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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)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $150 (Non-voting status)
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International Resident Member: $20 (voting in AAEM/RSA elections only)
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International Student Member: $20 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

Pay dues online at www.aaem.org or send check or money order to:
AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202 Tel: (800) 884-2236, Fax (414) 276-3349, Email: info@aaem.org.

President's Message

News from the 2013 Scientific Assembly

William T. Durkin, Jr., MD MBA FAAEM

Scientific Assembly 2013 was a huge success. The new longer format was well received, the mobile app made it easier for attendees to keep track of any schedule changes, and the preconference courses were all well subscribed. Dr. Jim Keaney gave a fine keynote, telling the story around the founding of the Academy as only he can. Co-founder Scott Plantz gave an excellent summation of the first few years and recognized those who were on the first board and helped get the Academy up and moving. Dr. Stephen Bergman, aka Samuel Shem, gave the 1st annual Joe Lex Keynote address. Our new lobbyists, Williams & Jensen, addressed the assembly and met with a couple of the state chapter groups as well. Kudos to Dr. Mike Epter, the Scientific Assembly and Education Committees for another fine job!

There is some news that came out of the meeting that I would like to share with those who were unable to make it:

Pain Management Policy

The board of directors passed the *American Academy of Emergency Medicine Model ED Pain Treatment Guidelines*. In an effort to be more proactive we thought it best to get this out in the public view before any more politicians take it upon themselves to tell us how to practice our specialty. It is a broad guideline meant to give a useful basis for each department to draw up their own guidelines. Seems that ever since pain measurement became the fifth vital sign, prescription narcotic abuse has been on the upswing. Deaths from these medications have now become a major concern nationwide. Many emergency physicians find themselves in the uncomfortable position of dealing with drug seeking while trying not to be graded downwards on satisfaction surveys. We understand that, clearly, something needs to be done. This was the tool we put out there to assist our members in taking the lead on this issue. Available on the AAEM website at: http://www.aaem.org/em-resources/position-statements.

Alliance with ACPE

One of the needs that has been identified by our members is a need for some leadership training. Others with whom I have spoken over the course of the year admit that they do not have any business knowledge and want a chance to learn the basics.

Rather than try to come up with these offerings in house, I thought it would be a better idea to partner with the best organization in the business for these kinds of offerings, the American College of Physician Executives (ACPE) (http://www.acpe.org/). We have reached an agreement whereby our members will get the ACPE member rate on any of their course offerings. The Physician in Management course (PIM) is an excellent basic course in management and business principles. They also offer several highly rated courses in leadership training.

I have received two calls in the past year from members whose groups were being sold as the "exit strategy" by the contract holder. Unfortunately, in both cases the contracts went to large national CMGs. In one instance, only four of the group of 30 physicians had any interest in trying to buy the group themselves. The main reason was that the remainder knew nothing about business or management and did not feel comfortable taking the group over. This is very unfortunate and it is my hope that members will avail themselves of this new opportunity, so that more can feel comfortable with the business side of the practice. As a group, emergency physicians are naturals for leadership positions within their hospitals. We interact with all specialties daily, we know the strengths and weaknesses of the facility, and we interact with the administration, nursing, and ancillary services as well. I urge all of you to take a look at the ACPE course offerings and take advantage of this new liaison.

We will continue to find new ways to add value to AAEM membership, improve the educational offerings that we already have, and assist our members in taking control of their careers. We remain the only organization to do this. I am always open to hearing other suggestions from you, our members! ■

Contact the President: president@aaem.org

Happy Birthday AAEM!

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

The American Academy of Emergency Medicine turns twenty this year, and *Common Sense* will honor that milestone in several ways. In this and future issues throughout 2013, you will find two new features: "Blast from the Past" and "The Founders' Forum." "Blast from the Past" will reprint highlights and whole articles from early editions of *Common Sense*, among other historical tidbits. "The Founders' Forum" will feature articles from the two emergency physicians who founded the Academy, Jim Keaney and Scott Plantz, as well as some of those who helped create AAEM's bylaws and mission statement during its first year (see the photo in this issue's "Blast from the Past").

Many things about AAEM have changed over the past 20 years. The Academy is much bigger, of course, with just over 7,000 members. *Common Sense* is published six times a year instead of once, and each issue is about five times bigger than those early issues. Despite attempts by many during its first few years to characterize it as a fringe organization populated by malcontents, AAEM is now widely admired as occupying the ethical high ground in emergency medicine, and looked to for leadership on controversial issues in our specialty. It has influence far beyond its size.

Some things have changed very little, such as the Academy's mission statement, printed in this and every issue of *Common Sense* since it was first published in 1995. The parts of AAEM's Mission Statement that attracted me to the organization were 1) the commitment to legitimate board certification and, 2) the desire to protect the individual, clinical emergency physician — the "scrubs" rather than the "suits," as Dr. Keaney labeled them in *The Rape of Emergency Medicine*.

When I joined AAEM, I had been a member of ACEP since my first year as an emergency medicine resident in Jacksonville. In those days emergency medicine was still struggling for recognition as a legitimate specialty. One of the marks of a legitimate specialty is that it plays by the same rules as other specialties. This means that, after a period of years for the founders of the specialty to "grandfather" into board certification, residency training in the specialty is required in order to sit for board exams in the specialty. During and after residency, I was disappointed at what I saw as ACEP's failure to vigorously defend this principle. It seemed conflicted on the issue because of the large number of its members who were not eligible for ABEM or AOBEM certification. I remained a member, however, thinking that eventually the College would come around.

While a resident, one of my attendings in Jacksonville, Bob Wears, did his best to prepare us for the cutthroat world of business he knew we would face. I was surprised and disappointed to learn that I could not trust other physicians to treat me as a colleague — that the rules of the marketplace (anything short of force or fraud is acceptable) would apply in most emergency medicine jobs, rather than the professional ethic of a brotherhood of physicians that I saw among doctors in my hometown, in my medical school and residency, and in the Hippocratic Oath. I worked for two corporate megagroups when I completed residency, and then settled in an academic job where I reviewed contracts for residents and tried to teach them some of what I had learned from Dr. Wears and from hard experience. I became increasingly disappointed with ACEP's failure to combat the predatory exploitation of one emergency physician by another — or by non-physicians. I attributed this to the significant number of ACEP leaders who owned or held management positions in megagroups. But I remained a member, thinking that eventually the College would come around.

Even after I learned of AAEM's founding and joined the Academy, I remained a member of the College. I thought to myself, "Until ACEP sees the light and starts doing the right thing, I'll do what I can to better emergency medicine through AAEM. Eventually the College will come around." It took several more years before I finally gave up on the College ever coming around, grew tired of paying its higher dues, and faced the inevitable. I wrote a letter explaining my reasons, renounced my fellowship (FACEP) status, and resigned. I do not write this to suggest that anyone else should share my opinion or resign from ACEP. Many Academy members, including several on its board of directors, are also members of the College. I review the evolution of my thinking on ACEP only because, in reading the first issue of *Common Sense* that is largely reprinted in this issue, I was struck by how reluctant AAEM's founders seemed to be to create the Academy. What they really wanted was for ACEP to come around — just like me. And they finally gave up — just like me.

Did I do the right thing? I am certain I did. More importantly, did the Academy's founders do the right thing? Has AAEM made emergency medicine a stronger and better specialty than it would have been with ACEP alone? Are emergency physicians better off because of the Academy? I am certain that the answer to each of those questions is "yes." The battle for board certification and legitimacy as a specialty seems to be won. We haven't had to beat back one of BCEM's (the

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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.

Board of Certification in Emergency Medicine) attempts to gain legislative or regulatory legitimacy in several years, and as far as I know the only state where BCEM won recognition for its diplomates is Florida. (For more on that 2001 event and other highlights of the board certification story, see my article in *Common Sense* from 2010.)[1] That wouldn't be true without AAEM. Not only has the Academy led the way on this issue, having AAEM to compete with put pressure on ACEP to do the right thing. Since the unfortunate actions of some of its members in Florida, ACEP has been a defender of legitimate board certification.[1] The College requires board certification or residency training for new members, and stopped granting fellowship (FACEP) status to members without board certification at the start of 2010. It may sound odd, but I think AAEM has made ACEP a better and thus stronger organization.

Unfortunately ACEP, in my opinion, has not come around on the other issue that led me to join AAEM: fair treatment for those emergency physicians who do the work of patient care; those who work nights, weekends, and holidays rather than nine-to-five on weekdays; those who wear scrubs to work instead of suits. In many EDs some still profit unjustly from the labor of others, rather than earning their own way. The Academy continues to fight this, and despite weathering some defeats, has won several important victories. Although the problem remains, I believe things are better now than when I entered the specialty in the 1980s, and better than when AAEM was founded. That definitely wouldn't be the case without the Academy. I shudder to think what the situation would be like if AAEM had not been created, and prospered as it has. So thank you to Drs. Keaney and Plantz, and all those who nurtured the American Academy of Emergency Medicine. I hope that we are making you proud and will leave AAEM even bigger, stronger, and better than when we found it. Emergency medicine, and emergency physicians, still need the Academy. ■

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1. Walker A: Legitimate. *Common Sense - the newsletter of the American Academy of Emergency Medicine*. 17(3): 8-12, 2010.

Letter to the Editor

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

Dr. McNamara, a former president of the Academy, recently received the email below. His reply follows it. For more on the writer's frustrations and burnout, see Dr. Walker's editorial and Dr. Gaudio's article in this issue of Common Sense.

— The Editor

Dr. McNamara,

Emergency medicine needs this organization. I was boarded in November 2011 and so excited about my career. I have been working in a community hospital for a year and have been very dissatisfied about how things are going. Whether it's BS patient complaints, scapegoated by lazy surgeons, or getting complaints from my regional director from nursing stating I am hanging up the phone too hard. It's never about medicine or patient outcomes. It is always something esoteric and meaningless. I would always be asked by family and friends about why I am so unhappy. "You make great money!" They don't understand I am walking on eggshells every shift trying not to piss people off to save my job. No one taught me this in residency. I have been completely blind-sided. I then started surfing the net and I realized that my experiences are not singular to me. It's everywhere! I have a couple of buddies going into EM and I have given them multiple warnings about what to expect. I recently lamented to them via text about the very high likelihood of them leading a nomadic professional and possibly personal lifestyle. I always wondered why ER docs always held down two or three jobs. Now I know.

A couple of my colleagues had talked to me about AAEM, but I never really looked into it. My ACEP membership ran out a few months ago and I have not been affiliated with anyone. I received a pamphlet about two weeks ago from you guys and really dug into it. It's about 3am central and I was on your site. I watched the video and I was sold!! Finally. Man, if you were not preaching the gospel. "Hell yeah!" came out of my mouth quite a few times. I cannot wait to join and I will by the end of this week. I sent the link to all of my EM colleagues via Facebook. This is the good fight. I did not work my ass off all these years to get the little respect I do. Keep up the good work and keep fighting for us — we need you. Your work is invaluable and I cannot thank you enough. There is some hope for us docs after all.

— Name withheld by request

Thanks for your note. AAEM formed because ACEP was ignoring these issues, among others. As the corporations seek more profit the problems will continue, but AAEM will continue to pursue physician control of their own destiny. Given that you are fresh out of residency, I encourage you to look at the AAEM YPS (Young Physicians Section) as a place you can share experiences/gain insight.

May I ask what residency you trained at? We are trying our best to get out there to educate residents on these issues before they hit the job market, and we can send out a feeler to see if they will have us in (or you might email the PD yourself with a similar message and urge them to have us come by). ■

— Bob

Robert McNamara, MD FAAEM
Chairman, Department of Emergency Medicine
Temple University School of Medicine

"Fiscal Cliff" Agreement Signed Into Law: Includes Temporary "Doc Fix"

Williams and Jensen, PLLC

On January 2, President Obama signed into law H.R. 8, the American Taxpayer Relief Act of 2012 (ATRA). The legislation addressed a range of the "Fiscal Cliff" issues on a permanent or temporary basis. It included a one-year doc fix that extends current Medicare physician payment rates through December 31, 2013. The $25 billion fix was fully paid for by a mix of healthcare cuts, including: (1) repeal of the Community Living Assistance Services and Supports (CLASS) program); (2) re-basing of State Disproportionate Share Hospital (DSH) allotments for fiscal years 2021 and 2022; (3) adjustment of the equipment utilization rate for advanced imaging services; (4) Medicare payment of competitive prices for diabetic supplies and elimination of overpayment for diabetic supplies; (5) Re-basing end stage renal disease (ESRD) payments for dialysis drugs and Medicare payment adjustments for non-emergency ambulance transports for ESRD beneficiaries; (6) Documentation and Coding (DCI) adjustments to recover over-payments to hospitals resulting from utilization of Medicare Severity Diagnosis Related Groups (MS-DRGs); and (7) elimination of all funding for the Medicare Improvement Fund.

A number of Members on both sides of the aisle have expressed their preference for a permanent "doc fix." In February, the Congressional Budget Office (CBO) dramatically reduced the cost estimate for a permanent "doc fix," from $245 billion to $138 billion. This change strengthens the position of advocates for a permanent fix, but it remains far from clear whether Republicans and Democrats can achieve a bipartisan consensus on how to pay for this measure.

In addition to the one-year "doc fix," the bill includes a number of other Medicare extensions, including the physician work index, payment for outpatient therapy services, and ambulance add-on payments.

With the repeal of the CLASS program, the agreement established a new Commission on Long-Term Care composed of 15 Members appointed by the President and House and Senate Leaders. The Commission is tasked with developing a plan for the "establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such services and supports, including elderly individuals, individuals with substantial cognitive or functional limitations, other individuals who require assistance to perform activities of daily living, and individuals desiring to plan for future long-term care needs."

The bill also extended tax provisions of the 2001 and 2003 cuts for certain taxpayers. Notably, the lower rates expired for those with incomes above $400,000 ($450,000 for married filing jointly), with capital gains and dividends rates also increasing at this threshold. A deal was cut on the estate tax, with an increased exemption level ($5.12M) indexed for inflation. There was also a permanent fix to the alternative minimum tax (AMT).

The legislation delayed for two months the across-the-board discretionary spending cuts known as sequestration. The sequester was scheduled to begin impacting Federal agencies on January 1st, because Congress failed to enact at least $1.2 trillion in additional spending reductions following the passage of the Budget Control Act of 2011. These cuts would result in a cut of 8.2 percent for most accounts, although cuts to the Medicare program are capped at two percent. The legislation paid for the $24 billion cost to "turn off" sequestration for two months with a mix of spending cuts and revenue increases. The White House and Congressional Democratic Leadership have said that any further deficit reduction should be paired with revenues, while Congressional Republicans are opposed to any new tax increases. Absent an agreement, sequestration is set to start at the beginning of March.

House Approves Emergency Preparedness Legislation

On January 22, the U.S. House of Representatives passed H.R. 307, the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPA). The measure was approved by a vote of 395-29. H.R. 307 would facilitate the development of medical countermeasures (MCMs) to address our nation's public health preparedness infrastructure, including those mitigating a chemical, biological, radioactive, or nuclear (CBRN) attack. The legislation reauthorizes the Hospital Preparedness Program (HPP), which assists in the enhancement of medical surge capacity and other emergency preparedness measures at the state and local government level.

The bill reauthorizes $52 million annually through fiscal year 2017 for the National Disaster Medical System (NDMS). NDMS was established to assist the federal government in its medical response to a public health emergency. Finally, the bill reauthorizes the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals to help train and coordinate volunteers in response to a major disaster.

There are indications that the Senate may take up this bill in the near-term. It is possible that it could be taken up as a free-standing bill. There has also been some speculation that PAHPA could be passed in the Senate as part of the Animal Drug User Fee Act (ADUFA), which must be reauthorized this year. No specific plans for advancing the bill have yet been announced.

Fiscal Year 2014 Budget and Appropriations Process

The next several months are shaping up to be a busy time for the Congressional Appropriations and Budget Committees. The President's FY 2014 budget missed the February 4 release deadline, and is expected sometime in mid-March.

Meanwhile, Senate Democrats and House Republicans both face unique challenges as they prepare budget resolutions for FY 2014.

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The Senate will attempt to adopt a budget resolution for the first time since April 2009. In a memorandum sent to her colleagues, Senate Budget Committee Chair Patty Murray (D-WA) indicated that she will pursue a budget deal that is "balanced, fair for the middle class, and calls on the wealthiest Americans to pay their fair share." The 20 Senate Democrats that face re-election in 2014 represent a key voting block that is needed to secure support for this budget.

In the House, Republican Leadership has pledged to support a budget that balances in 10 years. This presents a steep challenge to Budget Committee Chairman Paul Ryan (R-WI), who will produce a leaner budget than the one that passed the House in 2012. Chairman Ryan's previous budget included major reforms to entitlement spending, including Medicare and Medicaid.

The House and Senate must also contend with the uncertainty of sequestration, which will start on March 1st in the absence of a deal to delay these cuts. If allowed to take effect for the remainder of 2013, sequestration will reduce the amount of money available in the budget by about $85 billion.

As a provision included in the deal to suspend the debt ceiling until May 19th, pay will be withheld for members of Congress serving in a chamber that does not approve a budget resolution by April 15th.

Obamacare Implementation Continues: Congress Continues to Consider Modifications

In January the IRS began receiving payments from medical device manufacturers, from a new 2.3 percent tax on the sale of medical devices. The measure was designed to raise $30 billion over 10 years to help offset the cost of Obamacare. A repeal measure passed the House in June 2012, but the Senate did not act to repeal or delay the tax. Opponents of the tax have indicated that they will continue to work with Congressional champions to seek full repeal.

Other major changes to Obamacare that could be considered in the 113th Congress include repeal of the health insurance tax set to take effect in 2014, and repeal of the Independent Payment Advisory Board (IPAB), which will begin impacting Medicare spending in 2015.

Four more key provisions of the health reform law are set to take effect in 2014: (1) health insurance exchanges (which CMS now wants to call "health care marketplaces"); (2) the employer mandate to provide health insurance; (3) "essential health benefit packages," which each plan sold through an exchange must offer; and (4) the individual mandate to purchase health insurance. Congress will continue to monitor and hold hearings on the requirement for states to establish these exchanges, and on related guidance from HHS. Congress is also expected to exercise its oversight authority to examine both the impact of the employer mandate on small and large businesses and IRS enforcement of the individual mandate.

CMS Releases Final Rule on Physician Payment Transparency

On February 1st CMS published a final rule entitled, "National Physician Payment Transparency Program: Open Payments." According to a CMS fact sheet, the rule will "make information publicly available about payments or other transfers of value from certain manufacturers of drugs, devices, biologicals and medical supplies covered by Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), defined as applicable manufacturers, to physicians and teaching hospitals, which are defined as covered recipients." CMS was required to issue the rule as part of a provision in Obamacare that was designed to foster greater transparency in the healthcare market.

The law requires these covered manufacturers to prepare an annual report to HHS that details all payments (i.e., gifts, fees, travel) to covered recipients, including physicians. Manufacturers are also required to report ownership and investment interests held in these entities by physicians and their immediate family members.

CMS indicated that data collection will begin on August 1, 2013, to allow sufficient preparation time for manufacturers and group purchasing organizations (GPOs). The data will be reported from August through December of 2013. CMS will release the data by September 30, 2014.

Additional Legislative Efforts

H.R. 574, the Medicare Physician Payment Innovation Act, was introduced in February by Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV). The bill provides for a permanent "doc fix" and annual positive payment updates for physicians over years 2015 to 2018. Additionally, the legislation requires CMS to test and evaluate new physician payment and delivery models by October 2017, and provides incentives for physician participation in these models. In 2019, physicians utilizing the new CMS-approved model will have the opportunity to receive higher pay in exchange for quality, efficiency, and cost improvemenwts. As the year progresses we expect additional "doc fix" proposals to be introduced in the House and Senate.

H.R. 235, the Veteran Emergency Medical Technician Support Act of 2013, would provide demonstration grants to states with EMT shortages. The legislation streamlines state EMT certification and licensure requirements for veterans who have completed military EMT training while serving in the Armed Forces. It makes it easier for them to become licensed EMTs without having to go through duplicative training. The bill authorizes $1 million for these grants over the next five years (FY 2014-2018). The House Energy & Commerce Committee reported the measure in a bipartisan vote and it is expected to have broad support in a vote before the full House. The legislation was introduced by Rep. Adam Kinzinger (R-IL) and Rep. Lois Capps (D-CA). ■

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 11-1-12 to 1-23-13.

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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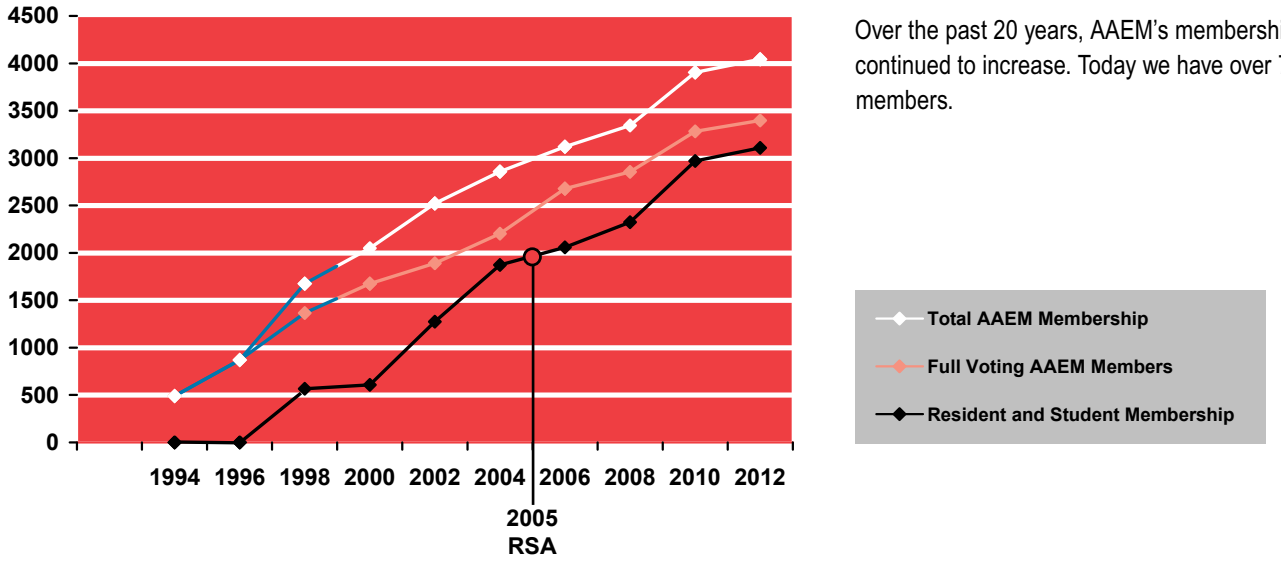
Blast from the Past

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board Member

In January of 1776, Thomas Paine published *Common Sense*, a 48-page monograph explaining why the colonies should separate from Great Britain and become an independent nation. It was an immediate best seller, and swayed a nation in which only a minority of the population supported independence. Its arguments were echoed months later in the Declaration of Independence. Between *Common Sense* and *The Crisis*, it is my opinion as a student of history that the United States would not exist without Thomas Paine and his brilliant writing. It takes more than bullets to win a war. It should be noted that *Common Sense* was edited and titled by Benjamin Rush, the most prominent American physician of the colonial era and a signer of the Declaration of Independence.

The American Academy of Emergency Medicine was founded in 1993, and one issue of the Academy's newsletter was published that year. It was named *Common Sense*, both to honor Thomas Paine and because of the similarities Drs. Plantz and Keaney saw in AAEM's founding compared with American independence from Great Britain. The entire newsletter can be found on the AAEM website, and I urge you to read it. Most of that issue is taken up with Scott Plantz's rewriting of parts of Paine's *Common Sense*, altered so that the American colonies become AAEM and Great Britain becomes ACEP. It is entertaining reading, especially if you are familiar with Paine's *Common Sense*. Unfortunately, it is too long to reprint here in its entirety. Plantz's introduction and selected highlights are included below, however, along with the front page and the last two pages of that first issue.

20 Years of Academy Membership



Over the past 20 years, AAEM's membership has continued to increase. Today we have over 7,000 members.

Disclaimer: Membership Data from 1994-1998 are estimates based on archive materials available.

when minutes count

COMMON SENSE

The Voice of the Specialist in Emergency Medicine — Premiere Edition

Why "Common Sense"?

by George Schwartz, M.D., F.A.A.E.M., Secretary, American Academy of Emergency Medicine

When the then thirty-seven year old Thomas Paine arrived in America late in 1774, the newcomer from England saw with fresh eyes the promise of America. Within six months he began to argue that the issues for America were far more than simply the catalyst for anger i.e. taxation without representation.

He began to write from his perspective and insight about the larger issues which made true independence from England necessary for America to grow and prosper. The first pamphlet dealing wholly with this issue was published in January, 1776 (a little more than a year after he arrived in America).

The pamphlet "COMMON SENSE" was literally an overnight sensation and became the talk of the colonies, selling more than half a million copies within a few months. "COMMON SENSE" allowed the general public of the time to see and understand the broader issues and is widely believed to be the major writing to influence and pave the way for the Declaration of Independence which was signed six months later.

From the perspective of AAEM, our "COMMON SENSE" will bring to Emergency Physicians a broader understanding of the issues underlying the need for a new organization — a revolution in Emergency Medicine. It is not just the taxation without representation at ACEP. It is not just the exploitation of emergency physicians and Emergency Medicine sanctioned by the American College of Emergency Physicians. It is the broader failure of ACEP to address the concerns and desires of the majority of its membership and instead to embark upon a destructive short and long-term strategy. An organization no longer responsive to its members becomes a tyrant to them.

"COMMON SENSE" is the newsletter voice of the AAEM, the organization of the specialist in Emergency Medicine. We have formed because ACEP has failed to guard the quality of Emergency Medicine we offer to the public as well as to disregard the well-being and desires of its membership. "COMMON SENSE" will bring to Emergency Physicians the information and reasoning which can serve as the underpinning to the Declaration of Independence from ACEP (= tyranny).

"There comes a time when silence is betrayal."
Dr. Martin Luther King, Jr.

This is Your Newsletter!

This is the premiere issue of Common Sense, the periodic official newsletter of the American Academy of Emergency Medicine (AAEM). It's purpose is to further the goals of the Academy — democracy, quality care at a reasonable cost, universal emergency medical care and equitable work arrangements — by communication amongst members through articles, letters, responsible criticisms and appropriate praises. Humor will also have its place! Contributions are encouraged, be they letters, articles, nominations for awards, or humor.

The Academy has high standards regarding ethics, fairness and honesty and it is expected that all contributions meet these standards. Although the editor will make every attempt to maintain these standards, it is understood that the views expressed are those of the authors and do not necessarily represent those of the academy.

Other considerations suggested by supporters are a matching system for physicians and hospitals desiring democratic groups, a legal column and a legal referral system for those members who have exhausted all other measures to resolve their grievances. Other ideas you have would be gratefully considered.

Please be aware that enormous thought and deliberation as well as some frank disagreement tranpired amongst the governing members of the academy concerning the contents of this newsletter. The aforementioned journalistic standards being assumed, we realize we walk a fine line in exposing the outrageous state of affairs in Emergency Medicine while trying to maintain the confidence of the overwhelming majority of emergency physicians who are honest hard-working professionals. It is a difficult balance. Your comments would be appreciated!

Please send newsletter contributions and any comments to the address below. We will gladly print articles and withhold the submitter's name. However, for purposes of editing and responsible journalism, the editor must know the contributor's identity. Hope to hear from you soon!

COMMON SENSE
Drew E. Fenton, M.D., Editor
421 N. Rodeo Drive #1524
Beverly Hills, CA 90210
Phone: 310-289-4491

ACEP bylaws allow a subcommittee to pre-approve individuals to run for the Board of Directors. It is, then, the board itself that determines the candidates and the President. The result has been that the majority of Presidents and Board Members of ACEP have been closely associated with Contract Companies or Sole Proprietorships.

20 YEARS
1993-2013

As the American Academy of Emergency Medicine began to blossom we became aware that our situation correlated in large measure to that of Colonial America, so much so that we adopted an American Revolutionary theme. Our contentions were so similar that we recognized one could literally take the writings of Thomas Paine in his "Common Sense" pamphlets and change the names from those of the Revolutionary era to the modern day Emergency Medicine arena, and the centuries-old logic still applied.

The following, then, is an example thereof, including contemporary Emergency Medicine issues and studies. As Thomas Paine's COMMON SENSE is believed to have been the major writing leading to the imminent signing of the Declaration of Independence, we at the American Academy of Emergency Medicine believe that our infusion of COMMON SENSE will pave the way for quality care, stability, and democracy in Emergency Medicine.

The argument was made at the 1993 ACEP Scientific Assembly that a limited selection pool of Board candidates is good, as these individuals represent many years of experience in the government of ACEP. What they fail to comprehend is that a Board made up of the same individuals year after year does not allow change and growth, and most importantly, an awareness of the views of the ACEP membership that they were "selected" to represent.

The same individuals, year after year, succeed in retaining their positions on the ACEP Board, insuring that the views of the membership, and the federal lobbying efforts of ACEP, are controlled by a small body of usurpers, whose personal interests have in many instances interfered with the good of its membership. Only through truly democratic elections will the powers that be, be removed from their seats of corruption.

The ACEP Board, by their silence, has supported the growth of Contract Companies. They in turn, have not supported the growth of trained Emergency Physicians or quality Emergency Medicine. Witness Coastal's recent national advertisement which solicits ANY physician, no matter what specialty he or she is currently practicing, to become an EMERGENCY PHYSICIAN.

The ACEP Board has supported the growth of Contract Companies which allow stockholders to invest in Emergency Physicians seeing and treating patients. We are the only specialty that encourages company intervention. Remember companies are doing this to make a profit. It is in their best interest to bill patients the most and pay physicians the least, to the detriment of the growth and respect of our specialty!

The ACEP Board has supported Contract Companies that include in their contracts unethical clauses which wrongfully exclude Emergency Physicians from the normal channels of peer review forcing them to practice migrant Emergency Medicine!

The ACEP Board has supported Contract Companies which buy and sell emergency department contracts (and physicians) and do not allow any physician input into the merits and acceptability of the sale.

At the 1993 ACEP Scientific Assembly discussion of resolutions concerning Contract Companies was disallowed!

The ACEP Board refused to allow its membership list to be used for an opinion survey regarding Contract Companies.

At the 1993 ACEP Scientific Assembly discussion was disallowed on a resolution concerning exploitation of Emergency Physicians (this resolution was developed from the current Bylaws of the American Society of Anesthesiologists).

Most recently the President of ACEP refused an open forum debate of the problems with Contract Companies' involvement in Emergency Medicine and quality of care issues.

On March 15, the President of ACEP, Dr. John McCabe suggested that democracy does exist in ACEP in that physicians are free to join or not to join by choosing whether or not to pay their dues.

The authority of the Board of ACEP and Contract Companies over the ABEM Certified physicians must sooner or later end. Of the 17,000 members of ACEP, only 7,000 are Board Certified Fellows. Now is the time for the 13,000 ABEM Certified Emergency Physicians to unite to form an order based on quality, democracy, equality, and veracity.

Firstly, it is time to abandon the Board of ACEP.

87% of Emergency Physicians believe that ACEP policy should be changed to allow candidates to run from the membership at large with a ONE PERSON/ONE VOTE system enacted. Yet, this will never happen, as the ACEP Board will never willingly give up their thrones or the Bylaws of ACEP which protect their lineage.

70% of Emergency Physicians believe ACEP most closely represents the interests of Contract Companies and Sole Proprietors. Since the ACEP Board has refused to confront this issue, no change in policy will occur.

48% of Emergency Physicians feel that an alternative organization to ACEP is needed to change present national Emergency Medicine policy toward Contract Companies.

Secondly, it is time to abandon Contract Companies and Sole Proprietorships that strangulate Emergency Medicine.

91% of Emergency Physicians would prefer democratic groups. Only 4% want to work for Contract Companies.

94% of Emergency Physicians support national Emergency Medicine Reform which affirms that exploitation of any Emergency Physician by another Emergency Physician is unacceptable unethical behavior.

If Emergency Physicians do not act quickly, it may soon become impossible to stem the tide of Contract Company growth. Already three Contract Companies control more than 25% of the Emergency Departments. Because of outstanding profits, and venture capital generated on the stock exchange, they are growing at an alarming rate. The next generation of Emergency Physicians even now faces a difficult time finding

Thirdly, it is time to take the moral high ground and affirm the stance of the American Academy of Emergency Medicine.

- Providing high quality Emergency Care.
- Holding democratic and open elections.
- Opposing exploitation by Contract Companies and Sole Proprietorships, including:
  - Non-compete clauses (turning Emergency Physicians into migrant workers)
  - Peer review exclusion clauses (allowing unfair firing of Emergency Physicians)
  - Sale of Emergency Department Contracts (wasting community funds)
  - Excessive Management Fees (encouraging unqualified physicians to practice our specialty)
- Encouraging specialty training and ABEM Certification in Emergency Medicine.
- Promoting a broad view of Health Care Reform and the need for cost-containing and productivity enhancement.
- Supporting equitable contracts, anti-profiteering legislation, and the overall well-being of Emergency Physicians.

N.B.: Statistics - 14,362 AMA LIST OF EMERGENCY PHYSICIANS, 1000 RANDOMIZED, 337 RESPONDENTS. AVERAGE YEARS OF PRACTICE 9.5. ACEP MEMBERS 72%. TRAINING - PRACTICE TRAINED 55%, EM RESIDENCY 45%. EMPLOYMENT - HOSPITAL 25%, DEMOCRATIC GROUP 32%, AND MEGA-GROUP/SINGLE PROPRIETOR 43%.

Periodic awards will be given to the person on institution impacting significantly, either positively or negatively, the goals of the academy i.e. quality care, democracy, cost-containment, and equitable professional arrangements. While we are loathe to be so critical, we feel that only by exposing the acts of the wrong-doers and the institutions which stand by passively contributing to the destruction of our noble specialty can we correct the damages inflicted which one court described as "unconscionable." We are optimistic that one day soon we will have only praises.

Common Sense dictates that the premiere award goes to Coastal, Inc. and St. Anne's Hospital of Fall River, MA. After being begged by Coastal to provide services at any reasonable fee, an emergency physician of impeccable standing double-boarded in both Emergency Medicine and Internal Medicine was welcomed on staff at St. Anne's. After months of delivering excellent emergency care the doctor faced, without incident, the challenge of working through a hurricane, only to be awakened one morning shortly thereafter by a Coastal employee on the phone who briefly identified herself, said "Don't go to work tomorrow," and without further explanation or parting salutation hung up!

ACADEMY AWARDS

After repeated inquiries to Coastal and St. Anne's Hospital, at first by the practitioner and later by legal counsel, were rebuffed, the legal waltz began with Coastal refusing to be deposed.

When the inevitable deposition occurred, legal documents quote the following from a Coastal employee when asked why the doctor was in effect denied emergency department privileges and a source of income:

> "The client hospital sent a letter to me requesting that [the emergency physician] not be scheduled at St. Anne's any longer after the date of that letter. And the way her contract is written says that if I get such a letter then her contract is terminated."

Shortly after firing the emergency physician Coastal, in its infinite wisdom, hired an OB-GYN doctor to work in St. Anne's emergency department, a doctor who had recently caused National Emergency Services a multi-million dollar settlement for intubating the esophagus of the teenage son of an emergency department nurse.

Now, those of you who have not yet experienced this commonplace debauchery of law and bylaw, pick yourselves up off the floor and dust yourselves off for the happy ending: a state court declared the contract unconscionable and in clear violation of the doctor's due process.

Quote of the Month

"Acquiring [doctor's groups] is like going fishing. I catch the fish and throw them in the back of the boat, then my operating guys decide whether to fillet them or throw them back." Coastal Chairman Dr. Steven Scott, Forbes Magazine, Oct. 25, 1993.

Anyone feeling "filleted" out there? Please write us.

An Invitation to Participate in the American Academy of Emergency Medicine

Full Voting Member: **$195.00**
(Board-certified in Emergency Medicine or Pediatric Emergency Medicine)
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(Nonvoting status: physicians, hospital administrators, nurses, health policy planners, etc.)
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The American Academy of Emergency Medicine is a non-profit professional organization.

Our Mailing List is Private

AAEM POLICY REGARDING FELLOWSHIP STATUS AND USE OF THE INITIALS FAAEM

Fellowship status in a specialty organization is bestowed upon those colleagues who have demonstrated through their actions special devotion to their patients, to their community and to the medical specialty.

The officers of the American Academy of Emergency Medicine (AAEM) have determined that those physicians who are board-certified in Emergency Medicine and become Founding Members are granted immediate fellowship status. Residents and other board-prepared physicians joining during the "founding" period will be granted fellowship status immediately upon ABEM board-certification.

The willingness to put one's honor on the line and to take a firm stand in favor of quality medical care for the public and against exploitation in Emergency Medicine is deemed worthy of the fellowship honor.

The action granting immediate fellowship status to the board-certified Founding Members of AAEM is taken after serious thought. The officers of the American Academy of Emergency Medicine recognize that becoming a Founding Member of our organization is a bold action and one that is not without risk.

After the "founding" period has expired, board-certified members of AAEM will be able to achieve fellowship status through criteria which will include length of membership, service to the community and to the organization.

A Public Resignation

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

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

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

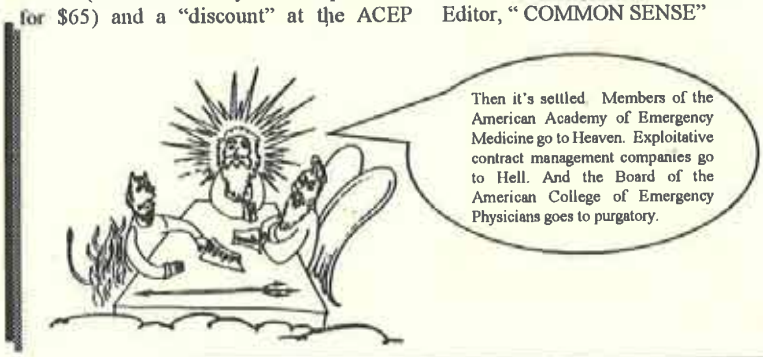
Words of the Phoenix rang in my ears - that it's hard for "us" to give up letters after our names (after all M.D. and D.O. cost 4 years and untold dollars.) And the "F" of F.A.C.E.P. was only a one time payment of $100 and included an additional four letters free (that's ten years worth of letters!) What else would I get for my $745 other than the Annals (available directly from the publisher for $65) and a "discount" at the ACEP convention? The only answer I could come up with after sitting through the ACEP Council meeting in Chicago was that I got a very expensive, swift kick in the rear!

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

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

Sincerely,

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



American Academy of Emergency Medicine
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Santa Fe, NM 87504
1-800-884-AAEM Fax: 505-983-1383

Drafters of the AAEM Mission Statement

AAEM WAS FOUNDED IN 1993. The following year, on April 30, in the Excalibur Hotel in Las Vegas, the group to the left met and wrote The Academy's first mission statement. It has changed little since then. The Academy's basic principles of organization were also settled upon, including things like open elections and one member — one vote.

Pictured in the photo from the Excalibur's pizza parlor are, from left to right: John Kealy, MD; Corie Conwell, staff person; Chris Minas, MD (deceased); Howard Freed, MD (standing); George Schwartz, MD; John Libby, MD; J. Douglas White, MD; Phyllis Troia, MD; Robert McNamara, MD; Les Zun, MD; Drew Fenton, MD; Rick Keys, MD JD (standing); Jim Keaney, MD; Scott Plantz, MD; and Harold Osborn, MD.

Drs. Keaney and McNamara would go on to serve as president of AAEM, while Dr. Zun is currently on The Academy's board of directors. Dr. Fenton served as editor of *Common Sense.*

AAEM MISSION STATEMENT

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

¶ Every individual should have unencumbered access to quality emergency care provided by a specialist in Emergency Medicine.

¶ A specialist in Emergency Medicine is a physician who has achieved, through personal dedication and sacrifice, certification by the American Board of Emergency Medicine.

¶ The practice of Emergency Medicine is best conducted by a specialist in Emergency Medicine.

¶ The Academy supports the growth of residency programs and graduate medical education, which are essential to the continued enrichment of Emergency Medicine, and to ensure a high quality of care for the patient.

¶ The personal and professional welfare of the individual specialist in Emergency Medicine is a primary concern to the AAEM.

¶ The Academy supports fair and equitable practice environments necessary to allow the specialist in Emergency Medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.

The Academy's original Mission Statement, reprinted from its first appearance in *Common Sense*, in January of 1995.

20 Years of Academy Leadership

AAEM has been lucky to have such great people serve as its officers, on its board of directors, and as editors of Common Sense. The Academy continues to work for you, the individual emergency physician, not corporations. If you want to further that mission, please get involved. Serve on or chair a committee, form a state chapter, run for the board of directors, or write for *Common Sense*. There is strength in numbers only if those "numbers" pitch in!

AAEM Past Presidents

1993* – March, 1996	James K. Keaney, MD MPH
March, 1996 – February, 2002	Robert M. McNamara, MD
February, 2002 – February, 2004	Joseph P. Wood, MD JD
February, 2004 – February, 2006	A. Antoine Kazzi, MD
February, 2006 – February, 2008	Tom Scaletta, MD
February, 2008 – February, 2010	Larry Weiss, MD JD
February, 2010 – February, 2012	Howard Blumstein, MD
February, 2012 – Present	William T. Durkin, Jr., MD MBA

*First AAEM election held in 1995.

Common Sense Past Editors

1993-1997	Drew Fenton, MD
1998-1999	Joseph Wood, MD JD
2000-2003	Robert West, MD JD
January 2004-June 2004	Jesse Pines, MD MBA
August 2004-June 2006	Howard Blumstein, MD
July 2006-Feb 2009	David Kramer, MD
March/April 2009	*Interim Editor, Larry D. Weiss, MD JD
May 2009-April 2012	David D. Vega, MD
May 2012-Present	Andy Walker, MD

The Founding and Flowering of AAEM

Robert McNamara, MD FAAEM
Past Presidents Council Representative

AAEM struggled when it was first formed in 1993. Jim Keaney, with assistance from Scott Plantz, created AAEM as a response to corporate influence in emergency medicine but few joined the cause. Keaney and others were deeply frustrated that the American College of Emergency Physicians (ACEP) had acquiesced to and perhaps even abetted that corporate influence. His book, *The Rape of Emergency Medicine,* exposed concerns with the quality of care in corporate-run EDs. These were important matters, but most in EM, especially those in academics, knew little of what he was crusading against because the corporate issue had been removed from the public eye of EM by the specialty's leadership (see below). The book was important, but AAEM needed a better hook to attract members.

Fortunately for AAEM and EM in general, Keaney had the wisdom to seize on a more visible controversy in EM — board certification. It was Keaney's adoption of a new membership criterion for full voting membership, American Board of Emergency Medicine (ABEM) certification, that allowed the Academy to quickly go from 100 to over 1,000 members.[1] At the same time Keaney was pointing out the corporate issues, the academic side of the specialty was embroiled in the Daniels lawsuit, litigation against ABEM for having closed the practice track to board certification as of 1988. Many academic physicians were sued or named as co-conspirators in this action. ACEP was alarmingly silent on this issue too, probably because a significant percentage of its members were not eligible for ABEM certification — but wanted to be. It was against the financial interests of ACEP to take a stand, and ACEP was also afraid of being caught up in the legal action. This issue created the opening that allowed AAEM to grow and gain influence, Keaney just needed to see the light.

Having read the book, I contacted Keaney because of a number of experiences — foremost of which was the displacement of our residency program from a two-hospital system in Philadelphia by a corporate group called Coordinated Health Services, which is now a subsidiary of EmCare. Our residency program's integrity was threatened by this, until we in turn were asked to take over the EDs in a different system, displacing a corporate group there. Seizing on this crisis as an opportunity, Jack Kelly and I researched the quality of care after the takeover and found evidence that EM training meant something.[2] Seeing this as proof of what Keaney had spoken of in his book, I reached out and he welcomed the academic connection. I told Keaney that if he adopted board certification as a criterion for full membership, I would join his board of directors. Facing little growth to date, he changed the membership criteria — the pivotal move that allowed AAEM to gain enough members to become a significant voice in the specialty.

As recently noted in AAEM communications, the Academy made its first big splash on the national scene in November of 1993, with the Mike Wallace 60 Minutes episode entitled "In Good Hands?," in which Keaney drew attention to corporate EM. I was interviewed for that show, based on the previously mentioned article on the increased quality of care after displacement of a corporate group. AAEM had the attention of all of EM. Keaney and Plantz had also been running conferences in Las Vegas with heavy attention to corporate and practice issues. At one such conference, on April 30, 1994, the mission statement of AAEM was created in a pizza shop in the Excalibur Hotel. In addition to Keaney, Plantz, and I, the emergency physicians in attendance at that event were Drew Fenton, Howard Freed, John Kealy, Rick Keys, John Libby, Chris Minas (deceased), Harold Osborn, George Schwartz, Phyllis Troia, Doug White, and Les Zun. It was an interesting mix of academics and those disgruntled with corporate EM. Most were founding board members.

In discussions regarding potential membership, it was clear that the academic community represented a key area of focus for AAEM, given its influence in the specialty and over graduating residents. With the notoriety of 60 Minutes, the Society for Academic Emergency Medicine (SAEM) afforded Keaney an audience at its meeting in May of 1994, and his presentation on the two issues of board certification and the exploitation of residency graduates was well received. The initial growth of AAEM was fueled largely by "pounding our shoe on the table" about board certification. This growth allowed us to bring our other main issue, corporate EM, to the table with a powerful voice.

In addition to growing AAEM, the founders attempted to change ACEP by submitting these issues to it. It was the initial thought of many on the board that if we could get ACEP to take a meaningful stand on these matters, AAEM could disappear after having served its purpose. Members of AAEM proposed resolutions at the 1993 ACEP Council meeting, calling for action on corporate issues such as restrictive covenants, and were shot down by legal counsel with the claim that to take such action would violate antitrust laws. In 1994 we came back with the right wording to allow these resolutions to be discussed, but they still failed to pass muster. Importantly, we also sought to change ACEP's membership criteria to require board certification. Plantz, Schwartz, and I ran for the ACEP board from the floor, as another way to get our message out. I was particularly proud of AAEM when we had a chance to see a huge boost in membership over a proposed change in ACEP's Fellowship Criteria, but did the right thing for the specialty anyway. In 1994, at the same time we were proposing board certification as a requirement for membership in ACEP, an ACEP committee came up with a proposal to allow FACEP status for non-boarded emergency physicians. I testified to ACEP, with the support of the AAEM board of directors that we would gain 1000 members if ACEP passed this and urged its defeat. It almost passed anyway, falling only eight votes short of the needed two-thirds majority. I believe our presence and testimony was a key factor in stopping this ill-advised action. This was an early example of AAEM doing what was right regardless of the consequences. Of

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course ACEP went on to open a path to fellowship for its non-boarded members in 2007, amid great controversy, and then closed that path at the start of 2010.

Those early days were tumultuous. We were accused of being radicals who were trying to "divide the house of EM". We certainly represented a major threat to those not board certified, but they had formed their own organization (AEP) at the same time, so we felt little remorse about our high standards. More importantly, we represented a group unwilling to accept the status quo of EM practice by corporations and a system in which a few physicians make an exorbitant amount of money by preying on their colleagues. This was a situation that had been allowed to develop with no resistance from ACEP, which should have been looking out for its members. Obviously, if ACEP had been viewed as effective on these two major issues, AAEM would never have had a membership base.

To explain in detail how ACEP became a bystander relative to the corporate groups would require another article, but in my opinion there were three major steps. One was the takeover of its leadership by physicians such as Leonard Riggs, the 1981 ACEP president who founded EmCare (and sold it to Laidlaw in 1996 for $40 million), and numerous other corporate types who were making money off the rank and file. The second step was for these "leaders" to radically change the original bylaws of ACEP, which condemned corporate practice and the taking of fees from colleagues. The third step was keeping the rank and file "dumb and down on the farm" regarding these issues. Part of this involved "shutting off the press," by refusing to allow further debate on these issues in the major journal of the specialty.[2] ACEP members who were disgruntled with profiteering were told to take their concerns to the ACEP Council, a body with a large number of those financially benefiting from the new EM model, and where any discussion of these issues was restricted by the anti-trust bogeyman.

At the time of AAEM's founding, a huge swath of emergency physicians were clueless as to their status as itinerant, exploited workers serving the interests of the few. They blindly accepted the pablum from the leadership that there was no need to see what was paid in their names or to have due process and other traditional physician rights. Across the board, when privately held physician groups tried to resist corporate takeover there was no one to stand up for them. As Bob Simon stated in 1983, greed in the specialty was destroying its future.[3] Simon also predicted the rise of the Academy, calling for another group to address the issues ACEP was ignoring.

As a comparatively small organization, all AAEM could do initially was rant and rave to stir up the masses. For the first few years we had little impact outside of awakening the specialty to the issues. Then, in 1998, AAEM was contacted by a group of EM physicians who practiced in the Catholic Healthcare West (CHW) system. They were confronted with the loss of their private practices and professional autonomy, not

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to mention a huge chunk of their income, when CHW purchased the assets of EPMG of California and created its own entity to take over the ED contracts in its system. Since CHW was one of the largest hospital systems, numerous EDs were threatened. California ACEP turned down pleas for help from its own members, dismissing the situation as "a private business matter." AAEM stepped in and the rest is history. Using the twin issues of fee-splitting and the California ban on the corporate practice of medicine, these physicians — with AAEM's backing — won the right to keep their practices. A specialty society in EM had stood up for the little guy, despite legal threats from CHW and unfounded fears of anti-trust violations. EM would no longer blindly follow the vision of the fat-cat EM leaders, with bedside physicians as sheep to be sheared. The CHW case was pivotal for the specialty, and if AAEM had not stepped in it is likely that every major hospital system would have viewed it as open season on emergency physicians in private practice.

The growth of AAEM allowed it to take additional steps for the bedside doc, including the first legal action ever filed by an EM professional society against a corporate entity, in the Mt. Diablo hospital matter involving Team Health. This suit was also settled in a manner favorable to the physicians AAEM was defending. Early on we also sought to elevate the game in educational conferences, by targeting talks only to board certified emergency physicians. This tradition, established in our first Scientific Assembly, continues today. There have been many other successes, such as aiding the growth of EM in the rest of the world, defeating attempts by BCEM to achieve legal equivalence to ABEM and AOBEM, and alliance with the *Journal of Emergency Medicine* — but it all started with the simple step of Jim Keaney deciding it was important to have an organization made up purely of board certified emergency physicians. ■

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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

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

August 21-23, 2013
- AAEM Written Board Review Course
  Orlando, FL
  http://www.aaem.org/education/written-board-review-course

September 8-11, 2013
- Mediterranean Emergency Medicine Congress VII (MEMC)
  Marseille, France
  www.memc2013.org

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.

AAEM-Recommended Conferences

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
  www.theairwaysite.com

September 27-29, 2013
- The Difficult Airway Course: Emergency™
  Baltimore, MD
  www.theairwaysite.com

November 22-24, 2013
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

Current news and updates

can now be found on the AAEM website

www.aaem.org

new!

Procedural Sedation and Advanced Resuscitation Expertise Card

The Advanced Resuscitation Expertise Card now includes procedural sedation.

Access and download your card from your AAEM member account
www.aaem.org/myaaem

The Business of Emergency Medicine

From Care to Compensation, Part 3 — Billing to Collection

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

In the final installment of this three-part series we continue to shine light into the "black box" of billing, to see how a patient encounter turns into cash. In the first article we discussed the process from the point of care to the filing of a claim, or billing a patient. The second article outlined service pricing, claim filing, tracking for proper payment, appealing payment denials, patient statements, and handling patient phone calls. This third and final installment deals with how to analyze the performance of your billing company, deal with payers (commercial insurers, Medicare, Medicaid), and maximize collections.

Measuring key performance components is the first step toward managing them. Remember the management principle: billers will respect what you inspect, so inspect for what you expect.

Implement Financial Controls

When payments arrive after claim filing and patient billing, key financial controls need to be in place. Money, like water, flows freely away unless it is channeled properly. Tying bank deposits to billing reports is a key control. You must first decide where the billing receipts will be deposited.

Good financial control requires that all deposits be reconciled with payments to assure that payments don't get lost or diverted, and that all payments received are applied to patient accounts.

A common arrangement is to have a commercial bank receive your deposits through a "lockbox" operation. Mailed payments are received at a post office box controlled by the bank, with deposits and electronic remittance received by a bank account dedicated to your billing. Commercial lockbox services copy or scan the checks with their associated payment vouchers or remittance notices, called Explanations of Benefits (EOBs), and transfer these along with patient and payer correspondence to your billing company.

Larger banks can do this electronically and billers usually like the organized batches, which tie deposits for the day to payment posting batches for reconciliation. But it's never as easy as the banks make it sound, and it's more expensive than you might think.

Banks charge for this service, with fees that are often hard to track. Fees for an average 30,000 visit ED can range from $350-800 per month. Going with the least expensive lockbox at your little community bank is often not worth the savings. Deposits might not be timely, batch amounts are incorrect, deposits belonging to someone else are credited to you — or worse, your payments go to another account. These are common problems. In addition to banks, many billing companies will perform this function for you, depositing payments into your account at no additional charge. If you choose this route, make sure none of your money goes into the billing company's own account by mistake.

Monthly reconciliation of payments deposited against payments posted as received is necessary for many reasons. For example, when billers don't post all payments received on time, follow-up bills will go out incorrectly — they will not reflect payments received and deposited — and patients will complain. You can track the timeliness of posting with a log that shows deposits reconciled to amounts posted, by date of posting.

More than 70% of all payer remittances are now sent electronically. Your biller must carefully monitor these, as payers commonly send electronic remittance advice notices (ERAs) to the biller for an amount other than what was actually paid. Without ERA reconciliation to the posting files, you might not realize that you are being paid less than the payer says you are.

Payer Contracting and Provider Enrollment

Provider enrollment is the process whereby your payer learns where to send your payments, who your physicians are, and determines whether they meet the payer's requirements as a qualified provider. Payer credentialing is essentially a legal process with forms and signatures needed in just the right place, at just the right time (Medicare will not pay you for service provided more than 30 days before the date they received your provider enrollment packet), accompanied by just the right documents.

Billers often provide enrollment services to assure this is done right, as it is a specialized function. Incorrect or untimely form preparation can have disastrous consequences, including barring your physicians from participating with the payer.

Payer contracting is also a legal process, one that requires careful attention to the profitability of the contract. The major goals of contracting are to keep or increase profitable patient volume, and protect your relationship with the hospital by reducing patient complaints about bills. Often payers deliver only the latter goal — reduced patient complaints — and sometimes they deliver on neither goal.

Contracts come at a price. Payers want to pay you far less than you charge and much less than is profitable for you. In some insurance markets payers are capable of redirecting patients to a contracted emergency department, but patients rarely check to see if emergency physician services are contracted (in-network) before presenting for care. They go where they believe they get the best care.

Your relationship and contract with the hospital must allow you to negotiate in good faith with payers. This has a **huge** impact on your bottom line. The hospital may argue that other specialists are happy with a payer's rates, so you should be too. However, payers have to pay enough to bring other specialists onto their panel, or patients won't

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choose that plan. In contrast, payers know that patients do not choose health plans based on whether their emergency physician bills will be covered, and they know that there is no need to pay reasonable rates to emergency physicians if the hospital will simply force you to sign the contract anyway.

Contract Rate Considerations

A reasonable payer contract involves much more than just the rate of compensation. Other terms in the agreement can make rates almost unimportant. Negotiate other terms as carefully as you do rates.

When billed properly, the commercially insured but non-contracted patient is normally where the group practice earns its profitability. In a well coordinated payer follow-up and patient billing process, you earn more cash per visit from non-contracted patients, even if they receive the insurance payments before paying you. Collecting from these non-contracted patients is more expensive for the biller, but normally yields better results for you.

Balance billing laws in some states, promulgated as "patient protection" legislation, prohibit billing certain non-contracted patients for amounts other than deductibles and co-pays. States with balance billing prohibitions but without fair payment laws are difficult for emergency physicians. Payers are free to reduce payments to a minimum if there is no threat of unhappy beneficiaries complaining about low insurance payments.

Balance billing laws usually pertain only to managed care plans, but they must be known before contracting. California, for example, has very strict balance billing laws but non-contracting is still preferred in most cases.

Payers want to contract at a percentage of Medicare, knowing that Congress is unlikely to allow pay increases at even the rate of inflation, and that Medicare payments may drop dramatically in the future. Contracts based on a percentage-of-Medicare rate for each CPT code should usually be avoided for a variety of reasons, but can be acceptable if a known Medicare payment rate is coupled to a prohibition on future reductions, and annual fee increases are allowed.

Never accept language that does not define exactly what the "Medicare rate" means per CPT code. Payers commonly use outdated and unfavorable Medicare rates or simply make up their own.

Common contract terms involve a fixed fee schedule per CPT code, case rates (a single payment for all services rendered, not tied to the CPT code submitted), dollars per RVU, or some combination of these. More progressive payers are also doing "quality rating" and "shared savings" contracts. These are currently limited in scope and volume but are likely to proliferate.

There are six essential data points you must know before you can negotiate a sustainable payer contract:

- Payer volume in your ED.
- Intensity of services (visit levels and procedures).
- Percentage of allowed amounts that the payer will require the patient to pay.
- Market rates of other payers.
- Your per-patient cost to deliver services.
- The degree of difficulty due to dealing with down-coding, bundling, denials, delays in payment, and audit defense.

The payer has all of this information and will use it against you. Be prepared with accurate and timely information of your own. Billing data are critical and can be obtained from your billing company, and nearly all billing companies will help you negotiate with payers. With this information you need to calculate your net payment per case (PPC) and your payment per RVU (PPRVU). Again, your billing company will provide this to you.

You must track acuities to assure that payers don't suddenly send you only their sickest beneficiaries. A contract that pays $170 per case to a practice with a $150 cost per case seems profitable, unless the intensity of those cases is such that you can only see 1.8 patients per hour (earning $306/hr), while you normally see 2.2 patients per hour (earning $330/hr). That means that if the average RVU/case for the practice is 3.50, but for this payer it is 4.28, the average PPRVU for the practice is $42.85, while for this payer it is only $39.72. Profitability is actually even more complex than this, as marginal per-patient costs are much less where small volume increases occur. A practice seeing 30,000 patients a year might easily be able to see another 1,000 pt/year at a very low incremental cost per visit. Determining whether lower PPRVU contracts actually produce more volume is an important contract consideration.

Audit Defense

All health plans have the right to audit your charts, in that their insurance policies pay only for correct coding and medically necessary care. If the record does not support the medical necessity or complexity of care, they have no obligation to pay for it.

However, you have the right to contest audit results, with particular rights for Medicare and Medicaid audits. You must exercise this right. Medicare audits have a well-defined course: five levels of appeal with certain actions, documents, and evidence needed at each level. You can learn a lot about Medicare audit defense just by doing an internet search on "Medicare Appeals Process."

Coding errors happen, so don't be afraid to admit them and refund over-payments. Admission of a coding mistake is not an admission of fraud. Initiate a compliance review of coding to be certain these were only infrequent errors, and learn from the mistakes.

Do not ignore an audit with a high error rate because only small over-payments were made. This is essentially an admission of large-scale wrongdoing and a promise to change your billing pattern. Refund requests often state such an admission. On the other hand, if the payer is wrong you must defend your practice. It is part of the cost of doing business with the payer.

Demand an actionable explanation for the payer's decision in each case — the payer must state clearly what you should have done differently in order to bill the claim accurately. The payer's vague allegation that "services were not medically necessary" or "history was incomplete" does

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not tell you what you should have done differently. This level of discussion forces the payer to address its own policy inconsistencies.

Be prepared by knowing CPT coding rules. Payer auditors are surprisingly careless and inaccurate, and when pressed often cannot defend their own decisions. You do not need a lawyer in the lower levels of appeals but you must know the coding rules. Auditors rarely understand even essential emergency care or clinical risks and considerations, so be ready to explain why the patient received the care delivered. This is another thing most coding/billing companies will help you with.

A final word about Medicare audits: be prepared for more of them in the near future. Medicare payments for visit level codes rose faster in emergency medicine than almost any other specialty from 2005-2010, because higher levels of care were being coded more frequently each year. A 31% increase in Medicare expenditures on emergency care occurred despite a volume increase of just 3.7%, because of increased coding of higher levels of care.[1]

The highest level of care in the ED, CPT 99285, is the most frequent code submitted to Medicare by emergency physicians. It is now the seventh most expensive line item in the Medicare Part B budget ($1.674 billion in 2011).[2] The OIG and the Department of Justice now believe that EHR cloning and "note bloat" are causing up-coding in emergency departments, and that high-level codes are being reported on patients who did not need or get that level of care.[3,4]

Arguably, much of the more intensive visit level reporting comes from an aging population that is living longer and has more complex problems.[5,6] Emergency physicians must be vigilant about coding and billing accurately, to meet this new challenge to the integrity of the specialty.

We welcome you to join the AAEM Practice Management Committee if you are willing to contribute your knowledge and insight into the billing, coding, and collecting issues that will shape the specialty in the coming years.

James R. Blakeman
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1. Raw data is taken from CMS annual utilization reports published with the Final Rule each year from claims filed by June 30 for dates of service January 1-December 31 of the prior year. CMS reports that this represents about 99% of all claims that will be allowed for payment each year. Data is by Specialty Designation, HCPCS code, modifier and facility versus non-facility.
2. Part B Physician/Supplier National Data–CY–2011. Top 200 Level 1 Current Terminology Codes, listed under CY 2011 Top 200 Level 1 CPT Codes Ranked by Charges http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/04_MedicareUtilizationforPartB.asp#TopOfPage
3. HHS Office of Inspector General, Coding Trends of Medicare Evaluation and Management Services, 2012 May, OEI-04-10-00180, recommended that CMS "encourage its contractor to review physicians' billing for E/M services" and to "review physicians who bill higher level E/M codes for appropriate action." Emergency department visits were singled out for notable shifts to billing higher level E/M codes.
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Another New Feature: "Curbside Consult"

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

Common Sense is introducing another new feature this year, an advice column called "Curbside Consult." It will not dispense clinical advice, but will answer questions from Academy members on nonclinical issues such as jobs and contracts; dealing with difficult colleagues, administrators, nurses, and other coworkers; personal finance; handling lawsuits and other legal problems; getting into the residency you want; running an independent group; dealing with shift work; keeping the spouse happy; and anything else nonclinical that someone asks about.

We not only welcome your questions, we need them to make this column work, so please submit a question on anything you need help with. Questions may be submitted anonymously by going to the AAEM website and clicking on "Curbside Consult," after logging in as an Academy member. We intend to answer questions quickly on the website, and then publish the most useful questions and answers in the print edition of *Common Sense* — just like "Letters to the Editor." Dr. Jonathan Jones, Emergency Medicine Program Director at the University of Mississippi Medical Center, came up with the idea for the column and will be primarily responsible for it, under the direction of Dr. Mark Doran, Asst. Editor of *Common Sense*. So whether you are a medical student, resident, or attending — send us your questions! ■

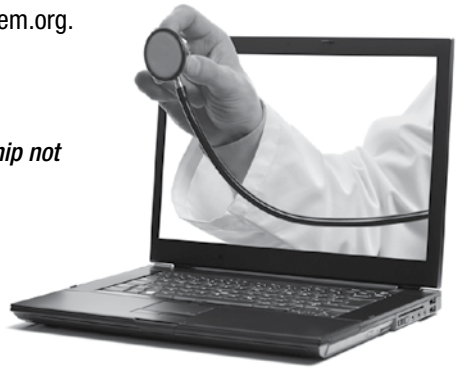
AAEM
Young Physicians Section
Invested in your future.

Call for Mentors

Interested in shaping the future of emergency medicine? YPS is looking for established AAEM members to serve as volunteers for our virtual mentor program.

For more information, visit **http://www.ypsaaem.org/mentors/** or contact us at info@ypsaaem.org.

YPS membership not required.



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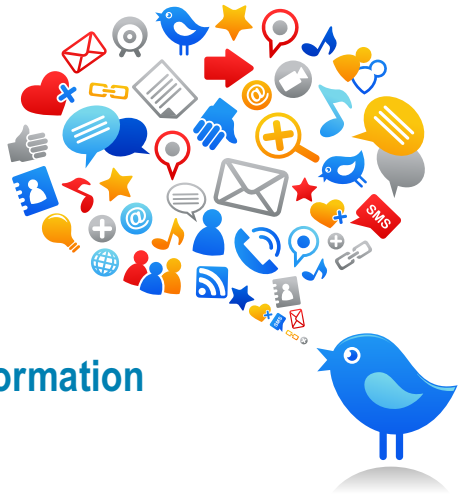

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19th Annual Scientific Assembly
The Cosmopolitan • Las Vegas, NV. • February 9-13th, 2013

Scientific Assembly attendees had the opportunity to interact with over 70 different organizations in the exhibit hall. We thank our exhibitors and sponsors for helping to make Scientific Assembly possible.

Amal Mattu, MD, speaking in his plenary session, "Best of the Best in Cardiology"

James Keaney, MD MPH, addresses attendees in his keynote remarks, "Past is Prologue: 20 Years After The Rape of Emergency Medicine"

The 2011-2012 AAEM Board of Directors: *First row (L-R):* Howard Blumstein, MD; Robert McNamara, MD; Kevin Rodgers, MD; John Christensen, MD; David Lawhorn, MD. *Second row (L-R):* Steven Hayden, MD; David Vega, MD; Michael Pulia, MD; Leslie Zun, MD MBA; Andy Walker, MD; William T. Durkin, Jr., MD MBA; Robert Suter, DO MHA; Mark Reiter, MD MBA. Not pictured: Michael Epter, DO; Joanne Williams, MD; Leana Wen, MD MSc

19TH ANNUAL SCIENTIFIC ASSEMBLY
FEBRUARY 9-13, 2013

Celebrating 20 Years: Many of AAEM's founding members attended this years Scientific Assembly.

Samuel Shem, MD PhD, author of *The House of God* and *The Spirit of the Place* presents his keynote address, "Staying Human in Medicine"

A full house gathered to hear **keynote remarks** from James Keaney, MD MPH, and Samuel Shem, MD PhD

James Keaney, MD MPH and Scott Plantz, MD, AAEM Founders, shake hands following their keynote remarks

2013 Award Winners

Below is a listing of the awards presented at the 19th Annual Scientific Assembly. AAEM recognizes and congratulates our dedicated members for their outstanding service, academic excellence, and commitment to the field of emergency medicine.

AAEM Awards

James Keaney Leadership Award — Roger Stone, MD MS FAAEM

Peter Rosen Award — Amal Mattu, MD FAAEM

Joe Lex Educator of the Year Award — Michael L. Epter, DO FAAEM

Master of the American Academy of Emergency Medicine —
Amin Antoine Kazzi, MD MAAEM FAAEM
Joseph P. Wood, MD JD MAAEM FAAEM

Young Educator Award — Michael S. Pulia, MD FAAEM

Resident of the Year Award — Leana S. Wen, MD MSc

Mitchell Goldman Service Award — awarded for serving as an examiner for AAEM's Pearls of Wisdom Oral Board Review Courses.

30 sessions:
Bill Gossman, MD FAAEM

15 sessions:
Bryan K. Miksanek, MD FAAEM
Allen Yee, MD FAAEM

10 sessions:
Terence J. Alost, MD MBA FAAEM
Michael N. Habibe, MD FAAEM
Michael H. LeWitt, MD MPH FAAEM
Martin A. Makela, MD FAAEM
Robert C. Oelhaf, Jr., MD FAAEM
Greg Lyle Palmer, MD FAAEM

5 sessions:
Alexander J. Cummings, MD FAAEM
Robert A. Hoogstra, MD FAAEM
Lee Malcolm Marks, MD FAAEM
John C. Owens, MD FAAEM
John C. Perkins, Jr., MD FAAEM
Alexandre R. Picard, MD
Timothy J. Rupp, MD FAAEM
Leslie V. Simon, DO FAAEM
Troy Sims, DO FAAEM
Andrej Urumov, MD FAAEM

Written Board Course Awards:

Top Speakers
Nima Majlesi, DO FAAEM
Kevin G. Rodgers, MD FAAEM

10 year awards:
Kevin G. Rodgers, MD FAAEM
Richard D. Shih, MD FAAEM

Open Mic Award:

Stephen Tantama, MD FAAEM

AAEM/JEM Resident & Student Abstract Competition Winners:

1st Place: Lauren G. Oliveira, DO
2nd Place: Weston Seipp, MD
3rd Place: Travis G. Deaton, MD

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Burnout and Productivity

Frank Gaudio, MD FAAEM
Operations Management Committee

Burnout is an operations management issue impacting not just the individual, but department throughput, risk management, patient satisfaction, employee morale, and department productivity. It's an operational nightmare for the entire department, which is why it needs to be addressed with administrative skill — and promptly.

Frank Gaudio, MD FAAEM, a member of the Operations Management Committee, authors the second article in this series on ED operations, following the article on patient satisfaction by Tom Scaletta, MD FAAEM, in the Sept/Oct 2012 edition of Common Sense.

The Operations Management Committee is proud to present this ongoing series, focused on operational best practices from around the country.

— Joseph Guarisco, MD FAAEM
Chair, Operations Management Committee

"Got a minute?"

As a director you know that it's going to be a bad day when you are walking to the ED and an administrator asks you that. Turns out one of your top docs received a complaint because of an altercation with a patient. Upon your review of the chart and interviews with other staff that were present, it turns out that the intoxicated psych patient refused to be examined – and after 15 minutes of verbal abuse the emergency physician and nurses had "had enough and decided to do things the hard way."

"Isolated incident or the beginning of a pattern?"
"Totally justifiable or absolutely unacceptable?"
"What, if anything, should be done?"

These are the questions that you as the director must address, but a larger question that you should consider is, "Could this be a case of burnout?"

The Problem

My patients' favorite medical reference, Wikipedia, reminds us, "Burnout is not a recognized disorder in the DSM, although it is recognized in the ICD-10 specified as a 'State of vital exhaustion' (Z73.0) under 'Problems related to life-management difficulty' (Z73)". Value or personality changes (becoming more angry or sarcastic), initial obsession with followed by a loss of interest in work, and withdrawal from or neglecting life outside of work (relationships, previously enjoyable diversions, and even basic needs like sleep, proper diet, and health) are manifestations of burnout. Burnout is not just exhaustion. Burnout is when every little thing is irritating and nothing is fulfilling, even work you once valued. Even fun isn't fun anymore. Practically every time I take a history from a patient when I suspect anxiety is a big part of the problem, the patient reports having a nerve-wracking job. It does not matter if the patient is the CEO of a Fortune 500 company or the grounds-keeper at a Fortune 500 company's headquarters: "Doc, my job is so stressful!" Many careers practically guarantee stress, but being unable to concentrate or neglecting your own well-being is depression or burnout or both.

Rabbi Abe Twerski, one of the world's experts on substance abuse, used this analogy to describe burnout. When his son left for college Rabbi Twerski gave him an iron. He doubted the iron would get much use, but during a visit on Parent's Weekend his son asked for a replacement. "I have had the same iron for 20 years, how did yours break?" he asked. His son answered, "I used it to iron a few clothes, and before it burned out it made a great cocoa maker and pizza warmer!" In the same way, excessive work at high levels can result in human failure as well. Does any of this sound familiar: a worker whose traits include determination; compulsion; high personal expectations; and the ability to neglect his own needs in order to focus solely on work, which is often over-scheduled because the worker feels irreplaceable? The poignant irony is that this list of qualities selected us and made us successful in medical school and residency. "I can't stop right now, what would my colleagues think if I took time for lunch? It is an Emergency Department!"

Its Impact on the Emergency Department

While burnout is a significant problem for the individual, it can wreak havoc in the workplace. No matter how productivity is measured, or what we think of the measuring stick or benchmark, any director knows that productivity drives the relationship between the group and the hospital. People perform better and are more productive when they are working in a positive milieu. The burnout of one person affects the entire department and group. The challenge for the director is to recognize the forces that are disrupting the department and address them successfully. Burnout is an administrative challenge on a number of fronts.

Productivity Costs

Reluctance to leave work is an early sign of burnout, while absenteeism because of lack of fulfillment with work or sub-par performance from unhealthy behaviors, like substituting substance abuse for a sense of satisfaction with work, are late signs. Nearly 40 percent of U.S. workers experience fatigue, according to a study in the *Journal of Occupational and Environmental Medicine*. Researchers noted that the lost productivity due to fatigue and its impact on health includes not just absenteeism, but also time the employee spends at work but is under-performing. Workers with fatigue cost $36 billion per year in lost productivity compared to their colleagues. Eighty-four percent of these costs were related to reduced performance rather than absences.[1]

Customer Satisfaction Costs

Then there is the issue of diminished customer satisfaction, whether it's patients, their families, members of the medical staff, or even

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administrators. One study showed that nurses who were burned out or were working under unsatisfying conditions had a 50% lower patient satisfaction rate.[2] These suboptimal interactions generate complaints for which the director must perform "customer satisfaction rescue." A survey of employers revealed that 22% of them experienced "damaged business relationships" because of disgruntled employees.[3]

Quality Costs

Quality outcomes are another victim of burnout's collateral damage. In a study of quality issues and burnout as measured by physician-reported error, in *Health Care Management Review*, Eric Williams found "a greater likelihood of making errors and a more frequent instance of suboptimal patient care" in the subgroup of sampled primary care physicians that reported stress and burn out.[4]

Morale Costs

Morale may be akin to obscenity in that is difficult to define, but to paraphrase Supreme Court Justice Potter Stewart, "I may not be able to define it, but I know it when I see it." Every director wants his team to have it (good morale), but measuring it can be difficult. Max Messmer, CEO of Robert Half International, pointed out that in one survey 35% of CFOs felt an employee with poor morale "greatly" affected the morale of the work team and another 60% said it did "somewhat."

Replacement/Retention Costs

The decision whether to retain or replace a worker is never easy. Both options carry costs. This lose-lose scenario is what the director who does not recognize and "handle" the burned out employee early faces. Under-performing employees require significant attention from employers, distracting managers from critical initiatives and causing other team members to pick up the slack. Those managers spend an average of 15-20% of their days dealing with employees who aren't performing well. Alternatively, recruiting – plus the orientation period and time it takes for a new physician to become truly efficient in a new system – could easily range from three to nine months. The total financial cost can approach $150,000.

Scope of the Problem

1. Researchers at the Mayo Clinic surveyed 7,288 physicians on their quality of life and job satisfaction. 46% of respondents reported at least one burnout symptom.[5]
2. In a report to a Wellness Task Force, 25% of 1300 ABEM diplomats in Illinois felt burned out or impaired.[6]
3. A Massachusetts Medical Society survey showed 28% of physicians were contemplating a career change due to the practice environment. Those numbers included 56% of neurosurgeons and 36% of emergency physicians.[7]
4. In a survey of 1350 emergency physicians with 763 respondents (56.5%):
   - 12% somewhat or very likely to leave EM within next year
   - 26% planned to leave EM within 5 years
   - 57% planned to leave EM within 10 years[8]

Recognizing Burnout

Identifying burnout is often a case of "the one with the problem is the last to know." This makes the role of the director even more important, not only in terms of repairing the ED but also in rescuing the physician and his career. Once burnout is spotted, the director can provide an independent and honest opinion of the physician's metamorphosis, or simply hold up a mirror. Signs of burnout include:

- A change in demeanor, such as becoming more irritable or having a generally negative attitude.
- General apathy towards work, chores, and other tasks; coming to work late or increased absenteeism; under-performance; inability to concentrate; constant exhaustion; loss of interest in new challenges; focusing on busy-work while turning life into a series of mechanical functions; and feelings of stagnation or boredom.

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- Personal values and beliefs may begin to lose their importance; the individual and work are no longer viewed as valuable; excessive pessimism; avoidance of previously enjoyable past-times like reading, vacationing, or entertainment.
- Withdrawal from social circles, crumbling personal life, feelings of detachment, or changes in relationships – especially family and colleagues.
- Neglect of personal hygiene; difficulty with healthy habits of exercise, diet, and regular sleep; trouble winding down after a shift (craving mind-altering substances to relax), or needing a double espresso to start the day.
- Psychosomatic complaints such as headaches, lingering colds, and other idiopathic issues.
- Depression and feelings of helplessness.

Solving the Problem

A large part of an ED director's job is to find emergency physicians with a burning desire to do their best, mold them into a team, retain them, and then inspire them to constantly improve. Unfortunately, too many organizations take the shortsighted approach of pressuring physicians to work harder and faster and, much like the college student's iron, they burn out prematurely. The smart and long-term view is to create a work environment which allows EPs to perform at the high level almost all of them aspire to – resulting in greater productivity, better career satisfaction, less burnout, less time spent answering complaints, and less time finding replacement physicians!

Accepting the obvious, that no one is perfect and neither is any job, the management and reclamation of the burned out physician is a challenge. To that end, there are several actions you may want to consider.

Step up and address the problem early. Recognizing and acting on a problem in its infancy, when it has yet to impact the department, requires much less time and effort than waiting until the problem grows into a major morale, quality, and psychological issue permeating the entire organization.

Get the burned out doc to admit there is a problem. This may be easy if his psychological defenses are low and he is open to finding a solution. Trying to deal with someone who has been compensating for their shortcomings by denial, and refuses to hear constructive criticism during performance reviews, will be considerably harder. Enlist the help of a colleague the physician trusts, if that physician won't listen to you.

Determining the cause of burnout may or may not be straightforward. Nonetheless, it must be done. Pay particular attention and practice active listening to the conversations of your colleague, and you should eventually have your answer. It may be as simple as finding a way of dealing with a disruptive physician on the medical staff, an intractable nurse, or demanding family members during patient interactions. It may be as complex as feeling unhappy at work and growing more frustrated with everyone because of loss of control over the workplace. Psychologists tell us that nothing correlates more strongly with a worker's stress than having no control over his own environment. EMR and CPOE software that do not work and that the physicians had no hand in choosing, radiology or lab report delays, and admitted patients held in the department resulting in a gridlocked ED are examples of things beyond our control that we are held accountable for by administrators, patients, and sometimes even our own families. All the outside mandates that EDs and emergency physicians must deal

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with now; from the Joint Commission, insurers, government regulators, and others; distract us from our true mission – taking care of people with serious illnesses and acute injuries. No one knows better than emergency physicians how we should do our job or how an ED should operate, yet it often seems that we are the most powerless people in the system. Be the cause simple or multi-factorial, discovering and dealing with the source of burnout is paramount – and nothing will lead to burnout faster than responsibility without power. From day one, work aggressively with your hospital administration to make sure emergency physicians have power/authority commensurate with their burden of responsibility.

Once identified, the source of burnout needs to be eliminated when possible, mitigated and adapted to when necessary. If it is an unavoidable part of the job, try everything you can think of to mitigate it. Don't let your people overwork themselves. Make sure a healthy work-life balance exists. Persuade people to take time away for vacation, CME, or to recharge. As Gregory Henry writes in *EM 360*, "The reason we go to meetings with other professionals is not necessarily for the information; we get to commune with people who understand the world from the same perspective we do. You get to understand you're not alone." Keep in touch and communicate feedback regularly. Ask about the shift, their general emotional condition, and pay attention not just to the words but also to subtle cues like facial expression and body language. Not all sources of burnout can be changed, but if all parties are committed to salvaging the relationship, most can. Making serious change is hard. "MapQuest" a road map for change and stick with it. Change alone can be the necessary catalyst to make everyone feel like things are improving. If change, or enough change, isn't feasible it may be time to move in a different direction. When parting ways becomes the best option, counsel the colleague to exercise care to avoid a similar situation when moving forward. Changing careers or jobs is a scary time and rash decisions are usually not good ones. Taking time for an honest self-assessment is warranted, as is reflection on the "Serenity Prayer":

> God grant me the serenity to accept the things I cannot change,
> The courage to change the things I can,
> And the wisdom to know the difference.

Encourage healthy lifestyle modifications. Burnout encourages us to overlook our own needs. Insist that people address these. Pick a type of physical activity or regular exercise. Start slow and stick to it. Build on this beginning and always try to find a workout companion that will make you exercise when you would rather not, and vice versa. Improving one's diet will take willpower, given the pace of the ED. Allow people time to get out of the department for 30 minutes to eat uninterrupted. Determine the five healthiest food choices the staff enjoys and purchase them for the department once a week. Finally, do anything necessary to sleep better and longer.

Make an effort to get the docs to leave at the end of their shifts. Overlapping schedules help tremendously. Spending too much time at work intensifies the feelings of burnout, diminishes productivity, and shortens careers.

Talk to a therapist. Not exactly an item on everyone's "bucket list", but given the nature of our business it might be worthwhile. Greg Henry again, "We are virtually isolated. We work next each other, but not *with* each other… In addition, we live in a punishing society; we have set out for ourselves unachievable goals, such as zero defects. You will have good days and bad days; if you fail to recognize that, you will be manipulated and forced into certain positions that over time will wear you down." A therapist can help dump some of the psychological baggage that we collect over a lifetime of work, before it becomes pathological.

Spend time with people who are important to you, doing things that are important to you. Family and true friends are the people we can count on to be honest and supportive. Connecting with friends we have not seen for a while may permit us to avoid talking about work gossip or daily events, and will open up new social and networking opportunities. Be unpredictable. Doing something completely random and out of character can make a huge difference. Breaking your routine is a simple way to feel refreshed.

The ED seems to be the final common pathway for the dark side of all societal problems. Violence, addiction, psychopathology, and the reality of those on the margins of society are what we are expected to

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perform miracles on every day, usually without the support of anyone outside the ED – even in our own hospitals. Finding a diversion is the key to balancing inner peace with the human onslaught that is our patient population. There are many different avenues that can be explored within medicine, such as teaching, writing, speaking, joining medical societies, taking an administrative role, etc. There are also opportunities outside of medicine. Coach a sports team of young people or find some other worthy cause you believe in, and volunteer there.

Finally, be patient and do not get discouraged. Burnout did not set in overnight and it will take more than a few days to recover. Set short and long-term goals to remind everyone that recovery is a process. This is not a straight-line graph, but rather two steps forward and one step back. Track progress, and over time achieving these goals will be therapeutic. Do not forget, "The person who needs help the most is least likely to ask for it." ■

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2013 ED Groups

We would like to recognize and thank our newest ED groups for participating in our 2013 100% ED Group Membership and ED Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

AAEM 100% ED Group Membership

Emergency Physicians of Community Hospital Anderson — Anderson, IN

American University of Beruit — Beruit, Lebanon

AAEM ED Group Membership

University of Mississippi — Oxford, MS

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified & board eligible physicians. Each hospital/group that participates in the group program will now have the option of two ED Group Memberships

- 100% ED Group Membership — receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- ED Group Membership — receives a 5% discount on membership dues. 2/3 of all board certified and board eligible physicians at your hospital/group must be members.

For these group memberships, we will invoice the group directly. If you are interested in learning more about the benefits of belonging to an AAEM ED group, please contact our membership manager at info@aaem.org or (800) 884-2236.

For a complete listing of 2013 ED Group members, go to http://www.aaem.org/membership/aaem-ed-group-membership.

Editorial: A Personal View on Burnout

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board Member

Both Dr. Gaudio's article on burnout and the young emergency physician's email to Bob McNamara (included in this issue) struck home with me, since I am now semi-retired at the age of 53, due in large part to my own feelings of burnout. How did this happen? More importantly for those 20 years younger than I, how can you avoid it? Or, given the current conditions in our nation's emergency departments, can you avoid it at all?

I chose emergency medicine because of its variety, unpredictability, procedures, opportunity to make diagnoses (solve problems), and occasional chance to save a life with quality years left in it — whether a young trauma victim, young asthmatic, or a kid with meningitis (when I started we didn't even have the H. flu vaccine, much less the pneumococcal vaccine, so there was still lots of meningitis around). I still love those things about the specialty, and if the clinical practice of emergency medicine allowed me to spend most of my time caring for patients with acute injuries and serious medical illnesses, I would still be happily at work full-time. One obvious source of burnout never bothered me: taking care of addicts, alcoholics, the poor, the deranged — patients Dr. Gaudio notes are "those on the margins of society." After all, if you want to take care of **sick** people, patients who **really** need a physician, you have to take care of the poor and others "on the margins." In an affluent country like the U.S., few people other than these and trauma victims suffer actual emergencies before old age. I once thought shift work was the only bad thing about our specialty, but even that didn't bother me too much — even in middle age. So why did I leave the full-time practice of a specialty I loved as recently as two years ago — one I enjoyed so much I always thought I would continue to do it part-time even if I won the lottery?

I found myself spending very little time, seemingly less and less in the last few years, taking care of people who actually belonged in an ED — or even needed the services of any physician at all — much less an emergency physician. And before you conclude that I am an unrealistic adrenaline junkie: I am not complaining that too few of my patients had life or limb threatening problems. I got over that in my youth. I am complaining about patients with problems so flagrantly trivial that **they** knew they didn't need to come to the ED. Chronic back pain patients without an acute exacerbation; other chronic pain patients with nothing new or different going on; prescription drug addicts with no acute medical issue at all, who just wanted more prescription drugs; people with ordinary colds; people who skipped work the day before and wanted a doctor's note; an ever-growing number of people attempting to use the ED as a way around their insurance companies, so they could obtain some diagnostic test that required preapproval outside the ED; and a shocking number of people who wanted me to "fill out these forms so I can get on disability, just like momma." These people weren't the famous "worried well" we all know, because they weren't worried — at least not about anything medical. In fact, I am convinced that if my ED had charged everybody $20 up front (illegal, I know), half our patient volume would have disappeared — with no impact at all on anyone's health.

While this situation did rob my work of a lot of its satisfaction, alone it wouldn't have been enough to burn me out. I was still seeing enough people who needed my help, even if it was just to reassure them and ease their anxiety, that I derived some satisfaction from the job. And, as part of an equitable democratic group, I was earning a nice income. That, along with knowing my labor was not enriching some profiteer at home in bed while I was up and working at 0300, helped a lot.

So what pushed me over the edge? Outside interference by non-physicians in my practice and loss of control over my own work environment, especially as exemplified by the electronic medical record (EMR) and computerized physician order entry (CPOE). My former hospital saddled the ED with what must be the worst software in the business. Neither the hospital administrator nor his corporate bosses asked me or my colleagues what we thought of the software they chose, and no emergency physician was involved in its selection. They ignored our unsolicited advice, which included warnings of how these systems would drastically cut productivity (patients/hour) in the ED. To make matters worse, our EMR and CPOE systems were separate and didn't communicate with each other, so we had to perform many tasks twice.

Even after we climbed the learning curve, this redundant and inefficient system caused permanent declines in every physician's pt/hr statistics. Of course the hospital administration complained about this, even though they were responsible for it and were warned about it in advance. The ED charts created were so incoherent that the hospitalists and other inpatient doctors complained they were incomprehensible. They certainly provided us with little legal protection in the event of a bad outcome. In many cases, in fact, the EMR charts were so disconnected from what actually happened in the ED that they would have helped the plaintiff. Worst of all, the CPOE software wasn't just slow — it was dangerous. It simply would not allow some important orders, but administrators told us it was too expensive and difficult to reprogram the software to permit those functions. And it was as though it had been designed to generate medication errors. In the couple of years that I labored under CPOE, I saw more drug errors and near-misses than in my previous 25 years of practice.

The end-result of this comedy of errors: I went from being able to see a patient, generate a chart, and discharge that patient in 15 minutes in the best-case scenario, to taking 25-30 minutes to see and discharge even the simplest patient who required no tests at all. I went from creating a medical record that told a coherent story as unique as the patient encounter that generated it, and was a shield against litigation, to an EMR chart that was a poor reflection of reality at best and an aid to the plaintiff's attorney at worst. I went from 25 years without a significant medication error to seeing drug errors roughly once a week. Worst of

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all, I went from spending most of my time talking to patients and their families to spending at least 90% of my time in front of the computer, point-and-clicking — a glorified data-entry clerk rather than a physician. And because of the nature of my hospital administration and its corporate superiors, my colleagues and I were powerless to make any changes.

To add insult to injury, we started to come under pressure to avoid **all** patient complaints — apparently even if that meant feeding the habit of drug abusers, treating viral infections with antibiotics, etc. Instead of "Do the right thing for the patient," it was "Make the customer happy at all costs." Despite volume of over 48,000 patients per year, no physician in my ED generated more than six non-billing complaints per year, and the vast majority of these were from drug abusers who were treated politely but appropriately. Yet every complaint resulted in unwelcome attention from hospital administrators, none of whom seemed to understand what goes on in an emergency department or the nature of our patient population. A complaint from a drug abuser who was treated correctly was given the same weight as one from the rare patient who found us on a bad day and really should have been treated better. Complaints were not being evaluated; they were simply being reacted to.

While I once looked forward to going to work, I now dreaded it. In January of 2012, after reviewing my financial affairs in preparation for filing tax returns, I realized that I didn't have to work anymore. I told my partners I wanted to switch to a half-time job. They agreed, but after doing that for a couple of months I realized it didn't solve the problem — I just dreaded going to work half as often. So, to the relief of the hospital administrators who were tired of hearing me complain, I quit.

I now work just 2-4 days per month in an ED slow enough that I can take time to talk to patients, even with the EMR and CPOE. This allows me to continue to act as an expert witness in emergency medical litigation, which I enjoy tremendously, and I can still call myself an emergency physician — an identity I remain proud of.

To quote Dr. Gaudio's article one last time, "...nothing will lead to burnout faster than responsibility without power." That is what happened to me. I found myself in an ED in which all the important decisions were being made by non-physician administrators, but the emergency physicians were then held responsible for those decisions — which we had warned of as misguided and destructive. Destructive of efficiency (patient flow), destructive of staff morale (two other physicians, a dozen nurses, and a couple of PAs left my ED in the months around my departure), and destructive of patient safety. From talking to other emergency physicians, I know I am far from alone. Most of the non-academic emergency physicians I know around my age seem to be looking for a way out of clinical practice. I am even hearing this from doctors in their early 30s, like our colleague who wrote Dr. McNamara.

If our specialty is to continue to prosper, we must regain control of our own practices. Non-physicians should not be making decisions that affect the clinical functioning of the ED. Only emergency physicians and nurses know what they need to perform at the highest level. Would a government bureaucrat, insurance company, tort lawyer, hospital administrator, corporate shareholder, or the Joint Commission go into the cockpit of a jetliner and tell a pilot, "You need to nose down and accelerate right now," or "You have to avoid turbulence at all costs, even at the risk of running out of fuel?" Well, some are so arrogant they might want to, but should they? Of course not. A wise hospital administrator asks his emergency physicians, "What do you need from me to do your job better?" Only an arrogant fool says, in effect, "I have chosen for you how you will do your job, including which tools you will use, and I don't care what you think about it." But that is just what those who create the regulations, mandates, legal threats, and administrative directives which now choke our EDs have done. Compliance with regulations and the avoidance of complaints have become more important in many EDs than quality patient care. Of course emergency physicians are burning out.

Our specialty overcame its first hurdle when the American Board of Emergency Medicine and its osteopathic counterpart were granted the status of full-fledged, independent boards. Since then AAEM has successfully fought off attempts to weaken the value of legitimate board certification. The Academy continues to fight to ensure that emergency physicians are treated fairly in the workplace, and are not robbed by contract management group CEOs and others asleep in bed at night while emergency physicians are generating income for them, taking care of patients. We have won some battles in that war and lost others, and the struggle continues.

I believe the time has come for us to take on a new cause, and fight against what drove me into early semiretirement: non-physicians forcing me to practice in inefficient and dangerous ways, and driving me away from the patient's bedside. This is an issue we should take on before more emergency physicians burn out and leave practice. ■

Attention YPS and Graduating Resident Members

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Thank You!

Elizabeth Hall, MD FAAEM
President, Young Physicians Section

As another year comes to an end, I would like to take a moment and thank all those around me. It would not have been possible to accomplish everything we did without the help of so many wonderful individuals.

Jennifer Kanapicki served as Vice President and worked hard in the development of the new YPS iPhone/iPod application. Michael Ybarra served admirably as Secretary-Treasurer. Michael Pulia, our Past President & YPS Director, remained dedicated to all YPS endeavors. Heather Jimenez worked hard as our Education Chair, while Sandra Thomasian took charge of Membership and Jeff Pinnow served as the Editorial Chair. Michael Tang did a great job serving as our Government Affairs Chair while Stephanie Gardner served as our RSA Director. Lastly, I would like to recognize Ginger Czajkowski and Janet Wilson for all their hard work behind the scenes as part of the AAEM office staff.

It has been an honor and privilege to work alongside all these incredible individuals this past year. I look forward to staying involved with the YPS as the Past-President this coming year.

I would also like to take a moment to thank all of you for what you do everyday.

Medicine can be difficult. There is an ever-increasing demand to see more patients as the volume of our departments keep increasing. There are pressures to order fewer tests and admit fewer patients, in hospitals that are overcrowded and at many times have few available in-patient beds. We spend an increasing amount of time sitting at the computer documenting, and less time at the patient's bedside. We call consultants and occasionally have to fight for our patients. We work all hours of the day — including nights, weekends, holidays — but don't always receive the respect and appreciation we deserve. However, we continue to work and return day after day.

I ask everyone to always remember why you went into medicine. Remember that we are here because of our patients. The febrile infant, the adolescent who presents with the sprained ankle, the young adult with an excruciating headache, the elderly man who is septic from his urinary tract infection, or the wife of the cardiac arrest patient you just pronounced — we are here for our patients and their families. That is what matters.

I thank all of you for what you do every day. Please remember to provide all your patients the time that they deserve, tell your colleagues you appreciate them, and know that you do make a difference in the lives of every patient and family that you encounter. What you do matters, and the people that you touch every day appreciate it.

Thank you! ■

AAEM/RSA President's Message

Preserving the Humanity of Our Patients and Fostering Our Own

Leana S. Wen, MD MSc
AAEM/RSA President

We EPs know that life in the ED is fast-faced, extremely busy, and ever-challenging. When things get crazy, it becomes habit to see our patients as "the chest pain in room 6" or "the lac in the hallway." We turn people with their amazing lives and fascinating stories into chief complaints and tiles on our electronic tracking board.

It's a practice that's easy to justify. After all, taking a long time with one patient can delay care for all the other people who are waiting to see us. However, the patient's story and the context of his illness are important to him — and critical to the care we render.

Learning our patients' stories also makes our professional lives more fulfilling. Last month I was supervising one of our excellent junior residents, who saw a patient she was confident she knew how to treat and disposition correctly. "Room 8 is an old guy from a nursing home with dementia, who was recently here for aspiration pneumonia. He comes in with altered mental status and a cough. He is A&OX1, febrile to 101. His lungs sound junky, otherwise neuro intact and vitals are fine. I'm going to get a chest x-ray and do an infectious workup. He probably has pneumonia, and will need to be admitted."

That sounded like a straightforward plan to me. It was a busy day, and the attending and I went into see this "old guy" who probably had pneumonia. We introduced ourselves to a woman in his room, his daughter, who was holding a book. It was on love: the metaphysical interpretation of love.

She saw me looking (frankly, I'd never thought about this topic). "Have you ever read it?"

I shook my head. "Well, it's my father's book," she said. "It's been printed in 100 countries."

Indeed, this "old guy from a nursing home" was one of the foremost experts on the philosophy of love. He had had a phenomenal career, filled with interesting adventures. The daughter was one of many people who made up his loving family — they were more than happy to tell me about him. In a few minutes, I had learned so much more about him as a person and as a patient.

How often do we find out, really find out, about our patients? Here's how not to find out: ask, "Do you have chest pain? Shortness of breath? Abdominal pain?" These yes/no questions may seem important to us as we check off a list on their review of systems, but they don't tell us anything about who the person in front of us is. We need to remember that every single one of our patients has stories. Everyone is someone's child, someone's spouse, someone's friend. They had careers they devoted effort to, accomplishments they are proud of, and goals they strove for.

As I near the end of four years of residency, I think back to the most memorable moments of my training. What stands out aren't the crazy traumas or the critical procedures, or the lectures or journal clubs. What I remember are the people I met, the patients I have been privileged to take care of, and their stories.

I remember Sharon, a lady who was dying of cancer. Her husband showed me a picture of the two of them when they were both three — they had met in a sandbox 80 years ago, and had been inseparable since then. I remember Fan, a middle-aged man who was so serene after a serious car accident that resulted in tetraplegia. I later found out that he was a Buddhist monk, one of the most revered in Asia. I remember Sydney, a drug addict I saw as an intern who returned two years later saying he was now totally clean and running a recovery program for teens. These are the stories I take away from my residency.

We EPs are in a humbling profession, an incredibly rewarding one, and we are honored to meet people from all walks of life. Instead of shying away from this task and turning people into chief complaints, I urge you to embrace the gift that our patients are giving us. Ask your patients about themselves. Not just what pain they have, or do they have this or that symptom — ask them who they are, what they do, what drives them, what makes them happy. Not only will it add depth to your diagnosis and treatment, knowing your patients will make you a happier doctor, one more attuned to the humanity of your patients — and to your own.

I explore issues in this column in my new book, When Doctors Don't Listen: How to Avoid Misdiagnoses and Unnecessary Tests. *I welcome your comments. Please email me, wen.leana@gmail.com and follow me on Twitter, @DrLeanaWen, and my blog, http://whendoctorsdontlisten.blogspot.com.* ■

Resident Journal Review

Procedural Sedation

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The ability to administer procedural sedation and analgesia (PSA) is a necessity for today's emergency physician (EP), and the list of indications for its use have grown over the years. The quest to determine the safest, most efficacious method continues, producing ongoing research on sedation techniques both old and new. This edition of "Resident Journal Review" focuses on selected updates on familiar agents and investigations into novel regimens over the past two years. For detailed discussion of the individual articles please see the full article that can be found on MedScape. Presented here is a listing of the articles reviewed and the take home points that we feel are important knowledge for all EPs.

Propofol

Since being first identified in 1996 by Swanson and colleagues as an agent suitable for aiding in completion of brief-yet-painful and anxiety-provoking procedures, propofol's use has increased significantly and is now one of the most popular sedative agents in the emergency department (ED).[1] It has a short onset and duration of action, with no active metabolites, making it ideal for use in the ED setting. Its adverse effects include nausea, vomiting, hypotension, pain on infusion, over-sedation, respiratory depression and the potential for respiratory arrest.[2] Despite this side effect profile, recent studies confirm the ability to administer propofol safely for procedural sedation and provide appropriate dosing in a variety of age groups.

Articles and Take Home Points:

McGrane O, Hopkins G, Nielson A, Kang C. Procedural sedation with propofol: a retrospective review of the experiences of an emergency medicine residency program 2005 to 2010. *Am J Emerg Med* 2012;30(5), 706-711.

- Propofol is safe for procedural sedation in emergency departments. Emergency physicians should be prepared with intravenous fluids and airway maneuvers in case of hypotension or hypoxia, although these are infrequently necessary.

Jasiak KD, Phan H, Christich AC, Edwards CJ, et al. Induction dose of propofol for pediatric patients undergoing procedural sedation in the emergency department. *Pediatr Emerg Care* 2012;28(5), 440-442.

- The effective induction dose in pediatrics appears to be inversely proportional to age with a mean dose of 2.1mg/kg; in particularly young patients it is advisable to keep a need for higher dosing in mind but to start low and titrate upward.

Weaver CS, Terrell KM, Bassett R, Swiler W. ED procedural sedation of elderly patients: is it safe? *Am J Emerg Med* 2011;29(5), 541-544.

- Propofol usage, at decreased dosages, is safe in elderly patients >65 years. There may be an increased chance of hypotension in older patients, so providers should be prepared to give intravenous fluids if needed.

Etomidate

Favored for its neutral hemodynamic profile, etomidate is often used to facilitate procedures in patients who are hypotensive or without hemodynamic reserve when the procedure is expected to be short in duration. There have been several studies in adult populations, but few prospective studies regarding etomidate use and safety in children.

Mandt MJ, Roback MG, Bajaj L, Galinkin JL, Gao D, Wathen JE. Etomidate for short pediatric procedures in the emergency department. *Pediatr Emerg Care* 2012;28(9):898-904.

- When using etomidate with concomitant opiates for analgesia in pediatric procedural sedation, providers may start with a dose of 0.2mg/kg and monitor patients closely for adverse respiratory events.

Ketamine

Ketamine has become a popular agent in PSA due to its combination sedative-dissociative-anesthetic properties. It has a rapid onset of action although slightly longer half-life than other agents, and is an attractive agent in patients who are at risk for hypotension due to its chronotropic and inotropic effects that help maintain their cardiovascular status. Its use has generally been avoided, however, in patients with suspected eye injuries due to reports that it might increase intraocular pressure (IOP), which has been controversial in recent literature.

Continued on next page

Articles and Take Home Points:

Drayna PC, Estrada C, Wang W, Saville BR, Arnold DH. Ketamine sedation is not associated with clinically meaningful elevation of intraocular pressure. *Am J Emerg Med* 2012;30(7):1215-1218.

Halstead SM, Deakyne SJ, Bajaj L, Enzenauer R, Roosevelt GE. The effect of ketamine on intraocular pressure in pediatric patients during procedural sedation. *Acad Emerg Med* 2012; 19(10):1145-1150.

- Ketamine does not appear to result in clinically significant elevations in intraocular pressure in pediatric patients without eye injury.

Tsze DS, Steele DW, Machan JT, et al. Intranasal ketamine for procedural sedation in pediatric laceration repair: a preliminary report. *Pediatr Emerg Care* 2012;28(8):767-770.

- Intranasal administration of ketamine of 9mg/kg can produce adequate sedation in children, but more research is needed to fully test its use and determine the optimal dosage for both safety and efficacy.

Ketofol

Because of their opposing effects on respiratory drive and hemodynamics, concurrent use of propofol with ketamine ("ketofol") for sedation has also become an increasingly common tool for procedural sedation, and its use has been supported by preliminary data in ED and OR settings.[3] Recently, three randomized, prospective trials have compared ketofol with other standard regimens for procedural sedation.

Articles and Take Home Points:

Nejati A, Moharari RS, Ashraf H, Labaf A, Golshani K. Ketamine/propofol versus midazolam/fentanyl for procedural sedation and analgesia in the emergency department: a randomized, prospective, double-blind trial. *Acad Emerg Med* 2011 Aug;18(8):800-6.

David H, Shipp J. A randomized controlled trial of ketamine/propofol versus propofol alone for emergency department procedural sedation. *Ann Emerg Med* 2011 May;57(5):435-41.

Andolfatto G, Abu-Laban RB, Zed PJ, Staniforth SM, Stackhouse S, Moadebi S, Willman E. Ketamine-propofol combination (Ketofol) versus propofol alone for emergency department procedural sedation and anesthesia: a randomized double-blind trial. *Ann Emerg Med* 2012 Jun;59(6):504-12.e1-2.

- Ketofol reliably provides more effective sedation at steadier levels than propofol alone or fentanyl/midazolam in concert. The combination of ketamine and propofol does not, however, appear to balance out their individual respiratory, hemodynamic, and CNS effects; episodes of respiratory depression were equally common with or without ketamine (20-30% of patients) and emergence reactions continued to occur in up to 30% of patients receiving ketamine despite the addition of propofol.

Dexmedetomidine (Precedex®)

Dexmedetomidine (Precedex®) is an alpha-2 adrenergic agonist that causes central nervous system (CNS) mediated sedation without affecting the respiratory drive. It is, however, limited by occasional hypotension and bradycardia. With shortages of common medications for procedural sedation presently looming, dexmedetomidine may be an increasingly available option in some emergency departments. There are no prospective studies or retrospective reviews of dexmedetomidine in emergency medicine journals, but its use in procedural sedation has been evaluated in other settings and we include some pertinent publications here.

Takasaki Y, Kido T, Sembra K. Dexmedetomidine facilitates induction of noninvasive positive pressure ventilation for acute respiratory failure in patients with severe asthma. *J Anesth* 2009;23:147-150.

- Dexmedetomidine has been reported to successfully facilitate tolerance of noninvasive positive pressure ventilation and thereby avoid the need for intubation in asthmatic respiratory distress.

Fan TWV, Ti LK, Islam I. Comparison of dexmedetomidine and midazolam for conscious sedation in dental surgery monitored by bispectral index. *Br J Oral Maxillofac Surg* 2012. http://dx.doi.org/10.1016/j.bjoms.2012.08.013 (Article in Press)

- It is unclear whether dexmedetomedine has a more or less favorable efficacy or safety profile compared to midazolam, but it appears to be an effective sedation agent for PSA.

Liao W, Ma G, Su QG, Fang Y, Gu BC, Zou XM. Dexmedetomidine versus midazolam for conscious sedation in postoperative patients undergoing flexible bronchoscopy: a randomized study. *J Int Med Res*

Continued on next page

2012;40:1371-1380.

- Dexmedetomidine for procedural sedation results in higher minimum oxygen saturations than benzodiazepines during particular procedures but may have a higher rate of bradycardia, the clinical significance of which is uncertain.

Novel Opioids (Alfentanil & Remifentanil)

Alfentanil is an opioid that induces sedation and anesthesia with a duration of action similar to propofol. It has no amnestic properties, and its side effects include skeletal muscle rigidity, hypotension, bradycardia, and respiratory depression. Remifentanil is a synthetic opioid analgesic with a therapeutic potency similar to that of fentanyl. It is rapidly hydrolyzed in the blood and therefore has a very short half-life with less accumulation. It also does not relax skeletal muscle, and its primary side effects are respiratory depression, nausea, bradycardia and pruritis.[4] There have been scant publications regarding use of these agents for procedural sedation in EDs over the past decade, and many EPs remain unfamiliar with their use.

Articles and Take Home Points:

Sachetti A, Jachowski J, Heisler J, Cortese T. Remifentanil use in emergency department patients: initial experience. *Emerg Med J* 2012 Nov;29(11):928-9.

- Remifentanil has a very short duration of action and shows promise as a hemodynamically stable analgesic, although may need concomitant treatment with anxiolytics and/or muscle relaxants depending on the procedure.

Miner JR, Gray R, Delavari P, Patel S, Patel R, Plummer D. Alfentanil for procedural sedation in the emergency department. *Ann Emerg Med.* 2011 Feb;57(2):117-21.

- Alfentanil appears to be efficacious and provides patient satisfaction, but has an adverse event rate similar to that of sedatives providing deeper sedation, and is associated with subclinical respiratory depression as evidenced by capnography.

Capnography in Procedural Sedation

While several studies, including some reviewed here, have utilized capnography and $ETCO_2$ measurements in evaluating for respiratory depression, this monitoring parameter has not yet been defined as standard of care in emergency department procedural sedation.

Sivilotti MLA, Messenger DW, van Vlyman J, Dungey PE, Murray HE. A comparative evaluation of capnometry versus pulse oximetry during procedural sedation and analgesia on room air. *CJEM* 2010;12(5):397-404.

Deitch K, Miner J, Chudnofsky CR, Dominici P, Latta D. Does end tidal CO2 monitoring during emergency department procedural sedation and analgesia with propofol decrease the incidence of hypoxic events? A randomized, controlled trial. *Ann Emerg Med* 2010 Mar;5(3):258-64.

- There is still not enough strong evidence to make an overarching recommendation for or against standard utilization of capnography monitoring during PSA. Further research comparing its use in groups with and without supplemental preoxygenation might be helpful. Until further data is available, it seems reasonable to use capnography in situations where preoxygenation is provided, so as not to miss respiratory depression masked by O_2 supplementation. In healthy populations not receiving supplemental oxygenation, pulse oximetry is an effective predictor of impending hypoxic respiratory failure.

Additional Resources:

1. Swanson ER, Seaberg DC, Mathias S. (1996). The use of propofol for sedation in the emergency department. *Academic Emergency Medicine*, 3(3), 234-238.
2. Miner JR, Burton JH. (2007). Clinical practice advisory: emergency department procedural sedation with propofol. *Annals of Emergency Medicine*, 50(2), 182-187.
3. Thomas MC, Jennett-Reznek AM, Patanwala AE. Combination of ketamine and propofol versus either agent alone for procedural sedation in the emergency department. *Am J Health Syst Pharm* 2011 Dec 1;68(23):2248-56.
4. Egan TD. Remifentanil pharmacokinetics and pharmacodynamics. A preliminary appraisal. *Clin Pharmacokinet* 1995 Aug'29(2):80-94.
5. Phillips WJ, Halpin J, Jones J, McKenzie K. Remifentanil for procedural sedation in the emergency department. *Ann Emerg Med* 2009 Jan;53(1):163.
6. Dunn MJ, Mitchell R, Souza CD, Drummond G. Evaluation of propofol and remifentanil for intravenous sedation for reducing shoulder dislocations in the emergency department. *Emerg Med J* 2006 Jan; 23(1):57-8.

Medical Student Council President's Message

Thoughts on "Everyday Leadership"

Mary Calderone, MS3
AAEM/RSA Medical Student Council President

There is something magical about what the New Year symbolizes: a fresh start, a new beginning, a chance to reflect on who we've been over the past year and how we can continue to better ourselves. This was the impetus for me to listen to Dr. Amal Mattu's speech from the 2011 AAEM Scientific Assembly, entitled "Everyday Leadership," over my Christmas break. With a rare abundance of downtime, I had the perfect opportunity for self-reflection, and given that the third year of medical school is one of the most formative times in a physician's career, I had no shortage of material upon which to reflect.

Broadly, the concept of leadership equates to serving as a catalyst for positive change. As Dr. Mattu says in his talk, leadership involves mentoring, inspiring, challenging, teaching, motivating and empowering people. The modifier "everyday" is important; it signifies that effective leaders constantly serve as an example of what they wish to see in others, in both their personal and professional lives, regardless of the setting. Inspiring another person toward accomplishing a goal is much more powerful than delegating a task. In this manner effective leadership not only improves the lives of others, but also improves our own lives by requiring us to strive for our personal best in order to serve as an example to others. Effective leadership doesn't necessarily require great feats, but reflects the cumulative sum of our everyday attitudes and actions.

As I've transitioned from the first two years of medical school to the last two years, the topic of leadership has grown in pertinence, as it permeates many aspects of the clinical setting. Despite the importance of leadership for effective patient care, especially given the increasingly team-based approach to medicine, no formal curriculum exists in most medical schools for teaching leadership skills. Rather, most medical students develop such skills through their interpretation of the examples they witness during their clinical experiences. Our observation of the interactions between attendings, residents, patients, and ancillary staff compromise the basis for how we understand the way health care teams function. Dr. Mattu says in his talk, "As a physician, every breath you take is a lesson learned to someone." The actions that we witness from our superiors serve as the basis for what we understand as acceptable and appropriate.

Rather than simply designating our observations as "the norm," we must reflect upon the examples we see as we progress through our training. We need to ask ourselves as we work with different individuals: "Is this an example of who I want to be? Or is this an example of what I wish to avoid?" We will one day become the residents and attendings whose actions influence medical students and thereby the next generations of physicians. We should seek to emulate only the examples consistent with our values, and we should remain aware of the influence of our actions on those who witness them.

As medical students, we may think of ourselves as "the lowest on the totem pole." With this philosophy, we may resign ourselves to simply observing the leadership skills of our superiors, rather than practicing and employing our own. However, the principles of effective leadership that Dr. Mattu discusses are relevant even to our conduct as medical students, especially when it comes to our interactions with fellow students. One particularly valuable piece of advice is to strive to be a positive person. Be the type of person that other people enjoy to working with and being around. While you should always aim for your personal best, do so in a manner that is genuine and gives others a chance to shine as well. Share opportunities with your peers. Support and help them even if you don't ultimately receive any acknowledgment for their success. As Dr. Mattu says in his talk, "A candle loses nothing of its light by lighting another candle." Be a team player. Achieving these ideals is easier said than done, but having high expectations for oneself and others is another key aspect of effective leadership.

If you wish to develop your leadership skills even further, seek additional opportunities to practice leadership. My involvement in AAEM/RSA has been one of the best forms of leadership training I have ever experienced. It has provided me with excellent examples of leadership and the opportunity to develop, reflect upon, and continually improve my own skills. With elections for the medical student council approaching, I encourage you to apply for a position. If you find yourself seeking some inspiration, check out the recording of Dr. Mattu's "Everyday Leadership" talk on the AAEM website. You won't be disappointed! ■

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