30 ng/ml was used as a cutoff for "safe" levels in patients undergoing possible thrombolysis or surgery. Sensitivity and specificity were calculated for each DOAC, and receiver operating characteristic (ROC) analysis was used to calculate optimized PT, aPTT, and TT cutoff values that were >95% specific for concentrations <30 ng/ml.

For dabigatran, a normal aPTT was 91% sensitive but only 49% specific for a level <30 ng/ml. Adding a normal PT did not significantly increase specificity. A normal TT was 100% specific for a level <30 ng/ml, but only 26% sensitive. Increasing the cutoff levels for TT increased sensitivity to

Continued on next page

95-99% but decreased specificity to 90%. For rivaroxaban, a normal PT was 77% specific with 94% sensitivity, and as with dabigatran, addition of PT values did not improve accuracy. The coagulation assays were unreactive to apixaban; normal test results had a less than 20% specificity for apixaban concentrations <30 ng/ml. The modified cutoff values obtained with ROC analysis for dabigatran and rivaroxaban improved specificity but markedly decreased sensitivity (to 22% and 47%, respectively). Enhanced cutoffs could not be established for apixaban.

Overall, this study demonstrated that these standard coagulation tests are not sufficient to reliably identify patients with DOAC serum concentrations safe for surgery or thrombolysis. While using the modified cutoffs can increase identification of patients with higher dabigatran and rivaroxaban concentrations, the low sensitivities decrease the identification of patients who do not necessarily require the time and expense of additional reversal. Strengths of this study include investigation of the more commonly used oral anticoagulants and application of tests commonly and rapidly available in emergency departments nationwide. Despite the determination of reagent-specific optimized cutoff ranges, it remains unclear whether the specific reagents used for this study are standardized or rapidly available.

Pollack CV, Reilly PA, van Ryn J, et al. Idarucizumab for Dabigatran Reversal –- Full Cohort Analysis. *N Engl J Med.* 2017;377(5):431-41.

The increased use of dabigatran led to an increased incidence of dabigatran-related hemorrhage, requiring the creation of its reversal agent idarucizumab (Praxbind®). In 2015, interim analyses of the REVERSE AD (A Study of the RE-VERSal Effects of Idarucizumab on Active Dabigatran) trial were published, resulting in the licensing of idarucizumab use in several countries. This paper reports results from the full cohort analysis of the REVERSE AD trial.

Pollack, et al., designed a multicenter, prospective, single-cohort study to evaluate the reversal effects of idarucizumab in patients known to be on dabigatran who presented with life-threatening bleeding (group A) or need for non-bleeding related emergent surgery within 8 hours (group B). "Life-threatening bleeding" was defined as fatal bleeding, symptomatic intracranial bleeding, reduction in hemoglobin of at least 5g/dL, transfusion of at least 4 units of blood or packed cells, bleeding associated with hypotension requiring the use of inotropic agents, or bleeding necessitating surgical intervention. The primary endpoint was the maximum percentage reversal of anticoagulant effects within 4 hours of administering idarucizumab 5g intravenously. Labs were monitored both on site and at a central laboratory, but results from the latter were not revealed to treating physicians. Locally, complete reversal was defined as normalization of diluted TT or ecarin clotting time. Centrally, aPTT and concentration of unbound dabigatran were also reviewed. Additionally, clinicians performing the surgery or procedure evaluated and rated hemostasis as either normal or mildly, moderately, or severely abnormal.

There were 301 patients in group A and 202 in group B. The majority of bleeding was gastrointestinal (39%) intracranial (35%), and trauma-related (18%). The median maximum percentage reversal within 4 hours after the administration idarucizumab was 100% (95% CI, 100 to 100). Among the non-ICH Group A patients (n=203), bleeding cessation was confirmed in the first 24 hours and median time to hemostasis was 2.5 hours (95% CI, 2.2-3.9). In Group B, peri-procedural hemostasis was reported by treating clinicians as normal (93.4%), mildly abnormal (5.1%) and moderately abnormal (1.5%). Four of the 503 patients experienced potential hypersensitivity reactions, although two of these patients were on separate medications that could also have been responsible. Other adverse events were deemed by the authors to actually be worsening of the index event or sequelae of critical illness rather than secondary to idarucizumab administration (e.g. delirium, cardiac arrest, septic shock).

The main limitation of this study is the lack of a control group. The authors argue, however, that in the setting of no other effective reversal agents it would be unethical to withhold the reversal agent and randomize patients to a placebo or treatment with PCC only.

Connolly SJ, Milling TJ, Eikelboom JW, et al. Adnexanet Alfa for Acute Major Bleeding Associated with Factor Xa Inhibitors. *N Engl J Med.* 2016;375(12):1131-41.

This article was an interim report of the Andexanet Alfa, a Novel Antidote to the Anticoagulation Effects of FXA Inhibitors (ANNEXA-4) trial, an ongoing multicenter, prospective, open-label, single-group study of andexanet alfa (andexanet), a recombinant modified human factor Xa decoy protein that specifically reverses the effects of both direct and indirect factor Xa inhibitors by binding to the inhibitors themselves.

Patients over the age of 18 years with acute major bleeding who were reported to have received a factor Xa inhibitor (apixaban, rivaroxaban, edoxaban, or enoxaparin) within the past 18 hours were enrolled. "Acute major bleeding" was defined as potentially life-threatening overt bleeding with signs or symptoms of hemodynamic compromise, decrease in hemoglobin of at least 2 g/dL, hemoglobin of ≤8 g/dL with no baseline available, or acute symptomatic bleeding in a critical area or organ. Exclusion criteria included use of an anticoagulant other than a factor Xa inhibitor within the prior seven days, intracranial hemorrhage with a GCS less than seven, major thrombotic event within the past two weeks, large cerebral hematoma volume, expected survival of less than one month, or need for emergent surgery within 12 hours of ED arrival. Patients received an andexanet bolus over 15-30 minutes followed by a 2-hour infusion. The primary outcomes included percent change in anti-factor Xa activity and rate of hemostatic efficacy. Visible bleeding hemostasis was considered "excellent" if there was cessation of bleeding within 1 hour and "good" if within 4 hours. Intracranial hemorrhage was considered to have excellent hemostasis if there was a less than 20% volume increase on repeat imaging at 1 and 12 hours. Analysis was performed on an efficacy population, a sample selected to represent ideal and controlled circumstances, in which baseline anti-factor Xa activity was 75 ng/ml or more.

Of the 47 patients studied, 26 were on rivaroxaban, 20 were on apixaban and 1 was on enoxaparin. Gastrointestinal (49%) and intracranial bleeding (42%) were the most common etiologies of hemorrhage. After administration of andexanet, anti-factor Xa activity decreased by 89% (95% CI 58-94) in patients on rivaroxoban and 93% (95% CI 87-94) in patients on apixiban. The results of a single enoxaparin patient are not significant nor than they be generalized.

Continued on next page

Overall, 79% of patients had excellent or good hemostasis following andexanet infusion with no documented infusion reactions. During the 30-day follow-up period, thromboembolic events occurred in 18% of patients and there were 10 deaths. Although this study shows early preliminary evidence for the efficacy of andexanet alfa, its single cohort design with no control group or blinding, and its reliance on a non-widely available measurement of chemical activity are important limitations to recognize.

Conclusions

The use of DOACs will likely continue to increase as further evidence to support their safety is published. It is important to note that standard coagulation tests cannot be relied upon to identify DOAC activity or determine need for reversal strategies. Idarucizumab significantly reverses dabigatran's anticoagulant effect without major adverse reactions and should be used in life-threatening dabigatran-related hemorrhage. Andexanet alfa is currently in development and shows promising benefit. A newer drug, aripazine (ciraparantag), has shown favorable results in reversal of multiple anticoagulant agents[5] but has yet to be examined in a clinical human study. Given the limitations of unblinded, single-cohort studies that measure chemical effect and subjective hemostasis as opposed to long term benefits to mortality, it is still important for physicians to follow the results of additional post-marketing studies. Further studies are needed to identify reliable markers of apixaban and edoxaban activity as well.

Answers:

1. Analysis of post-market data continues to demonstrate that DOACs are likely no more dangerous than warfarin.
2. Standard coagulation tests cannot be reliably used to identify DOAC activity or to indicate when emergent interventions or procedures can proceed without anticoagulation reversal.
3. Idarucizumab should be given to patients who are on dabigatran and present with life-threatening bleeding or emergent need for surgery.
4. Preliminary analysis of the ANNEXA-4 trial shows adnexanet alfa can rapidly and successfully decrease anti-factor Xa levels and produce effective hemostasis in patients on apixaban and rivaroxaban. ●

Additional References:

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Medical Student Council President

A Reflection on Four Years

Chris Ryba, MS4
Medical Student Council Immediate Past President

Hopefully by the time this article is finished I will have opened my envelope on Match Day to good news with one hundred sixty of my classmates with whom I've spent a large chunk of my last four years with. The end of fourth year, as many of you know, is a very interesting time. Medical school is a fast-paced roller coaster with hundreds of ups, downs, loops, banks, and corkscrews. Then suddenly when you least expect it, the coaster comes to a screeching halt and a period of pure uncertainty overcomes you. Classes are winding down, boards are for now complete, and there isn't much else to do aside from check the remaining boxes on your transcript while you await word on where you will be for the next three plus years of your life.

I had the good fortune of receiving both my medical and undergraduate education from Loyola University Chicago. Loyola is a Jesuit institution and one of the key aspects of Jesuit teaching is the art of reflection. For years we were always asked to reflect upon our experience, our teachings, and events that had an effect on us each and every day. I initially did not care for this as daily reflection seemed tedious, but I soon found how its application could foster growth in my education and with my daily life. So, as my medical school education begins to wind down, I felt it appropriate to apply the Ignation Spirit of Reflection to take a look back upon (with my own reflection twist) three clichés I heard prior to entering school that I can now confirm are true.

"Medical school is like trying to drink water from a fire hose"

If there is one statement that can sum up the past four year it is this one. The sheer volume of information that comes at you as a rapid frequency is astounding. Many nights are spent crouched over the books, flipping through power point slides, and going back through notes three or four times on material covered that morning. It's nearly impossible to grasp all of the information so a great deal of time is spent trying to decipher which information is necessary now and which can be looked at later. Everyone has their study habits, and most of the time what worked for you in undergrad is not going to work in medical school. The key is learning to take the largest gulp of water you can muster without drowning as the water can fill up very fast if you fall behind.

"School will feel like a lifetime until you look back and it feels like a minute"

I remember hearing this time and time again during orientation week first year. Everyone would tell me how fast med school went while I would be looking around thinking time was actually moving backwards. Fourteen hour days made up of lectures, notes, power points, more notes, flash cards, review, and more notes can make any day feel like an eternity. I can distinctly recall many moments where I wondered if my time to graduate would ever come. But now it's here and I can honestly say I don't know where all that time went. I had a job for two years that I left right before starting school and to this day I can't believe that I have actually been out of that job for double the amount of time I worked it. I sat down the other day in a chair in the library that I would sit in for hours on end my first two years. I hadn't sat there in the few years since, but when I sat and looked around, it felt as if I had never left. I attribute a lot of this to the friendships I made throughout school. It was important to me to try and stay active by playing in recreational volleyball leagues with classmates or taking an hour out of the day to wonder on over to the gym for some basketball. Simple breaks allowed those long days to seem much shorter.

"Make sure you keep in touch with family and friends as life will continue to move on despite yours essentially standing still"

This was by far the most important piece of advice I received before entering school and I am very happy I made sure to follow it. I remember them telling me in orientation week that there will come a moment where all of your friends will be starting their jobs, starting families, buying houses, taking vacations, and over all progressing with their lives and you will find yourself studying in the library at 10pm on a Saturday night. Most probably won't be able to buy a house, most marriage plans will be placed on hold for a few years, and most importantly you will watch your loan numbers increase all the while not having a steady income. This is probably the most frustrating part about school, despite knowing that our time will come. It just so happens to be what this profession brings. The advice comes in to not letting that keep you from reaching out and taking some time out of your day to grab a coffee or go on a walk with people to not lose touch. Most people won't understand the need to study so much. They won't understand the time commitment. It may take a lot more effort on your part but in the end, it will be worth it. There will come a time when the studies lighten up and you will be very happy to not have lost those few years of friendship. Getting away from school for a bit also helped me recharge and stay fresh with my studies. Not going to lie, it was also nice not having to hear about the Kreb's Cycle when out grabbing dinner.

Medical school had its ups and downs, but at the end of the day I couldn't be happier with my career choice. I have met some of the most amazing and talented people along the way and many I am happy to have made life-long friendships with. Yes, there were plenty of sleepless nights and stressful days along the way, but I'm happy to say I'm still here with a smile on my face. ●

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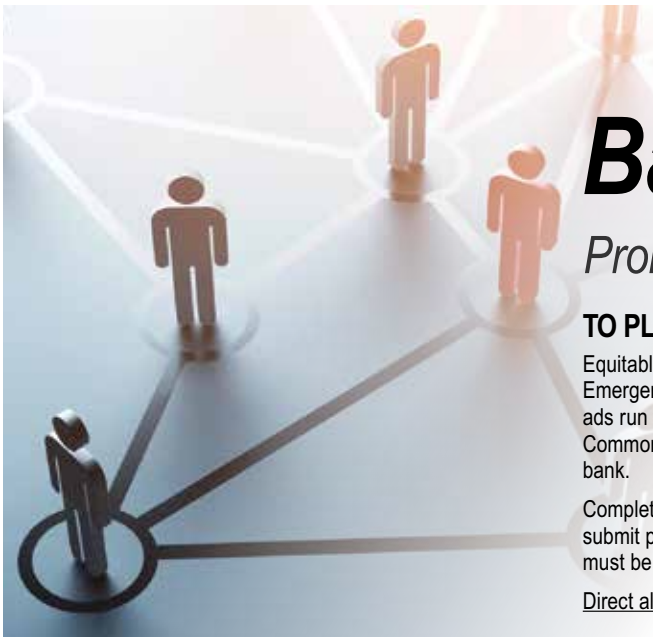

AAEM Job Bank Service

Promote Your Open Position

TO PLACE AN AD IN THE JOB BANK:

Equitable positions consistent with the Mission Statement of the American Academy of Emergency Medicine and absent of restrictive covenants, will be published (upon approval). All ads run for a six month period or until canceled and will appear in the AAEM member magazine Common Sense and online. For pricing and more information visit www.aaem.org/benefits/job-bank.

Complete a Job Bank registration form, along with the Criteria for Advertising Section, and submit payment. If you are an outside recruiting agent, the Job Bank Criteria for Advertising must be downloaded and completed by a representative from the recruiting hospital/group.

Direct all inquiries to: www.aaem.org/benefits/job-bank or email info@aaem.org.

POSITIONS AVAILABLE

For further information on a particular listing, please use the contact information listed.

Section I: Positions in full compliance with AAEM's job bank advertising criteria, meaning the practice is wholly-owned by its physicians, with no lay shareholders; the practice is equitable and democratic; due process is guaranteed after a probationary period of no more than one year; there are no post-employment restrictive covenants; and board-certified emergency physicians are treated equally, whether they achieved ABEM/AOBEM/RCPSC certification via residency training or the practice track.

Section II: Positions that cannot be in full compliance with AAEM's job bank criteria, because they are employee positions with hospitals or medical schools and the practice is not owned by its emergency physicians. Thus there may not be financial transparency or political equity.

Section III: Positions that cannot be in full compliance with AAEM's job bank criteria, because they are government or military employee positions. The practice is not owned by its emergency physicians, and there may not be financial transparency or political equity.

Section IV: Position listings that are independent contractor positions rather than owner-partner or employee positions.

SECTION I: POSITIONS RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA

ALABAMA

Exciting opportunity to join democratic group in Fairhope, Alabama. Located on the eastern shore of Mobile Bay. Baldwin Emergency Physicians have been in continuous practice at Thomas Hospital since 1994. Main ED has volume of 36K in a 28 bed ED built in 2011. 2.2 patients per hour including patients supervised with mid-level provider staffing an 8 bed "fast track". All major specialists with the exception of neurosurgery, PICU, multi-system trauma. Also, BEP will be staffing newly built free standing ED 12 miles north of Fairhope scheduled to open late summer of 2017. Currently we have eight full time physicians, six boarded in emergency medicine. Open Book, Fee for Service arrangement, immediate scheduling equity. Total compensation: In excess of $300,000. Medical insurance, fully funded retirement, A-rated malpractice carrier. Partnership opportunity after 6 months with 2 year partnership track. Contact: Randall Knutson, MD FAAEM, 251-504-1174. (PA 1660)
Email: rbknutson@yahoo.com
Website: http://www.baldwinemergencyphysicians.com/default.html

ALASKA

New full time position for a BC/BE emergency medicine physician to join a stable, democratic group of 10 physicians. This is a hospital practice based at Fairbanks Memorial Hospital. Annual visits exceed 36,000. Fairbanks Memorial Hospital is a JCAHO accredited 159-bed hospital that is the primary referral center for the 100,000 residents of Alaska's interior. Fairbanks is a truly unique university community with unmatched accessibility to both wilderness recreation and urban culture. We aim to strike a balance between life and medicine, offering excellent compensation and benefits with a two year partnership track. 10 hour shifts with excellent mid-level coverage. Visit our website at www.ghepak.com. For additional information please contact: Michael Burton MD, Chief Operating Officer 907-460-0902, mrb5w@hotmail.com or Art Strauss MD, President 907-388-2470, art@ghepak.com. (PA 1691)
Email: mrb5w@mac.com
Website: http://www.ghepak.com

CALIFORNIA

Coastal Santa Cruz, California, Join physician friendly group with more than 80 providers! Dignity Health Medical Group – Dominican, a service of Dignity Health Medical Foundation (http://dhmf.org/dominican), seeks urgent care physician to work shared weekends, holidays and during 10am–8pm clinic hours. Shareholder opportunity, outstanding support staff and physicians who've been in community 30+ years. Excellent earning potential, including a salary guarantee period. Sign-on bonus, relocation assistance, CME, benefits. Aligned with one of the largest health systems in the nation and the largest hospital system in California. Forward CV: Lori Hart, 888-599-7787 or email the address below. (PA 1679)
Email: providers@dignityhealth.org
Website: http://dhmf.org/dominican

FLORIDA

The Escambia County BCC is recruiting for a medical director. The medical director will supervise and assume direct responsibility for the medical performance of all emergency medical technicians and paramedics of Escambia County Public Safety and all medical staff of the Escambia County Corrections Department. Training and Experience: Medical degree required and a minimum of three (3) year experience in an institutional health care setting. Licensing and Certifications: Florida Medical License, current ACLS Instructor, and CPR certification. For more information on job position, benefits, and to apply visit: www.myescambia.com/jobs (PA 1694)
Email: jmfloyd@myescambia.com
Website:
https://myescambia.com/our-services/human-resources/employment

GEORGIA

Georgia, Athens: Private, democratic group of 24 physicians; all RT/BC EM. Recruiting two additional physicians, RT/EM, to expand coverage. 365-bed regional referral center. All major specialties on staff. Dedicated hospitalists, pediatric hospitalists, surgicalists, OB hospitalists. Level II Trauma center, STEMI-Receiving Facility, Stroke Center. 86,000 visits; admissions rate 23%. 50 bed department. Excellent package of clinical hours, salary and benefits. Well-established group in its 30th year at a single hospital. Large university community; branch of state medical school in town provides teaching opportunities; abundance of sports, recreational and cultural activities one hour from Atlanta. Contact Eric Sewell, MD, at Eric.Sewell@GEMS-ED.net (PA 1682)
Email: Eric.Sewell@gems-ed.net

SECTION I: POSITIONS RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA

INDIANA

Memorial Hospital of South Bend. Stable, democratic, single hospital, 23 member group seeks additional emergency physicians. 60K visits, Level II trauma center, double, triple and quad physician coverage. Equal pay, schedule and vote from day one. Over 375K total package with qualified retirement plan; group health and disability insurance; medical, dental and CME reimbursement, etc. Favorable Indiana malpractice environment. University town, low cost of living, good schools, 90 minutes to Chicago, 40 minutes to Lake Michigan. Teaching opportunities at four year medical school and with FP residency program. Contact Joseph D'Haenens, MD, at the email address below. (PA 1678)
Email: southbendemergency@gmail.com

MAINE

Eastern Maine Medical Center is seeking BC/BE emergency medicine physicians for full time permanent positions at locations in Bangor, Blue Hill, Waterville, and Ellsworth. Dynamic physician-led collaborative emergency medicine model, supportive hospital administration, engaged patient populations, join well-established team at a primary site, with options to work at other sites within our system. Flexible schedule/no call, medical student teaching options, full spectrum of sub-specialty backup and consultation In-house collaborative radiology and Night Hawk Services. In System LifeFlight of Maine Air/Ground Critical Care Transport Program. In-System ACS-Verified level II trauma center < 1 hr away. Trauma Service, Critical Care Intensivists, & Pediatric Intensivists: on call consult. J-1 visa candidates welcome to apply. EMMC and affiliates are located in highly desirable, family-centered locations throughout Maine! Enjoy year-round access to Maine's unmatched coastline, mountains and lakes with limitless outdoor recreational opportunities and unspoiled natural beauty! Contact: Amanda Klausing, AASPR, Physician Recruiter 207-973-5358. (PA 1697)
Email: aklausing@emhs.org
Website: https://www.emmc.org/

MARYLAND

Join a national leader in academic and community-based emergency medicine. University of Maryland Emergency Medicine is currently recruiting BE/BC emergency medicine physicians interested in either an academic career or a community setting to join our organization and work clinically at one of our 14 locations throughout the Maryland and Washington, DC area. (PA 1677)
Email: recruitment@umem.org

MASSACHUSETTS

Democratic, physician owned and managed group seeks BC/BE EM physician for full time or per diem positions. We are the largest community hospital in central Massachusetts with an annual volume of almost 50,000 visits. We offer an excellent salary and benefit package including malpractice, CME, medical/dental, 401K, and profit sharing. Dedicated night physician team, scribe service, Epic EMR, and a no buy-in partnership track. Conveniently located close enough to Boston for city culture and airport access, but far enough for reasonable cost of living in addition to excellent local school systems. Please send inquiries to: Chris Reilly, Wachusett Emergency Physicians 60 Hospital Road, Leominster, MA 01453. Call 978-466-2994 or email the address below. (PA 1681)
Email: creilly@healthalliance.com

NEW HAMPSHIRE

Emergency medicine physicians, Frisbie Memorial Hospital, Rochester, New Hampshire; Frisbie Memorial Hospital serves the health care needs of the greater Rochester and Seacoast Region of New Hampshire. We are currently seeking board certified or eligible emergency medicine physicians for our main campus in Rochester, NH and our White Mountain Medical Center Walk-In Care location in Sanbornville, NH. Frisbie Memorial Hospital's Emergency Department in Rochester is one of the largest and busiest facilities in the Seacoast Region of New Hampshire, treating more than 30,000 patients each year. Frisbie is a full-service Medical Center in Rochester, NH. White Mountain Medical Center Walk-In Care in Sanbornville provides medical care to patients that have immediate (sudden start), non-life-threatening injuries or illnesses. Frisbie offers a competitive salary and benefits package. Contact: Jeanette Rowlinson, PHR, SHRM-CP, RACR; Human Resources Business Partner; Frisbie Memorial Hospital; 603-330-7989 J.Rowlinson@FMHospital.com; All inquiries will remain confidential. No agencies; EOE (PA 1686)
Email: J.Rowlinson@FMHospital.com

OHIO

Top Four Largest Emergency Medicine Group in the Entire Country; One of the top four largest emergency medicine groups in the country world-class integrated group offering emergency, hospitalist, and observation medicine to their hospital partners. Annual compensation of $460,000 to $540,000, sign-on bonus from $60,000 to $100,000, full benefits including paid malpractice, health, dental, vision, employer funded retirement, and several other unique benefits offered by no other emergency medicine group in the country, industry leading employer-funded 401K—add 10% to your earnings—that is the amount contributed by the group on your behalf—no employee contribution required. Multiple hospital locations to choose from within the health systems—varying volumes and acuities based on your preference, very low turnover—5.5%—industry average is 12%. Community: three metro cities - your choice. Choose between three metro cities with respective populations of 2M+, and 700,000, 5-star amenities including some of the best shopping, dining, professional sports, and arts and entertainment in the entire country, relatively low cost of living and excellent education systems. Have the best of both worlds—be in one of the best emergency medicine groups in the entire country and your choice in three highly-rated metropolitan cities. (PA 1692)
Email: medcareers@merritthawkins.com

WISCONSIN

Wisconsin Emergency Medicine - Located on the picturesque Chequamegon Bay of Lake Superior, the world's largest freshwater lake, this pristine part of Wisconsin has outdoor recreation for all seasons. The nearby Apostle Islands National Lakeshore consists of 22 islands and a 12-mile strip of mainland shore line. This emergency medicine department will be staffed 24 hours by five EM physicians, advanced providers and eight EM nurses. The hospital is modern and technologically advanced with over 50 full time physicians on staff. To learn the exciting details - contact George Ivekich TODAY at 262-241-9400 or email the address below. (PA 1680)
Email: givekich@strelcheck.com

SECTION II: POSITIONS NOT RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA

(Employee positions with hospitals or medical schools and the practice is not owned by its emergency physicians.)

COLORADO

Denver Health Medical Center, in collaboration with the University of Colorado School of Medicine, is now accepting applications for an emergency medicine residency program director. The program director is responsible for providing an educational experience enabling resident physicians to obtain the knowledge, skills and attitudes necessary to practice independently, to pursue sub-speciality training, or to become innovative leaders in emergency medicine administration, education, and research. The program director ensures delivery of education and skill building opportunities in the program for residents to achieve certification by the American Board of Emergency Medicine. The program director develops, conducts, and oversees the residency program in accordance with requirements of the Denver Health GME Committee and the ACGME Emergency Medicine Residency Review Committee, and overall provides the faculty, facilities, support services, equipment, and educational resources to achieve the goals and objectives of the program and maintain program accreditation. The successful candidate will be board certified in emergency medicine and eligible for licensure in Colorado. The applicant should have academic credentials to be appointed to the rank of Associate Professor or Professor at the University of Colorado School of Medicine, and have a demonstrated national reputation of excellence in scholarship, teaching and mentoring, and clinical care. Applicants should submit a cover letter and CV to: Aaron Ortiz, Manager, Provider Recruitment aaron.ortiz@dhha.org or 303-602-4992 (PA 1696)
Email: aaron.ortiz@dhha.org
Website: https://www.denverhealth.org/

COLORADO

The Department of Emergency Medicine of Denver Health is recruiting an energetic and talented emergency physician to be medical director of the adult emergency department and associate director of the department of emergency medicine. A major academic affiliate of the University of Colorado School of Medicine, Denver Health is the academic safety net health care system for the city and county of Denver, Colorado. Approximately 120,000 patients are seen annually in our adult emergency department, pediatric ED and urgent care, and adult urgent care center. The Denver Health Residency in emergency medicine has operated continuously since 1974. A level one trauma center, the adult ED encompasses 38 acute treatment spaces and a 9-bed ED observation unit. Approximately 57,968 patients were treated last year, with a 25% admission rate; more than 60% of Denver Health's admissions come from the ED. Staffing is provided by board certified emergency physicians, PGY 1- 4 residents, EM sub-specialty fellows, and a stable cadre of NPs and PAs. Nursing leadership is stable and the relationship is close and highly collaborative. The adult ED medical director is responsible for the daily operations of the adult ED, including relations with consulting departments and support services, the adult ED quality and safety program, and process improvement initiatives. He or she reports to the Vice Chair and Director of Service, Department of Emergency Medicine. This position is 60% clinical, 40% administrative. All faculty physicians contribute to the patient care, educational, and research missions of the department, and all have faculty appointments in the University of Colorado School of Medicine. The ideal candidate is an experienced emergency physician with a strong background in ED operations and quality, excellent leadership and communications skills, and a passion for innovation and data-driven systems improvement. Successful previous experience analyzing organizational performance and designing and leading positive organizational change is strongly desired. Board certification in emergency medicine is required. This position is available immediately, and applications will be considered in a rolling fashion until the right candidate is found. Applicants should submit CV and cover letter to: Aaron Ortiz, Manager Provider Recruitment aaron.ortiz@dhha.org (PA 1700)
Email: aaron.ortiz@dhha.org
Website: http://www.denverhealth.org

SECTION II: POSITIONS NOT RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA

(Employee positions with hospitals or medical schools and the practice is not owned by its emergency physicians.)

LOUISIANA

Ochsner Health System announces an exceptional opportunity for a proven administrator educator to serve as the founding Program Director for the Emergency Medicine Residency. Ochsner Health System has dedicated significant funding to support the development and accreditation of a robust emergency medicine resident training program. The program's first residents are projected to arrive in 2020, with as many as 36 residents in emergency medicine by 2023. Ochsner Health System is Louisiana's largest non-profit, academic, multi-specialty, health care delivery system with 30 owned, managed and affiliated hospitals and more than 60 health centers. Ochsner employs more than 1,100 physicians in over 90 medical specialties and sub-specialties and conducts over 600 clinical research studies. Ochsner is one of the largest non-university based physician training centers in the U.S. and the largest teaching hospital in Louisiana. The successful candidate for the Director of the Emergency Medicine Residency Program will demonstrate effective education and administrative abilities, understand the regulatory requirements for an academic residency program and enjoy the mentoring and development of residents, students and faculty. For confidential consideration or to nominate a colleague, please contact: Joyce Tucker, EVP, Managing Principal, Cejka Executive Search 800-209-8143 or email the address below. (PA 1664)
Email: jtucker@cejkasearch.com

LOUISIANA

Emergency Medicine Chairman; Ochsner Health System, located in New Orleans, Louisiana is seeking a chairman for the department of emergency medicine. The successful candidate will join a multi-hospital, expanding 85+physician emergency medicine service line. We seek a board certified emergency medicine physician with at least five years of leadership experience to serve as chairman. We are searching for an individual with leadership skills who enjoys direct patient care in a group practice setting, teaching residents and fellows, and participating in our new emergency medicine residency program that will launch in 2019. Opportunity Details: Ochsner Medical Center in New Orleans is a major transfer center with extreme case complexity seeing 65,000+ visits/year. All facilities utilize Epic electronic health records integrating care across the system and facilitating seamless multi-hospital practice. Advanced practice providers and scribes facilitate practice performance at all locations. Operational excellence with 1.6% LWBS and 30 minutes D2D system average. Employed physician group that offers competitive fair market compensation plus benefits. All specialties available for consultation and easy one-call transfer from our community emergency departments to our main campus. Ochsner Health System is Louisiana's largest non-profit, academic, multi-specialty, health care delivery system with 30 owned, managed and affiliated hospitals and more than 60 health centers. Ochsner employs more than 1,200 physicians in over 90 medical specialties and sub-specialties and conducts over 600 clinical research studies. Our medical school, the Ochsner Clinical School, in partnership with the University of Queensland in Australia, enrolls 130 medical students each year. We are also one of the largest non-university based physician training centers in the U.S. and the largest teaching hospital in Louisiana. Ochsner is proud to be recognized among the top hospitals in the nation. Ochsner is the only hospital in Louisiana recognized by U.S. News & World Report as a "Best Hospital" in three specialty categories as well as receiving five star ratings for six conditions and/or procedures. Ochsner was also recognized by Becker's Hospital Review as one of the "150 Great Places to Work in Healthcare. Interested candidates should apply to the email below. Sorry, no J1 visa opportunities. Ochsner is an equal opportunity employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, disability status, protected veteran status, or any other characteristic protected by law. (PA 1690)
Email: bambilynn.jordan@ochsner.org
Website: https://ochsner.wd1.myworkdayjobs.com/OchsnerPhysician/job/New-Orleans---New-Orleans-Region---Louisiana/Physician-Emergency-Medicine-Chairman---New-Orleans_REQ_00024806

MINNESOTA

Mayo Clinic Health System in Mankato, Fairmont, and New Prague Minnesota invite residency trained, board certified/eligible emergency physicians to join their team! Learn, teach, and grow with an organization that provides exceptional resources in education, teaching, and state-of-the-art equipment. Experience institutional support and access to prompt consults from world-renowned sub-specialty experts and join a team that operates under one mission, vision, and value! To learn more and to apply, please contact Aaron Hooks, Mayo Clinic Physician Recruiter at hooks.aaron@mayo.edu or by phone at 507-296-0169. (PA 1702)
Email: hooks.aaron@mayo.edu

MISSISSIPPI

George Regional Hospital; 929 Winter Street Lucedale, MS 39452; ED Physician, Medical Director Over $400,000 annually. At least one year of experience. Opportunity: NEW ER to open mid-summer of 2018, $40k sign-on/tuition assistance/relocation/retention, BC EM to join a thriving hospital, minimum of 14, 12 hour shifts per month, 403b and 457 retirement plans. Level IV trauma general surgeon on call 24/7, specialists in the area to accept referrals easily, ER sees 16,000 visits annually. If interested please contact Greg at 601-947-9148. (PA 1675)
Email: jsteele@georgeregional.com
Website: http://GeorgeRegional.com

MISSISSIPPI

The Magnolia Regional Health Center (MRHC) Emergency Department has full time clinical educator opportunities for BC/BE emergency physicians. MRHC is an active teaching hospital with ACGME training programs in medicine and cardiology and a planned 2019 emergency medicine residency. Our independent department has opportunities in all areas of academic emergency medicine including research, ultrasound, administration, education, and simulation. Corinth, MS is a growing, affordable city with easy access to cultural events and outdoor activities situated close to Memphis and Nashville. Total compensation over $450,000 with paid time off and retirement. Interested candidates should email a cover letter and current CV. (PA 1722)
Email: mngraber@gmail.com

OHIO

Emergency Services Institute at Cleveland Clinic; The Emergency Services Institute at Cleveland Clinic is currently seeking board eligible/certified emergency medicine physicians for our academic-affiliated regional hospitals. The Emergency Services Institute (ESI) consists of 15 full service emergency departments with over 550,000 annual visits. These facilities are staffed by board certified emergency medicine physicians and advanced practice providers. These dynamic opportunities offer a salary above the 90th percentile and enhanced by a very comprehensive benefits package and a collegial work environment with patients per hour ratio of 1.8 or less. (PA 1676)
Email: forstl@ccf.org
Website: http://www.clevelandclinic.org

PENNSYLVANIA

St. Luke's University Health Network, the region's largest, most established health system, a major teaching hospital, and one of the nation's 100 Top Hospitals is seeking an emergency medicine residency program director to start a new emergency medicine residency program, based out of St Luke's Anderson Campus. The founding program director will be responsible for leading, administering, and supervising all aspects of the emergency medicine residency program in accordance with the ACGME Program Requirements and Institutional Goals and Objectives. The program director will have dedicated time for administrative, educational, strategic, and research initiatives and provide oversight and development of the emergency medicine residency program and participate in our academic mission through our Temple/St. Luke's School of Medicine partnership. In addition, the program director will be expected to maintain a clinical practice with allocated time to develop and lead the residency program. Program director and clinical duties will be split to accommodate. In joining St. Luke's University Health Network, you will enjoy team-based care with well-educated, dedicated support staff, teaching, research, quality improvement and strategic development opportunities, a culture in which innovation is highly valued, exceptional compensation package, and a rich benefits package, including malpractice, health and dental insurance, CME allowance. Qualifications: must be board certified in emergency medicine, must have a minimum of three years of experience as a core faculty member in an ACGME-accredited emergency medicine program, must be clinically active in emergency medicine, have previous leadership/administrative experience and strong team building skills, willing to combine administrative and diagnostic (teaching) responsibilities (50/50), candidates with recent scholarly activity such as peer-reviewed funding, publication of original research or review articles in peer-reviewed journals, chapters in textbooks, publications or presentation of case reports or clinical series at scientific society meetings, or participation in national committees and/or educational organizations highly encouraged to apply. About St. Luke's Anderson Campus: Opened in 2011, Anderson Campus consists of a four-story, 108 bed acute care hospital (soon to be 210 beds), state-of-the-art cancer center, a 75,000 square foot ambulatory surgical center, and medical office building. The 32 bed emergency department currently has 45,000 patient visits per year. Private inpatient rooms are state-of-the-art with the latest technology and amenities. Consisting of over 500 acres, Anderson Campus also includes auxiliary gardens, a two-mile walking path, and a pond with a fountain and sitting area to promote wellness. About St. Luke's University Health Network: We are the region's largest, most established health system with 10 hospitals spanning 9 counties. In partnership with Temple University, St. Luke's created the region's first medical school. Repeatedly, including 2017, St. Luke's has earned Truven's 100 Top Major Teaching Hospital. St. Luke's is a member of the AAMC Council of Teaching Hospitals and a regional branch campus and major affiliate of Temple University School of Medicine. Please visit us at www.SLUHN.org. About the Lehigh Valley: Number 9 on America's 50 Best Cities to Live! Rich with history, fantastic recreational activities, eclectic restaurants and midway between Philadelphia and New York City. https://www.discoverlehighvalley.com/ (PA 1693)
Email: corrine.calderon@sluhn.org
Website: http://www.slhn.org/

PENNSYLVANIA

UPMC Pinnacle Director of Clinical Ultrasound; UPMC Pinnacle is currently seeking a director of clinical ultrasound to join our new ED residency program located in Harrisburg, PA. About the Position: Oversight of the core ultrasound faculty, responsible for the delivery of a state of the art ultrasound curriculum, tailored to the appropriate learner group, develop and disseminate quality and safety parameters for point-of-care ultrasound, including guidance and recommendations regarding image storage, maintenance, documentation, and billing, oversees emergency ultrasound in a large urban ED in central PA, oversees the EM residents' ultrasound training, provides EM faculty training in point-of-care ultrasound, provides EM advanced practice provider (PA/NP) training in point-of-care ultrasound, supervises credentialing of emergency medicine faculty, oversees maintenance and functioning of ultrasound equipment, supervises emergency ultrasound research opportunities, participates in ACEP and/or SAEM ultrasound sections, and develops and disseminates state-of-the-art management of image storage, and proper documentation and coding of emergency ultrasound studies. Professional Skills: EM board certification, completion of an emergency ultrasound fellowship, expertise in emergency ultrasound education – curriculum development and dissemination; experience as an educator at the regional and national level, track record of scholarship in clinical ultrasound, experience with safety, quality and security of images, documentation and coding, track record of highly collaborative and innovative leadership style. Benefits: Health, life, and disability insurance, medical malpractice insurance, defined contribution plan; 403(b) plan with employer match, professional dues and CME allowance, relocation assistance, and potential sign-on bonus. To Apply: visit UPMCPinnaclehealth.com/Providers and click on "Current Physician Opportunities." For the latest information on physician opportunities at UPMC Pinnacle, please contact: Rachel Jones, MBA, FASPR, Physician Recruiter, 717-231-8796 or email the address below. About South Central Pennsylvania: features both rural and suburban living and boasts an abundance of sports, arts, cultural events, and entertainment, close to historically significant areas such as Gettysburg and world-famous Hershey Park and Hershey's Chocolate World, offers top-rated public schools, blue-ribbon private schools, and some of Pennsylvania's top colleges and universities. Area school districts are consistently ranked in the top 20 percent of Pennsylvania. With affordable homes — a composite cost of living index of 99.7, compared to 126.5 in Philadelphia — it's a great place to grow a career and family. Listed among Forbes.com "America's Most Livable Cities," and ranked in U.S. News & World Report's "Best Cities to Live" in 2017. We are a two to three hour drive away from New York City, Philadelphia, Pittsburgh, Baltimore, and Washington, D.C. About UPMC Pinnacle: UPMC Pinnacle is a nationally recognized leader in providing high-quality, patient-centered health care services in central Pennsylvania and surrounding rural communities. The

SECTION II: POSITIONS NOT RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA

(Employee positions with hospitals or medical schools and the practice is not owned by its emergency physicians.)

not-for-profit system anticipates caring for more than 1.2 million area residents in FY 2018. For more information, visit www.UPMCPinnacle.com. Apply Here: http://www.Click2apply.net/rpx8w487jwq2wrxn PI101820012 (PA 1704)
Email: rajones@pinnaclehealth.org

PENNSYLVANIA

UPMC Pinnacle Associate Program Director, Emergency Medicine Residency Program; UPMC Pinnacle is currently seeking an associate program director to join our planned EM residency program located in Harrisburg, PA. About the Position: Assist program director with administrative and clinical oversight of a planned ACGME accredited emergency medicine residency program to begin in 2020. Recruits highly qualified residents and works with PD and GME staff to apply and receive approval for ACGME accreditation. Provide emergency medicine training to residents and medical students in a patient centered care environment. Dedicated time for the administrative and scholarly pursuits. Participates in academic societies and in educational programs designed to enhance educational and administrative skills. Professional Skills: EM board certification, track record of scholarship in emergency medicine, and track record of highly collaborative and innovative leadership style. Benefits: • Health, life, and disability insurance, medical malpractice insurance, defined contribution plan; 403(b) plan with employer match, professional dues and CME allowance, relocation assistance, and potential sign-on bonus. To Apply: visit UPMCPinnaclehealth.com/Providers and click on "Current Physician Opportunities." Contact: For the latest information on physician opportunities at UPMC Pinnacle, please contact: Jessica Gering, Physician Recruiter, 717-231-8383 or email the address below. About South Central Pennsylvania, features both rural and suburban living and boasts an abundance of sports, arts, cultural events, and entertainment. Close to historically significant areas such as Gettysburg and world-famous Hershey Park and Hershey's Chocolate World. Offers top-rated public schools, blue-ribbon private schools, and some of Pennsylvania's top colleges and universities. Area school districts are consistently ranked in the top 20 percent of Pennsylvania. With affordable homes — a composite cost of living index of 99.7, compared to 126.5 in Philadelphia — it's a great place to grow a career and family. Listed among Forbes.com "America's Most Livable Cities," and ranked in U.S. News & World Report's "Best Cities to Live" in 2017. We are a two to three hour drive away from New York City, Philadelphia, Pittsburgh, Baltimore, and Washington, D.C. About UPMC Pinnacle: UPMC Pinnacle is a nationally recognized leader in providing high-quality, patient-centered health care services in central Pennsylvania and surrounding rural communities. Its more than 2,900 physicians and allied health professionals and approximately 11,000 employees serve a 10-county area at outpatient facilities and eight acute care hospitals with 1,360 licensed beds: Carlisle, Community Osteopathic, Hanover, Harrisburg, Lancaster, Lititz, Memorial, and West Shore. The not-for-profit system anticipates caring for more than 1.2 million area residents in FY 2018. For more information, visit www.UPMCPinnacle.com. Apply Here: http://www.Click2apply.net/nz3j2f5gh4hxfctm. PI101819997 (PA 1708)
Email: jessica.gering@pinnaclehealth.org
Website: http://www.Click2apply.net/nz3j2f5gh4hxfctm

WEST VIRGINIA

Join New Energetic Employed Hospital Group; Charleston Area Medical Center is seeking to employ full time and per diem emergency medicine physicians (ABEM or AOBEM). Serving a multi-county area, the four emergency departments see over 100,000 patients per year. This regional, tertiary medical center also sponsors an accredited emergency medicine residency program. Facility Opportunities: CAMC Memorial Hospital - 30 beds with four assessment beds, CAMC General Hospital – level 1 trauma center with 26 beds and additional fast flow areas, CAMC Teays Valley Hospital – 10 beds with two assessment beds, CAMC Women and Children's Hospital – 20 beds. Mid-level coverage all shifts, 24/7 hospitalists coverage, complete specialty and surgical support, strong administrative support, salary & benefits: Competitive compensation package based on national benchmarks, generous sign-on bonus, retention bonus, critical staffing bonus, night shift bonus, complete CAMC benefit package, occurrence based malpractice insurance, CME stipend plus five CME paid days off. Professional fees/dues and subscriptions allowance. Charleston, WV, is a vibrant diverse community and offers an excellent family environment, with unsurpassed recreational activities and outstanding school systems. If quality of life is important to you and your family, Charleston is the perfect balance of lifestyle and career. (PA 1661)
Email: carol.wamsley@camc.org
Website: http://www.camc.org

UNITED ARAB EMIRATES

Al Jalila Children's Specialty Hospital is seeking BC/BE, fellowship trained pediatric emergency medicine physicians. Practice Information $395,000. Call is included. Work week can be 40-48 hours/week depending on call rotation; 200-bed state-of-the-art facility. Take advantage of all that Dubai has to offer, Reputation - International affiliations with world-class organizations. Practicing at Al Jalila Children's Specialty Hospital will provide a unique opportunity to participate in the growth and development of this beautiful new facility. (PA 1689)
Email: kmurray@cejkasearch.com
Website: https://www.cejkasearch.com

SECTION III: POSITIONS THAT CANNOT BE IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA

(Below are government or military employee positions. The practice is not owned by its emergency physicians, and there may not be financial transparency or political equity.)

No positions available at this time.

SECTION IV: POSITION LISTINGS THAT ARE INDEPENDENT CONTRACTOR POSITIONS RATHER THAN OWNER-PARTNER OR EMPLOYEE POSITIONS.

NEW HAMPSHIRE

WorldClinic is a 20-year old private telemedical practice seeking a chief medical officer (CMO). Our practice excels at using personal tech and connectivity (smart phones, iPads etc.) to connect patients with the clinical expertise of our physicians and staff 24/7. In this regard, we are a "virtual ER" and primary care team for our patients who include global families and corporations, touring performers and isolated remote communities. Successful CMO candidates are board certified in EM, possess superior diagnostic skills and enthusiastically embrace our culture of constant learning and personal integrity. This is an excellent position for an experienced "old school" physician seeking to lead a great team and the freedom to deliver care independent of third party reimbursement mandates. An engaging bedside manner is essential and prior military, administrative and/or management experience is a plus. For a full job description and application details, please visit: www.worldclinic.com/CMO (PA 1667)
Email: asteel@worldclinic.com
Website: https://www.worldclinic.com

TEXAS

Do you have an engineering degree? Are you a physician who is tired of the increasing corporatization, commercialization and consolidation of health care today? Have the latest health care changes increased your overhead and lowered your take-home pay while increasing your work hours? BRC offers a stimulating alternative to the increasingly corporate and cost-based world of health care. BRC is a nationally recognized consulting firm looking for physicians with engineering degrees. BRC employs full time physicians with engineering degrees who specialize in the objective analysis of the human body's response to forces and accelerations, in order to determine how injuries are caused. We offer rewarding and long-term, non-clinical careers to physicians interested in fully utilizing their skill set. BRC is seeking physicians with engineering degrees who are experienced in practicing medicine and ideally have some practical engineering work experience. Qualified physicians will have a bachelor's level or higher in biomechanical, aerospace, biomedical, mechanical, electrical, or chemical engineering areas and will have practiced in orthopedics, emergency medicine, neurology, family practice, aerospace medicine or surgery. Board certification in one of these specialties is required. Relocation to San Antonio, Texas is required. BRC Offers: No patient care; No on call, a place to apply your medical and engineering training in tandem, relocation assistance, physicians with engineering degrees, immigration assistance, and long-term, competitive compensation and benefits package. If you have these qualifications and are interested in the non-clinical opportunities BRC has to offer, please send your CV to jsanchez@brconline.com or call 210-582-0709 for more information on this great opportunity. Alternatively, if you know of someone who is qualified and interested please forward this posting to them. "BRC is an Equal Opportunity/Affirmative Action employer. All qualified applicants will receive consideration for employment without regard to sex, gender identity, sexual orientation, race, color, religion, national origin, disability, protected veteran status, age, or any other characteristic protected by law." Jesse Sanchez - Executive Recruiter, BRC 5711 University Heights Ste. 107, San Antonio, Texas 78249, Ph: 210-582-0709; Fax: 210-691-8823 (PA 1684)
Email: JSanchez@BRCOnline.com
Website: http://www.brconline.com/

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