COMMON SENSE

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AAEM™
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2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
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President's Message

Coming Back to Life … Let's Break the Silence!

David A. Farcy, MD FAAEM FCCM
President, AAEM

"For millions of years mankind lived just like the animals
Then something happened which unleashed the power of our imagination
We learned to talk"
— Pink Floyd, *Keep Talking*

"Lost in thought and lost in time
While the seeds of life and the seeds of change were planted
Outside the rain fell dark and slow
While I pondered on this dangerous but irresistible pastime
I took a heavenly ride through our silence
I knew the moment had arrived
For killing the past and coming back to life"
— Pink Floyd, *Coming Back to Life*

This will not be another article on wellness, but rather about the reality of the effects of lack of wellness. This article is about depression and suicide as the end of the road. This is my personal point-of-view and is not research based. In the past eight months, tragedy has struck all around me. On August 18, 2017, one of my attendings, who was never late to a shift, was found dead by me when he did not show up to work. It was discovered that his death at age 55 was related to his chronic alcoholism. On November 20th, a friend, mentor, and leader in EM education was murdered in his home at age 62. On April 20th, a dear friend and world famous musician took his own life at age 28. On May 25th, an acquaintance working in the nightlife/hospitality took his own life at age 55. Why? How? But most important, could any of these have been prevented? Could I have done anything more?

Much of what is written on burnout has been about recognizing and preventing it, but there is very little discussion about what to do when we are unwell. We define "burnout" as a state of emotional, mental, and physical exhaustion caused by prolonged stress. We all know the affect it can have on our body, psychology, work, and personal relationships. We are told what we need to do: drink less, exercise more, spend more time with our family, do yoga, get adequate sleep, be thankful for what we have, etc. Physicians are goal oriented, over-achievers. If we are given a list of ways to improve and be well, we often feel as though we failed at taking advantage of an "easy solution" and that it is our fault for being unwell. We feel as though we are broken, rather than the system is breaking us.

Physician suicides have been increasing over the past century and even more alarming — suicide is the second cause of death among medical students. The numbers are reported to be 300-400 per year, but this is often under reported.

In my early years, I could not understand suicide. I saw it as a sign of weakness. Then, I served in the Air Force during Desert Storm and Desert Shield and something happened when I got home and separated from the service that I could not understand, could not explain and most importantly, could not face or admit that it was happening to me. I had lost the joy of life. I had survivors' guilt, but I wasn't aware or did not want to deal with it. At a skydiving event, my older brother came to see me, and jokingly I made the comment "God does not want me, if he wanted me, he would have taken my life already." That day, I broke the safety limits off while opening my parachute for fun, and later had a major malfunction. If my safety device had not opened my reserve, I would not be here today to write this. My brother was petrified and looked at me and told me "Bro, I love you, please stop this shit, we all love you, please."

Like most emergency physicians, we are great at dealing with stress. We pride ourselves that we can multi-task, but what we really do is put our issues in boxes and tuck them away in our subconscious and forget about them — out of sight out of harm. I was great at this — put it away and

do not address anything and press on. On the night before 09/11/2001, I was working the overnight shift at Maimonides Medical Center. The next morning, we received a report at 8:48am that "a plane had crashed into the World Trade Center." I jumped at the opportunity to skip out on computer training and respond to the disaster ... the rest is history. Still, I would not talk about the horrific events that happened that day and placed everything in yet another box. Exactly one year later at residency conference, my program director, had one minute of silence at 9am and at that exact moment, I became paralyzed and in tears. Why not me, why am I alive? My program director brought me down to her office to

Continued on next page

talk, and told me I needed help. She sent me to our ACGME office, where they listened to me ramble for an hour and from there, we went to a psychologist trained in PTSD and survivor's guilt. After, a few sessions and group therapy, I realized that I was not the only one, others felt exactly like me. I was not crazy or abnormal. My journey to acknowledge the stressor and what I needed to do was a long painful one. But after several years, I know how to cope with it and I thank GOD for sparing my life because of all the patients I had the opportunity to save, and make a difference in their lives, who might not have survived without me.

But, we all have something in common … the stigma of being labeled, the fear of being seen differently, the fear of losing our job. As physicians, we have been competing against each other for years, we criticize each other, we work countless hours with each other without really knowing each other. Then something happens and we all ask each other "How did we miss it?" When my attending died that I worked closely with for years, I questioned myself for weeks. How did I miss it? Were there any red flags? He was a model employee, always early for his shift, smiling and joking, and not showing signs that would raise any concerns. No one really knew him outside work; we only knew what he wanted us to know. In retrospect, work was his sanctuary — his happy place. But looking back, no one questioned why he wasn't at the last three holiday parties, our residents' graduation night, or any wellness event.

There are common themes among those suffering burnout and depression. Some of the first themes are: to withdraw, consume an excess of alcohol, not want to be involved, not care anymore. But the worst is the feeling that you have no one to talk to or that you cannot because you feel isolated, you feel that you are going crazy. During my stress reaction, I would hear a lot of people telling me what I needed to do, but no one really wanted to hear what I had to say and the voices in my head were telling me "They don't understand," "this is useless." So, when someone asks you, "Hey, can we go have a drink, I need to talk," please take a moment from your busy schedule and say, "Yes." And, if the person starts opening Pandora's box, let them know that it is safe for them to share and let them speak. Listen to them, don't offer your opinion unless it is asked for. Reassure them that they are not the only one, that what they are feeling is normal, and help is available. Many people can be talked off the edge just by listening. Next, get a small group of colleagues and friends together and formulate a plan. Make a point to get that person involved, even if it means driving to their house to check on them. Let them know it is safe for them to call you when the "darkness overcomes the light."

Finally, and most importantly let us de-stigmatize depression as something that happens to others, have regular discussions about it, learn the signs, educate yourself and your colleagues. Let's treat each other with respect and create plans within our institutions with a "safe talk" environment where one can express their feelings without fear of consequence. If a life-changing event happens, get involved and check on each other. Let's break down the barriers and recognize we all at one point in our life will contemplate suicide, and let's look out for each other. We learned to talk, but let's learn to listen.

For more information on suicide, visit the AAEM wellness committee website:
www.aaem.org/get-involved/committees/committee-groups/wellness

Get involved, perform an annual burnout survey, and do something. Let's break the silence and take action.

Looking for more resources? Visit the Clinician Well-Being Knowledge Hub: https://nam.edu/clinicianwellbeing/. You can find articles, research studies, and other resources.

Dedicated to Tim. "Now I'm running away my dear. From myself and the truth I fear. My heart is beating I can't see clear. How I'm wishing that you were here." — Avicii, Without You

Addendum

We are please to report that our advocacy efforts and your voice has been represented in D.C. A due process bill to guarantee that due process rights cannot be waived and must be guaranteed was introduced at the federal level. We still have a long way to go, see the following press release if you missed it.

https://www.aaem.org/resources/publications/news-releases/due-process-legislation

From the Editor's Desk

Pilgrimage

Andy Mayer, MD FAAEM
Editor, *Common Sense*

A **pilgrimage** is a journey or search of moral or spiritual significance. Typically, it is a journey to a shrine or other location of importance to a person's beliefs and faith, although sometimes it can be a metaphorical journey into someone's own beliefs. (Wikipedia).

I am reflecting on my recent trip to San Diego for AAEM's Scientific Assembly, and what this gathering means to me. At first glance this might seem a trivial activity, since people usually go to San Diego for sun, sand, food, and fun — and there was plenty of that at the Scientific Assembly. But there was much more. Emergency physicians, from the elders and leaders of our specialty to the wide-eyed medical students who volunteer to be ambassadors for the meeting, come together for this important event. I look back on the many Scientific Assemblies I have attended, and want to share what the Scientific Assembly has meant to me as an individual and as an emergency physician.

> "The sense of community is why I attend the Assembly. Being with a thousand others who know what it is like to walk in my shoes is what makes the experience important to me."

Clearly, all emergency physicians have stress and concern about their practice and employment. The stressors are legion, and we must recognize them if we are to have any chance of overcoming them in a healthy way. I find that many emergency physicians feel isolated and alone. My concern is that they think their current issue, which might be anything from the latest sepsis or stroke core measure to another senseless patient complaint, is unique and special to them. They may feel their difficulty dealing with the numerous and oppressive burdens placed on them represents a character flaw or an abnormal inability to cope.

Remember, we emergency physicians have climbed many a mountain and crossed many a raging river to get where we are, usually without a lot of help. The worst thing one could do in my residency was admit weakness. You could stand before the elders and be publicly shamed at a Morbidity and Mortality Conference, but you could not be weak. You were required to suffer any burden in silent resignation and accept all responsibility as a normal part of the medical education and indoctrination process. Does this make us strong, or is it actually making us weak?

This brings me to the real value of the Scientific Assembly. Of course, hearing fantastic lectures from the icons of our specialty can help us learn and grow. I was fascinated by the pain and ketamine lectures of Dr. Reuben Strayer. I don't think I will be starting Suboxone therapy in my emergency department, but his ideas on opioid naiveté and the use of low dose ketamine for pain caused me to think about changing my practice. The usual star lecturers are always welcome, and hearing a thought-provoking lecture from the coroner of the District of Columbia certainly made me consider the current realities of poverty and violence in America. The small group sessions I attended on epistaxis and vertigo were incredible. This is really a great approach to learning. These are not entry-level talks for physicians from other specialties. They are directed and modeled to help the board certified emergency physician. But enough about the Scientific Assembly as a forum for clinical learning. This isn't the biggest reason I attend the Scientific Assembly.

The sense of community is why I attend the Assembly. Being with a thousand others who know what it is like to walk in my shoes is what makes the experience important to me. It is a chance to catch up with old friends from residency or practice. Seeing heads shaking in unison in the lecture hall, listening to the problems and issues discussed during lectures, and commiserating over a cup of coffee in the exhibitor hall makes you realize that you are not alone. The problem that seems insurmountable to you has already been faced by others, who are glad to help or at least listen to you vent about whatever protocol or patient satisfaction measure you may be struggling with. Everyone claims their patients are the worst and sickest humans on the face of the Earth, and that their hospital administration is the most unreasonable. The more you learn about other practice environments, the more you realize how similar our issues and frustrations are. Whether you are in a small rural hospital or a large urban trauma center, there really are more similarities than differences in our practices and our problems.

I really go to the Scientific Assembly as a pilgrimage. I personally need to recharge my batteries on multiple levels. Certainly, the medical education portion rekindles my interest in the practice of emergency medicine.

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Learning a new trick or tip which I can bring home and use reminds me that I need to continuously learn to stay relevant and connected. My biggest recharge though, comes from speaking to my colleagues from across America and learning about their personal, community, and state challenges and how they are responding to those. That makes me feel more like a professional in an ever-expanding specialty, which continues to grow and develop. We need to take pride in emergency medicine and remember that we are special. We are healers, who sacrificed a lot to practice in a specialty where we can and do make a difference in our patients' lives every day.

I encourage all of you to attend the Scientific Assembly next year and see if it changes your perspective. It is a quick refresher and soul re-charging experience. You, as an emergency physician, have much to be proud of and you must remember that even when you feel like a highly paid data-entry clerk. Attend some of the incredible Wellness Committee events, which are designed to help you thrive and grow during your career, especially when that career is at its most difficult and frustrating. You are a real professional and an important specialist, and maybe attending the Scientific Assembly will help you reconnect with that important reality. ●

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What stood out to you from this issue of *Common Sense*? Have a question, idea, or opinion? Andy Mayer, MD FAAEM, editor of *Common Sense*, welcomes your comments and suggestions. Submit a letter to the editor and continue the conversation.

Check out the redesigned *Common Sense* online at:
www.aaem.org/resources/publications/common-sense

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

WELLNESS

BY JOHN KEALY, M.D.
CHAIRPERSON, AAEM EDUCATION COMMITTEE

Wellness! The word is starting to come up in the most unlikely places from the most unlikely sources. It is now an "in" word,. prompting articles, books, seminars, and workshops-the focus of the nineties and hopefully beyond. The search for wellness is as old as the human species. We instinctively know what it is *not*. We know it is *not* about staying healthy and living to be as old as Methuselah. It is *not* about making a lot of money and having the "good life." These things certainly make life palatable and may be consequences of wellness but they don't constitute it. Wellness exists within the framework of birth, life, living, dying, and death. Somehow, somewhere there exists a way of being in relationship to this paradigm that produces wellness.

The science of medicine, as distinct from its art, has traditionally been focused on body health, with the spiritual and mental dimensions addressed in other disciplines and institutions, e.g. psychiatry, religions, and spiritual practices. Everything has been neatly separated to the point that even patients are referred to as "the tibia in room 4." When presented with this evidence we smile and say that we don't really mean ***that!*** The reality is, consciously or not, this separation of mind and body has fragmented our lives to the point that we may live with relationships that lack integration and inspiration. That integrating and inspiring essence is the Holy Grail of Wellness. What it is for each person is a unique lifelong discovery process. Some never start, others are awakened to its presence by the pain of unexpected change while others take on the challenge with passion and excitement.

"People don't grow old. When they stop growing they age."

Chopra's quote captures the essence of the odyssey to wellness. Growth is usually seeded in the challenging and sometimes painful experience of change. The change could be the personal loss of job, family, security, or a loved one. It can be the challenge of taking on something new, doing things in a different way, or going the extra mile. In all cases there is a change in the status of an existing relationship or set of relationships. One thing becomes obvious to anyone involved in change: when one relationship changes, everything changes. You cannot break the pretzel in one spot! One aspect of wellness is the relationship we have to ourselves. This relationship is the cornerstone of any work in the arena of wellness. This personal growth and development is the most important of all relationships and the one that may be the least nourished. It requires great honesty, and many times can be most difficult. ***The AAEM meeting in Las Vegas was a moving experience. It was an expression of wellness at an individual and group level.*** There was the necessary "kvetching", the commonality of shared experiences, the intimacy of shared pain, the excitement of shared vision, and the identification of a mission that would reflect the values of our lives as committed human beings and physicians. It was a great start for wellness at a group and institutional level. The building blocks for this success is the individual commitment we make to our personal health and well-being. *"Physician, heal thyself."*

Be well!

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LEAD-EM Contributions – Thank You!

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AAEM AMERICAN ACADEMY OF EMERGENCY MEDICINE

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

The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from **1-1-2018 to 6-25-2018**.

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Common Sense Announces New Assistant Editor

The staff of *Common Sense* would like to thank Dr. Jonathan Jones who has been faithfully serving as our Assistant Editor. He has been elected as the new Secretary/Treasurer of the American Academy of Emergency Medicine and will be relinquishing his role as assistant editor.

Common Sense would like to welcome Dr. Mehruba Anwar Parris as our new assistant editor. She is currently the Associate Medical Director of the Emergency Department at Jackson South Medical Center in Miami, Florida. She completed medical school at Stony Brook University and her emergency medicine residency in 2014 at the New York Presbyterian-Brooklyn Methodist Hospital. She has also completed a toxicology fellowship at Emory University. The editor and staff of *Common Sense* are excited about Dr. Anwar Parris joining our team. ●

AAEM Online

AAEM
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AAEM18 is Now Available on AAEM Online!

Didn't get a chance to make it to AAEM18 or missed a couple lectures that you really wanted to see? AAEM Online is a FREE member's only benefit that allows you to stream video or audio from past AAEM scientific assemblies online, or download the MP3 or MP4 files.

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Upcoming Conferences: AAEM Directly, Jointly Provided & Recommended

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

AAEM Conferences

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

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

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

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

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

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

AAEM Jointly Provided Conferences

September 12, 2018
Louisiana Chapter Division (AAEMLa) Residents' Day and Meeting
Shreveport, LA
www.aaem.org/get-involved/chapter-divisions/aaemla/aaemla-residents-day-and-meeting

September 13-16, 2018
Mediterranean Academy of Emergency Medicine Congress
Beirut, Lebanon
http://www.aub.edu.lb/fm/CME/Pages/Registration.aspx

AAEM Recommended Conferences

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

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

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

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

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

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

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

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

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

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2018 AAEM & AAEM/RSA Health Policy Symposium & Advocacy Day Recap

AAEM AMERICAN ACADEMY OF EMERGENCY MEDICINE

RSA Innovate. Educate. Advocate.

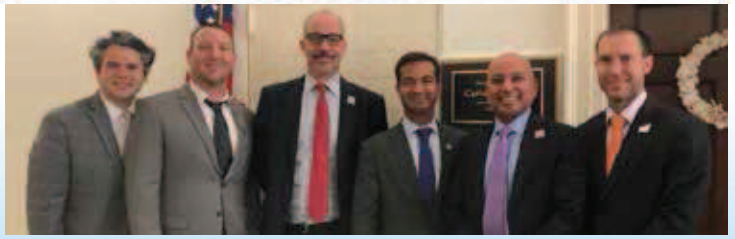
On June 11-12, 2018, members of AAEM and AAEM/RSA gathered in Washington, D.C. to advocate for the specialty of EM.

VISITED WITH:

- 40 Members of Congress and/or senior Congressional staffers who focus on health care issues
- These Members represent 14 different states

TOPICS DISCUSSED INCLUDED:

- Due process rights for emergency physicians
- Prudent layperson standard
- Key issues impacting care in EDs across the country



Washington Watch

Two Days in D.C. with AAEM

Haig Aintablian, MD
AAEM/RSA Board of Directors

It would ultimately take 11 hours for my flight from Los Angeles International Airport to reach D.C.'s Reagan National Airport. Four aborted landing attempts due to poor weather and a high tailwind, a diversion to Baltimore to refuel, and our original pilots clocking out on their FAA regulated "Duty Hours" of sorts (take note, ACGME) took a five hour flight and more than doubled it. With such a rough start, I was convinced my three day trip to D.C. would end up with me begging to be back at home. But actually, my stay in D.C., the capitol of capitols, soon became one of the best experiences I've ever had. I was in town for HPEM, or Health Policy in Emergency Medicine, American Academy of Emergency Medicine's informational series on what policies and issues are affecting emergency medicine and what we can do about it. This day stands right before AAEM's Advocacy Day on Capitol Hill, where emergency physicians meet senators, congressmen/women and their staffers to discuss these issues in person.

As a member of the RSA's advocacy committee, I helped planned this event and knew a good bit about the policy issues surrounding emergency medicine. But after hearing the topics discussed during HPEM, things regarding CMGs running residency programs, the fight for due process rights, the rise of standalone EDs, and so many more, my knowledge seemed elementary compared to those who spoke about them.

The preparation of HPEM for Advocacy Day was critical to our interactions with politicians the next day, giving us nuggets of golden information to help educate our policy makers into the issues we've been facing.

"The work we do is something that society cannot live without, and showing politicians our issues through our presence makes our message a genuine one."

Advocacy day came with a sweet 70 degrees and some D.C. sun. Most of our day was scheduled to be spent speaking with politicians and/or their staffers, the value of which I didn't fully understand until it was actually happening. Speaking with the representative of a district first hand, I felt as though this opportunity to simply sign up for free and become an integral part of emergency medicine policy making was an untapped gem.

Whether the flight to D.C. is five hours or 11 hours (I hope not), HPEM and Advocacy Day are events I'll be attending every year. It's difficult to explain how much value we, as students, residents, and physicians in EM, have when we speak to policy makers in person about the issues that affect us. The work we do is something that society cannot live without, and showing politicians our issues through our presence makes our message a genuine one. And although this year went well, we still have many, many things to cover. So I'll see you there next year! ●

AAEM Lauds Introduction of Federal Due Process Legislation

FOR IMMEDIATE RELEASE

July 16, 2018

MILWAUKEE, WI — The American Academy of Emergency Medicine (AAEM) congratulates Representatives Chris Collins (R-NY), Raul Ruiz (D-CA), and Pete Sessions (R-TX) on the introduction of landmark federal legislation today to protect physician due process rights. AAEM is proud to recognize Representative Collins as a champion in the field of emergency medicine, and will continue to work closely with him and Members of Congress on both sides of the aisle in the coming months to tackle this critical problem.

"The protection of due process rights has long been the top advocacy priority for AAEM," said David Farcy, President of AAEM. "We are thankful to Representatives Collins, Ruiz, and Sessions for recognizing the importance of this issue, for taking the time to listen to the concerns of emergency physicians and patients around the country, and for taking the initiative to address this public health imperative."

In June, AAEM led a group letter to the Centers for Medicare and Medicaid Services (CMS) urging them to take concrete action to protect physician due process rights. It was signed by eight other leading organizations in the field of emergency medicine: AAEM/RSA, ACEP, ACMT, ACOEP, AOA, CORD, EMRA, and SAEM.

A physician that lacks due process rights loses the ability to advocate for his or her patients without fear of termination. By requiring the Secretary of Health and Human Services (HHS) to move forward with a rulemaking to protect due process rights, this bill restores the sanctity of the doctor-patient relationship in emergency medicine, and enables physicians to do the right thing for those in need of care. This common-sense measure not only has the benefit of promoting quality care, it also empowers doctors to fight waste, fraud and abuse in the health care system.

For decades, a growing number of emergency physicians have been forced to waive their due process rights as a condition of employment. This bill will reverse this trend.

AAEM urges Congress to follow Representative Collins' lead and swiftly enact this pro-patient and pro-taxpayer legislation.

###

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine and the champion of the emergency physician. ●

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September 6-7, 2018 • Sheraton Austin at the Capitol • Austin, TX

Learn more and register today for the first-ever ED Management Solutions bootcamp!

www.aaem.org/education/ed-management-solutions

Presented by the AAEM Operations Management Committee

The ED Management Solutions Course is a live two-day event that brings together current and future medical directors. Not a medical director, but interested in operations management? This course is for you too! Topics covered are both timely and cutting edge. The first day will focus on the fundamentals of operations and then you will dive deeper into emergency department management and leadership on day two.

Course Features

- Two-day boot camp covering the principles & practice of ED management - including deep dives into revenue cycles, change management, organization psychiology, and much more!
- Taught by leaders in ED operations management
- Multiple modes of learning - lectures, small group work, panels, etc.
- Networking opportunities with other medical directors and physicians interested in operations management

ED Management Solutions Course Planning Committee:

Joseph R. Twanmoh, MD MBA FAAEM - Course Director
Joseph Guarisco, MD FAAEM FACEP
Jason Hine, MD FAAEM
Benjamin White, MD FAAEM

Dollars & Sense

Size Does Matter … For Your Expense Ratio

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

I published this article three years ago in Common Sense*, but this is such a critical concept that it bears repeating every few years. In addition, the recent price war among investment firms has made it even easier to lower your investment costs.*[1] *There has never been a better time to take a solid look at the investment costs you are paying.*

Whether you are managing your investments by yourself or getting help, you need to understand one critical concept, the expense ratio of your investments. Every mutual fund and exchange-traded fund (ETF) has an expense ratio and keeping it as small as possible is key to your long-term financial success. Size does matter.

What is an Expense Ratio?

An expense ratio is the percentage of a fund's assets that is used for expenses. In other words, if you invest in a mutual fund with a 1% expense ratio and that fund makes 10%, you'll only get a 9% return on your investment because 1% goes to pay expenses. The less of your return you use to pay expenses, the more you get to keep.

What is an average expense ratio? An average stock mutual fund has an expense ratio of about 1%, but the expense ratios for mutual funds that are similar in their composition can vary wildly. For example, if you look at a list of Standard & Poor 500 index funds offered by investment companies, you'd find expense ratios as low as 0.032% for the Thrift Savings Plan (TSP) C Fund (a military only retirement investment) and as high as 1.36% (State Farm S&P 500 Index B, SNPBX).[2,3] While 1.33% does not seem like that large of a difference, keep in mind that costs last forever and that small differences compounded over years will cost you a lot of money. Incidentally, that is one of the major benefits of the military retirement plan – its industry leading low cost.[4]

Love Your Grandparents

Let's pretend that when you were 25 years old your grandparents gave you $10,000 to invest in an S&P 500 index fund for 50 years, during which you earn a 9.5% return. If you invested in the State Farm index fund with the 1.36% expense ratio, you would have $500,000. That sounds pretty good! However, if you invested in the TSP C Fund with the 0.032% expense ratio, you would have $921,000.

That 1.33% difference in the expense ratios cost you $421,000!

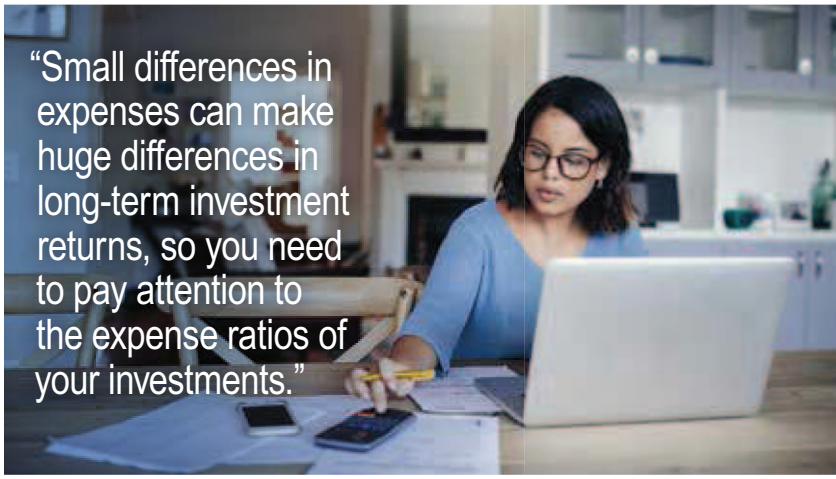
Small differences in expenses can make huge differences in long-term investment returns, so you need to pay attention to the expense ratios of your investments.

This difference is even more dramatic when you compare actively managed funds to passively managed index funds. Because actively managed funds have higher expense ratios than index funds, it is very difficult for an active manager to beat his/her comparative index over the long-term. This is why I invest 100% in index funds.

Shop Around

When you are picking your investments, keep in mind that you can't control what happens to the market, but you can control which investments you choose and the expenses that they charge. Any time you are looking to invest in a mutual fund or ETF, you should search for similar funds and compare expense ratios, which you should try to keep below 0.5% (or even 0.25% if possible). You can find the expense ratio easily by looking up the fund you're considering on Morningstar.com.

Make sure that at a minimum you take a look at the Vanguard version of the investment you are considering since their expense ratios are consistently among the lowest in the industry and they never charge extraneous fees, like loads.



There is no reason to pay more expenses for what is the same investment product. The size of your expense ratio matters. It could cost you A TON of money over the long-term.

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

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

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- BE/BC by ABEM or ABOEM
- Observation experience is a plus

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We welcome you to a community that emulates the values Milton Hershey instilled in a town that holds his name. Located in a safe family-friendly setting, Hershey, PA, our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Known as the home of the Hershey chocolate bar, Hershey's community is rich in history and offers an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

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AAEM Master's Series - MAAEM

AAEM: Now More Than Ever!

Larry D. Weiss, MD JD MAAEM FAAEM
AAEM Past President

Several days ago, I retired from the practice of emergency medicine after an enjoyable and emotionally rewarding 39 year career. As I reflect on my career, I had many different sources of professional satisfaction. I always enjoyed my clinical work, but primarily valued my work as faculty in an emergency medicine residency program. However, if I had to choose my single favorite professional activity, I would readily choose advocacy.

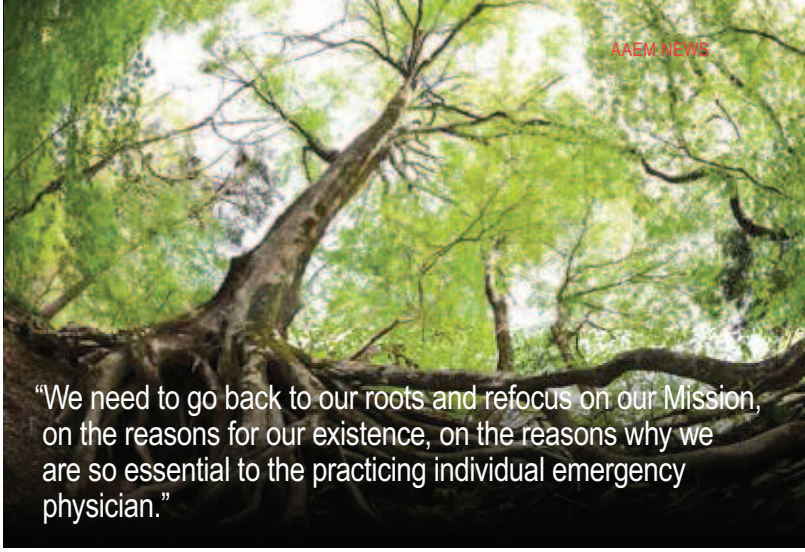
I recall my joy when I heard about the formation of AAEM in 1993. I readily became a charter member when AAEM began issuing memberships the following year. Prior to the formation of AAEM no society advocated for the practice rights of emergency physicians. I lamented the fact that so many of my colleagues had no basic practice rights at their hospitals and no one seemed to care. I was always convinced that emergency physicians could not adequately advocate for our patients if we did not have due process protections at our hospitals.

To this date, no other society advocates for emergency physician practice rights. No other society advocates for the rigorous application of state corporate practice of medicine (CPOM) laws, and no other society adequately advocates in support of proper board certification in emergency medicine. If not for AAEM, individual emergency physicians would have no advocates.

My residents at the University of Maryland love AAEM. Every year, all of our second year residents attend the AAEM Scientific Assembly. However, even though I repeatedly talk with them about AAEM, for most of our residents AAEM is just another society with a great annual meeting where they can present posters and attend fine lectures. We have to do a better job explaining the AAEM Mission to residents and recent graduates. We have to do a better job explaining the unique characteristics of AAEM and why we are the one essential organization necessary for the future well being of emergency physicians and our patients.

Unlike some of my colleagues at AAEM, I never felt any anger toward the American College of Emergency Physicians (ACEP). However, I always felt disappointed by ACEP. Despite having some good policies, ACEP doesn't advocate for the imperiled practice rights of emergency physicians. Unlike AAEM, ACEP does not advocate in support of the enforcement of state CPOM laws. Despite the fact that 38 states have laws restricting or prohibiting lay ownership of medical practices, lax enforcement of these laws has resulted in the steady growth of lay corporations operating more and more emergency departments in the U.S.

ACEP always disappointed me with regard to their record of not supporting the academic integrity of emergency medicine. Until the year 2000 they allowed non-ABEM eligible physicians to become full members, and they even had a membership section that advocated for these members and for alternative board certification that did not require residency



training in emergency medicine. What message did it send to other physicians when the largest organization of emergency physicians advocated for alternative boards that did not require EM residency training? This sent the message that EM was not a legitimate specialty with a unique body of knowledge requiring residency training. Even though ACEP enacted some positive reforms in 2000, eight years later they granted fellowship status (FACEP) to non-ABEM eligible members, again undermining the academic integrity of EM. At that point, I quit ACEP after 29 years of membership. I concluded ACEP would not begin to do the right things during the course of my career.

In its earlier years, ACEP had several national presidents who also served as officers of lay corporate contract management groups (CMGs). Two years ago, ACEP had another president who served as a national vice-president of a lay corporate CMG. This year they had a president-elect who was not ABEM-eligible. I assume these two individuals are fine people. However, the fact that they ended up at the top of ACEP leadership makes a statement about the ongoing orientation of ACEP toward lay corporations, and a less than emphatic endorsement of ABEM certification.

Down through the years, I knew many fine people who served on the ACEP board of directors. I know several fine people who I highly respect who currently serve on the ACEP board. Even though ACEP attracts some outstanding individuals who sit on their board, the institutional agenda of ACEP still does not allow it to adequately advocate for the practice rights of its members, to adequately advocate in support of proper board certification, and to oppose illegally incorporated lay entities that are taking over our specialty. The crises of emergency medicine cannot be resolved by such an approach. Only AAEM advocates in these areas. Therefore, emergency physicians need AAEM now more than ever.

Most emergency physicians who I interacted with in the past 10 years do not understand the differences between AAEM and ACEP. I even believe most AAEM members do not understand the important differences between the two organizations. AAEM does many things well. Like ACEP, we have great educational programs. Like ACEP, we provide some direct benefits to our members. However, we need to go back to our roots and refocus on our Mission, on the reasons for our existence, on the reasons why we are so essential to the practicing individual emergency physician. If we stick to our original Mission and make it the strong focus of our activities, we will get to the point when most board certified emergency physicians will realize the necessity of AAEM membership. ●

Emergency Medicine at Risk?

Robert Frolichstein, MD FAAEM
AAEM Board of Directors

You may have heard it said that we really don't have a health care system, rather a health care mess. I disagree. Our system is actually quite good at doing what it is designed to do. Let me explain by starting with some definitions.

Health care is the prevention, treatment, and management of illness or injury by health professionals.

"Emergency medicine needs to understand that change is coming and that it is a particular threat to our specialty."

Physicians deliver health care along with the advance practice providers, nurses, techs, respiratory therapists, physical therapists, etc. that we guide. Hospitals, insurance companies, pharmaceutical companies, pharmacies don't deliver health care. They may be part of a system within which health care is delivered but they don't deliver health care. What should their role be? Let's look at another definition.

According to the Business Dictionary a system is an organized, purposeful structure that consists of interrelated and interdependent elements (components, entities, factors, members, parts etc.). These elements continually influence one another (directly or indirectly) to maintain their activity and the existence of the system, in order to achieve the goal of the system.

If you think of the various entities in our "system" — pharmaceutical companies, hospitals, insurance companies, medical device manufacturers, contract management groups, pharmacies, and a host of others — they are certainly interrelated and continually influence on another to maintain their activity. They just have the wrong goal. Their goal is to make money and as evidence by the fact that we spend around 18% of our GDP on the delivery of health care they are very good at it. The goal should be to support the delivery of health care. Everything these entities do should foster and facilitate the physician-patient relationship. We all know from our various experiences that our system does not support but rather uses and in some cases corrupts the physician-patient relationship. That corruption is the root cause of much of the burnout we observe in our practices, in my opinion. But I digress.

Change is going to happen because the economists and other "experts" believe that the spending is not sustainable. They are probably right but it is a by-product of our system so efforts to control the spending must necessarily change the system. This will be a monumental task simply because there is so much money involved and no one will voluntarily give that up. Those with the best lobbyist have their turf protected. Physicians are very bad about organizing and devoting their time and money to protect their turf, believing the sanctity of the patient physician relationship will protect them. I may be cynical but I think that belief is naive.

I think this poses a very real threat to emergency medicine. It is widely believed that the care delivered in the emergency department is too costly. Efforts to show that it is only a small part of the overall health care spend are important but I believe will not be enough to protect our turf. Strides to defend the prudent layperson standard and prevent post treatment denials of payments such as Anthem has announced, are crucial. I am not sure they will be enough. I believe that someone will figure out how to keep the patients that "don't need to be there" out of the emergency department. I am not talking about the patients that we can all agree that don't need to be there — they probably don't even need a doctor. I think the big challenge is those patients that we see every day that don't need to be there but we don't know this until after we see them. Pay attention during your next shift. How many patients can you determine after one or two minutes don't need to be there? I know that the professional fees are not the problem. The facility fees are typically 5-10 times the professional fees. The hospitals are not going to bring those in line. Anthem and United recognize this and that is why they are retrospectively denying payments.

With challenges comes opportunity. Emergency medicine is a unique specialty we are defined by a patient population (those that present to an emergency department) and not, like most other specialties, defined by an organ system or disease process. We still may be defined by a patient population but within the house of medicine our role has evolved. We are now the specialty that treats almost all patients with undifferentiated acute illness. We are the specialty that puts the puzzle together and makes the diagnosis. Our skill set is crucial. Is it necessarily tied to hospital based emergency departments? Sure, we need some tools to do our job but the decreasing cost of tools no longer necessitates them being in hospitals. The growth of freestanding emergency centers (FSEC) in many areas of the country was fueled by this recognition and may be part of the solution. However, the "cost" of the FSECs are not much less than the hospitals. Urgent care centers largely lack the expertise and equipment to make a big impact.

Emergency medicine needs to understand that change is coming and that it is a particular threat to our specialty. But also recognize that our expertise is crucial and put forth "out of the box" solutions before the "system" defines our role going forward. Our "system" is very good at what it does — make money. If we don't define the solutions we run the risk of being left out of the money. ●

The Members Speak - AAEM Membership Survey

AAEM recently completed a membership survey trying to understand what our members want from their organization. Hundreds of members also wrote in responses to questions and the board thought many of the responses might be of interest to our members. Below are some of the member responses to one of the questions.

How do you perceive AAEM as being different?

- AAEM is not a slave to the corporate CMG's and actually stands up for emergency physicians. They are willing to take controversial stances and care more about our specialty than just making money.
- More in favor of the doctor than the corporation.
- Fights for the pit doctor.
- Not a slave to corporate medicine, clearly views the many evils of corporate EM groups.
- I believe it cares much more about individual ED docs — and the daily struggles.
- Absolutely committed to EM without compromise.
- Very personal!!!!!
- Less in-bed with drug companies.
- Not associated with large corporations, which place their employees on boards and use them as puppets to control our specialty.
- AAEM is clearly an organization of by and for practicing EP's.
- Holding steadfast to board certification and distinguishing these EM physicians from other Advanced Practice Clinicians/others who portray themselves as equal. Not everyone can nor should do what we do & that is okay.
- Genuinely puts the provider first. Speaks for us.
- AAEM is the champion of emergency medicine physicians, support fair compensation, treatment, and keeping alive the idea of democratic groups. In addition, AAEM has not prostituted themselves to the CMG's of the world like ACEP or elected non-EM physicians to represent the specialty.
- Supportive of the specialty rather than the large business entities of emergency medicine.
- Not tainted by outside influences. Still dedicated to the ED physician.
- They still fight for the independent practitioner and rage against the dying of the light.
- Pure defender of standards for EM, wellbeing of the practitioner, democratic groups without the profit motive for lay people, and due process rights to protect against arbitrary termination for resisting the corporate practice of medicine.
- Works for the individual; AAEM is NOT part of the group-think monoculture that makes individualism redundant and forces people to be just a cog in the machine or another brick in the wall. ●

AMA Annual Meeting

Sexual Harassment and Venture Capitalists' Purchase of Medical Practices

Joseph P. Wood, MD MAAEM FAAEM
AAEM Past President

The AMA held its annual meeting in Chicago June 8-13, 2018. While most physicians don't belong to the AMA, it is still the largest physician organization and consequently has a significant impact on legislative and regulatory initiatives. Virtually every professional society (including AAEM) have lobbyists in Washington, D.C. Inevitably, legislators will always ask a lobbyist; "What is the AMA's stance on the issue?" So, in short, if we can't get the AMA's support on an issue, it is unlikely a legislator will have much interest. AAEM holds a membership seat in the Specialty and Services Section (SSS) and on the AMA Section Council of Emergency Medicine.

Non-Physician Entities Purchasing Medical Practices

Dr. Paul Kivela (ACEP President) gave a short presentation to the SSS about non-physician entities purchasing medical practices. This is not just happening in emergency medicine. It is a growing trend in all hospital-based specialties, primary care, hospitalist, and dermatology. There are a variety of purchasers that include hospitals, insurers, and private equity groups. The motives of the purchasers vary from a need to ensure and control coverage to a return on investment (profit). The motives to sell a practice vary from stability and survival to "cashing out" a lucrative practice. We discussed this at the Emergency Medicine Section Council and questioned the two candidates for AMA president-elect about their position on non-physician entities buying medical practices. The AMA candidates expressed a concern about this trend resulting in a loss of physician autonomy. For instance, when a private equity group purchases a medical practice, as the owner, it will influence volume of patients seen and procedures performed by the employed physicians. The AMA is studying this issue with a goal to develop a fact-based policy. For AAEM the issue is straight forward. Non-physician, lay-entity, ownership of a medical practice should be unlawful. On this issue, medicine should follow the example of the legal profession. It is unlawful for non-licensed entities to own and control a law firm. AAEM policy has always called for strengthening the traditional ban on the corporate practice of medicine, or any scheme, that results in non-physicians controlling a physician's practice. We will continue to push AMA policy in that direction.

Sexual Harassment in the Medical Workplace

One of the best attended educational sessions was on "Sexual Harassment in the Medical Workplace." Studies were cited showing that at least 40% of young female, and 5% of male physicians still experience some sexual harassment early in their careers. The career impact of this harassment can include increased anxiety, loss of confidence, reluctance to seek leadership roles, and absenteeism. It was recognized that the #MeToo movement has stimulated a national conversation on what constitutes sexual harassment and what should be done when it occurs. There is a growing consensus that sexual harassment is common in health care and needs to be corrected by prevention. There is also a feeling that harassers may have their behavior addressed by counseling with a "zero tolerance" warning going forward. There have been at least 1,000 physicians reported to the National Practitioner Data Bank (NPDB) for sexual misconduct. Emergency physicians should educate themselves on this very important aspect of workplace behavior as "stepping over the line" not only harms their coworkers, it can seriously derail their employment options.

Other Social and Practice Issues

Many other social and practice issues were the subject of lively debate at this year's AMA meeting. These include physician assistance with the dying process, gun safety, and requirements of licensure of international medical graduates. AAEM members who are interested in participating in organized medicine are encouraged to join the AMA. Because of the AMA structure and rules, our voice is strengthened by the number of our members who join the AMA. ●

CPC-EM Achieves Inclusion in PubMed and PubMed Central

Clinical Practice and Cases in Emergency Medicine (*CPC-EM*), published by the Department of Emergency Medicine at the University of California Irvine, has achieved the milestone of inclusion and indexing in PubMed and full-text inclusion in PubMed Central (PMC) beginning with its first issue published March 2017. *CPC-EM* is an internationally recognized, fully open access journal affiliated with the MEDLINE-indexed *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*.

CPC-EM, offers a wide range of patient care case reports, images in the field of emergency medicine (EM), state-of-the-art clinicopathological cases and insightful medical legal case reports. Its editor-in-chief is Rick McPheeters, DO, chair of the Department of Emergency Medicine at Kern Medical and an associate clinical professor of medicine at the David Geffen School of Medicine at UCLA.

CPC-EM's founding principle is the free dissemination of research and best practices to the world. It encourages submissions from junior authors, established faculty, and residents of established and developing EM programs throughout the world. *CPC-EM* has published more than 192 papers to date in quarterly issues.

The journal would like to recognize the authors, section editors, editorial board, and sponsors: California ACEP, American College of Osteopathic Emergency Physicians, and the California Chapter Division of AAEM who have supported and contributed to *CPC-EM*.

View the journal index on PubMed website: https://www.ncbi.nlm.nih.gov/pubmed/?term=clin+pract+cases+emerg+med+%5BJour%5D.

To submit a new article, visit www.CPCEM.org. ●

*West*JEM's 2017 SJR and Scopus Citescore Rankings Achieve Notable Growth

The *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health* (*West*JEM), published by the Department of Emergency Medicine at the University of California Irvine, is one of the few fully open-access emergency medicine journals and now ranks 16 worldwide of 78 EM journals, per the newly released SCImago Journal Rank (SJR) statistics for 2017. This represents a notable jump from *West*JEM's 2016 SJR ranking of 25 out of 80 EM journals. The SJR website provides an overview of how *West*JEM compares with its EM peers.[1]

The 2017 Scopus CiteSource rankings list *West*JEM at 20 of 77 EM journals. *West*JEM also received a journal h-index of 21 in SJR. At the Scopus website additional information on the h-index, as well as graphs documenting *West*JEM's development, can be found.[2]

*West*JEM continues its 10-year history of growth with the dedicated work of editor-in-chief Dr. Mark Langdorf, Professor of Clinical Emergency Medicine at UC Irvine, and its esteemed editorial board. As the journal continues to extend its scope and reach throughout the United States and the world, its founders recognize that the journal could not have achieved this degree of scholarly influence without the constant support of its authors, section editors, editorial board, and three major sponsors: the California ACEP, the American College of Osteopathic Emergency Physicians, and the California Chapter Division of AAEM.

As its subtitle indicates, *West*JEM focuses on the integration of population health with emergency care. The journal is indexed in all major medical databases including MEDLINE and PubMed and is a member of the Open Access Scholarly Publishers Association.

To learn more, visit: https://westjem.com. ●

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Operations Management Committee

ED Crowding and Boarding: A Shift in Strategy

Joshua Joseph, MD MS FAAEM
President, CCMS

While crowding and boarding inpatients in the emergency departments seem to be yearly hallmarks of flu season, throughout the year they remain enduring problems. Both reflect significant structural problems, such as a lack of inpatient bed capacity and delays in transporting admitted patients out of the ED, and are therefore difficult for emergency physicians to address directly.[1] However, short of taking a year to train in a waiting room medicine fellowship,[2] there are some direct, practical ways for us to help mitigate the effects of crowding and boarding.

For emergency departments that are part of larger hospital networks, sometimes rethinking inpatient capacity across hospitals can be equivalent to adding capacity. Admitting lower-acuity patients to crowded tertiary-care facilities may misalign resources. A relatively stable patient with a COPD exacerbation or pneumonia may be served as well by a community hospital as a tertiary-care center, but the inpatient bed that they occupy at the tertiary-care center might be the one that a patient with an NSTEMI or stroke needs. While many patients who arrive at a tertiary-care or academic center might bristle at the idea of being transferred to a lower-acuity facility, when given the option of an inpatient bed versus the prospect of a night boarding in the emergency department, their perspective may change rapidly.[2]

Placing a doctor at triage can lead to improvements in length of stay and department flow, but can also lead to significant increases in cost and the frequency of testing.[3] Some larger emergency departments may have enough demand for a dedicated doctor in triage to make a substantial difference in throughput; however, for many departments, the same effect can be accomplished by allowing doctors to "flex" into triage at times of high crowding or boarding. This will help to expedite needed tests and reduce door-to-doctor times, and can be particularly useful if there's no available beds in the emergency department to see new patients and the waiting room is filling up.

Rethinking your groups' shift schedules or patient assignment strategies can also yield significant dividends. We tend to have a much greater capacity to see new patients early on in our shift – so even if your group tends to schedule more physicians to work at periods of higher demand, they might be less productive than a single doctor who is coming onto their shift fresh.[4] Similarly, many of us have an unconscious tendency to slow down when working together with a colleague. Instituting a rotational strategy of alternating new patients between providers (or another strategy to balance the load) can help keep everyone at an even pace.[5]

Radiology and laboratory testing can represent significant bottlenecks for workups in the ED. Although adding an additional CT scanner or a lab in the ED might seem like appealing solutions to improve throughput, like adding inpatient capacity, these are major capital investments, and often involve the conflicting interests of many stakeholders (for whom improving crowding isn't a priority). Often, streamlining protocols with other departments, such as radiology or pathology, can yield similar benefits. Allowing just a few critical tests to be point of care tests completed at bedside, such as creatinine for expediting CT scans, or troponin for chest pain, may have an outsized effect on throughput. Similarly, some routine practices in radiology, such as oral contrast for abdominal CT scans, can be safely eliminated for many patients, yielding a major improvement in throughput without affecting accuracy.[6]

Sometimes the most effective strategy is to keep low-acuity patients out of the emergency department altogether. Converting a single room within the emergency department to a low acuity zone with multiple chairs, or repurposing a portion of the waiting room as a "results pending" area for ambulatory patients with minor injuries can make a substantial difference in patient flow. While it often runs against our instincts and sense of duty as emergency physicians to prioritize patients who have minor complaints or quick dispositions, sometimes it really is necessary to get these patients out of the department quickly, if only to ensure that available beds in the emergency department are available to those who need them. ●

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Critical Care Medicine Section

CCMS Update

Joseph Shiber, MD FAAEM FACP FCCM
President, Critical Care Medicine Section

At the AAEM Scientific Assembly (AAEM18) in San Diego, the Critical Care Medicine Section (CCMS) held our business meeting and had numerous members give presentations. To focus on the tremendous job the section members are doing for AAEM and at Scientific Assembly, I would like to summarize it here. First, David Farcy, the founder of the CCMS was inducted as president of AAEM. Congratulations to Dr. Farcy on this great honor! Another long-time supporter of EM-CCM, Evie Marcolini, was co-chair of the AAEM18 planning committee this year and will again lead the planning for AAEM19 in Las Vegas, March 9-13, 2019.

There were eight EM-intensivists from the section who gave outstanding presentations on EM-CCM topics, including:

- David Farcy "Certainty Will Kill"
- Haney Mallemat "Critical Care Year in Review"
- Wendy (Wan-Tsu) Chang "Neuroimaging: CT Angiography, Magnetic Resonance Imaging (MRI), Oh My!"
- Peter DeBlieux "Don't Make Me Blue: Mechanical Ventilation Choices in the ED that Change Outcomes"
- Harmon Gill "When Pressors are not Enough"
- Andrew Phillips "LVAD Management"
- Evie Marcolini "End of Life Discussions in the Emergency Department"
- Ani Aydin "Pearls and Pitfalls of ED Mechanical Ventilation"

These lectures were well received by the audience who clearly enjoyed and appreciated the expertise and experience of the speakers.

The CCMS meeting was led by president-elect, Ashika Jain, who has done a great job for the last two years truly doing all of the work to get this section moving forward so successfully! Confirmed as secretary/treasurer is Andrew Phillips, who has already been contributing to the efforts of the section. We will be looking for members interested in nominations for president-elect next spring, so please contact section leadership if you will have finished your CCM fellowship by 2019 since you are required to have fully completed your EM and CCM training.

AMERICAN ACADEMY OF EMERGENCY MEDICINE
CRITICAL CARE MEDICINE SECTION

During the section meeting, the two major topics discussion were:

1. Reiterating of the major goal of the section to mentor residents and fellows as well as junior faculty for career development in EM-CCM.
2. The recent application by the Neurocritical Care Society (NCS) to have Neurocritical Care (NCC) recognized by American Board of Medical Specialties (ABMS). For over a decade, NCC has been a specialty with formalized fellowship training and a certification examination by the United Council for Neurologic Subspecialties (UCNS). For the NCS application, which is also supported by ABEM, AAEM was asked to write a letter of support which the CCM Section and AAEM gladly did. One aspect of the application that has been debated is that Neurosurgery (NS) is asking for an exemption to allow for their residency graduates to be eligible for the NCC certification without any additional fellowship or in some cases having a total of 12 months (but not consecutively) of NCC training during their residency. This waiver is not supported by the Society of Critical Care Medicine (SCCM). During the section meeting, representatives from ABEM as well as SCCM, our own section member Dr. Heatherlee Bailey, who is the also the president-elect of SCCM, led our discussion on this issue. AAEM and our section have since written a letter to ABMS supporting the application of NCC as a newly recognized specialty with the suggestion that NS have a finite "grandfathering" period of possibly five years.

I encourage all AAEM members (students, residents/fellows, or attendings) who are interested in CCM to join our section and get involved in its activities. ●

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

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

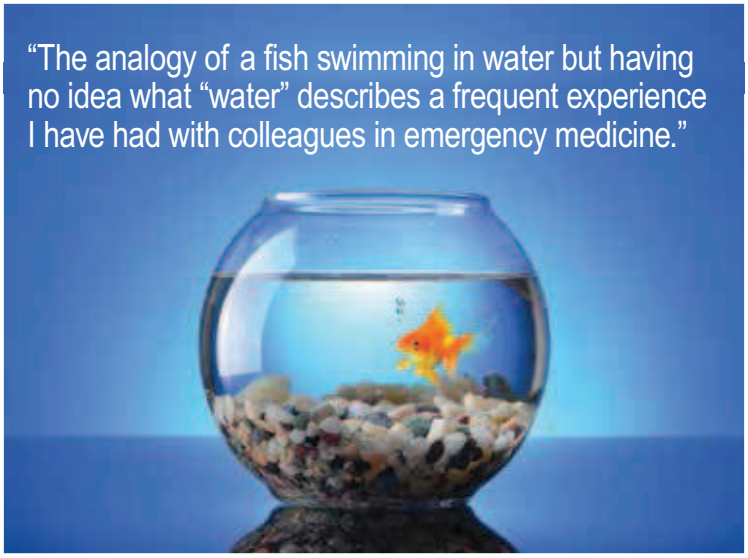
Diversity and Inclusion

A Brief Career Overview

L.E. Gomez, MD MBA FAAEM
Chair, Diversity and Inclusion Committee

The analogy of a fish swimming in water but having no idea what "water" describes a frequent experience I have had with colleagues in emergency medicine. Twenty years ago I beat my head against a wall sharing with fellow residents and faculty in my program that implicit bias and prejudice were adversely affecting the health outcomes of the patients for which we cared. In the words of my mostly white and male colleagues they just didn't see it. To them, I simply "had a chip on my shoulder." When it came time for senior grand rounds presentations and I proposed the topic of racial dissonance and miscommunication leading to poor clinical decision-making and health inequity. My program director advised me that no one on the faculty had any expertise in that area and our department chair's comment was "I don't think anyone here knows what you're talking about." Several residents shared a conviction that affirmative action was no longer needed, as we were serving a largely poor African American community on the South Side of Chicago and "doing these people a favor." One white peer shared that I should feel fortunate to be there as an African American. After all, there were now two of us in the program. Interestingly, though mentors pejoratively suggested I look into an MPH, my black peer and I leaned toward pursuit of an MBA, believing we might have more impact as business leaders than as advocates for health justice policy. Twenty years later the situation in that residency has improved as a result of diversity and inclusion (D&I) efforts; presently there is a senior black mentor in leadership and half of the residents in the program now are women. Unfortunately, the vast majority of training programs are still 'swimming in the water' of white hegemony: even when managing to achieve diversity, they still struggle with inclusion.

"The analogy of a fish swimming in water but having no idea what "water" describes a frequent experience I have had with colleagues in emergency medicine."



Diversity is not inclusion.

A similar dynamic awaited in the corporate world of contract management groups (CMG). My first job as a newly boarded EDP was as associate medical director for a CMG site at a Catholic Hospital serving a largely Latino community near Humboldt Park on Chicago's West Side. It was useful and gratifying to be the one bilingual physician on staff, even when I didn't have a clue how to fix the problem. The community welcomed me, inviting me to advocate for their interests. The hospital public relations coordinator invited me to record televised public service announcements on health and safety for our local Telemundo/Univision affiliate. Meanwhile, I tried to balance meeting benchmarks (which had already become the sole index used for increasing revenue) against support for patients struggling against the real determinants of health: social and economic constraints. No, cultural competence was not a company priority, even though inclusion was clearly on the hospital's agenda. Any emphasis on community advocacy seemed superfluous to my medical director who I considered an ally until he made clear he was not interested in how health disparities affected the revenue cycle. Eventually the hospital's identity transformed both its mission and its market. It became a designated Stroke Center and tertiary care referral center over the last decade shifting its mission to healing ministry rather than serving the local community. That contract group is now long gone from there and they still have no blacks or Latinos in senior leadership roles, though they do have an Asian American VP.

Inclusion seems a threat to some and possibly irrelevant to those not serving minority communities. With this lesson learned, I moved to where a vast minority Latino community existed, in part because I reasoned it not be made a marginalized market. Herein lies one of the greatest hypocrisies and formidable challenges to understanding diversity and inclusion: Latin American society in South Florida is more vested in white hegemony than Anglo-culture is in America. I thought my childhood experience with racist Cuban-Americans-in-exile would be different tempered by my professional credentials. In fact, Cubans on those hospital staffs routinely expressed the racist view that blacks, particularly American ones, are inherently inferior to whites. I commonly interrupted conversations in the physician lounge peppered with loud references to a black presidential candidate they called "the monkey." This toxic and deplorable behavior is entrenched in the culture. (As recently as a week ago, a new black student movement at the University of Miami was set off by the increased frequency of white students using the n-word, monkey emojis, and calling for the enslavement of blacks. All of this despite the establishment of a diversity task force the year before to combat such bigotry). It was around this time I moved to a hospital in North Miami Beach serving a largely black community. Around that time, I met David Farcy and several other forward-thinking

Continued on next page

physicians, becoming increasingly active in Florida Chapter Division of the American Academy of Emergency Medicine (FLAAEM) as well as the National Medical Association, in part, to call attention to health equity, professionalism and ethics in emergency medicine practice. A culturally diverse group of professional friends and I put together a TV series called "Connections" at a small station in Miami to speak to unity in the minority melting pot of our South Florida community, but it was nowhere near enough to put a dent in the inertia of divisiveness.

Minority presence does not equal diversity or impede hostility in the workplace.

I set out to acquire the language of the C-suite with a health care MBA with a goal to promote a new model prioritizing health creation and helping curb wasteful expenditure on catastrophic care. Clearly everyone could tell health disparities led to a lack of care for chronic disease and the unequal allocation of power and resources. A significant part of the $4 trillion misspent yearly in this country could be addressed by funding relatively simple preventative measures. My classmates and I came up with proposals for strategic corporate philanthropic efforts that included community-based health care academies and clinics, to provide education for local labor pools and career paths into training. We researched how clinical documentation systems could be used to help patients save money and limit health expenditures. Of course none of this fit current business models or ongoing strategies focused on the next quarter. Ultimately it dawned on us that if we wanted to be included in current health care business structure, we could not sell reinventing the wheel. Notably, even in meetings set up by a small consulting group I joined later, we never met black people in leadership to champion novel strategies.

Being open to diversity does not guarantee it and health equity requires powerful leaders.

I headed north to pursue an interest in policy and advocacy, finally accepting that may be a better path to health justice after all. What better area for that than D.C. and the mid-Atlantic? I took part in AAEM's Policy and Advocacy Congressional Elective while awaiting the completion of my credentialing process at a hospital where I accepted another leadership position. This time it was medical director at a small hospital in a rural, mostly farming, community. The welcome can best be summed up this way for anyone familiar with the movie "Blazing Saddles": I was the new Sheriff, Bart. Shortly after I started, two of the scribes and a unit clerk let me know they heard one of the EDPs on my staff repeatedly vocalized racist remarks about me whenever I was not around. I immediately met with that physician about the remarks which he emphatically denied and then notified our regional director (RD) about the issue. The response from the RD: "nothing could be done about it." At this point, I decided this company was not worth any more of my time and energy. I had been active in the National Medical Association (NMA) and a colleague there suggested I join the teaching staff at Howard University College of Medicine. I did, and have been in practice there as an associate professor for emergency medicine since. Initially, there was enthusiasm for collaborative work on social justice, however, since then; the contract was taken over by … another CMG.

Diversity and inclusion requires integrity and commitment.

Last summer while attending Emergency Medicine Section Lectures at NMA Scientific Assembly, I ran into our brilliantly energetic new AAEM president-elect, Lisa Moreno-Walton. She invited me to join the D&I Committee at AAEM and join a panel to speak on that subject at our Scientific Assembly. We all understand that the enthusiasm around D&I in most organizations is fueled by concerns such as avoiding lawsuits or compliance and workplace safety. Many D&I initiatives and officers are not taken as seriously as other leadership, but I can tell you that even my limited involvement has already been immensely rewarding. At my first AAEM Scientific Assembly about 20 years ago I felt isolated and alone as one of a handful of black EM docs wandering aimlessly from one lecture to the next. This time, I wandered about expecting to interrupt those same disconnected countenances. More often the response was simply a positive greeting or suggestion to connect and collaborate, but on one occasion a few weeks ago, I came across a young black physician recently out of residency whose response was: "I have been wandering around this conference not knowing where to go and you just made my week. Thank you for helping me feel part of this."

Inclusion is an open invitation to be valued equally. ●

Women In Emergency Medicine Committee

Burning Both Ends of the Candle

Faith Quenzer, DO
Co-Chair, WiEM Committee

I wasn't out of the woods yet. After the birth of my first child, my son would keep me up every two to three hours a night. This was not what I imagined life to be as a mother. Additionally, I was out of the department for several months taking time off and doing outside rotations. However, I was struggling to keep things together at home and in the emergency department during shifts. Balancing life inside and outside the home was difficult until my working husband and I got extra help. My mom helped watched my son until he was 10 months old. My husband worked from home two days of the week, but his work was based primarily in San Diego. This still was too much for everyone. So we decided to use my residency income to pay for daycare five days per week. "Finally, a break." I thought to myself.

Fast forward a year, my father goes to see a cardiologist for his persistent dyspnea he has had for several months. I had bugged him about it for a while and he agreed to see someone at the hospital where I work. Finally, we figure it out; his heart has an ejection fracture of 15%. My hopes could not sink any further than the depths of the sea. The cardiologist decided to take him to cardiac cath lab and I, as the both daughter and the doctor in the family, took a deep breath and braced myself. I noticed the cold temperature of the cardiac cath suite as the cardiologist prepped and draped. Dad is out with a touch of Versed and the dye squirted in and very slowly trickled through the brittle appearing arteries.

Even worse news comes. I listened to the cardiologist say, "95% occlusion of the LAD, 99% occlusion of the RCx, 90% occlusion of LCx. Faith, I'm sorry to say, but ... he has the ejection fracture of 8% due to severe ischemic cardiomyopathy. There was nothing to stent except for this small branch. No interventional cardiologist will touch that, because he would die on the table. From the looks of things, there is no viable heart muscle to perform the CABG procedure. There is nothing we can do here. I'm sorry. He will need to be transferred somewhere for LVAD or heart transplant." I tacitly nodded.

"Oh the news … how will she take this?" I thought to myself. My mother was in the waiting room to our cath lab. She looked to me for an answer. The doctor in me calmly assured her to wait. Dr. K began to tell her the news, and her eyes filled to the brim with tears. It was in that moment, she understood that this could be the beginning of the end of my father. Nothing in the world could prepare a wife or the only daughter of this man the devastating news. "Stay strong and stay steady," I resolved to tell myself. My dad was quickly admitted and transferred to San Diego. The support at my hospital was wonderful. The case manager got him transferred to an LVAD/Heart Transplant Center near where my parents own a home. This was during Thanksgiving week, my father transitioned to spending his time in the hospital.

"Is this how hospitals are? I haven't had one wink of sleep since I was transferred. I'm bothered by nursing staff every hour. Well, at least the nurses are beautiful." my dad half-jokingly complained.

"It's a hospital, not a hotel. You're not exactly on vacation. Besides, that's why mom is here to protect you from the beautiful nurses." I reply. For a week, my husband, my son, and my mother spent a holiday weekend visiting my father in the ICU. Speaking with my dad's ICU nurse, I pleaded to see if we could get him out of the unit for an hour to enjoy a decent, home-cooked, salt-free, Thanksgiving dinner with the rest of the family. She was kind enough to oblige. My dad's case was taken to transplant committee, they deliberated for two meetings to determine whether or not he would be a good candidate. Meanwhile, I figured out how to finish the rest of my shifts for the month, catch up on much needed reading time, and other residency responsibilities. I was happy for the support, but dreaded the fact that I have an equally demanding family life.

I was as they say, "burning both ends of the candle." I felt like I was doing this quickly and I start thinking of ways in which I could cope. I know I can't change outcomes, but I do the following:

1) Get support
   a. Communicate early and honestly with colleagues and supervisors as information is given.
   b. Find a close circle of friends that consists of physicians and non-physicians who know what it is like to have to take care of both children and a sick or dying parent.

2) Prioritize your commitments
   a. "Family comes first" is the mantra of our program director. We often need to do what our family needs. Usually, things do fall into place after a while.
   b. Say "no" to extra commitments. Sometimes, I often have to let go and organize and fold the clothes.

Continued on next page

3) Make time for physical fitness
   a. Even a small 15 minute walk everyday can help fight against depression. You don't need to be an ultra-marathoner. But, studies have shown a little can go a long way.

4) Cultivate interests/hobbies
   a. An ER physician that I used to shadow had a collection of orchids that he would upkeep. My program director likes to ski and often takes his family with him. Our department director is an avid scuba diver. I like to break away and do yoga and surfing.

5) Forgive
   a. Sometimes consultants give me a hard time when I'm admitting a patient. At times, I really have to fight to make it work. One of my faculty mentors will often try and make me think about how bad the day is going for my consultant. Maybe they also have a dying relative also?
   b. Some patients are difficult. No one wants to be in the ER and it's the often the worst day of their lives. Other patients are there because they are addicted to the pain medications. We know that addiction to opioids is like any other medical problem. This just complicates our relationship with the patient. Our patients may not be aware of their addictions and we have to counsel accordingly.

6) Disengage with anything electronic
   a. I dare you. Take eight hours a week and get real rest. Sleep in. Put that phone down. The email and texts can wait. Twitter won't evolve into a vortex if you are not on it for a day. Do things that will make you feel fulfilled without it being "work." Go to the zoo with the kids. Meet with friends over dinner. There is the concept of the Sabbath which really means a day of rest.

7) Give Back and Find a Niche
   a. I know this seems counter-intuitive, but it is definitely the reason why I love being part of AAEM/RSA. I love to write, publish, and to contribute to emergency medicine. In both residency and medical school, I have found a love for writing and it is what I would want to do in the future. I believe that cultivating a niche in emergency medicine will contribute to career longevity. There is value in feeling like you are positively contributing to the bigger community. Writing has been an outlet for me in good times and in the worst of times.
   b. Being part of leadership and part of a committee not only keeps me abreast with the new developments in emergency medicine, but it also gives me an avenue to have my voice heard in a very democratic organization.

Special thanks to: Drs. Joel Stillings and Michelle Mouri.

Government/National Affairs Committee

Update from the Government and National Affairs Committee

Andy Walker, MD FAAEM
Chair, Government and National Affairs Committee

Like most AAEM committees, the GNA Committee does most of its business via email. However, we had an energetic and productive in-person meeting on April 8, 2018, at the Academy's Scientific Assembly in San Diego. The main topics of conversation were attempts by the insurance industry to enhance its profits at the expense of the nation's medical safety net — emergency departments (EDs) and emergency physicians.

The main way insurers are attempting to increase profits is to shift more costs onto their clients — our patients — by increasing the percentage of medical costs patients must pay out of pocket and reducing the percentage paid by the insurer. One way to do this is to move patients to high-deductible policies, the other is to make it harder for patients to find an in-network provider, since every policy stipulates that the insurer is liable for a much lower percentage of the bill if the patient uses an out-of-network physician or hospital.

Since insurers know emergency physicians and EDs are legally bound by EMTALA to take care of every patient first and seek payment later, emergency medicine groups are particularly vulnerable to insurance companies that demand intolerable fee discounts in order to be in-network. Unlike office-based specialists, we cannot screen out and turn away out-of-network patients. We have no bargaining leverage at all, except for the threat to stay out-of-network and bill the insurer at the "usual and customary" rate, which is higher than the discounted in-network rate.

At the same time insurers have been driving EM groups to stay out-of-network, however, they have been working in state legislatures to cap the out-of-network fees hospital EDs and emergency physicians can charge. The insurance industry has already won in a few states; been turned back at least temporarily in many, including my home state of Tennessee; and been defeated outright in Connecticut, which passed a bill that protects ED patients from steep out-of-pocket costs and shifts the burden back where it belongs – with insurers, rather than emergency physicians.

While AAEM's leadership, the GNA Committee, and the Academy's representative in DC – lobbying firm Williams and Jensen – continue to keep an eye on the situation, the insurance industry has little chance of getting the victory it hoped for in Washington on this issue. All the action on out-of-network fee caps will be at the state level. **I urge you to contact your state legislators about this now and begin educating them on how uniquely this affects EDs and emergency physicians and threatens to unravel the medical safety net.** Almost none of them realize that, because of EMTALA, we can't tell patients we are out-of-network with their insurer (or even ask about insurance or payment) until after the medical screening exam is complete and any emergency medical condition found has been "resolved." Legislators don't realize that emergency medicine groups lose money on Medicaid and self-pay patients and roughly break even on Medicare patients, and depend on the small minority of our patients with commercial insurance to stay open, pay our bills, and fund our huge charity mission. Capping out-of-network fees would remove whatever incentive insurers have to bargain with emergency medicine groups, allowing them to pay as little as they want for emergency medical care to both in- and out-of-network groups. This would destroy the medical safety net, unless government stepped in to keep EDs open. (For complete background on this issue, see the Academy's paper on the subject: https://www.aaem.org/UserFiles/BalanceBillingPaper.pdf.)

Some insurers have also recently explored the possibility of violating the prudent layperson standard, which forces them to pay for an ED visit based on the presenting complaint rather than the final diagnosis. Imagine if an insurer could refuse to pay you anything but a $28 fee for a medical screening exam when the patient's chest pain turned out to be anxiety rather than an MI – after four hours in the ED with two EKGs, two troponins, a chest x-ray, and lots of your time and expertise. That's what some insurers are pushing towards. The prudent layperson standard is written into federal regulations, and there is no chance it will be repealed, but enforcement is left up to the states. So again, most of the action on this will be at the state level. **There is no substitute for you being in regular contact with your state legislators, whether you call, email, or write.**

It isn't just your own welfare that requires you to be politically involved in your home state. Our profession, our specialty, and our patients depend on it. Lots of people with no medical training at all want to tell you how to do your job, or make it impossible for you to do your job in any way other than the one they choose. Patients needlessly suffer and even die when that is allowed to happen. Develop a relationship with your legislators and their staff. Educate them on how things affect our specialty, because emergency medicine is truly unique in all of medicine and you can't rely solely on your state medical society. Be involved with your chapter division of AAEM – or found one if your state doesn't have a chapter. And finally, stay in touch with me or a member of the GNA Committee in your state. If something comes up that we need to know about, the sooner we hear about it, the more we can do. ●

Get in touch with the GNAC at info@aaem.org.

International Committee

International Scholarship Winners

AAEM has a long history of involvement in international emergency medicine through conferences, committees and the operation of the AAEM Scientific Assembly. In recent years, AAEM had partially or fully funded multiple international EM physicians for participation in AAEM Scientific Assembly through an international scholarship program. The objective of this program is to aid development of liaisons and fostering of opportunities for exchange of information, education, and ideas with international EM societies and organizations.

The program is administered by the International Committee and participants are invited to apply. Applications are reviewed by committee members and applicants are ranked by several factors including the strength of their resume and potential to promote emergency medicine in their country of origin.

— Ashely Bean, MD FAAEM, Chair, International Committee

Dear American Academy of Emergency Medicine,

I am writing to express my sincere gratitude to you for making the AAEM international scholarship possible. I was thrilled to learn about being selected for this honor and immensely appreciative of your support.

I am currently working at Parami General Hospital Emergency Department and Myin Chan AAM Emergency clinic with hopes of becoming an emergency physician. The financial assistance you provided was a great help to me in paying my travel expenses, and it enabled my dream of discovering more about emergency medicine, a wish came true. I was proud to experience the incredible teamwork between physicians and technological advancement of emergency medicine, which makes an invaluable impact every second, not only in the U.S. but also around the world. It was an unbelievable sight, but seeing is believing, and now that I have seen what you had achieved in EM, I have the direction for myself and my country's emergency medicine development.

One of the two parts of the conference that attracted my attention were the variety of lectures and topics. The second was the great enthusiasm of emergency physicians in U.S. who are willing to contribute to the development of international emergency medicine. Without these people, I might not have been able to learn emergency medicine and I would not be this passionate to pursue emergency medicine.

If I were to be given another chance to participate in next conference, I would love to visit different types of emergency room from the States.

To end this note, I would like to thank you once again for your generosity, support and most of all, for your belief in developing international emergency medicine. I promise that I will work very hard to give something back to my society, both as an emergency physician and as a scholar to young physicians.

Yours sincerely,

Myint Than Htike
Myanmar

Dr. Myat Noe at AAEM17 in Orlando, FL

Last year, I attended the 23rd Annual Scientific Assembly by American Academy of Emergency Medicine (AAEM). At that time, I was a resident, studying emergency medicine at Stanford Emergency Medicine International. Now, I have graduated and I am working here (Myanmar) together with my boss, Dr. Tony Ohn. I also graduated from Paris Graduate School of Management in the field of Master of Business and Administration. I work together with my boss in many fields related to emergency medicine, (i) continuing our diploma course in emergency medicine with Stanford Emergency Medicine International, (ii) establishing a new emergency clinic in a rural area, named Myin Gyan Clinic, (iii) coordinating in tele-radiology project to work together with Government, (iv) practicing emergency medicine in both International Emergency Services (IES), which is an urban ER, and Myin Gyan Clinic, which is a rural ER, (v) teaching and training EMTs and doctors about basic life support and advanced cardiac life support, (vi) collaborating with Medical Team International to train basic EMTs, (vii) processing pre-hospital care system with Free Funeral Services Society (FFSS).

Regarding attending AAEM's 23rd Annual Scientific Assembly, I was so excited and happy when I first saw the email from AAEM that I got the scholarship to attend that Assembly.

The organization created a nice assembly. The weather was fine and the environment made us fresh and alert. Firstly, the opening ceremony was done. After that I got a chance to see my old friends. Most of the topics were interesting and among them, I especially liked the sessions about: "Emergency Physicians Should Use Twitter," "Ten Factors that are Important for Anaphylaxis," and "USG (Lung Scan)". Moreover, I also attended the topic by Dr. Joe Lex, which was about Placebos. On next day I had a valuable chance to attend the International Committee meeting with many members of AAEM. I grasped that chance to share my thanks for the scholarship program. Because of this assembly, I got some more networking experience with emergency physicians from United States of America. Moreover, I obtained more experiences about emergency medicine that I can use as references for my country as well.

Finally, I would like to say thank you again to AAEM Board of Directors who allowed me to attend the 23rd Annual Scientific Assembly. This was one of the best chances for my life. I will definitely share this experiences with my colleagues, seniors, and juniors and I will persuade them to do emergency medicine with me as well.

Thank you very much!

Dr. Myat Noe
Myanmar ●

Wellness Committee

Emergency Medicine Still Revs Our Engines, So Why Do We Feel Like We're Running on Empty?

Larissa Coldebella, MD
AAEM Wellness Committee

One of the objectives of the wellness committee is to examine the current state of physician burnout in order to promote wellness and career longevity. Using the Oldenburg Burnout Inventory, we surveyed our members and asked additional open ended questions in order to identify the root causes of burnout. Although the limitations of this data include a response rate of about 10%, there were over 700 unique and individual respondents to the pre and post Scientific Assembly survey giving us a large sample size for qualitative analysis. The results of this survey provide insight into the major drivers of burnout and the elements of our work that appear to be protective. So first, the good news: as a whole, taking care of patients in the emergency department still gets our juices flowing. Inherent to the practice of emergency medicine are the diagnostic challenges, the interesting cases, the adrenaline and the pressure that comes with treating critically ill patients. Based on our survey results, these elements are still very much alive. An overwhelming majority (>80% positive response) reported that they always find new and interesting aspects of their work, can tolerate the pressure of our work well, and find emergency medicine to be a positive challenge. Now for the flip side: The majority of physicians also report feeling tired, weary, worn out, and emotionally drained, as well as needing more time to recuperate after a shift.

So what gives? If our job is to take care of patients in an environment that challenges us – why has burnout become such a problem for emergency physicians? Analyzing the qualitative data reveals some common themes that give insight into what really wears out an emergency physician. Surprise! It has nothing to do with the patients. The themes that came up time and time again can be broken down like this – burnout appears to be driven by workplace related and systems issues in health care rather than patient care.

Respondents voiced frustrations about the system in which they work – including a focus on non-patient centered metrics, government imposed bureaucracy, and the inefficiencies of the EMR. In addition to the constraints created by the health care system, many docs voiced concern about a lack of support from their own employers. What ensued is a call to action for employers to value EPs as both professionals and people – striving for physician satisfaction in addition to patient satisfaction in pursuit of the best possible patient care. Suggested solutions include fighting for paid time off, schedules that are amenable to work life balance, and policies that support life outside of medicine including raising a family and providing resources for unpredictable life stressors.

There are several current initiatives that aim to tackle these systems based issues. AMA's Organizational Foundation for Joy of Medicine is an online module taking a look at how institutions can create organizational structures that result in more satisfied and productive physicians. The module provides powerful tools for making a case with your institutional leadership to prioritize physician wellness. "Putting Patients First by Reducing Administrative Tasks in Health Care" is a position paper of the American College of Physicians, adopted by AAEM, that serves as a guideline for analyzing unnecessary administrative tasks that provide no benefit to the physician or patient and advocating for their removal. The future of tackling the systems based issues is recently underway with an all EM organization physician working group that has been meeting over the past year, as well as with initiatives put forth by the National Academy of Medicine. Although encouraging, these initiatives only begin to set the stage for future progress.

Emergency physicians are tough. As a profession, we have chosen to work in arguably the most stressful environment in medicine, taking care of the most vulnerable, difficult and sick patients in our communities. The physical and emotional toll that this takes requires that we care for ourselves. The EM community has clearly realized this, with a recent boom in literature emphasizing tools such as resilience and mindfulness to combat burnout. While these skills are helpful, they rely solely on the participation of the physician. It's time to recognize that combatting burnout is a shared responsibility between physicians and the organizations they work for. EPs need to have the support of their employers and governing bodies in helping provide the best possible care. This is only possible by also prioritizing the care of the physician and supporting the initiatives that champion this ideal. ●

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Life is No Longer Linear: Let YPS be Your Guide!

Danielle Goodrich, MD, YPS President and Daniel Migliaccio, MD, YPS Vice President

Welcome to the Young Physician Section (YPS)! As the incoming vice president and president of YPS, we are excited for the upcoming year. As a board, we want to contribute to the amazing organization of AAEM and uphold its model of being the "Champion of the Emergency Physician." The recent re-branding of AAEM, bringing forth the values and ideals of the organization, provides an excellent milieu for the development of YPS. As an organization, AAEM seeks to uphold to the most current evidence based practice in emergency medicine and promotes education in our field more than any other group. There's no better time to promote education and physician development than during the first years of practice after residency training. YPS is a section of AAEM that supports physicians within the first seven years of practice.

As newly practicing clinicians quickly come to realize, this time can be extremely challenging and difficult to navigate. As we transition from residency into clinical practice, the responsibilities grow in order of magnitude. For many, this is when "adulthood" (having regular responsibilities outside of an educational environment) first kicks in. While many of your friends and family have had approximately a decade to develop these skills (the average training duration of an emergency physician from "I want to be a doctor" to graduating residency), you have had your head buried in textbooks, your body deprived of sleep and exercise, and have probably missed out on participating in a life event or two. We do this because it is our calling, and we have sense that we can be the champion of emergency medicine and a champion for the patients we treat and the students we teach.

Throughout your early life and education, there has always been a linear direction to your life path. You went to medical school, you did your rotations in EM, you matched into EM, you graduated from residency and you landed your first job out of residency. Now what? As you come out into the "real world," this sense of linear directionality disappears. This can be extremely disheartening and lead to feelings of emptiness and early burnout. As a group, YPS-AAEM can offer guidance to give you some direction in this tumultuous time.

How YPS can serve you in your early "adult" life:

1. **EM Flash Facts App**
   First and foremost, you are developing your clinical skills as a young physician and seeking to become a board-certified emergency physician. YPS can help you prepare for the American Board of Emergency Medicine certification exam with our EM Flash Facts App. This app can be conveniently accessed on your phone or tablet. The flash facts provide high-yield information that can be reviewed in preparation for your exam. Use them and you are in a good position to do exceedingly well on your board examination!
2. **Mentorship Program**
   Transitioning into a new hospital system as an attending physician can be a stressful scenario. You may be working in a hospital you have never been affiliated with, and there may be no familiar faces. This year, we will be revamping our mentorship program. This will enable YPS to connect you with physicians that have recently gone through these same transitions. These mentors are from all walks of life including academic medicine; community medicine or rural medicine and can provide you with insight to the issues that a young attending physician deals with on a daily basis.
3. **CV and Cover Letter Review Service**
   As a professional, the Young Physician Section offers CV coaching and will review your CV to ensure it is of utmost quality so you are lined up to succeed in your career choice.
4. **Professional Development**
   Further, YPS offers opportunity for professional development with an opportunity for authorship for its members. Interested individuals (or groups of YPS) can submit ideas for the *Common Sense* magazine for publication. This is an excellent opportunity for writing development and looks amazing on your CV! Similarly, the YPS has strong representation at the Scientific Assembly on a yearly basis. The board hosts the Open Mic Competition, an opportunity (for those proposals that are accepted) for national speakership. As a member of the YPS, you can ask a mentor for coaching with your submission to the open mic contest.
5. ***Rules of the Road for Young Emergency Physicians* eBook**
   Lastly, there are significant financial changes that develop as you make these life changes. Salaries increase, loan repayment begins and maybe mortgages and family planning become new realities. As a YPS member, you will be provided a free copy of *The Rules of the Road for Young Emergency Physicians* eBook. This is an amazing, easy to read book that speaks to topics related to the financial aspect of emergency medicine that may have been nebulous during your training. Topics covered include fee splitting and profiteering, the restrictive covenant, and the corporate practice of emergency medicine.

Besides all of these wonderful benefits to being a YPS member we are aiming to develop even more exciting opportunities during the year, including the potential to have a more senior YPS member as your personal coach. The word coach better embodies what the YPS hopes to provide. We want to be here to provide life and wellness guidance, as well as career advice. We hope to be your lifeline and your support system to become a "Champion of Emergency Medicine."

We hope to see you as a member of the Young Physician Section!

For any questions you may have, please contact us:
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AAEM/RSA President"s Message

The Year Ahead

MohammedMoiz Qureshi, MD
AAEM/RSA President

This last year has been an absolute whirlwind for RSA. From the horrific tragedy of losing a dear mentor and colleague in Dr. Rodgers, to putting on the first official RSA track at Scientific Assembly, we have had our fair share of ups and downs. As we look forward to the year ahead, I want to take a moment to highlight some of RSA's biggest accomplishments this past year and bring light to the hard work and initiatives we have coming up!

Most remarkably the 2018 Annual Scientific Assembly in San Diego, was the first time RSA put on an independent educational track. "The Missing Curriculum" discussed the business side of emergency medicine and was an absolute showstopper. The pertinence and relevance of this education was not lost on any participant and in the modern day era of various practice opportunities, we hope to continue this track as an invaluable resource to all our members.

RSA will also continue its involvement in discussing and resolving controversial topics that surround our residents and students. We have taken leadership roles in key issues such as the AAMC Standard Video Interview project and have actively relayed our resounding support for students and have made it known that RSA cannot, and will not, support any project or initiative that adds burdens to students emotionally or financially. We are publishing our first set of official position statements on various topics. Other issues we continue to address include the importance of maintaining board certification as regulated by ABEM/AOBEM, and are also working to battle legislation peddled by insurance companies that is attempting to thwart the values of the "prudent layperson standard" that will directly affect our specialty reimbursement, but most importantly patient care.

In this last year, RSA has also made it an integral part of our culture to be a proponent for diversity in our specialty. We have created the Diversity and Inclusion Committee that provides two scholarships annually to attend the FIX Conference in New York City. The D&I committee has also created a database of clerkships for medical students that are underrepresented in emergency medicine and provides information on diversity programs throughout the country. As emergency medicine becomes exceedingly more competitive every year, the International committee plans to create a mentorship program for international EM residents to mentor international students looking to match into emergency medicine.

We have also started expanding our medical student symposiums nationwide and have received phenomenal feedback to their success. They have been so well received in fact that there have already been attempts at emulating similar symposiums. To that we are honored as we feel the sincerest form of flattery is mimicry! On our own accord however, we are excited to have new applications this year for upcoming symposiums planned to take place in Louisiana, California, and New York, alongside our annual flagship symposium in Illinois.

Following along our dedication to education, we have also regularly met with the American Board of Emergency Medicine and are actively involved in addressing the proposed overhaul to the ConCert Exam™. Since our specialty is considerably affected by dynamic practice guidelines and we believe it to be imperative for every working clinician to be able to learn and adopt these guidelines in a constructive and structured way to best serve our patients. RSA supports developing a more regular review course that would emphasize the importance of remaining relevant and practicing up to date evidenced based medicine. With this in mind, RSA is also working behind the scenes on a new study and review resource that we hope to reveal as an exciting exclusive member benefit in the coming months!

Clearly, the past couple years under our unyielding leadership with Drs. Haas and Alker at the helm, RSA has thrived. This short review does not nearly do justice to them and their boards and the many endeavors RSA has undertaken. It is truly an honor to serve as President this next year and represent the AAEM/RSA torch that burns so bright. Working with our members and friends we hope to continue this tremendous growth for RSA, because there are testing times coming for our specialty. The need for our board certification is questioned when other EM organizations are headed by non EM boarded physicians, mid level providers have come demanding an equal scope in our daily practice, our sedation guidelines are being commandeered by other specialties, and our independent physician practices are targeted for hostile takeover by corporate medical groups. With these tangible threats on the horizon, RSA is ready to uphold the values we so strongly believe: to continue to educate and advocate for our members, to be the eyes and the ears for our residents and students, and to ultimately be *The Champions of the Emergency Medicine Physician*. ●

AAEM/RSA Editor

Find Your Power Ballad

Aaron C. Tyagi, MD

The ED is a naturally stressful environment, where sensory overload is the norm. At any given moment, you can simultaneously be handed two stat EKGs while receiving an EMS refusal and have a consultant return a page. As a senior resident, I have taken to reflecting on this and how I will approach this in my own independent practice going forward. In doing so, I have found that I have already subconsciously been finding my own ways of mitigating my own stress. One of my favorite methods of doing this on-shift is music.

In one of the EDs we staff, there is a cordoned-off area for the physicians. It is pseudo-open. What I mean by that is there are door-less entryways so staff are pretty consistently passing through, but overall, it is an area where the attendings, residents and medical students can discuss cases, place orders, write notes and such. I am not fan of laptops so I typically sit behind a desktop computer. After signing in and (depending on the acuity of the day) getting settled in, one of the first things I like to do here is open my Spotify account and tee up and album. Lately I have been starting with Guardians of the Galaxy, Volume II soundtrack. As the shift goes along, I will adjust the music (genre, artists) to fit the mood. The tunes will vary from country to classic rock to hip-hop, Corey Smith to Wu-Tang Clan. I take requests. This is something that takes a minimal amount of time, but after coming out of a long arrest or otherwise complex poly-trauma, just hearing a brief snippet of the dulcet tones of Freddy Mercury crooning out "Don't Stop Me Now" will help right my ship.

At another ED we staff, everything is much more open. Thus, playing even low-volume music is somewhat inappropriate, where patients and families are just a few feet away. So I will try and steal a minute or two and put in one headphone and get a quick tune in.

As I was doing a quick Google-search to see how much (if any) research or even editorials/anecdotes along these same lines are out in the world, I found a few interesting things: With the recent push for wellness, there is no lack of recommendations for de-stressing after a shift or outside of work. Things like controlled breathing exercises, yoga and other organized activities are popular. However, there is not much related to listening to music on-shift.

Music in the ED is not something novel. There are attendings and other residents in my own program (and undoubtedly countless others) that play music throughout their shifts. Today, I simply want to write about something that I have personally found to be therapeutic and a quick and easy pick-me-up.

I am sure most of us can recall rotating on surgical services and reflect on how different attending surgeons would play music in the OR, as a means of aiding focus and their overall mental state during operations. This dates back to as early as 1914, where a surgeon named Dr. Kane brought a gramophone into his ORs.

Diving deeper, I even found things related to music therapy in the ED for patients. With respect to older patients, for whom an ED visit may be an especially stressful situation, there is even a clinical trial at Columbia University looking at music and its anti-anxiolytic potential.

I come from a background of the "hard sciences." Music therapy was not ever much on my radar growing up. However, I was exposed to music early on, through sports (work outs and pre-game) and continued pursuing good music via concerts, festivals, etc. While I am no professional on the effects of music therapy, it is definitely something I will carry with me as I go off into the world of independent emergency practice. As I head off to an afternoon shift, I am looking forward to that next track. ●

Congressional Elective

My AAEM/RSA Congressional Elective Experience

Alister Martin, MD MPP
AAEM/RSA Congressional Elective Fellow

My congressional elective experience through AAEM was an incredible, zoomed-in, view of how our congressional process works. The work I did was largely split into two different tasks. The first was day-to-day health policy research and data gathering for the office as the Congressman sought to reinforce and advance his health policy positions. The Congressman has an incredibly deep understanding for domestic health policy drawing both from his role directly involved in patient care as an emergency physician and also stemming from his extensive education in health policy receiving advanced degrees at the Harvard Kennedy School of Government and the Harvard School of Public Health. He buttressed this domestic health policy expertise by training as an International Emergency Medicine Fellow at Brigham and Women's Hospital, doing international relief work in Haiti, and by serving as a consultant to the Ministries of Health of both Serbia and El Salvador. When he needed to have specific information to help inform his position on a crucial decision, I worked with the team including other health policy fellows and congressional staffers in the office to gather this data and helped to present it in a way that was concise and useful.

I also sat in on Congressional hearings and briefings germane to the Congressman's health policy interests. I learned an incredible amount at the Congressional Hearing on the DEA's role in preventing the opioid crisis and what more could be done from its vantage point. I was blown away at a Congressional briefing by the American Public Health Association on the specific ways in which Congress can come together to promote sensible gun control policy.

The highlight of these briefings however, was a briefing on 'Strategies to Increase Access to Quality Health Care in Rural America' convened by the Congressman himself on the role of telehealth in rural communities. Among the invited speakers were: The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), Directors from Farmworker Justice, Vista Community Clinic, and Campesinos Sin Fronteras, and they all spoke with rare clarity about the specific needs presented by patients living in rural communities all across America.

This briefing served as the foundation for the other important part of my work in the Congressman's office. He sought to explore federal legislative reforms that would allow telehealth to be used as a vehicle to serve patients with limited access to care nationally. Segments of his district are composed of rural farmworkers who would benefit from increased access to health care. The Congressman has been focused on how to bring quality, cost-effective, timely health care to these constituents who previously have not had easy access to primary and specialist care.

Telehealth services offer an opportunity to do this but currently there are several legislative barriers that are affecting telehealth spread in rural populations and it was my job to better understand the nature of those barriers so we could explore legislative solutions that addressed and removed those barriers, where possible. The constellation of legislative ideas that came out of determining how these legislative barriers would be addressed may serve as the foundation for a new legislation that could then be molded by the Congressman and his staff to a workable solution.

I spent the last few weekends in D.C. exploring, seeing the beautiful kaleidoscope of colors in the blooming cherry blossoms on the National Mall, appreciating the Martin Luther King Memorial 50 years after his death, and hearing the chants from our nation's youth for smart gun control policy during the March for Our Lives march on the Capitol. I came to experience D.C. at an interesting time in our nation's history and it will have a lasting impact on both my professional and personal development. I will be forever grateful to the Congressman, his exceptional staff, and the team at AAEM and AAEM/RSA who worked to make this unique opportunity possible.

Policy Paper

Residents of rural areas experience significant challenges in accessing quality health care. Broadening the use of telehealth is one promising strategy for increasing access to care in rural communities. Despite the promise of telehealth for improving access in rural areas, however, there are seven distinct federal policy barriers which impede the proliferation of telehealth capacity in rural areas. These span several areas: reimbursement restrictions, limitations on broadband infrastructure, and onerous CMS administrative rules. It is only by understanding the nature of these seven federal barriers to using telehealth as a means to increase health care access in rural areas can we identify potential legislative opportunities to address these barriers.

Seven Barriers to Expansion of Telehealth in Rural Communities

Store and Forward Restrictions

Background: Store and Forward is the transmission of medical information, such as digital images, to a provider who uses the information to

Continued on next page

evaluate the case outside of a real-time or live interaction. Example: A PCP sends an image of a suspicious skin lesion to a distant dermatologist, who can review the image and determine the need for an in-person visit.

Barrier: Currently Medicare reimbursement of this service is only permitted in Alaska and Hawaii.

Remote Patient Monitoring (RPM) Restrictions

Background: RPM is the transmission of personal health data from a patient in one location to a provider in a different location. Example: A rural patient with a painful red lesion on their leg can record their temperature with a connected health device and have this automatically pushed to his PCP who can trend their fever curve.

Barrier: Currently, Medicare does not reimburse for RPM services for general Medicare beneficiaries. It does reimburse specific RPM services for beneficiaries who have Medicare Advantage.

Originating Sites Restrictions

Barrier: In order for a provider to be reimbursed for telehealth services Medicare requires that the patient be present at an "originating site," such as a physician's office, federally qualified health center, clinic, or hospital. Furthermore, this originating site has to be in a "rural health profession shortage area," in counties that are not included in a metropolitan area. Medicare will not cover telehealth services if the patient is at home during the provision of care except in two conditions: telestroke evaluation and care for at home dialysis patients.

Provider Type Restrictions

Background: Currently, only Medicare defined "practitioners" may be reimbursed for telehealth services. This list includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists and clinical social workers, registered dietitians, and nutrition professionals. Rural communities face numerous health care challenges, including: hospital closures, lack of access to health care services, health care professional shortages and lack of culturally appropriate services. Community Health Workers (CHW), or Promotores de Salud in Spanish-speaking communities, are the backbone of the primary care network in rural health areas because they are able to expand access to health services in areas where transportation and provider shortages pose a problem

Barrier: CHWs are currently not an approved telehealth "practitioner" type by Medicare.

Broadband Limitations

Background: Rural health clinics require stable and fast broadband connection speeds in the range of 50-100 Mbps connection to engage in quality telemedicine. Currently, the majority of rural health clinics operate on a broadband connection speed that is far below the broadband requirement to initiate Telehealth services. Roughly 60 percent of rural health clinics have broadband connections less than 10 Mbps.

Barrier: The Federal Communication Commission's Rural Health Care (RHC) program, a program dedicated to helping rural health areas expand access to broadband has an annual cap of $400 million. This was set 20 years ago given demands at that time. Experts state that this cap does not meet the current need for broadband access in rural communities and that an $800 million annual cap more accurately reflects current needs to establish adequate broadband capabilities.

Underfunded Telehealth Resource Centers

Background: Fourteen federally designated Telehealth Resource Centers around the country currently offer extensive hands-on experience in telemedicine development for providers seeking to expand their telehealth efforts. Resource centers provide technical assistance, program support, and help providers establish best practices in telehealth reimbursement and operations.

Barriers: Funding shortfalls consistently plague TRCs which constrain their ability to provide support to rural health providers considering telehealth.

Restrictions on Billing for Multiple Visits and Definition of a Visit

Background: The main source of primary care in rural communities occurs in FQHCs. Medicare has imposed restrictions on billing for multiple visits for the same patient in one day except in cases of an emergency or a new chief complaint. Medicare will allow billing for multiple visits in one day for the following scenarios: mental health, dental health, and nutritional evaluation.

Barrier: Many patients in rural health areas inconsistently seek medical attention and have a disproportionately high no show rate for follow up visits. When they are present at their FQHC and being evaluated by their PCP they cannot stay on site that day to receive another telehealth specialist evaluation except in the above scenarios.

Conclusion

The promise of telehealth in rural areas can only be fully actualized through addressing federal policy barriers which currently impede its widespread adoption. Legislators interested in expanding access to telehealth should consider federal legislative reforms that:

- cover store and forward services in designated rural health areas.
- expand the list of covered conditions that can be reimbursed in the home to include conditions affecting rural workers like diabetes, hypertension, asthma, and obesity.
- include CHWs as a reimbursable telehealth provider.
- increase funding to the FCC's Rural Health Care (RHC) program which could be designated to building the broadband infrastructure needed to support telehealth efforts in rural health areas.
- increase DHHS funding to resource centers that contain large portions of rural health areas could be proposed to help in these efforts.
- mandate that CMS remove the restriction on reimbursement of multiple visits in FQHCs in rural health areas if care is being given by telehealth.

The effective use of telehealth in rural communities, paired with the necessary legislative changes outlined above, has the potential to dramatically improve both access to care and quality of care in rural communities across the nation for years to come. ●

Resident Journal Review

It is Not a STEMI, Now What?

Authors: Lee Grodin, MD; Raymond Beyda, MD, Theodore Segarra, MD, Taylor Conrad, MD
Editors: Kelly Maurelus, MD FAAEM and Kami M. Hu, MD FAAEM

Question: What evidence is there for Optimal Medical Therapy (OMT) alone versus OMT combined with invasive coronary revascularization in patients presenting to the ED with symptomatic Coronary Artery Disease (CAD) that is a Non ST-elevation Myocardial Infarction (NSTEMI)?

Introduction: Given the large proportion of patients visiting the ED for chest pain, evaluating for cardiac ischemia is one of our "bread and butter" skills. So what evidence can guide us in how to treat these patients? At one extreme, we are confident that STEMI cases should prompt emergent cardiac catheterization laboratory activation. At the other end, OMT for stable CAD has gained acceptance. Current standard of care according to the American Heart Association (AHA) and European Society of Cardiologist (ESC) guidelines recommend early cardiac catherization in patients with active disease (e.g. changing EKGs with symptoms, hemodynamic instability, acute heart failure), high risk comorbidities (e.g. kidney disease, diabetes mellitus, prior cardiac interventions) or rising cardiac enzymes[1,2]. There may be a cohort of patients in between; however, with non-STEMI ACS for whom there seems to be less certainty regarding ideal care. Here we review several articles that discuss investigations into therapies for CAD and NSTEMI, as well as one that introspectively reviews its home institution's care.

Boden WE, O'Rourke RA, Teo KK, et al. Optimal medical therapy with or without PCI for stable coronary disease. *N Engl J Med*. 2007;356:1503-16.

In 2004, 85% of all percutaneous coronary interventions (PCI) were elective and performed for stable CAD with the thought that stenting of significant lesions could help prevent ACS and reduce mortality. Later that year, Boden, et al. published the results of the COURAGE trial, which was designed to determine whether PCI plus OMT was indeed superior to OMT alone in this patient population.

The COURAGE trial was a large, multicenter (50 sites in the United States and Canada), randomized, controlled trial, performed between 1999 and 2004, involving 2,287 patients who had known CAD and evidence of myocardial ischemia. Inclusion criteria required that patients have both significant CAD (at least 70% stenosis seen on angiography) as well as evidence of myocardial ischemia by reported symptoms (classic, exertional, or anginal) or testing (resting ECG showing ST depressions or T wave inversions; or stress testing showing ischemic ECG changes or perfusion deficits). Exclusion criteria included a) persistent Canadian Cardiovascular Society (CCS) Class IV angina, b) markedly positive stress test (substantial ST depressions or hypotension during stage I of the Bruce Protocol), c) refractory heart failure or cardiogenic shock, d) ejection fraction (EF) <30%; e) revascularization within the last 6 months, and f) coronary anatomy not suitable for PCI. Patients were then randomized to either intensive medical therapy or intensive medical therapy with PCI.

The medical therapies in both arms consisted of aspirin 81-325 milligrams per day, blood pressure and heart rate control with a combination of metoprolol succinate, amlodipine, and isosorbide mononitrate, secondary prevention with lisinopril or losartan, cholesterol management with a combination of simvastatin with potential addition of ezetimibe, niacin, or fibrates, and exercise. In addition, all patients who received PCI were subsequently treated with dual antiplatelet therapy (DAPT). Patients were followed for 2.5-7.0 years (median 4.6 years) and were assessed for the composite primary outcome of all-cause mortality and non-fatal MI. Secondary outcomes included hospitalization for troponin-negative ACS (unstable angina), MI, and the composite outcome of all-cause mortality, non-fatal MI, and stroke.

At the median follow-up time of 4.6 years, the authors determined that despite relatively high rates of adherence to medical therapy (LDL goals were met in 70% of patients, systolic blood pressure goals met in 65% of patients, diastolic blood pressure goals met in 94% of patients, and HbA1c goals met in 45% of patients) and high success rates in revascularization via angioplasty and/or stenting, there was no significant difference between PCI plus OMT and OMT alone for the composite primary outcome of all-cause mortality and non-fatal MI. They similarly found no significant differences in any of the secondary outcomes. Furthermore, at the 5-year point, both groups boasted a rate of >70% of patients being free of anginal symptoms, with no statistically significant difference between the groups (74% PCI group vs 72% medical therapy group).

Although the trial itself was designed to minimize bias, there are a few caveats to consider. One major limitation lies in the study's lack of diversity, with an 86% white and 85% male distribution of patients. The results may not be applicable to other populations as they may not reflect the same incidence of disease, pathology, or response to therapy seen in non-white and non-male patients. Another point to consider is the exclusion of patients with low ejection fraction; these patients could possibly have improvement in their heart failure and reduced mortality following revascularization of an artery supplying a territory with a reversible ischemic defect. This study was not spared the ubiquitous restraint of nearly all research: it was limited to its time. Most of the stents were bare metal stents, which have since fallen out of favor.

Overall this trial demonstrated that PCI of stable coronary lesions does not provide any additional benefit to OMT alone, and that PCI can be safely deferred in patients with stable CAD, even perhaps in the setting of extensive multi-vessel disease and inducible ischemia, as long as they receive OMT. Importantly these results point to a critical distinction in coronary artery pathology. The authors explain that the severely stenotic lesions which are often seen on angiography and cause persistent anginal symptoms are most often due to stable fibrous plaques which, though symptomatic, are stable and rarely rupture and cause ACS or death. In contrast, the unstable coronary lesions which tend to rupture and lead

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to ACS often grow outwardly, leading to fewer areas of angiographically visible stenosis, and so are also less likely to cause persistent anginal symptoms. As a result, they postulate that the role of PCI should be limited to patients with ACS, and possibly for patients with refractory stable angina despite OMT.

Frye RL, August P, Brooks MM, et al. A randomized trial of therapies for type 2 diabetes and coronary artery disease. *N Engl J Med*. 2009;360(24):2503-15.

With prior studies, such as the COURAGE trial, calling into question the benefit of early revascularization with OMT for stable CAD, the authors of the Bypass Angioplasty Revascularization Investigation 2 Diabetes (BARI 2D) trial sought to address the question of whether revascularization, whether PCI or coronary artery bypass grafting (CABG) should play a role in management of stable CAD in diabetics with moderate-risk CAD characteristics. Of note, diabetics were not well represented in the COURAGE trial. In the BARI 2D study, patients were excluded who had left main coronary artery disease, severe renal impairment, heart failure class III or IV, or who needed immediate revascularization for ACS. In addition to the role of revascularization, the authors included the comparison of two glucose management strategies (insulin sensitization vs. insulin provision), which will not be focused on in this review.

This large, multi-center, international study used the primary outcome of death from any cause at an average follow-up of 5.3 years and the secondary endpoint of any major cardiovascular event (a composite of death, myocardial infarction, or stroke). This study was not designed to compare PCI to CABG. Of the 2,368 patients enrolled, 763 were selected for CABG and 1,605 were selected for PCI. Patients were first assigned to receive either planned PCI or CABG and then randomized to receive either OMT plus prompt revascularization (performed within four weeks from date of randomization) or OMT alone. Notably, patients in the medical therapy group could undergo revascularization during follow-up if indicated due to worsening angina or the development of ACS or severe ischemia.

By six months, 95.4% of patients in the revascularization group had undergone revascularization as compared with only 13% of patients in the medical therapy group. At approximately five years of follow-up, there was no significant difference between groups in the primary outcome of survival (88.3% in the revascularization group and 87.8% in the OMT-only group, p=0.97). Additionally, there was no difference in the secondary outcome of freedom from major cardiovascular events (77.2% and 75.9% respectively, p=0.70).

Some limitations include the exclusion of patients without intervention-amenable coronary anatomy (patients who would not be determined to require revascularization in the first place), which limits the generalizability of the study's results. Additionally, it was left to physician discretion as to whether patients would receive PCI or CABG; theoretically more severe CAD would prompt a decision for CABG. Finally, it is worth noting two things: 1) that there was a not-insignificant amount of crossover – that is, at 5-year follow-up, approximately 40% of patients randomized to the OMT group had undergone some sort of revascularization, and 2) A subgroup analysis of the CABG group indicated there may be a significant increase in freedom from cardiovascular events in patients who had undergone CABG (77.5% versus 69% in OMT, p=0.01). These issues notwithstanding, the general lack of difference in mortality seems to suggest that patients with type 2 diabetes and CAD can be managed successfully with OMT alone.

Hoedemaker NPG, Damman P, Woudstra P, Hirsch A, et al. Early Invasive Versus Selective Strategy for Non-ST Segment Elevation Acute Coronary Syndrome: The ICTUS Trial. *J Am Coll Cardiol*. 2017;69(15):1883-93.

One of the major distinctions of the ICTUS trial was that it analyzed patients with non-ST segment elevation acute coronary syndromes (NSTE-ACS) ten years after enrollment which was a considerably longer follow-up than the majority of other inquiries. It obtained data for 96% of the 1,152 patients a decade after they were initially enrolled. It also only enrolled patients with a positive troponin. In the original ICTUS trial, 1,200 patients with elevated cardiac troponin T levels were randomized into OMT with early invasive versus selective invasive treatment strategies for treatment of NSTE-ACS. Patients in the early invasive group underwent coronary angiography within 24 to 48 hours, with revascularization by either PCI or CABG dictated by angiographic findings, while the selective invasive strategy group received OMT, with a subset of these patients going on to angiography only for refractory ischemic chest pain or ischemia induced by provocative testing prior to hospital discharge.

The primary outcome was the composite of all-cause death and spontaneous MI, but the authors also looked individually at the outcomes of death or MI, all-cause death, cardiovascular death, non-cardiovascular death, MI, spontaneous MI, and procedure-related MI. There were 604 patients in the early invasive group and 596 patients in the selective invasive group, with 98% of the early invasive group and 53% of the selective invasive group undergoing angiography. At one-year follow-up, 79% of the early invasive and 54% of the selective invasive groups had undergone revascularization. When the authors accounted for the competing risk of death, at 10-year follow-up the revascularization rates were 83% and 61% in each group respectively.

There was no statistically significant difference in the primary composite outcome of death or spontaneous MI between the early invasive and selective invasive groups. With regards to the individual outcome of death or MI, there was a statistically significant increase in the early invasive group [37.6% vs 30.4%, HR1.30 (95% CI 1.07-1.58, p=0.009)]. There was no difference in the rate of all-cause death, cardiovascular death, non-cardiovascular death, MI, or spontaneous MI. There was a higher rate of procedure-related MI in the early invasive group compared to the selective group [6.5% vs 2.4%, HR 2.82, 95% CI 1.53-5.20, p=0.001)]. Finally, there were no differences in rates of death or spontaneous MI regardless of risk stratification according to patient age, presence or absence of diabetes and hypertension, body mass index, history of prior MI, and the presence or absence of ST-segment depressions.

The results of this study are distinct from prior studies that compared early versus selective invasive strategies in NSTE-ACS patients. Regardless of treatment strategy, approximately a third of patients experienced death or a spontaneous MI, with no apparent benefit offered by

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an early invasive strategy. The authors offer some possible explanation for these findings, including the fact that compared to earlier studies, this investigation was a follow up of a contemporary cohort of patients utilizing optimal statin and anti-platelet therapy as well as modern stents and peri-procedural anti-thrombotics. In addition, there was a higher rate of angiography in the non-invasive (i.e. selective) group in this study compared to older trials. Even in older trials that did show a mortality benefit to an early invasive strategy, this benefit disappeared five to ten years later during long-term follow up. This study, therefore, suggests that invasive angiography may not confer a statistically significant benefit beyond OMT in patients experiencing NSTE-ACS.

Shepple BI, Thistlethwaite WA, Schumann CL, et al. Treatment of Non-ST Elevation Myocardial Infarction: A Process Analysis of Patient and Program Factors in a Teaching Hospital. *Crit Pathw Cardiol*. 2016; 15(3):106-11.

This retrospective chart review analyzed the treatment of 242 patients diagnosed with NSTEMI at a single institution with a standardized STEMI protocol, but no protocol for the management of NSTEMIs. Inclusion criteria were patients who presented with symptoms suggestive of an MI, had an elevated troponin level, and a discharge diagnosis (based on ICD-9 codes) consistent with NSTEMI. The study excluded patients who were ineligible for anticoagulation or antiplatelet therapy, had STEMI, or had an NSTEMI secondary to any cause other than plaque-rupture causing ACS. Data regarding the characteristics and treatment of these patients, as well as whether they presented during the day or night and on a weekday or weekend, were collected and reported.

There was fair uniformity in the early management of these patients (i.e. aspirin administration, procurement of an ECG, and serum troponin collection), but farther down the line there was a large variability in time to any other treatments, whether pharmacologic or procedural in nature. The time to revascularization was greatly associated with the hour and day of presentation, with prompt procedural intervention occurring more frequently during daytime hours and on weekdays.

Interestingly, the authors note that large studies have demonstrated that while early invasive strategies are beneficial in high-risk patients, this sentiment is not uniformly accepted among clinicians. It seems, at best, controversial as to whether patients without STEMI should have prompt revascularization, and some question whether this cohort should undergo revascularization at all. It is possible that the source of heterogeneity of treatment amongst their NSTEMI patients is due to a lack of protocol, time of patient presentation, or ownership over the patients' care by various departments (emergency, cardiology, or internal medicine departments), but could also be attributable to the lack of consensus regarding optimal NSTEMI treatment.

Conclusion: Over the past decade there has been a large amount of research into the optimal treatment of ACS beyond the standard of emergent PCI for STEMIs. Some studies suggest that OMT may confer benefit without the addition of PCI. The last published article review also analyzes what one institution does and does not do for NSTEMI. Across the country, the acute management of NSTEMI may vary. With that said, EPs should continue to advocate for our patients and for early PCI over OMT alone, especially in high-risk patients, as per the current AHA and ESC guidelines. For low-risk patients that do not fall under such categories there is interesting data to suggest that delayed revascularization in a selective cohort, or no revascularization therapy beyond adequate OMT may be potential treatment options to look out for on the horizon.

Answer:

Current standard of care guidelines recommends PCI for patients presenting with NSTEMI and active disease. However, OMT may have value for patients that do not fall under these categories. Continued research is needed to determine which patient cohorts may benefit simply from OMT alone without any PCI. ●

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MSC President/Spotlight On

Medical Student Council President's Welcome

Shea Boles

Hello! My name is Shea Boles and I am honored to be serving as the new AAEM/RSA Medical Student Council President for the coming 2018-2019 academic year. I became interested in Emergency Medicine while working as a scribe in a small hospital near my hometown of Sonoma, CA. I became involved with AAEM/RSA when I entered medical school as an M1. Since then I have attended and helped plan the annual AAEM/RSA Midwest Regional Medical Student Symposium each year, which is held at Loyola University Chicago Stritch School of Medicine every September. I will soon be entering my fourth year of medical school at Loyola and look forward to planning this year's symposium as well!

It is my pleasure to announce the other members of the AAEM/RSA Medical Student Council for 2018-2019: Vice President Joshua Novy, (University of Miami Miller School of Medicine); South Regional Representative Theddy Blanc, (Nova Southeastern University College of Osteopathic Medicine); Midwestern Regional Representative Henrik Galust, (Northeast Ohio Medical University College of Medicine); Northeastern Regional Representative Jordan Powell, (University of Rochester School of Medicine and Dentistry); Western Regional Representative Mitchell Zekhtser, (College of Osteopathic Medicine of the Pacific Western University of Health Sciences); and International Ex-Officio Representative Hannah Mezan, (University of Queensland - Ochsner Clinical School). We are all very excited to be serving as your Medical Student Council and look forward to working together.

Besides the upcoming Midwest Regional Medical Student Symposium held in Chicago, we are working on student symposiums in a few more locations. Be on the look-out for more information online! We also have a few ideas on how to increase student involvement and leadership opportunities. If you are interested, please feel free to reach out! For formal involvement in AAEM/RSA, consider joining a committee. We have 6 committees and are transitioning to our new board liaisons. The committees and their liaisons are: International Committee: Crystal Bae, MD; Education Committee: Trisha Morshed, MD; Advocacy Committee: Haig Aintablian, MD; Wellness Committee: Lauren Falvo, MD; Social Media Committee: Nick Pettit, DO, PhD; and Diversity & Inclusion Committee: Faith Quenzer, DO. Check out the website for information on becoming involved!

Approximately 1,300 medical students have a membership to AAEM/RSA and enjoy access to numerous published and electronic resources that can be found under the member benefits section on our website (aaemrsa.org). These include a free copy of *Rules of the Road* career guide for medical students, free registration to the AAEM Scientific Assembly, RSA Podcasts, multiple scholarship opportunities, a month-long advocacy elective with Congressman Raul Ruiz, and networking events. So take advantage!

Once again, our Student Council looks forward to working with our members and would love to hear your ideas. Please check out our website and feel free to reach out with any questions. Here's to a great year ahead!

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