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OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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COMMONSENSE

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AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
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*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

A Good Year

William T. Durkin, Jr., MD MBA FAAEM

What an exciting year this has been! A very busy and challenging one, but a great time. I am really looking forward to 2013.

During the past year, I have traveled over 100,000 miles promoting the Academy. While attending the IFEM meeting in Dublin, I had the honor of meeting Dr. Arafat and giving him our International Award. Meeting an emergency physician who stood up to the leader of his country and won was a rare experience. Giving a keynote address and teaching at the inaugural Pan Pacific Emergency Medicine Congress (PEMC) in Seoul, South Korea, after working on that meeting for two years, was a real honor. The success of the meeting was the result of a lot of work and planning by many of us, and it really paid off.

Residency visits have become one of my favorite duties. I met some excellent people and always learn something at each visit. It is my hope that the residents learned more about the outside working environment and understand why being a part of the Academy is so important to their career development. Many thanks to those of you kind enough to have invited me, and I look forward to meeting those of you that I didn't get to in 2012.

State chapters are continuing to grow. I had a chance to meet with members of the new Missouri chapter and discuss with them ways to grow their new chapter. The Virginia chapter has begun to tackle some of the political concerns in that state. They are actually taking the lead in Virginia on the Medicaid issue. A great start for a new chapter. The Florida chapter of AAEM (FLAAEM) recently concluded their 2nd Scientific Assembly. It was a great meeting and I would urge many of you to consider attending next year. Florida in January is a lovely place! Florida is one of the states with very high CMG penetration, which presents some frustrations but also some opportunities. I talked to one new grad who had already experienced first hand how tenuous a job can be when working for a CMG. This individual was aware of the problems from the start but felt she had no other option. We can do better in preparing our residents and young physicians for what they need to be aware of when working for these entities, and what other options may be out there for them.

One of my goals this past year was to establish liaisons with organizations that represent the people with whom we work daily. Nurses, physician extenders, and administrators are just a few of these. We had mixed results but will continue working on that in the coming year. Some of these groups have been invited to send representatives to this year's Scientific Assembly. I look forward to hearing their impressions.

We are doing other new things as well. By now, most of you realize that the Scientific Assembly is bigger by a half-day and an additional evening. The Practice Management Committee is more active, as is the Operations Management Committee. This will be of great value to those in the community managing their own practices. We have started a monthly legal podcast. Our former presidents, Drs. Weiss and Wood, will be doing the first in this ongoing series. We also hope to have a critical care podcast up and running before the Scientific Assembly. These will be available on our website as member benefits.

After Dr. Mike Ybarra and I interviewed lobbyists this past fall, the board of directors agreed to hire Williams and Jennings as our new lobbyists. This is a quantum leap in our political endeavors and should help us be out in front of political issues as they come up. They were responsible for facilitating the meeting I recently had with Senator John Barrasso (R-WY). John is an orthopedic surgeon and fellow Georgetown alumnus. We had a fruitful discussion and he has agreed to help us going forward.

One of my biggest frustrations of the past year was to learn that, after 20 years, we are still not widely known within and without the medical community. As the organization that was founded to promote the fair treatment of EPs, democratic groups, and ownership of our own practices, we still have some distance to go. It is imperative that those of you in training programs foster the notion of responsible hospital and community citizenship, as well as the importance of having a basic knowledge of the business side of medicine. There are opportunities out there for all of us. The Academy will continue to support its members and provide the tools necessary for them to attain and keep control of their practices. We need our members to promote the Academy to peers and colleagues as the organization that is best for emergency physicians, our specialty, and ultimately our patients. This message is in my talks for 2013. ■

Contact the President: president@aaem.org

From the Assistant Editor's Desk

Mark Doran, DO FAAEM
Assistant Editor, *Common Sense*

As I'm writing this article, the 2012 presidential election is about to be decided at the polls. A culmination of months of campaigning, debates, and no lack of discussion as it pertains to health care. As you're reading this article, the votes have been counted and hopefully a winner declared. Either way, whether your candidate won a stay at 1600 Pennsylvania Avenue or earned a one-way ticket back to his residence outside of the capital beltway, the American experiment begun in 1776 marches onward, tasked with improving health care for its populace.

There isn't enough space in *Common Sense* or my column to outline the pro's and con's of each health care plan as put forth by the presidential candidates or their respective political affiliations. Plus, there's no lack of resources available if you have yet to familiarize yourself with what has been proposed and/or already put into law. Friends, family, and patients have asked for my thoughts on the future of health care and the legislative debate. I preface it with the disclaimer that I am none of the following: a politician, lawyer, or insurance industry executive. I do preface it with the disclaimer that I am the following: an emergency medicine physician, husband, father, and every once in while, a patient. So, I have some "stake in the game" — as do you.

At this point you're probably looking for my personal commentary on health care reform … but I'm not here to be anyone's adversary or ally. Instead of soap-boxing my views, all I ask is that you … we … emergency medicine physicians take an interest in the debate of proposals and resultant decisions that impact our professional world. Granted, the national debate can get a bit overwhelming. That's ok. In fact, local and state politics hold just as much if not more value. Your statehouse and local legislator are a direct link to your immediate practice and a community's health care needs. Strive to do what is best for your patient population. Collaborate with your colleagues in the ED, in the hospital, and in your community. Anyone who has worked in an ED knows that much of what constitutes health care at some point involves emergency medicine services. Am I tooting our own horn? You bet — and why not?

It's common sense that we have a lot to gain (or lose), in respect to emergency medicine, as to how our respective communities make health care more comprehensive and a better business model. *Common Sense* … an appropriate and telling name chosen by AAEM for its professional newsletter and a phrase that we need to keep in mind! Many say "common sense" is dead. I say that reports of its demise have been greatly exaggerated! Don't be afraid to use it! We all make it our professional goal to do what is right for our patient … incorporating medical facts and knowledge with the "*common sense*" of what patient dynamics will allow. That same "*common sense*" can be a useful tool in making sense of and maintaining the importance of emergency medicine in the debate of health care reform. We're all in this together. Let us not forget that physicians have an inherently unique vantage point in health care delivery. It buys us a seat at the table of debate — if we're willing to voice our opinions. We need to work together and see to it that "*common sense*" doesn't get thrown to the wayside in developing a better health care plan for our country and more importantly for the communities in which we live. ■

Yours in Medicine,
Mark P. Doran, DO FAAEM

AAEM Antitrust Compliance Plan:

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

COMMONSENSE

Submit Your Letter

Letters to the Editor

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board of Directors

Letter in response to the July/August 2012 "From the Editor's Desk" article, titled "Law of the Land."

Sometimes a valuable perspective can be obtained by stepping outside of one's frame of reference, so I offer my opinion from emergency medicine in Australia.

It is noted, through international experience, that a government insurer substantially reduces health expenditure with improved overall outcomes for the population. However, due to ethos ingrained in the American heritage this initial proposal gained no traction, so you have been left with an inferior alternative of the forced purchase of private insurance.

Sadly, it may not achieve the substantial efficiencies and cost reductions of a government insurer, but perhaps it will be a step in the right direction. While the angst of the restriction of being "forced" to buy something may grate on the locals, it is not dissimilar to taxation which we all live with.

Bizarrely, medicine is one of the few industries where government involvement actually saves money. Hopefully one day this will be palatable to the American populace and you can finally apply the brakes to your extraordinary and quite uniquely American excessive health cost inflation. This will save you tax in the long term.

Anand Senthi, MD

Dear Dr. Senthi:

Thank you for your letter and your Australian perspective. Your comments are quite perceptive. I think everyone agrees that the medical care system in the United States is broken. Right now we have the vices of both capitalism and socialism with the virtues of neither. Insurance companies seem to be running things here, and are doing all they can to avoid insuring anyone who might actually need insurance, while denying, reducing, and delaying payments to physicians after their professional services have been rendered. Yet, at the same time, we suffer under an incredible burden of interference and micromanagement from federal and state governments (which have been the source of the majority of dollars spent on medical care here for many years, despite the objections of some to "socialized medicine"). Everything from EMR and CPOE mandates, to lab regulations, to wasteful and sometimes even dangerous Joint Commission policies (a de facto federal agency), to EMTALA — which makes emergency departments the national medical safety net without providing any funding for that purpose. And now, even though federal law requires that EDs care for all comers, a growing number of states are refusing to pay for that care through their Medicaid programs if the patient turns out — after a complete diagnostic work up — not to have a real emergency. All this bureaucracy plus the pillaging I outlined by private insurance companies, whose CEOs make tens of millions of dollars a year even when the company is "nonprofit," and yet in most states we are still left entirely at the mercy of a civil legal system so insane as to be beyond the imagination of any physician outside the United States. And I almost forgot: American medical students now average over $160,000 in debt on graduation from medical school. "Extraordinary and uniquely American" indeed!

Our system is so bad that going in either direction, back to the free market we abandoned nearly 50 years ago, or to a true single-payer system, would be an improvement. The only thing we could possibly do to make things worse would be to turn tax money over to private insurers and then leave them in charge of the system, which is just what Obamacare does. You are right to say this "... will not achieve the substantial efficiencies and cost reductions of a government insurer ..." because it does not allow for the rationing of a single-payer system. There are lots of ways to save some money in American medicine, but only two ways to save big money: profound tort reform that goes far beyond caps, and rationing. As everyone outside the United States seems to know, rationing is not a dirty word. In a free market patients make their own rationing decisions. In a single-payer system a national, provincial, or state government does it. For any system to work without devouring the entire economy somebody has to ration care, but private insurers are the last people we want doing that.

Finally, you insightfully mention the "ethos ingrained in the American heritage." This is known here as "American exceptionalism" A concept largely forgotten now, it does still get mentioned occasionally during election campaigns when our politicians pay lip-service to independence and self-reliance. American exceptionalism came from the belief, once nearly universal in the United States, that the national government should be constitutionally restrained with enumerated and severely limited powers. Our Constitution does not authorize the federal government to run a national health system, and this puts Obamacare in conflict with this cultural ethos that persists in some quarters. This is a moot point, however. The founders' vision for the federal government has been dead for nearly 80 years, and the Supreme Court just reaffirmed that with its decision in NFIB v. Sebelius. Assuming for the sake of argument that large parts of the Constitution and Bill of Rights are obsolete, however, I would still feel safer if we amended it rather than twisted and ignored its actual meaning. Once the Supreme Court decides the Constitution is a "living document," one that says whatever we want it to at the moment so we can achieve some desired public policy goal, none of our liberties are safe — and neither are we. ■

— The Editor

An Introduction from Williams and Jensen

Matthew Hoekstra

The Academy's board of directors recently voted to retain a new lobbying firm, Williams and Jensen, to represent AAEM in Washington.

— The Editor

As your representation in Washington, we would like to serve as your resource and home-base in the nation's capital. Our goal is to help you stay informed on current legislation and regulations impacting your organization, and communicate to Congress your point of view on key issues. To that end, we will have a regular "Washington Watch" column in *Common Sense*.

Williams and Jensen is excited about the opportunity to work with AAEM. We look forward to building relationships with AAEM members and working with AAEM to implement a strategy in support of your federal policy goals.

Williams and Jensen is a top-ranked Washington lobbying firm that was established over four decades ago. Our team of principals, associates, and research staff will serve as a resource for AAEM.

In addition to our work on AAEM's federal priorities, we anticipate working with AAEM to provide advice and consulting on a range of other services, such as state activities and media strategy.

We look forward to working with AAEM's leadership to both engage the membership and strengthen your relationships with Congress.

Susan Hirschmann will lead AAEM's Williams and Jensen team. Susan will work with AAEM to develop and implement congressional strategy and will provide advice on press and media outreach.

Karina Lynch will be an integral part of AAEM's outreach to federal agencies and the Senate. Karina has expertise on a wide range of health care issues, including Medicare and Medicaid policy and Oversight and Investigations.

Jenny DiJames works on a range of issues, including appropriations and health care policy. She works with key agencies such as CMS.

Christopher Hatcher leads the tax practice at Williams and Jensen. He will work with AAEM on issues pertaining to the SGR, other end of year extenders, and related tax items.

George Olsen has been involved in federal healthcare policy for over three decades. He has worked with key House and Senate members and committees on a broad range of healthcare issues.

Matthew Hoekstra leads Williams and Jensen research and will report on Congressional hearings for AAEM. He will also help coordinate communication between the Firm and AAEM.

Erin Book will communicate with key members of Congress and their staffs to gather intelligence on upcoming health care issues of concern to AAEM. She will also work with House leadership on AAEM priorities. ■

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 9-25-12 to 1-14-13.

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

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The Business of Emergency Medicine

From Care to Compensation, Part 2 — From Claim to Billing

James R. Blakeman
Senior Vice President, Emergency Groups' Office

In this three-part series we are looking into the "black box" of billing to see how a patient encounter turns into cash. In the first article we addressed the process from the point of care to the filing of a claim. In this installment we examine how a claim is handled — and can be mishandled — and processed into a payment.

This is a little like painting a picture with a broom — broad, sweeping strokes are in order. Billing and coding are complex, and the rules governing the process have a multitude of exceptions, given the obvious payer and clinical variability. This is a broad outline and some details will be roughed over.

Once the chart reconciliation, insurance verification, and coding processes described previously have been completed and data are in the billing system, insurance claims or patient statements are sent to the responsible parties by your billing company. The claim or statement will itemize the various CPT codes relating to the services provided, along with a fee associated with each code.

Pricing

The entire billing and payment process is controlled by three all-encompassing rules:

1. No one pays you what you charge, they pay you what you have negotiated.
2. Everyone wants to pay you much less than you have negotiated.
3. Everyone wants to take forever to pay you at all.

So, how much should you charge for your services? There are more than 500 occasionally reported CPT codes that each need an assigned price. The setting of professional fees has several determinants:

- Market value — what others are commonly charging and being paid in your geo-economic area.
- Intrinsic value — what you feel is fair for the associated work.
- Relative value — how the complexity of the service compares to other charged services.
- PR value — what will be acceptable to your patients and your hospital administrator.

There are national and regional sources to assist in setting fees, including Medicare's "Fee Schedule and Relative Value Units" and various commercially available fee sources. The free service www.FAIRHealthconsumer.org is a good place to start. Much can be said about rational fee setting, but most important is that fees must generate sufficient revenue to cover practice costs — including physician salaries — and be reasonable for the market.

Claim Filing and Payment Processing

Let's address insurance claims first. There are essentially five types of claim processing problems: (1) lost claims, (2) rejected claims, (3) denied claims, (4) delayed claims, and (5) underpaid claims.

In most billing operations, 70-90% of all insurance claims are now filed electronically, either through electronic clearinghouses or directly to the payer's claim administrator. Copies of your chart documentation almost never accompany claims in the first submission. It hinders flow, and even the few payers who still demand a copy of the chart before paying the claim will separate it and ignore it in the payment process. This doesn't decrease the importance of what you document. We'll talk in the next article about when your documentation makes all the difference in how payers treat your claim.

Lost Claims

Claims get lost occasionally in the electronic transfer process, when leaving the billing system or entering the payer's processing system. Tight controls must be in place to track the electronic submission of batches of claims, to know when they arrived in the payer's system, the total number of claims accepted, and the dollar amount of each claim batch.

It is common for electronic clearinghouse or payer systems to attempt to process a batch of claims, get part of the way to completion, and then fail to finish. Lost claims will obviously not get paid until someone notices that they are lost and fixes the problem.

Rejected Claims

Rejected claims occur when certain data on the claim are incorrect, such as a mismatch in the patient's personal information. Payers recognize their patients from their assigned beneficiary and group ID numbers. If the ID numbers don't match certain elements in the payer's profile, the claim will be rejected. The billing office must monitor and correct these when they occur — and they sometimes occur en masse.

Remember, your billing office is entirely dependent on your hospital registration team to capture all the necessary data elements and enter them correctly. Visit your registration staff from time to time, get to know them, and make certain they know you. Their work is often undervalued in the hospital but is critical to your success. Listen when they raise problems about the process and be ready to solve problems in their workflow. You want them appreciating you when they're trying to get more accurate information into the registration system.

One best practice is to always capture an image of the front and back of the patient's insurance card, showing the necessary patient ID information as well as where to call regarding coverage. Many hospitals capture these images electronically and can pass the images along to your billing office. Working unpaid accounts is much easier when a biller is reading information from the card rather than relying on data entered at the hospital.

Continued on next page

Denied Claims

Claim denials occur because of billing errors, as well as payer misbehavior when they edit claims for irrelevant reasons or make gross misjudgments about the service. These must be corrected and appealed.

Common denials are for lack of medical necessity, e.g., the diagnosis on the EKG or critical care code did not meet the payer's criteria, bundling one or more CPT codes into a single service (paying the visit code but denying the laceration repair as "bundled" into the visit), and "down-coding" (a higher level of service is reclassified by the payer to a lower level).

Delayed Claims

Each state has a Department of Insurance (DOI) that regulates the activity of the health plans doing business in the state, mostly to protect consumers from unscrupulous sales and contracting tactics. In most states that does not include intervening when payers refuse to pay claims reasonably or even according to the law.

You might get some help when you file disputes with the state Insurance Commissioner. However, unless your bad health plan is already under scrutiny you will get only limited help. Taking legal action to have state laws enforced can get your appealed claim paid, and your billing office must know the laws and be prepared to demand adherence when payers behave badly. It is effective and now common for physicians to sue health plans for illegal and unfair business practices.

Payment delays are sometimes for fair reasons, like determining whether a second insurance source might be responsible or to get the claim to the right plan office. Many states have timely payment laws, with fines and penalties for payment delays, and you can collect on these. A common delaying tactic is paying a portion of the initial claim to see if you'll settle for it, then making full payment only when you refuse and your appeal is processed.

Underpaid Claims

Everyone wants to pay you less than they fairly owe, but what is fair payment? Fairness is usually defined by the terms of the contract you have with the payer. Essential principles to follow when considering payer contracts will be addressed in the next and final article in this series.

Federal programs like Medicare and Medicaid have well defined payment terms, and these can easily be monitored for variances because the payments are predictable. Some states have laws governing fair payment for non-contracted claims.

Your business office should employ billing software that tracks payment errors. The volume of these for an average emergency department is too great to be effectively managed manually. Health plans have a variety of rules they employ to determine payment, and often you cannot know them before the payment arrives. The complexity of determining the appropriate payment rate is surprising, and requires a well-reasoned process for monitoring.

Patient Billing

Commonly, patient statements are not generated until after the insurance claim has been filed and a reasonable time has elapsed to allow payers to pay. Insured patients often will not get their first bill until 45-60 days after their claim was filed with the payer.

It is useful to time the presentation of the patient's bill to the time when you expect the patient to receive their notice of payment from their insurer. Nearly every hospital has a registration process in which patients sign a document acknowledging their financial responsibility and assigning their insurance payments to the provider. Be certain that the document presented by the hospital specifically and correctly names your group as the assignee for claim payment.

Non-contracted payers in most states will simply pay the patient and ignore the patient's request to send payment directly to your business office ("assignment of benefits"). Getting this money back from the patient is often next to impossible. Thus, sending payment to the patient is a payer tactic to force you to contract with them, so that payments will then come directly to you. Be certain your billing office is aware of your state's assignment laws.

The statement should itemize the services billed with the associated fees, the dates involved, and all insurance payments and contractual adjustments so that patients are clear about what they are required to pay. Most health plans, including governmental plans, have a copayment and deductible that is the patient's responsibility.

Health plans have begun to increase these copays to push more of the cost of care onto the patient. Legislation in some states controls this but does not eliminate it. The Accountable Care Act has provisions that control how much of the cost a payer can force onto a patient, particularly in an emergency care situation.

There are two approaches to balance billing patients who have services unpaid by the health plan. One assumes that after 45-60 days, anything not paid by the insurer is the patient's immediate responsibility and the full amount is due. The other says that patients will be more responsive to bills after reasonable attempts to get the health plan to pay are exhausted.

While it is not your fault that the patient has a poor payer, patients are less inclined to pay bills when they have no idea how to get their health plan to pay its fair share. Patients are not billing experts and are most unhappy when you don't help them seek relief from their insurer. When you intervene with payers, it generally results in higher overall collections and reduced collection agency costs.

Patient Phone Calls

Patient statements generate telephone calls to the business office asking about the status of the account, the reason insurance did not pay, or to offer corrected insurance information — among other reasons. It is vital that these calls are handled quickly and professionally. From the patient's perspective, the ED encounter is not over until the bill is resolved. If your business office makes that difficult, it reflects poorly on your practice.

Continued on next page

Hospital CEOs are commonly measured on patient satisfaction scores. Poorly handled billing inquiries that result in calls to administration will give the CEO the impression that your group is not an active partner of the hospital.

Unhappy patients can become litigious patients. You must be informed by the billing office whenever a patient threatens to sue you. Many complaints about care are really about the size of the bill. Work with the business office to identify problem patients, both to avoid complaints to administration and turning patients into plaintiffs.

In the next and final article we will address issues related to banking and payment processing, provider enrollment and principles of payer contracting for emergency physician services, handling refunds, defending yourself in a payer audit, and dealing with collection agencies. ■

Certificate of Excellence in Emergency Department Workplace Fairness

The American Academy of Emergency Medicine strongly supports fair working practices for emergency physicians. Consequently, it will certify excellence in the ED workplace if ED physician employees are guaranteed the following five workplace conditions: due process, financial transparency, financial equity, political equity, and no post-contractual restrictions.

Applicants pending receipt of the Certificate of Workplace Fairness include the following:

Fredericksburg Emergency Medical Alliance, Inc.
Fredericksburg, VA

Emergency physicians are encouraged to contact AAEM (anonymously if desired) at http://www.aaem.org/forms/certificate-of-fairness-report.php to report a listed group that they believe is not in compliance, along with an explanation. Members interested in receiving the Certificate of Workplace Fairness for their group may apply online at www.aaem.org/benefits/certificate-of-workplace-fairness.

Law and Emergency Medicine

Trade Secrets and Emergency Medicine Employment Contracts

Howard Blumstein, MD FAAEM
AAEM Board Immediate Past President

Restrictive covenants have no place in emergency medicine. They restrict patient options in choosing a physician and are thus harmful to the public at large. These noncompete clauses may have a role in other types of business, but in emergency medicine they are used to coerce physicians into conforming with rules imposed by their employers, under threat of termination and being forced to move away from their established homes. AAEM, the AMA, and many other medical organizations have condemned restrictive covenants (see the AAEM White Paper on Restrictive Covenants http://www.aaem.org/em-resources/position-statements/2007/restrictive-covenants). They have been struck down by various courts as being contrary to the public interest and many states have laws prohibiting them. Interestingly, restrictive covenants are considered unethical by the legal profession. An attorney who offers a contract containing a restrictive covenant to another attorney can be disbarred.

I often review employment contracts for residents in my department. It is my sense that employment contracts these days are less likely to contain restrictive covenants than in the past. That would seem to be a good thing, but in the last several years I have noticed the rise of a new type of noncompete clause — the trade secrets clause.

Trade secret clauses go something like this:

- The physician agrees that by working for a given employer, she has access to trade secrets developed by that employer.
- If the physician leaves the first employer and goes to work for a second emergency department or group, she would inevitably bring those trade secrets to her new employer.
- The physician agrees that sharing these trade secrets with other employers would cause irrevocable harm to the first employer.
- The physician, therefore, cannot work for any competitor for some stated period of time within some stated geographic area.

This is essentially a restrictive covenant, but because it is based on the protection of trade secrets developed by the employer, it seems more enforceable. For the same reason, it might circumvent some of the ethical objections to restrictive covenants for physicians.

A trade secrets clause can also be used to circumvent the legal restrictions on restrictive covenants. Consider the state of Colorado; by statute, noncompete clauses are void and unenforceable there. There are some exceptions to this, however, and one of these involves the protection of trade secrets.

There are definitions of what constitutes a trade secret. In general, the owners of a trade secret must have expended considerable effort to develop the secret, they must be taking measures to protect the secret, the secret must be information that is not publicly available, and the loss of the secret must be harmful to its owner. For the life of me, I cannot imagine what information would constitute a trade secret in the world of emergency medicine. If anybody can think of a secret that meets this definition, please contact me. I would love to hear it.

A physician working for an unscrupulous employer under a contract that includes a trade secret clause would encounter considerable difficulties if the employer tried to enforce that clause. Lawyers are expensive, lawsuits are long and drawn out, and there is no guarantee that the courts will understand the very public nature of the business of medicine.

Young physicians are increasingly aware of the disreputable nature of restrictive covenants. Several have told me that they were on the lookout for such clauses. They show me their contracts with considerable pride in the fact that they were able to avoid restrictive covenants. But, hidden within the body of the contract is a discussion of trade secrets and the restrictions described above. The proverbial "wolf in sheep's clothing" lurks in the fine print.

For those of us who spend time with young physicians and those of us interested in educating our peers about employment practices, it is time for a discussion of trade secrets clauses. They should be added to the list of underhanded legal shenanigans that already includes noncompete and hold-harmless clauses. ■

AHA Urges Delay in IRS Rule Prodding Nonprofit Hospitals to Deliver More Charity Care

John Reichard
Editor, *CQ HealthBeat*

The story below was reprinted with permission from The Congressional Quarterly. It describes just one way AAEM defends emergency physicians, who already bear a back-breaking charity burden. According to "The Impact of EMTALA on Physician Practices," published in 2003 by Carol Kane at the AMA's Center for Health Policy Research, in 2001 emergency physicians donated almost $140,000/ year per physician in uncompensated care — more than ten times the all-specialty average. That number is undoubtedly even higher now. The last thing we need — or deserve, given what we already do for this country — is a legally mandated eight month delay before we are allowed to start collection efforts on unpaid bills.

— The Editor

Hospitals are urging federal officials to put off until 2014 a new rule requiring them to better notify patients about what free or discounted care they offer, according to comments filed with the IRS.

Hospitals are still waiting for federal guidance on the expansion of Medicaid and the creation of insurance exchanges under the health care law, the American Hospital Association (AHA) said in a lengthy comment letter requesting the delay.

Without such guidance, facilities could be announcing financial assistance policies that comply with the new rule just as new information is becoming available about coverage expansion and exchanges that might require them to change those policies, the AHA said in the Sept. 24 letter.

At issue is a requirement under the health care law that nonprofit hospitals do more to show what they do to justify their tax-exempt status. Sen. Charles E. Grassley, R-Iowa, has long complained that hospitals should be providing more free or low-cost care to the poor to justify that status. While Congress has refused to impose a minimum requirement for charity care, it put pressure on hospitals through the health care overhaul (PL 111-148; PL 111-152) to deliver more services to the poor.

Specifically, the law calls for IRS rulemaking to require a written financial assistance policy, or FAP. The policy must state eligibility requirements for financial assistance but lets individual hospitals decide who is eligible. The policy must say whether assistance means free or discounted care. It must explain how the policy will be widely publicized.

In addition, the law says those eligible for financial assistance can't be charged more than insured customers. And hospitals must make "reasonable efforts" to find out if a patient is eligible for financial assistance before taking "extraordinary collection actions."

The comment period for proposed IRS regulations implementing the provisions closed Sept. 24, prompting scores of comments.

Hospitals complained that the proposed version would bog them down in inefficient practices and could be overly punitive. Meanwhile, consumer advocates emphasized the importance of IRS rulemaking to ease access to hospital treatment.

For example, the National Immigration Law Center noted that despite sharply reducing the uninsured population, the health care law will leave millions of people without coverage and unable to afford costly hospital care. They would be in a position to benefit from greater clarity about what free or discounted care is available, the center said.

"While approximately 30 million citizens and lawfully present immigrants will gain health coverage as a result of the [Affordable Care Act's] historic coverage expansions, 30 million U.S. residents are expected to remain uninsured," the center said.

About one-quarter of those 30 million will be ineligible for coverage because they are not legal immigrants and therefore cannot get federal subsidies in the exchanges, federal non-emergency Medicaid, or coverage under the Children's Health Insurance Program, the group said. Others will be eligible for Medicaid but not enrolled, it added. And "the remaining will be ineligible for subsidies but still unable to afford coverage, exempt from the requirement to buy insurance, or choose to pay the penalty rather than purchase coverage."

AHA said there would be too many administrative headaches involved in implementing the proposed version of the requirements, which pertain to implementing sections 501(r)(4)-(6) of the IRS code.

For example, hospitals would have to assume every patient is eligible for financial assistance until proven otherwise through an FAP application and "reasonable efforts" process. "That is an unnecessarily time-consuming and costly requirement," AHA said.

The proposal for requiring a reasonable effort to determine if a patient is eligible for financial assistance would create "a labyrinth of steps and timelines that must be navigated over a period of eight months."

The American Academy of Emergency Medicine had a similar beef. It said that, in effect, hospitals would have to wait eight months before taking collection action. "The proposed 120-day period for an individual to submit an application for financial assistance, and the additional 120 days to complete an application — a total of 240 days — is unprecedented in any other industry. We recommend a 30-day period for individuals to complete and submit an application for financial assistance."

Catholic facilities joined the AHA in expressing concern about how violations of the requirements would be enforced. The IRS should issue guidance on how it plans to enforce the requirements, they said.

"Will there be an opportunity for remediation for some or all violations?" the Catholic Health Association asked in its comment.

Continued on next page

In that regard, the AHA said the IRS should establish "intermediate sanctions." Doing so would recognize that "infractions that are cured should not result in the loss of tax exemption, and that any penalty should be calibrated to the significance of the violation."

Hospitals also wondered about what powers they would have to collect co-payments, and about the method of calculating what they charge insured patients for purposes of making sure they don't charge more to the uninsured. They said, for example, that Medicare payment rates shouldn't be included in figuring rates charged to the insured because those rates are too low.

But the National Health Law Program (NHLP), a public interest law firm that assists the poor, said the deadline for filing for financial assistance should be longer than the proposed 240 days. The group said it should be at least 365 days after the facility provides the patient with the first billing statement, or 365 days after discharge, whichever is later. "Many patients may not realize that money is owed until after 240 days, particularly if they are insured and believed that outstanding charges will be covered by their insurer," NHLP said. Financial assistance may be available to low-income patients who are underinsured, as well as those who are uninsured.

The organization also said the requirement that FAPs be widely publicized must ensure that people with limited knowledge of English know and understand the hospital's policies.

Families USA praised the proposal, saying "we know from our own local experience, as well as from our interactions with advocates around the country, that previously it was difficult to get accurate information about charitable hospital's financial assistance policies."

It also said that the rule "should emphasize that it is not sufficient to provide only emergency care in a FAP" and that "the requirement to provide medically necessary care is in addition to that."

Families USA also said "we heartily applaud" provisions to widely publicized the FAP. "It has been very hard for consumers and consumer helpers to get accurate information about hospital financial assistance policies in the past, and the requirements to post the policies and applications on the Internet and throughout the hospital will be a great help."

Hospitals have called on the IRS to allow a "paperless" approach that would let them simply post their policies on the Internet unless a patient lacked Internet access. ■

Upcoming Conferences: AAEM Sponsored and Recommended

AAEM is featuring the following upcoming endorsed, sponsored and recommended conferences and activities for your consideration.

For a complete listing of upcoming endorsed conferences and other meetings, please log onto http://www.aaem.org/education/aaem-recommended-conferences-and-activities

February 9-13, 2013
- 19th Annual Scientific Assembly
  The Cosmopolitan of Las Vegas
  Las Vegas, NV
  http://www.aaem.org/education/scientific-assembly

February 9, 2013

PRECONFERENCE COURSES
- Pediatric Emergencies: Children Are Not Little Adults!
- Advanced Ultrasound
- Introductory Ultrasound

February 9-10, 2013

PRECONFERENCE COURSES
- Emergency Department Operations Management: Cracking the Code!
- Resuscitation for Emergency Physicians

February 10, 2013

PRECONFERENCE COURSES
- Introduction to Wilderness and Operational Medicine
- Pediatric Emergency Department Simulation: Critical Skills from Birth to the School Bus!
- Medical Student Track

  The Cosmopolitan of Las Vegas
  Las Vegas, NV
  http://www.aaem.org/education/scientific-assembly

April 10-11, 2013
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas, NV
  http://www.aaem.org/education/oral-board-review-course

April 20-21, 2013
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, IL
  Dallas, TX
  Los Angeles, CA
  Orlando, FL
  Philadelphia, PA
  http://www.aaem.org/education/oral-board-review-course

AAEM-Recommended Conferences

January 15-17, 2013
- ICEM 2013
  Muscat, Oman
  www.icemmuscat.org

March 8-10, 2013
- The Difficult Airway Course: Emergency™
  Orlando, FL
  www.theairwaysite.com

April 5-7, 2013
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

April 24-28, 2013
- 51st Annual Weil & UC San Diego Symposium on Critical Care & Emergency Medicine
  Las Vegas, NV
  http://cme.ucsd.edu/weil

April 26-28, 2013
- The Difficult Airway Course: Emergency™
  Boston, MA
  www.theairwaysite.com

June 7-9, 2013
- The Difficult Airway Course: Emergency™
  New Orleans, LA
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September 27-29, 2013
- The Difficult Airway Course: Emergency™
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November 22-24, 2013
- The Difficult Airway Course: Emergency™
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Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Marcia Blackman to learn more about the AAEM endorsement approval process: mblackman@aaem.org.

All sponsored and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

ABEM to Grant Certification in Emergency Medical Services

The American Board of Emergency Medicine (ABEM) has been approved to grant certification in the subspecialty of Emergency Medical Services (EMS). Certification in EMS is open to any physician who is certified by an American Board of Medical Specialties (ABMS) Member Board and fulfills the ABEM Policy on Medical Licensure and the EMS Eligibility Criteria. Both of these documents and the Core Content of EMS Medicine are available on the ABEM website.

The application period for the first EMS certification examination opened October 1, 2012, and will continue through June 30, 2013. The first EMS subspecialty certification examination will be administered October 23-25, 2013, at Pearson VUE professional testing centers.

ABEM is also preparing for the EMS Maintenance of Certification (MOC) program. Each physician who attains certification in EMS in 2013 will begin participating in EMS MOC in 2014. One component of MOC is Lifelong Learning and Self Assessment (LLSA). LLSA addresses issues of relevance to current practice.

The LLSA tests are multiple-choice, open-book tests based on a number of relevant readings. ABEM encourages EMS organizations and individual physicians to submit suggestions for readings. The form for submitting articles and additional information are available on the ABEM website (there are also links from the home page). ABEM has also developed FAQs on EMS certification and EMS MOC. Additional information can be found on the Emergency Medical Services section of the ABEM website.

If you still have questions after checking these sources, please call ABEM at 517-332-4800 ext. 387, or email subspecialties@abem.org.

The American Board of Emergency Medicine (ABEM) certifies emergency physicians who meet its educational, professional standing, and examination standards. Its mission is to protect the public by promoting and sustaining the integrity, quality, and standards of training in and practice of emergency medicine. There are currently nearly 29,000 ABEM-certified emergency physicians. ABEM is not a membership organization, but a non-profit, independent evaluation organization. ABEM is one of 24 medical specialty certification boards recognized by the American Board of Medical Specialties. ■

Public Service Announcement: Nail Gun Safety

Raymond Roberge, MD MPH DABEM DABPM
National Institute for Occupational Safety and Health
Pittsburgh, PA

Raymond Roberge, who once served on the board of directors of AAEM and is currently with the National Institute for Occupational Safety and Health, reports that NIOSH has developed an informational brochure regarding nail gun injuries. Since emergency physicians are those who most frequently treat these injuries, he has requested that we publish the announcement below.

— The Editor

Nail guns are used daily by construction workers and other consumers. They boost productivity — but also cause painful injuries and an estimated 37,000 emergency department visits each year. Health care workers evaluate and treat these injured construction workers and consumers when they seek medical attention at emergency departments (hospital-based and free standing) and clinics. In addition to providing emergency care, emergency physicians and nurses are a source of preventive medicine information to their patients.

The National Institute for Occupational Safety and Health (NIOSH) and the Occupational Safety and Health Administration (OSHA) are pleased to announce the availability of both English and Spanish-language educational materials on nail gun safety: "Nail Gun Safety: A Guide for Construction Contractors" and "Seguridad con las pistolas de clavos: Guía para los contratistas del sector de la construcción." They are available on the NIOSH and OSHA websites at: http://www.osha.gov/Publications/NailgunFinal_508_02_optimized.pdf and http://www.osha.gov/Publications/NailGun3505_sp.pdf. Hard copies are available by calling either the OSHA publications office at 1-800-321-OSHA or www.osha.gov; or NIOSH at 1-800-CDC-INFO or http://www.cdc.gov/niosh/pubs/default.html.

Emergency department health care personnel can assist in preventive medicine endeavors to reduce the incidence of these painful and oftentimes debilitating injuries by directing treated nail gun injured patients to these educational websites, or downloading and printing a copy, as a supplementary and complimentary addendum to standard discharge instructions. ■

IFEM Members Meet in Denver

AAEM president William T. Durkin, Jr. MD MBA FAAEM (top row, sixth from left), AAEM member Terrance Mulligan, DO MPH FAAEM (top row, fifth from left), and AAEM board member Robert Suter, DO MHA FAAEM (top row, second from right) attended the International Federation for Emergency Medicine's event at the ACEP Scientific Assembly in Denver, CO, in October. © The Photo Group 2012, All rights reserved.

AAEM and AAEM/RSA Receive MarCom Awards for Website and Publications

AAEM has been recognized by the MarCom Awards for the creative design of the AAEM website and the bi-monthly newsletter, *Common Sense*. In addition, AAEM/RSA received recognition for their recruitment brochure. The MarCom awards are an international creative competition that recognizes outstanding achievement in marketing and communication.

The awards are administered and judged by the Association of Marketing and Communication Professionals. This international organization consists of several thousand creative professionals and oversees awards and recognition programs, provides judges, and sets standards for excellence.

Based upon the evaluation of the judges:

- The AAEM website achieved Gold Winner status in the "Association Website" category.
- The Resident and Student Association (AAEM/RSA) received Gold Award status for their "With You All the Way" recruitment guide in the "Brochure/Recruitment" category.
- Additionally, *Common Sense*, achieved an Honorable Mention in the "Print Newsletter Design" category.

The judges are industry professionals who look for companies and individuals whose talents exceed a high standard of excellence whose work serves as a benchmark for the industry. AAEM and AAEM/RSA joined nearly 6,000 entrants from throughout the United States, Canada, and several other countries in the MarCom Awards 2012 competition.

The Gold Award is presented to those entries judged to exceed the high standards of the industry norm. The AAEM website and the AAEM/RSA brochure were among approximately 18 percent of entrants that were Gold Winners.

Honorable Mention certificates are granted to those entries that meet the expectations of the judges. *Common Sense* was among approximately 10 percent of entrants that were Honorable Mention winners. Both the website and *Common Sense* have recently undergone design changes. A brand-new website design was launched in May 2012, and *Common Sense* debuted a new layout in the July/August 2012 issue. ■

3rd Annual National Update on Behavioral Emergencies

Leslie Zun, MD MBA FAAEM
AAEM Board Member

The 3rd Annual National Update on Behavioral Emergencies was held December 5-7, 2012, in Las Vegas, at the Flamingo Resort. Experts from the US, Canada, and France presented a broad array of topics germane to care of the patient with a behavioral emergency. The speakers also included representatives from the Centers for Medicare and Medicaid Services, the National Alliance on Mental Illness, and the Emergency Nurses Association. Topics included process improvement, when to send the suicidal patient home, ketamine use, international emergency psychiatry, difficult patient presentations, and dealing with psychiatric boarders. Two pre-conference seminars were held, one on the basics of behavioral emergencies and the other on process improvement. The process improvement seminar was sponsored by the Institute for Behavioral Healthcare Improvement. The behavioral emergency basics seminar included topics on psychosis, dementia and delirium, agitation, and substance use. The board of directors of the American Association for Emergency Psychiatry conducted a business meeting during the conference. The Suicide Prevention Resource Center also conducted a meeting during the conference, to spearhead their initiative on suicide prevention in the emergency department. The conference was attended by over 100 people representing emergency physicians, psychiatrists, nurses, social workers, psychologists, and other health care providers. **Please join us next year** for the 4th Annual National Update on Behavioral Emergencies in Orlando, December 11-13, 2013. For further information go to www.behavioralemergencies.com or contact Dr. Les Zun at zunl@sinai.org. ■

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So You Want Me to Give a Lecture?

Jennifer Kanapicki, MD FAAEM
Vice President, Young Physicians Section

Very often in our careers we are asked to lecture. It might be a CPR class to the EMS group, a chest pain talk to medical students, or Grand Rounds to your entire department. Regardless of the topic, lecturing can bring anxiety and be an additional burden to your already heavy workload. Nonetheless, you still want to deliver more than just a good lecture. You want to rock it! You want to impart knowledge to your learners to stimulate and motivate them.

Lecturing others is an important aspect of our careers, allowing us to inspire our colleagues and future colleagues in emergency medicine. It is an art to be mastered. The goal of this article is to give you the tools to enhance your lecture skills. I'm going to keep it simple: four easy P's.

1. Prepare

As coach John Wooden said, "failure to prepare is preparing to fail." Many lecturers fail because they never developed a game plan. Develop an outline for your talk. What do you hope to accomplish? What are your objectives? By knowing where you want to end up, you can plan how to get there.

A good maxim for preparing a talk is to tell the learner what you are going to tell them, tell them, and then tell them what you just told them. I hate to be the bearer of bad news, but most learners will only remember three things about your talk. So it is essential that you start your talk with an outline, deliver the body of your talk, and end with a summary slide of take home points. Tell them what three points you want them to remember when they walk out of your lecture.

2. Perfect Your Slides

You have 20 seconds — most learners will only give undivided attention to the first 20 seconds of a lecture. Secure their attention by telling a story or asking a question. Tell your learners why your topic is important to them and why they need to know it.

Let's talk about slides — many lecturers try to fit too much information into one slide. Use the "rule of 6's" for slides: no more than six words per line; no more than six lines per slide. Following this rule ensures that your audience isn't overwhelmed tying to read rambling slides, but is instead focused on you. Your slides should be a guide, so aim to use bullet points, rather than paragraphs.

Also, don't overdo your slide design. If you use different color sets, make sure that people can read the slides from the back of the room. Use only 28-point font and above. DO NOT USE ALL UPPERCASE LETTERS — see how annoying that is? Edit your slides. It is very distracting to listen to a lecture while seeing glaring typos on screen; it detracts from the lecture and makes the presenter look careless. Don't be afraid to spice it up — consider including videos and interactive tools in your presentation or try polling your audience during the talk. Keep your learners engaged and active.

3. Practice

We've all seen renowned speakers deliver seemingly effortless, captivating talks. It makes you wonder — how do they do it? The secret is simple: practice. The best speakers practice many, many times, until it feels natural. You should do the same. Use that expensive smartphone to time and video your talk; this will help you identify distracting behaviors you would not otherwise have been aware of. Make sure you are not too short or too long on time. Try to avoid nervous habits such as: "um's," swaying, apologizing frequently, reading your slides, leaning on the podium — basically anything that distracts the learner from your message.

Go the day before to familiarize yourself with the location and AV equipment, and practice on site if you can. Make sure you look better than your audience. As for the lecture, make sure you have multiple copies of the lecture for back up. Cloud drives such as Dropbox allow you to access your lecture anywhere via the Internet, but also bring your talk on a flash drive just in case. As a final backup, bring a paper copy of your slides for the off chance that all electronics fail and you need to go "old school." Act like you are in the ED, and plan for any emergency possible.

4. Post-Lecture Assessment

Learn from the experience of giving a lecture — you don't want to repeat the same mistakes. Immediately after your presentation, write down what worked in your talk and what did not. Was there a section that lost the audience? Do you want to make any slide changes? Things are always easier to remember when they are fresh in your mind.

These four steps should enhance your lecturing skills and benefit your future learners. Remember, it's an honor to be asked to lecture. So, the next time you are asked, "Do you want to give a lecture?" — jump at the chance! ■

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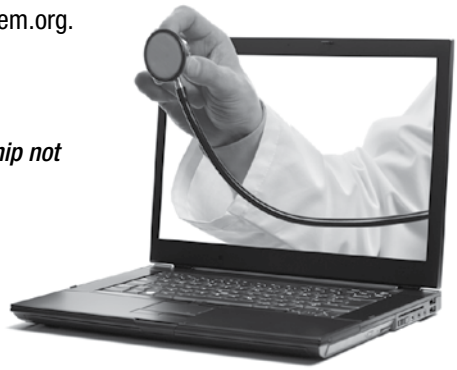

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AAEM/RSA President's Message

"Too good to be true? It just might be." — Notes and Pitfalls from the Job Trail

Leana S. Wen, MD MSc
AAEM/RSA President

'Tis the season to find a job. At least it is for me and my senior resident colleagues across the country.

The first thing we learn is that this job search process is unlike any other we've gone through before. It's certainly different from the rest of our medical training. Getting into medical school was no walk in the park, but it was a structured process, often with ample guidance from professors. The Match may have its own share of problems, but the process was uniform. Now, looking for an attending job, there are so many options and so many uncertainties. Whether it's community or academia, there is no clear path to getting that ideal job.

I'm writing this article about pitfalls on the job trail, and though the content is new to me, it contains critical information that is as important for you as it is for me. To make sure that I have the information correct, this article has been reviewed by leaders in our field, Dr. William Durkin and Dr. Andy Walker, who have many years of experience and have advised dozens of EPs.

First things first. Does this article even need to be written — are there really so many pitfalls in finding an EP job? Aren't we sought-after, and isn't that why recruiters are calling us every day? The answer is a resounding 'yes' and the incessant phone calls from recruiters are actually a clue that there are plenty of landmines around. More than other specialists, EPs are at risk of being taken advantage of. Most EPs rely on someone else to employ them. There are several corporate groups — also called contract management groups (CMGs) — that dominate the marketplace. CMGs like EmCare and TeamHealth have some 300+ contracts with hospitals to staff their EDs. This means when you work for a hospital that contracts with a CMG, you are an employee of, or an independent contractor, with the CMG and paid by the CMG.

So what's the problem with CMGs? I have to confess that prior to getting involved with AAEM, I had no idea about this — the corporatization of medicine is not exactly taught in the medical school curriculum. But there are a few issues that every EP should be aware of.

First, the very goals of CMGs are contrary to the interests of EPs. CMGs aim to increase profit by acquiring more contracts and minimizing physician pay. This often leads to physicians being torn between corporate goals and patient advocacy. At the end of the day, you work for a group that is not looking out for you or your patients, or sometimes even your hospital, but for itself. AAEM has been involved in many legal battles, defending the "little guy" — the individual EP who gets fired by a CMG — not because he or she did something wrong, but because profit and contract acquisition and maintenance were put before optimal emergency medical care.

Which leads me to the second issue to watch out for: CMGs often put restrictive covenants and other toxic clauses in their employment contracts. Again, I had no idea that contracts could vary so much, but they do. Some contain a noncompete clause that prevents you from working for another emergency group within a certain number of miles for a certain number of years. Says Dr. Mark Reiter, AAEM's Vice-President, "This is a problem because if you quit, are terminated, or the group loses its contract to another group, you may be forced to not just find another job, but also move, sell your house, and send your kids to a new school." Others include clauses that allow for termination without cause, or that deprive you of due process. These are practices that aren't accepted in other medical specialties or in other professions, such as law.

Third, many CMGs are involved in fee-splitting — meaning they make money off of your hard work by essentially charging you a fee for the privilege of having a job. Calculations based on publicly reported business data show that their profit margin is roughly equivalent to one shift a week. In other words, one shift a week of your time goes to making money solely for the CMG rather than yourself.

Finally, many CMGs do not allow open books. You should know what is being billed and collected for your professional services. This is not only fair, but it also has legal implications because federal agencies hold EPs responsible for their billings and collections, whether they are aware of them or not.

Taking a step back, I don't mean to imply that all corporate groups are inherently bad, and sometimes you may have to work for a CMG. A third of all EPs work for one and in a lot of regions a CMG may be the only option. You should also be aware that other employment models, like being employed directly by a hospital, university, or individual contract-holder, can be similarly abusive and exploitative. Moreover, there are CMGs that adhere to fair and equitable business practices, like due process and open books, and that allow for partnership.

So what should we do? Know that not all practice opportunities are created equal. Be on the lookout for those that adhere to the principles of fairness, which will give you the best shot at a long and happy career in emergency medicine. AAEM issues a Certificate of Workplace Fairness. You should ask potential employers if they have this, and then verify that at www.aaem.org. If not, consider why this is so.

Also, ask about what "democratic" really means. A lot of groups like to portray themselves this way (an "undemocratic" group doesn't have the same ring to it), but confirm what this really means in terms of financial consequences, decision-making, and a pathway to partnership. Says Dr. Reiter, "You should ask questions about who has not become a partner in the past several years and why, as some so-called democratic

Continued on next page

groups have essentially unobtainable partnership tracks." Dr. Durkin, AAEM's President, adds, "A democratic group should expect you to be active in hospital governance — serve on committees, for example. Beware the group that discourages you from doing so. That will make it easier for them to get rid of you!"

Make sure you speak with several EPs in the group during the interview process. Not allowing you to speak with multiple physicians is a red flag. You should find out how many EPs have left the group in the last few years. If possible, speak with those who left. Find out if there are unrealistic expectations for your job: very high patient-per-hour ratios, an overly demanding schedule, poor nursing and ancillary staff backup, etc. These will lead to unsafe clinical practices, legal exposure, and unhappiness down the line.

Get help with your contract. Watch out for restrictive covenants and clauses that limit your autonomy. Don't sign something that wouldn't be acceptable in any other field. You are a highly sought-after professional, so why compromise yourself? Get trusted mentors to review your contract, and then make sure you have an attorney look at it before signing. Strike out any restrictive covenants and other unacceptable clauses and insist on a fair contract.

If something sounds too good to be true, watch out. In recent years, CMGs have been offering large signing bonuses, including bonuses that begin paying residents as early as their junior year, if they sign the contract and commit to the job at that time. While it is appealing to be paid as a resident for a job you don't yet have to work at, be careful of what this entails. There's no such thing as a free lunch, and many of these contracts are for undesirable areas, with highly restrictive clauses, and with a period of indentured servitude that does not have a clear exit option. In the words of Dr. David Lawhorn, an AAEM board member from Tennessee, "accepting an offer like this is like signing up for a credit card with a 25% interest rate." It may be what you do in the end, but know what strings are attached and go in with your eyes wide open.

Graduating resident Dr. Ali Farzad, from the University of Maryland, agrees, "I have offers to go to dinners and events where they try to schmooze you all the time. Everything comes down to a bottom line, and one thing residents should understand is that all this money they are spending to impress and recruit is not coming out of their pockets ... but ultimately out of attending salaries." Consider the money spent on recruiting you to CMGs. Think about all the dinners and receptions you are invited to that are paid for by CMGs, often with the blessing of other emergency medical societies. Just like drug companies wouldn't schmooze doctors if they didn't think it would increase their sales, CMGs wouldn't spend money on you if they didn't think they would get the money back later — from your hard work.

One last takeaway: remember that AAEM can help. AAEM was founded in part to fight the corporatization of our profession, and every day its leaders advocate for the individual EP. The Academy is not funded by CMGs or other corporations that make money from your labor, and it has no ulterior motive in assisting you — its goal is to look out for our specialty and its practitioners. AAEM is also not AGAINST you going to work for a CMG, if you have made a thoughtful and informed decision that it is the best job for you. As another AAEM leader, Dr. Joel Schofer, says, "My opinion is that people should be able to do whatever they want. We just need to educate residents about the pluses and minuses of CMGs so that they can make informed decisions." Dr. Durkin cautions, too, that those who find there is no better choice than a CMG in their area should always have a second part-time or per diem job. "That way, should you be taken 'off the schedule' with the CMG, you will have a fall back and some income while you look for something else."

So, for those of you in the midst of your job search — get all the information you can — and good luck! AAEM and AAEM/RSA will be right there with you. May we avoid the landmines and pitfalls along the way and find the perfect job that we have worked so hard for!

I would love to hear your comments on my columns! Please email me, wen.leana@gmail.com and follow me on Twitter, @DrLeanaWen, and my blog, http://whendoctorsdontlisten.blogspot.com. ■

RSA Resident Editor's Letter

Spotlight on Leaders in Emergency Medicine: Antoine Kazzi, MD FAAEM

Ali Farzad, MD
AAEM/RSA Publications Committee Chair
Linda J. Kesselring, MS ELS, Copyeditor

Antoine Kazzi, MD FAAEM

Many of our readers may be familiar with Dr. Antoine Kazzi, recognizing him as a past president of AAEM and a dynamic leader who has spent many years representing our specialty in a variety of capacities. Born and raised in Lebanon, Dr. Kazzi was trained and board certified in emergency medicine in the United States. He has received numerous awards and recognitions for his leadership and scholarly pursuits. As an advocate for our specialty, he has focused on policy creation, reimbursement and practice issues, and international emergency medicine. Dr. Kazzi has been recognized by our Academy with a number of national awards, including the David K. Wagner and the International EM Leadership Awards for his contributions to the specialty of emergency medicine.

Dr. Kazzi has shown dedication to serving his community no matter where he resides. He remains active in the United States through AAEM and has spent the past several years leading efforts to advance emergency medicine in Lebanon. His efforts began in the 1990s, culminating in the establishment of an ACGME-compliant emergency medicine residency program at the busiest emergency department (ED) in Beirut. He led the development of the first academic department of emergency medicine in Lebanon — at the American University of Beirut — which welcomed its first class of emergency medicine residents in July 2012! He proudly explains, "All the full-time attendings in my department are AAEM members and the faculty complies fully with the AAEM practice principles of fairness and transparency."

In a recent interview with Dr. Kazzi, we discussed what caused him to return to Lebanon and the initiatives he has undertaken there. He described the challenges of establishing an ED and residency program in Beirut and shared his plans and visions for the future of emergency medicine in Lebanon.

AF: Tell me about your background and training.
Dr. Kazzi: I am from Damour, a Christian town about 10 miles south of Beirut, which bridges zones that are traditionally multi-sectarian. Being a strategic crossing point on the road to Beirut, Damour has been victim to many wars. In 1976, Damour suffered a massacre as part of a series of events during the Lebanese Civil War, in the context of the Christian-Muslim divide. After a two-week siege with heavy bombardment, Palestine Liberation Organization units commanded by the Assad Syrian regime broke through our defense lines. They killed every one they found. We were the only family that survived the slaughter of a whole neighborhood. This went on for four additional days. Four-thousand homes were burned and bulldozed. Survivors became internally displaced in Lebanon for more than 20 years.

As a teenager, I spent four years in the militia, defending East Beirut against the Syrian Army. By the time I turned 18, common sense got me out of the trenches to pursue college education. I chose to complete my studies in the university where I practice now, which was located in the area dominated by the militias of other sects. I led a student movement that was initially underground and then turned public in 1982, becoming the largest and most active student movement on campus between 1982 and 1984. Eventually, however, the campus fell back under the control of the Assad Syrian regime and its proxies, and I was forced to leave because of safety concerns.

In September 1984, I found myself on a plane for the first time in my life, heading to the United States. I ended up spending 22 years in America. I graduated from the UCLA School of Medicine in 1988 and completed emergency medicine residency training at Henry Ford Hospital in Detroit, where I served as chief resident and faculty for a year. I subsequently moved to California to work at UC Irvine for 13 years. Late in 2005, I moved back to Lebanon to establish and chair the first department of emergency medicine in Lebanon, at the American University of Beirut.

AF: You've been a leader in AAEM in a variety of capacities. How did you first get involved with our organization?
Dr. Kazzi: Soon after I moved to the United States, I grew a liking to emergency medicine. Since I enjoy community and had no family around, emergency medicine rapidly became my family and community. I felt and cared about the struggles, needs, and aspirations of my colleagues. Naturally I did what I could to help. I was inspired by leaders in our specialty such as Drs. Robert McNamara, Peter Rosen, Joe Wood, Ramon Johnson, Scott Plantz, Mark Langdorf, Edward Panacek, Steve Hayden, Andy Jagoda, and James Keaney.

AF: How did you reach your decision to return to Lebanon after establishing a successful academic career in the United States?
Dr. Kazzi: My decision to return to Lebanon was not hard. I simply could not let go of my deep-rooted memories and feelings. A fire was burning throughout my days and often in my sleep, calling me to do something about what was plaguing the community and land where I was brought up.

The world must initiate active and effective dialogue between its civilizations. What we have been witnessing since the turn of the millennium is very worrisome. Unless religions, national governments, and world leaders start engaging in a sincere dialogue, we are heading toward global wars and terrible calamities. Civil and inter-sectarian strife will only escalate and turn more and more destructive.

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Of course, I loved the life I had in the United States, and I shall always remain proud and appreciative of all the opportunities it provided me. It granted me a blessed career and pride in my American citizenship. It granted me 22 years of daily opportunity to live and cherish the principles of justice, reason, love, equal opportunity, freedom of speech, and democracy. Where else could I have earned the confidence of a nation and of a community such as the one we have through our specialty and in AAEM?

My move to the United States literally saved my life and blessed me with skill and a career that I will cherish for the rest of my life. How can I ever forget how my EM friends and colleagues at UC Irvine and Henry Ford and in AAEM, CORD, SAEM, and ACEP touched my life? They all embraced me as a friend or family member, and I have so many fond memories spanning the years I spent in the United States. No other country or community would have accepted me the way America and the specialty of EM have. This has saved me. It gave me my life.

As a good dual citizen, it is my duty to share and spread the knowledge, skills, and values I have acquired. In 2005, the Lebanese Prime Minister Rafic Hariri was assassinated and a revolution against the Syrian occupation started. I was determined to be part of it. That led me back to Lebanon and to my hometown. I began helping them rebuild the infrastructure that had been devastated repeatedly since 1976. I rapidly established myself as a local community leader and ran for a seat in Parliament in 2009. I will be doing this again in 2013.

More importantly, I have also been raising a lovely family. As many in AAEM know, I met my wife, an EM specialist who trained in Romania, at the AAEM-EuSEM Mediterranean EM conference, and we already have two beautiful children: Aya-Katrina and Alexandre Nikolae. My wife, Cristina, is now running and staffing the only freestanding ED in an area that serves more than 100,000 people and spans more than 25 miles on the Mediterranean littoral just south of Beirut.

We provide uniform care to all our ED patients regardless of their ability to pay. We evaluate and medically screen everyone coming through our ED doors and, of course, resuscitate and try to stabilize everyone who needs it. We strive for excellence in our services, which include urgent care, teleradiology, a comprehensive lab, and seven specialty clinics. This has been a true fiscal challenge and strain, since we receive no help or support from any entity or individual.

AF: What is your current position and what is a normal workweek like for you as an emergency physician in Beirut?
Dr. Kazzi: After serving as the founding chair for our department, I was appointed and have served for the past 2 years as the deputy chief of staff for our university medical center. In addition, I work three clinical ED shifts per week. I remain active in attending and organizing national conferences, seminars, and activities, and I serve on national commissions for improving emergency medicine. In particular, I am working on national legislation that would categorize hospitals and EDs based on their preparedness and capacity in regard to emergency medicine, critical care, and trauma care and would promote a proper emergency medicine society that focuses on credentialing.

AF: How is running an ED in Lebanon different from running an ED in the United States?
Dr. Kazzi: In Lebanon, we face many exceptional challenges. To start, patients, physicians, and third-party payers do not know what emergency medicine is and do not understand how we can replace the traditional model that relies on residents, interns, students, and moonlighting general practitioners. Early on, all ED care was fragmented and under serious shortages of qualified personnel, emergency providers, and resources. Hospitals, patients, and third-party payers were misusing the ED for inappropriate access to healthcare resources or to restrict the access of patients with limited or no financial means or coverage to pay for their care. Turf battles were abundant and remain that way across other institutions. Prehospital care consists of fragmented systems and ill-supported personnel, with the exception of our Lebanese Red Cross, which relies on volunteers and has serious challenges in the retention of expertise and the provision of more than basic life support during transportation.

AF: What was the process of starting a residency and finding residents like for you? What is the current status of emergency medicine in Lebanon?
Dr. Kazzi: It was hard to start from scratch, but at the same time it was very rewarding. It is difficult to convince applicants to come to Lebanon when institutions in the United States would sponsor them for green cards and promise appealing academic or private practice careers. I had to ensure that our efforts to start a program would succeed. It was hard to convince our students to go into emergency medicine and join the fight, but we did it … we engaged them and got them to recognize our presence and the value of learning how to deliver proper ED care.

I should pause here and say that none of our emergency medicine accomplishments in Lebanon would have been possible without the contribution, excellence, dedication, talent, and sacrifices of my ABEM-certified colleagues who joined me in developing our department and residency program, staffing our ED 24/7, and developing our mission. I'll mention them in order of when they joined the American University of Beirut: Dr. Afif Mufarrij (Ford), Dr. Eveline Hitti (Hopkins), Dr. Mazen el-Sayed (Maryland), Dr. Gilbert Abu-Dagher (Ford), and very recently Dr. Kim Medlej (NY). It was simply heartening to see them all step into leadership positions, chairing, running, and directing our department, operations, and residency program.

AF: What are your personal thoughts about the current political climate and how the civil war in Syria has affected Lebanon?
Dr. Kazzi: The whole Middle East is going through a historical, delicate, and volatile period. Nations and national identities are being redefined. Inter-sectarian strife is escalating rapidly and could spread to nations other than Syria, Iraq, Bahrain, Yemen, and Lebanon. The confrontation with the Iranian and Syrian regimes can only escalate, in my opinion. What will the political and national landscapes be like when all this settles? What new regimes and borders will be established, and how will those changes affect us and the rest of the world? We do not know, but we certainly prefer to go through this rather than

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remain where we were … dominated, ruled, and occupied by Syrian and Iranian regimes and their proxies. To stay where we were would have been the end of diversity and the Western values I spoke about. Yes, of course I worry we shall have more devastation in Syria, similar events in Lebanon, and a regional war that could involve Iran, Israel, Turkey, and the regional and international superpowers. The next three to five years will definitely prove to be historical.

AF: In the context of this political uncertainty, how do you envision of the future of emergency medicine in Lebanon?

Dr. Kazzi: I envision a bright future and exponential growth and development in our field. We will develop more programs and our local specialist certification board. Emergency departments and hospitals will be categorized and prehospital services will be reorganized. However, this will take another 20 years. In the short run, we will see the growth of residency programs, the recruitment of our graduates by hospitals across Lebanon and the region, and the development of increasingly large numbers of lecture series, workshops, seminars, and exchange opportunities. Emergency medicine standards of care will improve as we spread our discipline to other EDs and engage other medical staff and communities in understanding and accepting what we have to offer as a specialty.

AF: What advice do you have for young emergency physicians about leadership and community service? Is there anything in particular that you want our readers to know or understand?

Dr. Kazzi: I recommend that all students and residents get involved early in their communities and in their profession. Practice issues and physician well-being should get equal time and attention to that we devote to research and scholarly activities. Students should be exposed to the facts that will affect their practice early on, to help them engage safely and more effectively in their careers. I also recommend that they think of the global and bigger picture; to always plan ahead and have expectations of where they want to be in five, 10, and 20 years; and to make time to start their own family. As importantly, they should take time to rest, read, sleep, dream, and spend time enjoying the precious little moments of life while it lasts. I urge them to remember to seize the day. I hope they will all find cause, passion, and time to love and be loved. ■

Editor's note: We would love to have your feedback on this interview. Please send comments and suggestions of other leaders you would like to see profiled to alifarzadmd@gmail.com.

Resident Journal Review

Anticoagulation

Authors: Susan Cheng, MD MPH; Jonathan Yeo, MD; Allison Regan, MD; Eli Brown, MD
Edited by: Michael C. Bond, MD; Jay Khadpe, MD

This Resident Journal Review focuses on the new oral anticoagulants and their use for stroke prophylaxis in patients with atrial fibrillation, venous thromboembolism (VTE), and acute coronary syndrome (ACS). Vitamin K antagonists such as warfarin have historically been used to reduce the risk of stroke in patients with atrial fibrillation. Atrial Fibrillation is responsible for 15% of strokes in people of all ages and 30% in people over 80. Traditionally, warfarin has been the anticoagulant of choice in these patients and has been shown to significantly reduce the risk of stroke. Warfarin, however, is difficult to manage as it requires frequent laboratory monitoring and has multiple interactions with common foods and drugs. Furthermore, many people receiving warfarin therapy still have inadequate anticoagulation. Therefore, there is a significant need for new oral anticoagulants that are safe, effective, and convenient to use. As medical providers, it is important to be familiar with the pharmacology of these new oral anticoagulants, indications for their use, and reversal therapy in the setting of major hemorrhage.

Pollack CV, Jr. New oral anticoagulants in the ED setting: A Review. *American Journal of Emergency Medicine*. 2012.

This review by Pollack focuses on the three new oral anticoagulants being discussed in our review: dabigatran, rivaroxaban, and apixaban. Dabigatran is a direct thrombin inhibitor, which prevents the conversion of fibrinogen to fibrin. Rivaroxaban and apixaban are selective factor Xa inhibitors, which work on the preceding step in the coagulation cascade to prevent the conversion of prothrombin to thrombin. To date, the US Food and Drug administration (FDA) has approved dabigatran and rivaroxaban for stroke prevention in patients with non-valvular atrial fibrillation. Rivaroxaban has also been approved for deep vein thrombosis (DVT) prophylaxis in patients undergoing knee or hip replacement surgery. None of the three drugs have been approved for the treatment of VTE or ACS.

One of the most attractive features of these novel drugs is that routine laboratory monitoring is not necessary. All three drugs are administered orally and are partially excreted by the kidneys; therefore, they need dose adjustments in patients with renal insufficiency. They also have a rapid onset and offset of action compared to warfarin, and do not require overlap with low molecular weight heparins (LMWH) or unfractionated heparin (UFH).

One potential problem with these new oral anticoagulants is the inability to monitor their activity or drug levels, especially in emergency situations such as overdose or overt bleeding. In addition, no antidote exists for these three drugs if reversal is indicated. Therefore, it is important to be able to quickly and reliably assess coagulation function in patients with overt bleeding. Although not widely available, Ecarin clotting time may be a reliable assay to assess coagulation with dabigatran. For rivaroxaban and apixaban, anti-factor Xa assays may be useful in the future to monitor activity.

In the EINSTEIN trials published in the *New England Journal of Medicine* (***NEJM***) in 2010 — 3,449 patients with proximal DVT without pulmonary embolism (PE) were randomized to receive either rivaroxaban, or enoxaparin plus an oral vitamin K antagonist (VKA).[1] Symptomatic recurrent VTE occurred in 2.1% of the rivaroxaban group and 3% of the enoxaparin/VKA group. The rates of bleeding were similar between the groups. A study published in 2012, enrolled 4,832 patients with PE and randomized them to the same treatment groups as the DVT study.[2] This study showed similar efficacy in both groups with rivaroxaban having fewer major bleeding events. In the RE-VOLUTION trials, dabigatran was evaluated against warfarin in the treatment of acute VTE.[3] All 2,539 patients were initially treated with unfractionated heparin (UFH) or low molecular weight heparin (LMWH) and then randomized to receive either warfarin or dabigatran. The primary outcome of recurrent VTE occurred in 2.4% of patients receiving dabigatran compared to 2.1% in the warfarin group. Combined major and clinically relevant non-major bleeding rates were higher in the warfarin group (8.8%) compared to the dabigatran group (5.6%). Apixaban was studied in the Botticelli DVT trial, which included 520 patients with DVT who were randomized to apixaban or LMWH/VKA combination.[4] Both groups had similar rates of recurrent VTE as well as bleeding.

The data on the three new anticoagulants roles in ACS was also discussed by Pollack. A phase II trial was published where 1,861 patients with ST and non-ST elevation myocardial infarction (NSTEMI) were randomized to receive four different doses of dabigatran versus placebo along with dual antiplatelet therapy.[5] They found that the dabigatran groups had significantly higher rates of bleeding with no significant improvement in cardiovascular death, nonfatal MI, and hemorrhagic stroke compared to the placebo. Rivaroxaban was also studied and became the first of the new anticoagulants to successfully complete a phase III trial for ACS. This trial enrolled 15,526 patients stabilized after an ACS event.[6] They were randomized to receive either two different doses of rivaroxaban or placebo in addition to standard medical therapy in all groups. The risk of cardiovascular death, MI and stroke occurred at a rate of 8.9% in the rivaroxaban groups and 10.7% in the placebo group. The lower dose of rivaroxaban also reduced the rate of all-cause mortality when compared to placebo (2.9% vs. 4.5%). The rivaroxaban group did have a higher rate of bleeding events compared to placebo (2.1% vs. 0.6%) but there was no significant difference in fatal bleeding between the groups. Apixaban also had a phase III trial for ACS that was terminated early due to higher rates of major bleeding events in the apixaban group. Over 7,000 patients were assigned to receive either apixaban or placebo and no significant difference in rates of recurrent ischemic events was found.[7]

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Granger CB, Alexander JH, McMurray JJ, et al. Apixaban versus Warfarin in Patients with Atrial Fibrillation. *N Engl J Med.* 2011 Sep 15; 365:981-982.

This randomized, double-blind trial compared apixaban, a direct oral factor Xa inhibitor, with warfarin in patients with non-valvular atrial fibrillation. The primary outcome was rate of stroke (ischemic or hemorrhagic) or systemic embolism in patients receiving warfarin versus those receiving apixaban. Patients were eligible if they had atrial fibrillation or flutter at time of enrollment or at least two episodes of atrial fibrillation or flutter on ECG at least two weeks apart in the twelve months prior to enrollment. Eligible patients also required one or more of the following risk factors for stroke: age greater than or equal to 75 years; prior stroke, transient ischemic attack, or systemic embolism; symptomatic heart failure within the last three month or ejection fraction less than or equal to 40%; diabetes mellitus; or hypertension requiring medication.

Patients were randomized to receive warfarin, apixaban, or placebo. The standard dose of apixaban administered was 5mg twice daily. Patients received a reduced dose of 2.5mg daily if they met two or more of the following criteria: age over 80, serum creatinine greater than 1.5, or body weight less than or equal to 60 kg. Warfarin doses were adjusted to achieve a goal INR of 2.0 to 3.0. The primary efficacy outcome of interest was stroke or systemic embolism and the key secondary outcome was death from any cause. The authors also monitored for major and non-major bleeding as well as other adverse events and liver function abnormalities.

The study recruited 18,201 patients, 9120 of whom were assigned to the apixaban group and 9,081 to the warfarin group. Enrolled patents had similar baseline characteristics (demographics, medical history, etc.) and the mean CHADS2 score was 2.1. Patients assigned to the warfarin group had a goal INR (2.0 to 3.0) for a median of 66.0% of the time and a mean of 62.2% of the time. Stroke or systemic embolism occurred in 212 patients in the apixaban group (1.27% per year) and in 265 patients in the warfarin group (1.6% per year). Ischemic stroke occurred in 149 patients in the apixaban group and in 155 patients in the warfarin group. In patients with ischemic stroke, hemorrhagic transformation occurred in 12 patients who received apixaban and in 20 patients who received warfarin. The rate of death from any cause was 3.52% per year for patients in the apixaban group, compared with 3.94% per year for patients in the warfarin group. Major bleeding occurred in 327 patients in the apixaban group (2.13% per year) and 462 patients in the warfarin group (3.09% per year). The rate of intracranial hemorrhage was 0.33% per year in the apixaban group and 0.8% per year in the warfarin group, while the rate of any bleeding was 18.1% per year in the apixaban group and 25.8% per year in the warfarin group.

The authors concluded that in patients with non-valvular atrial fibrillation and at least one additional risk factor for stroke, apixaban was superior to warfarin for prevention of stroke or systemic embolism. The most notable reduction found was risk of hemorrhagic stroke. They also found that patients randomized to the apixaban group had fewer episodes of major bleeding and lower risk of death from any cause than those patients in the warfarin group.

One of the main limitations to this study is that the patients randomized to receive warfarin had INRs in the therapeutic range only 62% of the time. While this is a fairly common occurrence in clinical practice, sub-therapeutic INRs may alter the efficacy of warfarin in prevention of ischemic strokes and systemic emboli, while supra-therapeutic INRs can contribute to the relative increase in risk of hemorrhagic stroke seen in the warfarin group compared to those who received apixaban. This may have been remedied had the authors included a subgroup analysis of patients with INRs in the goal range.

In addition to the superior efficacy and reduced risk of bleeding found by this trial, apixaban offers additional benefits over warfarin such as the lack of need for monitoring and few, if any, drug or food interactions. However, in the setting of major bleeding, an effective reversal agent for apixaban is yet to be determined. In addition, the cost of apixaban far exceeds that of warfarin. These concerns must be addressed and further studied before apixaban is able to replace warfarin as the preferred agent for stroke prevention in patients with non-valvular atrial fibrillation.

Connolly SJ, Ezekowitz MD. Dabigatran versus Warfarin in Patients with Atrial Fibrillation. *N Engl J Med.* 2009; 361: 1139-1151.

The Randomized Evaluation of Long-Term Anticoagulation Therapy (RE-LY) is a randomized non-inferiority trial comparing fixed doses of dabigatran to adjusted-dose warfarin in patients with atrial fibrillation and a risk of stroke. The primary outcome of the study was either stroke or systemic embolism, and the primary safety outcome was major hemorrhage. Inclusion criteria consisted of a documented history of atrial fibrillation on electrocardiogram (ECG) within 6 months of screening plus at least one of the following: a previous stroke or transient ischemic attack, congestive heart failure with an ejection fraction of less than 40%, an age of at least 75 years, or 65-74 years with either diabetes mellitus, hypertension, or coronary artery disease. Patients were excluded if they had: a severe heart-valve disorder, stroke within 14 days or a severe stroke within six months, a condition the increased the risk of hemorrhage, a creatinine clearance < 30mL per minute, active liver disease, or pregnancy.

This study recruited patients from 951 clinical centers in 44 countries in order to obtain 18,133 participants. Participants were randomly assigned to receive one of two doses of dabigatran, or anticoagulation therapy with warfarin. The dabigatran dosage was blinded, as participants received either 110mg or 150mg twice daily. The warfarin was administered in an unblinded fashion and adjusted to an INR of 2.0 to 3.0.

Final follow-up visits were recorded with a median follow-up period of 2.0 years. Stroke or systemic embolism occurred in 182 patients receiving 110mg of dabigatran (1.53% per year), 134 patients receiving 150mg of dabigatran (1.11% per year), and 199 patients receiving warfarin (1.69% per year). The relative risk for 110mg of dabigatran was 0.91 (95% CI 0.74-1.11; p<0.001) for non-inferiority. The relative risk for 150mg of dabigatran was 0.66 (95% 0.53-0.82; p<0.001) for superiority.

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Major hemorrhage occurred at a rate of 3.36% per year in patients within the warfarin group. It occurred relatively less in those receiving dabigatran at 2.71% per year in the 110mg dosed group (relative risk 0.93; 95% CI 0.81-1.07; p =0.003) and 3.11% per year in the group that received 150mg of dabigatran (relative risk 0.93; 95% CI 0.81-1.07; p=0.31). The only adverse effect found to be significantly more common with dabigatran was dyspepsia.

This study found both dabigatran doses to be non-inferior to warfarin with respect to prevention of stroke or systemic embolism. Furthermore, the 150mg dose of dabigatran twice daily was superior to warfarin in stroke or systemic embolism prevention, and the 110mg dose of dabigatran was superior in regards to major bleeding. Therefore, dabigatran should be considered as an alternative to warfarin therapy for the prevention of strokes in patients with atrial fibrillation in the setting of normal kidney and liver function and no severe heart-valve disorder.

Patel MR, Mahaffey KW, Garg J, et al. Rivaroxaban versus warfarin in nonvalvular atrial fibrillation. *N Engl J Med* 2011; 365: 883-91.
This randomized, double-blind, trial that included patients with non-valvular atrial fibrillation compared rivaroxaban and warfarin in the prevention of stroke and systemic embolism. Inclusion criteria were patients with non-valvular atrial fibrillation documented on ECG with elevated risk of stroke based on presence of at least two of the following criteria: heart failure or ejection fraction of 35% or less, hypertension, age ≥ 75, or diabetes mellitus.

Patients were randomized to receive rivaroxaban 20mg daily or adjusted-dose warfarin with goal INR of 2.0 to 3.0 in addition to a placebo tablet. Patients with reduced GFR who were assigned to the rivaroxaban group received a reduced dose of 15mg daily. The study generated sham INR values for patients in the rivaroxaban group. The primary efficacy outcome was rate of hemorrhagic or ischemic stroke and systemic embolism. Secondary end points included death from cardiovascular causes. The primary safety outcomes were major and non-major bleeding events.

The trial enrolled 14,264 patients, with 7,131 randomized to the rivaroxaban group and 7,133 randomized to the warfarin group. Age, coexisting illnesses and other demographics were similar between the two groups. Mean and median CHADS2 scores were 3.5 and 3.0, respectively. For patients assigned to the warfarin group, INR was within the goal range (2.0 to 3.0) a mean of 55% of the time.

Stroke or systemic embolism occurred in 188 patients in the rivaroxaban group (1.7% per year) and in 241 patients in the warfarin group (2.2% per year) (hazard ratio in the rivaroxaban group, 0.79; 95% CI 0.66-0.96; p<0.001 for non-inferiority). Major and/or clinically relevant non-major bleeding occurred in 1,475 patients in the rivaroxaban group (14.9% per year) and in 1,449 patients in the warfarin group (14.5% per year) (hazard ratio in the rivaroxaban group, 1.03; 95% CI 0.96-1.03; p=0.44). Rates of major bleeding were 3.6% in the rivaroxaban group and 3.4% in the warfarin group. Rates of intracranial hemorrhage were 0.5% in the rivaroxaban group versus 0.7% in the warfarin group, while rates of major gastrointestinal bleeding were higher in the rivaroxaban group (3.2% versus 2.2% in the warfarin group).

The authors concluded that rivaroxaban was non-inferior to warfarin in the prevention of stroke or systemic embolism in patients with non-valvular atrial fibrillation. In addition, there were no significant differences between rivaroxaban and warfarin in rates of major and non-major bleeding and a lower incidence of intracranial hemorrhage in the rivaroxaban group. While fatal or critical bleeding occurred at similar rates in the rivaroxaban and warfarin groups, bleeding from gastrointestinal sites occurred more frequently in the rivaroxaban group.

Once again the main limitation of this study is that patients assigned to the warfarin group had INRs within the therapeutic range at a mean of only 55%. However, the authors cite this lower rate as a possible consequence of including only North American sites. They also state that in other studies, rivaroxaban has been proven to be equally effective in cohorts with the best INR control as well as with the poorest control. One does have to wonder though if stroke rates would go down with the INR being ideal at all times, though the risk of bleeding may also increase.

Similar to other direct factor Xa inhibitors, rivaroxaban offers the benefit of not needing blood tests or any other monitoring; however, additional trials are needed to compare it with warfarin in patients with a greater percentage of INRs within the therapeutic range in order to accurately compare its efficacy.

Eerenberg ES, Kamphuisen PW, Sijpkens MK, Meijers JC, Buller HR, Levi M. Reversal of Rivaroxaban and Dabigatran by Prothrombin Complex Concentrate: A Randomized, Placebo-Controlled, Crossover Study in Healthy Subjects. *Circulation*. 2011; 124: 1573-1579.
This was a randomized, double-blind, placebo-controlled study with 12 healthy male volunteers to evaluate the potential of prothrombin complex concentrate (PCC) to reverse the anticoagulant effect of

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rivaroxaban or dabigatran. Half of the volunteers were randomized to receive rivaroxaban 20 mg twice daily for 2.5 days, while the other half received dabigatran 150 mg twice daily for the same 2.5 days. Afterwards, the volunteers were randomized to receive either a single infusion bolus of 50 IU/kg of PCC or saline infusion as placebo. The brand name of PCC used was Cofact, which contains factor II, VII, IX, X, protein C, S and antithrombin. Volunteers were not blinded to type of anticoagulant, but were blinded to PCC or saline. Laboratory technicians were blinded to anticoagulant and type of infusion. Blood was collected from each volunteer at baseline, on the third day of anticoagulant use prior to infusion of PCC or saline, and at multiple time intervals post infusion (15 minutes, 30 minutes, one hour, two hours, four hours, six hours, and 24 hours). This was followed by an 11-day washout period and the volunteers repeated the process with the other oral anticoagulant.

Rivaroxaban increased prothrombin time (PT) that was immediately and completely reversed by PCC ($p<0.001$). Rivaroxaban also inhibited endogenous thrombin potential (ETP) that was normalized with PCC ($p<0.001$). Dabigatran increased activated partial thromboplastin time (aPTT), ecarin clotting time (ECT) and thrombin time; however, none of these coagulation tests were reversed by PCC. Dialysis is an alternative for reversal of dabigatran, but it has limited effectiveness because 1/3 of dabigatran is bound to plasma and therefore not dialyzable. Rivaroxaban is 95% bound to protein, and therefore cannot be dialyzed.

This is the first study conducted in humans that shows that nonactivated PCC immediately reverses the effect of full-dose rivarobaxan and is a promising option for reversal in the setting of bleeding or emergent pre-operative measures. The study used randomization and a crossover design to minimize bias, however, the study was limited. The test subjects were healthy males around 24 years old and there were only 12 subjects. It would be difficult to generalize to an older patient population and or those with medical co-morbidities. Coagulation profiles were analyzed as a surrogate marker for bleeding risk, and this may be difficult to translate directly into clinical practice. In addition, the dose of PCC was chosen from animal study data and further studies are needed to confirm the efficacy of a lower dose of PCC to reverse rivaroxaban. Future studies should also test alternative formulations of PCC for their possible reversal effects.

Summary

This Resident Journal Review includes recent studies concerning the use of new oral anticoagulants for stroke prophylaxis in atrial fibrillation, VTE, and ACS. Although the studies have not demonstrated efficacy in their use for ACS, they are encouraging that dabigatran, rivaroxaban, and apixaban can provide comparable if not superior efficacy and reduced risk of bleeding when compared to warfarin in the treatment of VTE and stroke prevention. However, effective reversal agents have yet to be identified and studied adequately for use in the setting of a major bleed. Regardless, we will continue to see patients taking new oral anticoagulants and must be familiar with the pharmacology of each and how to approach reversing the anticoagulation in the safest and most rapid manner possible. ■

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Medical Student Council President's Message

Making the Most of Third Year

Mary Calderone, MS3
AAEM/RSA Medical Student Council President

Aside from intern year, the third year of medical school is traditionally considered one of the most formative experiences in a physician's life. Suddenly, we're propelled from passively sitting in a lecture hall to thinking on our feet. Our thought process now has the potential to impact how we care for a patient, rather than just how we answer an exam question. Just as we impact the lives of patients, patients also impact us in powerful ways. We begin to make decisions about the future of our medical careers, ruling out certain specialties and exploring others further. As we navigate these new challenges, we gain an increasingly keen sense of self-awareness. Our strengths and weaknesses stare us straight in the eyes, whether we realize them through self-reflection, hear about them from one of our senior colleagues, or experience some combination of the two. We start to contemplate our life goals and our requirements for happiness and well-being. By the time we're fourth years, we're expected to have decided upon an area of medicine after a whirlwind of speed-dating with different specialties.

While many students enter medical school with some idea as to their future specialty, studies have shown that the majority of students change their minds. I entered my M1 year with a passion for emergency medicine that has only continued to grow as I've gained more clinical experience. Entering medical school with relative confidence in the area of medicine you wish to practice has its advantages and disadvantages. On one hand, you can direct your efforts toward a concrete goal. You can lay the foundation for pursuing a career in a given area of medicine early in your training. You can participate in activities and opportunities that prepare you well. You can find the right mentors. On the other hand, you may fail to consider all of the exciting possibilities for your career, thereby prematurely closing your mind to an area of medicine that you might otherwise have loved. Your bias toward one specialty may cloud your judgment of whether or not you actually fit well into its culture. You may even disregard the importance of a clerkship because you think it won't ultimately be relevant to the type of medicine you plan to practice, thereby cheating yourself of a fulfilling and valuable experience.

Despite these potential pitfalls, I've found that entering medical school passionate about emergency medicine has in no way detracted from my clerkship experiences thus far. In fact, understanding that a solid grasp on the core areas of medicine is essential to being an effective emergency physician has motivated me to approach all of my rotations with the same vigor, enthusiasm, and intellectual curiosity with which I would approach an emergency medicine clerkship.

My psychiatry clerkship, for instance, offered me valuable experience evaluating patients presenting for substance abuse or suicidal ideation, common reasons for ER visits. It allowed me to master the mental status exam and pick up on important subtleties during patient interviews. It also gave me insight into the common issue of malingering.

Family medicine, just like emergency medicine, requires the ability to evaluate, manage and relate to patients of all ages with a broad spectrum of medical and psychosocial issues. It involves advocating for patients so they have access to outside resources, a component of care also relevant to emergency medicine. Consequently, I approached the rotation with a desire to focus on improving my skills in these areas.

On pediatrics I learned the importance of observation and physical exam in the evaluation of infants and children, who cannot provide the same detailed history that an adult can. I improved my ability to identify and differentiate a toxic-appearing patient from a relatively healthy one, a critical skill for an emergency physician. I also learned how to effectively work with patients' families, including ways to appropriately elicit and address their concerns in addition to the patients' issues.

Throughout my three clerkships thus far, I've also paid particular attention to the most serious conditions in to each, so that I will keep these diagnoses on my radar and remember to rule them out when necessary. I have no doubt that I will continue to learn valuable concepts and clinical skills on my remaining clerkships, which will serve me well as an emergency physician.

In sum, whether you're simply considering emergency medicine as a possible career choice or you've definitely decided on it, it's important to take of all of your clerkships seriously. Disregarding a core area of medical knowledge because you've decided to specialize in another is shortsighted, especially in the case of emergency medicine. Identify the concepts and skills that may be relevant to your practice as an emergency physician, and utilize clerkships as opportunities for competency or even mastery in these areas. ■

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