

# COMMON SENSE

VOLUME 21, ISSUE 2  
MARCH/APRIL 2014



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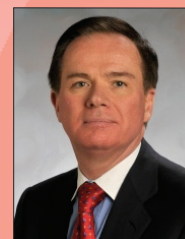
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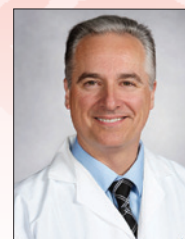
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### AAEM Mission Statement

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

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

### Membership Information

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

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## President's Message

# Looking to the Future

Mark Reiter, MD MBA FAAEM

I am excited and honored to begin my two year term as president of the American Academy of Emergency Medicine. As president, I promise to do everything I can to promote the Academy's mission. Our Academy is on firm footing, with soaring membership, expanded advocacy efforts, continued improvements to our excellent educational meetings and courses, a prominent international presence, and solid financial footing. I write this president's message two days after the conclusion of our 20<sup>th</sup> AAEM Scientific Assembly, an exceptional meeting (and still free to members!) that again broke prior attendance records. I'd like to recognize the great work of the outgoing board, under the leadership of past president Dr. Bill Durkin, who has been instrumental in the Academy's recent successes. I would also like to welcome new members to the AAEM board: Dr. Joel Schofer (Secretary-Treasurer), Dr. Andy Mayer (At-Large Member), and Dr. Michael Ybarra (Young Physician Section Director). I've worked with Joel, Andy, and Michael on AAEM projects extensively over the years — they are tireless advocates for the Academy and they will make AAEM's leadership stronger.

During my term, AAEM will continue to take a strong stand on advocacy issues important to our members, such as advocating for emergency physician practice rights and defending the value of board certification. AAEM has recently significantly increased our presence in Washington, D.C., with the help of our new lobbying firm and through the hard work of the AAEM board and many interested AAEM and RSA members. In addition to creating a dialogue with many key congressional members about our issues, we have had good communications with leaders within key federal agencies, such as the Department of Health and Human Services. The AAEM board and many of our AAEM State Chapters have also been advocating successfully for our members on the state level. These efforts will continue to be a major focus for the Academy. You can help in a variety of ways, such as contributing to the AAEM Foundation, participating in our Advocacy Days in Washington, D.C., participating in AAEM committees, and keeping AAEM informed as new issues of importance to our members arise.

Another core area of focus over the next two years will be to provide expanded support services to help private emergency physician groups better compete in the marketplace. In recent years, there has been a trend towards consolidation at the hospital and physician group level. AAEM will play a more prominent role in providing education, support, advice, and services to our members. We have just launched the AAEM

Insurance Program to provide tailored professional liability insurance to our members and their groups. If there is demand from our members, we can expand this program to offer other related services such as health insurance, disability insurance, etc. Later in the year, we will unveil a comprehensive guidebook on forming and managing a democratic emergency physician group. We are in the process of launching the Practice Fairness Toolkit™, offering resources to help our members evaluate different physician group practice environments. We are considering developing a spectrum of practice management services geared towards private democratic groups. You can help us by volunteering for one of the several AAEM committees involved in these initiatives and by providing feedback on our new services and on how the Academy can best help you or your group.

Keeping our members informed will continue to be a top priority. We have made many recent changes to our website at [www.aaem.org](http://www.aaem.org). We now have thousands of members communicating with AAEM via social media. Our new podcast program has been very successful (and we are always looking for new ideas and new speakers). In addition, Dr. Andy Walker has done an exceptional job of further developing *Common Sense* into a top-notch platform for the Academy in the past year.

Keep your eyes open for information about new appointments to AAEM committees. This is a great way to support AAEM, get involved, learn something, and meet new colleagues. Also, let us know if you have an idea for a project that you would like to work on with AAEM. I want to make sure we can involve as many interested members as possible. I love to hear feedback from our members — feel free to email me at [mark.reiter@yahoo.com](mailto:mark.reiter@yahoo.com). ■

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](mailto:info@aaem.org) or by calling 800-884-AAEM.



# Malpractice

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



"The fault, dear Brutus, is not in our stars,  
But in ourselves, that we are underlings."

— Cassius, in Shakespeare's *Julius Caesar*

Does the United States have a malpractice problem? No, absolutely not. True medical malpractice is exceedingly rare in this country. Studies have consistently shown that patients are injured by negligence in less than 1% of hospitalizations.

Obviously we would like to drive that number even lower, especially given the large number of hospital admissions that occur every year, but a negligent injury rate of below 1% is a pretty good starting point. Furthermore, I suspect that the rate of physician malpractice is even lower. I graduated from medical school in 1985, and can count on one hand the cases of actual malpractice that I have seen. I trust that your experience is similar. What we have is a lawsuit problem.

In theory, to win a malpractice suit the plaintiff-patient must show that the defendant-doctor committed negligence (violated the standard of care), and that this negligence caused harm. If this theoretical standard applied in the real world, we wouldn't have a lawsuit problem and physicians wouldn't be wasting countless hours and dollars on defensive medicine, because medical negligence is defined as something a reasonable physician would not do under similar circumstances. In other words, the standard of care isn't perfect care or good care, it isn't even average care. It's just **reasonable care under the circumstances**. At most medical decision points there is a range of reasonable options — not just one or even two. Unfortunately, this standard of **reasonable** behavior is not applied in the real world, the world in which we practice emergency medicine and get sued. The good news is that roughly 70% of malpractice suits end with no payment to the plaintiff. The bad news is that the occurrence of malpractice has surprisingly little influence on the outcome of the lawsuit, or even on whether or not a lawsuit is filed.<sup>1,2</sup> Only permanent disability is reliably correlated with the outcome of a medical malpractice suit.<sup>4</sup> Worst of all from a physician's point of view, 16% of malpractice suits involving **no injury of any kind** to the patient still result in a payment of damages, and 28% of malpractice suits in which there is no error — not just no negligence but **no error at all** — result in a payment of damages!<sup>2</sup> And in the latter case, the damage award averages over \$313,000!<sup>2</sup> That is why we practice defensive medicine and live in fear — because any bad outcome can result in a lawsuit that has a reasonable chance of winning, even if we performed flawlessly.

So why all the lawsuits against physicians, including emergency physicians? Perhaps more importantly, if nearly all these lawsuits are unjustified, why are so many successful? Much of the blame lies with the legal profession. The United States has far more lawyers than it needs, to the point that many law school graduates now cannot find a job that requires them to pass the bar. We need a certain number of attorneys to write contracts and handle wills, estates, trusts, divorces, etc. — and

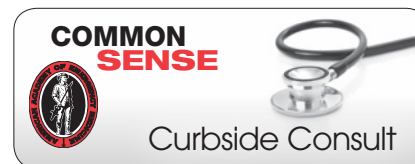
most importantly to help keep the various levels of government honest through litigation and criminal defense — but when there are too many lawyers for the constructive and necessary work available, they create work for themselves by creating mischief for everyone else. Too many lawyers seem to be completely amoral, caring nothing for justice and willing to do anything marginally legal if it's profitable. Some of the blame also lies with a segment of the American public, whose ignorance of science and probabilistic reasoning, unrealistic expectations, and sometimes just plain greed drives them into the arms of a lawyer whenever anything bad happens to them in a medical setting.

As emergency physicians we cannot control those things. Part of the blame, however, lies with something we can control: ourselves. No medical malpractice suit can proceed without at least one expert witness for the plaintiff, a physician who is willing to say that negligence occurred and that it harmed the patient. Who are these "experts" who testify against emergency physicians? After doing expert witness work for several years myself, I believe I can answer that question.

Many aren't emergency physicians at all. They are cardiologists, neurologists, radiologists, orthopedists, psychiatrists, etc. who think they know what the standard of care is in emergency medicine. They worked briefly in the ED during medical school or residency, moonlighted in an ED during training, occasionally talk to an emergency physician on the phone, or admit a patient from the ED; and are both ignorant enough and arrogant enough to think that gives them an understanding of our

Continued on next page

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





specialty. I see this in almost every case I participate in: a cardiologist (for example) thinks that because he understands the standard of care for treating acute coronary syndromes, he is qualified to testify on the standard of care in emergency medicine. What he doesn't understand is that the issue is almost never how to recognize a STEMI on the EKG or treat MIs, it is how to approach a patient with undifferentiated chest pain in the ED, where we see dozens of people every day with chest pain — few of whom turn out to have MIs. Most of the emergency medicine lawsuits I see revolve around the signal to noise issue that all of us wrestle with every day, and that no other specialty understands, because we act as filters for them — they see only the patients we select for them to see. In a patient with a normal EKG and troponin, how high does your suspicion for an acute coronary syndrome have to be to justify a cardiology consult or admission to a hospital where you can't get an exercise or other stress test immediately? One chance in ten? Absolutely. One chance in 1,000? Absolutely not. One in 100? Probably not. One in 50, one in 20? How much noise are you willing to put up with to catch a signal? No physician in any other specialty understands how emergency physicians act as filters for them and for the hospital, and how we roll the dice every time we send a patient home — and **no one from another specialty should ever be allowed to testify on the standard of care in emergency medicine.** This is a tort reform we should push vigorously in every state where it isn't currently the law, including my own.

Some expert witnesses are simply prostitutes, and will say anything the attorney wants them to say in return for money. These are easy to spot, not just because their allegations of negligence are ridiculous, but because of the volume of expert witness work they do and how exorbitantly they charge. After all, a soul is an expensive thing to sell. These mercenaries make up a minority of plaintiffs' experts, however, and are usually defeated by a good defense lawyer and ethical defense expert. If you run into one of these, please report him to AAEM's "Remarkable Testimony/Due Process" website.

Believe it or not, most plaintiff's experts are honorable, well-intentioned emergency physicians — and while the first two types discussed above make me angry, these break my heart. Why would a good emergency physician incorrectly claim another emergency physician has committed malpractice? There are three reasons: 1) not understanding what *standard of care* and *negligence* mean, 2) hindsight bias, and 3) the ivory tower syndrome.

I encourage you to act as an expert witness if called upon, because it gives you a chance to bring a voice of reason to our horribly unfair and broken tort system. To do that, however, you must remember what negligence means and what the standard of care is. *Negligent* means unreasonable; not imperfect, mediocre, average, or even below average. The standard of care is not perfection. It is not how you do things or how things were done where you trained. It is most certainly not a good outcome (see hindsight bias) — the vast majority of bad outcomes occur despite proper medical care, not because of bad medical care. Standard of care means within the bounds of reason. And remember, if **there is a controversy raging in our specialty, then there is no standard of care** on that issue — no matter what your personal opinion of

the evidence is (tPA for stroke, for instance).

You must also be aware of your own unavoidable hindsight bias and strive to overcome it. When you know in advance the patient died of a PE, everything about the case screams the diagnosis at you. You must put yourself in the shoes of the emergency physician who was seeing the patient in real time, and then decide if his behavior was within the bounds of reason. Sure, the patient had pleuritic pain, hypoxia, and shortness of breath. He also had sinus congestion, rhinorrhea, a cough with purulent sputum, and the radiologist called pneumonia on a chest X-ray. Are you going to say that every patient with a URI and pneumonia should have a D-dimer or CTA of the chest? That's what you're saying when you say that defendant emergency physician was negligent. Always consider where your opinion will take our specialty when your line of reasoning reaches its conclusion.

Finally, for those of you in academia, if the lawsuit involves a community hospital ED and you haven't recently worked extensively in one — you have no idea what you are talking about and are **not qualified** to offer an opinion on the standard of care in such an ED. Try to get over your hubris. When you are not only the only physician in the ED, but the only physician in the building, the situation is completely different than when you have half a dozen EM residents around you and getting a consult means having another doctor come down the elevator, rather than transferring the patient to a completely different hospital. Just as no doctor from another specialty should ever be allowed to testify on the standard of care in emergency medicine, no academic from a tertiary care center should ever testify on the standard of care in a small community hospital.

There is little we can do about unethical medical experts, absolutely nothing we can do about bad lawyers, and reforming our dysfunctional tort system is difficult and will take years of effort, one state at a time. We can, however, change our own flawed behavior. When you are the medical expert — be humble, be fair, and be honest. Understand exactly what you are doing and think carefully about everything you say. A bad outcome is not proof of malpractice — it usually isn't even evidence of malpractice.

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## Call for Assistant Editor — Join the *Common Sense* Team

*Common Sense* needs an assistant editor. I am looking for someone who enjoys reading and writing, who is passionate about AAEM's values, and who is dedicated to fighting for individual emergency physicians, our specialty, and our patients by spreading news of the Academy and growing its membership. Responsibilities include editing articles for accuracy, grammar, and to some degree, for style. Our goal in editing is to make every article an easy and interesting read while leaving the author's original voice and intent intact.

The assistant editor will always edit the "Resident Journal Review," as well as anything else I need help on, and write an occasional "From the Editor's Desk" column when I need a break. An important part of the job will be to recruit authors and solicit interesting material to publish. I hope the assistant editor will also contribute ideas on how to make *Common Sense* more interesting, useful, and popular to AAEM members.

If you are interested, please contact either me ([cseditor@aaem.org](mailto:cseditor@aaem.org)) or Laura Burns ([lburns@aaem.org](mailto:lburns@aaem.org)) and explain why you want the job and think you would be right for it. A sample of your writing would be appreciated. Note that this is a volunteer job, just like all AAEM leadership positions — including my own. ■



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# Letters to the Editor

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

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](http://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 November/December "Medical Student Council President's Message" titled "That's So Meta': Cognitive Bias."

Kudos to MS4 Calderone. It's encouraging to see someone so early in his/her career realize our "science" is hindered or enhanced by our own personal psychology. I encourage her and other young physicians to continue to delve into this subject as it belies the arguments of medical malpractice. Our profession would be well-served if she, and others like her, took upon themselves, as part of their career, to educate his/her fellow physicians and, more importantly, the general public about the nuances of the clinical decision-making process. It is

important for society to understand that medicine is not an algebraic equation. For better or worse, our past experiences play a starring role in our thinking process. Two reasonable physicians can start with the same set of facts and reach different conclusions. Not because one is smarter and the other one is careless. But because our clinical decision-making process cannot be divorced from our humanity.

— Hector Peniston Feliciano, MD FAAEM

Thanks for your letter. I agree. That's why I encourage all physicians who act as expert witnesses to remember two things above all else. 1) Be aware of your own hindsight bias when you evaluate a case. When you know in advance the pt eventually suffered a posterior circulation stroke, what looked like peripheral vertigo to the original physician was "obviously" a vertebrobasilar TIA. If the pt had no diplopia or other cranial nerve deficits, however, calling that negligent means you are saying that every pt with vertigo must have a CT angiogram or MRA of the head and neck before being sent home. Be fair, and think about where your chain of reasoning will end up. 2) Remember what "standard of care" and "negligent" actually mean. The standard of care is not perfection, what you do in your practice, or what they do where you trained. It is reasonable care. Negligence is something a "reasonable" physician would not have done under similar circumstances. "Reasonable" includes a broad range of medical choices and actions, many of which you might not have chosen. Unfortunately a tiny fraction of physicians will say anything if paid well enough for their testimony. Most plaintiff's experts, however, are sincere and well-intentioned — but blinded by their own hindsight bias or misunderstanding of what constitutes negligence in emergency medicine. ■

— Andy Walker, MD FAAEM  
Editor



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EDUCATION IN EMERGENCY MEDICINE.





# Congress to Contend with Doc Fix, Health Reform Legislation in 2<sup>nd</sup> Session

Williams & Jensen, PLLC

In December, Congress passed the Bipartisan Budget Act of 2013, a significant budget agreement on spending levels for 2014 and 2015. The package also included a three month patch to the Medicare Sustainable Growth Rate ("SGR," or "doc fix"), preventing a 24% cut in physician payments that would have commenced on January 1st. The bill was paid for in part by a provision that extended the 2% across the board Medicare cut for providers that was enacted as part of the Budget Control Act (BCA) of 2011. The cut had been set to expire in 2021 but will now be in place until 2024, following passage of the budget deal and a subsequent fix to pensions for military veterans.

Key House and Senate policymakers cite continued progress towards a permanent SGR fix, but they must still decide how to pay for the measure, which is expected to cost over \$120 billion. SGR fixes are typically financed with other cuts in the health care sector, and Congress is mulling a list of dozens of policy changes that could save the government anywhere from \$50-250 billion over the ten year budget window. An agreement on major entitlement reform has eluded negotiators from Congress and the administration over the last several years, so the focus has shifted to consideration of smaller cuts.

In February, three key congressional committees introduced the *SGR Repeal and Medicare Provider Payment Modernization Act* (H.R. 4015), a bipartisan, bicameral bill to permanently repeal the SGR and replace

it with a positive payment update for physicians of 0.5 percent over each of the next five years. A period of stable, positive updates is an approach endorsed by numerous physician advocacy groups. Following this period, payments will again be updated, and physicians would be able to begin earning additional payment adjustments for meeting certain benchmarks.

Other aspects of the legislation include (1) improving fee-for-service by reforming the current system by merging existing quality programs into a single "Merit-Based Incentive Payment System;" (2) encouraging adoption of alternative payment models (APMs) by providing bonus payments to physicians who enter into APMs or patient centered medical homes (PCMHs); and (3) increase Medicare transparency by providing more data to patients and allowing certain data to be used for quality improvement and patient safety.

While the House and Senate have been working on plans to repeal the SGR for the past year, the introduction of this legislation marks the first time in this Congress that a bill has been introduced that has the endorsement of the key Committee leaders. In its current form, the legislation does not specify how the permanent fix would be paid for, but key members of Congress continue to maintain that provisions to offset the cost of the bill would be attached prior to it being brought before the full House or Senate.

In the meantime, with the SGR fix set to expire at the end of March, Congress is now looking for ways to enact another temporary patch while negotiators continue to work on permanent repeal. Congressional leaders had considered attaching a nine or 21-month SGR patch to legislation extending the nation's debt limit, which would have prevented cuts from occurring until the end of 2014 or 2015. The debt limit has now been signed into law without the SGR patch, which means Congress will likely try to pass a short-term patch (nine months or less) to prevent the cuts from occurring on April 1st.

Congress is continuing to closely monitor implementation of the Affordable Care Act (ACA). The White House is touting numbers released in February that suggest a significant uptick in enrollment through the exchanges, as 3.3 million people had enrolled through the end of January. While it remains unlikely that the initial target of 7 million enrollees by the end of March will be reached, the administration also argues that a surge in young people signing up for insurance is a sign that the law is working. The White House has announced a number of changes to the law in response to concerns from lawmakers and other groups, notably that individuals with health plans that were cancelled are eligible to purchase catastrophic plans through the law's "hardship exemption." Congressional Republicans contend that this and other changes and delays announced by the administration demonstrate that the ACA is not working, and the modifications are contributing to the public's confusion about the law.

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In January, several key Senate Republicans unveiled an alternative to the ACA, entitled the *Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act*. The sponsors wrote about their intent to “further refine and improve upon the proposal” before formally introducing legislation. The framework includes a number of concepts and ideas, notably the capping of non-economic damages for claims under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) statute. Other aspects of the plan include: Repeal of the Affordable Care Act (ACA); requiring health plans to continue to allow dependent coverage up to age 26 and to allow individuals with pre-existing conditions to remain covered as long as they were “continuously enrolled” in a health plan; incentivize states to examine medical liability laws; enhance ability for states to enact Medicaid reform in ways that increase accountability.

The House has already enacted several smaller bills related to the ACA this year, including legislation pertaining to data security and mandating enhanced transparency for the exchanges. The House also plans to introduce and vote on a legislative alternative to the ACA in 2014. The White House opposes these bills and the Senate is not likely to consider any of these measures in the coming months.

## CMS Issues Guidance on Appropriate ED Use, Announces Public Release of Physician Medicare Billings

In January the CMS Center for Medicaid and Chip Services (CMCS) released an informational bulletin entitled “Reducing Nonurgent Use of Emergency Department and Improving Appropriate Care in Appropriate Settings.” In the memorandum CMS identifies the need to reduce unnecessary ED usage, as utilization of services across the health care system increases as a result of individuals gaining coverage under the ACA.

The first section of the bulletin, “Strategies to Reduce ED Use,” outlines three strategies that CMS has identified to reduce inappropriate ED use. Options cited in the paper include broadening access to primary care services, including extended hours for primary care medical and health homes, and increasing urgent care and retail clinic access for patients with non-emergency conditions at alternative primary care sites. It is also suggested that state and local entities focus on frequent ED users or, “super-utilizers,” who are commonly defined as individuals with four or more ED visits annually. As an example, CMS cites an ambulatory ICU clinic built on site at Minnesota’s Hennepin County Medical Center. The clinic was created to provide enhanced outpatient care to super-utilizers, and a 38% decrease in ED visits and 25% decrease in hospitalizations among its client population was observed during the first year.

Continued on next page

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Finally, CMS suggests a targeted strategy to reduce high utilization by individuals with substance abuse or mental health problems. The bulletin said that states and health plans have had “dramatic success” in reducing overall ED usage by this population, and notes that in many examples case managers are used to connect this population with the appropriate behavioral health entities that can help meet their needs.

The second part of the paper, entitled “Differentiating Emergency and Non-Emergency Use of the ED,” notes that states can utilize payment methodologies that encourage providers to “direct patients to more appropriate cost settings,” and can implement cost sharing “based on a distinction between non-emergency and emergency use of the emergency department.” CMS points out that some states have approved payment strategies designed to reduce inappropriate ED use, such as lower reimbursements for non-emergent ED visits, as “determined retrospectively by chart review, or based on a coding algorithm.” CMS states that these payment strategies must not be designed in a way that impede care in the ED and that they must be compliant with the EMTALA statute.

CMS and Congress are very interested in ED utilization following passage of the ACA. When AAEM is on the Hill, emergency physicians are frequently asked to comment on their experiences with the law and

whether or not they are seeing an increase in patients following the expansion of Medicaid and the opening of the state and federal health insurance exchanges.

On January 17, CMS published a “Modified Policy on Freedom of Information Act Disclosure of Amounts Paid to Individual Physicians Under the Medicare Program.” Beginning on March 18<sup>th</sup>, CMS will disclose Medicare physician billings on a case-by-case basis in response to requests made under the Freedom of Information Act. Under the new policy, CMS plans to “weigh the balance between the privacy interest of individual physicians and the public interest in disclosure of such information.” Prior to the new decision, HHS was prohibited from disclosing identifiable Medicare reimbursement payments of individual physicians.

In August, CMS requested public comment on the potential release of Medicare physician data. AAEM has been a vocal advocate for enhanced billing transparency, and submitted comments urging the adoption of a responsible policy that would provide emergency physicians the ability to see what is being billed and collected in exchange for their professional services. It is not clear whether the new policy will give physicians access to additional information. AAEM has also applauded Congress’ willingness to consider Medicare transparency provisions as a part of SGR legislation. ■

## Advocacy Fellowship Rotation on Capitol Hill Approved

William T. Durkin, Jr., MD MBA FAAEM  
AAEM Immediate Past President



“OK, let’s do it!” With those words Congressman Raul Ruiz (D-CA) ended a four month long discussion between myself and his office, which began during the RSA’s Advocacy Day last fall. Working through our lobbyists, Williams and Jensen, I met twice with the congressman and had several discussions with his aides about setting up a month-long rotation in his office, where by an interested resident could get a firsthand

view of how the legislative process really works. Dr. Elizabeth Johnson, who is currently working for the congressman, was a real champion of this cause. After I met her last December, she facilitated the entire process and we came up with a written plan, which the congressman approved a week before the Academy’s Scientific Assembly in February.

The experience promises to be invaluable for all involved. The congressman wants the participant to be able to brief him on hearings, know how to write a position paper, help with legislative efforts, and spend a week in his district seeing how the office works at the grassroots level. The participant will be awarded a certificate at the end of the fellowship and will then become part of Congressman Ruiz’s “alumni network,” which

he may wish to consult from time to time on legislative matters regarding health care. The Academy will gain a cadre of members who have experience on Capitol Hill and will be able to assist, along with Williams and Jensen, in our advocacy efforts. **We are the only professional society in emergency medicine to offer such an experience to its members.**

Applications are available to anyone interested. The application process includes two essays, the Academy and AAEM/RSA will select candidates for each month-long rotation and send these names to Congressman Ruiz’s office, where he and his staff will make the final selection. Those interested must fund themselves. Matt Hoekstra and Jenny DiJames, of Williams and Jensen, have offered to assist in orienting selected candidates to the area and to congressional protocol and procedure.

I would like to extend our deep appreciation to Congressman Ruiz for volunteering to provide this opportunity to our members; to Dr. Elizabeth Johnson for her part in facilitating this; and to Matt Hoekstra, Jenny DiJames, and Susan Hirschmann for their help in making this possible.

For more information and to apply, please visit: [www.aaemrsa.org/congressional-fellowship](http://www.aaemrsa.org/congressional-fellowship). ■

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#### May 14-16, 2014

- Fifth Inter-American Emergency Medicine Congress  
Buenos Aires, Argentina  
<http://www.aaem.org/education/iaemc>

### AAEM - RECOMMENDED CONFERENCES

#### March 14-16, 2014

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

#### April 2-6, 2014

- 52<sup>nd</sup> Annual Weil/UC San Diego Symposium on Critical Care & Emergency Medicine  
Las Vegas, NV  
<http://cme.ucsd.edu/weil>

#### April 4-6, 2014

- The Difficult Airway Course: Emergency™  
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#### May 2-4, 2014

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#### May 3, 2014

- Vanderbilt Emergency Medicine 20<sup>th</sup> Reunion/CME  
Nashville, TN  
[www.vanderbiltem.com](http://www.vanderbiltem.com)

#### May 21-24, 2014

- High Risk Emergency Medicine  
San Francisco, CA  
<http://www.ucsfcmecme.com/2014/MEM14002/info.html>

#### May 30-June 1, 2014

- The Difficult Airway Course: Emergency™  
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#### June 11-14, 2014

- International Conference on Emergency Medicine (ICEM 2014)  
Hong Kong  
[www.icem2014.org](http://www.icem2014.org)

#### July 25-27, 2014

- 2nd International Trauma, Emergency & Critical Care Conference  
Bayahibe, Dominican Republic

#### September 12-14, 2014

- The Difficult Airway Course: Emergency™  
Baltimore, MD  
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#### 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 approval process: [edeillers@aaem.org](mailto:edeillers@aaem.org). All sponsored 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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**Newest Episode: The ACA, Medicaid, and the ED – What's the Bottom Line?**

In this Policy Prescriptions® edition of this podcast, Cedric Dark, MD MPH, Assistant Professor of Medicine at the Emergency Medicine Residency Program at Baylor College of Medicine, speaks with Jesse Pines, MD MBA FAAEM, Director of the Office of Clinical Practice Innovation at George Washington University. The discussion points include: how will the ACA and Medicaid interact with emergency departments? What will this mean for the bottom line for emergency departments around the country?

### *Critical Care in Emergency Medicine*

**Newest Episode: Procalcitonin in Adult ED and ICU Patients**

David Farcy, MD FAAEM FCCM, Chairman, Department of Emergency Medicine at Mount Sinai Medical in Miami Beach, Florida, speaks with David Huang, MD FAAEM, Associate Professor at the University of Pittsburgh. They will discuss the role of procalcitonin — what is it and how is it used ED? To address this topic, the main articles that will be discussed are the ProHOSP and ProRATA trials.

### *Emergency Medicine Operations Management*

**Newest Episode: Scribes in the ED Part 1 & 2**

Joseph Guarisco, MD FAAEM, ED Chair at Ochsner Hospital (New Orleans, LA) and Chair of the AAEM Operations Management Committee, interviews Todd B. Taylor, MD FAAEM, an emergency physician and independent consultant in the areas of health care IT and practice management. In part one of this episode, Drs. Guarisco and Todd discuss scribes in the emergency department covering the history and definition of scribes, in addition to data surrounding the financial and efficiency outcomes of these programs.



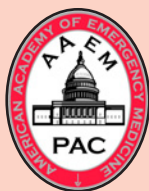
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# Medical Liability and the Emergency Physician: A State by State Comparison — Part 3

Gregory Roslund, MD FAAEM  
Legal Committee



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 third installment of this state by state review. The initial installment, in the July-August 2013 issue of *Common Sense*, analyzed the first ten states in alphabetical order (Alabama through Florida) and included a "Methods" section detailing how these ratings were calculated. The second installment, in the November-December 2013 issue, analyzed ten more states (Georgia through Maine).

For this installment, addressing the next 15 states, 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.<sup>31</sup> 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](mailto:cseditor@aaem.org).

Now, let's look closely at the next 15 states, Maryland through North Dakota.

## Maryland ★★★★★

**Caps:** \$725,000 cap on non-economic damages (soft cap, increasing \$15,000 annually).<sup>3</sup>

**Average 2013 premiums:** \$48,500 (estimated) for EM, \$12,700 to \$26,000 for IM, \$40,000 to \$116,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Despite the enactment of a cap on non-economic damages in 2004,<sup>3</sup> Maryland remains a hazard for well-intentioned EPs. Physicians (in all specialties) near Baltimore and D.C. can expect to pay some of the highest premiums in the nation.<sup>31</sup> For instance, surgeons and OB-GYNs typically pay between \$115,000 and \$158,000 per year in the greater D.C. and Baltimore areas.<sup>31</sup> Maryland's damage cap was successfully upheld in 2010.<sup>35</sup> However, the cap (currently set at \$725,000) will continue to increase \$15,000 per year indefinitely. The average closed claims severity in Maryland has risen from \$423,000 in 2006 to \$750,000 in 2012 — this further supports the argument that the current cap on non-economic damages is too high to be effective.<sup>39</sup> Maryland's per capita malpractice payout (\$19.40 per year) is the 7th highest in the nation.<sup>36</sup> Maryland has no joint liability reform,<sup>3</sup> no collateral source reform,<sup>3</sup> no limits on attorney fees,<sup>3</sup> and no significant expert witness reform.<sup>8</sup> The state's statute of limitations ("within five years of the date of the alleged wrongful act" or "three years from the time the alleged injury was discovered") is one of the most plaintiff-friendly of its kind.<sup>8</sup> And recently a Maryland court of appeals decided to waive even this statute in a wrongful death suit filed against a physician 14 years after he allegedly misdiagnosed a patient's cancer.<sup>39</sup> Typically, a malpractice claim must first be reviewed by an arbitration panel. However, there are numerous exceptions and plaintiffs may waive this step or appeal the panel's decision.<sup>8</sup> On a positive note, Maryland has been blessed with two physician-friendly medical liability reforms: (1) the plaintiff is required to file a certificate of merit from a qualified expert within 90 days after the claim is filed, and (2) Maryland is one of the few remaining states that recognizes the traditional common law doctrine of pure contributory negligence. Thus, any negligence by a plaintiff will bar his recovery completely. This deep-rooted law was successfully upheld by a Maryland high court in 2013.<sup>38</sup>

**Assessment:** Caps on non-economic damages have failed to significantly improve this state's high risk environment. Its high court's recent decision to uphold the doctrine of "contributory negligence" is a step in the right direction for EPs. **Grade:** 1.75 stars out of 5.

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**Massachusetts** ★★★★★

**Caps:** \$500,000 cap on non-economic damages (soft cap).<sup>3</sup>

**Average 2013 premiums:** \$33,600 (estimated) for EM, \$13,600 to \$17,400 for IM, \$40,700 to \$63,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** While the Massachusetts medical liability environment is far from perfect, the Bay State has distinguished itself as an innovative leader in Medical Liability Reform.<sup>57,58</sup> MA is one of the only states on the east coast to have enacted caps (\$500,000) on non-economic damages.<sup>3</sup> Unfortunately the cap can be lifted if the claimant can show “a substantial or permanent loss or impairment of a bodily function or substantial disfigurement.”<sup>3</sup> The state has also enacted sliding-scale limits on attorney fees,<sup>3</sup> collateral source reform,<sup>3</sup> and mandatory prelitigation screening panels — and panel opinions are admissible in court.<sup>8</sup> The state has failed to enact joint liability reform,<sup>3</sup> meaningful expert witness reform,<sup>8</sup> and periodic payment reform.<sup>3</sup> The statute of limitations is three years.<sup>8</sup> Massachusetts is heavy on lawyers, the fourth highest per capita in the U.S.,<sup>15</sup> and litigation dollars remain high. Massachusetts's per capita malpractice payout (\$22.73 per year) is the fourth highest in the nation.<sup>36</sup> The most notable component of the state's approach to Medical Liability Reform is an avant garde process known as “DA & O” (Disclosure, Apology, and Offering).<sup>58</sup> Similar to early arbitration in other states, this initiative focuses on early disclosure of mistakes, apologizing when appropriate, and offering up-front compensation in an effort to avoid costly and time-consuming litigation.<sup>58</sup> Everyone appears to appreciate the emphasis on transparency and the added opportunity to establish systems to prevent the recurrence of adverse incidents.<sup>58</sup> This new approach has been embraced by parties on all sides of the fence — lawmakers, physicians, and the general public.<sup>58</sup> In fact, two emergency physicians — Drs. Alan Woodward and Peter Smulowitz — were very active in bringing this model to Massachusetts.<sup>58</sup> While all of this is promising, a multitude of barriers need to be overcome: physician discomfort with disclosure, opposition by liability insurers, and concerns that this model may not be replicable in certain settings.<sup>58</sup> And finally, on the docket currently is S.1012 — a bill that would provide a gross negligence standard for EPs, similar to a law in Texas.<sup>57</sup> This bill grants “qualified civil immunity to physicians, nurses, and other healthcare professionals who provide emergency medical services, so-called EMTALA providers, except in the case of willful or wanton misconduct or reckless disregard.”<sup>57</sup> This bill pending before the MA Committee on Public Health.<sup>57</sup> Needless to say, this would be a sensational victory for Massachusetts EPs as well as any other specialists providing care in an emergency setting.

**Assessment:** With caps on non-economic damages and a revolutionary DA & O approach, Massachusetts is a rising star on the east coast. Premiums remain in the the mid-range and the state's malpractice payout per capita remains high. **Grade:** 3.25 stars out of 5.

**Michigan** ★★★★★

**Caps:** \$280,000 cap on non-economic damages, but up to \$500,000 in catastrophic cases (soft cap, adjusted annually for inflation).<sup>3</sup>

**Average 2013 premiums:** \$48,500 (estimated) for EM, \$7,900 to \$35,000 for IM, \$30,000 to \$121,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** The battered Wolverine State, home to the beleaguered Motor City, has seen its share of hardship over the years, both inside and outside of the medical community. While the lawmakers of Detroit need to be doing everything possible to keep talented EPs practicing in their struggling city, physicians in “The 3-1-3” (as it's affectionately referred to by Eminem in the movie 8 Mile) pay some of the highest premiums in the country.<sup>31</sup> OB-GYNs and surgeons practicing in Wayne, Oakland, and Macomb counties typically pay over \$100,000 per year in premiums.<sup>31</sup> There is immense variation in premiums throughout the state, with physicians in the western and northern regions paying considerably less.<sup>31</sup> Despite the presence of reasonable caps on non-economic damages (\$280,000, enacted in 1993),<sup>3</sup> Michigan is still considered a risky state — especially for physicians in and around the Detroit (personal communications, 2013). The cap on non-economic damages can be increased to \$500,000 in cases involving brain damage, spinal cord damage, damage to the reproductive system which prevents procreation, or injury to cognitive ability that leaves the plaintiff unable to live alone.<sup>3</sup> Michigan has enacted collateral source reform,<sup>3</sup> limits on attorney fees,<sup>3</sup> expert witness reform (experts must practice in the same specialty as the defendant),<sup>8</sup> and a certificate of merit requirement.<sup>8</sup> The state lacks joint liability reform,<sup>3</sup> periodic payment reform,<sup>3</sup> and pre-litigation screening panels.<sup>8</sup> The statute of limitations is two years but can be extended to six years under special circumstances.<sup>8</sup> Following the recent passage of the Patients First Reform Package (SB 1115 and SB 1118), the state appears to be moving in the right direction.<sup>53</sup> This newly enacted legislation clarifies the existing cap on non-economic damages, the statute of limitations, and how pre-judgment interest is calculated.<sup>53</sup> A new bill (HB 4354) was recently introduced which would increase the burden of proof in cases involving EPs and other physicians providing care in the emergency setting, similar to existing laws in Georgia, Texas, and North Carolina.<sup>55</sup> The bill states, “the immunity would not attach if the plaintiff proves by clear and convincing evidence that the health care professional's actions constituted gross negligence.”<sup>55</sup> This would be an enormous win for Michigan EPs, but as expected, there has been intense opposition from the Michigan Defense Trial Council, the Oakland County Bar Association, and even the Henry Ford Hospital System(?).<sup>56</sup> A recent *Detroit News* article discussed this bill, as well as the importance of recruiting well-trained EPs to the Detroit area.<sup>54</sup> That being said, recruiting new docs to D-town is not as big a problem as it might seem — the Detroit area is home to 14 emergency medicine residencies, bringing the total for the state to 26, with over 100 newly minted EPs graduating each year.<sup>52</sup>

**Assessment:** The Great Lakes state is a mixed bag for EPs. Caps on non-economic damages have been upheld, but premiums remain sky-high in Motor City. Recent legislation is encouraging, but has yet to make an impact. **Grade:** 2.75 stars out of 5.

**Minnesota** ★★★★★

**Caps:** None.<sup>3</sup>

**Average 2013 premiums:** \$8,500 (estimated) for EM; \$3,375 to \$4900 for IM; and \$11,300 to \$14,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Some call it

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"Minnesota Nice," but there is some truth to this cultural stereotype.<sup>32</sup> In keeping with their Scandinavian heritage, Minnesotans tend to be averse to confrontation and unlikely to sue.<sup>32</sup> And just like their Iowa neighbors, Minnesota EPs may pay some of the lowest premiums in the country despite nonexistent tort reform.<sup>31</sup> Most notably, in addition to a plaintiff-friendly four-year statute of limitations,<sup>8</sup> the North Star State has absolutely no caps on damages,<sup>3</sup> no limits on attorney fees,<sup>3</sup> and no substantial expert witness reform.<sup>8</sup> For many practicing Minnesota physicians, reform is simply not a priority because the current liability environment is generally favorable (personal communications, 2013). The state does have soft joint liability reform,<sup>3</sup> collateral source reform,<sup>3</sup> and periodic payment reform.<sup>3</sup> Plaintiffs must file an affidavit stating that the case has been reviewed by a qualified expert within 180 days of filing the claim.<sup>8</sup> Interestingly, despite opposition from the Minnesota Medical Association and the Minnesota Hospital Association, the state's Supreme Court recently established a "loss of chance" doctrine,<sup>33</sup> departing from a precedent set in the state in 1993. Patients are now allowed to seek damages in cases of "medical negligence that reduces his or her chances of recovery or survival."<sup>33</sup>

**Assessment:** Overall, a physician-friendly state. Litigation is rare. Premiums are very low, despite the absence of meaningful reform.  
**Grade:** 3.5 stars out of 5.

### Mississippi ★★★★★

**Caps:** \$500,000 cap on non-economic damages (hard cap).<sup>3</sup>

**Average 2013 premiums:** \$19,000 (estimated) for EM; \$4,300 to \$8,500 for IM; \$27,000 and \$36,000 GS.<sup>31</sup>

**Liability environment for emergency physicians:** Along with Texas, Mississippi is considered a "poster child" for tort reform. For many years Mississippi was Tort Hell.<sup>34</sup> In 2004, the state enacted powerful reforms, including a hard \$500,000 cap on non-economic damages and strong joint liability reform.<sup>34</sup> Since then, liability insurance costs have dropped

nearly 50% and the number of lawsuits has fallen 70%.<sup>35</sup> Premiums remain low,<sup>31</sup> and many insured physicians are receiving refunds from their carriers.<sup>35</sup> Mississippi's per capita malpractice payout (\$4.17 per year) is now the fourth lowest in the nation.<sup>36</sup> The state has a two-year statute of limitations,<sup>8</sup> and periodic payment reform.<sup>3</sup> Also, plaintiffs must file a certificate of merit stating that the case has been reviewed by a qualified expert.<sup>8</sup> Relative weaknesses include a lack of collateral source reform,<sup>3</sup> no limits on attorney fees,<sup>3</sup> and no meaningful expert witness reform.<sup>8</sup> In 2013 Mississippi EPs celebrated, when the state's hard cap on non-economic damages was once again upheld.<sup>37</sup>

**Assessment:** With low annual premiums and a strong, recently upheld cap on non-economic damages, the Magnolia State should be the "go-to" destination for EPs heading to the southeast. **Grade:** 4.25 stars out of 5.

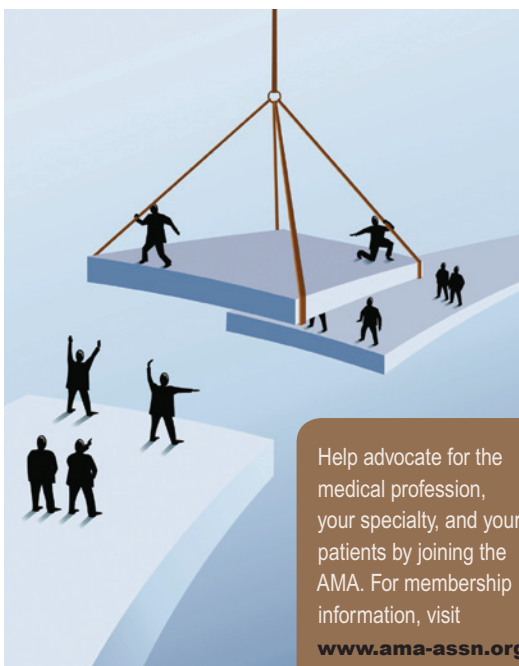
### Missouri ★★★★★

**Caps:** None.<sup>3</sup>

**Average 2013 premiums:** \$31,325 (estimated) for EM; \$10,600 to \$22,200 for IM; \$28,500 to \$64,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** While many states have achieved success on the road to tort reform over the past ten years, Missouri's story is one of tragic collapse. Missouri enacted a \$350,000 cap on non-economic damages in 2005, replacing its existing \$625,000 cap, in response to a state-wide medical liability crisis — the average award against medical care providers in the state had increased by 52% between 2001 and 2005.<sup>17</sup> In the five years that followed, the cost of liability insurance in Missouri decreased collectively by \$44 million.<sup>17</sup> Both claim frequency and cost per claim declined sharply, from 1,512 claims in the state in 2005 to 816 in 2011.<sup>45</sup> In 2012, the courts overturned this effective cap, siding with plaintiffs' attorneys over doctors.<sup>17</sup> The clock was turned back to a time when well meaning

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physicians were forced to leave the state due to skyrocketing premiums.<sup>17</sup> Missouri borders eight states — some with very favorable liability environments — so MO EPs interested in jumping ship have plenty of nearby options to choose from (especially in Kansas City, where docs can simply hop across the border to take advantage of Kansas' five star reforms). The Missouri House of Representatives passed HB 112 in April of 2013, which would reinstate the cap, but as yet there has been no vote on the bill in the senate.<sup>46</sup> As of now, annual premiums for EPs remain in the mid-range, but this is expected to change if caps are not reinstated.<sup>31</sup> MO has also enacted partial joint liability reform,<sup>3</sup> periodic payment reform,<sup>3</sup> and a case certification requirement.<sup>8</sup> The state has no limits on attorney fees,<sup>3</sup> no collateral source reform,<sup>3</sup> no pretrial panels,<sup>8</sup> and no expert witness reform whatsoever.<sup>8</sup> The statute of limitations is supposedly two years, but it can be extended up to ten years in special circumstances.<sup>8</sup> Recently, Missouri passed the Volunteer Health Services Act — an act that (1) waives civil penalties against volunteer health workers and (2) allows physicians licensed in other states to practice in Missouri as long as they are providing free care.<sup>47</sup> MO is the eighth state to have enacted this type of legislation.<sup>47</sup>

**Assessment:** The “Show Me State’s” recent decision to terminate caps on non-economic damages has triggered another crisis. MO docs are looking elsewhere as premium costs and litigation frequency are expected to increase. **Grade:** 1.75 stars out of 5.

### Montana ★★★★★

**Caps:** \$250,000 cap on non-economic damages (hard cap).<sup>3</sup>

**Average 2013 premiums:** \$39,075 (estimated) for EM; \$13,500 to \$16,500 for IM; \$56,300 to 70,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** The Big Sky Country — known for elk herds, golden eagles, rich mineral reserves — and a longstanding, powerful cap on non-economic damages.<sup>3</sup> Montana’s \$250,000 cap, upheld in 1995 and again in 1997, is global — it applies to total non-economic damages, even if caused by a series of acts by more than one health care provider.<sup>3</sup> Additional favorable Montana laws include partial joint liability reform,<sup>3</sup> collateral source reform,<sup>3</sup> periodic payment reform,<sup>3</sup> and partial expert witness reform — experts must be in the same specialty as the defendant and show proof of substantial clinical practice during the five years leading up to the incident.<sup>8</sup> All potential claims must be reviewed by a pre-litigation screening panel of three physicians and three attorneys. However, the panel’s decision is neither binding nor admissible in court, and no member of the panel may be called to testify at a subsequent trial.<sup>8</sup> Unfavorable state laws include no limits on attorney fees,<sup>3</sup> no case certification requirement,<sup>8</sup> and a three-year statute of limitations that can be extended to five years.<sup>8</sup> Most notably, EP malpractice premiums are substantially higher than average.<sup>31</sup> This is unexpected and inexplicable, considering the state’s physician-friendly tort reform laws.

**Assessment:** There is a puzzling disconnect between the state’s malpractice premiums, which are fairly high, and the state’s tort reforms, which include a powerful \$250,000 cap on non-economic damages.

**Grade:** 3.75 stars out of 5.

### Nebraska ★★★★★

**Caps:** \$1.75 million in total damages (hard cap).<sup>3</sup>

**Average 2013 premiums:** \$7340 (estimated) for EM; \$2,800 to \$4,060 for IM; \$9,500 to \$13,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** The Cornhusker State is one of six states placing a hard cap on total damages.<sup>35</sup> This hard cap (\$1.75 million per case) was introduced in 1975 and has been successfully upheld three times (1984, 1986, and 1992).<sup>3</sup> Physicians carry minimum levels of liability insurance and then pay a surcharge into an excess coverage fund.<sup>3</sup> Physicians are not liable for more than \$500,000 per case, and any excess damages are paid for from the excess fund.<sup>3</sup> On average, EPs practicing in Nebraska pay the lowest premiums in the country, and these estimated figures include the excess coverage fund surcharge.<sup>31</sup> Additional state reforms include joint liability reform,<sup>3</sup> collateral source reform,<sup>3</sup> and a strict two-year statute of limitations.<sup>8</sup> All cases must be initially reviewed by a pretrial screening panel consisting of three physicians and one voting attorney.<sup>8</sup> This panel will determine whether the defendant failed to meet the standard of care and whether the damages were proximately caused by this failure to meet the standard of care.<sup>8</sup> Most importantly, the panel’s findings are admissible in court.<sup>8</sup> Minor weaknesses in Nebraska’s medical liability reform environment include: no limits on attorney fees,<sup>3</sup> no meaningful expert witness reform,<sup>8</sup> and no certificate of merit required at the time of filing.<sup>8</sup> Despite strong reforms, average awards/settlements are relatively (and curiously) higher than average.<sup>7</sup> One explanatory hypothesis is that the lack of a cap on non-economic damages allows plaintiff attorneys to push awards for pain and suffering closer to the \$1.75 million total cap (personal communications, 2013).

**Assessment:** Thanks to robust caps and mandatory pretrial screening panels, EPs in this state pay the lowest premiums in the nation! **Grade:** 4.25 stars out of 5.

### Nevada ★★★★★

**Caps:** \$350,000 on non-economic damages (hard cap).<sup>3</sup>

**Average 2013 premiums:** \$47,250 (estimated) for EM; \$8,000 to \$34,000 for IM; \$29,000 to \$118,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Despite the overwhelming presence of the plaintiff-friendly Sin City, the state’s medical liability environment strongly favors physicians — thanks to conservative lawmakers advocating for physicians in the northern half of the state (personal communications, 2013). Nevada’s medical liability crisis came to a head in 2002, when the state’s only trauma center closed due to the lack of available surgical specialists.<sup>51</sup> Astronomical jury awards led to skyrocketing premiums, which then lead to physicians moving out of Nevada because they could no longer afford liability coverage.<sup>51</sup> Lawmakers quickly passed sweeping reforms to stabilize the situation.<sup>51</sup> The initial reform package, passed in 2002, included a \$350,000 cap on non-economic damages (with exceptions), a shortened statute of limitations of three years, a case certification requirement, and expert

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witness reform requiring experts to be at least 75% clinically and/or academically active and of the same specialty as the defendant.<sup>35</sup> In addition, the Nevada legislature passed an extraordinary new law offering cardinal protection for emergency physicians: a \$50,000 cap on non-economic damages for any case involving emergency care (this applies to EPs as well as specialists providing emergent on-call coverage).<sup>35</sup> In 2004, Nevada took another step in the right direction with the “Keep Our Doctors in Nevada” campaign, which included: a reinforced cap on non-economic damages (with no exceptions), enhanced joint and several liability reform, periodic payment reform, and limits on attorney fees.<sup>35</sup> Keeping doctors in Nevada, and recruiting new ones, is a priority for this state (personal communications, 2013). Nevada’s population is rapidly growing and training programs in the state are few and far between.<sup>52</sup> With the majority of physicians across the country ultimately practicing in the same state in which they complete their residencies, states like Nevada that offer limited training opportunities are left under-served.<sup>50</sup> In 2002, only seven new physicians obtained a license to practice medicine in Nevada. By 2004, thanks to the state’s transformed medical liability environment, more than 200 physicians were applying each year.<sup>51</sup> The only weaknesses in Nevada’s liability system include: ambiguity involving the state’s certificate of merit law (the time frame for submission is not specified),<sup>8</sup> the lack of pre-litigation screening panels (phased out in 2002),<sup>8</sup> and most notably, outrageously pricey malpractice premiums in Las Vegas.<sup>31</sup> Premiums are especially high for specialists.<sup>31</sup> Las Vegas docs typically pay twice as much as their colleagues practicing in the remainder of the state.<sup>31</sup> Data exist to support the notion that Nevada’s reforms have lowered costs.<sup>35</sup> For example, the Independent Nevada

Doctors Insurance Exchange lowered its premiums for internists and surgeons by more than 20% in 2007, and rates have held steady since this decrease.<sup>35</sup> Nevada’s per capita malpractice payout (\$4.95 per year) is now the eighth lowest in the nation.<sup>36</sup> With formidable reforms, unparalleled damage caps favoring EPs, and legitimate proof of cost savings within the system, the current annual premiums for EPs, estimated at \$40,000-\$50,000 per year, are unjustifiable. If annual premium costs were not factored into the equation, Nevada’s medical liability environment would receive a five star rating.

**Assessment:** Thanks to 2004’s “Keep Our Doctors In Nevada” initiative, the Silver State is home to the country’s most EP-friendly liability environment — at least on paper. Non-economic damages in cases involving EPs are capped at an unprecedented \$50,000! Yet, premiums for EPs remain remarkably high. This is beyond puzzling. **Grade:** 4.0 stars out of 5.

## New Hampshire ★★★★★

**Caps:** None.<sup>3</sup>

**Average 2013 premiums:** \$31,050 (estimated) for EM; \$11,200 to \$14,700 for IM; \$45,000 to 53,200 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Compared to other states in the northeast, New Hampshire offers a slightly more favorable medical liability environment. New Hampshire’s per capita malpractice payout (\$17.02 per year) is the ninth highest in the nation.<sup>36</sup> Premiums are above the national average, but EPs practicing in the Granite State will pay less than their colleagues in neighboring New England states.<sup>31</sup> New Hampshire has no caps of any kind (voted down in 1980),<sup>3</sup> no collateral source reform (also voted down in 1980),<sup>3</sup> no expert witness reform,<sup>8</sup> no certificate of merit requirement,<sup>8</sup> and no limits on attorney fees (the court must approve these fees, but there are no limits).<sup>3</sup> The state’s two year statute of limitations was recently deemed unconstitutional, and the statute has been extended to three years.<sup>8</sup> The state has enacted joint liability reform and periodic payment reform.<sup>3</sup> New Hampshire’s only substantial liability reform comes in the form of a mandatory pre-litigation screening panel. This law, established in 2005, requires all claims to first be vetted by a panel consisting of a chair appointed by the Chief Justice, and an attorney and a health care provider selected by the chair. This panel decides whether the defendant deviated from the standard of care and proximately caused the alleged injury.<sup>8</sup> Unfortunately, the findings of the panel are confidential and not admissible as evidence, unless the panel’s determination is unanimous and the opposing party takes the case to trial.<sup>8</sup> Since the law was enacted, juries have always sided with the panel when its findings were unanimous — until now.<sup>30</sup> For the first time ever, a New Hampshire jury recently awarded a plaintiff’s estate 1.5 million dollars after disregarding the panel’s unanimous findings of no fault.<sup>30</sup> On a final positive note, New Hampshire lawmakers recently passed an act establishing an early-offer alternative in medical injury cases.<sup>30</sup> Essentially, the patient has the option to settle medical liability claims within 90 days of injury.<sup>30</sup> While this new program is admirable, its impact remains uncertain.

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**Assessment:** Premiums are reasonably affordable despite the lack of meaningful reform. Mandatory pretrial screening panels have been helpful. The state's "early-offer alternative" is promising, but remains in the development phase. **Grade:** 2.0 stars out of 5.

### New Jersey ★★★★★

**Caps:** \$350,000 (or five times compensatory damages, whichever is greater) on punitive damages.<sup>3</sup>

**Average 2013 premiums:** \$41,125 (estimated) for EM; \$17,000 to \$19,700 for IM; \$54,800 to \$73,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** The following quote from ATRA says it best. "Medical liability cases continue to pop up like weeds in the litigious Garden State, and there seems to be no shortage of 'detestable' plaintiffs and personal injury lawyers otherwise willing to make outrageous claims against Little Leaguers, life-saving police officers, and girlfriends who send their boyfriends text messages."<sup>17</sup> In 2011, New Jersey's 630 new medical liability claims more than doubled those in Ohio, a state with roughly 2.5 million more residents.<sup>17</sup> Even Texas, a state with nearly three times New Jersey's population, had fewer new claims with 550.<sup>17</sup> New Jersey's per capita malpractice payout (\$23.31 per year) is the third highest in the nation.<sup>36</sup> While already saddled with an extremely high cost of living, NJ docs pay some of the highest malpractice premiums in the country.<sup>31</sup> On a positive note, New Jersey has enacted partial joint liability reform,<sup>3</sup> collateral source reform,<sup>3</sup> a two year statute of limitations,<sup>8</sup> and a sliding-scale limit on attorney fees.<sup>3</sup> An affidavit of merit must be filed within 60 days of filing a claim.<sup>8</sup> Expert witnesses must be in the same specialty as the defendant and must spend the majority of their time in clinical practice or teaching.<sup>8</sup> Punitive damages are capped at \$350,000 or five times compensatory damages, whichever is greater.<sup>3</sup> This cap is insignificant, as punitive damages are rarely relevant.

**Assessment:** Modest expert witness reform and caps on punitive damages have been completely overshadowed by this litigious state's massive malpractice payouts, and the exorbitant premiums that docs are forced to pay as a result. **Grade:** 0.75 stars out of 5.

### New Mexico ★★★★★

**Caps:** \$600,000 cap on total damages.<sup>3</sup>

**Average 2013 premiums:** \$36,700 (estimated) for EM; \$13,344 for IM; \$45,000 to \$60,203 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Long before there was *Breaking Bad*, there was a period in the 1970s when physicians were fleeing New Mexico in droves due to a medical malpractice crisis.<sup>44</sup> Recruiting new docs to this rural state became an insurmountable challenge.<sup>44</sup> In response, the state enacted a package of meaningful reforms. Most notably: 1) a \$600,000 cap limiting total damages,<sup>3</sup> and 2) mandatory pre-litigation screening panels.<sup>8</sup> NM is one of just six states to impose a cap on total damages,<sup>35</sup> and NM's cap is the smallest of the six.<sup>3</sup> The cap excludes medical expenses and punitive damages.<sup>3</sup> Physicians are only responsible for \$200,000 and any award in excess of this amount is paid by a patient compensation fund.<sup>3</sup> Despite all of this, malpractice premiums are relatively (and curiously) higher

than average.<sup>31</sup> One explanatory hypothesis is that the lack of a cap on non-economic damages allows plaintiff attorneys to push awards for pain and suffering closer to the \$600,000 total cap (personal communications, 2013). Additional strengths within the state include joint liability reform,<sup>3</sup> periodic payment reform,<sup>3</sup> and a medical review commission made up of three attorneys and three physicians — with two from the same specialty as the defendant — which reviews all claims prior to filing.<sup>8</sup> Unfortunately, the panel's determination is non-binding and inadmissible in court.<sup>8</sup> Additional minor weaknesses include no collateral source reform,<sup>3</sup> no limits on attorney fees,<sup>3</sup> a three year statute of limitations,<sup>8</sup> no case certification requirement,<sup>8</sup> and an expert witness law with a major loophole ("expert testimony is generally required unless negligence is so apparent that a lay person could so comprehend").<sup>8</sup> Also unfortunately, the state's \$600,000 cap is in the process of being challenged.<sup>44</sup> Higher courts will decide whether this cap applies to a single injury or to every instance in which the injury may have been addressed.<sup>44</sup> In the case in question, a patient went to three ERs in one night — all three treating physicians were accused of having mismanaged her heart attack. A lower court ordered all three physicians to pay \$600k, for a total award of \$1.8 million, and to share the costs of her medical care based on their portion of fault.<sup>44</sup>

**Assessment:** The state's hard cap on total damages, pre-litigation screening panels, and patient compensation fund have helped EPs. Premiums are above mid-range and higher than expected given the state's reforms. **Grade:** 3.75 stars out of 5.

### New York ★★★★★

**Caps:** None.<sup>3</sup>

**Average 2013 premiums:** \$54,200 (estimated) for EM; \$7,000 to \$36,000 for IM; \$25,300 to \$148,500 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** New York, New York — it can be a hard place to live and an even harder place to work as a doc. You know what they say: "If you can make it there ... "as an EP and endure the crushing medical liability environment, the traffic, cold winters, and extraordinarily high cost of living "... you can make it anywhere!" New York state holds the dubious distinction of having the worst medical liability environment in the country. With the second highest concentration of attorneys per capita,<sup>15</sup> the Empire State is referred to as "Sue York" by ATRA.<sup>17</sup> New York leaders can't seem to break free of the grip of the personal injury bar. Damage caps are non-existent and all physicians, EPs included, pay the highest malpractice premiums in the country.<sup>31</sup> Surgical specialists in and around NYC routinely pay over \$100,000 per year.<sup>31</sup> Neurosurgeons in Nassau and Suffolk counties reportedly pay \$315,524 per year.<sup>41</sup> New York's per capita malpractice payout (\$38.99 per year) is the highest in the nation.<sup>36</sup> According to the Kaiser Family Foundation, in 2011 NY state had 1,379 paid medical liability claims — over 50% more than the next highest state and 80% more than the third highest state.<sup>7</sup> The state does offer partial joint liability reform, collateral source reform, sliding scale limits on attorney fees, and periodic payment reform.<sup>3</sup> The statute of limitations is 2.5 years,<sup>8</sup> and New York is one of just six states in which the clock begins running at the time the negligence occurs rather than at the time the negligence is discovered. However, this law is in the process of being challenged.<sup>42</sup>



The state's laws regarding expert witnesses are exceedingly weak: "expert testimony is required unless within the ordinary experience and knowledge of a lay person, negligence is apparent. Experts are generally not deposed prior to trial and their identity need not be revealed prior to trial."<sup>8</sup> The laws regarding case certification are even weaker: "an affidavit of merit is not required if such consultation could not occur due to time limitations or because the attorney made three separate attempts to obtain a consultation and three physicians would not agree to a consultation. This does not apply in cases where the 'facts speak for themselves'."<sup>8</sup> Physician morale in this state remains low, as evidenced by a recent survey noting that only 22% of NY physicians would recommend to medical students that they practice in New York state, with the majority of the respondents setting the extraordinarily high liability costs as the reason.<sup>43</sup>

**Assessment:** This highly litigious state spends more on malpractice per citizen than any other state in the union. Premiums for all physicians, especially those practicing in NYC, are astronomical. Will this situation ever get better? As Sinatra says, "It's up to you, New York, New York!"  
**Grade:** 0.0 stars out of 5.

### North Carolina ★★★★★

**Caps:** \$500,000 on non-economic damages.<sup>3</sup>

**Average 2013 premiums:** \$26,500 (estimated) for EM; \$9,000 to \$11,000 for IM; \$33,000 to \$53,000 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Back in the day,

North Carolina's dubious justice system gained notoriety as John Edwards and his disciples raked in millions — thanks to excessive jackpot jury awards at the expense of competent, dedicated obstetricians.<sup>48</sup> Those days are gone. In response to the state's deteriorating medical liability environment and an impending crisis, the "Tar Heel" state passed vigorous reforms (SB 33) in 2011.<sup>35</sup> The most pivotal aspect of this reform package was the enactment of a robust \$500,000 cap on non-economic damages.<sup>35</sup> Plaintiffs are limited to \$500,000 per incident, regardless of the number of defendants involved.<sup>35</sup> Weaknesses associated with this cap include adjustments for inflation every three years, exceptions in cases involving "disfigurement, loss of use of part of the body, permanent injury or death," and exclusions if "the defendant's acts or failures, which are the proximate cause of the plaintiff's injuries, were committed in reckless disregard of the rights of others, grossly negligent, fraudulent, intentional or with malice."<sup>35</sup> For emergency physicians and specialists actively participating in emergency call, the most auspicious component of SB 33 came in the form of an increased burden of proof for physicians providing care in the emergency setting.<sup>35</sup> For cases involving the treatment of an "emergency medical condition" as defined by EMTALA, plaintiffs must prove a violation of the standard of care by clear and convincing evidence. The prior standard was defined as "by greater weight of the evidence," more commonly known as by a preponderance of the evidence.<sup>35</sup> North Carolina has no joint liability reform, no collateral source reform, no limits on attorney fees, no periodic payment reform,<sup>3</sup> and no case certification requirement.<sup>8</sup> Expert witnesses are required to either practice or teach in the same specialty as the defendant, but there are no requirements regarding state licensing, board certification, or time devoted to active clinical practice.<sup>8</sup> The statute of limitations is three years from the date of the last act giving rise to the action, or within one year of when the injury should have been discovered, but in no event more than four years.<sup>35</sup> In the case of wrongful death, the statute is a strict two years.<sup>35</sup> With only two years passing since the enactment of SB 33, it is difficult to assess its efficacy. Premiums for EPs remain in the mid-range, and there are no data on whether or not premiums have decreased since this legislation was passed.<sup>31</sup> Malpractice costs for the state are definitely on the low end — North Carolina's per capita malpractice payout (\$4.55 per year) is now the seventh lowest in the nation.<sup>36</sup> North Carolina is one of just four states that has upheld the traditional common law doctrine of pure contributory negligence.<sup>49</sup> Thus, any negligence by a claimant will bar his recovery completely.<sup>49</sup>

**Assessment:** The "Tar Heel" State is the "comeback kid" of Medical Liability Reform. With recently enacted caps on non-economic damages and an increased burden of proof providing physicians with added protection in the emergency setting, North Carolina is one step closer to EP Nirvana. Premiums remain mid-range. **Grade:** 4.5 stars out of 5.

### North Dakota ★★★★★

**Caps:** \$500,000 cap on non-economic damages (hard cap).<sup>3</sup>

**Average 2013 premiums:** \$13,500 (estimated) for EM; \$4,700 to \$9,000 for IM; \$15,400 to \$25,250 for GS.<sup>31</sup>

**Liability environment for emergency physicians:** Yes, the temperatures



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are ice cold, but the state's economy is red hot. With a booming oil industry and the lowest unemployment rate in the nation,<sup>40</sup> the non-litigious "Rough Rider State" might be the ideal opportunity for an EP contemplating a new adventure. Malpractice premiums for EPs are relatively low,<sup>31</sup> and North Dakota's per capita malpractice payout (\$3.06 per person per year) is now the second lowest in the nation.<sup>36</sup> The state has capped non-economic damages at \$500,000 since 1995.<sup>3</sup> Furthermore, economic damage awards in excess of \$250,000 are closely scrutinized.<sup>3</sup> Additional strengths include a two year statute of limitations,<sup>8</sup> as well as joint liability reform, collateral source reform, and periodic payment reform.<sup>3</sup> Also, North Dakota has the lowest number of attorneys per capita of any state in the union.<sup>15</sup> Weaknesses of this state's medical liability environment include no limits on attorney fees,<sup>3</sup> as well as no expert witness reform, no pretrial screening panels, and no special reforms for physicians treating patients in an emergency setting.<sup>8</sup> An affidavit must be filed within three months of filing a claim, but this law contains numerous exceptions.<sup>8</sup> This rule does not apply to cases involving retained foreign objects, lack of informed consent, performing a procedure on the wrong person or the wrong body part, or any case involving "obvious malpractice."<sup>8</sup>

**Assessment:** If you can endure the frigid winter wind and the punishing summer humidity, this thriving state (with its low premiums, damage caps, and limited litigation) is the place to be! **Grade:** 4.5 stars out of 5.


Look for this series to continue in future issues!

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## Remarkable Testimony & Due Process Cases Requested

The Legal Committee is requesting your help! The AAEM Remarkable Testimony/Actions webpage highlights notable due process cases and testimony in malpractice cases that is "remarkable." The Legal Committee is seeking more cases to supplement this page. For more information and to submit a case for posting consideration, please see

<http://www.aaem.org/aaemtestimony/>.



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## 20<sup>th</sup> Annual Scientific Assembly Competitions Winners

### AAEM/JEM Resident & Student Abstract Competition Winners —

This competition is designed to recognize outstanding research achievements by residents and students in emergency medicine. Out of a total 57 submissions, eight were selected for oral presentation. The top oral presentations are as follows:

1<sup>st</sup> Place: Matt Gaffigan, MD, "Haldol/Benadryl vs. Reglan/Benadryl for Treatment of Acute Headache in the ED — An RCT"

2<sup>nd</sup> Place: Shannon Toohey, MD, "Reasons for Visit: Comparing Patient Perceptions to Emergency Screening Index (ESI)"

3<sup>rd</sup> Place: Brenton Taggart, MD, "Lactate Levels in the Acutely Ill Patient: Does the Tourniquet Falsely Elevate the Result?"

### Photo Competition Winners —

Ninety-nine original photographs were presented at the AAEM 20<sup>th</sup> Annual Scientific Assembly in New York City. Photographs of patients, pathology specimens, gram stains, EKGs, and radiographic studies or other visual data were submitted. The top photos are as follows:

1<sup>st</sup> Place: Katarzyna Hampton, MD RDMS, "Not so FAST"

2<sup>nd</sup> Place: Beth Kushner, DO, "My Belly is Killing Me"

3<sup>rd</sup> Place: Justin McNamee, DO, "Digging 'Deep' for Details"

### Diagnostic Case Competition Winner —

In the 2<sup>nd</sup> Annual Diagnostic Case Competition, salient features of an

emergency department case were highlighted, differential diagnosis was offered, and a logical discussion was provided to argue to a final diagnosis. Although an accurate final diagnosis is important, the majority of the judging was focused on the discussion and presentation.

Michael Takacs, MD MS FAAEM, "What Do You See?"

### Open Mic Winners —

Assembly attendees had an opportunity to present a 25-minute lecture on any topic of their choosing, allowing 16 "new voices" in emergency medicine to be heard and evaluated by education committee members and conference attendees. The top two speakers will be invited to give a formal presentation at the 2015 Scientific Assembly in Austin, TX.

1<sup>st</sup> Place Faculty: Andrew Sloas, DO RDMS FAAEM

2<sup>nd</sup> Place Faculty: Cameron Berg, MD FAAEM

1<sup>st</sup> Place Resident: Siavash Sarlati, MD

2<sup>nd</sup> Place Resident: Katarzyna Hampton, MD RDMS

**Emergency Medicine PA Fellowship Challenge Bowl Winners** The 1<sup>st</sup> Annual AAEM Emergency Medicine PA Fellowship Challenge Bowl is a friendly competition among Emergency Medicine PA Fellows designed to be entertaining and educational for students, faculty, graduates, and guests.

1<sup>st</sup> Place: Chadd Allen, PA-C, and Libby Shern, PA-C, Regions Hospital ■



# 2014 AAEM Award Winners

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

**Anthony DeMond, MD MAAEM FAAEM**

**James Keaney, MD MAAEM FAAEM**

**Tom Scaletta, MD MAAEM FAAEM**

This award recognizes senior AAEM fellows who demonstrated a long career of extraordinary service to AAEM, service as an exemplary clinician and/or teacher of emergency medicine, service to emergency medicine in the area of research and/or published works, service as a leader in the hospital, the community or organized medicine, service in the areas of health policy and advocacy, volunteerism, and other activities or high honors that distinguished the physician as preeminent in the field of emergency medicine.

## Peter Rosen Award — Steven Rosenbaum, MD FAAEM

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

## James Keaney Leadership Award — Joanne Williams, MD FAAEM

This award was named after the founder of AAEM and recognizes an individual(s) who has made an outstanding contribution to our organization. The nominees for this award must be AAEM members and have 10 or more years experience in EM clinical practice.

## David K. Wagner Award — Larry Weiss, MD JD FAAEM

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 — Michael Ybarra, MD FAAEM

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

## Joe Lex Educator of the Year Award — Lillian Oshva, MD FAAEM

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 5 years. The Educator of the Year Award was renamed the Joe Lex Educator of the Year Award to recognize Dr. Joe Lex for his devotion and commitment to AAEM and its educational programs.

## Administrator of the Year Award — Steven Johnson, PhD

This award recognizes an administrator deserving special recognition for their dedication to emergency medicine and patient care.

## Resident of the Year Award — Meaghan Mercer, DO

This award recognizes a resident member who is enrolled in an EM residency program, and has made an outstanding contribution to AAEM.

## Program Director of the Year — Jacob W. Ufberg, MD FAAEM

This award recognizes an EM program director who has made an outstanding contribution to AAEM. The winner of this award is chosen by the AAEM Resident and Student Association.

## AAEM/RSA Lifetime Achievement Award — Carey D. Chisholm, MD FAAEM

This special recognition was presented to Dr. Chisholm by AAEM/RSA in recognition of his dedication to emergency medicine and residents.

## Departing Board Members — Michael S. Pulia, MD FAAEM; David Vega, MD FAAEM

## 2013 Mitchell Goldman Service Awards —

These awards recognize individuals who made an outstanding contribution by supporting AAEM's educational mission by teaching at oral board review courses. The award was renamed the Mitchell Goldman Service Award to recognize Dr. Goldman for his devotion and commitment to AAEM's Oral Board Review Course and its educational programs.

35 sessions: William Gossman, MD FAAEM

30 sessions: Mitchell Goldman, DO FAAEM FAAP

25 sessions: David Dabell, MD FAAEM

20 sessions: Kevin Rodgers, MD FAAEM

15 sessions: Michael Matteucci, MD FAAEM; Richard Brantner, MD FAAEM; Matthew Vreeland, MD FAAEM; Ben Wedro, MD FAAEM

10 sessions: Sudhir Baliga, MD FAAEM; Ross Berkeley, MD FAAEM; Michael I. Omori, MD FAAEM; James W. Small, MD FAAEM

5 sessions: Michael Burg, MD; Tawni Christensen, MD FAAEM; Ralf Joffe, DO FAAEM; Mohamad Moussa, MD FAAEM; Rika O'Malley, MD; Theodore Paraschos, MD; Chad Viscusi, MD FAAEM

## Written Board Course Awards —

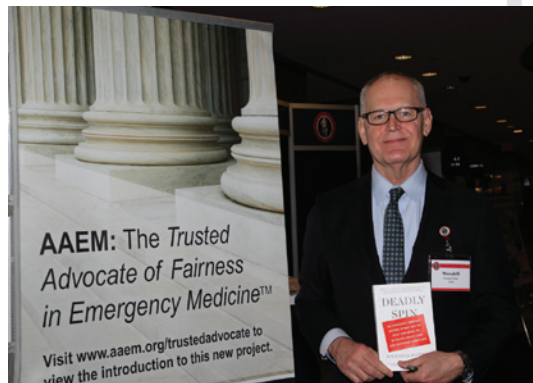
These awards recognize individuals who made an outstanding contribution by supporting AAEM's educational mission by teaching at written board review courses.

Top Speaker: Michael E. Winters, MD FAAEM

10 Year Award: James E. Colletti, MD FAAEM ■



A full house gathers to hear the Scientific Assembly opening remarks.



Keynote speaker, Wendell Potter, noted health care advocate.

# 20<sup>th</sup> Annual Scientific Assembly

February 11-15, 2014

New York Hilton Midtown • New York City, NY



Mark Reiter, MD MBA FAAEM, speaks during the 2014 Candidate's Forum. Dr. Reiter was elected as president for a two year term, 2014-2016.



A Scientific Assembly attendee browses one of the abstracts submitted in this year's competition. Over 90 photos and over 50 abstracts were submitted, making 2014 a record year for AAEM competitions. Thank you to all who participated!



Anthony DeMond, MD MAAEM FAAEM, receives the Master of the American Academy of Emergency Medicine Award from William T. Durkin, Jr., MD MBA FAAEM, president.

Michael Epter, DO FAAEM, receives a certificate of appreciation from William T. Durkin, Jr., MD MBA FAAEM, president, for his work as the Education Committee Chair.



Over 1,200 dedicated attendees braved the cold to join us in New York City. A new registration record!





Tom Scaletta, MD MAAEM  
FAAEM, receives the  
Master of the American  
Academy of Emergency  
Medicine Award from  
William T. Durkin, Jr., MD  
MBA FAAEM, president.



Stephen Hayden, MD FAAEM, Editor, *Journal of Emergency Medicine* (far left) stands with AAEM/JEM Resident and Student Research Competition Winners. (L-R) First place: Matt Gaffigan, MD; second place, Shannon Toohey, MD; third place, Brenton Taggart, MD.



The 2013-2014 AAEM board of directors. Front row (L-R) Howard Blumstein, MD; Andy Walker, MD; Leslie Zun, MD MBA; Kevin Beier, MD. Second row (L-R) Meaghan Mercer, DO; David Vega, MD; Robert Suter, DO MHA; Mark Foppe, DO; William T. Durkin, Jr., MD MBA; Robert McNamara, MD; Stephen Hayden, MD; Mark Reiter, MD MBA; John Christensen, MD. Not pictured: David Lawhorn, MD; Michael Pulia, MD; and Kevin Rodgers, MD.



Career fair attendees had a chance to interact with potential employers in the first AAEM/RSA Career Connections Fair.



Participants in the preconference course "Living the Tactical Life: Lessons and Skills from Tactical Emergency Medicine" get some hands-on experience with equipment.



Attendees gather in the exhibit hall for the opening reception.



Celebrating the conclusion of our 20th year and highlighting 20 years of education — AAEM featured a cake by the famous "Cake Boss" at the opening reception on February 12, 2014.



This assembly featured the first EM Physician Assistant Fellowship Challenge Bowl. Here, participants stand with challenge bowl organizers, Kishla Askins, PA-C (far right) and Gary Gaddis, MD PhD FAAEM (second row). Congratulations to winners Chadd Allen, PA-C, and Libby Shern, PA-C, from Regions Hospital.

## Passport to Prizes Winners!

Throughout the conference, attendees visited various exhibitors to collect stamps in their “passports.” Completed passports were then drawn to select winners. Congratulations to the winners and thank you to all participants.



- Magnifying Loupes, courtesy of Airway CAM Technologies — Rob Clodfelter
- \$100 Quirky.com Gift Card, courtesy of Beckerman Institutional — Pedro Perez
- \$100 American Express Gift Card, courtesy of DuvaSawko/Emergency Medicine Professionals, P.A. — Sarah Malka
- Kindle Fire HD, courtesy of Emergency Medicine Associates, P.A., P.C. — David Sercl
- \$250.00 gift card for STK steakhouse in NYC, courtesy of First Choice Emergency Room — Don Snyder
- One Night Stay with Breakfast at Hilton Austin & Austin stereo cooler bag with souvenirs (Our 2015 Scientific Assembly location), courtesy of Hilton Austin, TX & Austin, TX Convention and Visitors Bureau — Ben Wallace
- iPad Mini, courtesy of LocumTenens.com — David Liss
- \$100 American Express Gift Card, courtesy of Martin Gottlieb & Associates — Killian DeBlacam
- \$100 American Express Gift Card, courtesy of MedData, Inc. — Darren DePalma
- One Night Stay with Breakfast at New York Hilton Midtown & NYC canvas tote bag with souvenirs (Our 2014 Scientific Assembly location), courtesy of the New York Hilton Midtown & NYC & Company (NYC Convention and Visitors Bureau) — Michael Takacs
- One Northwestern Seminar of your preference, courtesy of Northwest Seminars — Mark Kricheff
- \$100 Starbucks Gift Card, courtesy of PercuVision, LCC — Ted Fagrelus
- Fitbit Flex Wireless Activity + Sleep Wristband, courtesy of PracticeLink.com — Tamara Halaweh
- \$100 iTunes Gift Card, courtesy of Questcare Partners — Scot DePue
- Kindle Paperwhite, courtesy of Shift Administrators, LLC — Zach Gibson
- Gift of the Season — choose from 39 gift clubs with a gift arriving every 3rd month, courtesy of SoutheastHEALTH — Greg Thompson
- \$100 Cash, courtesy of Weatherby Healthcare — Steven Rosenbaum ■

## Medical Student Ambassadors

Thank you to the dedicated medical students who volunteered to assist with the 20th Annual Scientific Assembly. We truly appreciate the time and hard work they gave to aid in the success of Scientific Assembly.

Taras Babiak  
Lindsay Ball  
Adam Field  
Roya Laura Mahana  
Lena Ning  
Michael Poulson  
Faith Quenzer  
Tatiana Ramage  
Lauren Sims

Nicholas Smith  
Anais Ovalle  
Michael Coletta  
Theodore Fagrelus  
Summer Jones  
Olga Kovalerchik  
Martin Minwoo Kim  
Kellie Morris  
E. Brooke Schrickel

Thank you to Kevin Rodgers, MD FAAEM, and Gaston Costa, MD, for coordinating this program. ■



# Through the Patient's Eyes

Craig Norquist, MD FAAEM  
Chair, Practice Management Committee

You ask why I came in today as opposed to yesterday or last week. Does it really matter to you? I am here now and want help in figuring out what is going on, or at least in making sure it isn't something serious. There is no other place for me to go. I called my doctor's office, but they can't see me for several days or weeks. They told me to go to the emergency department. So, why do people treat me as if I am imposing on them by being here? Believe me, there are hundreds of places I would rather be right now than on this uncomfortable stretcher. I sense the subtle rolling of eyes or sighs from some after I tell them what is wrong. My problem may or may not be new, but that is why I am here — to try to figure out what is wrong. Sure, I might have been seen here before — last year, last month, or even last week. Heck, I might have been here yesterday. But now something feels wrong. The doctor told me to come back if anything changes or gets worse. The discharge instructions have that written on them. Why do I feel like I have to apologize for being here?

While sitting in this less than private room, I can hear the staff laughing and telling stories about other patients. I am not sure, but I think I can even hear the doctor joining in. It makes me embarrassed to tell you all of my story. I hesitate to divulge information that I think might be used in the next round of stories after I leave, even if that information might help you figure out what is wrong with me.

I am afraid to ask for more pain medication for fear of being labeled a drug seeker. Morphine really doesn't work for some people, but god-forbid they say so and face the scowl of hospital workers assuming they are drug addicts. Instead I agree to try several rounds of less effective medications before I ask for the one that always works. I suffer longer, make more work for the nurse and doctor, and stay here longer — all so I am not labeled a drug-seeker.

You may think my chest pain or abdominal pain is run of the mill or a slam dunk, but for me it is the first time I've experienced something like this. Your cavalier attitude towards my complaint makes me feel stupid, and I don't want to agree with anything that you have to say, let alone your diagnosis and plan to send me home. I expect you to be confident, not arrogant. I want your critical decision-making, not your criticism. Your assumptions really don't help. I might have pancreatitis due to a prescribed medication rather than alcoholism. The way you asked that question is subtle, but tells me a lot about how to answer those that follow. Your judgment, though silent, is apparent.

I show up at the emergency department because I believe I will be seen and treated by the best doctors. If there is somewhere more appropriate for me to go, why doesn't anyone tell me? I am forced to seek help in a broken system without anyone to point me in the right direction, so I'll go to the place that I know can treat me. I know that you are busy and often see people who might not need to be here, but I am sure my condition is different. I wouldn't be here if I knew this was just a cold. I am concerned about so much more. You might not ever understand.

You ask me what is wrong and I tell you my symptoms. If you were to ask what most concerns me or what matters to me the most, I would

probably answer differently. If I was comfortable with you and you hadn't rolled your eyes or sighed, I would admit that I Googled my symptoms and now I am terrified that I have cancer — or maybe something even worse. Without knowing this, you will never be able to satisfy me or address why I came in. If you were kind enough to ask and I thought you actually cared, I would admit what I am most afraid of and would appreciate your opinion — free of sneers or chuckles. Remember, this is what you do every day of your working life. I don't know as much about the human body and I am scared.

I don't understand the terms you use. What does benign tumor really mean? All I hear is tumor, which I know is bad. Why do you have to say otitis externa, when I understand swimmer's ear or ear infection? If you make me feel uncomfortable I will not ask what your words mean, but will wait and look them up afterward, often getting them wrong.

I realize that you ordered a bunch of tests and did some scans or something, but if I leave without understanding what really happened or what you were thinking, in my mind you didn't do anything for me. If my discharge diagnosis is the same as my initial complaint and I leave without understanding what has been ruled out — and just what "ruled out" means — then can you honestly say you did do anything of worth for me?

Just as with other purchases, I will eventually make a decision based on numerous factors. If the service I receive in your ED is not what I expect for what I pay, then I might not ever return to your department, even if I am having a heart attack or stroke. The way you make me feel will outlast anything that you say or do to me, so please think twice about treating me as if I don't belong. ■

## Certificate of Excellence in Emergency Department Workplace Fairness

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

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

St. Mary's Janesville Hospital — Janesville, WI

Emergency physicians are encouraged to contact AAEM (anonymously if desired) at <http://www.aaem.org/forms/certificate-of-fairness-report.php> to report a listed group that they believe is not in compliance along with an explanation.

Members interested in receiving the Certificate of Workplace Fairness for their group may apply online at <http://www.aaem.org/benefits/certificate-of-workplace-fairness>.

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**IF YOU MAKE BIG FINANCIAL MISTAKES, IT PROBABLY WON'T GET BETTER!**

I know 3 BIG outcomes you want...Financial independence so you can work on your terms. Freedom to enjoy other aspects of your life besides practicing medicine. And the ability to make work optional not mandatory.



Why should you believe me? I'm Setu Mazumdar, MD, CFP®, and I'm a board certified emergency medicine physician just like you. I'm also **President of Physician Wealth Solutions**, where I help doctors like you and me get our financial lives in order so you can get closer to financial independence.

**This is embarrassing to admit...**I messed up big time with my finances and investments early in my career. But I still retired from practicing full time medicine before age 40! How? I made finances and investments a priority in my life. **Many doctors are miserable because they have to work not because they want to.** Why? Because they don't have their finances in order, may have been burned by financial advisors, or don't have the time, knowledge, interest, or discipline to achieve a successful investment experience for the rest of their lives.

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# Rob Rogers on Technology's Potential for Promotion in Academic Emergency Medicine

Ali Farzad, MD

Immediate Past Chair, AAEM/RSA Publications Committee

Cardiovascular Emergencies Fellow

Department of Emergency Medicine, University of Maryland School of Medicine

Linda J. Kesselring, MS ELS

Copyeditor



Rob Rodgers, MD



In previous articles, we explored the advancing role of technology in emergency medicine (EM) education and training by interviewing emergency physicians who are leaders in the field. We started with Dr. Mel Herbert (@MelHerbert), who suggested that the more traditional methods of learning and teaching are redundant, ineffective, and downright archaic.

Later, Dr. Amal Mattu (@amalmattu) explained how technology can be a double-edged sword and stressed caution in how it is used, but also suggested several ways it can be used to increase efficiency. Next, Dr. Scott Weingart (@emcrit) gave us several tips on how to take control of our online identity and master social media for educational benefit. Most recently, Dr. Haney Mallemat (@criticalcarenow) described what he thinks the future of EM education will look like and, for those new to #FOAMed, listed resources that would forever change the way they access information and learn. Over the short course of time that I have been writing these articles, there has been a drastic evolution — if not a revolution — in how we create, consume, and disseminate medical information.

Through the efforts of educators like these, a widespread movement has begun to modernize medical education through unconventional methods. The concepts of asynchronous learning and the flipped classroom have come to the forefront and appear to be the future of medical education. Fortunately, emergency medicine is leading the pack. But are the virtues of technology in EM education limited by its shortcomings?

Traditionalists claim that the lack of a rigorous peer-review process and an established curriculum limit the quality and reliability of information contained in blogs and modern media. FOAMites would argue that traditional peer-review is itself fatally flawed, and that information in a digital format is more easily updated and subject to the healthy skepticism that promotes objectivity. Regardless of where you stand on these issues, both sides can agree that the educational climate is changing. Even the traditional process of promotion and tenure is being rattled, as department chairs note the influence of these newer teaching methods. The meaning of scholarship in academic medicine is still loosely defined. Will contributions to EM education through non-traditional methods contribute to academic promotion and advancement? Will the powers that be recognize the potential of these new educational methods, or will they be reluctant to buy in? To answer these questions, I sat down with one of my mentors, who influenced me to learn more about all of this.

Dr. Rogers (@EM\_educator) is a seasoned EM educator who has lots of experience with both traditional and modern teaching methods. As an EM/IM physician and faculty member at the University of Maryland School of Medicine, Dr. Rogers has published several books on education, lectured internationally, earned several teaching awards, and designed faculty development courses all over the world. He is a co-creator of the iTeachEM blog, where he works with #FOAMed pioneers Drs. Mike Cadogan (@sandnsurf) and Chris Nickson (@precordialthump) to deliver the latest on medical education to the rest of us. He is a respected clinician and master educator and has a unique perspective on this topic. Now, let's find out why he thinks the world of academic emergency medicine and #FOAMed are bound to collide.

## **AF: How have technology and #FOAMed in EM education affected and influenced your career?**

**RR:** FOAMed has literally exploded in recent years. It seems like everyone is talking about it, and it keeps spreading around the globe like a brush fire. The real question is, how did I get to FOAMed in the first place? The answer to that question is simple: Twitter. Essentially, it all started on Twitter. I joined Twitter several years ago, thinking it was a cute way to communicate with friends and colleagues. After using it for a few years, I discovered that it was actually helping me in my career. I am now convinced that Twitter is a very useful faculty development tool and one that can propel your career forward.

Here is just a partial list of what Twitter has done for me and how it might benefit your career:

1. Twitter is a powerful social media tool. I have met tons of people on Twitter, which has led to invitations to speak, write, and collaborate. Big opportunities can come your way if you stay engaged. It's pretty amazing. I am convinced that some opportunities might not have been offered to me had it not been for social media.
2. You can find out about new books (not boring textbooks), articles, and websites long before you would ever stumble upon them yourself. Many of the excellent books I have been reading this year were mentioned by people on Twitter. In this way, Twitter keeps you current and wondering what other fantastic reads are out there.
3. Another very cool thing about Twitter is that you can use it to help and mentor others and thus contribute to their development and success. In the United States, this is an important tool in faculty development. And it's a lot of fun. Help others, and they will help you. A win-win.

Continued on next page

4. When I was a kid, whenever I asked my parents a question they would invariably say, "Go look it up in the encyclopedia." Probably because they didn't know the answer! I have found that if I have a question about any topic, I can ask it to the cyber collective and get a really useful answer. In a sense, Twitter becomes a Wikipedia of sorts. Maybe we can call it "Twitterpedia." Yes, I just coined that. Like it?

5. You can stay up to date with the current literature. People are always posting new articles, having stimulating discussions, and referencing new and interesting data. It's much more fun than relying on journals all the time — and more stimulating!

6. You can brand yourself, which will lead to great things. Develop a logo that centers around your area of interest. Mine is medical education. You will one day realize that you are in a valuable network of people with similar interests, and this will propel your career forward.

Twitter, for me, is intricately linked with FOAMed. I think they are inseparable. Do you need to have a Twitter account to learn from and teach about FOAMed resources? No. But belonging to the Twitter community allows you to be constantly up to date. In addition, staying engaged leads to increased creativity and the development of innovative ideas. That's the fun part.

I could go on and on, but these are few of the most important benefits.

In order for Twitter to help you, you have to be actively engaged and involved. You can't sit back and watch tweets. Jump in and get started!

The FOAMed movement has been fascinating to watch. I am friends with the Australian emergency physician who coined the phrase, and it's interesting to note how much the FOAMed movement has taken off. I think people in medical education, particularly emergency medicine, were waiting for something to push teaching and learning into a new realm. And I think FOAMed has done just that. It's taught us that books are outdated and that we need to continue to push medical education and what we teach our learners.

**AF: How are you incorporating this technology to educate your students and residents?**

**RR:** Technology is an important part of educating students and residents, but it is often overemphasized. Medical technology has blossomed over the past several years, but I think some people have forgotten what an effective teacher is supposed to be doing. In my opinion, the effective educator and mentor has a duty to inspire the life-long desire to learn.

Any tool that an educator can use to do this is a welcome addition to the teaching armamentarium. It turns out that newer medical education technologies are actually a valuable tool to "turn on" learners and inspire them to greatness. In this sense, I am all for using the technology to teach. The mistake, I think, is to use technology just because it is there. Technology has to be used with a clear plan in mind, not just because "it's cool." This won't stimulate learners like many people think it will.

I use a lot of medical education technology like websites, FOAMed resources, and podcasts, to inspire learners and lead them down the initial path to life-long learning. An educator's job is to teach and inspire.

**AF: Do you think these newer and less traditional teaching methods have value to academic departments? How do blogs and tweets compare with lectures and journal articles?**

**RR:** In traditional academia, you have to publish to advance. "Publish or perish" was the old adage. I don't think that's still true in most places, but there is still heavy emphasis on publishing in journals. Tweeting and blog posting won't get you promoted in most places. What social media can do is set you up to be in a situation where you can easily collaborate with others to perform the more traditional activities that lead to promotion. Currently, Twitter and other tools will position you to get more and more involved in academic activities and stay engaged. I suspect that in the future there will be more (that is, some) credit for these incredibly valuable tools.

One issue I have encountered is trying to get faculty to believe that getting involved in social media such as Twitter, will do anything positive for their careers. In recent years, a lot of really good things have happened in my career, and a lot of them can be traced to interactions and friendships developed on Twitter. No joke. From being invited to write papers to invitations to speak, social media can propel your career to a level that will blow you away. Trust me. It is one of the best faculty development tools we have today.

**AF: What advice do you have for senior residents/junior faculty who are pursuing careers in academic medicine?**

**RR:** Get involved in Twitter and social media and start collaborating early. I promise that engaging in this process will lead to great things. If you aren't convinced, talk to others who have used these tools to help their careers. But you can't just join Twitter and expect to be promoted. You have to engage, send tweets, and join the conversation with like-minded individuals.

Continued on next page



**AF:** Tell our readers about your blog/podcasts so they know where they can learn more about getting involved.

**RR:** I currently run the iTeachEM blog and podcast with a buddy of mine, Chris Nickson. Chris is a brilliant EM/CC doc in Australia who is heavy into education. He works with Mike Cadogan and others to run Life in the Fast Lane.

The iTeachEM blog and podcast ([www.iTeachEM.net](http://www.iTeachEM.net)) are all about medical education in emergency medicine and critical care. The theme of this newer podcast is the same as for my former podcast, EMRAP Educators Edition, which was sponsored by Mel Herbert. I also have a medical education video series on YouTube that covers topics in medical education (<http://mededumem.tumblr.com/>).

**AF:** Are you optimistic about the direction the field is taking? What do you think EM education will look like in the future?

**RR:** My first prediction is that medical education will continue to grow and that the FOAMed movement may very well take over the world. Well, that's a bit dramatic, but I do think it will take over at least part of the world. FOAMed is huge, and it is already being incorporated into many EM residencies in the United States.

My other prediction is that people will finally realize that many great things can be achieved by joining the social media movement. Folks have been a little reluctant so far, mainly because they think Twitter is used for posting what you are doing during the day.

*Note: I would appreciate your comments and suggestions for future articles about technology and emergency medicine. Please contact me at [alifarzadmd@gmail.com](mailto:alifarzadmd@gmail.com). You can also follow me on Twitter @alifarzadmd.* ■

## Networking

Leslie Zun, MD MBA FAAEM  
AAEM Board of Directors



The AAEM board of directors moved aggressively about a year ago to increase AAEM's interactions with other organizations. The goal of these liaison activities is to make AAEM the "go to" organization in emergency medicine. In order to accomplish this goal, the board first developed a list of organizations to contact. The list varied from nursing and U.S. physician organizations to international ones.

Since I took the lead on this task, I thought that it was important to communicate the status of these activities.

A number of organizations were contacted to determine their interest in working with AAEM in some fashion. For some organizations this meant an enhancement in their current relationship with AAEM, for others it was a new outreach. Specific liaison activities varied depending on the needs of both organizations and ranged from joint membership recruitment to discounted conference fees, mutual promotion of conferences, shared speakers for conference tracks, presentations to boards of directors, and input into clinical policies, procedures, and protocols.

Responses from the organizations we approached varied. Some were enthusiastic, some ignored our invitation. For some of these organizations it was the start of new relationship and for others it strengthened an existing relationship. We were warmly received by our colleagues from Canada (CAEP), physician assistants from the Society for Emergency Medicine Physician Assistants, the American College

of Physician Executives, and nurse practitioners from the American Association of Nurse Practitioners. We continue to work on improving our relationships with osteopathic emergency physicians (ACOEP), the osteopathic emergency medicine boarding organization (AOBEM), the Emergency Nurses Association, the Association of Academic Chairs of Emergency Medicine, the American College of Healthcare Executives, the American Hospital Association, the Emergency Medicine Patient Safety Foundation, the National Medical Association, the American Association for Emergency Psychiatry, the National Association of EMS Physicians, SAEM, and ABEM. A few organizations have so far shut us out completely. For example, the Academy of Administrators in Academic Emergency Medicine has not responded to any of our gestures.

These outreach activities have increased our visibility and increased awareness of AAEM. This is one means of letting organizations know who we are and what sets AAEM apart from other emergency medicine organizations. In addition, joint ventures with some of these groups and discounted fees for AAEM members from others increase the value of your Academy membership.

On the horizon, we plan not only to continue to strengthen our current relationships and pursue new ones, but to keep working on the organizations that have been recalcitrant. Enhancing our network of relationships improves our already enviable position in the house of medicine. If you have any personal contacts or relationships with organizations that could be important to AAEM, or suggestions about other organizations, please contact me [zunl@sinai.org](mailto:zunl@sinai.org). ■

# Groundbreaking Conference on Behavioral Emergencies Continues

Leslie Zun, MD MBA FAAEM  
AAEM Board of Directors

Although emergency providers frequently care for patients with behavioral emergencies, there are few educational programs dedicated to this topic. There is a need for health care providers from emergency medicine, psychiatry, nursing, social work, and allied health to discuss relevant topics in the field and a forum for the presentation of scientific research on behavioral emergencies. To continue to meet these needs, the 4th Annual National Update on Behavioral Emergencies was held December 11-13, 2013, in Orlando, Florida.

Experts from the fields of emergency medicine and psychiatry presented a broad array of topics germane to care of the patient with a behavioral emergency. The speakers also included representatives from the Centers for Medicaid and Medicare Reimbursement and the National Alliance on Mental Illness. Topics included when to send the suicidal patient home, ketamine use, deadly psychiatric emergencies, and dealing

with psychiatric boarders. A preconference seminar was held on process improvement in the setting of psychiatric emergencies, sponsored by the Institute for Behavioral Healthcare Improvement. The board of directors of the American Association for Emergency Psychiatry (AAEP) conducted a business meeting during the conference. Ten scientific papers were presented at the meeting.

The conference was attended by over 100 people representing emergency medicine, emergency psychiatry, nursing, social work, psychology, and other health care providers. Please join us next year for the 5th Annual National Update on Behavioral Emergencies on the west coast, tentatively scheduled for December 11-12, 2014. For further information, go to [www.behavioralemergencies.com](http://www.behavioralemergencies.com) or contact Dr. Les Zun at [zunl@sinai.org](mailto:zunl@sinai.org). ■



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## CHAPTER REPORT: Virginia AAEM

The Virginia Chapter of AAEM continues to be an advocate for its members. Our recent efforts have focused on elimination of the PEND program. Created in the 1990s, the PEND program reduces reimbursement to emergency physicians to a “triage payment” of \$22.06, based on review of the final diagnosis after services have been provided to Virginia Medicaid and Medicaid Managed Care Organization patients.

On December 5th, 2013, Virginia AAEM members from Chesapeake Emergency Physicians, local emergency physicians, and I met with the Governor of Virginia, Bob McDonnell, and urged him to eliminate the PEND program. As a result of this meeting, Governor McDonnell agreed to include elimination of the PEND program in his proposed budget. As I write this there are still some legislative hurdles to jump in January, but this is a major step toward elimination of this program.

On December 6th, 2013, we met with Congressman Randy Forbes to discuss the PEND program, and as of this writing we have a meeting scheduled in January with Congressman Forbes and the Centers for Medicare & Medicaid Services to discuss the legality of the PEND program and other programs like it.

In summary, hard work by the Virginia Chapter and its members has contributed significantly to elimination of the PEND program. This battle has been fought for over 15 years, and will hopefully soon come to a successful conclusion. It serves as a perfect example of why AAEM needs strong, active state chapters to ensure that it meets the local needs of its members.

Joel M. Schofer, MD RDMS FAAEM FACEP  
President, Virginia AAEM  
Commander, US Navy Medical Corps

*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. ■*



Governor Bob McDonnell meets with emergency medicine physicians from Hampton Roads. The discussion focused on the elimination of the Medicaid PEND program, which the Governor agreed to support.

Pictured from left to right: Josh Smith, MD, Peninsula Emergency Physicians; Todd Parker, MD FAAEM, Chesapeake Emergency Physicians; Todd Vanden Hoek, MD MBA FAAEM, Chesapeake Emergency Physicians; Bob McDonnell, Honorable Governor of Virginia; Joel Schofer, MD RDMS FAAEM FACEP, President, Virginia Chapter of the American Academy of Emergency Medicine; David Pitrolo, MD FAAEM, Chesapeake Emergency Physicians; Lewis Siegel, MD FAAEM, Chesapeake Emergency Physicians.



Congressman Randy Forbes meets with emergency physicians from Hampton Roads. The discussion focused on the elimination of the Medicaid PEND program and future meetings with CMS to discuss this and similar programs.

Pictured from left to right: Rob Stambaugh, MD FAAEM, Chesapeake Emergency Physicians; Lewis Siegel, MD FAAEM, Chesapeake Emergency Physicians; Tien Vanden Hoek, MD; Todd Vanden Hoek, MD MBA FAAEM, Chesapeake Emergency Physicians; Congressman Randy Forbes; Joel Schofer, MD RDMS FAAEM FACEP, President, Virginia Chapter of the American Academy of Emergency Medicine; David Pitrolo, MD FAAEM, Chesapeake Emergency Physicians.





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## YPS President's Message

# Five Reasons Why This Year's Scientific Assembly was the Best Ever for YPS

Jennifer Kanapicki Comer, MD FAAEM  
YPS President



AAEM just wrapped up another amazing Scientific Assembly. Yes, New York was a bit cold and snowy, but well worth the trip to hear thought-provoking lectures, reunite with many amazing colleagues, and see the New York City sites. For YPS, this year's Scientific Assembly included showcasing new advances, implementing successful improvements, and ultimately an even brighter future for YPS. It was quite possibly the best Scientific Assembly ever! Here are five reasons why:

### 1. Launching of EM Flash Facts App

We have just put the final touches on the EM Flash card app that will be launched through iTunes! YPS has been working hard on this project to make sure we give our members the best educational products possible. For those who have not heard about our new member benefit, EM Flash Facts is an educational flashcard application for your mobile device that allows you to review EM questions on the go. This application is a fun, interactive way to help you prepare for the boards, help you teach EM topics to students (perfect for new faculty), and ultimately keep you fresh on EM pearls!

### 2. Improving Mentor Relationships — One Breakfast at a Time

We at AAEM/YPS know just how important mentorship is. Our new initiative to establish and strengthen these relationships led us to establish a mentor/mentee breakfast at Scientific Assembly. This forum was a wonderful opportunity for young physicians to connect with and develop relationships with physician mentors. Given its success we look forward to making this an annual event!

### 3. Our Board. Enough Said.

This year we had more applicants for YPS board positions than ever before. It is so exciting to see more and more young physicians looking to get involved with AAEM/YPS and further its advancement. We ended up with a stellar new board, complete with fresh faces and fresh ideas (secretary-treasurer, Robert Stuntz, MD; at-large board members, Jonathon Jones, MD; Kristin Fontes, MD; Megan Healy, MD; Terez Malka, MD; and our past-president Betsy Hall, MD). I look forward to seeing what we will accomplish.

### 4. Open Mic Success

YPS began sponsoring Open Mic last year. We thought this was the perfect role for YPS: giving opportunities for young physicians to break into the lecture circuit. This year's Open Mic was the best yet. We had all the on-site spots filled and heard 16 high-quality lecturers. It was such a tough decision to pick just one winner that we picked two! I encourage any young physician that is interested in breaking into the national

lecture circuit to sign up next year. As shown by last year's winner, Dr. Daniel Firestone, truly remarkable lecturers come out of Open Mic!

### 5. The New Frontier: Social Media

The brainstorming of potential uses for social media at the board meeting was astounding! Social media has become an essential tool in education, information dissemination, and networking. The YPS board considered potential avenues for incorporating this technology. Some ideas included podcasts with topics geared for the young physician, utilizing twitter for educational pearls and communication, and the use of FOAM (Free Open Access Meducation). Please look for more information on this ... possibly by tweet.

Scientific Assembly was once again a huge success, even with a snowy NYC. For YPS it was the best year yet. My goal is to have YPS continue to grow and advance so that next year I get to write an article with the same title. ■

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## AAEM/RSA President's Message

## AAEM/RSA — With You All the Way

Meaghan Mercer, DO  
AAEM/RSA President



It has been an exceptional year for RSA. I want to thank everyone on the board for their dedication and hard work over the last year. We have had a strong increase in our membership, with many new 100% residencies. Three residencies were sponsored through the generosity of those who contributed to the Founders' Circle, and we appreciate their investment in the future of our specialty and society.

The Advocacy Committee hosted an outstanding Advocacy Day in Washington, D.C., with over twenty participants. Our conversations with legislators led to RSA-supported bills advancing and a stronger presence for our organization on Capitol Hill. The committee continues to work on projects that advocate for both emergency physicians and our patients on a local level.

The Publications Committee just launched the RSA blog, which features posts on clinical pearls, new advances in medicine, and the latest articles from *Common Sense* and *Modern Resident*. We are also excited to announce that the newest edition of *Rules of the Road for the Medical Student* is now available and *The Written Board Review Book* is coming out soon! We continue to publish *Modern Resident* and have had many members contribute content and count it as a valuable resource in their medical education.

The Education Committee had a great resident track at the 2014 Scientific Assembly, and another huge thank you goes out to Dr. Mattu and Dr. Brady for offering the high-risk EKG course free to all residents! The Vice-President's Council also hosted our first job fair, where all participants supported AAEM's principles. We enjoyed meeting everyone that attended and cannot wait to see everyone again next year in Texas.

Last fall we participated in the Mediterranean Emergency Medicine Congress, and continue to expand our international connections. The International Committee has created a resource to help residents find rotation opportunities. We continue to offer an international resident and student membership.

Our medical student council has seen continued growth by providing free one-year membership, offering highly regarded medical student symposia, and producing excellent educational materials. Congratulations to Michael Hayoun and Jennifer Cotton for receiving this year's medical student scholarships for their dedication and passion for EM.

AAEM/RSA aspires to a future in which all patients have access to excellent emergency care by a board-certified emergency physician. Developing emergency physicians will receive the highest quality training in a supportive practice environment with an emphasis on personal wellness and career mentorship. The RSA board is proud to represent such a passionate, dedicated, and involved membership. AAEM/RSA is with you all the way. ■

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## RSA Editor's Letter

## The Salesman-Doctor

Edward Siegel, MD MBA  
AAEM/RSA Publications Committee Chair



I remember one of the early classes at my business school, when the lecturer asked how many of the students had been in sales prior to starting their MBA. I was one of the minority of students who raised their hands, as most of my classmates were in fields like engineering, consulting, and finance before starting their MBA program. Then the lecturer

asked how many of us thought we would be in sales after graduating with our new degree. Though my memory is hazy, I think I was the only person to raise his hand. The lecturer asked me why I **wanted** to be in sales, and I told her that it wasn't because I wanted to be in sales, but that I was going to be **required** to be in sales — that all of us, no matter what our background, skills, or abilities — were at one point going to have to sell ourselves to get jobs, convey the value of our ideas, and work with others. I went on to say that I had been working in sales in one form or another since I was a teenager, and that being a salesman was nothing to be ashamed of.

I think that most of my classmates felt that being in sales was beneath them, especially if they had earned an MBA and a ticket out of the lower-end job pool. If business school students didn't think they would have to stoop to doing sales, how do you think doctors approach the concept that they too are in sales?

The truth is, we as doctors are increasingly being graded, measured, and rewarded just as salesmen are — based on how well our “customers” are satisfied by our work. The pre-eminent organization that is grading the nation's doctors is Press Ganey Associates. In 2011, Press Ganey sent out 70 million patient satisfaction surveys for over 10,000 health care organizations. That year Press Ganey logged \$217 million in sales with over \$80 million in profits (EBITDA\*). Hospitals across the country, including my own, contract with Press Ganey to obtain patient satisfaction surveys and then compare themselves to hospitals in their region that are similar to them in size, that have similar patient bases, etc.

At Press Ganey's recent annual conference, over 2,000 hospital administrators paid over \$1,000 each to be told how to run their hospitals better. One of the keynote speakers at this conference was Jillian Michaels, who is a trainer on the TV show *The Biggest Loser*. I wonder if those attending the conference appreciated the irony of someone who isn't a doctor, but pretends to be a health expert on television, telling hospitals and doctors how they should be taking care of people.

Unfortunately, joking about the absurdity of having people who are not doctors or hospital administrators being pawned off as having the authority to lecture doesn't diminish the power of organizations like Press Ganey. If anything, their influence is growing by leaps and bounds. For example, part of the Affordable Care Act calls for reducing reimbursements to hospitals with poor patient satisfaction scores by some \$850 million.

On the individual level, doctors — including those in the emergency departments — are being told how to manage their practices based on the results of patient satisfaction surveys. Those of us who find ourselves saying “no” to things like unwarranted requests for antibiotics and narcotics may find ourselves on the wrong end of a bad patient satisfaction grade, even as we practice good medicine and care for our patients.

How important will this be in our lives once we become attendings? A recent survey by the Hay Group, a management consultancy, found that 66% of their surveyed health care groups rely on patient satisfaction scores to measure and reimburse their physicians — a 23% increase over the previous two years.

If you're told that your value as a doctor and your paycheck will be based on patient satisfaction, what do you do? A survey of more than 700 emergency physicians found that 59% admitted they increase the number of tests they order because of patient satisfaction surveys. Compound this by the number of tests obtained as defensive medicine, and one can find billions of dollars being spent not to protect patients, but to protect doctors from patient complaints.

Continued on next page



## AAEM/RSA

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# Introducing the AAEM/RSA Blog!

AAEM/RSA is excited to announce the launch of our blog! The blog is a great resource for both residents and students, featuring:

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To be fair, holding a mirror up to the world of medicine has a lot of value. Our department and those around the country are constantly taking steps to improve patient care and reduce unnecessary costs. I recently joined a committee to help improve patient satisfaction, focusing on how we treat the family members of our patients in the ED. Without the information on this topic generated from our Press Ganey surveys, we would not have known that this was a problem or how important it was to our patients.

Similarly, we frequently read or hear about innovations made by institutions to improve care. Many of these innovations come as the result of patient feedback to surveys like those obtained by Press Ganey. Sycamore Medical Center in Miamisburg, OH, recently published the results made by changes in their ED's patient flow. By making changes in how patients were being cared for, they were able to reduce their left-without-being-seen rate from 4% to 0.04%, while raising their patient satisfaction scores from the 70th percentile to the mid-nineties. The hospital is continuing to hone its practice by making case managers available at peak times, using walkie-talkies instead of overhead pages to reduce unwanted noise, etc. All these changes — and their positive effect on patient care — were driven by patient satisfaction surveys.

As a doctor, I rely on the skills I learned as a salesman almost every day. Sometimes it is convincing a patient with a sore throat but no Centor criteria that they don't need antibiotics, sometimes it is convincing a septic patient that they need a central line. The common thread is getting a patient to accept a level of care that they weren't expecting when they came to the ED, and getting them to feel that they were part of the decision-making process. Just as my classmates in business school didn't want to believe that they were all in sales, neither do my fellow doctors. The truth is, however, that we are in a business that is almost as reliant on customer satisfaction as that of a run-of-the-mill salesman. We may not like this reality, but the sooner we can learn to work within it the better off we will be.

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\*EBITDA = earnings before interest, tax, depreciation, amortization ■



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## Resident Journal Review

## Mechanical Ventilation in the Emergency Department

Authors: Michael Allison, MD; Kami Hu, MD; David Bostick, MD MPH; Phil Magidson MD MPH; and Michael Scott, MD

Edited by: Michael C. Bond, MD FAAEM and Jay Khadpe, MD FAAEM

## Introduction

Patients with respiratory failure are commonly encountered in the emergency department (ED), and many of these patients progress to require endotracheal intubation and mechanical ventilation. Mechanical ventilation strategies were the focus on a recent *Annals of Emergency Medicine Clinical Controversy*.<sup>1,2</sup> Since its publication, there have been a number of newer studies suggesting that perhaps ventilation with low tidal volume can improve outcomes for many ED patients with respiratory failure, not just those with the acute respiratory distress syndrome (ARDS). This "Resident Journal Review" goes through the pertinent recent literature on low tidal volume ventilation.

We begin with an investigation regarding the use of low tidal volume ventilation in the ED among patients with and without ARDS. The investigators found that low tidal volumes are infrequently used in both scenarios. The impact of this becomes clearer, as the following three articles note a variety of improvements in patients ventilated with lower tidal volumes. There is a suggestion that even a 1mL/kg difference from a lung-protective strategy can worsen clinical outcomes.

**Fuller BM, Mohr NM, Detmer M, et al. Mechanical ventilation and acute lung injury in emergency department patients with severe sepsis and septic shock: An observational study. *Acad Emerg Med*. 2013;20(7):659-669.**

This is a retrospective, observational cohort study of ED patients who required intubation and met criteria for severe sepsis or septic shock. The primary outcome was development of acute lung injury (ALI) within the first five days of admission to the ICU. ALI was defined using the American-European consensus definition of ARDS, which includes the presence of bilateral alveolar infiltrates on chest x-ray,  $\text{PaO}_2/\text{FiO}_2$  ratio  $<300$ , and absence of any clinical evidence of left atrial hypertension.<sup>3</sup> The authors evaluated the number of ED patients ventilated with "lung-protective" ventilation (defined as  $<8\text{mL/kg}$  ideal body weight (IBW)), whether patients already meeting criteria for ALI were more likely to be put on lung-protective ventilation, and risk factors for development of ALI.

The authors found that 27.5% of patients developed ALI in the hospital. Higher BMI (adjusted odds ratio 1.09, IQR 1.03-1.14,  $p<0.001$ ), Sequential Organ Failure Assessment (SOFA) score (aOR 1.13, IQR 1.03-1.25,  $p<0.03$ ) and need for vasopressor use (aOR 2.80, IQR 1.16-7.20,  $p<0.02$ ) were the only statistically significant risk factors associated with development of ALI. Interestingly, high tidal volume ventilation was not associated with the development of ALI, but the study was not powered to find such a difference.

The findings characterizing the types of ventilation strategies used in the ED were revealing. Lung-protective ventilation was used in only 27.1% of patients in the ED. Furthermore, patients who met criteria for ALI at time of ED admission (8.8%) were no more likely to be placed on lung-protective ventilation settings than those without ALI at presentation

( $9.0\text{mL/kg}$  IBW compared with  $8.7\text{mL/kg}$  IBW,  $p=0.40$ ). The authors also note that ventilator settings were changed and plateau pressures were checked in the ED only 30% of the time.

Overall, this study suggests that patients with ALI, and those at-risk for developing it, are uncommonly placed on lung-protective ventilation strategies in the ED. This particular study found no correlation between higher tidal volumes and the development of ARDS, but that brings us to our next study.

**Neto AS, Cardoso SO, Manetta JA, et al. Association between use of lung-protective ventilation with lower tidal volumes and clinical outcomes among patients without acute respiratory distress syndrome. *JAMA*. 2012;308:1651-1659.**

This study examines the effect of lung-protective mechanical ventilation in patients who do not have ARDS. Current evidence has shown that lung-protective mechanical ventilation decreases morbidity and mortality in patients with ARDS, but whether there is any benefit in patients who do not have ARDS is less clear. This meta-analysis attempts to

Continued on next page

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determine if in fact higher or lower tidal volumes are associated with lung injury, mortality, pulmonary infection, and atelectasis in patients on mechanical ventilation who have no pre-existing evidence of lung injury.

Articles were included in the analysis if they evaluated two different ventilation strategies in patients without ARDS at the onset of mechanical ventilation. Both randomized trials and observational studies were included, without restrictions on language or whether patients were evaluated in the ICU or the operating room. The GRADE approach was used to summarize the quality of evidence for each outcome.<sup>4</sup> Development of lung injury was the primary end point. Secondary end points included overall survival, incidence of pulmonary infection and atelectasis, ICU and hospital length of stay, time to extubation, change in PaCO<sub>2</sub>, arterial pH, and change in the ratio of PaO<sub>2</sub> to fraction of inspired oxygen (FiO<sub>2</sub>).

Twenty articles met the inclusion criteria and data on 2,822 patients were analyzed. Of the articles included, 15 were observational studies and five were randomized controlled trials. Forty-seven of the 1,113 (4.2%) patients in the lung-protective ventilation group developed lung injury during follow-up while 138 of 1,090 (12.7%) developed lung injury in the conventional ventilation group (RR 0.33; 95% CI (0.23-0.47): NNT, 11).

Overall, mortality was lower in patients receiving lung-protective ventilation (RR 0.64; 95% CI 0.46-0.89; NNT 26). There was also a decreased incidence of pulmonary infection and atelectasis with lower tidal volume ventilation (RR 0.45; 95% CI 0.22-0.92; NNT 26 and RR 0.62; 95% CI 0.41-0.95, respectively). Protective ventilation was associated with shorter mean hospital stay (6.91 vs 8.87 days, 95% CI 0.20-0.82) and showed no difference in ICU stay or time of mechanical ventilation (3.63 vs 4.64 days, 95% CI -0.53-1.27 and 51.07 vs 47.12 hours, 95% CI -0.27-1.23).

The authors encourage the interpretation of these results within the context of the articles included. Publication bias may exaggerate the conclusions, as negative studies may have less chance of being published. Also, it is important to note that the majority of studies included patients ventilated for a short duration. Fifteen of the included studies had scheduled surgery as the indication for mechanical ventilation. This makes it difficult to extrapolate the results to patients intubated for different indications or who are ventilated for longer durations.

Overall, there is some reasonable evidence that low tidal volume ventilation in patients without ARDS results in improved outcomes.

**Fuller BM, Mohr NM, Drewry AM, Carpenter CR. Lower tidal volume at initiation of mechanical ventilation may reduce progression to acute respiratory distress syndrome: A systematic review. *Crit Care*. 2013;17:R11.**

While, as discussed above, it has become accepted practice to use low tidal volume settings in patients who meet criteria for ARDS,<sup>6</sup> the effect of "lung-protective" ventilation strategies on patients prior to the onset of ARDS has been less clear. In light of this conflict, Fuller et al., set out to examine the existing literature, specifically looking at high versus low tidal volumes and their effect on the development of ARDS.

Authors included 13 out of 1,704 studies found via a search of MEDLINE, EMBASE, CINAHL, the Cochrane Library, ClinicalTrials.gov, and a manual search of unpublished clinical studies. Studies were

included only if tidal volume for intubated patients was independently studied as a predictor of ARDS development. They excluded studies that did not objectively define ARDS, and in which tidal volume was not the only variable manipulated to examine effect. Appropriate studies for inclusion were agreed upon by independent review of two investigators, with disagreements settled by a third.

The 13 studies consisted of one RCT and 12 observational studies conducted between 2004 and 2011. The investigators reported that they were only able to assess the quality of the one RCT, as none of the observational studies commented on their adherence to STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guidelines. There was a great deal of variation between the methods and populations included in each study, as well as the underlying illnesses contributing to respiratory failure requiring ventilation, and the actual definition of ARDS used by the studies themselves. For this reason, the investigators felt it was inappropriate to perform a meta-analysis of all of the included data.

The RCT by Determann et al., found a 10.9% decrease in absolute risk for developing ARDS with tidal volumes of 6mL/kg predicted body weight, as compared to 10mL/kg.<sup>5</sup> One of the three studies set in the operating room (OR) found an association between tidal volume and development of ARDS, but its two variable groups were not significantly different in terms of tidal volume. Six of nine ICU studies found that tidal volume was an independent predictor of ARDS development, and five studies demonstrated a dose-response relationship between increasing tidal volumes and incidence of ARDS.

Continued on next page

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Overall, ARDS occurred early after intubation (primarily within four days), less often in OR patients compared to ICU patients (an average of ~1% vs. up to 44%, respectively), and corresponded to increased morbidity (length of stay, days ventilated, organ failure) and mortality. While not the focal point of this review, other factors such as presence of restrictive lung disease or transfusion of blood products also correlated with ARDS development, indicating that a multimodal approach is likely to be the most beneficial in preventing ARDS.

The authors of this review correctly concluded that they could not offer a definitive recommendation on the best tidal volume strategy for patients at risk of developing ARDS. The majority of their data came from observational studies, and there were too many inherent differences between the studies to equalize them with a meta-analysis, precluding any strengthening of the data by increased power (*n*).

Overall, the current evidence seems to point to a link between higher tidal volumes and development of ARDS, especially for patients at greater risk based on other factors.

**Needham DM, Colantuoni E, Mendez-Tellez PA, et al. Lung protective mechanical ventilation and two year survival in patients with acute lung injury: Prospective cohort study. *BMJ* 2012;344:e2124.**

Patients with acute lung injury requiring mechanical ventilation have high rates of mortality after hospital discharge. Lung-protective ventilation has been shown to reduce short-term mortality in these patients by nearly 10%.<sup>5</sup> Needham and colleagues' 2012 publication suggests that long-term mortality can also be reduced with greater use of lung-protective ventilation strategies in ICU patients with acute lung injury.

This prospective cohort study followed patients who were mechanically ventilated with acute lung injury for a total of 24 months after hospital discharge. The primary outcome was overall mortality. The authors reviewed patient data from a total of 13 individual ICUs in Baltimore, Maryland. Germane to the authors' review was not only whether or not a patient was mechanically ventilated and their long-term mortality, but the specific ventilator settings and if these settings were lung-protective. Adherence to lung-protective ventilator settings was defined as a tidal volume less than or equal to 6.5 mL/kg predicted body weight as well as a plateau pressure of less than or equal to 30 cm of water.

A total of 485 patients were included in this study, with 85% of these patients coming from medical ICUs. A total of 41% of these patients had ventilator settings considered to be lung-protective. The authors concluded that lung-protective ventilation strategies were associated with a statistically significant decrease in two year mortality of 3% (HR 0.97, 95% CI 0.95 to 0.99, *p*=.002). Further analysis of the data showed that, when compared to patients with no adherence to lung-protective ventilation, patients with 50% adherence had an absolute risk reduction of mortality over two years of 4.0% (0.8% to 7.2%, *p*=0.012) and patients with 100% adherence had a 7.8% reduction (1.6% to 14.0%, *p*=0.011). Also, for every increase of average tidal volume by 1 mL/kg of predicted body weight, there was an 18% relative increase in mortality.

The most significant limitation of this study is the observational aspect; so although there is correlation, causation cannot be proven. However, given that the ARDS Network has established the short-term mortality benefit in lung-protective ventilation strategies, a randomized controlled trial looking at long-term mortality benefit would not be ethical. The study was also only conducted in one geographic area and only at academic medical centers, which may limit its generalizability.

Despite these limitations, the study's results suggest that lung-protective ventilation is associated with an increase in long-term survival in patients with acute lung injury. This builds upon the conclusions of the ARDS Network study that showed a benefit to short-term survival. The results further emphasize that many patients with acute lung injury (59% in this study) may actually not be receiving lung-protective ventilation at all. Given this, there stands to be further improvement in overall post-ICU mortality if these parameters were more consistently applied in clinical practice.

Overall, adherence to lung-protective ventilator settings decreases overall mortality in patients with acute lung injury up to 24 months after hospital discharge. Increases of just 1 mL/kg above lung-protective settings increase long-term mortality.

## Conclusions

- Patients with ARDS are often not started on low tidal volumes in the ED.
- Low tidal volume ventilation in patients without ARDS may result in improved outcomes.
- In at-risk patients, higher tidal volumes are associated with the development of ARDS.
- Lung-protective ventilation decreases long-term mortality in patients with ARDS.
- Increases of just 1 mL/kg above lung-protective settings increase long-term mortality.

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## Medical Student Council President's Message

# Tales from the Trail

Mary Calderone, MS4



"What do you want in a program?" It seemed like a simple question when one of my seasoned mentors asked me, a bright-eyed and bushy-tailed third-year student. What shocked me at the time was how difficult it was to answer. I really didn't know much about all the different programs, aside from some general impressions based on word-of-mouth. Browsing

websites helped a little, but still didn't entirely demystify what characteristics mattered. Looking back on the last few months on the interview trail, my understanding of how programs differ has evolved immensely, and I'd like to share that with the rising fourth-years who might find it helpful as they navigate the upcoming application process. Here are a few ways in which programs vary that you should consider.

### Three versus four

The three-year versus four-year program argument is one you have most likely heard about long before the interview trail. One obvious advantage of a three-year program is an additional year of earning an attending's salary. However, some four-year programs may not hire graduates of three-year programs, because it would not make sense to have them supervising fourth-year residents, who effectively have the same degree of experience. Some graduates of three-year programs circumvent this by doing a one to two year fellowship, which offers the additional advantage of niche development. The general thought is that a four-year program may be better suited for those who wish to pursue a career in academics. However, graduates from three-year programs certainly do enter academics, especially following fellowship training. If you choose a four-year program, it is important to evaluate what the fourth year offers you in terms of your career development. For example, will you have extra elective time to pursue opportunities like international travel, or develop further in areas where you feel deficient? Will you have the opportunity to participate in a "mini-fellowship" that will allow you to develop a niche? Or do you simply value the opportunity to see more patients before losing the safety net of supervision?

### Practice environment(s)

The main classifications of emergency medicine practice environments include academic, community, and county. Most academic centers have a strong emphasis on research and teaching with faculty who reflect this. If they have an associated medical school or undergraduate university, this may increase your opportunities to teach pre-med students and medical students, or be involved in the EMIG. Academic centers tend to see medically complex patients who may come to that site because they have a specialist or were transferred from an outside hospital. Community practice environments are less resident-focused. For instance, rather than dealing with an on-call resident when you call a consult, you may be speaking directly with an attending physician

who will need to decide whether or not to come in from home to see your patient. Community emergency physicians tend to perform all procedures on their own, and there tends to be more of an emphasis on efficiency and patient satisfaction. Patients in community environments often have better access to primary care, and there is an emphasis on communicating with these primary care providers when making decisions and arranging follow-up. County environments tend to see a more under-served population and have a larger proportion of penetrating trauma. Often, these environments tend to have fewer resources and will help you develop creativity and adaptability. As a resident, you may need to help more frequently with patient transport, blood draws, and other duties taken care of by ancillary staff at better-resourced institutions.

### Single training site or multiple training site

Some programs offer only one practice environment because it provides an adequate combination of the different practice environments. The advantage is that you can get to know the ancillary staff as well as the residents and attendings from other services well, which facilitates collaboration and communication. You also don't have to deal with the stress of commuting to more than one site, or with learning a new system and EMR. Other programs send residents to multiple hospitals to ensure enough exposure to various practice environments. Although you may not get to know the staff as well and may struggle with mastering different systems and EMRs, having multiple training sites will teach you to be versatile and adaptable and may better prepare you to decide the environment in which you hope to land a job.

### Large versus small

Most of the residency programs I interviewed with had roughly twelve residents per class, but the number ranged from six to nineteen. A small residency program might lead to a more tight-knit class, as well as a more tight-knit program in general. You may also get to see more patients and do more procedures if the patient volume is divided among a smaller number of residents. However, you may run into difficulties with scheduling if you need to take time off for some reason, as there are fewer people available to cover you. Conversely, an advantage to a larger program is that you can more easily find someone to switch shifts with if you run into a conflict or find yourself dealing with an unexpected crisis. Although it may be more difficult to get to know all the residents in a large program really well, you might be more likely to find people who are more similar to you.

### Opportunities for niche development

In emergency medicine, it is becoming increasingly important to develop a niche, which offers emergency physicians one way to sub-specialize in something even though EM is such a broad field. Having a niche will ultimately make a residency graduate more marketable when applying

Continued on next page



for jobs. Areas for niche development include EMS, global health, ultrasound, simulation, administration, pediatrics, critical care, wilderness medicine, sports medicine, women's health, and research. Some programs offer opportunities for "mini-fellowships" integrated throughout the three or four years, or as a focus of the fourth year. These are often called "tracks" and residents can typically elect to focus on a particular area of interest. This usually presents an excellent opportunity to establish relationships with faculty mentors. Completion of these tracks may require a scholarly project that will help build your CV.

### The curriculum: Floor months versus more ICU time

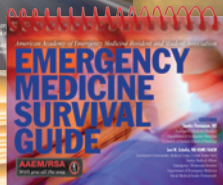
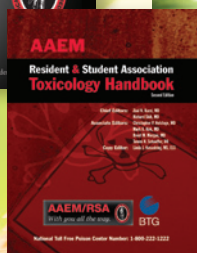
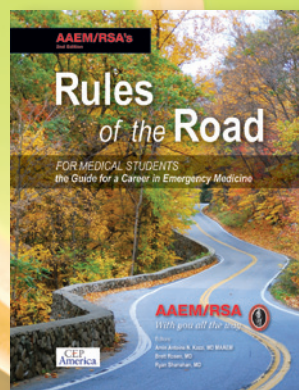
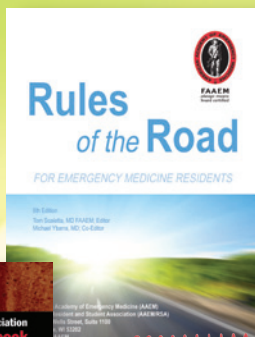
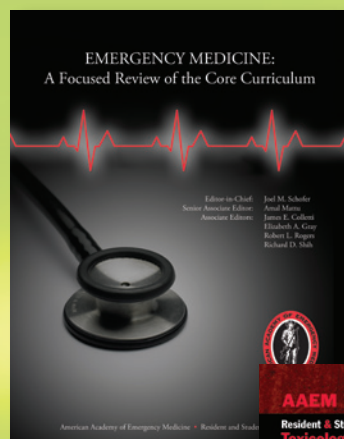
When you evaluate the curriculum for various programs, you will find that most look very similar. However, some incorporate more medicine or surgery floor months than others. Having those experiences may help you to better communicate with your colleagues when calling consults or

admissions, and may also help with decision-making in the ED by allowing you to better anticipate patients' needs once they're on the floor. However, some programs have reduced or eliminated floor months in order to make more room for ICU rotations, with the rationale that exposure to critically-ill patients is more valuable for the emergency physician than exposure to stable floor patients.

This is by no means a comprehensive list. Above all, the most important thing I've learned is that there are disadvantages and advantages of almost every aspect of a program. It's up to you to ask yourself "What kind of emergency physician do I aspire to be?" and subsequently "Which program will best get me there?" If you can answer those two questions by the end of interview season, you have done it right and have likely grown immensely through the process. ■

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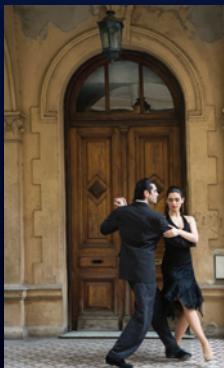


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