

# COMMON SENSE

**VOICE**  
OF THE AMERICAN ACADEMY OF  
**EMERGENCY MEDICINE**

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## COMMONSENSE

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### AAEM Mission Statement

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

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

### Membership Information

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

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

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## President's Message

**ABEM is Listening**

Kevin Rodgers, MD FAAEM  
President, AAEM



Based on feedback from diplomats and EM organizations, ABEM has already taken significant steps to improve its Maintenance of Certification (MOC) program. Although a cadre of Diplomats have campaigned to do away with MOC completely, it is clear that absence of physician self-regulation will result in governmental control. MOC participation assures the public that the physician is engaged in a rigorous program of

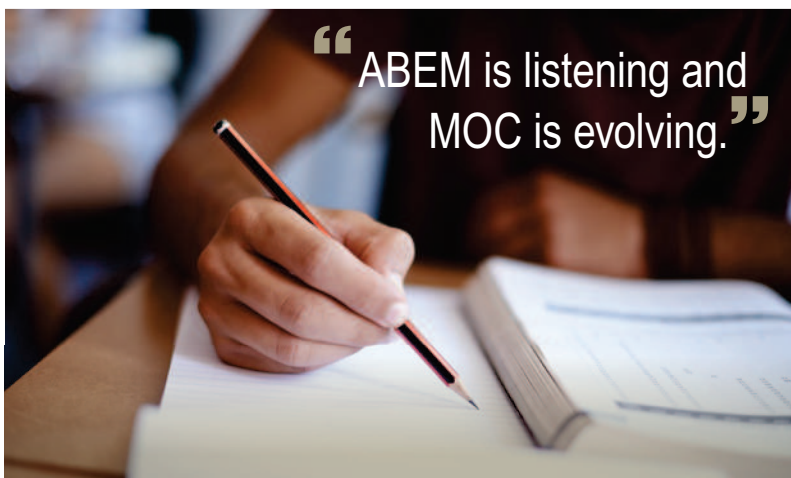
continuous professional development. Having a high standard for certification in emergency medicine is important because patients cannot choose their emergency physician. A January 2017 survey conducted online by Harris Poll revealed that 83% of the American adults believed emergency physicians should be required to pass a recertification examination to demonstrate that they are keeping up with medical knowledge throughout their career.

ABEM has always believed that periodic assessment is key to assuring the public that ABEM-certified physicians have the knowledge and skills they need to practice emergency medicine. This was reaffirmed in two different surveys, one conducted by ABEM and the other by AAEM, where the majority of diplomats found value in both the LLSA modules as well as the ConCert Exam. Additionally, in response to diplomat concerns, ABEM has frozen the cost of MOC for the last six years and has suspended the Communication/Professionalism (patience experience of care/patient satisfaction) component of Improvement of Medical Practice (Part IV). Now ABEM is looking to improve both the ConCert Exam (Assessment of Knowledge, Judgement and Skills) and well as finding novel methods for diplomats to complete the Practice Improvement component of MOC. Since costs seem to be a significant concern of many diplomats, it is important to note that ABEM's initial certification process is the least expensive of all 24 Boards. And MOC costs average \$265/year (includes LLSA) over the 10 year certification period which is at the mean for all medical specialties (the cost of a single night in a hotel at a national meeting).

So the beginning of October, ABEM held a summit meeting of EM organizations with a focus of examining the current ConCert Exam and potential options for the future. As many medical boards under the ABMS umbrella examine their maintenance of certification programs, ABEM likewise is looking to create a new generation of assessment

based on four considerations: current trends in education and evaluation; public opinion regarding the importance of periodic assessment of emergency physicians; successes and challenges of pilots conducted by other American Board of Medical Specialties (ABMS) Member Boards of alternatives to periodic exams; as well as diplomate perceptions of ConCert — its value as well as concerns.

As a starting point for the discussion, ABEM cited two axioms that will continue to govern both the periodic review of ConCert and consideration of other options: 1) ABEM will only offer time-limited certification 2) There must be episodic assessment of certified physicians. Only physicians who continue to meet the minimum standards for an ABEM-certified physician will be re-certified.



Based on information gathered to date, ABEM decided to investigate four options that range from an adaptive learning approach to mini-exams to a new oral examination to an option that introduces easy-to-implement improvements to ConCert. Each option has a different objective and focus, and each has advantages and disadvantages. Although ultimately ABEM will decide what option to implement, using a SWOT analysis the

Summit provided all EM organizations an opportunity to brainstorm future options for the exam. From more periodic but shorter exams to open-book tests to weekly questions/modules based on adaptive learning, no stone was left unturned. Significant time was spent discussing how to lessen the “high stakes” nature of the ConCert Exam while still maintaining its validity, impact and value. As you might imagine maintaining cost neutrality for any final option was also a hot topic; one possible option was switching to an annual MOC fee that covers the cost of all possible MOC components. Although evidence supports that testing in and of itself is an effective process for learning, options were also explored for making the process even more “formative” (providing more directive feedback, providing adaptive learning modules) in nature to aid in supporting the life-long

Continued on next page

**AAEM Antitrust Compliance Plan:**

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

learning concept of MOC. Summit members even discussed test security concerns and their impact on implementing “home computer” based testing. Like I said, no stone left unturned.

ABEM has also heard the complaints from diplomats concerning difficulties completing the Practice Improvement (PI) portion of the MOC. There is concern that EM physicians practicing in low acuity, low volume EDs or those who do locums, have significant difficulty with this requirement. ABEM is looking to develop novel methods which will satisfy this requirement while reducing the burden on the diplomat. AAEM has been asked to assist in this development — so stay tuned, we'll be asking for member input.

I would also like to take a moment to reinforce the rigor that goes into both building as well as scoring an ABEM exam. First, as a basis for the exam content, no other specialty has a document (EM Model) which outlines in detail what their clinical practice entails — both in terms of fund of knowledge as well as the KSAs needed to practice EM. Prior to building each exam, countless hours go into training question writers as well as validating each question. Two board members serve as Editors for each exam assisted by the item writers themselves as well as doctoral level staff with expertise in test development. Following every exam prior to scoring, each item is reviewed statistically. Any questionable items (identified by statistical analysis or through candidate comments on those items) are reviewed by the chair of ABEM's Test Administration Committee to determine whether the items should be scored. Few other Boards spend as much time, energy and money as ABEM does insuring the validity of their exams!

So ABEM is listening and MOC is evolving.

### Heroes

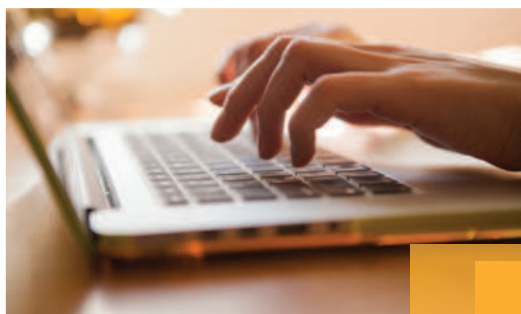
In the aftermath of Hurricanes Harvey, Irma, and Maria as well as the mass shooting in Las Vegas, our condolences go out to all the victims and their families. Our thoughts are also with all the first responders, ED nurses/techs and EM physicians, who despite all the incredible stressors, did a phenomenal job caring for them. Although a relative minor gesture in the scheme of things, based on a recommendation from a member (Lillian Oshva), AAEM sent food and drinks to the two Las Vegas EDs who handled the majority of the victims.

### Thanks!

I would like to take a moment to thank some very hard working AAEM members for their contributions to two of AAEM's major educational events. If you were lucky enough to be in Lisbon for MEMC IX, I think you would agree with me that the scientific program was absolutely outstanding and the venue and activities left nothing to be desired. I'd like to recognize both the MEMC Executive Committee (Lisa Moreno-Walton, Chair; Bill Durkin; Amin Antoine Kazzi; Terry Mulligan; and Salvatore Di Somma) as well as the Scientific Planning Committee (Gary Gaddis, Chair; David Farcy; Lisa Moreno-Walton; Terry Mulligan; Robert Suter; and Amin Antoine Kazzi) and the many track chairs who contributed to the Congress' success. I'd also like to thank the AAEM18 Planning Sub-Committee (Evie Marcolini, Co-Chair; Joelle Borhart, Co-Chair; Christopher Doty; Bernie Lopez; Kevin Reed; Zack Repanshek; R. Gentry Wilkerson; Siamak Moayed; Mike Buscher, William Goldenberg; Jonathan Jones; Tamara Kuittinen; Eric Morley; Jack Perkins; Teresa Ross; and Zaf Qasim) for their diligence and creativity in planning the 24th Annual Scientific Assembly which will be held in beautiful San Diego from April 7-11, 2018. The grid is nearly finished and it promises to be another unsurpassed learning event for EM physicians! Please mark your calendars now and plan to join us in sunny San Diego.

### Broken Record

Finally, my recurring requests. Please help AAEM spread our message to the next generation of EM physicians. Take a minute to inquire of your residency's leadership if AAEM has had the opportunity to speak to their residents on a variety of workplace fairness issues such as due process, restrictive covenants and open books. If not, please encourage them to accept our offer for FREE education on these important and often neglected topics. Finally, my perpetual plea, please consider recruiting a fellow EM physician to join AAEM. Our ability to accomplish AAEM's mission is directly related to our membership ... as they say, there is strength in numbers. ■



## Response to an Article? Write to Us!

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

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# Does Due Process Matter?

Andy Mayer, MD FAAEM  
Editor, *Common Sense*



"Virtue is persecuted by the wicked more than it is loved by the good." — Miguel de Cervantes, *Don Quixote*

Does due process matter in your practice, and do you have it? I suspect that many of you, especially younger emergency physicians, do not know if your employment contract provides you with due process and peer review protection under your

hospital's medical staff bylaws. Most emergency physicians are so thrilled and excited to finally be finished with their training and eager to enter the real world that they don't read the fine print in their contracts, which is why many of us make poor financial decisions. Contracts are signed without physicians understanding or really caring about the small details that don't directly affect their compensation, and many of these physicians later regret signing their contracts.

This makes me wonder if the Academy's quest for universal due process protection is a good cause or simply tilting at a distant windmill. Time will tell, but I think this is an issue worthy of discussion — especially for members of the Academy. Due process is the fifth principle of the AAEM's mission statement:

*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.*

AAEM created the Emergency Medicine Due Process Petition to promote due process and peer review for emergency physicians. It reads:

*We, the undersigned emergency physicians of this country, believe that due process is fundamental to our ethical mandate to care for our patients without being pressured by administrative or other external influences. We serve as direct advocates for our patients, many of whom go to emergency departments because they are vulnerable due to medical, social or financial issues outside of their control. In some cases, such advocacy may conflict with profit-driven or other non-patient-oriented forces. Therefore, we strongly oppose the contractual trend that allows hospitals or contract holders to terminate physicians without a fair hearing, since this hinders our ability to act at all times in the best interest of our patients.*

This statement sounds noble, just, and just plain good sense. The board of directors and other members have gone to Capitol Hill to lobby on this issue. Larry Weiss, our past president, and others have spent many hours lecturing and educating on the simple justice of this effort, and on its importance for patients. The Academy has tried to encourage regulatory

support for the requirement of due process rights for all emergency physicians by CMS. This would appear to be a simple issue, which all emergency physicians can wholeheartedly support, and there is a simple link at AAEM's website for signing the petition. To my surprise, I recently learned that only 2,714 emergency physicians have bothered to sign the petition, even though the process takes literally just seconds. I would think the subset of emergency physicians who join AAEM would be the most motivated to do something. Many of us have reasons for joining AAEM that relate directly to due process issues. Are we so burned out or disillusioned that we will not take a few seconds to sign a petition?

The perceived importance of due process rights varies. The idealist will tell you that due process protection is an essential right for all emergency

physicians. Due process can be used as a tool to protect our most vulnerable patients when we advocate for better care and coverage. This is clearly demonstrated by what happened to Dr. Wanda Cruz. ([www.tampabay.com/news/health/doctor-says-she-was-fired-for-reporting-low-staffing-at-brandonregional/2218497](http://www.tampabay.com/news/health/doctor-says-she-was-fired-for-reporting-low-staffing-at-brandonregional/2218497)).

She was fired by EmCare without any due process or peer review. Most contracts from corporate management groups (CMGs) require you to waive your due process rights. This is

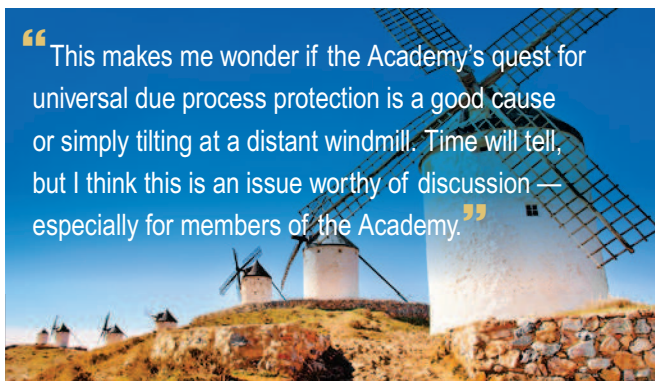
some of the fine print I was referring to above. This allows them to terminate you immediately and without any recourse.

The pragmatist will tell you that it doesn't really matter if you have due process rights or not. If your group, hospital administrator, or CMG wants you gone — you will be gone. Does it matter if you have staff privileges at a hospital but don't have a job there?

This brings me to *Don Quixote*. Trying to foster more conversation and interaction with my grown children, I challenged them to read two beautiful, leather-bound classics a year. We then discuss the books, which they get to keep. My two sons accepted the challenge. My eldest picked *Don Quixote* as our first classic. He recently had a "tilting at windmills" experience. He worked for a year in Afghanistan in an inspector general role, trying to ensure the Department of Defense was spending our money well. I think that is why he chose this novel.

Does due process protection "fix" the problems that confront us daily in our struggling emergency departments? Of course not, but maybe it is a symbol of control, which we seem to be losing. I believe that when people feel their actions and opinions are unimportant, they lose their sense of ownership in the process. And owners perform better than renters, as any landlord would tell you. This sense of ownership leads directly to the importance of physician owned and operated practices. When a practice

Continued on next page



is yours, it matters more to you. The department's failure is your failure. I suggest that the loss of due process is really just a placeholder for lost ownership rights, which are an essential tenant of our legal and moral heritage. When you have rights, you also have responsibilities.

What is the remedy for the problems in our emergency departments? Not many of us think more administration/management, patient satisfaction scores, and committee meetings will solve the challenges facing us when we arrive for a shift. It seems to me that lack of control is a major contributor to emergency physician burnout.

Obtaining due process protection is not a panacea for emergency medicine, but I challenge each of you to think about what due process and peer review mean to you, and ask yourself what are you going to do about it? Will standing with 2,714 other emergency physicians in

signing a petition make you happy? Maybe not, but maybe joining your colleagues in a just cause will begin to rebuild your sense of ownership in your practice and profession, and help each of us value ourselves and our hard won careers a bit more. ■

Sign the Due Process Petition at  
<http://www.aaem.org/dueprocess/petition/>



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- The presenter of the oral abstract judged to represent the most outstanding research achievement will receive a \$3,000 honorarium, while second and third place will receive \$1,500 and \$500 honoraria, respectively.

### AAEM/RSA & WESTJEM POPULATION HEALTH RESEARCH COMPETITION

- Submit a research abstract that affects the health of populations of patients.
- The top abstracts will be invited to present orally at AAEM18 and be published in *Western Journal of Emergency Medicine: Integrating Population Health with Emergency Medicine*.

### SHOWCASE YOUR PHOTO AT THE AAEM18 PHOTO COMPETITION

- All physicians, residents, and students are invited to submit a photograph for presentation of patients, pathology specimens, Gram stains, EKGs, and radiographic studies or other visual data.

### 16TH ANNUAL OPEN MIC COMPETITION

- Open Mic is a proud tradition within AAEM, it offers a unique opportunity to speak at a national meeting.
- This open-floor format allows 16 "new voices" to be heard and evaluated by education committee members and conference attendees.
- Ten of the time slots will be filled in advance by email. The remaining six time slots will be filled on a "first-come, first-served" basis by signing up onsite.

### YPS POSTER COMPETITION - NEW

- New this year, members of AAEM YPS and AAEM members who meet the YPS membership criteria are eligible to submit their research for a poster competition.

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**What's New in Emergency Cardiology - Susan P. Torrey, MD FAAEM FACP**

This presentation covers the current state in cardiology of importance to emergency physicians. First, Dr. Torrey discusses the importance of the emergency department as a site for the diagnosis and management of acute coronary syndrome. She then discusses the importance of the emergency department as a site for the diagnosis and management of acute coronary syndrome. She then discusses the importance of the emergency department as a site for the diagnosis and management of acute coronary syndrome.

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# Last Ditch Effort to Repeal and Replace Obamacare Collapses; Bipartisan Effort Proceeds Slowly

Williams & Jensen, PLLC



The latest effort by Congressional Republicans and the Administration to repeal portions of the Affordable Care Act (ACA) once again met with fatal resistance in the Senate, with several Republican Senators joining all Democrats in opposition to the plan authored by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA). Republican concerns, which came from Senators

John McCain (R-AZ) and Susan Collins (R-ME), were borne in part out of opposition to the bill's changes to Medicaid funding. Senator Rand Paul (R-KY) also opposed the bill after his demands for changes to the bill were not met.

This is widely seen as the last effort to have a chance to succeed in 2017, as the House and Senate have now turned their focus to tax reform. It is possible that momentum for one more effort could be generated in 2018, but it would certainly be complicated by the mid-term elections next year and could suffer the same fate as previous attempts.

The Senate is now looking once more to Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), who convened hearings in September to explore a bipartisan deal. The same tandem is working on extending the Children's Health Insurance Program, which expired at the end of September. Most states remain funded until November or December, at which point there is an expectation that Congress will reauthorize the program. These all form the ingredients of a potential deal on health care later in 2017. The success of this effort, which includes conversations between President Trump and Senate Minority Leader Chuck Schumer (D-NY), may hinge on the willingness of Republicans to agree to "fix" portions of the ACA – particularly those impacting the health insurance markets; and Democrats willingness to compromise in some areas of the ACA that they would prefer not to change.

The bipartisan efforts to stabilize the health insurance markets could also be impacted by a series of Administrative changes that could have an impact – positive or negative – on the affordability of such plans.

## Price Resigns as HHS Secretary; Administration Focuses on Changes to Health Insurance Market

Department of Health and Human Services (HHS) Secretary Tom Price resigned from his post in September in the wake of revelations that he extensively used private aircraft for travel to locations that were easily reached by commercial air service. Shortly after offering to repay the costs for his seat on the planes, he submitted his resignation to the Administration.

The policy impact is a disruption to the larger health care policy initiatives from the Department until a new secretary is nominated and confirmed. Eric Hargan is currently serving as Acting Secretary. He previously worked at the agency under the George W. Bush Administration, holding a range of positions including acting Deputy Secretary. Hargan was recently confirmed by the Senate to serve in the Deputy post, with seven Democrats joining Republicans voting in support.

The nomination and confirmation process for a new Secretary could take months. Frequently mentioned candidates include several Republican Senators, Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma, and Food and Drug Administration (FDA) Commissioner Scott Gottlieb.

In October, President Trump made two high profile health care announcements that impact the health insurance market. The Executive Order directs the Secretaries of HHS, Treasury, and Labor to increase health insurance access, affordability and choice. Trump said that under these rules, small businesses will be allowed to form associations to purchase health plans and that the agencies will explore options for increasing competition in the market, including the expansion of associations across state lines. Trump asserted that these association health plans will be widely available and affordable. Finally, he noted that the Order will direct the agencies to expand health reimbursement arrangements (HRAs) that allow employers to assist employees with health insurance coverage. Due to the rulemaking process, any changes from this Order would not go into effect until next year.

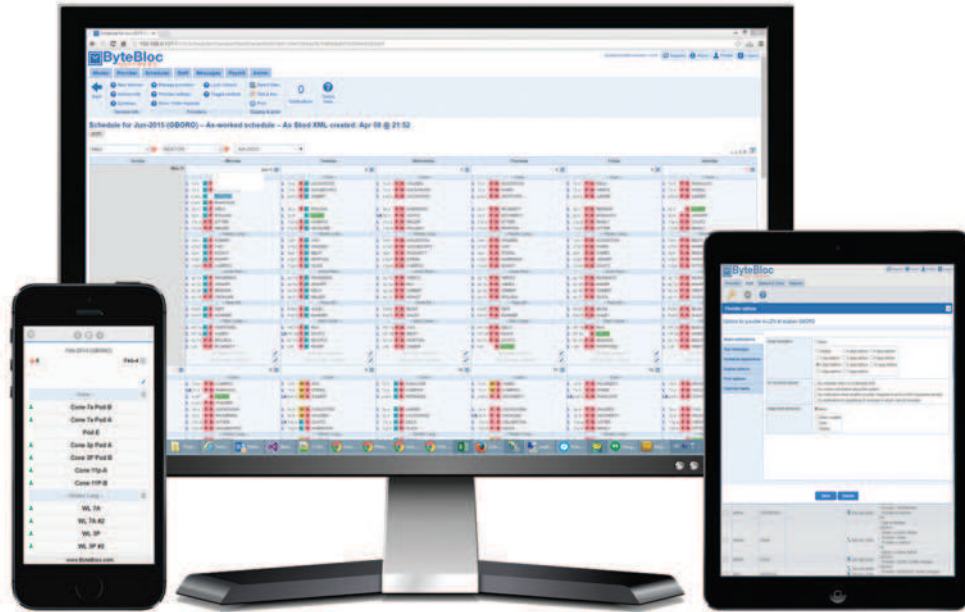
Trump also ordered the immediate end of the Administration's funding of cost-sharing reduction payments to insurance companies under the ACA. Trump has long mulled ending the program, which provides roughly \$7 billion in payments annually to subsidize the cost of health insurance for low-income Americans. The Congressional Budget Office (CBO) estimated this year that ending the payments would actually increase the deficit by \$194 billion over 10 years. New York Attorney General Eric Schneiderman announced that he would be suing the Administration to continue the payments. Another avenue to continue the payments would be through a Congressional appropriation, which could be agreed to in the context of a bipartisan health care deal.

The two actions were met with stiff opposition from many elected Democrats, who say that health insurance markets will be further destabilized and that the number of uninsured will increase. Many Democrats, including Leader Schumer, have indicated they would welcome conversations with Republicans about bipartisan legislation to make improvements to the ACA. The actions may increase the urgency on Capitol Hill for a deal, particularly if there is further erosion of the health insurance markets. ■



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Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1-1-2017 to 10-3-2017.

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

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AAEM 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](http://www.aaem.org/education/aaem-recommended-conferences-and-activities).

### AAEM CONFERENCES

#### April 7-11, 2018

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

#### AAEM18 PRE-CONFERENCE COURSES

##### April 7, 2018

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

##### April 8, 2018

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

### AAEM RECOMMENDED CONFERENCES

#### November 16-17, 2017

- The Combined ACLS/APLS Course 2017 #CPDaclsapls  
Vancouver, Canada  
<https://ubccpd.ca/course/acls-apls-2017>

#### November 17, 2017

- UGEMP: Ultrasound Guided Emergency Medicine Procedures Course  
Vancouver, Canada  
<http://ubccpd.ca/course-group/emp>

#### November 17-19, 2017

- The Difficult Airway Course: Emergency™  
San Diego, California  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### December 6-9, 2017

- ESEM: Emirates Society of Emergency Medicine Conference  
Dubai, United Arab Emirates  
[www.esemconference.ae](http://www.esemconference.ae)

#### December 11-12, 2017

- ACMT 2017 Seminar in Forensic Toxicology, "Opioids, Toxicology, and the Law: Medical-Legal Aspects of the Opioid Epidemic"  
Philadelphia, PA  
[http://www.acmt.net/2017\\_ACMT\\_Seminar\\_in\\_Forensic\\_Toxicology.html](http://www.acmt.net/2017_ACMT_Seminar_in_Forensic_Toxicology.html)

#### January 25-26, 2018

- 2018 Oncologic Emergency Medicine Conference  
Houston, Texas  
<https://www.mdanderson.org/education-training/professional-education/cme-conference-management/conferences/oncologic-emergency-medicine-conference.html>

#### April 6-8, 2018

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

#### May 15-18, 2018

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

#### June 5-9, 2018

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

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



## Make a Difference with AAEM's Educational Programs

To learn more about the responsibilities of all of our committees and to complete an application, visit: [www.aaem.org/about-aaem/leadership/committees](http://www.aaem.org/about-aaem/leadership/committees)

The ACCME Subcommittee, a branch of the Education Committee that maintains AAEM's CME Program, is actively recruiting members.

Subcommittee activities include reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly provided activities to ensure all guidelines are met that are set by the ACCME (Accreditation Council for Continuing Medical Education).





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## Dollars &amp; Sense

# Three Things Every Young Medical Student and Physician Needs to Know (Continued)

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



I gave this lecture at the 2017 Scientific Assembly, but there are many people who find it hard to attend the meeting, especially the target of the lecture, young medical students and physicians. In that vein, to recap last edition's article, here is the 1st thing every young medical student and physician needs to know:

**1. You can't control the investment markets, so focus on the two things you can control – investment costs and your asset allocation.**

Here are the 2nd and 3rd...

**2. Your savings rate is the most important factor determining your eventual net worth, and it should be at least 20-30% of your gross income.**

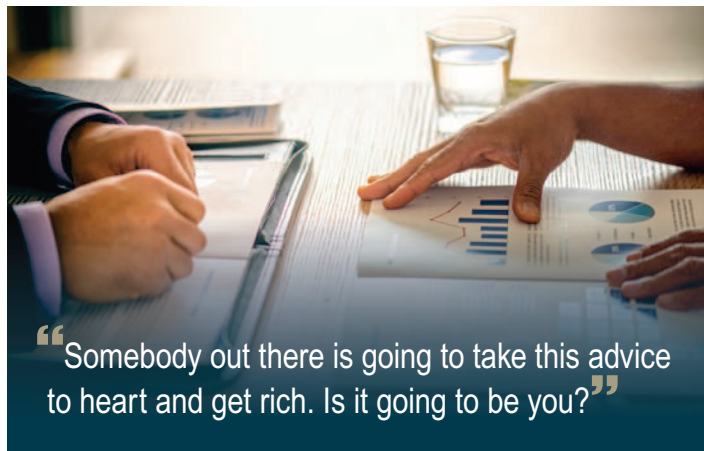
The most common recommendation you'll find or hear when it comes to saving for retirement is to save 15% of your gross or pre-tax income for retirement. There is nothing wrong with this recommendation, but built into it is the standard mentality of working until age 65 and then retiring. If you want the freedom to retire early, work as much or as little as you want, and achieve financial freedom/independence, then you will need to save much more than 15%. I've saved 30% over most of my adult life, and that's why I'm writing a personal finance column.

If you want to take a look at various saving rates and how they impact your financial life, you'll want to Google the blog post "The Shockingly Simple Math Behind Early Retirement" at MrMoneyMustache.com. There you will find a chart that shows you how many years you will have to work until you can retire based on your savings rate. If you go with the standard 15% savings rate, you'll have to work 43 years before you can retire. If you go with my 30% rate, you'll work 28 years. If you manage to save 50%, you can retire in 17 years! The more you save, the earlier you reach financial independence and can work as much or as little as you want.

The other standard advice you'll hear and read is that you'll spend approximately 80% of your pre-retirement income during retirement. For a physician with a typical high income, that can be a lot of money! You have to realize that 80% is probably high for a physician because after you retire you'll have greatly reduced expenses. This is because:

- You'll be in a lower tax bracket.
- You're no longer saving for retirement.
- You no longer need life or disability insurance.
- You've hopefully paid off your mortgage.
- Your kids are out of the house (if you had any).
- You have no more job-related expenses.
- You can give less to charity if you need to.

In the end, you can probably live off of 25-50% of your pre-retirement



“Somebody out there is going to take this advice to heart and get rich. Is it going to be you?”

income, not the standard 80%. This fact can multiply the effect of a higher than normal savings rate.

**3. You are your own financial worst enemy.**

Unfortunately for us, we engage in self-defeating behaviors all the time, including:

- Assuming too much debt.
- Living above our means in order to keep up with the doctor lifestyle.
- Purchasing too large and expensive a house.
- Purchasing too expensive a car.
- Not maxing out our tax-advantaged retirement account contributions.

Luckily there are some simple rules that, if followed, can keep young physicians and medical students out of trouble. First, realize that anytime you assume debt you are simply borrowing from your future self for current gain. Sometimes that is a good idea, like when you borrow to pay for medical school, but pausing before you assume debt to purchase something can help you out greatly. Getting down to brass tacks, no one really cares what medical school you went to, so you should probably go to the cheapest one you can get into. In addition, no one really cares how large your house is or what kind of car you drive. You think they care, but they really don't. Don't try to impress other people.

If you have student debt, you need to get smart about ways to refinance it or get it forgiven with the Public Service Loan Forgiveness Program. Thanks to the Navy and your tax dollars, I never had student debt, so I'm not going to pretend to be the expert on it. If you have student debt, go to WhiteCoatInvestor.com and learn about options to refinance or get your loans forgiven.

When it comes to houses and cars, if you can't afford the house you are purchasing on a 15-year fixed mortgage then you are probably buying

Continued on next page

too expensive of a house. Rent until you can put down a larger down payment or look at less expensive houses.

When it comes to cars, you should realize that you can buy a very reasonable used car that is 5-10 years old, plenty nice, and very reliable for much less than a new car will cost. You should make it your goal to pay cash for cars. If you can't pay cash, then you should purchase a cheaper car. Low or no interest loans are tempting because people think they are getting "free money," but using "free money" to pay for a depreciating asset (one that declines in value) is not a smart financial move. Your goal should be only to borrow money for appreciating assets (ones that increase in value), like businesses or real estate.

Finally, make sure you maximize your tax advantaged retirement contributions every year. It is one of the few legal ways to hide money from the IRS, and the compound growth year after year is an opportunity you don't want to miss.

In summary, here are the three things every young physician or medical student needs to know:

1. You can't control the investment markets, so focus on the two things you can control – investment costs and your asset allocation.
2. Your savings rate is the most important factor determining your eventual net worth, and it should be at least 20-30% of your gross income.
3. You are your own financial worst enemy.

Somebody out there is going to take this advice to heart and get rich. Is it going to be you?

If you have ideas for future columns or have other resources you'd like to share, email me at [jschofer@gmail.com](mailto:jschofer@gmail.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. ■*

## ABEM Updates

### Reasoning for Answers to LLSA Test Questions Provided

Have you ever wondered what the reasoning was behind a particular LLSA test question? Now, you'll be able to find out. Over the next few years, ABEM will be introducing several elements to increase the learning dimension. In response to diplomate requests, ABEM will provide the reasoning behind the correct answers to LLSA test questions, beginning with the 2017 EM LLSA test. The rationale for each answer to subspecialty LLSAs will be available starting in 2018. Consistent with learning and cognition research, each rationale will be available after you pass the test. In addition, score reports for all available ABEM LLSAs now show you which questions you answered correctly or incorrectly.

### Practice Pathways Closing

The practice pathway for **Anesthesiology Critical Care Medicine (ACCM)** will close in 2018 on the final date of the 2018 ACCM application cycle.

The practice pathway for **Emergency Medical Services (EMS)** will close in 2019 on the final date of the 2019 EMS application cycle.

If you have any questions about subspecialty certification, please contact ABEM at [subspecialties@abem.org](mailto:subspecialties@abem.org), or 517-332-4800, ext. 387. ■



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## ABEM Convenes a ConCert Summit

AAEM and AAEM/RSA along with every major emergency medicine organization, participated in a summit meeting convened by the American Board of Emergency Medicine (ABEM) to discuss modifications and alternatives to the ABEM Continuous Certification (ConCert™) Examination. The meeting, held October 2-3 in Detroit, Michigan, reviewed the role of the ConCert™ Examination in maintaining a credential that would best serve the interests of both the public and emergency physicians. ABEM will continue to solicit input from stakeholder organizations and ABEM-certified physicians. ABEM anticipates announcing specific examination options and a timeline for implementation, in spring 2018.

Participating organizations included:

- American Academy of Emergency Medicine (AAEM)
- AAEM Resident and Student Association (RSA)
- American Board of Emergency Medicine (ABEM)
- American College of Emergency Physicians (ACEP)
- Association of Academic Chairs of Emergency Medicine (AACEM)
- Council of Emergency Medicine Residency Directors (CORD)
- Emergency Medicine Residents' Association (EMRA)
- Residency Review Committee—Emergency Medicine
- Society for Academic Emergency Medicine (SAEM). ■



# Break Away from the Group to Start an Emergency Medicine Practice - Six Steps to Success

Charles D. "Chuck" Duva, MD FACEP CMM

## Editor's Note:

*An Emergency Medicine Billing and Management Company submitted this article and it is not a paid advertisement. This article was accepted for publication as it discusses steps involved in starting an independent emergency medicine group. AAEM does not endorse this specific company but does strongly endorse and encourage the formation of independent democratic emergency medicine groups.*

— Andy Mayer  
Editor, Common Sense

Are you and your fellow emergency department physicians looking to take the next step by starting your own independent democratic ED practice? Can you envision yourself at the helm of or as a part of a leadership team running an emergency medicine practice? Whether you are a part of a hospital employed group or are employed by one of the few ED practice consolidators out there, perhaps starting your own practice is your next logical step.

Over the last few years, there has been a steady increase in the number of democratic ED practices as well as emergency departments, with a 76% growth in number from 2008 to 2015.<sup>1</sup>

We have also seen a growth in the number of free-standing emergency departments across the nation. Like their hospital-based counterparts, a free-standing emergency department provides its patients with 24/7 access to health care professionals qualified in emergency services including a physician, registered nurses, as well as laboratory and radiology technicians. These facilities have the capacity to treat most emergent illnesses, such as heart attack, stroke, and trauma.

We've created a how-to guide that will identify the process, along with the necessary steps to ensure your success.

## 1. Develop a Strategy

Like any business, successful practices are built on solid and well-strategized foundations. This entails formulating a business plan that details the organizational goals as well as its financial and human resource needs.

Do a market analysis to identify issues in your market that will benefit or hinder your success. One such factor could be the location of your practice. When deciding on location, do research on the demographics to make sure the location is in line with your business plan.

Also important are the marketing tactics to be used to develop a patient base. Consider the ways in which your facility will best provide the care needed in your community. One such way is to become more involved with your city's chamber of commerce.

The American Academy of Emergency Medicine (AAEM) has put together a good resource to assist in the startup process. These suggested guidelines can significantly impact the planning of the initial stages of

your break from a group to start your own practice. They are outlined in the article, "The Business of Emergency Medicine ... Made Easy!"<sup>2</sup> In addition to the above points it provides some specifics on expenses and revenues, emergency coding and billing, salaries, loans, and even insurance.

## 2. Establish Potential Internal Partners

The journey to a successful and operational emergency medicine practice will be long and arduous. It can be made more rewarding when done with a partner. Align your practice with a partner who can take you through this process from beginning to end and ultimately set your new practice up for success.

Potential partners include medical school colleagues, spouses, and family members. When choosing a partner, make the necessary steps to establish a healthy professional working relationship. Some points to consider:

- Does this person share your passion?
- Do they share your vision?
- Do they have an extensive and well-connected professional network?
- Are they experienced?
- Are they comfortable with the risks associated with starting a new venture?
- Can they contribute financially to the startup costs?
- Are they honest and trustworthy?
- Do they complement your skillsets?

Give yourself six to 12 months to prepare and brainstorm your new venture. During this time you will also need to secure the services of a business attorney, business manager and an accountant. Retaining their services at the onset will be hugely beneficial to your venture as they will play a crucial role in helping you establish your business entity and lay the legal and financial foundations.

As an operating business, you will need to work with your attorney to choose the most suitable legal business structure. This decision will determine your tax filings and the extent to which you are personally liable for lawsuits, losses and debts. Your attorney will assist you by advising on the best course of action and drafting the necessary documents. Following this, you will need to register for an employer identification number on the Internal Revenue Service website. You will also need complete registration for your state and local taxes.

Hire an experienced IT consultant to oversee the design, setup, and implementation of your facility's IT closet. This includes all low voltage systems such as your fire alarm, security system, telephones, computer network, etc.

Last but not least, consider what your strategy will be for recruiting staff. Running a high-quality emergency department requires a significant amount of administrative time.

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Nothing poses a greater threat to the community and the facility's longevity than being frugal with emergency department staffing. The quality of care provided and the level of perceived compassion hinge on having a well-taken care of staff. This will in turn boost the facility's reputation and spur future business.

Successful administration includes oversight and continuous improvement of the facility's operations, maintaining an excellent staff, favorable CEO relations, and patient satisfaction.

### 3. Familiarize Yourself with the Health Care Laws in Your State

The laws governing the provision of fundamental health care services vary significantly across each state.<sup>3</sup> When launching your practice, it is crucial to be well-versed and in compliance with your state's health care laws. To ensure this, work closely with your legal counsel to discuss the best plan of action for your new venture.

Familiarize yourself with these three prominent areas of health care law which vary by state:

- **Corporate Practice of Medicine (CPM) laws:** It is currently illegal for practicing physicians to be employees of corporations in approximately half of the states in the U.S. This law was enacted to safeguard medical professionals against corporate influence and financial pressures. There are exceptions in most states, allowing physicians to be employed by not-for-profit organizations and hospitals.
- **Certificate of Need (CON) laws:** In 1974, the federal government enacted Certificate of Need Laws as part of the Health Planning Resources Development Act. The intention was to prevent the excessive use of health care services by limiting the number of health care provider facilities. There are still 36 states in which CON programs restrict and govern the development and licensure of medical services, despite the repeal of this law in 1987.
- **Health Care Licensing Laws:** Licensing laws and standards for health care services, facilities and professionals vary across each state. Every state has its departments of health with a licensing division responsible for processing new applications and renewals, performing site survey inspections, and revoking licenses if deemed necessary.

Although accreditation, Medicare certification and state licensure are separate, in some cases they are related by state law. Additionally, state licenses may differ based on the health care building life safety codes, also differing from those required by accreditation organizations.

Perhaps just as important to your firm's legal standing is abiding by federal law. Failure to do so can result in serious charges for your practice. One particular form of pervasive fraud to be avoided is Medicare fraud which is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person" by §455.2 in the Code of Federal Regulations.<sup>4</sup>



“Are you and your fellow emergency department physicians looking to take the next step by starting your own independent democratic ED practice?”

Some activities that could lead to fraud activities include:

- “Up-coding” — Billing the patient for services that were not provided or billing for more expensive or complex services than the ones provided
- Falsifying records to include services received that were not received
- Inputting ghost claims for patients who do not exist
- Duplicate billing
- Providing excessive treatments or tests

The penalties for fraud depend on the type of fraud committed. Some possible penalties include:

- False claim penalties are subject to jail time in addition to being required to pay back up to three times the fee charged from Medicare and \$11,000 for each false claim filed.<sup>5</sup>
- Receiving kickbacks is subject to a penalty of \$50,000 per kickback and three times the amount of each kickback, as well as five years jail time for each violation.

### 4. Start the Licensing Process

Here's what you'll need: State Licenses, NPI (National Provider Identifier #) and credentialing at the partner hospital and credentialing with payers. Typically, when going through the payer credentialing process for an already established process, you should allow for a roughly 30-60-day process. Now, this doesn't mean you won't be able to start work, but you won't be paid for any of your work till after that time. For a new group, however, that timeline could be extended to six months depending on the complexity of the group. It's best to partner with a group who specializes in ED credentialing.<sup>6</sup>

Get in touch with your state's Clinical Laboratory Improvement Amendments (CLIA) department to begin the process of obtaining a CLIA license. Time is of the essence as it can take up to six weeks for your application to be approved.

To be considered the Medical Director of an ED lab, ER physicians must take a 20 Continuing Medical Education (CME) hour online course. This is also a time-intensive process as it can take up to two-three months for your application to be reviewed.

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In order to begin accepting patient health insurance, you will need to get your credentials. During this time intensive process, you will need to provide information on your medical education, residency, and licensure. Depending on which state your facility is in, you may also need to have malpractice insurance. Research the most popular private insurers to negotiate reimbursement structures.

## 5. Funding the Venture

Per the Association of American Medical Colleges (AAMC), the average physician incurs a median debt of between \$170,000 and \$200,000 upon leaving medical school. It should then come as no surprise that fewer doctors are starting their own practices, due to the astronomical costs incurred in the startup phase.<sup>7</sup>

Considering these factors, the importance of a well-thought operating budget cannot be overstated. This budget will be a crucial benchmark when assessing practice performance as well as measuring your sources of revenue, expenses, and needs.

As a rule of thumb, you will need six to 12 months of cash to cover start-up costs.<sup>8</sup> Two general types of budgets will be required:

A **start-up budget** which details the fees related to consulting, legal, accounting, and real-estate, etc.

An **operating budget** to forecast revenue and expenses once the practice is live.

Like many small-business owners, you will have the option to take out a small-business loan to help cover startup costs.<sup>9</sup> Per *American Medical News*, there has been a steady increase in the number of loans to medical practices from the Federal Small Business Administration over the past decade.<sup>10</sup> In 2011, the SBA backed \$649.8 million in 1,516 approved loans to physicians, a 400% increase from 2001. Failing to shop for a banker can be a costly mistake. Evaluate and contact different banks with the intent of determining the ones with a history of giving loans to medical practices.

When approaching the banks for consideration of the SBA loan program, make sure to have your financial affairs in order. Poor credit and a previous bankruptcy declaration may prevent you from accessing the program. Don't let that dissuade you from moving forward as there are a multitude of options to consider.

There are many competitive loans that will facilitate the funding of your facility. The SBA 504 or Certified Development Company program is setup to provide funds for the purchase of fixed assets at below market rates. In this case, that would mean real estate and medical equipment. The SBA 7A program provides financing for the facility's working capital. You can expect to use \$500,000 to \$1 million before breaking even.

An alternative is to seek partner investments to finance your venture.<sup>11</sup> There are an increasing number of private-equity firms making investments in physician practices as investors begin to seize the opportunity to become early participants in value-based care.<sup>12</sup>

Upon deciding to start a practice, procure the services of a qualified CPA to provide guidance on tax and financial procedures including the practice's fiscal chart of accounts.

## 6. Identify Strong Reputable External Partners

A successful emergency medicine practice, like any other small business, must have a reliable billing and collection system to survive. Alleviate billing concerns and documentation requirements by working with an external partner.

Partnering with a firm that specializes in emergency medicine billing and management can ensure that all aspects of your new business venture are sound and virtually guaranteed for success. It is essential to understand that there is a significant variation in cost and quality amongst coding and billing companies. Do your research and choose your vendors wisely. Meet with your business manager to discuss logistics of how you will contract with payers and bill, discount, and treat the uninsured. Your decisions will substantially influence your bottom line.

## Conclusion

The intricacies of starting your own practice are numerous, but not impossible to overcome. With the right partners and a solid foundation you could be successful in launching a fully operational ED Practice in no time. Finding the right team to partner with will prove to be extremely beneficial throughout the startup process and even more-so in the long run.

## Author Information:

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Dr. Chuck Duva is the President and CEO of DuvaSawko. He is an experienced, and savvy emergency medicine physician-executive with special talents in managing and regenerating medical practices. Before co-founding DuvaSawko, Dr. Duva practiced emergency medicine for 20 years.

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11. <https://www.mergingtraffic.com/learn/raise-seed-capital-much-need/>
12. <http://www.modernhealthcare.com/article/20150418/MAGAZINE/304189980> ■



# Book Review: *Committed: The Battle Over Involuntary Psychiatric Care*

Les Zun, MD MBA FAAEM

This is the first book review for *Common Sense*. Its new editor, Andy Mayer, asked me to review *Committed: The Battle Over Involuntary Psychiatric Care*, by Drs. Dinah Miller and Annette Hanson, from the John Hopkins University Press. The authors describe the case for and against involuntary commitment as it relates to civil rights, but extend their discussion to involuntary medication and ECT use, restraints and seclusion, outpatient commitment, and the concept of danger to self and others. There are 14 chapters, from making the case for and against commitment to the various reasons for commitment. The book is well written, providing case studies with elaboration from health care providers and patients. The authors address some of the tough choices in the commitment process by showing us the experience through the patient's eyes. They also interview experts in the field to support their commentary.

The book raises, but does not address, all the difficulties in caring for these patients. The questions for the emergency physician include:

1. Who should be committed?
2. How long should the commitment last?
3. What is the process?
4. Who makes the determination?
5. What determines the need for commitment or continued commitment?

Answering these questions is made more difficult because each state's law dictates the details of commitment. These state laws are quite variable and make generalization impossible. I will, at least partially, address these questions anyway.

Involuntary commitment may be performed by emergency physicians, or personnel outside the emergency department who are authorized to do so by law. AAEM has a position paper on the role of the emergency physician in a commitment that was authorized by another person or entity:

*Emergency physicians have the responsibility for all emergency patients' care and disposition — including which patients require involuntary holds. The regulations concerning psychiatric holds or detainment vary from state to state. Some states require that law enforcement places a patient in an involuntary hold status without physician input. EPs should have the responsibility for patient care and disposition, including who needs involuntary hold or detainment. If the emergency physician is not able to place a patient on an involuntary hold, then the emergency physician must not be held accountable for any adverse consequences that result from decisions made by other authorized entities.*

The time period for this confinement varies, but 72 hours is the common limit. Most of the time the "medical professional" authorized to perform a commitment is any physician, but some states stipulate that it must be a psychiatrist.

The required paperwork also varies from state to state. For instance, once a physician decides a patient will be placed into involuntary commitment in Illinois, that physician is required to sign a statement that the patient has been notified of their rights not to continue any further evaluation. This "after the fact" requirement is a ridiculous state mandate from an era when emergency medicine did not exist as a specialty. A few lawsuits have resulted from patients alleging they were held without cause. State law varies on protecting physicians who use their best judgment in good faith.

The determination of commitment for some patients is not easy. Committing patients with reported suicidal ideation, the desire to hurt someone, or the inability to care for themselves is often a judgment call. How significant is the suicidal ideation? Is it a fleeting thought that occurs occasionally or does the patient have both a plan and the means to kill himself? Is the threat to harm others vague and ambiguous or specific and credible? Is the fear that the patient cannot care for himself based on a report that he hasn't eaten today, cannot find shelter, or was dancing in highway traffic — or is it because he hasn't taken his psychotropic medication in days? These decisions are not always easy and can be made harder by difficulties in obtaining prior psychiatric records, a lack of corroborating information, or the inability to talk to the patient's long-term mental health provider. How is the reason for involuntary commitment documented? Is it for 72 hours or a different time frame? Are there certain requirements of state law that must be met or other persons that must be involved? The challenges of the commitment process are tough, especially in a busy ED with countless competing demands.

This book is a recommended read. Short of reading it, emergency physicians should at least review the commitment laws in their particular state. It behooves every emergency physician to understand not only state law, but also the key concepts surrounding involuntary commitment. ■



# Resuscitating Resilience

Robert Lam, MD FAAEM  
Chair, AAEM Wellness Committee



"Resuscitating Resilience" is a new column for *Common Sense* about the art and science of being resilient and being well. Inevitably, we will face challenges and adversity throughout our lives as physicians, specifically by the nature of the work we do in emergency medicine. Resiliency is the art of learning to bend and not break in the face of adversity. It is about learning not only to bounce back to where we

were, but to cultivate skills that enable us to bounce higher than we were — with added knowledge, wisdom and life experience. It is about striving to be well; to be us at our very best.

And we must endeavor to do so if we are to effectively face one of the greatest challenges to our specialty: physician burnout. Through this column, we hope to equip, encourage and inspire you to not just survive but flourish despite the challenges we face as emergency physicians.

The problem with burnout is its complexity. Burnout may be defined as emotional exhaustion, disengagement and a low opinion of the work we engage in. The "job demands-job resources" model of burnout provides a framework to think about the systems-based key drivers of burnout in our workplace.<sup>1</sup>

Let's take a look at the demands of our job: high workload, time pressures, patient expectations, challenging physical environments and shift work. It is no surprise that the expected outcome of an imbalance of job demands is physical exhaustion. Likewise, let's consider the necessary resources in our work: meaningful feedback, personal satisfaction, appropriate degree of autonomy, support from your EM team, job security and supervisor support. If this part of the equation is similarly unbalanced then we feel disengagement. Sadly, our work environment often drifts into these imbalances, too many demands and too few resources, with burnout the understandable and unfortunate outcome.

We know from prevalence studies that over half of all emergency physicians are experiencing burnout. As such, the problem cannot solely lie with the individual. Burnout is a systems-based problem that requires systemic and organizational solutions, in addition to individual efforts.

Unfortunately, systems-based changes are some of the most difficult to enact and many of the systems in place are beyond our control. There has been a shift towards focusing on workplace interventions to address physician burnout.<sup>2</sup> Encouragingly, hospital leadership at leading health

care organizations are starting to acknowledge these workplace key drivers and are instituting the initial steps at their institutions to try to start to address these issues.<sup>3</sup> Unfortunately, too many institutions remain blind to these systems-based problems and it may be a long time before most physicians actually see changes to their work environment in meaningful ways. We need to be the voice advocating for change within our own institutions. This column will equip you with a strategy to bring wellness and resilience to your own institution and life.

Although it is tempting to point solely at the systems-based problems as the cause of burnout, we would be remiss not to consider other impor-

tant key drivers that lie with the individual physician and the unique nature of our specialty. As individuals, we must acknowledge our own life experiences and conditions that contribute to burnout and being unwell. Anyone who has struggled with depression, anxiety, suicidal thoughts, a divorce, compassion fatigue or second victim syndrome can attest that some primary driver of burnout are unique to us as individuals. Likewise, the nature of our work in emergency medicine contributes substantially: dealing with the public, caring for abused children and vulnerable adults, working to save victims of horrific

acts of violence including mass casualty and mass shootings and bearing witness to untimely deaths. This repeated exposure to the suffering of others contributes to the problem of burnout and compassion fatigue. And too few of us take self-care as seriously as we should, given our chosen work environment. The way forward must be a comprehensive approach that takes into account all of the key drivers: individual, societal, institutional, as well as the unique challenges of our specialty.

Although we can't possibly control every aspect of our work environment, we can control how we experience it and how we choose to respond to it. Being resilient is the art of training to bend and not break in the face of adversity. It is cultivating the emotional, spiritual, and intellectual flexibility that allows us to recover and go on after difficulty. It is learning how we can use evidence based practices like mindfulness, yoga and physical exercise to bounce back from a stressful job and difficult work environment. It is striving to be well, to be you at your best, by being intentional about self-care. And it is this intentional cultivation of holistic self-care and wellness that will allow us to continue to be compassionate and engaged physicians. It is exploring how art and the humanities can help us come together in our shared experiences as emergency physicians and



"Through this column, we hope to equip, encourage and inspire you to not just survive but flourish despite the challenges we face as emergency physicians."

Continued on next page

humans. Through telling our shared stories of the joys and perils of emergency medicine, we can remember the purpose of why we do the difficult work that we do and importantly, we are never alone, no matter how difficult life becomes. We will shed light and awareness on the epidemic of physician suicide and how we can advocate to save lives amongst our peers that are often suffering in silence.

*Bouncing Back* will also focus on being resilient throughout the entire arc of the career of a practicing emergency physician. We will look at the unique issues that threaten resilience and how we can flourish at every career stage — from being a student in those early years of practice to a mature well-established physician looking for ways to continue sustainably.

The first step towards resiliency starts with doing a self-assessment. You can start with online anonymous burnout inventory tools on the AAEM Wellness Page <http://www.aaem.org/about-aaem/leadership/committees/wellness-committee>. What key drivers of burnout are under your control? Is there a better balance in the amount of work that you take on in regards to your longevity? Can you shift your career to include new directions that add interest? Some suggestions include diving more deeply into your subspecialty interest in emergency medicine, such as wilderness medicine, or taking on an educational tasks. Would starting something new outside of work relating to your hobbies or interests refresh your mind? Do you need to engage in a better self-care plan to improve your wellness? Do you need to take a hard look at the institution you work for? Does your workplace give you the appropriate amount of autonomy,

transparency and fairness? Is the mission and values of your institution aligned with your own values?

The AMA has a nice online tool to help you start your own resiliency plan which can be found here: <https://www.stepsforward.org/modules/improving-physician-resilience>.

Physician resilience is art and science — and we will draw on both to meet our goal: to equip, encourage and inspire you to bounce back from adversity and live at your very best. We look forward to starting this journey together.

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**\*\* Note this article also appeared in EM News and has been edited for publication in Common Sense. ■**

## AAEM18 Wellness Activities

Be well with us at AAEM18

**STAY TUNED** for more information on wellness events available at the 24<sup>th</sup> Annual Scientific Assembly in San Diego — including the return of the Airway @ AAEM storytelling event!





# AAEM18: Breaking Down Barriers

Joelle Borhart, MD FAAEM  
 Evie Marcolini, MD FAAEM  
 AAEM18 Co-Course Directors



Planning is currently underway for the 24th Annual Scientific Assembly (AAEM18)! Mark your calendars and plan to join us in beautiful San Diego, California. Pre-conference courses will be held Saturday, April 7<sup>th</sup> and Sunday

morning, April 8<sup>th</sup>. The Assembly will begin at 12:45pm on Sunday, April 8<sup>th</sup> and end at noon on Wednesday, April 11<sup>th</sup> at the Marriott Marquis San Diego Marina.

AAEM Scientific Assembly has always provided premier continuing medical education brought to you by world-renowned speakers, and AAEM18 will be no exception. We are leading the planning committee and are excited to announce that for the first time, AAEM18 will have a theme: Breaking Down Barriers. We are committed to bringing diversity to the

forefront, including gender, ethnicity and community vs. academic medicine perspectives.

We will also be 'breaking down barriers' between the traditional educational tracks and are delighted to announce the outstanding AAEM18 educational content will be condensed into four new, distinct tracks: 'Nuts and Bolts,' 'Cutting Edge,' 'A New Twist' and 'Outside the Box.' These themes provide opportunities to address diversity and be inclusive, while linking similar topics together. Learn more about the hotel, pre-conference courses, speakers and the preliminary program by viewing the conference website at [www.aaem.org/aaem18](http://www.aaem.org/aaem18). Registration will open this fall.

AAEM has always led the specialty in championing emergency physicians, and it is an honor to be charged with making AAEM18 reflect AAEM's commitment to diversity and inclusion. Please accept our invitation to join us in San Diego and see what we have to offer you.



## 24<sup>th</sup> Annual Scientific Assembly April 7-11, 2018

MARRIOTT MARQUIS SAN DIEGO MARINA

**View the full  
 preliminary program online!**

[www.aaem.org/aaem18/program](http://www.aaem.org/aaem18/program)

**Check out this year's  
 Wellness Events**

[www.aaem.org/aaem18/wellness](http://www.aaem.org/aaem18/wellness)

**Book Your Hotel Room**

[www.aaem.org/aaem18/register/hotel](http://www.aaem.org/aaem18/register/hotel)



**Participate in an AAEM18 Competition**

**Deadline November 27, 2017**

[www.aaem.org/aaem18/competitions](http://www.aaem.org/aaem18/competitions)

**AAEM18 International Scholarship**

**Deadline November 10, 2017**

[www.aaem.org/aaem18/register/international-scholarship-program](http://www.aaem.org/aaem18/register/international-scholarship-program)

## AAEM18: BREAKING DOWN BARRIERS

### NEW FORMAT

AAEM is breaking the mold to bring you a fresh approach to its clinical emergency medicine conference.

We are excited to debut new track themes that link together similar diverse topics within a cohesive theme.



**Nuts & Bolts:** bread and butter topics, refresher on areas needed for Maintenance of Certification, the basics



**New Twist:** new ways, different procedures, process, research, new standard or a new way to practice medicine



**Outside the Box:** alternate perspective from another specialty or setting



**Cutting Edge:** the most up-to-date data on important topics

### REASONS TO JOIN US FOR AAEM18

**Collaborate and network with the emergency medicine community.**

AAEM18 draws exceptional emergency physicians from across the country and globe. Be a part of the vibrant AAEM community and interact with your colleagues face-to-face.

**Share in cutting-edge education and hear from new voices.** Our planning committee actively seeks new voices and innovative topics to bring you a fresh and engaging conference. We are diligently committed to the quality of education we present at AAEM18.

**Take full advantage of your AAEM member benefits.** As always, registration and CME for Scientific Assembly is **FREE** for AAEM members with refundable deposit. If you are not yet a member, we invite you to become a member and join our commitment to high-quality emergency medicine education.

### AAEM18 HIGHLIGHTS

**Design Your Own Schedule:** At AAEM18 you have the freedom to attend any of the concurrent sessions you wish, no need to pre-register, allowing you to customize the conference to your interests. Pre-conference courses and Small Group Clinic sessions do have a limited capacity and require pre-registration.

**Social Events:** AAEM18 offers a wide variety of social events to network with fellow attendees, speakers and exhibitors. Join our Opening Reception or one of the Chapter Division events to relax and meet others following a day of sessions.

**Wellness Opportunities:** We invite you to join us at AAEM18 for enriching education and also a motivational retreat where you leave feeling a renewed passion for emergency medicine. The Wellness Committee will be offering opportunities and events to promote wellness and resilience for a second year in a row – stay tuned for more details!

## PRE-CONFERENCE COURSES AT A GLANCE

Pre-conference courses offer the chance to take an in-depth and hands-on approach to the topic while maximizing your interaction with the instructor. Pre-conference courses have an additional registration fee and a limited capacity. Register early to take advantage of these valuable courses.

### Saturday, April 7, 2018

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

### Sunday, April 8, 2018

- State of the Art Pain Management in Emergency Medicine
- Emergency Neurological Life Support (ENLS)  
(Jointly provided by the *Neurocritical Care Society*)
- Ultrasound – Advanced
- 2017 LLSA Review Course
- 2018 Medical Student Track

**Interested in attending a pre-conference course?** Visit the AAEM18 website for full details and to register! [www.aaem.org/aaem18/program/precons](http://www.aaem.org/aaem18/program/precons).

**Registration for pre-conference courses is limited.** Courses are subject to cancellation in case of low enrollment. Attendees will be notified by March 6, 2018 if a course is cancelled. A transfer will be available to an alternate course or a full refund for the pre-conference course will be provided.

Register online at [www.aaem.org/AAEM18](http://www.aaem.org/AAEM18)



# Recap of MEMC-GREAT 2017 – Lisbon, Portugal

**The IXth Mediterranean Emergency Medicine Congress (MEMC)** was jointly organized by the American Academy of Emergency Medicine (AAEM), the Global Research on Acute Conditions Team (GREAT), and the Mediterranean Academy of Emergency Medicine (MAEM), held in Lisbon, Portugal on 6-10 September 2017.

## MEMC BY THE NUMBERS:

**566**

Delegates representing 45 countries

**365**

Abstract Submissions Accepted

**140**

Oral Abstracts – 131 Presented

**174**

Posters

**48**

Case Reports

**77**

Sessions (Tracks) making up: 6 Plenaries, 131 Oral Abstract Presenters, 303 Didactic Sessions

## KEYNOTE ADDRESS

from Prof. Lee A. Wallis,  
MBChB MD FCEM

## PLENARY SPEAKERS:

Kevin Rodgers, MD FAAEM; James Ducharme, MD; Eveline Hitti, MD MBA FAAEM; Amin Antoine N. Kazzi, MD MAAEM FAAEM; Amal Mattu, MD FAAEM; W. Frank Peacock IV, MD FACEP FACC



## AWARD WINNERS

### Dr. Cristina Costin Award:

Eveline Hitti, MD MBA FAAEM

### Founders Award:

Juliusz Jakubaszko, MD PhD

### Top Oral Abstracts

*Supported by the Journal of Emergency Medicine*

William Mower, MD: "Comparison of the NEXUS and Canadian Head CT Decision Instruments"

Jeremiah Hinson, MD: "Triage Accuracy and Variability using the Emergency Severity Index: A Multinational Study"

James Vassallo, MBBS: "Paediatric Traumatic Cardiac Arrest in England and Wales a 10 Year Epidemiological Study"

### Top Poster Awardees

*Supported by GREAT*

I-Jeng Yeh, MD

Cristopher Bartoli, MD







## AAEM/RSA President's Message

## Let's Get Political

Ashely Alker, MD PGY-3  
AAEM/RSA President



Woody Allen once told a Boston Globe reporter that 80% of success is showing up. There was no confidence interval for his study, but there is good reason to be confident in his advice. Those who are present make the rules, write history and can become leaders simply due to lack of opposition. A good example of this is the lack of physician presence in the creation of health care policy.

According to the AMA, in 2017 the United States has fourteen physicians in Congress, compared to the twenty-one physicians who held seats in 2012. Of the fourteen physicians currently in Congress, none are women and only two represent minority populations. There is currently only one physician representing emergency medicine — Congressman Raul Ruiz, MD. These numbers have clear and disturbing implications such as: The Children's Health Care Caucus has no pediatricians. Most of the lawmakers creating health care policy have never worked in a hospital and very few are physicians.

Fortunately, there are many examples of physicians who take active roles in policy-making. Dr. Leana Wen, former RSA president, is now the Commissioner of Health for the City of Baltimore. Dr. Congressman Raul Ruiz, MD represents emergency medicine physicians in Congress. There are also many residents involved in both RSA and EMRA who work endlessly to create a better future for medicine.

No matter your level of involvement in policy, it is important to realize how policy affects you. From the policies made by big government in Washington to the ACGME, residents' daily lives are impacted by regulations, often made without their presence. Governing bodies determine the conditions of your education and the future of how you practice medicine.

Here are two examples of how policy has affected your life as a resident:

Libby Zion was an 18-year-old girl who died after two residents made medical mistakes. Zion's father later wrote an article for the *New York Times* stating, "You don't need kindergarten to know that a resident working a 36-hour shift is in no condition to make any kind of judgment call — forget about life-and-death." This case established the Libby Zion Law creating work-hour restrictions in New York, later adopted by the ACGME. Work-hour restrictions continue to be a point of contention, with some arguing that hours worked equate to hours of learning. Others rebut this theory — in the current age of electronic health records, studies have shown 40% of resident work hours are not spent with patients. They are doing paperwork and ancillary care. This is an ongoing debate that affects daily resident life.

Another poignant case concerned whether The Match violates Anti-trust laws. Federal anti-trust laws apply to virtually every industry to promote fair competition and prevent monopolies. In 2003 there was a class-action lawsuit, *Jung v. AAMC*, which alleged The Match prevents medical residents from negotiating for better working conditions. During the case, Congress added a rider (an additional provision) to an unrelated bill, stating that The Match was now exempted from antitrust laws, effectively invalidating the ongoing *Jung v. AAMC* lawsuit.



Image credit: Eugena Ossi

Residency is a busy and stressful time, but you have more power than you realize. The medical systems in the United States are built on the backs of residents and you have the right to be involved in the policy-making affecting you. An important goal of the AAEM Resident and Student Association (RSA) is to educate residents on policy and give you opportunities to become involved.

RSA offers many educational opportunities in policy. During the April 7-11, 2018, AAEM Scientific Assembly in San Diego, the RSA resident track is expanding to a full day of programming concerning the *Hidden Curriculum* — covering legal, political and business aspects of emergency medicine. AAEM also provides FREE speakers to residencies to educate on these subjects at Grand Rounds or weekly conferences. Additionally, RSA is releasing a health care policy education curriculum, including ignite presentations pertaining to important policy topics in emergency medicine. In June, RSA planned the first annual Health Policy in Emergency Medicine Conference (HPEM) alongside AAEM. This is an annual free opportunity to get conference credit and learn about health care policy in Washington, D.C.

RSA continues to create opportunities for you to become involved in policy. In 2018 consider attending HPEM, the RSA resident track at the AAEM Scientific Assembly in April, or our AAEM and RSA lobbying day on The Hill. During our lobbying day each year, RSA meets with members and staff of Congress to lobby for such resident concerns as graduate medical education (GME) funding, medical student debt, no cap to Public Service Loan Forgiveness, and including emergency medicine in the National Health Service Corps (NHSC). RSA also has applications open for our advocacy committee and congressional elective. As an RSA member, you can apply for our congressional elective and scholarship, working one month in the office of Congressman Ruiz in Washington, D.C.

The world of policy can be a confusing and time-consuming environment, but RSA has created opportunities for residents to show-up and make our health care system successful.

Continued on next page

## Educate Yourself!

### Medical Policy Terminology ... *made easy.*

<b>ACA vs AHCA:</b>	Obama care vs Trump care
<b>Prudent Layperson:</b>	Guarantees that insurance will cover emergency care for anyone who thinks they are having an emergency
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<b>EMTALA:</b>	Makes sure that patients are transferred safely between medical centers, prevents dumping of patients and guarantees emergency medical care to anyone who needs it
<b>Due Process:</b>	Making sure if you are fired it is for a fair reason, as determined in a hearing by your medical peers
<b>Non-compete:</b>	You can't work for a competitor if you leave or are released from your current employer
<b>Fee Splitting:</b>	When a management company takes a part of your physician fee for service ■

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AAEMRSA017-008



# AAEM/RSA's Congressional Elective

Sathyaseelan Subramaniam, MD



Arriving in this country as an immigrant physician and negotiating its convoluted visa and immigration policies has made me acutely aware of the impact legislation

passed in Congress has on my everyday life. Since matching into pediatric residency in 2010, I've become particularly interested in how health care policy is drafted and enacted into law in America, and now that I'm about to embark on a career caring for children on a daily basis as an attending physician, I feel that understanding how health care legislation impacts this vulnerable group is vitally important. The last three years as a fellow in pediatric emergency medicine have allowed me more time to explore this topic, but it cannot compare to the insight and experience my Congressional elective month in Washington D.C has provided.

During my second year in fellowship, I applied for the American Academy of Emergency Medicine's (AAEM) unique opportunity to conduct a Congressional elective with Congressman Raul Ruiz, MD, also an emergency physician. I was approved within 2 months of my application, and 8 months in advance of my desired start date of May 2017.

Living on the Hill and working amongst legislative staffers was both an extremely novel and surprisingly familiar experience. An emergency room could be described as "controlled chaos" — not unlike the urgent pace of information gathering and team dynamics within the Congressional office. My immediate supervisor was the Congressman's legislative director. She gave me the freedom required to craft the elective and day-to-day activities to meet my individualized goals. I was provided a working space within the office with the rest of the team, and was asked for input on health care topics related to upcoming debates or bills. I helped the office conduct research into current issues like telehealth and treatment consent. I was even able to sit with the Congressman and meet with his constituents as they discussed health care issues and other matters that concerned them.

Congressional hearings were one of my favorite events to attend during my elective. They offered a rare glimpse into the vetting and testing of proposed bills, legislation up for renewal, budget allocation, and testimonials from noteworthy individuals. I attended numerous lunch briefings hosted by organizations like the Health Care Leadership Council, National Coalition for Maternal Mental Health and the American Society for Microbiology. These lobbying groups offered views to current health care problems that were vying for Congressional action. Topics raised included

"Overall, the AAEM Congressional elective rotation was very inspiring to me as an emergency medicine trainee. With the nation's health care system in flux, Dr. Ruiz has his hand on the pulse of health care policy."



shortages in the health care workforce, transplant list wait times, lead level monitoring, and vaccine dropout rates. Other activities that I partook in were attending news conferences and federally funded exhibitions on health technology that included key speakers from the National Institute of Health.

I also managed to observe bills being debated and voted by lawmakers on the Senate and House floors from the respective galleries, participated in medical history forums at the Library of Congress, and attended a lecture at the Supreme Court to gain a better understanding of the nation's justice system.

Overall, the AAEM/RSA Congressional elective rotation was very inspiring to me as an emergency medicine trainee. With the nation's health care system in flux, Dr. Ruiz has his hand on the pulse of health care policy. Learning more about this complicated field from him and his diligent staff has provided me with an in-depth knowledge of health care legislation and policy making that I hope to use for the betterment of the children I will serve. ■

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## Resident Journal Review

# Non-Invasive Positive Pressure Ventilation in the Treatment of Acute Respiratory Distress in the Emergency Department

Authors: Theodore J. Segarra, MD; Lee Grodin, MD; Taylor Conrad, MD; Ray Beyda, MD

Editors: Kelly Maurelus, MD FAAEM and Michael C. Bond, MD FAAEM

Over the last decade, non-invasive ventilation (NIV), including both bilevel positive airway pressure (BPAP) and continuous positive airway pressure (CPAP) modes, has become an important tool in the management of ED patients with respiratory distress due to acute pulmonary edema (APE) and chronic obstructive pulmonary disease (COPD) exacerbations. Many studies have shown its utility in successfully reducing the need for intubation and reducing length of stay (LOS) in the ICU. Given these positive results, interest in NIV for patients with undifferentiated respiratory distress has increased but very few studies have compared the outcomes of using NIV for other causes of acute respiratory distress, such as asthma, pneumonia, malignancy, or interstitial lung disease. This review aims to discuss the current literature on the non-standard use of NIV for other causes of respiratory distress in the emergency setting and to identify potential areas for further research.

## **Coggins A, Cummins E, Burns B. Management of critical illness with non-invasive ventilation by an Australian HEMS. *Emergency Medical Journal*. 2016**

An Australia group recently reviewed the pre-hospital use of NIV for the management of acute respiratory distress. Coggins and colleagues performed a retrospective observational study comparing outcomes in 106 patients who received NIV at some point during their pre-hospital course. One group was transported entirely on NIV ( $n = 58$ ), one group failed NIV at the referral hospital and required intubation prior to transport ( $n = 20$ ), and one group was able to be taken off NIV prior to transport ( $n = 28$ ). All patients were transported by the Greater Sydney Area Helicopter Medical Services and transport was either by helicopter or by ambulance.

The authors determined that of the 86 patients placed on NIV and stable for transport, none required intubation during transport, and none died within 24 hours of transport. Among the 106 total patients, the median age was 63, and the most common causes of respiratory distress were pneumonia (34%), cardiogenic (27%), and COPD (26%). However, they found that patients with cardiogenic causes (heart failure and cardiogenic shock) had the highest rates of intubation at 24 hours (38%) despite low rates of early failure of NIV. In addition, nearly 20% of the non-intubated patients eventually required intubation by 24 hours. They further noted an increased trend in failed NIV when the decision to choose NIV was made by a physician in training (registrar) rather than a trained physician (consultant).

The authors concluded that the use of NIV in the pre-hospital setting is safe, but that failure of NIV does lead to increased admission and treatment times. Though limited by a small sample size and the inherent limitations of a retrospective observational design, this study was able to highlight the safe use of NIV in patients with diverse etiologies of respiratory failure. As such, it lends support to the use of NIV in patients with undifferentiated respiratory distress. Furthermore, it highlights

the potential use of NIV in the pre-hospital setting as well as in the ED. Despite these positive findings, this study also demonstrates the need for additional randomized prospective studies to better compare outcomes and reduce potential confounders.

## **Green E, Jain P, Bernoth M. Noninvasive ventilation of acute exacerbations of asthma: a systematic review of the literature. *Australian Critical Care*. 2017 Jan 27. pii: S1036-7314(17)30017-6. doi: 10.1016/j.aucc.2017.01.003. [Epub ahead of print]**

Green et al., conducted a systematic review of the use of NIV for asthma. They searched EBSCOhost, MEDLINES, and PubMed using the terms "noninvasive ventilation," "BiPAP," "CPAP," "wheeze," and "asthma," and excluded reviews, studies on topics other than asthma, those not in English, and pediatric studies. Ultimately, thirteen studies were included. While NIV use is considered safe and is common in patients with asthma, this study sought to evaluate its efficacy. However, this review highlighted the need for more research on the topic and the barriers to doing so.

Most of the included studies examined NIV use in the ED. None of the studies were blinded and most had poor randomization. Given the obvious nature of the intervention, blinding providers and patients to its use is difficult. Six of the reviewed studies do not include biometric data for greater than four hours. The authors identify that traditionally respected endpoints such as mortality and LOS are difficult to use in studying asthma. Mortality is difficult given the rarity of inpatient deaths associated with asthma. The LOS is a difficult endpoint given that each study set different parameters and have confounding results.

The authors conclude there is inadequate information to endorse the use of NIV for acute asthma exacerbations. Background information does suggest it is safe and warrants further investigation.

## **Confalorieri M, Potena A, et al. Acute respiratory failure in patients with severe community-acquired pneumonia.. *Am. J. Respir. Crit. Care Med*. 1999;160(5):1585-1591.**

This multicenter, prospective, randomized controlled trial was designed to compare the efficacy of NIV versus standard treatment of supplemental oxygen delivered by Venturi mask in patients with severe community acquired pneumonia (CAP) and concurrent acute respiratory failure. The primary endpoint was the requirement of endotracheal intubation as determined by preselected criteria at any point during treatment. Secondary endpoints included complications during hospital stay, duration of required ventilator support, length of ICU and hospital stay, in-hospital survival, and 2-month survival. Severe community acquired pneumonia was defined as per the American Thoracic Society criteria. Pre-selected values for hypoxia, hypercapnea, and tachypnea with altered respiratory

Continued on next page

mechanics were used to define acute respiratory failure. Baseline characteristics were similar between the NIV ( $n=28$ ) and the standard treatment ( $n=28$ ) groups including APACHE II scores, presence of concomitant COPD, age, blood gases, and respiratory rate. Both groups received similar medical management with antibiotics and goal  $SpO_2 > 90\%$ . All patients were admitted and managed in an intermediate respiratory ICU and were only transferred to the full ICU if they required intubation or invasive monitoring.

Reasons for intubation included worsening hypoxemia, worsening hypercarbia, severe hemodynamic instability, and inability to tolerate secretions. Only 21% ( $n=6$ ) of the NIV group versus 61% ( $n=17$ ) of the standard treatment group met criteria for intubation ( $p=0.007$ ). Of note, only 14 patients in the standard treatment group were ultimately intubated as 3 patients in this group with concurrent COPD were given NIV after meeting criteria for intubation and subsequently improved. Duration of ICU stay was significantly less in the NIV group ( $1.8 \pm 0.7$  days) compared to standard treatment ( $6 \pm 2$  days),  $p=0.04$ . Patients

randomized to the NIV group also noted a rapid and sustained decrease in respiratory rate within 24 hours compared to the standard treatment group. Importantly, time to intubation was similar in both groups (mean of 44 hours with wide variability). Survival during hospital stay, 2-month mortality, and required intensity of nursing was similar between the two groups. The authors performed a post-hoc analysis comparing the subset of patients with COPD. The significant difference in a lower number of patients meeting criteria for mechanical ventilation was only seen in the COPD population. Additionally, a significant reduction in 2-month mortality was noted in the NIV group for patients with COPD.

For patients with severe CAP and respiratory failure who don't require immediate intubation, this study demonstrates that NIV decreases the intubation rate compared to standard treatment. An important feature of this study is that both groups noted similar APACHE II scores as well as time to intubation in those individuals requiring it. Both of these confounders have been implicated in skewing results of other studies regarding

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the use of NIV in severe CAP. Ultimately, the usefulness of NIV is likely in its ability to improve hypoxia and hypercarbia. This study is limited by the relatively small number of patients enrolled as well as the realization from the post-hoc analysis that the main effect was seen by the efficacy of NIV in COPD patients which is supported in other research. It is also important to note that the centers where the research was performed all had patients admitted initially to a more intensely monitored setting when compared to a regular floor ward, specifically to their respiratory intermediate ICU (likely comparable to some stepdown units although arguably different). Thus, it is difficult to generalize this to patients admitted to the hospital wards with lower levels of care. Nonetheless, NIV is useful as an early intervention in severe CAP with acute respiratory failure, especially in patients with COPD. It is important to note that NIV does not replace appropriate invasive monitoring and interventions required in patients with worsening respiratory failure.

**Mosier JM, Sakles JC, et al. Failed noninvasive positive-pressure ventilation is associated with an increased risk of intubation-related complications. *Annals of Intensive Care*. (2015) 5:4; 1-9.**

In this single center, retrospective, cohort study of medical ICU patients, the authors studied the potential detrimental effects of delayed intubation should a trial of NIV for acute respiratory distress fail. They compared patients intubated following failed NIV to patients intubated primarily without an initial trial of NIV. Specifically, they looked at the composite primary outcome of desaturations, hypotension, or aspiration events during intubations. There were no significant differences in age or gender between the NIV-trialed ( $n=125$ ) and non-NIV-trialed group ( $n=110$ ). However, there were differences in what the authors termed “difficult airway characteristics.” Specifically, in the NIV-trialed group there was less blood in the airway (5.6% vs 22.7%,  $p=0.001$ ), less airway edema (4.0% vs 13.6%,  $p=0.01$ ), and fewer desaturation events to less than 88% (20.8% vs 39.1%,  $p=0.003$ ). There was a higher frequency of short necks in the NIV-trialed group (37.6% vs 20.0%,  $p=0.004$ ). The severity of illness assessment scores (e.g. APACHE II, SAPS II, and APACHE IV) were also significantly lower in the NIV-trialed group. Of the patients in the failed NIV group, there was a higher incidence of intubation for hypoxemic respiratory failure (64% compared to 45.5%,  $p=0.006$ ), and 49% of these were intubated for pneumonia or acute respiratory distress syndrome (ARDS).

Most of the patients in this study had NIV initiated in the ICU (77.7%) as compared to the in ED (11.6%) or on the medical ward (10.7%). Causes for NIV were acute hypoxemia (55.9%), acute hypercapnia (25.4%), and increased work of breathing (8.5%). The main reasons listed for intubation in the study differed between the two groups; the NIV-trialed group was intubated less often for airway protection (6.4% vs 26.4%), patient control (0.8% vs 1.8%), hemodynamic instability (0.8% vs 5.5%), and severe metabolic acidosis (0.8% vs 3.6%), but was intubated more often for respiratory failure (91.2% vs 62.7%), with all of these differences being statistically significant ( $p=0.001$ ). There was no statistical difference between the two groups in the rates of hypotension, desaturation, or aspiration. While there was no statistical difference in the unadjusted odds

of the composite complication, there was increased odds of the composite outcome in a propensity-adjusted multivariate regression analysis with an odds ratio of 2.20 (95% CI 1.14-4.25), when adjusted for the presence of pneumonia or ARDS. Finally, the unadjusted odds of death was 1.79, when a composite complication occurred (95% CI 1.03-3.12).

This study suggests that in patients intubated after a trial of NIV, there may be an increased risk of the composite outcome of hypotension, desaturation, or aspiration, and if one of these should occur there may be an increased unadjusted risk of death in the ICU. Several possible explanations may account for these findings. The increase in the rate of intubation complications could account for the increased mortality associated with delayed intubation following NIV-trial failure. Respiratory failure, either hypercapnic, hypoxemic, or mixed, is caused by multiple different etiologies, and while patients with COPD or CHF exacerbations may benefit from NIV, those with other causes of respiratory failure may not.

Furthermore, in patients with non-COPD or non-CHF causes of respiratory failure, delaying primary intubation may lead to worsening respiratory failure and reserve, as well as make intubating conditions more difficult. This study has several limitations including its retrospective design, and the authors address these, encouraging more research into this topic. While propensity scoring was utilized in this study in an attempt to address variables that may have influenced the decision to pursue a trial of NIV, not all variables and clinical factors may have been considered in the model. In addition, the study population was of patients that were all intubated in the ICU, and not all NIV-trialed patients, as data on NIV success rates was not available to the authors. While this study has its limitations, it does suggest a possible association between failure of NIV in acute respiratory failure and complications during subsequent intubation. The benefits of NIV in COPD and CHF exacerbations have led to the adoption of this mode of ventilatory support in a broad spectrum of acute respiratory failure patients. While this may benefit some patients with respiratory failure, some may be harmed. In these subsets, earlier intubation may offer a more favorable risk benefit ratio.

### Conclusion:

Overall, these studies highlight the potential for expanding the use of NIV for the treatment of acute respiratory distress due to causes other than just APE and COPD exacerbations. Although the authors in these studies were able to show some promising results regarding newer applications of NIV, the overall strength of the current evidence is still significantly lacking, and the data from different studies has been conflicting. Furthermore, we must keep in mind the potential for harm in choosing to use NIV in the wrong settings or for the wrong patients. The most important point derived from these studies is that the field would benefit greatly from additional prospective, randomized trials comparing the risks and benefits of applying NIV more broadly in patients with undifferentiated respiratory distress. ■



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## Medical Student Council President's Message

# RSA Celebrates a Successful 9th Annual Midwest Regional Medical Student Symposium

Christopher Ryba, MS3



On Saturday, September 23, the 9th Annual AAEM/RSA Midwest Regional Medical Student Symposium was held at the Loyola University Stritch School of Medicine in Maywood, IL, located just outside of Chicago. This year, the event drew around 140 medical students primarily from medical schools in the Midwest, but also bringing in

students from all across the continental United States. The Symposium was attended by staff from 19 emergency medicine residency programs throughout the Midwest.

The day began with a welcome breakfast and student networking opportunity while registration was on going. This was followed by morning talks and presentations from AAEM President, Dr. Kevin Rodgers; AAEM/RSA Immediate Past President, Dr. Mary Haas; GLAAEM Representative, Dr. Michael Takacs; University of Michigan Program Director, Dr. Laura Hopson; University of Wisconsin PD, Dr. Mary Westergaard; Washington University PD, Dr. Jason Wagner; and University of Chicago PD, Dr. Chrissy Babcock. Morning talks covered subjects such as competitiveness in emergency medicine and options after residency.

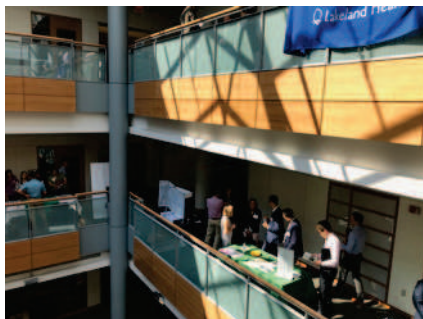
Students then broke up into class level of M1/M2, M3, and M4 and were given individualized talks from Dr. Kevin Rodgers, Central Michigan PD, Dr. Kathleen Cowling, and Rush University APD, Dr. Scott Heinrich. Lecturers were then joined by the other attending programs for an open forum Q&A session. During lunch, each program had a table assigned

that students were able to select to sit at and have a more informal open discussion while enjoying lunch.

The afternoon was filled with break-out sessions sandwiched around the residency fair. For the break-out sessions, students had the option to select from two of the following sessions: Airway/Intubation, taught by the Resurrection Residents; Ultrasound, taught by University of Chicago Residents; Suturing, taught by Loyola's Dr. Brian Barbas and assisted by Northwestern Residents; Simulation, managed by Loyola's Dr. Trent Reed and the Residents of Advocate Christ; and Sports Medicine, talk given by Dr. Christopher Trigger of Lakeland Health.

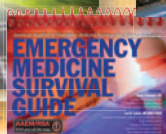
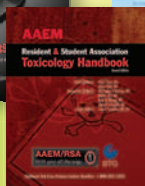
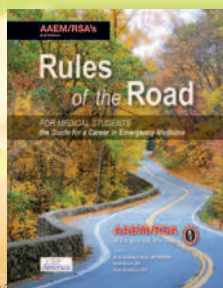
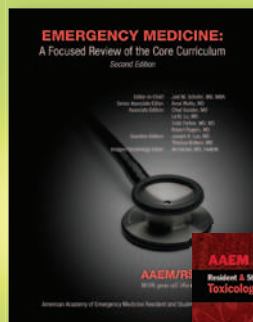
The residency fair, often the biggest draw of the day, featured all nineteen programs along with their residents plus a representative from Kaplan staged around the Atrium. Students had the opportunity to walk around to each table to speak with the programs where they could ask questions and gather information first hand. The symposium was once again a huge success.

I would like to thank AAEM/RSA for all of the support in putting on this event. Thanks to Shea Boles, MS3 and David Fine, MS2 of Loyola for all of their help in organizing and behind the scenes work to make sure the event ran smoothly. Special thanks to all of the Program Directors and Residents who took time out of their busy schedules to attend and really make this event all that it is. Finally, thank you to all of the participants without whom this event would not be possible. Keep an eye out for next fall. ■



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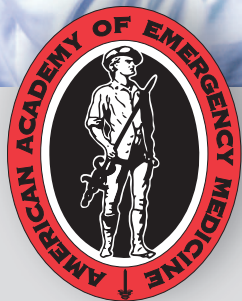
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**Submission Deadline: November 27,  
2017 at 11:59pm CT**

- AAEM18 Photo Competition
- JEM Resident and Student Research Competition
- AAEM/RSA & WestJEM Population Health Research Competition
- Open Mic
- YPS Poster Competition

[www.aaem.org/AAEM18/competitions](http://www.aaem.org/AAEM18/competitions)

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