THE NEWSLETTER
OF THE AMERICAN ACADEMY OF
**EMERGENCY MEDICINE**

# COMMONSENSE

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## INSIDE




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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)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
International Student Member: $30 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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

# Tenet Wants Emergency Physicians to Subsidize the Rest of the Hospital

Mark Reiter, MD MBA FAAEM

Tenet Health, one of the largest hospital networks in the country with 49 hospitals, recently put the contracts out for bid at 11 of its hospitals in California, to replace their emergency medicine (11), anesthesiology (11), and hospitalist (5) groups. Currently, most of the hospitalist contracts and some of the anesthesiology contracts include a subsidy from Tenet, while most of the emergency medicine contracts generate enough revenue through collected professional fees to be entirely self-supporting and quite profitable. According to some of the local groups involved, Tenet made it clear to the large contract management groups (CMGs) it is soliciting that it is looking for a no-subsidy arrangement for all 27 contracts (three specialties at 11 hospitals). Essentially, Tenet wants the profits from the emergency medicine contracts to cover its losses on the hospitalist and anesthesiology contracts. As only the largest CMGs can even hope to staff 27 new contracts at once, it looks like many local emergency medicine, anesthesiology, and hospitalist groups will be tossed out. This situation parallels the hospital-CMG joint ventures I wrote about a few months ago, since it is another attempt by hospitals — like CMGs — to feast on the professional fees of emergency physicians.

In the past, the quality of the care provided by a medical group was of paramount important to the hospital. But for Tenet Health, a for-profit hospital network, it appears that minimizing expenses and maximizing profit trumps everything else. Tenet earned a profit of $387 million in the first quarter of 2014. Perhaps by destroying the medical practices at 11 hospitals, Tenet will be able to cut its hospitalist and anesthesiology subsidies by a few million dollars in future quarters and make its investors happy. Of course, many of these groups have served their hospitals and their communities well for decades and built strong, productive relationships with their medical and nursing staffs. I've been told that many hospital CEOs are very supportive of their local medical groups, but the decision to put the contracts out for bid was made at Tenet's headquarters in Dallas. Tenet's corporate executives are not so easily swayed by simply providing excellent care — not when there is a chance to squeeze out more profit for investors and corporate officers.

If an emergency medicine group requires a significant financial subsidy from the hospital it serves, it will understandably be at risk of losing its contract. However, most of the ED contracts are quite profitable with a few requiring modest subsides. Rather, the plan is to allow a large CMG to take over lucrative emergency medicine practices in exchange for taking over money-losing hospitalist and anesthesiology practices. Essentially, the emergency medicine practices will serve as a piggy bank to be raided by the CMG and the hospital. Of course the CMG needs to show a nice profit to its investors too, which is hard to do without the anesthesiology and hospitalist subsidies. So, we can expect a lot more belt-tightening at the affected hospitals: less physician coverage, greater use of midlevels, and of course lower pay for physicians. The future is not bright for these emergency physicians, whose professional fees will now go towards subsidizing hospitalist and anesthesiologist salaries, in addition to satisfying investors in Tenet and the CMG — and to enriching the leaders of both corporations.

Federal fee-splitting laws, enacted to prevent kickbacks and abuse, prohibit the distribution of part of a physician's professional fee to any entity in excess of the fair market value of services provided to that physician. When part of a physician's professional fee is being distributed to a hospital or CMG, the parties involved may be in violation of those laws. If an emergency physician's professional fees were to go towards subsidizing other hospital-based specialists, or to pad the bottom line of a for-profit corporation, this would appear to be an extreme violation of federal fee-splitting laws. It is also important to recognize that California has some of the strongest corporate practice of medicine (CPOM) laws in the country. These laws, drafted to protect the public due to the potential for abuse when a corporation's fiduciary duty to its shareholders is in conflict with a physician's duty to his or her patients, prohibit non-physician, lay corporations from owning or controlling physician practices. Tenet Health is not a physician-owned corporation, and neither are EmCare and TeamHealth, two of the CMGs invited to bid on these contracts. Therefore, it seems to me and others within the Academy that if Tenet implements its plan, it will be in violation of both state and federal law.

If Tenet replaces the physician practices at 11 hospitals with one huge CMG, I expect the quality of care to suffer. I don't believe there is a group in existence that is capable of recruiting hundreds of highly qualified emergency physicians, anesthesiologists, and hospitalists to one state in a short period of time. In addition, highly qualified physicians are unlikely to join a practice where they will probably be underpaid, understaffed, and overworked — as will likely be necessary to cover both the eliminated hospitalist and anesthesiology subsidies and provide the CMG's profit. A pie can only be cut into so many slices. Most likely, the CMG will have to settle for whoever it can get to cover the schedule, which will include physicians who fall well short of the current community standard. In addition, the change will be highly disruptive to the hundreds of physicians who have learned the systems and processes of their practice over time, and have developed relationships with their hospitals and medical staffs — not to mention the disruption to local nursing staffs, patients, and communities.

Tenet's proposal to replace the physician practices at 11 hospitals is one of the largest attempted disruption of physician practices by a hospital

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network since the late 1990s, when Catholic Healthcare West (CHW), now Dignity Health, attempted to force EPMG and several other private emergency medicine groups at its hospitals to join Meriten, its wholly owned subsidiary, so that CHW would essentially own its emergency physicians' practices. In response, AAEM (with the support of the physician groups involved, California-AAEM, and the California Medical Association) filed suit, citing violations of corporate practice of medicine (CPOM) and fee-splitting laws. After initial unfavorable hearings in court, CHW sold EPMG back to its former physician-owners, who then reorganized into a fairer, more democratic, physician-owned group. This was a huge win for AAEM, for the private practice of emergency medicine, and for all the "pit-doc" emergency physicians involved.

The leaders of several groups affected by the current scheme have contacted AAEM and asked for our assistance. I have spoken at length with many of these physicians; have sent letters outlining AAEM's concerns to the relevant hospital leaders, hospital boards, and medical staffs; and have discussed the issue with local media. Several of the medical staffs at affected hospitals have contacted Tenet leadership and expressed support for their local groups, decrying any plan to replace those groups with out-of-state, for-profit corporations. Incredibly, Tenet is still considering moving ahead with its plan despite the opposition of local medical staffs. Apparently, corporate leaders in Dallas feel they know more about what Tenet's California hospitals need than do local hospital administrators and physicians. Local media have also been very supportive of the local medical groups. The emergency medicine practices at these hospitals are still on the chopping block, however, simply because they are to be cash cows for money-losing practices in other specialties.

The California Medical Association (CMA) recently announced its opposition to Tenet's takeover. AAEM and California-AAEM hope to repeat our success of 15 years ago, when we worked together with the CMA to resist the illegal takeover of emergency medicine in California. AAEM hopes that Tenet will come to its senses and realize that any imagined savings from destroying these group practices at 11 hospitals will be offset by new inefficiencies, decreased quality of care, staffing shortages, and backlash from nursing staffs, medical staffs, community leaders, and patients. Tenet should make the smart move and walk away from this plan. It is bad for Tenet, bad for its hospitals, bad for physicians, and bad for patients. Several of the local medical groups have told AAEM they do not intend to stand idly by while they lose their practices. If they choose to fight this seemingly illegal takeover, AAEM and California-AAEM will support them in any way we can.

Mark Reiter, MD MBA FAAEM
President, American Academy of Emergency Medicine ■

### 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.

# Will Work for Free

Jonathan S. Jones, MD FAAEM
Assistant Editor, *Common Sense*
YPS Vice President

I don't know about you, but I can't remember ever seeing a sign with this statement. I've seen the typical signs and some less than typical, but never, "Will Work for Free." However, I know this sign exists as apparently I've been carrying it around with me for quite a while. Perhaps you remember a small ad in the May/June issue of *Common Sense* announcing the call for an Assistant Editor. The announcement said something vague about a lot of work and zero pay. It sounded like the perfect job, so I applied.

As the new assistant editor, I first want to thank you for being an active member of AAEM. Without active members, there would be no *Common Sense* and without *Common Sense* there wouldn't be this wonderful job opportunity. Thank you for reading and thank you for engaging. As assistant editor, I have no agenda to promote, because that's not what assistants do. However, I do have interests and ideas on how to help keep *Common Sense* successful, and I want to share a little about these.

I've been an AAEM member for about seven years (ever since I finished residency). I knew very little about AAEM during residency but that changed quickly once I graduated. I started my career in academics (and have stayed in academics for my entire career so far) and was told that because I was an academician, AAEM didn't really apply to me. Either because I'm stubborn and stupid or maybe insightful and intelligent, I ignored that advice and joined the Academy.

As I began my EM career, AAEM appealed to me because I felt they represented real standards and values. Prior to joining I didn't read the official vision or mission statement, but I did pick up a copy of *Common Sense* which I found lying around the ED. I don't remember any of the articles but to me, they all seemed to have the same theme. From the President's Message all the way to the advertisements and the job bank, everything just seemed to be about delivering expert care to patients and protecting those who provided it. There wasn't much about billing and coding or sign-on bonuses. There was discussion about protecting EPs who practice good medicine, but annoy the hospital's surgeons. There was discussion about the importance of residency training. There was discussion about EPs only reporting to their patients and not to a corporate entity.

The cover of *Common Sense*, then as now, states "The Newsletter of the American Academy of Emergency Medicine." To me, then as now, that seems like the only lie published. Per Merriam Webster, a newsletter is "a short written report that tells about the recent activities of an organization." Maybe I skipped that part of the issue, but that's not what I got out of reading it. I decided to join AAEM because what I read excited me. It made me proud to be an Emergency Physician. It made me a little mad and nervous too. It made me realize that while practicing emergency medicine is the best job in the world, it might not stay that way.

Another word is defined by Merriam Webster as "a written statement declaring publicly the intentions, motives, or views of its issuer." To me that is what *Common Sense* is. And that is why it is so important. It is not written by one person or by the board of directors. *Common Sense* is written by AAEM members. Sometimes the articles are controversial, sometimes not. Authors may disagree with each other. But to me at least, the ultimate message is always the same: that patients deserve expert care, that physicians need to be allowed to provide expert care, and that expert emergency care is only provided by emergency medicine specialists.

I think that second definition fits a little better. It's gotten a bit of a bad rap recently, but the second word defined is "manifesto." Maybe that should be the new tagline: "*Common Sense* — The Manifesto of the American Academy of Emergency Medicine." OK, maybe not.

This is why I wanted the job of assistant editor though. Andy Walker is doing an amazing job as the editor and all the contributors are working hard to make this a worthwhile publication and one that continues to inspire and engage EPs. I thought that maybe I could help out. Over the last year or so, I've written a few articles for *Common Sense*, mostly through the YPS section. Some have been less than enthralling, I know. Others have generated some discussion, feedback, and "Letters to the Editor." I'll try to produce more of the latter.

In my last article in the May/June issue, I stated a few opinions of mine and asked a few questions. I also published my email address asking for feedback. It appears that the most controversial topic concerned mid-level practitioners. I stated that I felt that emergency care provided by non-physicians is not expert care. I then asked if we were prepared to eliminate mid-level practitioners from the ED. Maybe I'll get fired after my first week on the job, but I can't see ever changing my opinion that expert emergency care is only provided by emergency medicine trained physicians. However, as suggested in "From the Editor's Desk" in the same issue, the answer to the question about mid-level practitioners may be another question: Does every patient presenting to the ED require expert emergency care?

I'm not sure that *Common Sense* will answer every question members have about emergency medicine and that seems just fine. In fact, with the exception of knowing the date and location of the next scientific assembly, it seems to me that if you have more questions than answers after reading an issue, then it was a good issue. Other than the routine tasks of editing, that will be what I work towards.

As the program director of the EM residency at the University of Mississippi Medical Center in Jackson, MS, I also obviously have a keen interest in students and residents and so I will work to engage students and residents as well as young members. I also want to make sure that any resident or new physician picking up an issue of *Common Sense* has the same initial reaction to it that I did.

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Thankfully, I don't have to do this alone. Nor do I have to do it only with the help of the current editor, Andy Walker. We're not the only ones who thought a job with a lot of work and zero pay sounded like a good idea. This Academy was founded by such people and has grown by the work of such people, and I'm pretty sure that everyone reading this right now is such a person. Maybe we're all suckers, but we're also all dedicated to our cause. We're dedicated to EM and to our patients.

Organizations do not grow and thrive because their members are motivated by profit or personal gain. Rather, they thrive when their members are motivated by a common vision. The Academy's vision is, "A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference." I did not know this when I joined, and I feel fairly confident that most members did not know it either. I'll try to make sure that every single EP knows this vision, maybe not verbatim, but in essence. But I'll need some help. Let's make sure this isn't just a newsletter. Share your knowledge, experience, and opinions. Contribute to *Common Sense*. ■

## Do You Have Locum Tenens Experience?


**We are looking for emergency physicians with experience in locum tenens work who would be willing to share their experiences for an upcoming *Common Sense* article. We are hoping to put together a brief comparison between companies, as well as gather insight into what emergency physicians think of their locum experiences. If you would be willing to assist with this, please contact Christopher Thom at** ct9k@virginia.edu**.**

## We're listening, send us your thoughts!

COMMON SENSE
Letters to the Editor

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# Letters to the Editor

Jonathan S. Jones, MD FAAEM
Assistant Editor, *Common Sense*
YPS Vice President

A "Letters to the Editor" feature is now available on the *Common Sense* section of the AAEM website. Members must log in with their AAEM username and password to read or post letters, or to comment on letters (www.aaem.org/publications/common-sense). If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in *Common Sense*.

I hope to hear from many of you, even if you are criticizing me. I need your feedback to make *Common Sense* an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the "Letters to the Editor" feature to become a forum for civilized but vigorous argument, and the more vigorous the better.

— The Editor

**Letter in response to the May/June 2014 "YPS News" article titled "Why Don't EM Physicians Reproduce":**

I agree with your statements but would like to add one: The use of patient satisfaction surveys negate the importance of expert emergency care provided by board certified EPs.

If the patient is always right, then you do not need the expertise of a trained EP. If achieving high satisfaction scores by meeting unrealistic preconceived notions propagated by non-physicians and marketing executives has become the current goal in EDs across the country, the EPs will be forced to choose between providing good care and self-preservation.

Under this current system, we don't need any more experts. Every patient is their own expert. Until we start demanding to be treated like the limited resource that we are, this will not change.

Dave Bryant, DO FAAEM

Thank you for your letter and I couldn't agree more. Multiple recent studies have explored the relationship between patient satisfaction and outcomes and I presume that many more studies are underway. I am proud of the family of medicine's commitment to practice evidence based medicine and willingness to change practice based on that evidence. I am interested to see if administrators will be similarly committed to changing practice based on evidence.

— The Assistant Editor

**Letter in response to the May/June 2014 "YPS News" article titled "Why Don't EM Physicians Reproduce":**

Thank you for writing in *Common Sense*. I wonder why you say, "Are we ready to eliminate mid-level practitioners from the ED?" I am also wondering if you have read Dr. Walker's "From the Editor's Desk" article in the same issue of *Common Sense*. His article, about the percentages of patients with minor problems coming to EDs, would support more mid-level practitioners in EDs and not less. Certainly I am unaware of a move to eliminate mid-levels from EDs. Why do you want to do this? Your article does not make a case for such.

Are there plenty of ED patients who could be seen by mid-level practitioners? Are mid-level practitioners working with EPs cheaper than more EPs? Are there plenty of locations that have difficulty attracting EPs? I say we need to train more mid-level practitioners. I prefer that an ED with low acuity patients have several mid-levels and one or two EPs. I prefer that the mid-levels be directed by an EP.

However, in the current state of ED staffing there are not even enough EPs to supervise the mid-levels in many EDs. We don't need to eliminate the mid-levels but do need more EPs working with mid-levels.

In Colorado we still have EDs run by family practitioners turned ED docs. We have plenty of mid-levels in the EDs. Some places have family docs supervising mid-levels in the ED. Some places have an EP on call to the ED while the mid-level sees the patients. The EP comes in when called by the mid-level or when it gets so busy that the mid-level is falling behind. None of the above situations would support complete EM trained coverage. The system and the patients don't need it. The cost would be extreme. And I don't believe that patient care is suffering. Do you have evidence to the contrary? I just can't see why we would do this.

Anthony DeMond, MD MAAEM FAAEM

Thank you for your letter. As you mentioned, Dr. Walker's column in the same issue may have pointed us in the right direction, or at least asked another interesting question. As you, I am unaware of any move to eliminate mid-levels from the ED and in fact I would not support such a move. I stated, "Emergency care provided by non-physicians is not expert care." This is my opinion and I will always believe it, otherwise, I am not sure why I have been studying and working so hard for the last 15 years of my life. This statement does not mean that non-physicians have no role in an ED or cannot provide expert care in an ED. I asked the questions I did in an attempt to generate discussion on solutions to the problem of not enough EM trained physicians.

I agree that mid-levels will likely play a role in providing patients expert care. However, I strongly feel that the most complicated and dangerous

Continued on next page

patient is the undifferentiated patient, i.e. the emergency medicine patient. Dr. Walker correctly points out that not only do many of our patients not have an emergent medical condition, but that many of them do not even present as undifferentiated patients. I propose that these patients do not need expert emergency care. An effective model to deal with this reality could be similar to what you suggest: a team of highly qualified nurses and mid-levels working with a single similarly qualified EP. This group could likely provide expert emergency care to double, triple, or quadruple the number of patients cared for by one EP now. However, I see many obstacles in the way of making this a reality, not least of which is the current onerous, ineffective, and inefficient documentation standards and processes. ■

— The Assistant Editor


# Congratulations –
## AAEM Physicians Certified for 30 Years

This year, the American Board of Emergency Medicine (ABEM) is recognizing emergency physicians who have marked 30 years or more of being board certified in emergency medicine.

AAEM joins with ABEM in recognizing the dedication these physicians show to our specialty, the recognition of the value of board certification, and their commitment to caring for acutely ill and injured patients. Thank you.

Glenn E. Aldinger, MD FAAEM
W. Lynn Augenstein, MD FAAEM
Stephen R. Boster, MD FAAEM
Alan L. Buchwald, MD FAAEM
Scott H. Burner, MD FAAEM
John B. Christensen, MD FAAEM
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William Voelker, MD FAAEM
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Benjamin Wedro, MD FAAEM
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Arthur L. Diskin, MD FAAEM
Richard G. Houle, MD FAAEM
Sharon J. Pelton, MD FAAEM
Jerris R. Hedges, MD FAAEM
Daniel Mountcastle, MD FAAEM
Joseph P. Wood, MD JD MAAEM FAAEM

# Thank You!

We would like to recognize and thank the following ED groups for participating in our 2014 100% and 2/3 Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

### AAEM 2014 100% ED Group Membership

- Amarillo Emergency Physicians — TX
- American University of Beirut — Beirut, Lebanon
- Campbell County Memorial Hospital — WY
- Cascade Emergency Associates — WA
- Chesapeake Emergency Physicians — VA
- Doctor Urgent Care Clinic — LA
- Drexel University College of Medicine — PA
- Eastern Carolina Emergency Physicians (ECEP) — NC
- Edward Hospital — IL
- Emergency Physicians of Community Hospital Anderson (EPCHA) — IN
- Emergency Physicians at Sumner, PLLC (EPAS) — TN
- Emergency Specialists of Oregon (ESO) — OR
- Florida Hospital — FL
- Fort Atkinson Emergency Physicians (FAEP) — WI
- Fredericksburg Emergency Medical Alliance, Inc. — VA
- Glendale Adventist Emergency Physicians, Inc. — CA
- Long Beach Emergency Medical Group — CA
- Newport Emergency Physicians, Inc. — RI
- North ED Physicians — FL
- Northeast Emergency Associates — MA
- Physician Now, LLC — VA
- Salinas Valley Memorial Hospital — CA
- Southern Colorado Emergency Medical Association (SCEMA) — CO
- Temple University Hospital — PA
- University of Louisville — KY
- University of Mississippi — MS
- West Jefferson Emergency Physicians Group — LA

### AAEM 2014 ED Group Membership

- BayCare Clinic, LLP — WI
- Middle Tennessee Medical Center — TN

# AAEM 100% ED Groups

### AAEM 100% ED Group Membership

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified and 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. Two-thirds 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 visit us at www.aaem.org or contact our membership manager at info@aaem.org or (800) 884-2236.

For a complete listing of 2014 100% ED Group members, go to www.aaem.org/membership/aaem-ed-group-membership.

# AAEM and AAEM/RSA Team Up for Capitol Hill Advocacy Day

Williams & Jensen, PLLC

On July 15, AAEM and AAEM/RSA members attended meetings on Capitol Hill with members of Congress, health care policy staff, and committee staff to highlight issues important to the membership. First, participants took part in an informational session about key AAEM issues and learned best practices for Hill meetings. Later that day, participants attended approximately 40 Hill meetings with constituent House and Senate members and staff to advocate for physicians' right to due process and other issues impacting EDs across the country. Participants also discussed graduate medical education (GME) funding and the Academy's support of bipartisan legislation (H.R. 1201, Training Tomorrow's Doctors Today Act) that proposes to create 15,000 new GME positions over the next five years.

Participants enjoyed lunch with Representatives Joe Heck (R-Nevada) and Tim Murphy (R-Pennsylvania). Congressman Heck discussed his experience as an EP and the importance of visiting Capitol Hill. Congressman Murphy, a clinical psychologist, discussed legislation he has introduced entitled, "Helping Families in Mental Crisis Act." AAEM has endorsed the bill, which includes provisions to increase care for critically mental ill patients at psychiatric facilities, encourage the development of alternatives to long-term inpatient care for chronically mental ill patients with the goal of reducing ED visits and substance abuse, and provide relief from federal tort claims for physicians serving in a voluntary capacity at community mental health clinics and federally-qualified health centers.

Participants also attended several other meetings with physician members of Congress, including Senator John Barrasso (R-Wyoming) and staff of Representative Raul Ruiz (D-California). In addition to raising issues important to the Academy, AAEM and AAEM/RSA participants answered a variety of questions about emergency medicine and topical issues such as ACA implementation, the Medicare Sustainable Growth Rate (SGR), liability reform, and treatment of individuals that overdose on prescription drugs. Finally, participants invited members of Congress to visit their local EDs and offered AAEM as a resource if they have questions related to emergency medicine.

(L-R): Sheyna Gifford, MD; Mark Tschirhart; Mark Reiter, MD MBA FAAEM, Congresswoman Vicky Hartzler (R-Missouri); and Marc Pitarresi, Williams & Jensen Staff

### House & Senate Activity Winds Down in Advance of November Elections; Legislative Priorities Uncertain for End of 2014

Legislative activity picked up significantly during June and July, with both chambers in session for seven out of the final eight weeks leading up to the August recess. While the number of bills reaching the President's desk remains low, Congress was able to clear a landmark bill to reform veterans' health care at the U.S. Department of Veterans Affairs (VA). House and Senate negotiators began crafting bipartisan legislation after news broke earlier this year of long wait times for veterans seeking medical treatment and of the deaths of dozens of veterans while waiting to receive care at a Phoenix, AZ, facility. The scandal led to the resignation of VA Secretary Eric Shinseki at the end of May.

The $17 billion agreement passed by an overwhelming margin in the House and Senate, with just five House members and three Senators voting in opposition to the reforms. The bill aims to increase veterans' access to medical care and includes $5 billion in funding for additional providers and other VA medical staff, as well as investments in the VA's health care infrastructure. Another section of the bill will increase GME residency positions at VA medical facilities that are experiencing physician shortages and which are located in communities that have been designated as in need of health professionals. Over the next five years, the bill will add up to 1,500 additional GME slots. The legislation gives priority to residency positions in primary care, mental health, and any other specialty deemed appropriate by the VA Secretary.

The bill authorizes the VA to lease 27 new medical facilities across 18 states and Puerto Rico, and $10 billion in funding for the "Veterans Choice Fund," which will allow eligible veterans including those who have waited more than 30 days for an appointment with the VA or live more than 40 miles from a VA facility to receive health care from a private health care provider, community health center, U.S. Department of Defense health care facility, or an Indian Health Center.

Over the past two months, the House authorizing committee with jurisdiction over health care issues has turned its focus to a new project launched in May, the "21st Century Cures Initiative." The House Energy and Commerce Committee held nine hearings or forums relating to the initiative, covering topics from digital health care and technology to clinical trials modernization. In July, the committee advanced legislation reauthorizing the Emergency Medical Services for Children (EMSC) Program. The bill would continue the current funding level of $30 million annually over each of the next five fiscal years. The EMSC Program started in 1984 and provides grants to states and higher education institutions for the purposes of advancing pediatric emergency medicine.

Continued on next page

Meanwhile, the Senate Health, Energy, Labor and Pensions (HELP) Committee convened a hearing to examine the topic of preventable deaths and patient safety. Senators and witnesses discussed the need to reduce hospital acquired infections and to impose greater sanctions on hospitals that have extremely high infection rates.

**First Row** (L-R): Leslie Zun, MD MBA FAAEM; Mark Reiter, MD MBA FAAEM; Representative Tim Murphy (R-Pennsylvania); John Christensen, MD FAAEM; Sean Kivlehan, MD; William T. Durkin, Jr., MD MBA FAAEM; Terrence Mulligan, DO MPH FAAEM; Larry Weiss, MD JD FAAEM. **Second Row** (L-R): Sheyna Gifford, MD; Kyle Fischer, MD; Michael Ybarra, MD FAAEM; and Megan Healy, MD

At the end of July, the House and Senate left Washington for a five week recess and are set to return on September 8 for a brief session prior to another break for the November elections. Congress agreed on several "must-pass" measures before the recess, including a measure to temporarily keep the nation's highway system funded. Congress will return for two to three weeks in September, where they will seek to pass a "continuing resolution" (CR) that will keep the government funded beyond September 30. In 2013, Congress failed to pass a stop-gap measure, resulting in a 16-day partial government shutdown that interrupted administrative services at agencies like the Department of Health and Human Services (HHS), but did not have a significant impact on Medicare or Medicaid reimbursements which are part of the government's mandatory spending budget. However, last year's shutdown is unlikely to be repeated given the level of support that has been voiced for a short-term funding measure that will allow Congress to return to the issue following the November elections.

Beyond the issue of government funding and appropriations, the Congressional agenda remains unclear for the remainder of 2014. House Republicans recently elected a new leadership team, following the surprise defeat of the number two House Republican in a June primary election. Representative Kevin McCarthy (R-California) was elected to fill the Majority Leader position behind Speaker John Boehner (R-Ohio) while Representative Steve Scalise (R-Louisiana) was elected as Majority Whip. Leadership changes are possible in the Senate following the November elections, depending on whether Republicans are able to win a narrow majority.

(L-R): Rick Gustave, MD MPH; Representative Joe Heck (R-Nevada); Sheyna Gifford, MD; and Kyle Fischer, MD

Significant legislation can be passed during a lame duck session, particularly following a "status quo" election where control of the House and Senate remain unchanged. Advocates for a permanent fix to the Medicare Sustainable Growth Rate (SGR) are hopeful that Congress will return to this issue following the elections, although it is not yet clear whether leaders in the House and Senate can agree on how to pay for a permanent fix. Many members of Congress, including Senate Finance Committee Chairman Ron Wyden (D-Oregon), are anxious to enact a permanent fix and they believe that bipartisan agreement on the policy replacement is within reach if the two sides can agree on a way to offset the cost of the measure. Key members of Congress are also aware that the estimated 2015 cost of a permanent SGR fix could increase beyond the current estimate of $120 billion to $180 billion. The existing SGR patch is set to expire in April 2015.

As expected, the U.S. Department of Health and Human Services (HHS) issued a rule in July that requires compliance with the International Classification of Diseases (ICD)-10 beginning October 1, 2015. ICD-10 was scheduled to take effect this year, but Congress included a delay in the compliance date in the "doc fix" legislation passed earlier this year. ■

# Upcoming Conferences: AAEM Provided and Recommended

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

## AAEM CONFERENCES

**September 6-7, 2014**
- AAEM Oral Board Review Course
  Chicago, IL; Orlando, FL; Dallas, TX; Philadephila, PA; Los Angeles, CA
  http://www.aaem.org/oral-board-review

**November 12, 2014**
- AAEMLa State Chapter Meeting
  New Orleans, LA
  www.aaem.org/membership/state-chapters/AAEMLa

**November 20, 2014**
- CAL/AAEM Speaker Series
  San Francisco, CA
  www.calaaem.org/news

**November 20, 2014**
- Delaware Valley Chapter of AAEM Resident's Day Meeting
  Philadephila, PA
  www.aaem.org/membership/state-chapters/dv-residents-day

**February 28-March 4, 2015**
- AAEM 21st Annual Scientific Assembly
  Austin, TX
  www.aaem.org/AAEM15

## AAEM-RECOMMENDED CONFERENCES

**September 12-14, 2014**
- The Difficult Airway Course: Emergency™
  Baltimore, MD
  www.theairwaysite.com

**October 13-15, 2014**
- Pan Pacific Emergency Medicine Congress (PEMC)
  Daejon Convention Center, Korea
  www.2014pemc.com

**October 15-17, 2014**
- The Crashing Patient! Resuscitation & Risk Management Conference
  Baltimore, MD
  www.thecrashingpatient.com

**November 14-16, 2014**
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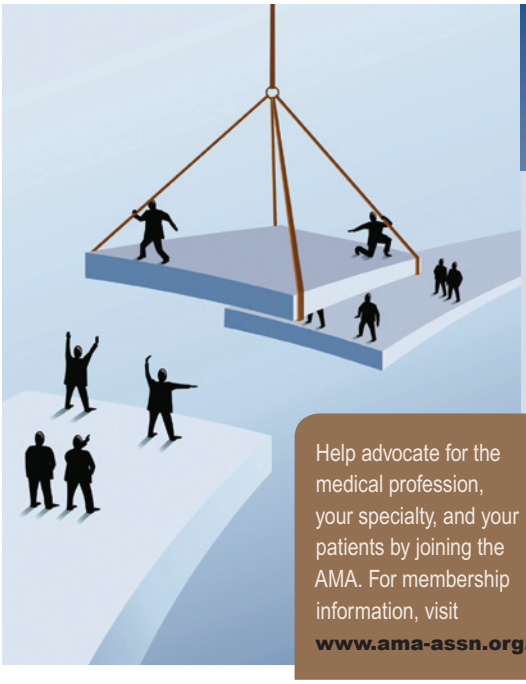
Do you have an upcoming education conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Emily DeVillers to learn more about the AAEM endorsement and approval process: edevillers@aaem.org.

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

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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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# Austin City, No Limits

Joseph Lex, Jr., MD MAAEM FAAEM

I am excited about what's happening as we plan our 21st Scientific Assembly, scheduled for February 28 through March 4, 2015 at the Hilton Austin in the Texas Capital.

First and foremost, our invited keynote speaker has accepted our invitation to speak. Simon Carley, Professor of Emergency Medicine at Manchester Metropolitan University, Consultant in Emergency Medicine, and co-founder of the BestBets website (www.bestbets.org) and the St. Emlyn's website (http://stemlynsblog.org) in mythical Virchester will visit with us in Texas. Dr. Carley has published more than 100 papers related to disaster medicine, diagnostics, evidence base medicine, and medical education. He is associate editor of the *Emergency Medicine Journal* and co-director of the Master of Science in Emergency Medicine program at Manchester Metropolitan University. He will give three talks, including our keynote session on "Evidence, Data, Belief, Denial and Cognitive Delusion: How Do We Really Practice Emergency Medicine."

The second exciting bit of news is the development of a separate subcommittee to develop the immensely popular pecha kucha (PK) (chit-chat) sessions. The group chair is Joelle Borhart, MD, FAAEM, of Georgetown. You may have heard Joelle speak at prior Scientific Assemblies. She is joined by Gentry Wilkerson, MD FAAEM, from the University of Maryland, and the husband-wife team of Zachary Repanshek, MD FAAEM, and Jennifer Fisher-Repanshek, MD, from Temple University in Philadelphia. Zack was the 2012 AAEM Resident of the Year. The final member is Siavash Sarlati, MD, from LSU/Charity, who was a resident winner of the 2014 YPS Open Microphone Session in New York City.

This group is putting together a dynamic, unique program over the near-ten hours of PK sessions scheduled for Monday, March 2, and Tuesday, March 3. It's an opportunity for some of the next generation of emergency medicine educators to step forward and be heard. Expect some exciting revolutionary ideas to come from this group as the Scientific Assembly nears.

The full organizing committee has had several phone conferences and exchanged hundreds of emails as we try to create the best possible educational experience for you to impact your patients. As always, the goals are to give you information and tools that you can use immediately to improve patient outcomes.

We are expanding the number of preconference workshops and plan to have at least ten for you to choose from, including the popular Resuscitation for Emergency Physicians and Ultrasound for learners at all levels. But there will also be sessions on The Business of Emergency Medicine, Essentials of Personal Finance, and the ever-popular FREE LLSA Preparation Course.

Continued on next page

## See you in AUSTIN!

AAEM's Annual Scientific Assembly — perpetually advancing emergency medicine for the clinician and proudly the premier clinical conference in emergency medicine.

### Scientific Assembly Highlights

- FREE registration for members, with refundable deposit
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- Expanded *pecha kucha* sessions (six minute and 40 second presentations)

### Invite a Friend

If you're a veteran of Scientific Assembly, or if you're planning on attending for the first time in 2015, consider inviting a friend or colleague to join you. Encourage residents and medical students interested in emergency medicine to attend as well. CME will be available; presented by the top clinician educators in emergency medicine.

### Travel to Austin, TX

In addition to attending the premier clinical conference in emergency medicine, take advantage of all the city has to offer. Austin features legendary live music, burgeoning restaurant scene, world-class museums, one-of-a-kind shopping, beautiful outdoor spaces, and a unique culture.

If you're visiting Austin, TX, from outside the United States, you may need a visa to enter the country. Visa requirements for entering the United States can be found at: www.aaem.org/AAEM15/travel.

### Register

Registration for the 21st Annual Scientific Assembly will open in the fall of 2014. For up-to-the-minute information about registration and Scientific Assembly — follow AAEM on social media. Visit AAEM Connect, our interactive dashboard, to view updates from Facebook, Twitter, LinkedIn, the AAEM blog, and podcasts www.aaem.org/connect. Look for hashtag #AAEM15.

Of course we are retaining the plenary sessions of literature reviews: Best of the Best from Cardiology, Toxicology, Pediatrics, Infectious Disease, Critical Care, and Resuscitation. We'll also do our best to bring you useful information in "When the Shift Hits the Fan" and "Stuff Our Consultants Want Us to Do." We'll spend time discussing the Choosing Wisely Campaign, deciding whether emergency medicine choses wisely. And expect a few more surprises.

And the speakers? You know by now to expect the best from AAEM. As I write this, the invitations have not been sent, but I promise that you will not be disappointed in either the topics or the presenters. After all, we have a reputation to uphold as the premier educational event in emergency medicine for the United States.

With Austin being one of the major music centers in the country, we are looking to arrange entertainment opportunities for attendees. Details will follow.

I will keep you updated as things change. By the time you see your next edition of *Common Sense*, I believe you will be able to peruse the entire program online. But trust me on this: you don't want to miss it. ■

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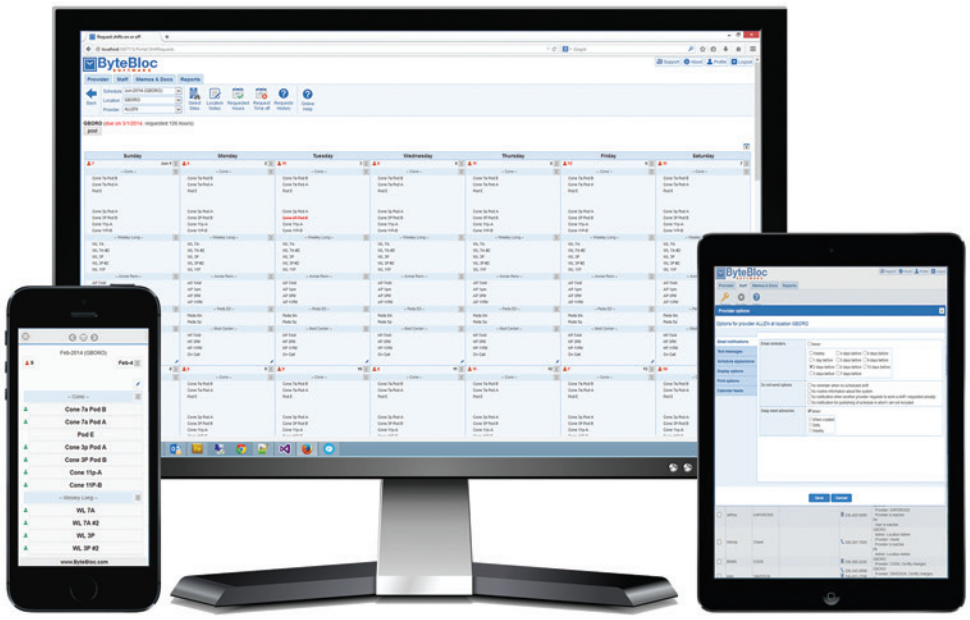

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# Dollars & Sense

Joel M. Schofer, MD MBA RDMS FAAEM
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Having adequate insurance is a fundamental part of your overall financial plan. It is also something that most people struggle with, as there are innumerable types of insurance with many options to choose from. At its most basic, insurance is a method of transferring risk from you to an insurance company, and you should only pay to transfer risks that you are not willing or able to shoulder. While insurance companies are happy to insure everyone and everything, in general you should only insure against losses too large for you to bear yourself. Below is one man's KISS (keep it simple, stupid) approach to insurance. This article discusses insurance you almost certainly need, while the next edition will discuss both insurance you might need, and insurance you probably don't need.

### Types of Insurance You'll Probably Need

If you cannot afford the costs involved in a particular loss scenario, then you should probably insure yourself against it.

### Professional Liability Insurance

If you are practicing emergency medicine, you need professional liability insurance. This insurance will cover attorney fees, expert witnesses, court costs, costs of gathering evidence, and settlements when you are sued — and you will be sued.

There are two types of policies: "occurrence" and "claims-made." Claims-made policies only cover you if a lawsuit is filed while the policy is in force. With this type of insurance, when you leave a job you need to purchase "tail coverage" that extends your liability protection. Tail coverage can be expensive, and before you take a job you need to make sure you know who is going to "pay the tail." Occurrence policies are more expensive because they cover you in perpetuity and do not require a tail.

### Disability Insurance

While you can use an emergency fund to "self-insure" against short-term disability, you will need help in the event of a long-term disability — unless you are wealthy enough that you no longer need to work. Typically, you should obtain enough coverage to replace 60-70% of your income up to the age of 65 in the event of total disability. The policy should cover your specific occupation as an emergency physician (known as an "own occupation" policy as opposed to an "any occupation" policy), so that collecting benefits will not require you to be unable to work in any other available job — such as urgent care, occupational medicine, or even a completely nonmedical job. You will also want partial coverage if you can only work part-time. Key components of the ideal policy include:

- Non-cancelable — they can't cancel your policy or raise your premiums if conditions change.
- Guaranteed renewable — no medical exam is required to renew.
- Residual benefit protection — pays you partial benefits or "residual benefits" if you are partially disabled or recover partially from complete disability.
- Cost-of-living allowance — the amount you are paid is adjusted for inflation.

If your employer's coverage is inadequate then look for a private policy, which may be expensive. Some companies that specialize in disability insurance can be found at unum.com, northwesternmutual.com, affordableinsuranceprotection.com, and DI4MDs.com. In addition, professional associations such as the AMA, ACEP, and state medical societies often have group policies available to members. AAEM has one in the works as well.

Try to reduce costs by lengthening your "waiting" or "elimination" period. The waiting/elimination period is the amount of time you have to wait after becoming disabled before your disability payments begin. If you have a substantial emergency fund, you can lengthen your waiting/elimination period and lower your premiums. If you don't, you may need a shorter waiting/elimination period and will pay higher premiums.

### Medical/Health Insurance

Unless you are wealthy enough to self-insure and pay your own medical bills in the event of a serious illness, you need medical insurance. If you can get it from your employer, that is probably the best way to limit your out-of-pocket expenses. If you can't get it through your employer, try professional associations. They often have plans available to members that are cheaper than purchasing it yourself. You should also check out healthcare.gov and similar commercial websites. One way to lower your rates is by having a deductible and co-pays on the policy that are as high as you can comfortably afford. Filing a $100 claim is often not worth the hassle, and higher deductibles and co-pays will lower your premiums. Always consider the policy's annual out-of-pocket maximum, and make sure it isn't more than you could afford to pay in any given year. The whole point of insurance is to protect yourself against unaffordable, unexpected expenses.

### Homeowner's Insurance

You need homeowner's insurance to protect the structure of your house, its contents, and to insure against injuries to other people or damage to other people's property. Make sure that the contents of your home are covered for "replacement cost" and not "actual cash value." For example, replacement cost coverage will give you $1,000 to replace the three year-old laptop that was damaged, while actual cash value would only give you the $300 the laptop is worth after three years. In addition, you will likely have to purchase a "rider" to cover any high-value items, such as jewelry, expensive art, coin or stamp collections, etc.

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### Renter's Insurance

If you rent, unless you can afford to replace all your belongings when a disaster wipes out your apartment building, you need renter's insurance. Renter's insurance also offers liability protection, similar to homeowner's insurance.

### Auto Insurance

You need auto insurance in case you have a serious accident and damage your car, injure yourself or others, or damage someone else's property. Lower your rates by having a deductible on the policy that is as high as you can comfortably afford, and carefully evaluate how much collision and comprehensive coverage you actually need. If you are driving an older vehicle, paying for this coverage may not make sense.

### Umbrella Liability Insurance

Umbrella liability insurance protects you in case you get sued for reasons unrelated to your profession, and adds liability coverage on top of your homeowner's (or renter's) and auto insurance. It will come in handy if your dog bites someone and they develop necrotizing fasciitis, the mailman slips and falls on your front porch and can no longer work, or a neighborhood child drowns in your pool. It is typically sold in $1 million increments and is quite inexpensive. A $1 million dollar policy will typically run $150-300 per year.

What if you are early in your career and have very few assets? You should still have umbrella liability insurance, since future wages can be garnished in some judgments against you — and being perceived as a "rich doctor" makes you an attractive target for lawsuits.

### Preview of the Next Edition

Types of insurance you might need:

- Life insurance
- Long-term care insurance
- Flood insurance
- Earthquake insurance

Types of insurance you probably don't need:

- Life insurance for children
- Rental car collision insurance (loss damage waiver)
- Flight accident insurance
- Travel insurance
- Credit protection insurance
- Extended warranties

If you have ideas for future columns or have other resources you'd like to share, email me at jschofer@gmail.com.

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

# Medical Liability and the Emergency Physician: A State by State Comparison — Part 5

Gregory Roslund, MD FAAEM

When it comes to medical malpractice law, there is immense interstate variability. Some states have passed sweeping reforms that have decreased litigation and provided increased access to medical care. Other states have been reluctant to change, and as a result malpractice insurance premiums have skyrocketed and physicians have departed in droves.

Which states are particularly favorable for emergency physicians and why? State by state information on medical liability has been compiled many times, but data specifically on emergency medicine have been hard to come by — until now. On behalf of the AAEM Legal Committee, I have constructed a medical liability state by state comparison — hopefully the most accurate and comprehensive medical liability database yet for emergency physicians.

Each state's medical liability environment was given a rating (one to five stars) based primarily on 1) the presence of damage caps, 2) malpractice premium costs, and 3) the presence of meaningful laws specifically protecting emergency physicians. In addition, I considered limits on attorney fees, expert witness reform, pretrial panels, and several other factors.

This is the fifth installment of this state by state review. The initial installment, in the 2013 July-August issue of *Common Sense*, included a "Methods" section detailing how these ratings were calculated.

For this installment, reliable information regarding annual malpractice premiums for emergency physicians could not be obtained. Therefore, I estimated the average EM premiums based on hard data gathered from The Medical Liability Monitor.[31] For each state, I listed ranges of average 2013 annual premiums for internal medicine (IM) and general surgery (GS) (approximate numbers representative of full time physicians with standard policy limits). Because emergency medicine premiums are typically somewhere between IM on the low end and GS on the high end, the average annual premiums for EM were calculated using the following equation for each state: (Avg IM + Avg GS)/2. These are rough estimates, as premiums can vary immensely within each state — especially in states with a variety of urban and rural areas. In general, for EM annual premiums less than $20,000 are considered low, annual premiums between $20,000 and $40,000 are considered mid-range, and annual premiums greater than $40,000 are considered high.

I welcome any and all feedback. Please direct your comments or questions to the editor of *Common Sense*, Andy Walker at cseditor@aaem.org.

Now, let's look closely at the final 11 states, South Carolina through Wyoming.

## South Carolina ★★★★½

**Caps:** $350,000 cap on non-economic damages, but up to $1.05 million for cases involving multiple providers/institutions (soft cap, adjusted annually for inflation).[3]

**Average:** 2013 premiums: $25,275 (estimated) for EM, $8,700-11,400 for IM, $36,000-45,000 for GS.[31]

**Liability environment for emergency physicians:** In many ways, the Palmetto State's medical liability environment is as pleasant and inviting as the low country in April. South Carolina is one of eight states to have passed a law specifically protecting EPs as well as other physicians providing care in the emergency setting.[86] Enacted in 2005, this legislation states that physicians providing care in an emergency situation (including an emergency department or a surgical/obstetric suite) cannot be found liable unless the physician is "grossly negligent."[86] The definition of "gross negligence" has been debated vigorously,[75] and the ultimate impact of this law on South Carolinian EPs remains unclear. The $350,000 cap on non-economic damages has been upheld, but this cap is adjusted annually for inflation and increased up to $1.05 million for cases involving multiple providers/institutions.[3] This exception significantly limits the cap's effectiveness, as this allows "stacking" and actually encourages plaintiffs to add defendants to the case. This may explain why premiums for EPs remain in the mid-range despite the presence of decent reforms.[31] Other notable aspect's of South Carolina's medical liability environment include: partial joint and several liability reform, a case certification requirement, and a three year statute of limitations that can be extended up to six years in certain cases.[3,8] The state has no collateral source reform, no limits on attorney fees, and no periodic payment reform.[3] South Carolina has upheld several laws governing who can testify as an expert witness, but there are exceptions.[8] Experts should ideally be board certified and actively practicing (or teaching) in the same specialty as the defendant.[8] The law reads, "an expert who is not licensed or board certified may still sign an affidavit if the expert has scientific, technical, or other specialized knowledge which may assist the trier of fact in understanding the evidence."[8] This opens the door for any nonprofessional walking along Myrtle Beach to testify.

**Assessment:** Righteous reforms (caps + an increased burden of proof in cases involving EPs) have made Palmetto docs proud. Premiums remain in the mid-range.

**Grade:** 4.25 stars out of 5.

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## South Dakota ★★★★½

**Caps:** $500,000 cap on non-economic damages (hard cap).[3]

**Average:** 2013 premiums: $8,575 (estimated) for EM, $3,700-4,800 for IM, $12,500-13,300 for GS.[31]

**Liability environment for emergency physicians:** "Great faces. Great places" — that's the catchphrase for the Mount Rushmore State. Perhaps "Low Med Mal. High Morale" would be a more fitting descriptor, given the state's benevolent medical liability environment. South Dakotan med mal reform is not particularly elaborate (no expert witness reform, no case certification requirement, no joint liability reform, and no limit on attorney fees), yet EPs practicing in the Black Hills pay some of the lowest malpractice premiums in the nation — second only to their Nebraska neighbors.[3,8,31] South Dakota does have collateral source reform, periodic payment reform, a commendable two year statute of limitations, and most importantly a hard cap of $500,000 on non-economic damages.[3,8] Litigation and malpractice costs are both kept to a reasonable minimum in this state, as evidenced by SD's annual per capita malpractice payout of $4.95 (ninth lowest in the nation).[36] South Dakota has been described as "non-contentious" by EPs actively practicing in the state (personal communications, 2013). Could this be due to a relative lack of access to trial attorneys? The Avery Index lists South Dakota as having the 3rd lowest attorney concentration in the nation.[15]

**Assessment:** Tort reform in the Coyote State is plain and simple. Thanks to a reasonable cap on non-economic damages and a non-litigious culture, EPs are paying some of the lowest premiums in the nation.

**Grade:** 4.5 stars out of 5.



## Tennessee ★★★½☆

**Caps:** $750,000 cap on non-economic damages (soft cap, may be raised to $1 million in cases of catastrophic injury).[3]

**Average:** 2013 premiums: $20,750 (estimated) for EM, $6,900-11,000 for IM, $29,000-36,000 for GS.[31]

**Liability environment for emergency physicians:** When it comes to med mal, Tennessee isn't exactly living up to its tag line, "America at its best." However, things have improved somewhat since the Volunteer State was slapped with the "crisis state" label by the AMA in 2002.[36] Several years ago Tennessee enacted a case certification requirement, requiring plaintiffs to provide an affidavit signed by a qualified expert before filing a case, and this has cut the number of lawsuits being filed in half,[8] (personal communications, 2013). In 2011 the state passed the Tennessee Civil Justice Act, which included a $750,000 limit on non-economic damages.[36] This relatively steep cap, which can be raised to $1 million in cases of catastrophic loss or injury such as quadriplegia, severe burns, and wrongful death, is probably too high to be effective as plaintiff attorneys push awards for pain and suffering right up to the million dollar limit.[36] EPs actively practicing in the state note that this cap has done little or nothing to help physicians (personal communications, 2013). Tennessee has enacted joint and several liability reform, collateral source reform, a limit on attorney fees (33.3%), a most excellent one year statute of limitations, and partial expert witness reform.[3,8] The law states that experts must be licensed in TN or any state that borders it, and "actively practicing" in the year preceding the date on which the alleged injury occurred.[8] The expert need not be in the same specialty — just "a specialty which would make that expert's testimony relevant to the case."[8] Also, "the court can waive the requirement if an appropriate witness is not available."[8] Tennessee offers no periodic payment reform, no pre-litigation panel review, and — despite the vigorous efforts of AAEM's Tennessee chapter — no laws specifically protecting physicians bound by EMTALA to provide care in the emergency setting.[3,8]

**Assessment:** The high cap on non-economic damages hasn't helped one bit, but renovation of the state's case certification requirement has made a difference and the statute of limitations is unbeatable. Premiums remain relatively low.

**Grade:** 3.25 stars out of 5.

## Texas ★★★★★

**Caps:** $250,000 cap on non-economic damages for health care providers. $250,000 cap on non-economic damages per health care institution (up to $500,000).[3]

**Average:** 2013 premiums: $10,000-30,000 for EM (personal communications, 2013), $8,800-$30,000 for IM, $23,200-$83,200 for GS.[31]

**Liability environment for emergency physicians:** Welcome to the Wild West — where the stars shine big and bright! Without question, thanks to the enactment of the Medical Malpractice and Tort Reform Act of 2003 and Proposition 12, the great state of Texas has the country's most EP-friendly medical malpractice environment. But it wasn't always this way.

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Like many other states (CA, NM, IN, OH, NV), it took a full-blown disaster to promote change in Texas. In 2002 the state's medical community hit a breaking point, with runaway jury verdicts and skyrocketing malpractice costs.[72] The malpractice crisis of 2002 and the fight that ensued was the Battle of the Alamo for Lone Star physicians — but with a happier ending. While some Texas doctors fought back with their feet, leaving in droves, others stayed and lobbied relentlessly. Governor Rick Perry responded by enacting the most formidable and comprehensive tort reform package of all time. Perry's legislation included a hard cap of $250,000 on non-economic damages, which has been upheld in court multiple times, most recently in 2012.[82] The cap is set at $250k per claimant regardless of the number of health care providers involved,[35] but claimants can receive an additional $250k or $500k (for a maximum total of $750k), if one or two institutions such as hospitals are also found to be at fault.[35] Damages in wrongful death suits are capped at $500,000.[35] Prop 12 also requires an increased burden of proof in cases taking place in the emergency setting, so claimants must now prove "willful and wanton negligence."[83] Since 2003 the liability climate in Texas has improved dramatically, with both litigation and premium costs dropping about 50% over the past ten years.[35] The state's annual per capita malpractice payout of $3.03 per year is now the lowest in the nation.[36] Access to care in Texas has improved substantially over recent years, as herds of physicians now migrate to Texas in search of greener grass. The Texas Medical Board licensed 3,600 new docs in 2011 — 70% more than it did in 2001 — with 82 counties experiencing a net gain in EPs.[35] While the explanation for this physician migration to Texas is debatable (with TX having good weather, low taxes, and a favorable cost of living), tort reform is often touted as the main reason. From 2002-2012, while the state's population grew 21%, the physician population within the state grew 44%.[84] Other notable aspects of Texas's medical liability environment include joint and several liability reform, periodic payment reform, a strict two year statute of limitations, a case certification requirement, and moderate expert witness reform (the expert must be in clinical practice and ideally in the same specialty as the defendant, but exceptions do exist).[3,8] There are no limits on attorney fees and there is no collateral source reform.[3] Many of these sweeping changes in the legal community have prompted trial attorneys and patient advocate groups to ask, "is the Texas medical liability environment too physician-friendly — are victims of genuine malpractice receiving the compensation they deserve?" Others have noted that tort reform in Texas has failed to curb the practice of defensive medicine, and in turn failed to decrease health care costs.[85] Despite the expected criticism from these groups, Texas is lauded as the epitome of tort reform. Moving forward, the state's medical community is committed to sustaining and building on this success. When it comes to reform, "Don't mess with Texas."

**Assessment:** Thanks to ten years of ten gallon reform, physicians are flocking to the Lone Star State. Premium costs and total malpractice costs have dropped 50% since 2003 and plaintiffs must prove "willful and wanton negligence" in cases involving EPs.

**Grade:** 5.0 stars out of 5.

### Utah ★★★★★

**Caps:** $450,000 on non-economic damages (hard cap).[3]

**Average:** 2013 premiums: $30,750 (estimated) for EM, $7,000-12,700 for IM, $37,000-66,300 for GS.[31]

**Liability environment for emergency physicians:** Utah (the second fastest growing state in 2013) is thriving thanks to a burgeoning energy sector and a pro-business climate, with one of the lowest unemployment rates in the nation (4%).[89] Major metropolitan areas such as Salt Lake City are bursting at the seams with newcomers in search of the Greatest Snow on Earth. Similarly, on the med mal front, Utah is rapidly improving, thanks to favorable laws that were passed to reinforce the state's cap on non-economic damages and to provide added liability protection for EPs and other well-meaning physicians providing emergency care.[35,79] As of 2009, in cases taking place in the emergency setting Utah requires

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a plaintiff to prove fault by "clear and convincing evidence," a standard more rigorous than the mere "preponderance of evidence" standard used in most jurisdictions. Utah thus became the eighth state to provide some form of added liability protection for providers bound by EMTALA to provide emergency care.[79] This law is encouraging, but contains some unique exceptions which significantly diminish its application. For instance, it does not apply if 1) the physician saw the patient within the preceding three months for the same condition, or 2) the physician is able to consult the patient's medical records.[79] In 2010 an amendment to Utah's Health Care Malpractice Act fixed the state's cap on non-economic damages at $450,000 (no exceptions).[35] Prior to 2010 the cap was adjusted for inflation.[35] Other physician friendly Utah laws include joint liability reform, collateral source reform, limits on attorney fees (33%), and periodic payment reform.[3] Most cases are initially screened by a pre-litigation panel consisting of a physician in the same specialty as the defendant, an attorney, and a layperson. However, the decision is not admissible in court and members of the panel may not be called to testify.[8] Plaintiffs are only required to submit a case certification if the panel deems the claim to be non-meritorious.[8] On the negative side of things, the state's statute of limitations is four years and expert witness reform is nonexistent.[8] All things considered, Utah looks great on paper but its Achilles' heel is its malpractice premium cost per provider.[31] Annual premiums for EPs are still significantly above the national average, clearly lagging behind some of the reforms enacted over the past five years.[31] Utah can be thought of as a work in progress, as some of its most auspicious laws are too new for their efficacy to be fully assessed.

**Assessment:** The Salt Lake State is heading in the right direction, thanks to propitious reforms involving caps and EMTALA-mandated care. The state's medical liability environment will join the elite five star circle, however, only if annual premiums for EPs are reduced substantially.

**Grade:** 4.0 stars out 5.

## Vermont ★★½☆☆

**Caps:** None.[3]

**Average:** 2013 premiums: $19,425 (estimated) for EM, $8,200-9,000 for IM, $28,000-35,000 for GS.[31]

**Liability environment for emergency physicians:** If you travel to Vermont, you'll likely encounter maple syrup farms, IBM executives, devout fans of the band Phish, and plenty of Ben and Jerry's ice cream. You will not come across anything resembling tort reform. This small New England state does not cap damages, nor does it require plaintiffs to provide an affidavit of merit.[3,8] The state has no joint liability reform, no collateral source reform, no periodic payment reform, no expert witness reform, and no limits on attorney fees.[3,8] The statute of limitations is three years.[8] Vermont's medical liability environment appears very unfavorable for physicians and overly welcoming to plaintiff attorneys, yet the state is not wasting much money on medical malpractice as a whole. Vermont's annual per capita malpractice payout of $4.37 is the sixth lowest in the nation, and annual premiums for EPs are surprisingly reasonable.[36,31]

**Assessment:** The Green Mountain State comes up short on med mal reform, but annual premiums are slightly below the national average.

**Grade:** 2.5 stars out of 5.

## Virginia ★★☆☆☆

**Caps:** $2,100,000 cap on on total damages (increasing $50,000 per year through July 1, 2031, to $3,000,000).[3]

**Average:** 2013 premiums: $40,275 (estimated) for EM, $7,700-$17,300 for IM, $30,800-$74,500 for GS.[31]

**Liability environment for emergency physicians:** "Virginia is for Lovers." I don't know exactly how or why this catchphrase became popular, but I always see it posted on billboards during my trips to Chesapeake

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Bay. In reality these signs should read "Virginia is for Lawyers." The medical liability environment in "The Birthplace of a Nation" is slightly better than its mid-Atlantic neighbors, but annual premiums remain relatively high, with EPs in the greater D.C. area paying some of the highest premiums in the nation.[31] Virginia is just one of five states that has incorporated a cap on total damages, but its $2.1 million cap is the highest in the country.[3] While this cap may be effective in curbing some of the rare, astonishing multimillion dollar awards, it does nothing to restrain the majority of cases which involve much lower amounts. The state does not cap non-economic damages, and this opens the door for plaintiffs to push awards for pain and suffering towards the $2 million mark. To add insult to injury, this cap will increase at $50,000 annually until it hits $3 million.[3] Additional weaknesses include no collateral source reform, no joint liability reform, no limits on attorney fees, and a meaningless case certification requirement.[3,8] The plaintiff must certify that he or she has contacted an "expert" and that this expert determined that the defendant deviated from the standard of care, and that the deviation was the proximate cause of the injuries claimed.[8] This need not be in writing and the expert does not need to meet the same qualifications as an expert who testifies at trial.[8] In recent years Virginia has become one of the few states to allow parents to sue for the wrongful death of a nonviable fetus.[30] Most states require a fetus to be viable in order to bring a wrongful death suit, while mothers who have lost a nonviable fetus are allowed to obtain emotional distress damages.[30] Virginia's medical liability environment does have a few redeeming features. The statute of limitations is two years (without exception), pre-litigation panels are an option, the state has upheld a pure contributory negligence clause in all medical malpractice cases, and experts are required to be in active clinical practice in the defendant's specialty or a related field within one year of the date of the allegedly negligent act.[8,49]

**Assessment:** The Old Dominion's $2 million cap on total damages has done very little to help physicians. Additional reforms have been marginally effective and EPs continue to pay out the nose on premiums.

**Grade:** 1.75 stars out of 5.

### Washington ★★½☆☆

**Caps:** None.[3]

**Average:** 2013 premiums: $29,800 (estimated) for EM, $10,500-$12,000 for IM, $37,300-$59,400 for GS.[31]

**Liability environment for emergency physicians:** Bill Gates's home state, the birthplace of high-tech juggernauts Microsoft and Amazon, will always be synonymous with innovation. However, Washington's medical liability environment is far from "cutting edge." While the vast majority of states have passed at least some type of reform over the years in an effort to reign in costs and preserve access to care, the state of Washington has done no such thing. Washington has no caps on damages, no joint and several liability reform, no limits on attorney fees, no expert witness reform, no pre-litigation panels, and no laws specifically protecting physicians in the emergency setting.[3,8] The state once required plaintiffs to submit an affidavit of merit, but this law was declared unconstitutional.[8] The statute of limitations in the state has always been an unusually long eight years, but even this was recently declared unconstitutional (January 2014) by the state supreme court, which then reinstated tolling of the statute for minors.[90] Very little has improved since 2002, when Washington was declared a "crisis state" by the AMA.[35]

**Assessment:** The medical liability environment in the avant garde Evergreen State is surprisingly archaic. While premiums remain high, they could be even worse considering the state has failed to enact any laws favoring physicians.

**Grade:** 2.25 stars out of 5.

### West Virginia ★★★☆☆

**Caps:** $250,000 on non-economic damages, but up to $500,000 in cases involving wrongful death, permanent and substantial physical deformity, loss of use of limb or loss of a bodily organ system, or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself and perform life-sustaining activities (soft cap, adjusted annually for inflation).[3]

**Average:** 2013 premiums: $40,375 (estimated) for EM, $19,500-$19,700 for IM, $55,300-$67,000 for GS.[31]

**Liability environment for emergency physicians:** The Mountain State seems to be in the midst of an identity crisis. Is West Virginia the most northern Southern state or the most southern Northern state? The state's medical liability environment also seems to be struggling with its identity. Is it a safe haven for well meaning EPs thanks to meaningful tort reform, or is it really the judicial hellhole that ATRA (the American Tort Reform Association) has called it for years? Without a doubt, West Virginia's medical liability environment was tragically collapsing back in 2002.[36] The AMA justifiably designated WV as a crisis state, as lawsuit abuse in the state was rampant and docs were jumping across the border en masse due to skyrocketing insurance costs.[36] In 2003 Gov. Bob Wise responded by enacting HB 2122, a bill that included an assortment of powerful medical malpractice reforms such as a cap on non-economic damages.[36] This soft cap (initially set at $250,000 and adjusted annually for inflation) is the same regardless of the number of plaintiffs or defendants, can be increased up to $500,000 in cases involving catastrophic circumstances, and does not apply in cases of "willful and wanton disregard."[3] Also, in what appeared to be a stunning victory for EPs, an additional amendment was passed capping total damages (economic + non-economic) in "emergency cases" at $500,000.[87] This law applies to any case involving "an emergency condition occurring at a designated trauma center," which includes the vast majority of emergency department cases in the state.[87] The $250,000 cap on non-economic damages has seen its share of challenges. Most recently, the state supreme court upheld it as constitutional in 2011.[67] Other strengths in the Mountaineer State include: joint liability reform, collateral source reform, a strong case certification requirement (must be filed 30 days prior to the filing of a professional liability action), and expert witness reform (experts must devote at least 60% of their time to clinical practice and/or teaching). The expert should ideally practice in the same specialty as the defendant, but exceptions do exist.[3,8] Weaknesses within the system include: no limit on attorney fees, no periodic payments, no pre-litigation panels, and a two year statute of limitations that can be extended up to ten years.[3,8] Despite enacting several

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physician-friendly laws, West Virginia is perennially labeled a "judicial hellhole" by ATRA due to its history of jackpot jury awards and several overly plaintiff-friendly jurisdictions.[67]

**Assessment:** Tort reform appears to be working in the Mountain State, but annual premiums for EPs remain inexplicably high.

**Grade:** 3.0 stars out of 5.

## Wisconsin

**Caps:** $750,000 cap on non-economic damages (hard cap).[3]

**Average:** 2013 premiums: $11,050 (estimated) for EM, $3,600-$7,000 for IM, $10,800-$22,800 for GS.[31]

**Liability environment for emergency physicians:** The medical liability environment in America's Dairyland is welcoming and physician-friendly thanks to strong reforms, low malpractice costs, and low litigation frequency. Annual premiums for EPs are some of the lowest on record and the state's annual per capita malpractice payout ($3.08) is the third lowest in the nation.[31,36] Perhaps not coincidentally, the state has the seventh lowest concentration of attorneys.[15] Other strengths include collateral source reform, joint liability reform, periodic payment reform, and a sliding scale limiting attorney fees to 33% of the first million recovered and 20% for any amount exceeding $1 million.[3] The state has a formidable patient compensation fund, which remains in good standing with a $361 million net balance.[22] The Injured Patients and Families Compensation Fund was created in 1975, and covers verdicts in excess of the physician's underlying coverage of $1 million per claim and $3 million per policy year.[22] 2013 was a banner year for Wisconsin docs from a medical malpractice perspective, thanks to three court decisions that ultimately favored physicians: 1) apology laws were finally enacted (WI became the 37th state to do so), 2) the $250,000 cap on total damages — which applies only to physicians employed by the University of Wisconsin — was successfully upheld, and 3) a new informed consent statute was passed. Wisconsin Act 111 repealed the former informed consent statute, a "reasonable patient standard" which had collapsed into a standard that had little or no definition, and replaced it with the "physician-based standard" which is based on a doctor providing information that other doctors would expect to be provided.[61,91,92] While Wisconsin's medical liability environment seems ideal, there are a few weak spots dragging it down: no expert witness reform, no affidavit of merit requirement, no specific laws providing added protection for emergency physicians, no pre-litigation panels, and a statute of limitations that can be extended to five years.[8] Most notably, while Wisconsin has enacted a cap on non-economic damages, it is relatively high at $750,000 (in comparison to the $250,000 "gold standard" enacted by states such as CA and TX).[3] A $350,000 cap was struck down in 2005, only to be almost doubled and reinstated in 2006.[3] Wrongful death actions are capped at $500,000 per occurrence for minors and $350,000 for adults.[3]

**Assessment:** Cheesehead EPs have been blessed with comprehensive reform and an essentially benign medical liability climate. Wisconsin's relatively high cap on non-economic damages is a minor weakness, but overall malpractice costs and annual premiums remain on the low end.

**Grade:** 4.25 stars out of 5.

## Wyoming

**Caps:** None.[3]

**Average:** 2013 premiums: $41,825 (estimated) for EM, $13,300-$19,000 for IM, $47,000-$88,000 for GS.[31]

**Liability environment for emergency physicians:** The sparsely populated Cowboy State, with just over 1,000 practicing physicians, has the fewest doctors of any state in the union.[88] With no accredited medical schools, just two accredited residency programs, and a large number of underserved communities, Wyoming needs to be doing everything possible to recruit and retain physicians.[88] Jackson Hole and Yellowstone are gorgeous selling points, but the state's medical liability environment is an eyesore. Little has changed since the AMA dubbed Wyoming a "crisis state" in 2002.[35] Premiums remain high and tort reform is almost nonexistent.[31] Wyoming is one of five states to specifically prohibit caps within its constitution.[3] The state offers joint and several liability reform, but there is no case certification requirement, no expert witness reform, no collateral source reform, no limit on attorney fees, and no periodic payment reform.[3,8] A strong two year statute of limitations is enforced.[8] Wyoming has embraced one redeeming feature — a mandatory pre-litigation panel for all medical malpractice cases.[8] The panel — composed of two health care providers, two attorneys, and one layperson — must determine whether malpractice occurred. The panel's decision is not binding but its findings are admissible at trial.[8]

**Assessment:** Emergency physicians are a scarce commodity in Wyoming. The state's high premiums are not helping the situation and its lack of meaningful reform is surprising.

**Grade:** 2.0 stars out of 5.

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# The Fifth Inter-American Emergency Medicine Congress

Gary M. Gaddis, MD PhD FAAEM

I had the pleasure of representing the American Academy of Emergency Medicine as the Scientific Co-Chair of the Fifth Inter-American Emergency Medicine Congress, held in Buenos Aires, Argentina on May 14-16, 2014. The meeting was held at the Palais Rouge, a conference center in the fashionable Palermo area of Buenos Aires. AAEM has worked in conjunction with the *Sociedad Argentina de Emergencias* (SAE) to create and grow this Congress, which will continue to be presented biennially by AAEM and SAE.

Attendees had the opportunity to obtain up to 24 hours of *AMA PRA Category 1 Credits*™ delivered by over 20 English-speaking lecturers, most of whom were AAEM members, while enjoying the sights, sounds, tastes, and smells of Buenos Aires. In addition, Terry Mulligan organized an excellent pre-Congress seminar in emergency department administration, which was held the day before the Congress began. A number of top-notch speakers delivered excellent talks. Simultaneous translation of English talks into Spanish made the English-language content readily available to the predominantly Spanish-speaking audience. The main themes of the sessions were airway emergencies, cardiovascular emergencies, pediatric emergencies, trauma, shock, and ultrasound.

Americans were not as numerous among the attendees as in prior Inter-American Congresses. This was probably partly due to the conflict between the Congress and the Society for Academic Emergency Medicine's Annual Meeting in Dallas at the same time. The Argentines have promised not to schedule the Congress in conflict with the SAEM meeting in the future.

In regard to growing the Congress and enhancing the collaboration between AAEM and SAE, the Argentines have expressed interest in developing two new projects. They would like more bilingual Americans to attend the next Congress and provide commentary in their consensus-building sessions, called "Mesas," and contribute an American perspective in Spanish. If you are a content expert who speaks Spanish and could contribute to these consensus sessions, the Argentines would value your participation in 2016 tremendously. If you would like to be involved in serving in this capacity, please drop me an email at ggaddis@saint-lukes.org stating your interest and areas of expertise.

The Argentines would also like a group of Americans to work with them toward the creation of practice guidelines designed for use in low or moderate-resource areas. A plurality of Argentine emergency physicians work within 50km of Buenos Aires, in hospitals that are fully equipped in a modern fashion, and Argentine emergency medicine specialists who work in other populous areas such as Mendoza and Cordoba also work in modern facilities. However, Argentina is a very large and predominantly rural nation, and the Argentines believe that guidelines are needed for practitioners in these lower-resource areas — not only for the good of patients, but also to help the Argentines grow their specialty society via sharing this resource. AAEM member Kristen Kent, MD FAAEM, has agreed to organize this effort. If you are interested in developing guidelines adapted for use in low to moderate-resource areas, contact her at kristenjkent@yahoo.com.

I hope that you make a mental note to reserve time in May of 2016 to attend the Sixth Inter-American Emergency Medicine Congress. It is a great way to meet our foreign colleagues, and to enjoy a beautiful city with many interesting cultural and historic sites and some of the best food imaginable! ■

# The HMA/EmCare Whistleblower Suits and the Implications for Coding

Jim Strafford, CEDC MCS-P

*Coding and billing might seem esoteric and boring — because they are. Coding/billing is certainly a world unto itself. However, coding and billing determine your income and thus your lifestyle. This is true whether you are in academics and far removed from coding and billing, selecting a coding/billing company to serve your independent emergency medicine group at a community ED, or one of the rare emergency physicians who does his or her own coding. Whatever their practice situation, every emergency physician should have at least a superficial understanding of coding and its financial and legal implications. Even if someone else codes your charts for billing and you have no input into that coding at all — even if it's someone you didn't hire yourself and had no hand in choosing — **you** are legally responsible for the accuracy of that coding and the resulting bills. If **your** name is the one on the chart, **you're** the one who will be charged with fraud if the coding is found to be fraudulent. It's true that the coders will be charged too, but will being one of many defendants make you feel better?*

— The Editor

The HMA/EmCare whistleblower lawsuits have been well covered in print and on TV (*Sixty Minutes*). The suits involve allegations by physicians and an administrator employed by EmCare that they were pressured by HMA to admit patients, with the collusion of EmCare, because more admissions meant more revenue for HMA. Stark law violations, fraud, and other criminal issues are in play. And the demonstrated interest of the U.S. Department of Justice certainly raises the stakes on these lawsuits. Perhaps not coincidentially, HMA has sent its CEO on a one year mission to South America.

Another aspect of these allegations has been overlooked by the media: the impact of allegedly improper admissions on the coding of emergency department services. In some ways this oversight is understandable, since coding tends to be an inside-the-industry issue and is not as sexy as allegations of pressuring doctors to make unnecessary admissions. This is similar to the recent SGR fix that was widely reported in the press, while yet another delay in initiating the ICD-10 was barely noticed. Industry insiders are aware that the ICD-10 delay has implications that go well beyond another SGR fix, but the news simply isn't interesting to the media or general public.

## EmCare and Coding Issues — A Brief History

This is not the first brush that EmCare has had with whistleblower suits. In the 1990s a whistleblower coding suit was brought against EPBS (Emergency Physician Billing Services). At the time EmCare used EPBS on the majority of its contracts. The president of EPBS was caught, on tape and in writing, making statements about coding that were completely inappropriate. EPBS coders were pressured to fraudulently up-code, much like EmCare emergency physicians were more recently allegedly pressured to increase admissions through the ED. EmCare quickly dropped EPBS and moved their coding and billing accounts to a start-up billing company called Reimbursement Technologies, Inc (RTI). EmCare then purchased RTI. RTI continues to code and bill for EmCare. Since EmCare owns RTI it is effectively a captive billing service, although RTI does retain some outside clients. Another recent industry development is that RTI, along with many other ED coding and billing companies, now processes a significant percentage of its ED charts overseas. Although there is no tie-in between off-shoring and alleged wrongdoing, shipping Protected Health Information that is subject to HIPAA guidelines overseas for coding could become an issue if coding is questioned by regulators or plaintiffs.

## Coding Implications

Let's take a look at the coding implications of the HMA/EmCare lawsuits. A bit of digging into the morass of ED coding guidelines will be required, but I will try to keep it simple.

According to *The Tampa Bay Business Journal* of Feb 1, 2014, "EmCare colluded with HMA and Newsome to increase inpatient admissions and demanded that, as a condition of employment, its physicians maximize admissions and order HMA selected medical tests regardless of whether the tests were necessary." Besides the obvious Stark issue, this statement is fraught with implications for the coding process. Shedding light on this tie-in requires an understanding of documentation guidelines.

## History/Physical Exam/Medical Decision Making

In order to code the highest and most lucrative non-time-based ED level (99285), a *Comprehensive* History and Physical Exam and *High Complexity* Medical Decision Making (MDM) must be documented. Unlike other sites of service that might require only two of three, in the ED all three elements (History, Exam, and MDM) must be documented at that level in order to code a 99285.

With the proliferation of EMRs with all kinds of documentation tools embedded in them (whether right or wrong), most Histories and Physical Exams are now documented at a *Detailed* level at least, and often at the *Comprehensive* level required for 99285. This trend has resulted in Medical Decision Making and the related Medical Necessity being the real documentation tie-breakers that coders use to determine if they are looking at a 99284 or 99285.

Most coders and most state Medicare carriers use something called The Marshfield Clinic Tool to determine the level of MDM. The tool consists of three parts that are consistent with CPT Guidelines. The first two, Diagnosis and Management Options and Amount/Complexity of Data, assign points for each management option or each element of data that is ordered or reviewed by the emergency physician — such as lab tests, old records, X-rays, etc. The third element of MDM is Risk. Risk is broken into three levels and the tool provides examples of each for guidance. The usefulness of the Table of Risk for ED Services has been debated for years, since the examples do not sync up well with ED services. For

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example, chest X-rays, ultrasonograms, and EKGs are in the minimal risk section of the table, but certainly don't go with low risk scenarios in the ED. The other two sections, Presenting Problems and Management Options, come closer to being in line with ED reality.

A coder needs to identify a *Comprehensive* History and Physical Exam as well as High Complexity MDM in the ED chart to code a 99285. We will assume a *Comprehensive* History and Exam are documented. Now MDM becomes critical in determining the coding level. To justify a 99285 level of service code, the coder needs to identify sufficient elements in two of these three sections: Management Options, Data Elements (diagnostic tests), and Risk. **The simplest way for Management Options to support a 99285 is for the patient to be admitted.** An admission "with additional work up planned" gets the coder to the necessary Management Options complexity for a 99285. Then the coder will look at the tests ordered and interpreted. If several tests were ordered and interpreted, the coder now has the necessary documentation in Data Elements to justify a 99285. And if unnecessary diagnostic tests were ordered and interpreted to support an unnecessary admission, the coder — again following the rules — will have the necessary documentation of complex Medical Decision Making to code a 99285. **Even without *High Risk*, the coder can support a 99285 based on the (allegedly unnecessary) diagnostic tests and admission, since only two of three MDM elements are required.** This may have resulted in high volumes of unintentionally (by the coders at least) up-coded ED services at HMA hospitals, based on allegedly unnecessary tests and admissions.

Medical Necessity is also a key element in determining the appropriate ED level of service code. The problem with Medical Necessity is that the definition used by CMS is subjective, and there is no quantifiable way to audit Medical Necessity. But even the most skeptical coder will code based on the H&P and MDM, and will not question the necessity of an admission or tests that support the *High Complexity* MDM for a 99285. Additionally, much ED coding is done overseas. Overseas coders, even more than domestic ones, will not question the information provided in the medical record and will strictly adhere to the guidelines provided by their stateside clients. Questioning guidelines typically may fall outside cultural norms in South Asia. This issue, along with the fact that there hasn't been full — or often any — disclosure of off-shoring by large billing companies, should be a cause for concern because massive numbers of ED charts (with Protected Health Information governed by HIPAA) are being reviewed in much less regulated environments overseas. The potential issue with the HMA/EmCare coding controversy is that coders did follow guidelines, but the guidelines were applied to allegedly unnecessary diagnostic tests done to support allegedly unnecessary admissions.

## Conclusion

ED Level of Service coding would almost certainly be affected by an unnecessary admission. Coders code based on the documentation and CMS/CPT guidelines that are given to them. It is likely that many 99285s were coded based on allegedly unnecessary tests leading up to allegedly unnecessary admissions. In addition to the obvious Stark issues involved in the HMA/EmCare lawsuits, it is reasonable to expect that at some point the Health and Human Services Office of Inspector General (or the Department of Justice) will take a hard look at this coding issue too.

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**Glossary**

CEO: Chief executive officer. The head of a company.

CMS: The Centers for Medicare and Medicaid Services, also known in the medical world as "the feds."

CPT: *Current Procedural Terminology*, a big book of codes used in billing for medical procedures.

EmCare: The nation's largest ED contract management group, at least in terms of number of EDs under contract. Team Health is the biggest in terms of revenue.

EMR: The electronic medical record, also known as the electronic health record (EHR).

HIPAA: The Health Insurance Portability and Accountability Act. Among other things, it seeks to protect the confidentiality of "protected health information."

HMA: Health Management Associates, a hospital chain.

ICD-10: *The International Classification of Diseases, 10th Edition*. The ICD-9 is currently used by physicians, coders, and the feds. The ICD-10 has been ready for years but is so much larger, more detailed, and more complicated than the ICD-9 that its implementation keeps getting delayed by the feds in response to protests from physicians and other users.

Level of Service code: Numerical codes from the ICD-9 and CPT that determine how much EPs, other physicians, and hospitals are paid for particular services.

SGR: Sustainable Growth Rate. A formula used by the federal government to determine how much EPs and other physicians are paid. Without an annual "SGR fix," physician compensation would automatically be cut by more than 25%. Congress aspires to a permanent SGR fix, but has been spectacularly unsuccessful.

Stark: Named after its congressional author, a body of federal laws against medical self-referrals. Physicians are prohibited from referring their patients to entities they own or have a large ownership stake in. Included in Stark are exceptions to this prohibition known as "safe harbors," which makes the law quite complicated.

Whistleblower suit: a *qui tam* lawsuit, in which a private citizen who knows of a fraud perpetrated against the federal government sues the perpetrator for damages. The federal government may then choose to take over the suit and bear the associated costs, and if the suit is successful it shares the damage award with the original plaintiff or "relator" who brought the suit. *Qui tam* suits alleging Medicare or Medicaid billing fraud seem increasingly common, and when a large hospital chain is alleged to have systematically defrauded Medicare or Medicaid, hundreds of millions of dollars in damages could be at stake.

According to the Legal Information Institute at the Cornell University Law School (http://www.law.cornell.edu/wex/qui_tam_action), in a qui tam action, a private party called a relator brings an action on the government's behalf. The government, not the relator, is considered the real plaintiff. If the government succeeds, the relator receives a share of the award. Also called a popular action.

For example, the federal False Claims Act authorizes qui tam actions against parties who have defrauded the federal government. 31 U.S.C. § 3279 et seq. If successful, a relator in a False Claims Act *qui tam* action may receive up to 30% of the government's award.

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**Appendix I: Amount and/or Complexity of Data Reviewed**

For each category of reviewed data identified, circle the number in the points column. Total the points.

| Reviewed Data | Points |
|---|---|
| Review and/or order of clinical lab tests | 1 |
| Review and/or order of tests in the radiology section of CPT | 1 |
| Review and/or order of tests in the medicine section of CPT | 1 |
| Discussion of test results with performing physician | 1 |
| Decision to obtain old records and/or obtain history from someone other than patient | 1 |
| Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider | 2 |
| Independent visualization of image, tracing or specimen itself (not simply review of report) | 2 |

Note: Points are assigned for labs, X-ays, other tests etc. Two points are assigned for an "Independent Visualization" which is often done in ED. So if ED physicians were allegedly under pressure to order unnecessary tests to support the allegedly unnecessary admissions, they would typically get to the 4 Data points that support MDM for 99285.

**Appendix II: Medical Decision Making**

**Number of Diagnoses or Treatment Options**

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

| A | B x | C | = D |
|---|---|---|---|
| Problem(s) Status | Number | Points | Result |
| Self-limited or minor (stable, improved or worsening) | Max=2 | 1 | |
| Est. problem (to examiner); stable, improved | | 1 | |
| Est. problem (to examiner); worsening | | 2 | |
| New problem (to examiner); no additional workup planned | Max=1 | 3 | |
| New prob. (to examiner); add. workup planned | | 4 | |
| | | | **Total =** |

Note: The highlighted "New prob; add workup planned" — which is pretty much every Emergency Department admission — gets the coder the 4 points needed for 99285 Level Management Options. ■

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# Founders Circle Mentor Challenge

Andy Mayer, MD FAAEM
AAEM Board of Directors

Emergency medicine residents are the future of our specialty. They are our intellectual children. Most of us took the Hippocratic Oath, which states "To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art; and that by my teaching, I will impart a knowledge of this art to my own sons, and to my teacher's sons, and to disciples bound by an indenture and oath according to the medical laws."

Our residency programs impart a wealth of knowledge on our future colleagues. However, this body of knowledge is incomplete. We congratulate them on completing a residency program and send them out into the world – often to a place where they will be exploited for the gain of others. I propose that AAEM and its members should teach other practical lessons which are essential for a successful career in emergency medicine.

I challenge each member of AAEM to mentor a young physician, in two ways. First, google "AAEM Founder's Circle" and you will find a page where you can sponsor a resident for membership in our Academy. This costs $60 per year and $200 for a four year residency. Next, google "AAEM mentoring program." This will bring you to a web page where you can sign up to personally mentor a young physician as he or she graduates residency and enters the workplace. Think back to when you made this jump. Did you have someone you could trust to give you advice on fair and equitable work environments, working with colleagues in the ED, dealing with difficult doctors from other specialties, personal finance, etc? ■

# AAEM Presidential Stipend Announcement

Howard Blumstein, MD FAAEM
AAEM Past President

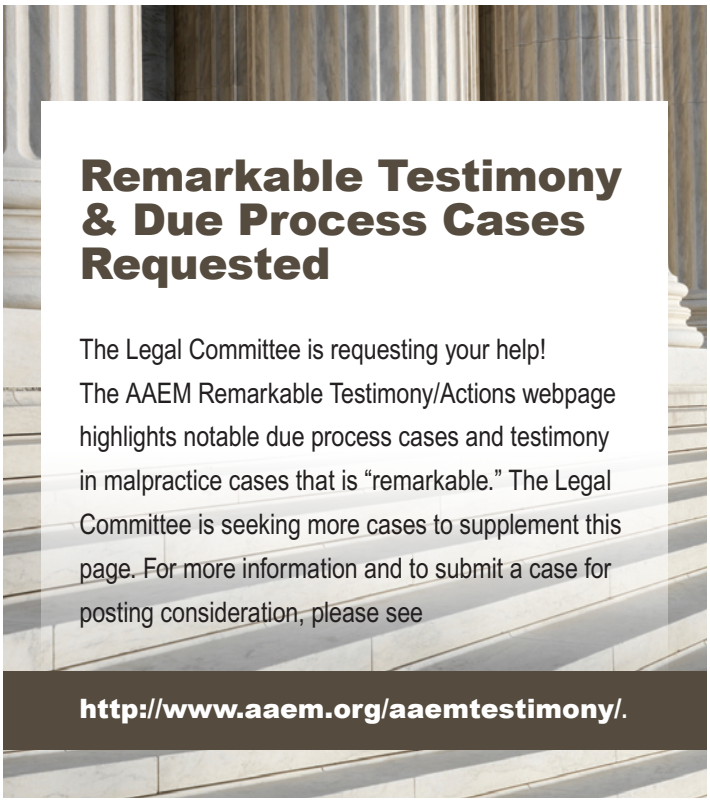
At the AAEM board meeting held just before the 2014 Scientific Assembly, the board of directors voted to establish an annual stipend for the Academy's president. The amount of this stipend was fixed at $50,000. While approving the stipend, the board also established a set of job requirements and performance parameters for the president.

Until this time, AAEM presidents have served without remuneration — as other officers and directors continue to do. As I and other former AAEM presidents can attest, the position requires a tremendous time commitment. This takes away significantly from full-time clinical or academic practice and other professional pursuits. Because of the huge commitment involved, and to attract more members to consider serving in leadership positions, it is common for professional societies to provide a stipend to their top leadership.

This stipend may seem generous. However, it is less than most other medical specialty societies and in my opinion is not equal to the personal and professional sacrifice required to serve AAEM as its president. The board made this decision after several months of consideration, and after appointing a task force — which I chaired — to look into the issue and make a recommendation to the board on the amount of the stipend. The board made this decision before the last round of AAEM elections, and it took effect with the Academy's current president.

The same motion that established the stipend also created a set of minimum responsibilities for the president. In keeping with the practices of other professional societies, the board also defined the activities expected of its officers. Attendance at specified meetings, presentations to residency programs, a president's column for each issue of *Common Sense*, and the development of future leaders are all now defined expectations for the president, although some can be delegated to designated officers. While the president still has the ability to pursue those activities important to them, there are now guidelines to ensure appropriate attention is paid to the activities considered essential by the board of directors.

Establishing both the stipend and the level of performance expected of the organization's top leader is an important step forward, as AAEM continues to emerge as a premier medical specialty society and remains **the** specialty society of emergency medicine. ■




# ABEM News: John C. Moorhead, MD, Elected Chair Elect of the ABMS

On April 24, 2014, the American Board of Medical Specialties (ABMS), composed of 24 member boards that oversee physician certification in the United States, announced the election of John C. Moorhead, MD, as chair elect of the ABMS board of directors. Dr. Moorhead has served as a member of the ABMS board of directors, including as a member of the Maintenance of Certification (MOC) Task Force and MOC Committee, the latter of which he served as chair. Since 2003, he has been a representative of the American Medical Association (AMA) House of Delegates, and since 2001 he has been chair of the AMA Section Council on Emergency Medicine. Dr. Moorhead is currently the immediate past president of the American Board of Emergency Medicine (ABEM) board of directors.

Dr. Moorhead currently is a Professor of Emergency Medicine, and Public Health and Preventive Medicine at the Oregon Health & Science University (OHSU) in Portland. In 1978, he joined OHSU's Department of Emergency Medicine, of which he is now Chair Emeritus. During his 30-plus years in the department, Dr. Moorhead has held many positions, including Director of the Emergency Medicine Residency program, a post he held for 13 years, and Department Chair, which he held for eight years. In addition to being a past president of ABEM, Dr. Moorhead was also president of the American College of Emergency Physicians (ACEP) and the Oregon Medical Association.

Dr. Moorhead received his medical degree in 1975 from Queens University Medical School in Kingston, Ontario, Canada, and completed his residency in emergency medicine in 1978 at Royal Victoria Hospital, McGill University in Montréal, Quebec, Canada. His interests are in the areas of medical education and health policy. To honor Dr. Moorhead's contributions to emergency medicine, OHSU established an endowment fund in his name. The fund will sponsor leading educators in emergency medicine to help shape and develop generations of emergency physicians for years to come. ■

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# Reporting Product-Related Injuries and Deaths to the U.S. Consumer Product Safety Commission (CPSC)

Marietta Robinson
Commissioner of the U.S. Consumer Product Safety Commission

Reporting product-related injuries and deaths to the U.S. Consumer Product Safety Commission (CPSC) through www.SaferProducts.gov is critically important to helping prevent future injuries. The CPSC's work to ensure the safety of consumer products — such as toys, cribs, power tools, cigarette lighters, and household chemicals — has contributed substantially to the decline in the rate of deaths and injuries associated with consumer products over the past 40 years.

Our data concerning product-related medical incidents, injuries, and deaths drive everything we do to carry out our public health mission. Other federal agencies, such as the Department of Health and Human Services and the National Highway Traffic Safety Administration, use our data in furtherance of their public health and safety missions as well. The CPSC collects two types of data: anecdotal and statistical.

## Anecdotal Data

The CPSC obtains its anecdotal data through several sources, but the most important is www.SaferProducts.gov. The website was authorized by Congress in 2008, went live in 2011, and over the past three years has become increasingly easy to use. To date we have received approximately 20,000 reports of product-related harm or risk.

Conspicuous by their virtual absence in reporting product-related harm to our website are the medical and public health communities. We are trying to correct that deficiency by informing these communities of our reporting website and the critical need for such reports, knowing that we share the goal of preventing unnecessary injuries and deaths.

**Health care professionals regularly see injuries associated with consumer products and are thus in a unique position to observe and report such safety concerns.** For example, emergency medical professionals are the first to know what toys given each Christmas are causing injuries when those toys are defective, used incorrectly, or overused. While ED personnel may identify a trend of injuries in the weeks following Christmas, the CPSC has to wait much longer for this type of information — unless the injuries are reported directly to us. T**hat is why I urge everyone in the health care community to report (or at the minimum urge their patients to report) consumer product-related injuries to the CPSC using www.SaferProducts.gov.** The CPSC needs to receive the best and most reliable data as quickly as possible in order to assess consumer product-related trends and detect emerging hazards as soon as possible.

There is a benefit to the medical community as well. As long as the reports contain certain minimum information required by law and the submitter consents, the reports are publicly searchable approximately fifteen business days after the report is submitted. You may use the database to search for similar injuries, incidents, and deaths and to identify trends in your particular practice or geographic area.

## Statistical Data — National Electronic Injury Surveillance System

As mentioned above, the CPSC receives statistical data as well, through its forty year-old National Electronic Injury Surveillance System ("NEISS"). The NEISS is comprised of approximately 100 hospital emergency departments specifically selected to allow statistical extrapolation of consumer product-related injuries to the national level. The NEISS collects approximately 400,000 product-related injury reports annually, that represent an estimate of over 14 million product-related injuries treated in hospital emergency departments each year. The NEISS data are also publicly available and searchable on the CPSC's website at www.cpsc.gov/en/Research--Statistics/NEISS-Injury-Data. Medical professionals and researchers use this database frequently.

Finally, thank you for your time, energy, and dedication as emergency physicians. Your passion to heal the public and keep us safe is admirable and inspirational.

## Reporting Data is Easy!

Go to www.SaferProducts.gov and fill in the electronic form online. The electronic form will require you to ask two additional questions of your patients about the type of product involved and takes only a few minutes to complete. You will be given the opportunity to register with CPSC when you begin. If you register, you will be able to save your electronic form so you may come back and complete it any time within the next 30 days.

*Marietta Robinson is a Commissioner at the U.S. Consumer Product Safety Commission. The thoughts and beliefs articulated in the article are entirely her own and in no way reflect the positions, opinions or statements of the CPSC or its staff. If you have any ideas, thoughts or questions about this topic, she may be reached at MRobinson@cpsc.gov.*

*Also note that the CPSC is a public health authority as explained in 45 CFR 164.512(b)(1)(i). The disclosure of protected health information to a public health authority is a permitted disclosure under the regulations promulgated by the U.S. Department of Health and Human Services, Standards for Privacy of Individually Identifiable Health Information at 45 CFR 164.502(a)(1)(vi) in connection with the Health Insurance Portability and Accountability Act of 1996.* ■

# Call for 2015 AAEM Board of Directors Election Nominations

## Nomination Deadline: December 1, 2014 — 11:59pm CST

AAEM encourages candidates for election to the board of directors who have a previous record of service and commitment to the Academy.

Five At-Large positions on the AAEM board of directors are open as well as the Young Physicians Section (YPS) director position. Any Academy member may nominate a full voting or YPS member (for the YPS director position only) for the board. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS director position.

Elections for these positions will be held at AAEM's 21st Annual Scientific Assembly, February 28–March 4, 2015, in Austin,TX. Although balloting arrangements will be made for those unable to attend the Assembly, all members are encouraged to hold their votes until the time of the meeting. Online voting will be available leading up to Scientific Assembly.

The Scientific Assembly will feature a Candidates Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference, and those elected will begin their terms at the conclusion of the Assembly.

In order to nominate yourself or another full voting member for a board position, please go to www.aaem.org/about-aaem/elections to provide the following information and complete the nomination form and attestation statement.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including Board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities, or any other information detailing why the nominee should be elected to the board. A photo for publication may accompany the statement if the nominee wishes.
6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A current CV for the nominee.
8. AAEM Attestation Statement filled out by the nominee.
9. **Conflict of Interest Form must be completed by the nominee prior to the nomination deadline.**

The information listed above must be submitted to the AAEM office before 11:59pm CST, on December 1, 2014. Any YPS member can be nominated and elected to the YPS director position. The nomination form and required information is the same as that for a board position.

The candidate statements from all those running for the board will be featured in the January/February 2015 issue of *Common Sense* and will be sent to each full voting and YPS member.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us the organization of specialists in emergency medicine. In AAEM, any individual, full voting or YPS member can be nominated and elected to the AAEM board of directors. ■

# Call for 2015 AAEM and AAEM/RSA Awards Nominations

## Deadline: December 1, 2014 — 11:59pm CST

AAEM is pleased to announce that we are currently accepting nominations for its annual awards. Award presentations will be made to the recipients at the 21st Annual Scientific Assembly to be held February 28–March 4, 2015, in Austin, TX.

Complete nomination criteria and the required online nomination form are found at www.aaem.org/about-aaem/awards. Self-nominations are not accepted.

Individuals can be nominated for the following awards:

### Administrator of the Year Award

AAEM encourages members to nominate an administrator deserving special recognition for their dedication to emergency medicine and patient care.

### David K. Wagner Award

As an organization, AAEM recognizes Dr. Wagner's contributions to the specialty by offering an award named in his honor to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives. Dr. Wagner himself was given the first such award in 1995.

### Young Educator Award

Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

### Resident of the Year Award

Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

### James Keaney Award

Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

### Peter Rosen Award

Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

### Joe Lex Educator of the Year Award

This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who have been out of their residency for more than five years.

### Master of the American Academy of Emergency Medicine (MAAEM)

Active members of AAEM may also recommend nominees to the AAEM executive committee for the Master of the American Academy of Emergency Medicine (MAAEM). Full criteria for this designation are available on the AAEM website. ■

## Program Director of the Year Award

This award recognizes an EM program director who has made an outstanding contribution to the field of emergency medicine and AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association (AAEM/RSA).

Nominations will be accepted for all awards until 11:59pm CST, December 1, 2014. The AAEM Executive Committee will review the nominees and select recipients for all awards except the EM Program Director of the Year Award, which will be selected by the AAEM Resident and Student Association. All nominations should be submitted in writing and include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award. ■

# AAEM Needs You! Join an AAEM Committee

Kevin Rodgers, MD FAAEM
AAEM Vice President

"There is nothing stronger than the heart of a volunteer." *General James Doolittle*

Looking to get involved, make a difference, contribute some experience, and impact your colleagues? How about joining an AAEM committee? From education to finance to practice management to social media and more — there's an opportunity just right for you. As AAEM continues to grow and expand member services, the importance of its committees has never been greater. As a grassroots volunteer organization, AAEM cannot exist without the expertise and contributions of its members. The officers and board of directors (BOD) cannot do it all by themselves.

The board of directors recently revamped the operational design of AAEM's committees, in order to improve functionality and productivity. This includes a more formal expectation of committee productivity as well as increased involvement in and support of each committee by the BOD.

Our members are the Academy's lifeblood — without your involvement AAEM grinds to a halt. In order to focus on the individual practitioners of EM and their expanding needs, our committees must to be strong. Strong committees require strong members. Please do not underestimate the value of your potential contribution. We need your brain power, your expertise, your service, your involvement, and your infectious energy. Two heads are better than one, and three better than two. This is your opportunity to "pay it forward" and improve the services that AAEM members enjoy.

Please examine the list of committees below and consider joining one today. If interested, please submit a Committee Interest Form via the webpage: www.aaem.org/about-aaem/leadership/committees. **Together we can make AAEM stronger and more productive than ever!**

The **Academic Affairs Committee** provides leadership in the area of academic advocacy and collaborates with other academic organizations such as CORD, SAEM, and NAEMSP.

The **Clinical Practice Committee** is responsible primarily for writing and updating evidence-based practice statements.

The **Education Committee** develops and coordinates the annual Scientific Assembly and supervises any other AAEM educational activities, such as the Written and Oral Board Review Courses.

The **ACCME Subcommittee** of the Education Committee is responsible for evaluating, approving and overseeing requests to AAEM for both in-house and extramural CME accreditation.

The **Oral Board Course Subcommittee of the Education Committee** is responsible for the operation and maintenance of the Oral Board Course

The **Emergency Medical Services (EMS) Committee** makes recommendations to the BOD concerning national EMS issues and monitors EMS legislation at the state and national level. This committee also collaborates with the Government Affairs Committee on developing and supporting EMS legislation.

The **Finance Committee** is responsible for making recommendations to the BOD concerning investments, dues structure, and future academy expenditures.

The **Government and National Affairs Committee** directs AAEM's lobbying efforts in Washington. This committee also coordinates legislative efforts by other AAEM committees; assists with AAEM's "watch dog" activities in regard to governmental and public health issues and supervises AAEM members' direct lobbying efforts.

The **International Committee** is responsible for analyzing and developing opportunities for exchange of information, education and ideas with international EM societies and organizations.

The **Legal Committee** monitors the EM legal arena and provides information to members regarding medico-legal matters related to emergency medicine. The committee is also responsible for writing white papers and articles for *Common Sense* on medico-legal issues that affect emergency physicians.

The **Membership Committee** develops methods to enhance and maintain membership in AAEM. This committee also defines the guidelines which govern the use of the AAEM membership list by other organizations.

The **Operations Management Committee** is responsible for creating and maintaining a catalog of operations management best practices, as well as a data warehouse for ED metrics and operational benchmarks. This committee is also responsible for developing educational products on Operations Management for the Scientific Assembly and *Common Sense*.

The **Practice Management Committee** monitors issues affecting the private practice of emergency medicine and provides information to members regarding such issues as workplace fairness, contracts, due process, ownership, restrictive covenants, coding/billing/reimbursement, fee splitting, and the implications for emergency medicine of EMTALA and the ACA.

The **Social Media Committee** is responsible for promoting the utilization of social media venues such as Facebook and Twitter, in order to improve communication with members and potential members. ■

# Something is Missing from AAEM

Megan Healy, MD
YPS Board Member

I'll give you a hint. Check out your March/April 2014 issue, featuring the new AAEM board of directors. The cover featured 16 (mostly) smiling faces, ready to take on the looming challenges that try our specialty. Photos of exceptional advocates, some of whom I have been lucky to work with, and some I hope to meet and learn from in the future. I'm glad to have them at the helm and their positions are well deserved. Here's the part that bugs me: there's just one woman on that cover. She's the talented Meaghan Mercer, president of RSA, who serves as the representative for our thriving resident organization. But all the full voting members of the board are men. So as a female emergency physician at the start of my career, I can't help but wonder: who will be the voice for someone like me?

Per recent membership data, about 85% of AAEM members are men. And as for this last board election, no females were nominated. We have a long way to go to reach numbers that are more representative of our specialty as a whole. Women of AAEM — this is a call to you. I know there are great leaders out there — I've met them at Scientific Assembly, heard them give excellent talks, and seen them achieving at my own institution. I think empowering these leaders starts with simple steps — as basic as a nomination for a board position. Perhaps if we get more of these women at the table, we can begin to learn how to better support and retain their power and address the core issues underlying the gender equity problem. Because as EPs — men and women alike —we all have a stake in issues like fair pay, job satisfaction, promotion, and work life balance.

The phenomenon of female under-representation in leadership is not unique to AAEM. It reflects a larger problem with the culture of academic medicine and traditional pathways of advancement. We have known for years that women are not progressing through the pipeline of academic medicine as expected. The AAMC's most recent report on U.S. Women in Academic Medicine (2009-2010) noted that the number of female residents in our specialty is rising: 40.6% in 2010, up from 27% in 1999 – and these numbers continue to grow. However, women account for 23% of associate professors and only 13% of full professors in our field. We have 19 clinical departments at the academic institution where I work: 100% of the chairs are men.

I joined AAEM/RSA as a resident, and remain a member of the Young Physicians Section (YPS) and AAEM today, because this organization was founded by pioneers who saw the problems within our specialty and envisioned something better. AAEM has shown itself over and over to be an organization unafraid of tackling big issues. I'd argue that the lack of advancement of women in our field is a crisis, worthy of attention and resources. We have a responsibility to all the bright and skilled female medical students, residents, and physicians at all stages of their careers to not only cultivate and retain their many talents, but champion and advance them to the highest levels of leadership.

With these facts in mind, I propose the development of a Women's Affairs Committee. The other EM specialty organizations are way ahead of us in this respect, and AAEM belongs at the forefront of change. SAEM developed an Academy for Women in Academic Emergency Medicine (AWAEM) in 2009, now 315 members strong. ACEP has a section, the American Association of Women Emergency Physicians (AAWEP), which grew out of a separate organization formed in the 1980s, Women in Emergency Medicine. The objectives of special interest groups like those I've mentioned include the recruitment, retention, and promotion of smart and capable women in EM. They also work to develop opportunities for collaborative research, writing, and building large resource networks that span other interests. By offering this type of professional development, AAEM can appeal to more women and make strides towards more diversity of ideas and talents, especially at the highest ranks.

I know there are reams of talented women EPs in AAEM who would jump at the opportunity to mentor, collaborate, and network with others in our field. If you are one of them, we need you. I'd love to hear your wisdom, work together on a research project, and learn from your experiences navigating our specialty. And I know I'm not alone. Let's get a few more female faces on next year's March/April cover — because to me, that's just common sense.

If you're interested in working together on the formation of a Women's Affairs Committee, please email me: megan.healy@tuhs.temple.edu. I'd love to hear your ideas. ■

### Letter of Response from the AAEM President

Dr. Healy brings up an important issue. I agree that our Academy would be stronger with more diversity and more female physicians in high-level leadership positions. Although we have significant female physician leadership in the Resident and Student Association (AAEM/RSA) and the Young Physicians Section (YPS), we have seen few female physicians interested in running for AAEM's board of directors, particularly recently. In light of this, shortly after becoming AAEM's president I reached out to three rising stars in the Academy: Dr. Lisa Moreno-Walton, Dr. Lisa Mills, and Dr. Leana Wen. I asked them to form a task force to bring recommendations to AAEM's board on how best to encourage and mentor female physicians to become leaders in the Academy. I also asked them if they felt there would be value in creating an interest group within AAEM geared towards female physicians. (AAEM had such an interest group years ago, but it became inactive and withered away). This task force met by conference call in early June and concluded that there is significant value in forming a Women in Emergency Medicine Interest Group. This interest group will create networking and mentorship opportunities, provide a voice on particular issues of interest, and groom leaders within AAEM. Drs. Moreno-Walton, Mills, and Wen plan to kick-off the Interest Group next February at the AAEM Scientific Assembly in Austin, Texas — likely with a networking event and a meeting of the working group. More info will follow as we get closer to the Scientific Assembly. Dr. Healy, I encourage you to join with Drs. Moreno-Walton, Mills, and Wen on this task force — we would love to get you involved in what we hope to be a great resource for our female members.

— Mark Reiter, MD MBA FAAEM
AAEM President

## AAEM/RSA President's Message

# Getting the Most Out of Residency

Meaghan Mercer, DO
AAEM/RSA President

As I enter my third year of residency, the end of training is becoming more of a reality every day. I have received many pearls of wisdom along my path from medical students to residents to soon-to-be-attendings. With less than a year to go, I remind myself every day that I should make the most of each day of my education — and I hope you will do the same. A huge thank you to the members of AAEM/RSA, who really have been with me all the way. Reflecting on these past few years, I want to share some advice that has helped me succeed.

Try things that you do not feel comfortable with. I selected a program that will give me the opportunity to see a large volume and every flavor of patient. Walking away from three years in Las Vegas, I know that I will have the skills to handle a sick patient and the ability to continue to learn throughout my career. Pick up every patient that you can while you have the safety net beneath you. Challenge not only yourself but also your teachers. Constantly strive to be better. Learn how to do challenging procedures and work though the frustrating psych case. Ask for at least one learning point per patient you see. You never know what you might learn from one more chest pain patient that may save someone's life when you are out on your own.

If you haven't already, find a mentor who will provide support and advice that will guide you and make life easier. Mentorship allows someone to be honest and reflect on your strengths and weaknesses. Find someone who will be invested in your success. And you don't have to settle for just one mentor; you can establish multiple relationships that help you in different aspects of your life. Pick someone who has goals similar to yours and who shares wisdom generously. Be open and honest with your mentor and listen carefully. Being part of a professional organization like AAEM/RSA gives you tons of potential mentors and is a great place to start.

Get organized. Start writing your CV. This is the document that describes your educational career and allows potential employers to gain some understanding of your background. Keep this document up to date and add to it monthly. This will allow you to have a template ready when the time comes to apply for a fellowship or a job. Once it is time to submit your CV, have multiple people look at it and edit it. Make sure the formatting is correct and that there are no spelling errors. You want your first impression to be a good one.

Most importantly, have fun. Stress and exhaustion can cloud the best aspects of your job and life as a resident. We get to take people's lives in our hands and learn from some of their most difficult days. Find joy in the job and the opportunity you have to impact others on a daily basis.

We are excited to welcome the newest members of our specialty, the incoming class of emergency medicine residents. Congratulations to all the residents who just graduated. We look forward to watching your success and hope you stay active in the Young Physicians Section of AAEM. ■

RSA Editor's Letter

# The Adult Learner Part 2: Where the Mark is Moving

Andrew W Phillips, MD MEd
AAEM/RSA Publications Committee Chair

Last month we explored the arguments for and against adult learning theory. We began with medical educators' attraction to the subject, evaluated the philosophical and psychological concepts behind it, and concluded that it is unlikely that there is a difference in how adults and children learn, making learning theories specific to adults unproductive for learner and educator alike. In this article we will evaluate the alternatives that are most popular and best supported in cognitive and educational psychology, and that have early support in medical education literature.

## History of Learning Theories

Briefly, current learning theories stem from two fundamental approaches to understanding learning: 1) rationalism, in which we eventually see classical cognitive science and "the human as a computing machine" mindset, and 2) empiricism, born from observations of social interactions. Today the most commonly accepted theories borrow from each other, and **the fundamental concept is that all senses and all interactions — with people, books, locations, etc. —contribute to learning**.

## Currently Most Popular Theories

Situated cognition became popular at the turn of the millennium and is composed of three theses. 1) Embodiment: cognition depends on both brain and body. 2) Embedding: cognition utilizes structures in the natural and social environment. 3) Extension: cognitive boundaries extend past individuals (i.e., society shares knowledge and builds on that individually). What this means with respect to how we learn and teach is that there is more to be gained from environmental and social interactions (e.g., being in the ED or a simulation experience) than reading a textbook that lacks greater environmental and social stimuli.

That is not to say that reading or hearing information is not helpful, but rather that information in the more restrictive settings will be learned in the context of previously experienced environmental and social interactions. For example, you can read about an elephant, but until you see one personally or in a picture the text is much less meaningful. **Gibson's theory of perception** and **complexity** theory are similar but less encompassing theories that have been previously applied specifically to medical education.

**Activity theory** and **sociocultural theory** are similar to situated cognition, but are earlier theories and place greater emphasis on the emergence of knowledge from interactions with the environment, most notably the cultural symbols in those interactions that create shared meaning. For example, a medical student may learn that seeing new patients quickly is important in the ED by observing attending physicians and hearing them talk about getting a patient's name "out of the red column." This theory speaks more to the cultural phenomena that create learning and is important in our increasingly diverse medical education settings. Patient priorities, physician priorities, and hospital priorities all stem from different cultures and affect what is taught, learned, and practiced. This is "the stuff you can't learn from a textbook" that many physicians learn during residency, and is no less important than the latest sepsis guideline or other clinical rule. Other theories with similar concepts that have been applied to medical education are **communities of practice** and **distributed cognition**.

The last of the learning theories I want to share are of the behaviorist-associationist family, and include behaviorism (Pavlov's famous dog) and social learning theory (not to be confused with the aforementioned "sociocultural learning theory"). The underpinning to both is the importance of external influences on behavior, whether by positive and negative stimuli or by observational learning. Although lay-people often see behaviorism as a thing of the past, it is a theory that still contributes to the understanding of how we learn.

## Instructional Theories

Learning and teaching are inherently related but not equivalent, and instructional theories differ from learning theories in their endpoints. An instructional theory gaining popularity that deserves special mention is cognitive apprenticeship, which began in the late 1980s and has been used in medical education since the turn of the millennium. It provides a framework for understanding the complex teaching involved in role-modeling, background instruction, and supervised experience. It is thus well suited to describing clerkship and residency instruction. Stalmeijer and Bleakley provide compelling descriptions of this theory.

In the 1980s David Kolb introduced experiential learning as a learning theory, but I characterize it here as an instructional theory, because if we accept the aforementioned learning theories' assertions that learning is a reflection of mind-body experience, then "experiential learning" is redundant. Experiencing is learning. For example, if you experience a bad outcome with a medication, you have now learned one negative effect of that medication. Experiential learning still provides insights into instruction, however, and its four-stage cyclical model that includes 1) an experience, 2) reflective observation, 3) abstract conceptualization, and 4) active experimentation informs curriculum design.

## Conclusions

Many additional theories and concepts have been posited that were not described here. The aforementioned theories (situated cognition, sociocultural learning theory, activity theory, behaviorism, social learning theory, cognitive apprenticeship, and experiential learning) can improve our understanding of how humans learn and how we teach. The most important thing to remember from this brief review is that learning and teaching are understood with a combination of theories and concepts, each of which may improve our abilities as life-long learners and teachers.

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Resident Journal Review

# Approach to the Dizzy Patient

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Dizziness, often a challenging presentation, refers to a variety of vague sensations including lightheadedness, disequilibrium, and vertigo. Life-threatening disorders, such as stroke, are easily mistaken for benign illnesses, such as acute vestibular syndrome (AVS). This review focuses on recent developments in the evaluation of dizzy patients including some bedside tests which may improve diagnostic accuracy and reduce the cost and time of the ED evaluation.

**Huh YE, Kim JS. Bedside evaluation of dizzy patients. *J Clin Neurol.* 2013 Oct;9(4):203-213.**

This article reviews various bedside exams that are useful in determining benign from central causes of vertigo including examinations for ocular alignment, spontaneous and gaze-evoked nystagmus, the vestibulo-ocular reflex, saccades, smooth pursuit, and balance. Paying special attention to eye movements (provoked and unprovoked) often reveals the etiology of the dizziness.

Nystagmus is a fast beating eye movement and is termed spontaneous when present without being provoked by head maneuvers. For spontaneous nystagmus, focus on the direction of the movement and how gaze effects the intensity and direction of the nystagmus. Nystagmus from peripheral pathology is horizontal-torsional, in the direction opposite to the lesion, and will be suppressed by visual fixation. Nystagmus from central pathology is more variable with no consistent direction or response to fixation.

Gaze Evoked Nystagmus (GEN) is a sensitive ocular-motor finding in central pathology. To test for GEN, the patient is asked to hold their gaze in an eccentric position. GEN will beat in the direction of the gaze.

Head shaking nystagmus may be present in patients with peripheral unilateral vestibular pathology. It is evoked by tilting the patient's head forward 20 degrees and shaking it in a sinusoidal fashion. The nystagmus will decrease after about 20 seconds and will point in the opposite direction of the lesion. Similar to spontaneous nystagmus, central causes of head shaking nystagmus are variable and can include intense nystagmus in response to weak head shaking, ipsilesional nystagmus, and nystagmus in the opposite direction to the spontaneous nystagmus.

Positional nystagmus is evoked by changing the head position relative to gravity. In peripheral pathology, such as benign paroxysmal positional vertigo, the positional nystagmus is paroxysmal (sudden onset and short lived). In central pathology, positional nystagmus is more often constant.

The most effective test for the vestibulo-ocular reflex (VOR) is the head impulse test. With the patient focusing on a fixed point, the examiner abruptly turns the patient's head. Normal patients and those with a central pathology will smoothly turn their eyes in the opposite direction of head movement to keep them fixed on the point. Patients with unilateral vestibular pathology will have a catch-up saccade back towards the target. This corrective saccade indicates a decreased VOR in patients with peripheral pathology.

**Kattah JC, Talkad AV, Wang DZ, Hsieh YH, Newman-Toker DW. HINTS to diagnose stroke in acute vestibular syndrome. *Stroke.* 2009 Nov;40(11):3504-3510.**

This prospective cross-sectional study compared the sensitivity and specificity of a 3-step bedside oculomotor examination (HINTS) to computed tomography (CT) and magnetic resonance imaging (MRI) in diagnosing stroke in patients presenting with AVS. The HINTS exam has three components: horizontal-head impulse test (h-HIT), nystagmus test, and test of skew. The h-HIT tests the VOR and a normal result strongly predicts a central origin of symptoms. An abnormal result will be seen in peripheral lesions, but can also be seen in lateral pontine strokes; therefore, it is unhelpful in eliminating central pathology. The second component is to test for GEN. Vertical or torsional nystagmus indicates central pathology. Test of skew is done through the alternate cover test. Vertical misalignment constitutes a positive test result and has high specificity for central pathology. If any one of these three tests is positive, then the HINTS exam is considered positive.

For a video of the HINTS exam, please visit http://content.lib.utah.edu/cdm/singleitem/collection/ehsl-dent/id/6.

The study enrolled 101 consecutive patients presenting with AVS and one or more risk factors for stroke. Patients were considered to have AVS only if they exhibited rapid onset of vertigo, nausea/vomiting, and an unsteady gait. Risk factors for CVA included smoking, hypertension, diabetes, hyperlipidemia, atrial fibrillation, eclampsia, hypercoagulable state, recent cervical trauma, prior stroke, and prior myocardial infarction. Patients were enrolled from the ED (59), as inpatients (4), and as transfers to the neurology stroke service (37). Patients with recurrent vertigo were excluded. All patients underwent both HINTS testing by a single neurophthomologist and neuroimaging. The HINTS examination was performed within an hour of the onset of symptoms in 75% of subjects, but the mean time from onset of symptoms to examination was 26 hours with a range of 1 hour to 9 days. Time of symptom onset was known for 96 patients and CT or MRI occurred within 72 hours of time of symptom onset in 97% of these. Central pathology was found in 76 patients (69 ischemic strokes, four hemorrhagic strokes, two demyelinating diseases, and one carbamazapine toxicity).

In this study the HINTS exam was 100% sensitive and 96% specific for stroke. The HINTS exam had a positive likelihood ratio of 25 (95% CI, 3.66 to 170.59) and negative likelihood ratio of 0 (95% CI, 0.00 to 0.11) for stroke.

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The HINTS exam may be better to "rule out" an acute stroke than neuroimaging. It also suggests that the skew test is a strong marker of brainstem stroke given that it was positive in two of three cases of lateral pontine stroke despite a positive h-HIT as well as in seven of eight cases in which MRI was falsely negative. Neuroimaging by MRI with DWI was falsely negative in eight of patients whose strokes were discovered on repeat imaging. Given the high rate of misdiagnosed acute posterior circulation strokes, this bedside exam may be very useful to emergency physicians.

The study has several limitations including the very high-risk population (76 of 101 subjects had a central lesion) which is not similar to the patient population seen in the ED with similar symptoms. Also, the results may not be generalizable as the study used a single neurophtholmologist as the examiner. Future studies conducted with typical ED patients and physicians may help determine whether the HINTS exam is a beneficial test in the ED.

**Tarnutzer AA, Berkowitz AL, Robinson KA, Hsieh Y-H, Newman-Toker DE. Does my dizzy patient have a stroke? A systematic review of bedside diagnosis in acute vestibular syndrome. *CMAJ.* 2011 Jun 14;183(9):E571–92.**

This systematic review included 10 studies with a total of 392 patients. Initially, 779 observational studies on the clinical features, diagnostic evaluation, and differential diagnosis of AVS studies were identified on MEDLINE. However, all but 10 met exclusion criteria: lacked original patient data, offered no symptom data about dizziness, provided no information about diagnostic accuracy for acute central or peripheral vestibulopathies, did not evaluate patients in the acute stage of disease, involved patients under age 18 years, or reported fewer than five patients.

Overall, there was insufficient data to evaluate the effectiveness of using tests for spontaneous nystagmus, smooth-pursuit eye movement, saccedes, or optokinetic nystagmus to classify symptoms as central or peripheral. However, some interesting associations were found.

Two studies included in the review (Kattah et al., 2009 and Norrving et al., 1995) addressed whether head or neck pain is associated with a posterior fossa stroke. A statistically significant association was found between head or neck pain and a central cause of AVS (38% vs. 12%, $p < 0.005$); however, lack of head or neck pain was diagnostically inconclusive in ruling out central pathology.

Seven case series examined focal neurologic signs in patients with acute dizziness. In aggregate focal neurologic signs were present in 80% (n=185/230) of patients with strokes, but this is likely a substantial overestimate due to diagnostic ascertainment bias. One prospective study of 101 patients with AVS found neurologic or oculomotor signs in 51% of the 76 patients with a central cause (Kattah et al., 2009). Findings included facial palsy, sensory loss, limb ataxia, hemiparesis, gaze palsy, and vestibular syndrome. None of the 25 patients found to have a peripheral cause had these deficits. However, some of the findings were subtle and may not be reliably detected by non-neurologists.

A normal result of the h-HIT was the single best bedside predictor of a central cause of AVS, with a specificity of 0.95 (95% CI 0.90-1.00) for detecting a stroke, essentially matching that of an MRI with a positive likelihood ratio of 18.39 (95% CI 6.08-55.64). An abnormal result of the h-HIT usually indicated a peripheral lesion; however, the systematic review found that 15% of patients with a central cause of AVS had an abnormal response to the h-HIT.

GEN was evaluated in six of the 10 studies and correctly identified central causes with high specificity of 92% (95% CI 0.86-0.98) but low sensitivity (38%). Skew deviation was evaluated in two of the 10 studies and also correctly identified central causes of AVS with high specificity (98%), but low sensitivity (30%).

The presence of any of the three signs of the HINTS exam had a sensitivity of 100% (n=76/76) and a specificity of 96% (n=24/25) for stroke. Another study by Cnyrim et al., of the three tests that make up HINTS found a sensitivity of 91% (n=21/23) and a specificity of 78% (n=31/40). The pooled sensitivity and specificity of the two studies (184 total patients) was 98% and 85% respectively with a negative likelihood ratio of 0.02 (95% CI 0.01-0.09). The data suggests that bedside utilization of HINTS can outperform MRI in ruling out stroke in early presentations of AVS.

Finally, based on this systematic review, parts of the history most suggestive of a stroke include multiple prodromes, headache, or neck pain. The presence of focal neurological signs or a normal head impulse test is likely indicative of a stroke; however, the absence of these findings is insufficient to rule out a stroke. However, a negative HINTS examination may essentially rule out a stroke with high sensitivity.

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**Newman-Toker, D, et al. How much safety can we afford, and how should we decide? A health economics perspective. *BMJ Qual Saf.* 2013 Oct;22 Suppl 2:ii11–ii20.**

In this article, the chief complaint of "vertigo" was used as an example to evaluate financial cost and health outcomes that evolve from misdiagnosis. The inappropriate use of diagnostic tests, specifically the overuse of CT scans, was highlighted by doing an economic analysis.

National health care costs now exceed $2.7 trillion and diagnostic errors leading to death or disability are increasing. Misuse of diagnostic imaging costs $25 billion and harms over 1 million patients annually in the U.S. False positive tests are a major cause of the increased costs.

Annually in the U.S., there are 4 million ED visits for acute dizziness costing $4 billion. While stroke or other central causes make up only 5% of these cases, a significant amount is spent to exclude these causes of vertigo. Despite overuse of available tests, one third of vestibular strokes are still initially missed. Patients with peripheral vestibular disease are generally over-tested, misdiagnosed, and undertreated. The authors report an 80% diagnostic error rate triggering complicated work-ups and unnecessary hospital admissions. This is despite the fact that the physical exam arguably identifies more than 99% of strokes.

CT scans are grossly overused to "rule-out" stroke despite having a disappointing sensitivity (16%) in the within 24 hours of symptom onset. In 1995, 9% of dizzy patients underwent CT scan compared to 40% currently. However, this dramatic increase has not increased the diagnosis of stroke or other neurologic pathology. The authors list possible causes of the increased utilization of CT scans including: algorithms or practice guidelines, local standards, family wishes, time-efficiency-driven practice, and risk-averseness.

Central causes of vertigo have a low prevalence and thus liberal scanning leads to many false positives. The authors assert that good diagnosticians can rapidly diagnose and disposition dizzy patients at the bedside without inappropriate imaging. They advise considering sensitivity and specificity as well as pre- and post-test probability before testing. Additionally they recommend against ordering tests, which have post-test probabilities that do not change management. The authors propose considering the *health utility* of a test, contemplating all possible resultant outcomes before ordering it. Despite training in analytic decision-making, physicians often do not follow this rationale.

Research generally focuses on diagnostic accuracy or immediate results of a test. However, the authors argue, that focus on patient-centered outcomes is more useful for calculating test utility. Unlike therapies, which are easily associated with patient consequences, the causal relationship of testing to downstream patient outcomes is often uncertain. There is a false assumption that correct diagnosis and subsequent treatment leads to better clinical outcomes.

To try and quantify the complex value of diagnostic tests, the authors assert that the standard measure of health effect used in economic analyses of medical treatments, the quality-adjusted life year (QALY), should also be applied to diagnostic test outcomes. Tests that cost less than $100,000 per QALY would be considered cost effective. The authors then apply this economic analysis to dizziness.

They argue that physicians may be misled to think highly sensitive and specific bedside tests are the most beneficial diagnostics if applied to high-risk patients. However, economic analysis shows that targeting this subset is not economically beneficial due to increased stroke work-ups and costs. By focusing on better diagnosis of benign causes of vertigo, societal costs can be reduced by decreasing many unnecessary stroke work-ups and admissions. They calculate $1 billion annually can potentially be saved from ED workups of vertigo.

Finally, the authors recommend economic analysis to guide QI approaches to reducing error in areas with the highest economic burden. Despite temptation to target therapies and diagnostics for rare life-threatening illnesses, closer analysis shows that targeting more common illnesses with high misdiagnosis and expensive error rates is more economic. Perhaps healthcare costs could be reduced and patient outcomes improved by focusing research on misdiagnosis and inappropriate testing-related harms.

## Conclusion

The correct ED approach to the dizzy patient remains unclear. The articles reviewed offer insight into several bedside neurologic examinations that may offer accurate and economic methods to evaluate patients presenting with dizziness. These tests may be more accurate than imaging at distinguishing between benign peripheral etiologies and more serious central ones. Many of these exams need to be further validated in in emergency setting. Ultimately these articles suggest that in evaluating the dizzy patient, using bedside exams as opposed to imaging may improve care and reduce costs. ■

## Medical Student Council President's Message

# Community Based Compression-Only CPR Training: An Interview with Marina Del Rios, MD MS

Mike Wilk, MS3
Medical Student Council President

An elderly woman walks down a busy neighborhood street and suddenly collapses as her heart stops. A young man in his twenties goes into sudden cardiac arrest (SCA) while playing basketball. Most health care providers in these situations would spring into action and immediately begin CPR. However, any chance of revival is often gone long before emergency medical services (EMS) arrive, let alone by the time the patient receives definitive care in the emergency department. Delayed time to CPR remains a major factor behind low survival rates in SCA.

Recent initiatives in various states seek to increase CPR training in our communities, in the hope of improving SCA survival rates. I will focus on one of these programs, the Illinois Heart Rescue (ILHR) Project, a collaborative effort among community leaders, health care professionals, emergency responders, and hospitals designed to increase sudden cardiac arrest (SCA) survival rates in Illinois by more than 100% over the next five years. ILHR is focused on developing and expanding SCA response systems by coordinating measurement, education, training, and the application of evidence-based best practices among the general public, first responders, EMS, and hospitals.

The Community Sphere of ILHR is tasked with improving bystander CPR and AED use. Compression-only CPR is easier than conventional CPR to teach, learn, remember, and perform. It is taught as three basic steps, known as "the three Cs": Check, Call, Compress. Check the patient, call 911, begin compressions without rescue breathing, and ask someone to find and use an AED. Compression-only CPR produces outcomes as good as or better than conventional bystander CPR. The program conducts these quick and easy training sessions everywhere from schools, festivals, and summer camps to major sporting events.

Since the program got off the ground in 2011, thousands of people all over the state have been trained through ILHR. I recently had the pleasure of interviewing of Dr. Marina Del Rios, MD MS, University of Illinois at Chicago Assistant Professor of Emergency Medicine and physician-leader of the Community Sphere for the ILHR project.

**Mike Wilk:** How and why did you get involved in the program?

**Dr. Del Rios:** I have been involved with Illinois Heart Rescue ever since it was an idea. I was one of many health professionals and community leaders who sat at round-table discussions as we planned and divided tasks while writing our proposal to become a Heart Rescue Partner in 2011. I was drawn by the energy of the group and by the idea that we can not only save lives but change lives. I knew this was a unique opportunity to make a meaningful difference, not only in the lives of individual victims of sudden cardiac arrest and their families, but in the population as whole.

**Mike Wilk:** What were some unforeseen challenges you faced with the program?

**Dr. Del Rios:** I can name several. One huge challenge in our state was the lack of data. Cardiac arrest is not a reportable disease and much of our data was initially extrapolated from disjointed sources. Data from EMS and hospitals was not linked, and it was practically impossible to follow a victim's progress through the medical system from the scene to (hopefully) hospital discharge. You cannot improve what you are not measuring. Expansion of the Cardiac Arrest Registry to Enhance Survival (CARES) into the state of Illinois now allows us a better process to track patient outcomes, and will no doubt lead to marked improvements in cardiac arrest survival.

For the community sphere, our biggest challenge has been gaining the community's trust. Even when we are well intentioned, we "ivory tower" folks are looked at suspiciously by many communities that have been victims of so-called "parachute" interventions. But persistence pays off, as does switching our mentality from outreach to engagement. By actively seeking input, conducting ongoing analysis of our processes, and keeping the public informed of our outcomes, we hope to sustain our partnerships beyond the Illinois Heart Rescue mission.

**Mike Wilk:** How has the program been successful?

**Dr. Del Rios:** I think that our biggest success has been in building strong partnerships. We started out as a handful of idealistic health professionals and community partners and are now an ever-growing monumental

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effort, with more requests for partnerships coming in every day. Even national organizations such as the American Heart Association have taken notice. We are honored that so many communities in Illinois look to Illinois Heart Rescue for advice on how to improve cardiac arrest treatment and survival.

**Mike Wilk:** What is planned for the program in the future?

**Dr. Del Rios:** So far we have concentrated most of our efforts in Chicago and adjacent suburbs, but we are rolling out to other regions in the state in the upcoming months. More EMS providers and hospitals are sharing their data through CARES, and every day I get more requests from community organizations interested in teaching their constituents about the importance of the bystander's role in the chain of survival. We are working to develop an integrated community response, so that every victim of sudden cardiac arrest in Illinois receives lifesaving, state-of-the-art care at the scene, en route, and in the hospital.

**Mike Wilk:** Is there anything else you would like to add?

**Dr. Del Rios:** I would like to thank Medtronic Philanthropy and our Heart Rescue partners throughout the U.S. for their support and wisdom. I also appreciate the tireless efforts of so many volunteers who are making this project a success. Improving cardiac arrest survival requires a culture change, and we are happy to report that change is happening now. I have been honored to work with people of different walks of life and diverse professions, ages, races and ethnicity, and socioeconomic backgrounds who recognize that survival improves when we all work together.

For more information about the ILHR visit illinoisheartrescue.com, facebook.com/IllinoisHeartRescue, or on twitter @ILHR_heart. Comments or questions? Please contact me at: mikewilk2@gmail.com. ■

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