THE NEWSLETTER
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

VOLUME 22, ISSUE 1
JANUARY/FEBRUARY **2015**

WWW.AAEM.ORG

INSIDE

~ELECTION~ ISSUE

SPECIAL ELECTION ISSUE

CANDIDATE STATEMENTS INSIDE!

FREE* REGISTRATION and CME for MEMBERS!

On-site Registration Available!

21ST ANNUAL SCIENTIFIC ASSEMBLY

FEBRUARY 28 – MARCH 4, 2015
HILTON AUSTIN ★ AUSTIN, TX

*With refundable deposit

COMMONSENSE

Table of Contents

Regular Features

Special Articles

Updates & Announcements

AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $150 (Non-voting status)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
International Student Member: $30 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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

AAEM-1114-231

President's Message

Due Process

Mark Reiter, MD MBA FAAEM
AAEM President

Being an emergency physician is a tough job. It can be difficult to effectively advocate for your patients, your group, and your department and still please everyone. In some hospitals, if you never ruffle any feathers you aren't doing your job right. Sometimes, hospital processes or medical staff actions place our patients at risk. As our primary duty is to our patients, we are obliged by ethical duty to be advocates for our patients, even if it is not in the hospital's or consultant's financial best interest. However, under many employment contracts, advocating for patients can easily result in an emergency physician being fired. Unlike most other physicians on the hospital medical staff, emergency physicians are routinely denied due process by contract. Due process in the workplace essentially means that an employer has to follow an appropriate, predefined process to terminate your job. In most U.S. hospitals, due process includes the physician's right to hear the charges and evidence justifying termination, having the ability to provide testimony and evidence in rebuttal or defense, and then being judged by peers — typically a group of physician-colleagues on staff at that facility. When a contract provides due process to physicians, neither the hospital administrator nor the contract management group (CMG) can terminate you without cause or for arbitrary, unfair reasons.

> "AAEM remains the only organization in emergency medicine that steadfastly defends a physician's right to due process"

Unfortunately for many emergency physicians, especially those working for several of the largest CMGs, their employment contracts include a clause by which the physicians waive their rights to due process. It is also common for contracts between hospitals and CMGs to grant the hospital the ability to have the CMG terminate a physician on demand. In a survey of emergency physicians performed by AAEM a few years ago, 52% replied that they could be terminated without due process. Due process rights are protected by the U.S. Constitution, the Health Care Quality Improvement Act of 1986, medical staff bylaws, the Joint Commission's Comprehensive Accreditation Manual for Hospitals, and the American Medical Association Code of Medical Ethics. However, it is very difficult for emergency physicians to successfully enforce their due process rights if they have waived these rights in an employment contract.

AAEM has recently provided support on two due process cases, in Colorado and in New York. In just my first year as AAEM's president, I have been contacted by seven different emergency physicians who were abruptly terminated without due process. In several of these cases the physician was terminated after raising quality of care issues. Unfortunately, by the time the emergency physician is unfairly terminated, much of the battle is lost. Legal expenses to enforce one's right to due process can easily reach into six figures, with little chance of being awarded legal expenses by the courts, and the legal process can easily take several stress-filled years. AAEM's efforts in these cases are funded by the AAEM Foundation, which relies on donations from our members.

> "Unfortunately, by the time the emergency physician is unfairly terminated, much of the battle is lost."

Some physician terminations are completely appropriate and justified. It is within an employer's rights to terminate a physician with cause for appropriate, contractually defined infractions after due process. As certain terminations can trigger a report to the National Practitioner Data Bank, a wrongful termination can significantly hamper a physician's future career prospects, making a fair due process decision essential.

AAEM strongly recommends that all emergency physicians review their existing employment contracts carefully, and attempt to negotiate the removal of any clauses that infringe on their rights to due process. More importantly for those considering a new job opportunity, perform your due diligence. Talk to current and even past physician-employees before accepting a job, to see if your employer has a track record of inappropriately terminating emergency physicians. Do your best to determine if recent physician departures raise any red flags. Another resource is the white paper on due process by past AAEM president Larry Weiss, MD JD FAAEM, available at: http://www.aaem.org/em-resources/position-statements/2007/due-process-whitepaper.

AAEM remains the only organization in emergency medicine that steadfastly defends a physician's right to due process. Over the past two years AAEM has been meeting with leaders from the Centers for Medicare and Medicaid Services (CMS), seeking to have CMS codify the right of all emergency physicians to due process and prohibiting the waiver of these rights in employment contracts, by building these principles into Medicare's Conditions of Participation so that every hospital in the country accepting CMS funds must comply. ■

Fairness, Exploitation, and the Future of Emergency Medicine

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

I will reverence my master who taught me the art. Equally with my parents, will I allow him things necessary for his support, and will consider his sons as brothers. I will teach them my art without reward or agreement; and I will impart all my acquirements, instructions, and whatever I know, to my master's children, as to my own; and likewise to all my pupils, who shall bind and tie themselves by a professional oath, but to none else.

— From the Oath of Hippocrates

My colleagues will be my sisters and brothers.

— From the World Medical Association's Declaration of Geneva

Fair must surely be one of the most beautiful words in the English language. It is a synonym for both justice and beauty. (There is often wisdom in etymology.)

A desire for fairness was the single biggest factor leading to the creation of AAEM: fairness for the emergency physicians known as *scrubs* — the doctors who are up at 3:00am taking care of the drunken, addicted, psychotic, self-destructive, old, sick, neglected, or unlucky — and sometimes being threatened, spat upon, and assaulted for their efforts. The fight for justice for emergency physicians, for fairness, remains one of the fundamental missions of the Academy. Unfortunately many emergency physicians are still treated unfairly, exploited for profit by laypeople and other physicians, even though the mercenary exploitation of one physician by another is a clear violation of the ancient ethical code of our profession, as well as updated versions of the code (see the quotes above). Even today, many emergency physicians (EPs) are denied the economic and workplace justice that all people deserve, much less all professionals, and that EPs must have in order to be strong advocates for patients few other doctors (and damn few hospital administrators) are eager to care for.

Although we have made great progress since James Keaney wrote *The Rape of Emergency Medicine*, we still have a long way to go before most emergency physicians are free to reap the fruits of their own labor, enriching themselves and their own families rather than corporate CEOs, stockholders, and the kind of emergency physicians known as *suits* — the doctors who work nine to five on weekdays in a corporate office, rarely lay hands on a patient, and rarely if ever cross the threshold of an ED on a holiday, a weekend, or at night.

AAEM Antitrust Compliance Plan:

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

Outside of academia, which has its own collegial rules and forms of due process, the best way to assure fairness for EPs is for them to own their own practice as part of an equitable, transparent, democratic group — or just democratic group for short. But exactly what do *equitable, transparent,* and *democratic* mean in practice, in the real world?

You should read AAEM's Vision Statement (www.aaem.org/about-aaem/vision-statement) for the Academy's official policy, but this is my personal opinion of what a democratic group should be. First, after some reasonable probationary period (one, maybe two years) following the hiring of an emergency physician, if the group decides to retain the EP and the EP wants to stay with the group, the EP should become an "equal partner" in the group. (Depending on the legal structure of the group a different term may be used, but the effect is the same). That means the EP has full and equal access to all important information on the practice: revenue, expenses, profits, how revenue is distributed to group members and outside vendors, etc. It means the EP has an equal say in group decisions — one partner, one vote — including choosing the leaders of the group and deciding on compensation for leadership and other administrative positions. It means the EP has the job security they need to be a strong advocate for patients — the EP cannot be fired except for cause, and only after due process before his peers (his partners). Finally, if an outside management company is used to manage group business, it is hired by the group and can be fired by the group — the EPs still own and control the practice.

Continued on next page

We're listening, send us your thoughts!

COMMON SENSE
Letters to the Editor

AAEM Blog

AAEM Connect

If a democratic group is the ideal in nonacademic emergency medicine, what is the opposite of that? A type of corporation known in Academy circles as a contract management group (CMG), although other names would probably be more accurate and descriptive, such as ED staffing company or even medical staffing corporation — especially since these companies are now branching out from emergency medicine into other hospital-based specialties. For the sake of consistency, however, I will stick with CMG.

Although the two biggest and best known CMGs are EmCare and Team Health, there are many others and my comments and comparisons below pertain to CMGs in general, not necessarily to either EmCare or Team Health in particular. So, how do CMGs differ from democratic groups?

- **Size:** Democratic groups tend to staff one or just a few hospital EDs, because there is little or no profit motive to expand (although there are other reasons to expand besides profit). Adding EDs doesn't increase compensation for the existing EPs, because adding EDs means hiring new EPs, and fairness demands that the new EPs keep most of the revenue they generate. CMGs staff from dozens to hundreds of EDs — as many contracts as they can get — because the more contracts a CMG has, the more profit there is to flow to its corporate officers and owners (shareholders).
- **Equity:** In a democratic group the EPs vote on how they should be compensated and on how profits should be divided, and everyone gets a fair share — whether that is based on hours worked; number of patients seen; nights, holidays, and weekends worked; RVUs generated; administrative burdens carried; or some combination of those factors. In a typical CMG contract the EP agrees to a compensation formula decided on by the CMG — take it or leave it. Crucially, the EP has no idea what the profit margin is, much less where the money goes. The EP often has no idea what the other EPs in his department are being paid. In fact, the employment contract may have a clause that forbids the EP from discussing his compensation with others. The analysis of public financial disclosures by Team Health (page eight here: http://www.aaem.org/UserFiles/file/commonsense0110.pdf) and EmCare (page 41 here: http://www.aaem.org/UserFiles/NovDec13CommonSense.pdf) has shown that on average both take over 20% of an emergency physician's collected professional fees as profit. And remember, that is **after** they charge their EPs for services rendered, such as coding & billing and malpractice insurance — often purchased from a wholly-owned subsidiary of the CMG itself. As Dr. Bob McNamara puts it, "That's like giving a shift a week to the company." I would not call that fair or equitable.
- **Transparency:** In a democratic group all the partners know where the money comes from and where it goes. In a CMG, the EPs have no idea. Often, even the ED director doesn't know exactly how much revenue the ED generates in physician fees.
- **Physician control of the practice:** If a democratic group needs management help, it shops around and then hires the business help it needs, at a price it likes. If the management services company doesn't perform up to expectations or isn't worth what it costs the group, it is fired. CMGs turn that relationship on its head. The CMG owns and controls the practice. It hires and fires the emergency physicians rather than vice versa, and in essence charges the EPs a bounty for the privilege of having a job. Corrupt political machines used to do something similar, and may still for all I know. The machine would give somebody a job with the city, and the public employee was expected not only to vote for the politicians who hired him, but to kick back part of his wages to them in return for the job.
- **Due process and peer review:** In a democratic group, the process for firing a partner is laid out on paper. A majority (or more) of the partners must vote in favor before a partner can be fired, and the imperiled partner has a chance to make his case to his colleagues and offer an explanation or rebuttal to the alleged misconduct before the vote. Every CMG contract I have seen says an EP can be fired without cause with some degree of notice, and most say an EP can be fired immediately if the hospital administration requests it. That makes it impossible for emergency physicians to stand up for patients. For instance, how hard are you going to push a temperamental cardiologist to admit your chest pain patient, if you suspect your hospital administrator will ask for you to be fired when the cardiologist storms into his office and demands your head on a platter? That has happened to countless emergency physicians. Hospital administrators want nothing more than they want complete control over the physicians in their hospitals. CMGs give them that.

> "The fight for justice for emergency physicians, for fairness, remains one of the fundamental missions of the Academy."

Those are the two extremes: democratic groups and huge staffing corporations, the CMGs. But are there other practice models between the two extremes? Absolutely. Many ED contracts are held by an individual emergency physician, who then hires other EPs — as either employees or, more commonly, independent contractors — to staff the ED. In my experience, most of these are as unfair and exploitive as CMGs. I call this type of individual contract-holder a *tyrant*. On the other hand, a few of the most open, equitable, and fair groups I have seen involved individual contract-holders who opened the books for all the EPs to see, gave everyone an equal voice in decisions, and took no revenue for themselves beyond what they earned through patient care and a fair salary for administrative work — and their colleagues could see for themselves what the administrative salary was. I call this kind of individual contract-holder a *benign despot*. This is a democratic group in all but name, and both democratic groups and benign despots should be praised for their ethics.

As AAEM has raised awareness of these issues over the years, and tried to educate residents before they are thrown to the wolves in the job market, another practice model has appeared: national and large regional staffing corporations that claim to be democratic. They advertise themselves as democratic groups, saying they are "physician-owned and operated" and that all their EPs are shareholders (no lay shareholders).

Continued on next page

I know next to nothing about how these groups actually operate. Are they transparent? Do their shareholder EPs really get to see where all the money goes? Are all partners equal, or is there a steep shareholder pyramid to be climbed over too many years? Do they guarantee strong due process and peer review, and stand up for medical quality when an administrator makes unreasonable demands?

Later in this issue of *Common Sense*, the chairman of AAEM's Operations Management Committee, Dr. Joe Guarisco, writes about the anticipated demise of democratic groups and the physician-owned private practice of emergency medicine. Referring to the democratic staffing companies I mention above, he says, "On the other hand, can a corporate CMG provide for fairness and transparency in the same way as a small, independent, democratic group? Possibly."

Once, all a democratic group had to do to hold onto a contract was practice excellent medicine, be nice to the medical staff and nursing staff, and not cost the hospital anything (no subsidy). Now, however, hospital-CMG joint ventures give CMGs a way to kick back money to hospital chains in return for ED contracts. And, in another form of kickback, CMGs are also offering to take on money-losing, hospital-subsidized anesthesiology and hospitalist practices — giving up the subsidy — in return for getting profitable ED contracts in the deal. In the latter case EPs can fight back by joining with their hospitalist and anesthesiologist colleagues in forming a democratic, multi-specialty group — leaving local physicians in control of their practices. In the former, however, there is no legal way to compete. If a democratic emergency medicine group offered a kickback to the hospital in return for being allowed to hang on to its ED contract, it would be in violation of federal law.

This joint venture movement does indeed threaten the physician-owned private practice of emergency medicine with extinction, and the Academy is trying to fight it through several means. Win or lose, however, there is a strong trend toward EPs and other physicians becoming employees. When they are hospital or university employees, I believe this isn't so bad. After all, being an employee means benefits and retirement plans, and usually some kind of due process and peer review before being fired. **Even better, employees can unionize and engage in collective bargaining**. I suspect that in the near future this will become a major source of power for physicians, especially hospital-based specialists like emergency physicians. Are democratic staffing companies also a way for EPs to be spared the exploitation of traditional CMGs? As Dr. Guarisco asks, "Could there be a potentially disruptive hybrid approach that provides economies of scale and delivers on the ethical, cultural, and mission-oriented elements that define emergency medicine practice?"

I don't' know the answer to that question. Please read Dr. Guarisco's article. If you are in a democratic group or some other form of private practice emergency medicine, strongly consider going to the Operations Management Committee's pre-conference in Austin before the next AAEM Scientific Assembly. **And please, if you work for one of the big staffing companies that advertises itself as fair and democratic: write me and tell me about it — for good or ill.** If you want anonymity for your "Letter to the Editor," just say so. Emergency physicians need to know which of these groups really are democratic, and which are lying. ■

Strength in Numbers

AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

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

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

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

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

www.aaem.org/publications

Get the AAEM Fact of the Day and other AAEM Updates. Find us on Facebook

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). 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 to the Editor: Thank You to AAEM

Having recently retired, it is time to reluctantly relinquish my membership in AAEM. In response to the annual plea for membership renewal, I am sending this long overdue letter to AAEM thanking you for your support many years ago, when my position as an ER doc in Camarillo, California, at a Catholic Healthcare West (now Dignity Health) hospital was threatened. Those of you who are of my vintage will remember that CHW attempted to turn all its emergency department contracts over to Meriten, its in-house subsidiary contract management group, taking them away from the then current contract holders, EPMG and others.

I was happy in Camarillo. We had a good hospital and a good community in which to practice. Our contract had been held by a single individual, who ran our group democratically, for over 20 years prior to this move by CHW. We had good community support but wondered how much help this would be in the face of a large, regional change by CHW. Anxiety and sleepless nights followed, as we encountered the usual worries of relocating — finding new jobs, dealing with mortgages, school issues, spouse's jobs, and family ties. Fortunately, the directors of EPMG acted promptly and decisively to resist this change.

California has strong prohibitions on the corporate practice of medicine, and the California Medical Association responded promptly to our request for help. But, despite the fact that most of us were members of ACEP, I was shocked and puzzled to find that ACEP met our pleas for help with total silence. I could not believe that our specialty's largest professional society felt this issue was none of its concern.

Fortunately for my colleages and me, AAEM stepped in and became our steadfast advocate. Much effort was expended by Bob McNamara and the other leaders of AAEM on our behalf, and CHW's attempts were finally rebuffed. As a result I joined AAEM and left ACEP, and I have never regretted that decision.

In preparing this letter, I see that history is now repeating itself: a very similar situation is happening with Tenet and its attempt to replace emergency medicine, anesthesiology, and hospitalist groups in its California hospitals with a single large staffing corporation — using profit from the emergency medicine groups to subsidize money-losing hospitalist and anesthesia programs in the process. I'm happy to see resistance to this move, including a website (http://coalitionforquality-care.com/).

This is an old story. I want to stress, particularly to those of you early in your career or in residency, that there will always be substantial pressure from others to take over the management of physicians, in an effort to siphon off the income for which you've put in countless hours of training and endured stress and fatigue in a work environment that is unimaginable to most people. This will not stop. It is suicidal for you to remain passive, sleepwalking through the financial environment of 21st century health care. Vigilance and resistance are required.

You are fortunate to have a responsive partner in AAEM, which will support you as it did me. You need to make strong efforts to convince your colleagues who are not currently members of the Academy to join, supporting each other and our specialty.

I'm sure you have the support of your medical staff, and I'm confident that the community you have worked in for years will support you, prompted by the gratitude of the families you have been treating with professionalism 24/7/365. We know the devastation that will occur in our communities and hospitals if Tenet's naïve and self-serving efforts are successful. Appealing strategically and courteously to influential people in your communities should help.

Best of luck. Stick together. Actively resist. AAEM worked for us, and it will work for you if you support it.

Ted Angus, MD
Ojai, CA

Thank you very much for your letter. Residents and young emergency medicine attendings weren't around for the Catholic Healthcare West (CHW) battle. Many older emergency physicians may not have been aware of it, and even those of us who do know about it need to be reminded of AAEM's important victories from time to time.

All emergency physicians should be aware of the significant differences between ACEP (the College) and AAEM (the Academy), and the CHW incident is a good example. The College stayed out of the battle, calling it a "private business matter" and (in my opinion) leaving its members to the tender mercies of predatory corporations motivated only by profit. I

Continued on next page

should point out that I have nothing against profit. It is being motivated only by profit that I object to, and those of us who practice the ancient profession of medicine have sworn to put other values first. Those values require that physicians control the practice of medicine so that patients are the highest priority, rather than allowing corporations to make shareholder profits and obscenely bloated CEO compensation the highest priorities.

For a fuller exploration of the differences between the College and the Academy, read three articles from the Jan/Feb 2014 issue of *Common Sense*: 1) Why AAEM?, 2) Legitimate, and 3) Highlights of AAEM's Legal Advocacy for Emergency Physicians (http://www.aaem.org/UserFiles/January-February14CommonSense.pdf). As you read the third article, ask yourself why the College would sit out each of the battles in which the Academy came to the rescue of local, independent EM groups. In my opinion the explanation is that, while the College no longer elects the owners and CEOs of contract management groups (CMGs) to its presidency, its leadership is still too riddled with the owners, CEOs, regional directors, and other management-level employees of CMGs - including its leadership at the state chapter level. This is a flagrant and unresolvable conflict of interest. As St. Matthew wrote, "No man can serve two masters." Many current issues in emergency medicine boil down to this: individual, practicing emergency physicians who want to take care of patients and be fairly paid for it vs. corporations that care about nothing but increasing share price and CEO compensation. It's the same old "scrubs vs. suits" conflict James Keaney wrote about in *The Rape of Emergency Medicine*.

Just as a man can serve only one master, a professional society can take only one side in the battle for the soul of our specialty. The Academy has chosen its side. In my opinion, so has the College. ■

— The Editor

Congress Ends 2014 with Unfinished Priorities; Sets Stage for Health Care Deals in 2015

Williams & Jensen, PLLC

As of December 1, fewer than 200 bills had been signed into law since the beginning of the 113th Congress, with few of these measures significantly impacting federal health policy. The Republican controlled House and Democratic controlled Senate and administration found few areas of agreement, with the GOP focused on repealing or limiting parts of the Affordable Care Act (ACA) and Democrats mostly resisting these changes. With control of Congress' upper chamber at stake, Senate leaders also clamped down on the number of bills and amendments considered in 2014. One area of bipartisan interest was permanent reform to the Medicare Sustainable Growth Rate (SGR), but after over a year of hearings and negotiations, Congress failed to enact a long-term solution, settling for a one year patch last spring that will expire in three months.

The lame duck session was dominated by negotiations to fund government agencies beyond December 11. Congress is poised to allow the expiration of the Medicaid pay boost for primary care at the end of 2014. This was a temporary provision included in the ACA, which AAEM argued should have included the emergency medicine specialty.

Ebola funding was also a focus in the latter part of 2014, with Congress and the administration seeking domestic and international funding to help contend with the spread of the disease. President Obama asked Congress for $6 billion in emergency funding to aid the Ebola response efforts, and Congress was set to approve part of this request as a component of the year end spending package. In October, AAEM provided written comments to a congressional panel seeking input on the Ebola response, pointing out the importance of ensuring that emergency physicians and the critical care community have the resources and access to expert personnel needed to diagnose, treat the sick, and protect caregivers and the public from further harm. Congress also specifically asked for AAEM's input on protocols for physicians returning to work after volunteering in Africa.

114th Congress Preview

There are signs that Congress is poised to make progress on multiple significant health care bills in the first part of 2015. The November elections gave Republicans control of the Senate by a 54 to 46 margin, so now Republicans control the House and Senate agendas. In the coming year, there are a number of important must-pass items that will have major implications on health policy, starting with the expiration of the current SGR patch on March 31. An SGR fix — permanent or temporary, will lead to additional discussions on health care spending, and this could also tie into the debate over domestic spending and mandatory budget control known as sequestration, which is set to return in fiscal year 2016 after a two-year delay. The reauthorization of the Children's Health Insurance Program (CHIP) will also be addressed next year, making 2015 a very active year for health care policy.

SGR Deadline

One of the first deadlines for the new Republican Congress is the expiration of the current SGR patch at the end of March. Committee leaders and other policymakers have continued to emphasize their goal of permanent SGR repeal. If Congress can agree on a series of cuts to pay for the bill, that are also acceptable to the Obama Administration, all indications are that a replacement physician payment policy is ready to be implemented. Two new committee chairmen, House Ways and Means Committee Chairman Paul Ryan (R-WI) and Senate Finance Committee Chairman Orrin Hatch (R-UT), will play a lead role in negotiating cuts to finance either a permanent repeal or a short-term deal to prevent the 25 percent payment cuts from starting on April 1, 2015. Notably, Chairman Ryan has led successful bipartisan negotiations with Senate Democrats in the past, striking a major budget deal with then-Senate Budget Committee Chair Patty Murray (D-WA) in 2013. Chairman Hatch and the Senate Finance Committee's Ranking Member, Ron Wyden (D-OR), will play a lead role in the Senate, and the committee has already presented dozens of options for health care cuts that could help finance a permanent agreement. Working against Congress' favor is the potential of a rising cost of a permanent fix, which could exceed $200 billion with inclusion of related Medicare payment fixes.

SGR legislation has the potential to be a vehicle for other reforms, particularly related to the Medicare system. AAEM supports a number of policy changes to accompany SGR legislation, including enhanced due process protections for physicians, billing transparency and reform that will allow emergency physicians to see what is billed and collected in exchange for their services, and increased funding and access for graduate medical education (GME). AAEM has advocated for a physician payment replacement policy that will allow specialty societies and medical boards to provide input in setting quality standards and performance bonuses, rather than a "one size fits all" model that does not account for fundamental differences between specialties. The AAEM board specifically focused on SGR policy and due process rights for emergency physicians during a series of December meetings on Capitol Hill.

Liability Reform

The change in Senate control is potentially a significant development in the area of medical liability reform. Incoming Senate Judiciary Committee Chairman Chuck Grassley (R-IA) has a long-standing interest in malpractice reform that has led to speculation that he may seek to partner with House Judiciary Committee Chairman Bob Goodlatte (R-VA) to change federal laws. Changes that have been championed by Republican members in the current Congress include limiting liability exposure for physicians treating patients under the federal EMTALA mandate and broader protections for doctors treating patients in a voluntary capacity. AAEM has supported these changes and advocated with sponsors of legislation in the House and Senate.

Continued on next page

ACA Changes

In a November editorial authored jointly by House Speaker John Boehner (R-OH) and incoming Senate Majority Leader Mitch McConnell (R-KY), the two leaders presented their vision for an agenda that would focus on ACA changes that could garner bipartisan support, including repeal of the law's individual mandate to purchase health insurance, the ACA's excise tax on medical devices, and elimination of the Independent Payment Advisory Board (IPAB). Republicans have also signaled they may be willing to utilize a process known as "budget reconciliation," which could allow the Senate to approve certain changes with only 51 votes, which is significant because Republican policy changes outside of the reconciliation process would require the support of at least six Senators that caucus with the Democrats. However, it is not clear if President Obama would approve any measure that passed strictly with Republican votes, and Senate Republicans face an even higher threshold (two-thirds) to override a Presidential veto. It is likely that some modest ACA changes will occur in 2015, but it is unclear if congressional Republicans can secure larger modifications to the law.

Other Health Care Priorities

Another congressional priority that received significant attention in 2014 but was not enacted into law includes mental health care legislation, notably a bill from Congressman Tim Murphy (R-PA), entitled the "Helping Families in Mental Crisis Act." The bill is one of several legislative efforts that has garnered additional attention following several violent crimes committed over the past several years by mentally ill individuals. Provisions of the legislation include: (1) clarifying HIPAA under certain circumstances to allow physicians to communicate information to caregivers of patients undergoing a mental health crisis; (2) encouraging alternatives to long-term inpatient care for the chronically mentally ill population such as the "Assisted Outpatient Treatment" program which has demonstrated promise in reducing substance abuse and ED visits; and (3) providing relief from federal tort claims for physicians serving in a voluntary capacity at community mental health clinics and federally-qualified health centers.

The U.S. Department of Health and Human Services (HHS) issued a rule earlier this summer that requires compliance with the International Classification of Diseases (ICD)-10 beginning October 1, 2015. ICD-10 was scheduled to take effect this year, but Congress included a delay in the compliance date in the doc fix legislation passed earlier this year. Some members of Congress are seeking an additional delay of ICD-10 implementation, which could become law as part of an SGR fix or a package of government funding bills.

House Energy and Commerce Committee Chairman Fred Upton (R-MI) and Representative Diana DeGette (D-CO) are set to unveil legislation related to their "21st Century Cures" initiative that was initiated last April. The primary focus of the bill will be policy changes that enhance and accelerate medical innovation and the development of new cures, but the legislation is also expected to include provisions on other advancements including the delivery of telehealth services. Depending on how it is drafted, this has the potential to be a significant health care bill that involves many aspects of the medical system.

Another potential vehicle for health care reforms is the extension of funding for the Children's Health Insurance Program (CHIP), which many states argue should be dealt with in early 2015 to provide budget flexibility prior to the expiration of funds later in the year. The House and Senate are expected to work closely on a bipartisan agreement, and the Medicaid and CHIP Payment and Access Commission (MACPAC) will be involved in providing information and recommendations to policymakers during this process. ■

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1/1/14 to 11/20/14.

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.

Donor

Lance H. Hoffman, MD FAAEM
Mark Reiter, MD MBA FAAEM
Michael S. Ritter, MD FAAEM
Joel M. Schofer, MD MBA CPE FAAEM
West Jefferson Emergency Physicians Group

Contributor

Juan F. Acosta, DO MS FAAEM
Leonardo L. Alonso, DO FAAEM
Terence J. Alost, MD MBA FAAEM
Aaron D. Andersen, MD FAAEM
Stephen H. Andersen, MD FAAEM
Jonathan D. Apfelbaum, MD FAAEM
Carmelito Arkangel, Jr., MD FAAEM
Aditya Arora, MD FAAEM
Kian J. Azimian, MD FAAEM
Eric Y. Baden, MD FAAEM
Garo Balkian, MD FAAEM
Jeffery R. Barnes, MD FAAEM
Robert Bassett, DO FAAEM
Paul S. Batmanis, MD FAAEM
Andrew H. Bauer, MD FAAEM
Philip Beattie, MD FAAEM
John W. Becher, DO FAAEM
Brett Bechtel, MD FAAEM
Dale S. Birenbaum, MD FAAEM
Joshua P. Bobko, MD FAAEM
Michael A. Bohrn, MD FAAEM
Mark Avery Boney, MD FAAEM
Peter D. Bosco, MD FAAEM
James K. Bouzoukis, MD FACS FAAEM
Eric W. Brader, MD FAAEM
Asher Brand, MD FAAEM
Richard D. Brantner, MD FAAEM
Greg Bredemeier, MD FAAEM
J. Allen Britvan, MD FAAEM
Kevin Robert Brown, MD FAAEM
Heather C. Bruner, MD FAAEM
Tyson O. Bryant, MD FAAEM
Mark Burr, MD JD FAAEM
Michael R. Burton, MD FAAEM
Bruce R. Bush, MD FAAEM
Thomas J. Calvert, MD FAAEM
Derek M. Carlson, DO FAAEM
John W. Cartier, MD FAAEM
Anthony Catapano, DO
Frank L. Christopher, MD FAAEM
Garrett Clanton, II, MD FAAEM
William K. Clegg, MD FAAEM
Robert Lee Clodfelter, Jr., MD FAAEM
David T. Coffin, MD FAAEM
Steven K. Costalas, DO FAAEM
John L. Coyner, MD FAAEM
Peter B. Cridge, MD FAAEM
Daniel S. Crough, MD FAAEM
Ramon L. Cruz Rivera, MD FAAEM
Eric S. Csortan, MD FAAEM
Stanley Czarnecki, MD FAAEM
Thomas R. Dalton, MD FAAEM
Robert J. Darzynkiewicz, MD FAAEM
Benjamin P. Davis, MD FAAEM FACEP
Jerry E. Davis, MD FAAEM
Francis X. Del Vecchio, MD FAAEM
Manuel J. Delarosa, MD FAAEM
Brandt A. Delhamer, MD FAAEM
Scot M. DePue, MD FAAEM
Cheryl L. Dickason, MD FAAEM
Robert L. Dickson, MD FAAEM
Steven E. Diebold, MD FAAEM
John J. Dillon, MD
John Timothy DiPasquale, MD FAAEM
Walter D. Dixon, MD FAAEM
Aaron D. Dora-Laskey, MD FAAEM
Louis J. Durkin, MD FAAEM
David A. Dwyer, MD FAAEM
Carolann Eisenhart, MD FAAEM
Elizabeth A. Fair, MD FAAEM
Michael J. Falk, MD FAAP FRCP FAAEM
David A. Farcy, MD FAAEM FCCM
Marc J. Farraye, MD FAAEM
Neal N. Faux, MD FAAEM
Jacob R. Fenster
Deborah M. Fernon, DO FAAEM
Clifford J. Fields, DO FAAEM
Patrick M. Flaherty, DO FAAEM
Mark A. Foppe, DO FAAEM
Robert J. French, DO FAAEM
Luke Friebertshauser
Robert A. Frolichstein, MD FAAEM
Brandon J. Fumanti, MD FAAEM
Paul W. Gabriel, MD FAAEM
Leigh S. Galatzan, MD FAAEM
Stuart M. Gaynes, MD FAAEM
Ronald T. Genova, MD FAAEM
Robert Bruce Genzel, MD FAAEM
Albert L. Gest, DO FAAEM
Kathryn Getzewich, MD FAAEM
Bassam Gholam, MD FAAEM FACEP
Steven R. Ginder, MD FAAEM
Samuel H. Glassner, MD FAAEM
Brad S. Goldman, MD FAAEM
Robert C. Greaves, MD FAAEM
Christopher R. Grieves, MD FAAEM
Kevin Griffith, MD JD FAAEM
Robert E. Gruner, MD FAAEM
Daniel G. Guenin, MD FAAEM
Neil Gulati, MD FAAEM
Michael N. Habibe, MD FAAEM
William B. Halacoglu, DO FAAEM
Dennis P. Hanlon, MD FAAEM
Jack L. Harari, MD JD FAAEM
Mark J. Harrell, MD FAAEM
John C. Haughey, MB BCH BAO FAAEM
W. Richard Hencke, MD FAAEM
David Anthony Hnatow, MD FAAEM
Victor S. Ho, MD FAAEM
Stephen Holtsford, MD FAAEM
Robert A. Hoogstra, MD FAAEM
John Hopkins, DO FAAEM
Roy S. Horras, MD FAAEM
Joseph C. Howton, MD FAAEM
David R. Hoyer, Jr., MD FAAEM
Felix Y. Huang, MD
Irving P. Huber, MD FAAEM
Elizabeth J. Hull, MD FAAEM
Michael A. Huott, MD FAAEM
Timothy J. Huschke, DO FAAEM
Tapio O. Innamaa, MD
Donald N. Janes, Jr., MD FAAEM
Carroll Don Johnson, MD FAAEM
Dominic A. Johnson, MD FAAEM
Donn E. Johnson, MD FAAEM
P. Scott Johnston, MD FAAEM
Shammi R. Kataria, MD FAAEM
Bilal A. Kattan, MD
Brian M. Kelley, DO FAAEM
John H. Kelsey, MD FAAEM
David W. Kelton, MD FAAEM
Brian J. Kempton, MD FAAEM
Erin M. Khouri, DO FAAEM
Christopher L. Klingenberg, MD FAAEM
Deborah Korik, MD FAAEM
Kenneth H. Koster, MD FAAEM
Ron Koury, DO FAAEM
Chris Kramer, DO FAAEM
Keith J. Kuhfahl, DO FAAEM
Erik Kulstad, MD FAAEM
Kenneth Kumamoto, MD FAAEM
Steven Kushner, MD FAAEM
Stephen Lamsens, MD FAAEM
Chaiya Laoteppitaks, MD FAAEM
David W. Lawhorn, MD FAAEM
Liza Lê, MD FAAEM
Jonathan D. Lee
Richard Lee, MD FAAEM
David A. Leeman, MD FAAEM
Stephen J. Leitner, MD FAAEM
Saul D. Levine, MD FAAEM
Donald J. Linder, DO FAAEM
David Liss, MD
Bruce E. Lohman, MD FAAEM
Richard C. Lotsch, DO FAAEM
John W. Love, MD FAAEM
Freda Lozanoff, MD DO FAAEM
Eric Lubliner, MD FAAEM
Eric D. Lucas, MD FAAEM
Michael Lucca, MD FAAEM
Maja L. Lundborg-Gray, MD FAAEM
Richard G. Lyons, MD FAAEM
Christopher K. Marcuzzo, MD FAAEM
Scott P. Marquis, MD FAAEM
Jennifer A. Martin, MD FAAEM
David Mason, MD FAAEM
John R. Matjucha, MD FAAEM
Andrew P. Mayer, MD FAAEM
Michael J. McCrea, MD FAAEM
Erica S. McKernan, MD FAAEM
Bernard T. McNamara, MD FAAEM
Edgar McPherson, MD FAAEM
Russell H. McUne, MD FAAEM
David E. Meacher, MD FAAEM
Chris A. Meeker, MD FAAEM
Nimish Mehta, MD FAAEM
Benson G. Messer, MD FAAEM
Lisa D. Mills, MD FAAEM
Peter B. Mishky, MD FAAEM
Jeffrey Alan Moore, MD FAAEM
Noel T. Moore, MD FAAEM
Teresita Morales-Yurik, MD FAAEM
Claud E. Morgan, MD FAAEM
Elizabeth A. Moy, MD FAAEM
Joseph C. Munafo, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Nicholas J. Musisca, MD
Melissa Natale, MD FAAEM
Michelle S. Nathan, MD FAAEM
Long Nguyen, MD FAAEM
Craig Norquist, MD FAAEM
Paul D. O'Brien, MD FAAEM
Stephen J. OConnor, MD FAAEM
Isaac A. Odudu, MD
Robert Verne Oliver, MD FAAEM
Alonso J. Osorio-Giraldo, MD FAAEM
John C. Owens, MD FAAEM
Diane M. Paratore, DO FAAEM

Continued on next page

Chris M. Paschall, MD FAAEM
Vanessa C. Peluso, MD FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Catherine V. Perry, MD FAAEM
Frank S. Pettyjohn, MD FAAEM
Patricia Phan, MD FAAEM
Donald G. Phillips, DO FAAEM FACOEP-D
Andrew T. Pickens, IV, MD JD MBA FAAEM
David Pillus, MD FAAEM
Matthew W. Porter, MD FAAEM
Robert H. Potts, Jr., MD FAAEM
Michael S. Pulia, MD FAAEM
Scott A. Ramming, MD FAAEM
Yadira Ramos-Arias, MD FAAEM
Kevin C. Reed, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Phillip L. Rice, Jr., MD FAAEM
Fuli Richie
Howard M. Rigg, III, MD FAAEM
Brian A. Rike, DO FAAEM
Alexander Riss, DO FAAEM
Ralph J. Riviello, MD FAAEM
Francisco Rodriguez, MD
Steven B. Rosenbaum, MD FAAEM
Eric M. Rudnick, MD FAAEM
Roque Ruggero, MD FAAEM
Stewart Sanford, MD FAAEM
Marc Santambrosio, DO FAAEM
Charles A. Schmier, MD FAAEM
Dirk C. Schrader, MD FAAEM
David T. Schwartz, MD FAAEM
H. Edward Seibert, MD FAAEM
Eric M. Sergienko, MD FAAEM
Sachin J. Shah, MD FAAEM
William M. Shapiro, MD FAAEM
Laura Shih, DO FAAEM
Richard D. Shih, MD FAAEM
Stephen Shipley, MD FAAEM
Jonathan F. Shultz, MD FAAEM
Michael E. Silverman, MD FAAEM FACP
Larry L. Simpson, MD FAAEM
Katarzyna B. Sims, MD FAAEM
Mark J. Singsank, MD FAAEM
Michael Slater, MD FAAEM
Evans S. Smith, MD FAAEM
Henry E. Smoak, III, MD FAAEM
Marc D. Squillante, DO FAAEM
Michael G. St. Marie, MD FAAEM
Christopher H. Stahmer, MD
Robert E. Stambaugh, MD FAAEM
Keith D. Stamler, MD FAAEM
David R. Steinbruner, MD FAAEM
Kenneth C. Stewart, DO FAAEM FACEP
Gregory J. Sviland, MD FAAEM
Jerry J. Tasset, MD PhD FAAEM
Mark D. Thompson, MD FAAEM
Jalil A. Thurber, MD FAAEM
Thomas R. Tobin, MD MBA FAAEM
Charles W. Todd, MD FAAEM
Jorge Danl Trujillo, MD FAAEM
Patricia L. VanDevander, MD MBA FAAEM
Christopher P. Visser, MD FAAEM
Roland S. Waguespack, III, MD FAAEM
James S. Walker, DO FAAEM
Steven M. Walkotte, MD FAAEM
Benjamin Walrath, MD FAAEM
Jonathan Wassermann, MD FAAEM
Marvin A. Wayne, MD FAAEM FACEP FAHA
Grant Wei, MD FAAEM
Scott G. Weiner, MD MPH FAAEM
Gregory A. West, MD FAAEM
Robert V. West, III, MD JD FAAEM
Ellen J. Westdorp, MD FAAEM
Christopher R. Westfall, DO FAAEM
Kay Whalen, MBA CAE
Brian J. Wieczorek, MD FAAEM
William David Wilcox, Sr., MD FAAEM
Joanne Williams, MD FAAEM
Justin Barrett Williams, MD FAAEM
Janet Wilson, CAE
Emily Wolff, MD FAAEM
Samuel Woo, MD FAAEM
Patrick G. Woods, MD FAAEM
George Robert Woodward, DO FAAEM
Susie M. Wyse, MD FAAEM
Marc B. Ydenberg, MD FAAEM
Anita M. Ziemak, MD FAAEM
Leslie Zun, MD MBA FAAEM

Donate to the AAEM Foundation!

Visit www.aaem.org or call 800-884-AAEM to make your donation.

Recognition Given to PAC Donors

AAEM PAC is the political action committee of the American Academy of Emergency Medicine. Through AAEM PAC, the Academy is able to support legislation and effect change on behalf of its members and with consideration to their unique concerns. Your support of AAEM PAC is essential to its success.

Levels of recognition to those who donate to the AAEM PAC have been established. The information below includes a list of the different levels of contributions. The PAC would like to thank the individuals below who contributed from 1/1/14 to 11/20/14.

Congressional

Brian J. Wieczorek, MD FAAEM
Michael R. Burton, MD FAAEM
Robert J. Darzynkiewicz, MD FAAEM
Michael S. Ritter, MD FAAEM
Joel M. Schofer, MD MBA CPE FAAEM

Member

Carol Anne Allen, MD FAAEM
Leonardo L. Alonso, DO FAAEM
Aaron D. Andersen, MD FAAEM
Stephen H. Andersen, MD FAAEM
Peter G. Anderson, MD FAAEM
Carmelito Arkangel, Jr., MD FAAEM
Eric Y. Baden, MD FAAEM
Garo Balkian, MD FAAEM
Mike Barker, MD FAAEM
Jeffery R. Barnes, MD FAAEM
Robert Bassett, DO FAAEM
Paul S. Batmanis, MD FAAEM
Andrew H. Bauer, MD FAAEM
Philip Beattie, MD FAAEM
Joshua P. Bobko, MD FAAEM
Mark Avery Boney, MD FAAEM
Peter D. Bosco, MD FAAEM
Eric W. Brader, MD FAAEM
Asher Brand, MD FAAEM
Greg Bredemeier, MD FAAEM
J. Allen Britvan, MD FAAEM
Mark W. Brodeur, MD FAAEM
Kevin Robert Brown, MD FAAEM
Mark Burr, MD JD FAAEM
John W. Cartier, MD FAAEM
Anthony Catapano, DO
Garrett Clanton, II, MD FAAEM
William K. Clegg, MD FAAEM
Robert Lee Clodfelter, Jr., MD FAAEM
David T. Coffin, MD FAAEM
Daniel S. Crough, MD FAAEM
Ramon L. Cruz Rivera, MD FAAEM
Eric S. Csortan, MD FAAEM
Brian J. Cutcliffe, MD FAAEM
Stanley Czarnecki, MD FAAEM
Christopher Xavier Daly, MD FAAEM
Benjamin P. Davis, MD FAAEM FACEP
Jerry E. Davis, MD FAAEM
Francis X. Del Vecchio, MD FAAEM
Brandt A. Delhamer, MD FAAEM
Scot M. DePue, MD FAAEM
Cheryl L. Dickason, MD FAAEM
Robert L. Dickson, MD FAAEM
Steven E. Diebold, MD FAAEM
Louis J. Durkin, MD FAAEM
Steven Elsbecker, DO
Elizabeth A. Fair, MD FAAEM
David A. Farcy, MD FAAEM FCCM
James E. Ferguson, MD FAAEM
Clifford J. Fields, DO FAAEM
Mark A. Foppe, DO FAAEM
Robert J. French, DO FAAEM
Luke Friebertshauser
Robert A. Frolichstein, MD FAAEM
Brandon J. Fumanti, MD FAAEM
Paul W. Gabriel, MD FAAEM
Leigh S. Galatzan, MD FAAEM
Steven H. Gartzman, MD FAAEM
Stuart M. Gaynes, MD FAAEM
Ronald T. Genova, MD FAAEM
Robert Bruce Genzel, MD FAAEM
Albert L. Gest, DO FAAEM
Kathryn Getzewich, MD FAAEM
Bassam Gholam, MD FAAEM FACEP
Daniel V. Girzadas, Jr., MD RDMS FAAEM
Hermann Gonzalez, DO FAAEM
Robert C. Greaves, MD FAAEM
Christopher R. Grieves, MD FAAEM
Daniel G. Guenin, MD FAAEM
Neil Gulati, MD FAAEM
Michael N. Habibe, MD FAAEM
Jack L. Harari, MD JD FAAEM
Mark J. Harrell, MD FAAEM
John C. Haughey, MB BCH BAO FAAEM
Thomas Heniff, MD FAAEM
David Anthony Hnatow, MD FAAEM
Victor S. Ho, MD FAAEM
Stephen Holtsford, MD FAAEM
John Hopkins, DO FAAEM
David R. Hoyer, Jr., MD FAAEM
Felix Y. Huang, MD
Irving P. Huber, MD FAAEM
Stephen E. Hunter, MD
Michael A. Huott, MD FAAEM
Donn E. Johnson, MD FAAEM
P. Scott Johnston, MD FAAEM
Shammi R. Kataria, MD FAAEM
Bilal A. Kattan, MD
David W. Kelton, MD FAAEM
Brian J. Kempton, MD FAAEM
Erin M. Khouri, DO FAAEM
Christopher L. Klingenberg, MD FAAEM
Kenneth H. Koster, MD FAAEM
Frederick Kotalik, MD FAAEM
Erik Kulstad, MD FAAEM
Kenneth Kumamoto, MD FAAEM
Steven Kushner, MD FAAEM
Stephen Lamsens, MD FAAEM
Chaiya Laoteppitaks, MD FAAEM
David W. Lawhorn, MD FAAEM
David A. Leeman, MD FAAEM
Saul D. Levine, MD FAAEM
Robert E. Leyrer, MD FAAEM
John W. Love, MD FAAEM
Freda Lozanoff, MD DO FAAEM
Eric D. Lucas, MD FAAEM
Maja L. Lundborg-Gray, MD FAAEM
Richard G. Lyons, MD FAAEM
Christopher K. Marcuzzo, MD FAAEM
Scott P. Marquis, MD FAAEM
Jennifer A. Martin, MD FAAEM
David Mason, MD FAAEM
John R. Matjucha, MD FAAEM
Michael J. McCrea, MD FAAEM
Bernard T. McNamara, MD FAAEM
Edgar McPherson, MD FAAEM
Nimish Mehta, MD FAAEM
Benson G. Messer, MD FAAEM
Keith Messner, MD FAAEM
Peter B. Mishky, MD FAAEM
Jeffrey Alan Moore, MD FAAEM
Noel T. Moore, MD FAAEM
John Bruce Moskow, MD JD FAAEM
Elizabeth A. Moy, MD FAAEM
Joseph C. Munafo, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Melissa Natale, MD FAAEM
Long Nguyen, MD FAAEM
Stephen J. OConnor, MD FAAEM
Isaac A. Odudu, MD
Robert Verne Oliver, MD FAAEM
Susan R. O'Mara, MD FAAEM
Alonso J. Osorio-Giraldo, MD FAAEM
Molly O'Sullivan Jancis, MD FAAEM
Ramon J. Pabalan, MD FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Catherine V. Perry, MD FAAEM
Paul M. Petty, MD FAAEM
Patricia Phan, MD FAAEM
Rian John Pillitteri, MD FAAEM
Robert H. Potts, Jr., MD FAAEM
Michael S. Pulia, MD FAAEM
Scott A. Ramming, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Howard M. Rigg, III, MD FAAEM
Brian A. Rike, DO FAAEM
Francisco Rodriguez, MD
Steven B. Rosenbaum, MD FAAEM
Eric M. Rudnick, MD FAAEM
Roque Ruggero, MD FAAEM
Stewart Sanford, MD FAAEM
Charles A. Schmier, MD FAAEM
Dirk C. Schrader, MD FAAEM
H. Edward Seibert, MD FAAEM
Sarah B. Serafini, MD FAAEM
Eric M. Sergienko, MD FAAEM
Sachin J. Shah, MD FAAEM
William M. Shapiro, MD FAAEM
Jonathan F. Shultz, MD FAAEM
Michael E. Silverman, MD FAAEM FACP
Katarzyna B. Sims, MD FAAEM
Michael Slater, MD FAAEM
Evans S. Smith, MD FAAEM
Henry E. Smoak, III, MD FAAEM
Donald L. Snyder, MD FAAEM
Lauren P. Sokolsky, MD FAAEM
Christopher H. Stahmer, MD
David R. Steinbruner, MD FAAEM
Kenneth C. Stewart, DO FAAEM FACEP
Gregory J. Sviland, MD FAAEM
Sharon A. Swencki, MD FAAEM
William E. Swigart, MD FAAEM
Christopher H. Taranto, DO
Mark D. Thompson, MD FAAEM
Jalil A. Thurber, MD FAAEM
Charles W. Todd, MD FAAEM
Evan B. Tow, DO FAAEM
Suzana Tsao, DO FAAEM
Patricia L. VanDevander, MD MBA FAAEM
Roland S. Waguespack, III, MD FAAEM
Steven M. Walkotte, MD FAAEM
Vivekananda Wall, MD FAAEM
Wm. Bruce Watson, MD FAAEM
James Allen Webley, MD FAAEM
Grant Wei, MD FAAEM
Scott G. Weiner, MD MPH FAAEM
Larry D. Weiss, MD JD FAAEM
Gregory A. West, MD FAAEM
Ellen J. Westdorp, MD FAAEM
Christopher R. Westfall, DO FAAEM
Gregory P. Wheeler, DO
Joanne Williams, MD FAAEM
Justin Barrett Williams, MD FAAEM
Emily Wolff, MD FAAEM
George Robert Woodward, DO FAAEM
Marc B. Ydenberg, MD FAAEM
Anita M. Ziemak, MD FAAEM
Leslie Zun, MD MBA FAAEM ■

Upcoming Conferences: AAEM Directly & Jointly Provided and Recommended

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

AAEM CONFERENCES

February 28-March 4, 2015
- AAEM 21st Annual Scientific Assembly
  Austin, TX
  www.aaem.org/AAEM15
  - **February 28, 2015 — Preconference Courses**
    Resuscitation for Emergency Physicians — 1.5 Day Course
    Ultrasound for Beginners
    The Opioid-Free ED: Theoretical BS or Practical Solution?
    Networked Learning: Lifelong Learning in the Social Era
    Violence and Self-Protection in the ED
    Pediatric and Maternal Simulations Philosophy of Practicing Emergency Medicine So You Think You Can Interpret an EKG?
    Creating a Sustainable Democratic Practice: What Works and What Does Not — Two Half-Day Courses
  - **March 1, 2015 — Preconference Courses**
    From Davy Jones' Locker to the Wild Blue Yonder: Extremes in Medicine — Jointly provided by USAAEM Advanced Ultrasound
    2014 LLSA Review Course — Free for AAEM members with conference registration!

April 11-12, 2015
- Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Orlando
  www.aaem.org/oral-board-review

April 15-16, 2015
- Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org/oral-board-review

April 18-19, 2015
- Pearls of Wisdom Oral Board Review Course
  Los Angeles, Philadelphia
  www.aaem.org/oral-board-review

AAEM JOINTLY PROVIDED CONFERENCES

April 25-26, 2015
- 4th Annual FLAAEM Scientific Assembly
  Florida Chapter of AAEM
  Surfside (Miami), FL
  www.flaaem.org

AAEM-RECOMMENDED CONFERENCES

March 6-8, 2015
- The Difficult Airway Course: Emergency™
  Orlando, FL
  www.theairwaysite.com

March 27-29, 2015
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

April 24-26, 2015
- The Difficult Airway Course: Emergency™
  Boston, MA
  www.theairwaysite.com

June 5-7, 2015
- The Difficult Airway Course: Emergency™
  St. Louis, MO
  www.theairwaysite.com

September 4-9, 2015
- Mediterranean Emergency Medicine Congress (MEMC VIII)
  Rome, Italy
  www.emcongress.org/2015

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

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

Pecha Kucha at AAEM Scientific Assembly

Jennifer Repanshek, MD FAAEM
Zachary Repanshek, MD FAAEM
Scientific Assembly PK Subcommittee

American Academy of Emergency Medicine

Architects talk too much.

That was the impetus for two designers to invent a new type of presentation. And, on a February night in 2003 in their gallery in Tokyo, they held the first ever Pecha Kucha session. Pecha Kucha (PK) comes from the Japanese term for the sound of a conversation, or more simply, "chit-chat." The PK format is simply six minute and 40 seconds or 20 slides, 20 seconds per slide.

If architects talk too much — what about doctors?

Prior to last year's AAEM Scientific Assembly, the PK format had never been used at a major medical conference. The short session was very well received, and this year it will be expanded to a two-day event. The PK sessions will highlight many up-and-coming emergency physicians as well as some veteran AAEM speakers.

The PK sessions are also the perfect time to stretch your tech muscles! Twitter will be an integral part of the PK experience. Audience members will have the ability to ask questions via the new Twitter handle @AAEM_PK during each six-minute session. In fact, start following the AAEM PK sessions now on Twitter at @AAEM_PK, for previews of the speakers and their topics.

The talks are fast-paced and packed with high-yield information. In other words, they are ideal for an audience full of emergency physicians!

So come join us in Austin on March 2nd and 3rd for what is sure to be an exciting educational experience. And remember the name Pecha Kucha — you don't have to be able to pronounce it to enjoy it! ■

www.aaem.org/AAEM15/PK

Thank You to Our Exhibitors!

A Study on ED Dizziness Presentations
Advanced Health Education Center
AHC Media, LLC
Biodynamic Research Corporation (BRC)
Cambridge University Press
CEP America
Challenger Corporation
Chiesi USA
CIPROMS
Cleveland Clinic
Duvasawko EM Billing & Management Solutions
Elsevier, Inc.
Emergency Medicine Associates, P.A., P.C.
Emergency Physician Affiliates
Emergency Physicians Insurance Company RRG
Emergency Service Partners, L.P.
EPOWERdoc, Inc.
Hippo Education, Inc.
Huddy Healthcare Solutions, LLC
Intermedix
Leading Edge Medical Associates
Legacy ER & Urgent Care
LocumTenens.com
LogixHealth
Martin Gottlieb & Associates
McKesson, Business Perfomance Services
MedData, Inc.
MEP Health, LLC
Mespere Lifesciences
Mint Physicial Staffing
National Medical Professionals (First Choice Emergency Room)
Navajo Area Indian Health Service
NeilMed Pharmaceuticals, Inc.
Nicka & Associates, Inc.
Northwest Seminars
Our Web Schedule
PEPID, LLC
Practice Velocity
ProScribe
SC Medical Books
SCAD Alliance (Spontaneous Coronary Artery Dissection)
Scribe Solutions, Inc.
ScribeAmerica, LLC
Shift Administrators, LLC
SMART Physician Recruiting
St. Jude Children's Research Hospital
Staff Care
Standard Register Healthcare
Texas Association of Freestanding Emergency Centers
Texas Tech Health Sciences Center at El Paso
Victoria Emergency Associates, LLC
Weatherby Healthcare
Wellsoft Corporation
Zerowet, Inc.
Z-Medica, LLC

View more at www.aaem.org/AAEM15/exhibitor-list.

Scientific Assembly Highlights: Your Guide to Austin

From the Editor: Attend the Candidates' Forum

I hope you are going to the upcoming Scientific Assembly. If so, please attend the Academy's business meeting. Not only will you get to examine candidates for office and vote, you will hear our president's address on the state of the Academy and all AAEM has done over the last year. AAEM fights important battles over issues ACEP and other organizations ignore, and you will be proud to be a member of the Academy when you hear all AAEM has done. The more AAEM members attend the annual business meeting, the healthier our Academy.

—The Editor

Opening Reception: Sunday, March 1st

Please join us for the special Opening Reception on Sunday, March 1st from 6:00-7:00pm in the Austin Grand Ballroom. Plan to visit with colleagues and exhibitors while enjoying light refreshments.

Candidates' Forum and Voting – Sunday, March 1st

AAEM continues to grow and advance the profession of emergency medicine through the direction and strategic vision of the board of directors' members. Learn more about the individuals who are stepping forward to represent you in the years ahead at the Candidates' Forum, Sunday, March 1st from 2-3:30pm. You won't want to miss this important session to listen, learn and ask questions. Voting will be available online to members with voting privileges. Paper ballots will be available onsite. Be sure to renew or update your AAEM membership status so your vote counts!

Texas Chapter Warm Welcome: Monday, March 2nd

The Texas Chapter Division warmly invites Scientific Assembly attendees to enjoy some down-home Texas hospitality on Monday, March 2, 2015, from 6-9pm. Enjoy local award winning barbeque from Stubbs BBQ and refreshments. Y'all come on down for a good time!

Career Connections Fair: Monday, March 2nd

Looking for a new employment opportunity? Residents and physicians interested in new opportunities are invited to network with physician recruiters at the Liberty Tavern, located on the lower level of the Hilton Austin on Monday, March 3 from 6-8pm. www.aaem.org/AAEM15/career-fair.

Women in Emergency Medicine Networking Event: Tuesday, March 3rd

Join fellow women in emergency medicine at their appetizer reception to network at nearby Moonshine Patio Bar and Grille, 303 Red River St, Austin from 6-8pm. Women in emergency medicine are warmly invited to attend!

Chapter Socials

Are you a member of a state chapter division? Select chapters will be planning something special at the Scientific Assembly. Watch your inbox and/or social media for other opportunities to network.

Passport to Prizes

All conference attendees will receive a passport book in their registration materials onsite. Visit all participating exhibitors in the exhibit hall March 1st-3rd to fill your passport with verification stickers. After you've collected all stickers, drop off your completed passport book at the AAEM registration desk. Passport books turned in prior to the daily drawing will be eligible for a series of prize drawings for that day. Winners will be directed to the designated exhibit booth to collect their prize. To view a list of sponsors, prizes, and rules and regulations, visit www.aaem.org/AAEM15/passport.

Dig into #AAEM15 Online

Visit the AAEM website for podcasts, videos, and other resources previewing the great educational content available at Scientific Assembly. Learn more about the clinician-educators who will be speaking and get a preview of the premier educational content you've come to expect from AAEM.

www.aaem.org/AAEM15/resources

Connect with AAEM15!

Download our mobile app by scanning the QR code or visiting http://eventmobi.com/aaem15.

The app includes an event guide, speaker profiles, exhibitor listing, evaluations & surveys and handout/PDF document access.

Follow @AAEMinfo on Twitter and use hashtag #AAEM15 for Scientific Assembly tweets.

Flight information? Dining recommendations?

Visit the AAEM Scientific Assembly travel page for resources to take your trip to Austin to the next level!

www.aaem.org/AAEM15/travel

Highlights for Residents and Students!

The 21st Annual Scientific Assembly is the ideal conference for residents and students to attend. With specialized tracks and content tailored to you, there are valuable opportunities to take advantage of every day of the assembly.

Learn more! **www.aaem.org/AAEM15/residents** **www.aaem.org/AAEM15/students**

Preconference Course Highlights

Accreditation Statement
The American Academy of Emergency Medicine (AAEM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Resuscitation for Emergency Physicians

Saturday, February 28, 2015 – 8:00am-12:00pm
Saturday, February 28, 2015 – 1:00pm-5:00pm
Sunday, March 1, 2015 – 8:00am-12:00pm

In recent years, it has become all too common for critically ill patients to remain in the emergency department for exceedingly long periods of time. It is during these early hours of illness that many detrimental processes begin to take hold. It is during these early hours of illness that lives can be saved … or lost! In order to prevent unnecessary morbidity and mortality, the emergency physician must be an expert at resuscitating the critically ill patient.

Resuscitation for Emergency Physicians (REP) is an outstanding resuscitation course for the emergency physician that encompasses a broad spectrum of topics including the critical airway, fluid resuscitation, cardiac arrest, post-cardiac arrest management, emergency transfusions, toxicology disasters, sepsis, CNS catastrophes, and pediatric resuscitation. REP is the first integrated resuscitation course developed by an emergency medicine professional society that is tailored to the needs of emergency physicians. Emergency physicians who want to take a single resuscitation course taught at an advanced level, rather than taking ACLS, PALS and ATLS, will find REP to be an outstanding experience. Quite simply, this course will help you save lives!

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **8.75** ***AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $500 AAEM member | $850 Non-member
Late registration (after January 26): $600 AAEM member | $950 Non-member

Ultrasound for Beginners

Saturday, February 28, 2015 – 8:00am-3:00pm

This year's AAEM pre-conference ultrasound course has been fully updated with participants wishes to design the ultimate US course. Each year after reviewing participants' comments we construct a new course to address their needs. This year we will be offering a new introductory course for beginners and adding on modules for the seasoned ultra sonographers.

Participants wanted more imaging of the heart and central line placement. Didactic lectures will provide state of the art audiovisual presentation by a veteran faculty, followed by small groups of a maximum four participants / one instructor allowing each individual participant ample time with their hand on the probe.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **5.5** ***AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $425 AAEM member | $575 Non-member
Late registration (after January 26): $525 AAEM member | $675 Non-member

The Opioid Free Emergency Department: Theoretical BS or Practical Solution?

Saturday, February 28, 2015 – 8:00am-12:00pm

The speakers will discuss the clinical feasibility, analgesic efficacy, and the increased safety of a non-opioid multimodal approach that targets pain-mediated receptors and channels in the management of acute and chronic pain in the ED. The ultimate goal of this session is to describe practical and evidence-based alternatives to inappropriate opioid administration in the ED, based on current research. Different classes of analgesics with their unique pharmacological properties as well as synergistic combinations which can be utilized to target various pain-mediated receptors and channels will be reviewed. This will include: blockade of COX and NMDA/ glutamate receptors, stimulation of GABA receptors, blockade of central calcium receptors and sodium channels, as well as stimulation of central alpha-2 adrenoreceptors.

Course attendees will learn practical evidence-based strategies for ED analgesia including utilization of intravenous acetaminophen, low-dose intravenous ketamine, intravenous and intra-articular lidocaine, intravenous clonidine and dexmedetomidine, intravenous propofol, and inhaled nitric oxide. In addition, recent data regarding oral analgesics such as gabapentin, pregabalin, and prednisone, will be described with respect to their ability to treat a variety of chronic painful conditions in the ED. In addition, special attention will be given to regional analgesia and anesthesia as a leading modality in managing traumatic and non-traumatic pain.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **3.5** ***AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $150 AAEM member | $300 Non-member
Late registration (after January 26): $250 AAEM member | $400 Non-member

Continued on next page

Networked Learning: Lifelong Learning in the Social Era

Saturday, February 28, 2015 – 8:00am-12:00pm

Social media is everywhere. Chances are pretty good that you've engaged in social media for personal connections, but have you ever considered how the same technology will allow you to keep up to date, continue to learn, and improve your practice of medicine? This course will introduce you to the concept of FOAM: Free Open-Access Medical Education. Participants will learn how to tap into the wealth of resources using commonly available tools such as RSS and Twitter. They will be introduced to content created by emergency physicians for emergency physicians with an overview of blogs and podcasts. Finally, we will put it all together and explain the concept of "personal learning networks" and how to utilize all of these resources to create your own.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **3.75 *AMA PRA Category 1 Credits*™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $150 AAEM member | $300 Non-member
Late registration (after January 26): $250 AAEM member | $400 Non-member

Violence and Self-Protection in the ED

Saturday, February 28, 2015 – 8:00am-12:00pm

According to the *Annals of Emergency Medicine*, 78% of ED personnel report at least one incidence of assault by a patient or patient family member in the preceding two years.

Would you really know what to do if a patient in the ED attacked you? For example:

Chris presented to the ED on Saturday night; his wife brought him and said that he had been in a fistfight with his brother-in-law. The history indicated the patient had a past history of assaults, with his wife claiming that it was all because 'his dad beat him up when he was a kid.' Chris seemed to have a hard time responding to the triage nurse and attending physician when more than one of them was asking questions. The ED doc ordered up a hand and wrist X-ray and prepared to treat the superficial cuts and bruises on Chris's face and left shoulder. At that point, Chris jumped up and began choking a nurse while screaming that she was poisoning him. Security was called, but prior to their arrival a 250-pound college nose guard who brought his sick girl friend to the ED, knocked Chris down and restrained him until security showed up.

What comes to mind about this patient? Could this situation have been prevented or short circuited? What happens next? Learn how to protect yourself from injury or death in the ED. Learn how to safely counter and restrain dangerous, self-destructive or otherwise violent patients and their companions, and do so legally. No, you don't have to be a trained martial artist or 250-pound college football player. Even a 90-pound EMT can benefit from this training.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **3.75 *AMA PRA Category 1 Credits*™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $250 AAEM member | $400 Non-member
Late registration (after January 26): $350 AAEM member | $500 Non-member

Pediatric Emergency Department Simulation: Critical Skills from Delivery to Stepping on the School Bus!

Saturday, February 28, 2015 – 12:30pm-6:00pm

This simulation course is designed for emergency physicians seeking a practical, hands-on course in the management of critical obstetric and pediatric scenarios including the performance of invasive procedures. Training is available for emergency physicians of all levels to teach skills not received during EM training, or to refresh delivery skills and procedures that are rarely used but "high-risk" when encountered in the ED setting. This course will focus on two areas. First, the delivery of a fetus, including complicated deliveries, is required training in emergency medicine residency. However, these deliveries are infrequent in the emergency department limiting EM residency and post-EM residency routine training, especially at large tertiary hospitals where obstetrics competition for procedures exists. It will include didactic and intensive simulation training in three high-risk deliveries scenarios: breech, shoulder dystocia and nuchal cord delivery requiring resuscitation of both mother and fetus. Second, participants will rotate through two pediatric critical case scenarios in which they will simulate the critical decision making skills and procedures required for the successful resuscitation of critically ill pediatric patients.

Junior physicians will have a hand at directing the management of simulated critically ill children and at performing procedures they may have not yet performed in practice. Senior physicians will be able to refresh their skills particularly in procedures and events that are infrequent in practice but high stakes when they are needed.

Faculty will guide participants through the stations and provide not only core instruction in indication, performance and management of complications, but also share their "tricks of the trade."

Participants will receive hands-on instruction by experienced EM and OB faculty. Task trainers and simulators will be used to recreate clinical vignettes. Critical actions will be reviewed and each participant will perform these simulated high-risk deliveries and pediatric critical care scenarios in a low-pressure setting. A post-training test and summary will ensure understanding of steps necessary for successful high-risk deliveries and pediatric critical cases in the future.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **4.75 *AMA PRA Category 1 Credits*™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continued on next page

Course Fee: Early bird registration: $400 AAEM member | $550 Non-member
Late registration (after January 26): $500 AAEM member | $650 Non-member

Philosophy of Practicing Emergency Medicine

Saturday, February 28, 2015 – 1:00pm-5:00pm

The practice of emergency medicine requires the interface between theoretical knowledge and the real-time assessment of the multiple variables associated with rapid patient care. In order to deliver state of the art care, emergency physicians must be able to understand and critique the scientific findings of multiple disparate studies and its translation to the bedside. Though medical school and residency prepare one with the practical knowledge to practice medicine the theoretical and philosophical framework necessary to logically assess and apply evidence is not routinely taught. This session will focus on the intersection between philosophy and medicine in the assessment of knowledge, thought, and science.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **3.5** ***AMA PRA Category 1 Credits***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $250 AAEM member | $400 Non-member
Late registration (after January 26): $350 AAEM member | $500 Non-member

So You Think You Can Interpret an EKG?

Saturday, February 28, 2015 – 1:00pm-5:00pm

Advanced EKG Interpretation – a course designed for emergency physicians seeking more experience in critical EKG analysis for acute care settings. The course will encourage systematic review of EKGs with emphasis of important differentials, including prolonged QRS, ST-segment elevation, and T-wave inversion.

The course will present an approach to difficult and challenging EKG assessment. Topics to be covered include a review of basic interpretation, ischemia and infarction, as well as various important EKG diagnoses. A series of challenging EKGs will be provided for discussion.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **4** ***AMA PRA Category 1 Credits***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $250 AAEM member | $400 Non-member | FREE for Residents!
Late registration (after January 26): $350 AAEM member | $500 Non-member

Creating a Sustainable Democratic Practice: What Works and What Does Not

Saturday, February 28, 2015 – 1:00pm-5:00pm
Sunday, March 1, 2015 – 8:00am-12:00pm

This preconference is a structured workshop presented as a series of interactive discussions with the overall goal of understanding the operational and management principles that will help guide their practice towards sustainability… which translates to keeping your contract! What are the critical operational, and practice management issues; and what are the solutions that contract management groups employ to compete with independent democratic groups. We will present a real ED independent group at risk and then dissect, analyze and discuss what operational and management behaviors and attributes create that risk. Framing this will be insights from leaders and executives within the industry and from organizations and groups that have found unique solutions to maintaining independence. This will be executed by an outstanding teaching staff of clinicians, educators, executives and entrepreneurs.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **7.25** ***AMA PRA Category 1 Credits***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $150 AAEM member | $300 Non-member
Late registration (after January 26): $250 AAEM member | $400 Non-member

From Davy Jones' Locker to the Wild Blue Yonder: Extremes in Medicine

Sunday, March 1, 2015, 8:00am-12:20pm

The USAAEM Chapter Division is offering a course on the extremes of care in emergency medicine highlighting the unique environments in which emergency physicians have to render care. We will offer experts in the fields of undersea medicine to high altitude and even aerospace medicine from our faculty of military emergency physicians. We will also provide education on the harsh environments of extreme heat/desert medicine and extreme cold weather medicine that our military personnel have had to face on deployments.

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Academy of Emergency Medicine (AAEM) and the Uniformed Services Chapter Division of the American Academy of Emergency Medicine (USAAEM).

Continued on next page

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **4 *AMA PRA Category 1 Credits*™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: $25 Students and Residents*
$50 Physicians and Allied Health Professionals*
*The registration fee is refunded within 30 days after the conference for USAAEM members who attend the course.

Advanced Ultrasound

Sunday, March 1, 2015 8:00am-12:00pm

This year's AAEM pre-conference ultrasound course has been fully updated with participants wishes to design the ultimate US course. Each year after reviewing participant comments we construct a new course to address their needs. This year we will be offering a new introductory course for beginners and addied on modules for the seasoned ultra sonographers.

Participants loved last year's course and we have added more modules. Didactic lectures will take place online at your convenience. The lectures will be available one month prior and one month following the advanced US course. There will be a maximum four participants / one instructor allowing each individual participant ample time with their hand on the probe.

Participants select five advanced application modules:

Echo & Aorta
eFast
EM Procedures
Gallbladder and Renal
Gastrointestinal
Head & Neck
Image Acquisition and Instrumentation
Landmark Documentation
Musculoskeletal
Ocular
Pelvic Ultrasound
Peripheral Nerve Blocks
Pitfalls and errors
Practice with an expert
Pulmonary
Shock
Shoulder
Sonosite Equipment
Vascular Access
DVT

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **3.75 *AMA PRA Category 1 Credits*™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: $300 AAEM member | $450 Non-member
Late registration (after January 26): $400 AAEM member | $550 Non-member

2014 LLSA Review Course

Sunday, March 1, 2015, 8:00am-12:00pm

This course is designed to provide the experienced emergency physician with an evidence-based review course for all of the required readings for the 2014 LLSA Review. Course content will be discussed both via PowerPoint® and through small group discussion on key topics for each mandated journal article.

Credit Designation Statement: The American Academy of Emergency Medicine designates this live activity for a maximum of **3.75 *AMA PRA Category 1 Credits*™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Course Fee: Early bird registration: FREE for AAEM members | $325 Non-member
Late registration (after January 26): FREE for AAEM members | $425 Non-member ■

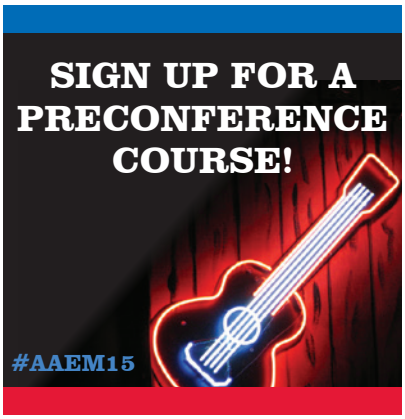
Continued on next page

The OMC's Take on CMGs: A Preconference Course

Joseph Guarisco, MD FAAEM
Chair, Operations Management Committee

We all know there is fierce debate regarding contract management groups (CMGs) in emergency medicine. At the American College of Emergency Physicians' scientific assembly in Chicago last October, the message spoken out loud or whispered everywhere was that soon we will **all** be working for a CMG — so get over it! That started me thinking about size in emergency medicine groups and the various ways emergency physician employment can be structured.

Maybe size and even corporate structure aren't the essential issues. What matters is whether or not emergency physicians are treated fairly and whether or not the business operations of the practice are transparent. It is possible that a small, privately owned and managed group may not treat its physicians in a fair and transparent way — any more than a typical, large, publicly traded CMG. On the other hand, can a corporate CMG provide for fairness and transparency in the same way as a small, independent, democratic group? Possibly.



The Cleveland Clinic has announced that it is creating an Emergency Service Institute and terminating its contract with a large, publicly traded CMG. It is bringing those emergency physician practices in-house. The Cleveland Clinic is a very smart organization, and thinks this move will provide greater standardization of practice and alignment with its organizational goals, culture, and mission. The Cleveland Clinic is headed in a new direction that, in a sense, will make it a CMG — and I'm certain it will deliver fairness in the workplace and fair, market-driven compensation for its physicians — with all the benefits and protections that employment rules and regulations afford. This is happening because that organization feels it can better guarantee cultural alignment if physicians look to Cleveland rather than Wall Street for guidance.

There are deliverables on both sides of the relationship: from the contract owner to physicians in terms of fairness and transparency, and from physicians to the contract owner/manager in terms of alignment and mission — and there are no guarantees in either direction. The point is that there is a dance between hospitals (or hospital systems) and the physicians who staff and manage their emergency departments. That relationship is complex and uncertain. There are economic and operational drivers that determine the outcomes of these relationships. Economic drivers may not always win. Operational excellence, as defined by culture and mission in the framework of quality and organizational alignment, may sometimes win out.

The real question then, is "can one identify and define a best practice in group structure that delivers fairness in the workplace, transparency in the group's business operations, and operational excellence in terms of how the practice performs and delivers on multiple aspects of patient care and organizational success?"

There is a revenue cycle best practice that delivers maximum operating margins. That revenue cycle best practice has specific elements that can be defined and emulated. Can anyone (or everyone) achieve that? The profit margin has to cover the risk and operating expenses of the contract holder, be it a democratic group or a large corporation. What happens to that revenue is what fuels the debate in emergency medicine — is it allocated to Wall Street or to subsidize other hospital-based physicians (such as hospitalists or anesthesiologists), or is it returned to the emergency physicians who generated it?

Operational best practice also has specific elements that can be defined and emulated, in terms of patient care quality, throughput efficiency, etc. Emergency medicine financial and operational best practices are certainly not owned by CMGs. All else being equal, does scale give CMGs an advantage? Things like benchmarking data, IT provider support, CME, and leadership development **may** come easier to large CMGs than small independent groups. Could there be a potentially disruptive hybrid approach that provides economies of scale **and** delivers on the ethical, cultural, and mission-oriented elements that define emergency medicine practice?

On February 28 and March 1, the Operations Management Committee is hosting a pre-conference at the AAEM Scientific Assembly in Austin. Among other things, we will discuss most or all of the issues I mentioned above. And yes, the Operations Management Committee should be and is focused on ED operations, but it is our hope that this pre-conference can tease out those operational best practices that give a competitive advantage to any group trying to keep its contract. This requires touching on business operations too. Maintaining a contract involves performance in many areas, including economics, operations, patient care quality, risk management, etc. The pre-conference will present case studies from both struggling emergency medicine groups and successful emergency medicine groups, and will present insights from executives of traditional CMGs as well as small, democratic, hybrid contract management groups. The Operations Management Committee will also present insights from executives of hospital systems struggling with the decision to outsource emergency physician services. Are the drivers of these decisions economic in nature or — as we are hearing from the Cleveland Clinic — more about culture, mission, and organizational alignment?

Below is the pre-conference schedule, subject to possible minor changes. I hope to see you there.

Continued on next page

Course Schedule

Saturday, February 28, 2015, 1:00pm-5:00pm — Part 1

1:00–1:15pm	**Introductions** *Joe Guarisco, MD FAAEM FACEP* *Chair, AAEM Operations Management Committee* *Ochsner Health System, New Orleans, LA*
1:15–1:45pm	**Framing the CMG Issue and the Opportunity for EM** *William Durkin, MD MBA FAAEM* *AAEM Past President*
1:45–2:30pm	**Profile of a Democratic Group at Risk: What Can We Learn?** *Bob Frolichstein, MD FAAEM* *President, Greater San Antonio Emergency Physicians (GSEP)*
2:30–2:45pm	**Analysis and Deconstruction**
2:45–3:30pm	**What Does the Executive Team Value in an ED: The CEO Perspective** *Kevin Spiegel, MBA FACHE* *President and CEO, Erlanger Health System* *Chattanooga, TN*
3:30–3:45pm	**Workshop Discussion**
3:45–4:00pm	**Break**
4:00–4:45pm	**Democratic Emergency Physician Groups: A Natural History of Competition** *Wes Curry, MD FAAEM FACEP* *President and CEO, CEP America*
4:45–5:00pm	**Workshop Discussion and Wrap**

Sunday, March 1, 2015, 8:00am-12:00pm — Part 2

8:00–8:15am	**Day 1 Review** *Joe Guarisco, MD FAAEM FACEP* *Chair, AAEM Operations Management Committee* *Ochsner Health System, New Orleans, LA*
8:15–9:00am	**What One Company is Doing to Save Independent Democratic Groups** *Scott Dillon, MBA* *Managing Partner, Hospital Physician Advisors LLC*
9:00–9:15am	**Workshop Discussion**
9:15–9:45am	**What's Right with these EDs: Profile of a Sustainable Democratic Group** *Bret Nicks, MD MHA FAAEM* *Chief Medical Officer, Wake Forest Baptist Health System*
9:45–10:00am	**Workshop Discussion**
10:00–10:15am	**Break**
10:15–11:00am	**Operational Excellence: Translating What We Have Learned** *Joe Twanmoh, MD MBA FAAEM* *University of Maryland, Baltimore, MD*
11:15–11:45am	**Workshop Discussion** *Speaker Panel*
11:45–12:00pm	**Closing Comments: The AAEM Perspective … What Now?** *Mark Reiter, MD MBA FAAEM* *AAEM President* ■

Should You Establish an Emergency Fund?

Joel M. Schofer, MD MBA CPE FAAEM
AAEM Secretary-Treasurer
Commander, U.S. Navy Medical Corps

The last two columns discussed insurance. After you set up your insurance portfolio, next on the list is to establish your emergency fund or cushion. Nothing is ever straightforward in the world of finance, and even something as bread-and-butter as an emergency fund can be controversial. Below are the aggressive and conservative approaches to establishing an emergency fund.

The Conservative Approach

Bad things happen to good people. Houses burn down or flood. Large medical bills come out of nowhere. Cars get totaled. Emergency physicians get fired. You need to prepare for these unanticipated events by keeping three to six months of living expenses in conservative investments that you can access in an emergency.

There are many places you can park your emergency cushion. Savings or checking accounts are Federal Deposit Insurance Corporation (FDIC) insured and offer immediate access to your money, even via ATMs. The downside is that the historic yield on these investments usually does not keep up with inflation, so you lose purchasing power over the long haul. Money market mutual funds are the most recommended place to park your emergency reserves, as they offer higher returns and allow you to write checks above certain amounts (commonly $250 or $500), giving you immediate access to the funds when you need them. Unfortunately, the yields on money funds are at historical lows — far below their approximately 3% historical average return, which would normally keep pace with inflation. Keeping emergency money in certificates of deposit is probably not a great idea, as you'll pay a penalty if you access the money early.

Not all savings accounts or money funds are the same, and if you shop around you can find a better deal. For accounts offered by banks, check bankrate.com. As I write this, the yield on savings and money market accounts ranges from 0.05% to 1.01%. For money market mutual funds, which are not FDIC insured but are almost as safe, check mutual fund companies. Commonly recommended company websites include fidelity.com, schwab.com, tiaa-cref.com, troweprice.com, or vanguard.com (my favorite). Important things to look for are the minimum initial investment, the smallest amount you can write a check for, and the expense ratio (the lower the better). If you find yourself in a higher tax bracket, usually 33% or higher, it may make sense to use a tax-exempt money market fund that invests in tax-free state and municipal bonds. These tax-exempt funds may offer a higher after-tax return, and some are targeted to the residents of particular states and thus offer state tax benefits as well. The mutual fund companies can usually help you decide which of their products is best for you.

The Aggressive Approach

The aggressive approach is to keep a smaller amount in reserve, one to three months of living expenses for example, and invest it more aggressively. You could keep one third of it in a money market fund, for example, with the other two thirds in a stock or bond fund or some combination of the two that will yield a higher return. This will allow your emergency fund to grow as your income grows, possibly reaching the recommended six months of living expenses or more. If you someday need more cash than is available in your emergency fund, a physician can usually borrow money using a home equity loan, for example, or a credit card. Obviously credit cards have a higher interest rate, but this is an aggressive approach and you probably won't have to borrow any money at all.

What Should You Actually Do?

Only you can decide what is right for you. For example, I'm in the Navy, have full medical insurance for my whole family through Tricare, and have as much job security as any emergency physician can have. I'm not getting fired — or at least I don't think I am. As a result, my emergency fund usually resides on the low end of the three to six month range, because there are very few emergencies I might have to deal with. On the other hand, if I worked as an independent contractor, provided my own health insurance, and felt that my contract could be reduced or eliminated at any time, I'd probably have six months of living expenses (and maybe more) providing a more substantial cushion.

Whether you take a conservative or aggressive approach or somewhere in between, what is clear beyond a doubt is that you and your significant others need to come up with a plan for emergencies that makes sense for you and allows you to sleep at night. If you are at risk of getting fired, and sadly most emergency physicians are, you need to keep enough of a reserve on hand to cover your expenses while you secure other employment.

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

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

Dear AAEM Member,

Enclosed are the candidate statements for the 2015 AAEM board of directors election.

As you are aware, the call for nominations was sent to all voting members. Those AAEM members who appear on the enclosed ballot have indicated their willingness to serve on the AAEM board.

Statements from each of the candidates and AAEM activities dating back five years are on the following pages. Please review the enclosed information, then exercise your democratic right to vote for the representatives you would like to see serve as AAEM's leaders. Remember, we have a one member, one vote system, so your voice counts. Please follow these instructions for casting your ballot in the 2015 election.

If You Will Attend the Scientific Assembly:

- ***We recommend that you do not complete your official ballot at this time.*** There will be a Candidates' Forum held during the Scientific Assembly on March 1, 2015, 2:00-3:30pm where you can hear the candidates respond to direct questions from the voting membership. You will be asked to submit your ballot at the conclusion of that Forum.
- ***If certain of your choices or unsure if you will attend the Forum,*** you may vote online at www.aaem.org/elections. Voting will remain open until March 1, 2015 at 11:59pm CT.

If You Are Unable to Attend the Scientific Assembly:

- You may complete your official ballot online at www.aaem.org/elections. Online voting will remain open until March 1, 2015, at 11:59pm CT. Mailed ballots must be received by February 24, 2015.

Balloting Procedure for 2015:

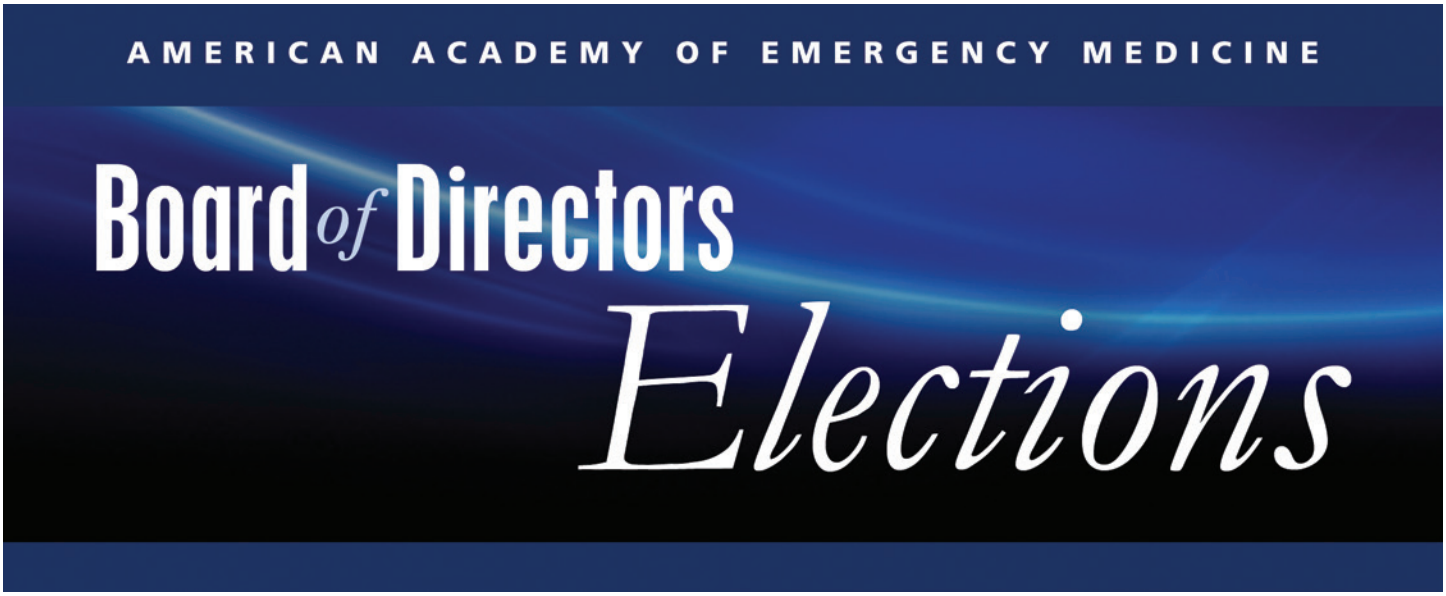
- ***Voting ballots will be available online only prior to Scientific Assembly.***
  Please visit www.aaem.org/elections to cast your vote electronically or download a paper ballot. You may submit ballots by mail to AAEM Elections, 555 E. Wells St., Suite 1100, Milwaukee, WI, 53202. *Please note that the paper ballot will supersede all online voting ballot submissions and all previously submitted ballots will be discarded.*
- ***Voting onsite at Scientific Assembly will occur by paper ballot.*** As in previous years, paper ballots will be distributed at the Candidates' Forum during the Annual Business Meeting to members who have not already cast their vote. Paper ballots will also be available at the registration desk throughout the conference. Online voting will remain open until 11:59pm CT on 3/1/15.

Thank you for your continued support of AAEM. Please call 800-884-2236 with any questions you may have regarding the election procedure.

Sincerely,

Kay Whalen

Kay Whalen
Executive Director



Candidate Platform Statements

AAEM does not endorse any statement made by candidates and specifically rejects anticompetitive statements.

The nomination period for AAEM's upcoming elections has ended. All individuals running for an open seat on the board of directors have been identified, and the race has begun. Presented here for the benefit of all AAEM full voting, emeritus, and Young Physician Section (YPS) members of AAEM are the formal platform statements of each of the candidates.

The elections will be held immediately following the Candidates' Forum scheduled during AAEM's 21st Annual Scientific Assembly, February 28 – March 4, 2015, at the Hilton Austin, Austin, TX. Although balloting arrangements will be made available for those unable to attend the Assembly, all voting members are encouraged to hold their ballots until the time of the meeting. The Forum will allow members the opportunity to question candidates directly about their vision of the association and its place in the specialty of emergency medicine. The responses offered in this session, in addition to the platform statements offered here, will provide members with the information they need to make intelligent and informed decisions.

AAEM's democratic election process is just one of the many things that make our organization unique among medical specialty societies. Please carefully review the information presented here, and make your arrangements to join us in Austin for the Forum and final elections.

Full voting, emeritus, and YPS members not planning to attend the Scientific Assembly should vote online or submit a paper ballot. Online voting and paper ballots are available at www.aaem.org/elections. Online voting closes at 11:59pm CT on March 1, 2015. Paper ballots should be returned to the AAEM office by February 24, 2015. Those attending the Austin conference are encouraged to hold their votes until the Candidates' Forum to be held on Sunday, March 1, 2015 from 2:00 to 3:30pm. ■

Online Voting Procedure

AAEM is offering online voting prior to Scientific Assembly for those members who are unable to attend the meeting or wish to vote in advance. Paper ballots will still be available for members to print and mail if they prefer. Please visit www.aaem.org/elections to access the online ballot or to print your personalized paper ballot.

For members who will be attending the Scientific Assembly, please review the candidate statements printed here and join us at the Candidates' Forum to be held on Sunday, March 1, 2015 from 2:00 to 3:30pm. Paper ballots will be distributed onsite for members who have not previously voted online. ■

AAEM-1114-231

David Farcy, MD FAAEM FCCM

Candidate for At-Large Director

Nominated by: Mark Reiter, MD MBA FAAEM and Mark Foppe, DO FAAEM

Membership: 2002-2015
Disclosure: McGraw Hill, Royalty

Florida State Chapter Board of Directors 2010-2011
Florida State Chapter President 2011-2014
Florida State Chapter Immediate Past President 2014-2015
Florida State Chapter Scientific Assembly Speaker 2011, 2013, 2014
Oral Board Review Course Examiner 2013
Scientific Assembly Speaker 2013, 2014
Delaware Valley State Chapter Resident's Day Speaker 2013
State Chapter Committee 2011-2014
AAEM Podcast Contributor 2012-2014

Dear Members,

It is an honor to be nominated for Board of the American Academy of Emergency Medicine. I have been a member of AAEM since residency and have always sought to serve this organization on the state and national level.

My background is that I was born and raised in France and moved to the US in 1987. After high school I joined the US Air Force and served as a medic; this is where my interest in emergency medicine began.

After my military commitment I graduated from Texas Tech.

My father (an orthopedic surgeon) recommended applying to Guadalajara's medical school as I would get more hands on experience. This was the best advice he had ever given me.

I completed an emergency medicine residency at Maimonides training under Dr. Davidson. While in residency I was enlightened by the lectures given by Dr. McNamara and Dr. Keaney about issues in EM. I saw the importance of the mission statement of AAEM and decided it was the only logical choice as the EM organization to join. AAEM was the only organization advocating for due process and the negative impact CMGs have on our profession.

As a resident member I joined the critical care committee and became the resident member for that section. My love for critical care drove me to complete an emergency medicine critical care fellowship at Baltimore Shock Trauma.

My first job was in Florida at Mt. Sinai Medical Center in Miami Beach and I immediately became active in the Florida Chapter of AAEM eventually serving on the FLAAEM Board and currently hold the position of Immediate Past President. During my tenure as FLAAEM President I developed the FLAAEM Scientific Assembly, and we are currently planning our 4th meeting. For AAEM I did one of the critical care podcast, which has had almost 1,200 downloads to date.

At Mt. Sinai Medical Center I hold the positions of: Chairman Department of Emergency Medicine, Director of Emergency Medicine Critical Care, Medical Director of the Surgical Intensivist. Although, I work in an academic setting, it is my desire to be a voice for the "pit docs." I have been dedicated to this organization since the beginning of my career and want nothing but the opportunity to continue to serve AAEM and our members. ■

Joseph Guarisco, MD FAAEM

Candidate for At-Large Director

Nominated by: Mark Reiter, MD MBA FAAEM and William T. Durkin, Jr., MD MBA CPE FAAEM

Membership: 1994, 2012-2015
Disclosure: Nothing to disclose at this time.

Operations Management Committee, Chair 2012-2014
Scientific Assembly Speaker 2013, 2014
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2013
AAEM Podcast Contributor 2013, 2014
Common Sense Author 2012-2014

I am honored to have been nominated for a seat on AAEM's Board of Directors. I was there in the beginning when AAEM was formed and I am here today ready to continue that agenda created on AAEM's founding principles and philosophies. The issues that created the framework for this organization are as relevant as ever.

To lead AAEM, one has to have a small bit of rebel in their makeup. Most of us in Emergency Medicine have that in our DNA, but that quality alone is not enough to generate success. Let me articulate why and how I can help by representing you as a board member.

1. I have 30 years' practice in emergency medicine. I know things.
2. I have experience in project management. I do things.
3. Leading an organization takes commitment. I have the time to get things done.
4. I work in an academic, physician led organization that supports physician governance and the importance of physician engagement, leadership and importantly practice ownership.
5. I am actively engaged, on a daily basis, on the issues that are at the forefront of AAEM's agenda.

As Chair of AAEM's Operations Management Committee for the last 2 years, we have produced 8 podcasts on a variety of topics, 8 articles in *Common Sense* and 2 pre-conference workshops for AAEM's Scientific Assembly. We are currently working on our third pre-conference focused on learning why some groups succeed and some don't and what creates success and risk in building sustainable independent democratic practices. Additionally in 2013 and 2014, I represented AAEM in Marseille, France and Hamburg, Germany at EuSEM, the European Society for Emergency Medicine, presenting on operations management issues related to capacity and throughput.

Over the years, I have led our emergency department to a number of achievements such as Ochsner Health System's Department of the Year, Press Ganey's National Success Story, and City of New Orleans Innovator of the Year twice to name a few. I take pride in what I do and am proud to be part of AAEM and have the opportunity to continue my efforts to make things better for our patients and for your practice.

Importantly, I have been Chair of Ochsner Health Systems compensation committee for the past 7 years working to create fair value to our physicians in all specialties in our organization and we all know how important this issue of fairness in the workforce is to AAEM.

Give me a chance to use my experience, my passion, my appreciation of the work that we as emergency physicians do, and my ability to execute on AAEM's agenda to create value for us and all of emergency medicine. ■

Joseph R. Lex, MD MAAEM FAAEM

Candidate for At-Large Director

Nominated by: Self Nomination

Membership: 1994-2014
Disclosure: Nothing to disclose at this time.

ACCME Subcommittee 2010-2014
Education Committee, 2010-2014
International Committee 2010-2014
Scientific Assembly Speaker 2011-2014
Delaware Valley State Chapter Division Resident's Day Speaker 2013
Developing EM Conference Speaker 2013
Inter-American Emergency Medicine Congress (IAEMC) Speaker 2012, 2014
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011

I am a founding member of the Academy, originator of the Written Board Review Course and the Oral Board Review Course, past-chair of the Education Committee (2001-2006), and current chair of the Scientific Assembly Subcommittee. I introduced many innovations to emergency medical education in general, including Open Mic sessions and most recently, Pecha Kucha sessions. In many countries — Poland, Argentina, Viet Nam, Turkey — I am the international face and voice of AAEM. I serve on committees of the International Federation for Emergency Medicine (IFEM) representing AAEM. My website www.FreeEmergencyTalks.net has for many years featured recordings from our annual Scientific Assemblies, giving AAEM worldwide exposure. Because of this I am considered the "godfather" of the Free Open Access Medical Education movement, aka FOAMed.

A core issue for a professional society is education of its members; I have the track record to further the best interests of members in the educational and international arena.

I think AAEM took a giant step backwards in the 2014 Scientific Assembly by hiring a commercial company to duplicate what EMedHome.com had been doing for years — record select tracks and post for CME credits. EMedHome had repeatedly offered these recordings free of charge to AAEM, but we never accepted. EMedHome also made the lectures available at no charge exclusively to AAEM Resident Members. Rather than engage EMedHome in discussions about what would further AAEM's goals, the board hired an independent firm to make duplicate recordings at a cost of many thousands of dollars. AAEM then put these recordings behind a paywall to all but members — the antithesis of the burgeoning FOAMed movement. I certainly understand the concept that these could possibly make the organization some money, but it would have been wise to talk to people who had this discussion more than decade ago and concluded there was no way to turn profit on such a project. We spent a lot of money needlessly wh ile giving no additional benefit to our members.

In 2001 AAEM partnered with the European Society of Emergency Medicine (EuSEM) for the Mediterranean Emergency Medicine Conference, which evolved into a world-class event. But after MEMC-VII in Marseilles in 2013, the EuSEM notified AAEM that they no longer required our services and would be the sole sponsors of future meetings. While painful to accept, it was not entirely unexpected. In 2001 we filled a much-needed gap in international emergency education: this gap no longer exists. AAEM's decision to have an independent Mediterranean meeting in Rome, Italy, during September 2015 has caused many in the international EM community to see AAEM in a less favorable light, as it will be in direct competition with EuSEM's next meeting in Turin, Italy, also in September.

AAEM would have been less likely to make these decisions had someone with my two decades of knowledge and expertise been available to discuss them. I run in order to represent our members' best interests in future decisions on education, and to represent AAEM in international decisions. ■

Lisa Moreno-Walton, MD MSCR FAAEM

Candidate for At-Large Director

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM; Gary Gaddis, MD PhD FAAEM; and Mark Reiter, MD MBA FAAEM

Membership: 2001-2014
Disclosure: Gilead Sciences, Inc., Primary Investigator, Grant Funding

ABEM Certification White Paper Task Force 2010-2011
Academic Affairs Committee 2010-2014
Education Committee 2010-2014
Learning Management System Task Force 2014
Scientific Assembly Subcommittee 2014
Women in Emergency Medicine Task Force 2014
Oral Board Review Course Examiner 2011
Scientific Assembly Speaker 2010, 2011, 2012, 2014
Scientific Assembly Abstract Judge 2012, 2014
Scientific Assembly Open Mic Judge 2014
Scientific Assembly Clinical Case Competition Judge 2014
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011, 2013
Mediterranean Emergency Medicine Congress (MEMC) Oral Abstract Moderator 2011
Pan-Pacific Emergency Medicine Congress (PEMC) Speaker 2012

When I decided to change my specialty from Surgery to Emergency Medicine, I never imagined that it was possible to ethically or responsibly practice another specialty without residency training. When I learned that some physicians did this, and encouraged me to do the same, I was shocked that any physician would risk her patients' wellbeing by practicing a specialty in which she had not been trained. Early in my EM residency, Dr. McNamara was invited to our didactic conference to speak about AAEM, and I learned that others shared my convictions about EM board certification and the imperative that doctors control the practice of medicine. Since that time, I have been a proud member and have served AAEM on the Academic Affairs Committee (2009-present), ABEM Certification White Paper Task Force (2009-2011), Education Committee (2010-present), Scientific Assembly Planning Subcommittee (2014), Content Management Task Force (2014, chair) and Women in EM Task Force (2014). Each year, I serve as judge for all or some of the Photo Competition, JEM Resident Research Competition, and Clinical Case Competition. I am an active reviewer for AAEM's official journal, the *Journal of Emergency Medicine*, and have served as a track chair and session moderator for several of AAEM's satellite conferences over the years (MEMC, Pan Pacific EM). I have taught six sessions of the Pearls of Wisdom Oral Board Review Course. I am an active member of the Louisiana Chapter, have been active in resurrecting the Chapter after the year that it was defunct, and now serve on the Chapter Board.

At Louisiana State University Health Sciences Center-New Orleans, I am Professor of Clinical Emergency Medicine and serve as Director of Research, Director of Diversity, and Director of HIV Testing. In addition to the clinical practice of EM, which I continue to find exhilarating and intellectually stimulating, I am a well-funded researcher and an award winning educator. Last year, I received the Marcus Martin Leadership Award "in recognition of significant and sustained contributions to SAEM's mission to attain diversity within EM through education and research". This year, I received the Alpha Omega Alpha Professionalism Award in recognition of my advocacy for the LGBT patient community. These awards reflect my unwavering commitment to the right of every patient visiting any ED anywhere to receive the highest level of care by a board eligible emergency physician, regardless of race, ethnicity, religion, gender, sexual orientation, disability or age.

AAEM has always had a policy of inclusion, but at times has lacked an active outreach to women and racial/ethnic minorities. My recognized expertise on diversity and cultural competency, coupled with my service to AAEM, CORD, SAEM, National Hispanic Medical Association, National Medical Association, International Federation of Emergency Medicine, AWAEM, and Academy of Diversity and Inclusion in EM (founder) give me a distinct advantage in furthering AAEM's mission of inclusion. I plan to bring the benefits of AAEM membership to the larger EM community, uphold our practice philosophy, and serve our current members with passion, dedication, excellence and pride. ■

Terrence Mulligan, DO MPH FAAEM FIFEM

Candidate for At-Large Director

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM; Amin Antoine Kazzi, MD MAAEM FAAEM; and Mark Reiter, MD MBA FAAEM

Membership: 2009-2015
Disclosure: Nothing to disclose at this time.

International Committee Co-Chair 2012-2014
Scientific Assembly International Track Chair 2013, 2014
Government and National Affairs Committee 2014
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011
Mediterranean Emergency Medicine Congress (MEMC) VIII Co-Organizer
Inter-American Emergency Medicine Congress (IAEMC) Speaker, Moderator, Preconference Course Director 2010, 2012, 2014
Pan-Pacific Emergency Medicine Congress (PEMC) Speaker 2014

I am pleased and honored to have been nominated for the position of At-Large Board Member of the American Academy of Emergency Medicine. I've been a member of AAEM for over 10 years, and have been very active in AAEM's international programs for 10 years or more. I'm currently the chair of the AAEM International Medicine Committee, where I also served as co-chair from 2012-2014, and committee member since 2006.

AAEM holds a crucial position in the field of global emergency medicine development, and can make tremendous contributions to developing EM systems around the world. Many EM systems, EM societies, universities and national governments are looking to established EM systems and EM societies for collaboration, cooperation and assistance with building their own national and regional EM systems.

AAEM holds within its membership tremendous institutional wisdom and experience in EM education, and in creating, building and strengthening EM systems.

I welcome the opportunity to continue to serve AAEM and its membership, and to foster and encourage AAEM's continued and growing collaborations in global emergency medicine development.

I completed two residencies (EM in 2001 and osteopathic manipulative medicine in 2002), three Fellowships (International EM in 2003, Health Policy in 2006, and EM Administration & Management in 2008), and two Masters degrees (MPH in 2003, Masters in Health Economics, Policy and Law pending).

I am double-board certified in Emergency Medicine and in Osteopathic Manipulative Medicine. I am a Clinical Associate Professor at the University of Maryland School of Medicine, and am Director of the International EM program. From 2006-2010, I lived and worked in The Netherlands, directing two emergency departments and EM residencies, two of the first EM programs in that country. I' m also a Visiting Assistant Professor at Stellenbosch University in Cape Town, South Africa.

Since 2012, I've served on the Board of the International Federation for Emergency Medicine (IFEM), representing AAEM, ACEP, SAEM, ACOEP and CAEP in Canada. I am a co-founder and Board member of the African Federation for Emergency Medicine (AFEM), a Board member of the Global Academy for EM (GAEM) and the American Academy of EM for India (AAEMI). I am a past Chairman of the ACEP Section for International EM, a past chairman of the ACOEP International EM Committee, a member of the SAEM Global EM Academy, and the co-founder of the International EM Fellowship Consortium. I am an Associate Editor and co-founder of the peer-reviewed journal, The African Journal of Emergency Medicine, and an executive editor of Emergency Physicians International magazine. I've initiated and participated in emergency medicine and acute care system development programs in over three dozen countries. I've established EM residencies, national and international EM societies and federations, Fellowships in EM and EM subspecialties, schools for emergency nursing, training schools for paramedics, relief agencies for underserved areas, disaster medicine and disaster preparation, hospital disaster preparedness and hospital trauma system development all around the world. I've delivered over 400 lectures, symposia and educational programs nationally and internationally for over twenty local, national and international EM organizations. ■

Robert Suter, DO MHA FAAEM

Candidate for At-Large Director

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM; Antoine Amin Kazzi, MD MAAEM FAAEM; and Mark Reiter, MD MBA FAAEM

Membership: 2010-2015
Employment: University of Texas Southwestern and American Heart Association
Disclosure: Service to other organizations, American College of Emergency Physicans and American College of Osteopathic Emergency Physicians Board of Directors

AAEM Board of Directors 2011-2015
AAEM Foundation Board of Directors 2011-2015
Emergency Medical Services Committee 2012
International Committee 2013-2014
Inter-American Emergency Medicine Congress (IAEMC) Speaker 2010, 2012
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011

Four years ago I ran for the AAEM Board of Directors reminding you of two things of which I will always be proud.

The first was in 1992, when an executive MBA mini-residency leading to ABEM eligibility for non-residency trained doctors was proposed. As EMRA President, I attacked the plan and persuaded its abandonment. Seven years later, as a new ACEP Board member, I successfully added "All physicians entering the practice of emergency medicine are residency trained in emergency medicine" to the ACEP Values, placing ACEP in opposition to others entering our specialty.

The second was in 2001, as one of ten medical directors sued by a CMG owner for 20 million dollars. Why? For supporting doctors who merely wanted to discuss a long term buyout based on his retirement schedule. Others folded under pressure, signing draconian non-competes to save their jobs. The owner and his non-physician partners openly bragged they would "spend (me) under the table and break (me)."Three years and $300,000 dollars in legal expenses later, I won the case on all counts. The lawsuit and resulting disclosures forced the sale of the CMG to the doctors, creating one of the largest democratic groups in Texas.

During my past four years on the AAEM Board we have continued our unflinching dedication to the primacy of EM residency training/board certification and practice fairness, transparency and due process. I believe these two values are shared by all AAEM members, and that they define our members as the elite physicians in our specialty dedicated to the highest ethical standards.

Why did you originally elect me, a past leader in other organizations, to serve on the AAEM Board? I believe you wanted an experienced, seasoned leader who could offer insights and knowledge to help AAEM effectively focus on our shared core values. I have humbly tried to live up to your confidence.

During the past four years I have attended all meetings, staffed committees, done residency visits, and worked on major projects, most recently planning the continuation of the Mediterranean EM Conference in Rome in September. My support for fellow Board members, our Officers, and our staff has been strong and mutual, as they have embraced the value that I bring to AAEM, and the sincerity with which I serve you.

Four years ago I offered my services to AAEM and you took a chance on me. Now, I am an experienced AAEM leader with the potential to serve one more term to accomplish even more going forward. You have invested four years to make me a better AAEM Board Member- vote for me to make me pay it back to you.

"Actions speak louder than words." Review my track record both before and after my election to the AAEM board and you will find that over the past 25 plus years no candidate has shown a greater level of passion and dedication to the core values that led to the creation of AAEM. Thank you for your support. ■

David Tanen, MD FAAEM

Candidate for At-Large Director

Nominated by: Joel Schofer, MD MBA CPE FAAEM
Membership: 2008-2015

Disclosure: Nothing to disclose at this time.

Uniformed Services Chapter Division President 2011-2013
Uniformed Services Chapter Division Immediate Past President 2014-2015
State Chapter Committee 2011-2014
Residency Program Directors Committee 2010
Toxicology Handbook Chapter Author 2010
Scientific Assembly Speaker 2012, 2013, 2014
Scientific Assembly Preconference Course Speaker 2010

As an Emergency Medicine educator for the past 14 years, I joined AAEM because I was attracted by their vision and accomplishments in the promotion and safeguarding of our specialty. With my background of having served in the Navy for over 21 years as an Emergency Physician and residency Program Director, I believe that I can bring a unique perspective on the rendering of emergency medical care, both in the battlefield and at our large tertiary care military hospitals. In addition to my military experience, since retiring from active duty two years ago, I transitioned to caring for the underserved at Harbor-UCLA, a large teaching county hospital where I am currently serving as an associate Program Director. As a subspecialist in Medical Toxicology, I have also been engaged in basic and clinical research and have been active in the American College of Medical Toxicology. I feel this experience can help bridge the two communities and may lead to opportunities of cooperation in the future. As a member of AAEM, I have served for the past two years as the President of the Uniformed Services section and am currently the Immediate Past President. I have also led and lectured at the successful USAAEM pre-conferences to the annual meeting, and coauthored chapters in AAEM's Toxicology Handbook and Emergency Medicine, A Focused Review of the Core Curriculum. I look forward to the opportunity to serve as a representative to the Board of Directors and hope to help guide the future of our specialty. ■

Leslie Zun, MD MBA FAAEM

Candidate for At-Large Director

Nominated by William T. Durkin, Jr., MD MBA CPE FAAEM and Mark Reiter, MD MBA FAAEM

Membership: 1993-2015
Disclosure: Service to other organizations, American Association for Emergency Psychiatry, President Elect; Teva Pharmaceuticals, Honorarium; Alexza Pharmaceuticals, Honorarium

AAEM Board of Directors 2011-2015
AAEM Foundation Board of Directors 2011-2015
AAEM/RSA Board Liaison 2012-2013
AAEM David K. Wagner Award 2011
Academic Affairs Committee 2010-2013
ACCME Subcommittee 2014
Education Committee 2011-2014
Finance Committee 2012-2014
Operations Management Committee 2010-2014
Practice Management Committee 2010-2014
AAEM Scientific Assembly Speaker 2011-2014
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011, 2013
Pan-Pacific Emergency Medicine Congress (PEMC) Speaker 2012
Inter-American Emergency Medicine Congress (IAEMC) Speaker 2014
Common Sense Author 2011, 2014

I am running for the at large position of AAEM to ensure we get out fair share. As healthcare continues to change and evolve, emergency physicians need AAEM more than ever to advocate for a fair and equitable workplace.

The ACO enrollment has pressured the marketplace to encourage physicians and hospitals to work closer together than they had ever done before. For some, this is an opportunity to collaborate to increase patient numbers and reduce costs. For others, it has provided an opportunity to squeeze out the independent democratic emergency medicine groups and enhance the role of contract management companies. AAEM has done a lot to fight back against the forces that view profits over quality. We must continue this fight.

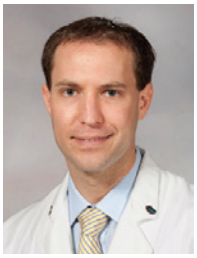
For those that do not know me, I attended the first organizing meeting of emergency physicians frustrated with their current specialty organization and have continued my involvement in AAEM since. I am a four term board member and have contributed to many of our position statements. I have given

lectures at our Scientific Assembly, Mediterrean Emergency Medicine Conference and Pacific Emergency Medicine Conference. I have been given the highest honor from AAEM, the David Wagner Award, for Service to Emergency Medicine in 2011.

I am residency trained in emergency medicine at the University of Illinois and went on to obtain a management degree from Northwestern University. Shortly thereafter, I was the interim chief executive officer for a 200 bed hospital in inner city Chicago. This was a great experience to learn how to work with administrators, nurses and physicians to turnaround a struggling institution. Currently, I am professor and chair of the Department of Emergency Medicine at Chicago Medical School, core faculty for the University of Chicago's Program in Emergency Medicine and chair the Department of Emergency Medicine in the Sinai Health System in Chicago.

Over the past few years, as a board member of AAEM, I have served on the education, finance, AAEM/RSA, scientific assembly, practice management and operations committee. I served the members by starting and enhancing liaison activities with a number of related institutions including the Canadian Association of Emergency Physicians, American Board of Osteopathic Emergency Medicine, American College of Physician Executives, Society for Emergency Medicine Physician Assistants and American Association of Nurse Practitioners. This has been our best means to get out there as the "go to" specialty organization. To promote our organization, I have also spoken as a board member to a number of residency programs and student meetings. We developed a consulting resource to enable hospital administrators to build an independent group and to assist physicians in obtaining hospital contracts. We have exhibited at the American Hospital Association and American College of Healthcare Executives. With my encouragement, AAEM joined the National Quality Forum, the organization that reviews measures prior to approval by the Centers for Medicaid and Medicare Services.

AAEM must continue to push for the rights of the practicing emergency physicians. I look forward to serving the membership in this role. ■



Jonathan S. Jones, MD FAAEM

Candidate for YPS Director

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM and Michael Ybarra, MD FAAEM

Membership: 2009-2014
Disclosure: Service to other organizations, Mississippi Chapter American College of Emergency Physicians, Past President

Education Committee 2014
Oral Board Review Course Examiner 2011-2014
YPS Board of Directors 2013-2014
YPS Vice President 2014-2015
YPS Mentoring Program 2012-2014
Common Sense Assistant Editor 2013-2014
Common Sense Author 2012-2014

First, thank you for being a member of the Academy. Second, thank you for participating in the election process.

I humbly ask for your vote to serve as the YPS Director. My desire to serve as the YPS Director stems from my admiration of and dedication to the Academy. AAEM's vision and mission statements are excellent and if you have not read them, please do. However, I truly think one simple sentence could describe them just as well, AAEM will always support what is best for the patient seeking emergency care and what is best for the specialist providing that care without regards to interests outside the physician-patient relationship.

As a proud member of the Academy, I desire to serve in order to help the Academy continue and expand its work. While membership is growing, too many physicians are not members, and most of these are even unsure why they should be members. Many of these physicians are young physicians or resident physicians. The future of any organization is in its new members. As YPS Director, I will work to increase young physician membership and involvement.

I have served on the AAEM-YPS Board of Directors for two years and currently serve as AAEM-YPS Vice-president. During this time, YPS membership has increased 14%; good but clearly we need to keep working.

Primary means of engaging membership are quality benefits and communication. With YPS, I've worked to increase and improve benefits including: Open Mic at Scientific Assembly, YPS Mentoring program, and CV review service. To improve communication, I've written several articles for *Common Sense* and have recently assumed the role of Assistant Editor for the publication. Additionally, I serve on the Education Committee.

I've worked with AAEM and YPS because I believe in it and love it. I do pretty much the same thing in my real job. As Residency Program Director at the University of Mississippi Medical Center, I strive to provide new graduates with the skills and knowledge they need to be excellent physicians. Excellent physicians need to possess great medical knowledge, be adept at clinical care, and communicate effectively. But this is not enough. They also need to know about the world outside their ED. They need to know about the external threats which they and their patients will face and they need to know how to deal with these. With AAEM's assistance, I believe I have prepared my residents to be truly excellent physicians. 100% of our residents are AAEM members, and with a little reallocation of funds, our entire PGY-2 class is now able to attend the AAEM Scientific Assembly.

I believe that my experience and involvement with residents, young physicians, AAEM, *Common Sense*, and the AAEM-YPS Board have prepared me to serve as the YPS Director. If you agree, then I ask for your vote. I am always happy to answer any questions, please just let me know. My email is jsjones3@umc.edu. My cell number is 601-421-1033. Thank you. ■

AAEM to the Rescue: A Success Story

Lee Williams, MD FAAEM

The Importance of Responding to Members and Having a Responsive Lobbyist

One of the many aspects of being President I enjoyed was the opportunity to help a member in need and truly make a difference. The case below is an example of such an opportunity. I received an email from Dr. Williams relating what was going on and asking for advice and assistance. After talking with him at length, it became clear that the Academy needed to become involved and that I had to do what I could to reverse what was happening.

*The Academy had recently hired a new lobbying firm, and I turned to Matt Hoekstra and Susan Hirschmann of Williams and Jensen and asked them to get me an appointment with the Congressman in the district where the hospital was located, so that I might discuss this with him and his senior staff. My main argument was that competent, ABEM-certified docs would be lost, possibly compromising care at a military medical facility. The new group was clearly not qualified to staff an ED — I researched them before the meeting. I did meet with the Congressman briefly but spent much more time with his senior staff, discussing the issue and my concern about the care that active duty troops, dependents, and retirees might be losing if Dr. Williams' ED group were replaced with the new CMG. Apparently my message got through and the Congressman actually kept his word! This success story is just one example of how Academy leaders go beyond their job descriptions to help members — **something no other emergency medicine organization would even consider.***

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

There are at least two models for the practice of emergency medicine: the business model wherein the emergency physician works as an employee or independent contractor for a contract management group (CMG) like Team Health or EmCare; and the model wherein the physician owns a stake in the group, participates in management decisions, and shares duties for scheduling, training, risk management, peer review, quality assurance, etc. Your destiny can either be controlled by someone else or you can maximize the return on your educational investment by owning your own practice, running your own group, and reaping the fruits of your own labor — enriching yourself by the sweat of your brow rather than corporate officers and shareholders. While AAEM believes that emergency physicians are usually better off if they own their practices through democratic groups — and patients are **always** better off when emergency physicians have complete clinical control of their practices — the Academy can sometimes also help its members who are caught **between** CMGs when an ED contract changes hands.

I work as a subcontractor for a CMG that holds the contract for ED services on an Army post. When the Army puts a contract up for bids, the request for proposals is typically layered with lots of social politics on top of the business requirements. The desire to further the civilian leadership's political agenda is a key element in the decision to award the contract. Minority-owned, small, disadvantaged businesses receive preference points in the selection process so they can compete with huge corporations.

After working for the Army through a staffing company I'll call CMG1 for three years, the contract was taken away from CMG1 and awarded to a supposedly small, disadvantaged, minority-owned company I'll call CMG2. What could be wrong with that? We're upholding the social contract and uplifting a small, disadvantaged business while we take care of America's soldiers — right?

CMG2 contacted everyone on staff to assure us that our jobs were safe under the new regime. We were thanked for our prior service under CMG1 and assured we could "be all you can be" while helping CMG2 "serve those who have served us." However, CMG2 offered to keep us on at a rate 25% less than CMG1 was paying. This was $10/hr less than the rate at which some of us were hired six years earlier, when ED volume was less than half its current level. This made us wonder who was behind CMG2 and what their background and qualifications in ED management were. The "new" group (us under a new CMG) was to begin staffing the ED four months after being awarded the contract. It was no surprise to us that the contract was awarded to the group making the lowest bid. What were they going to provide that CMG1 wasn't already providing? How would this change in management affect our practice?

While some in our group felt we should accept the terms of the new contract, most of us were not happy and were determined to have the contract award re-evaluated before CMG2 actually took over.

Two of us led this effort. We learned that CMG2 had never managed an ED. While the company had been awarded a previous ED contract at another military facility, it failed to perform on the contract and was unable to secure a single emergency physician to staff the ED! Despite that, CMG2 was not barred from pursuing further government contracts because it withdrew from the award before it could be formally held in default.

Continued on next page

We also learned that CMG2 was defined as a "small, disadvantaged company" in spite of the fact that, in the two years prior to being awarded the contract to staff our ED, it held government health care contracts for 56 and 59 million dollars — and had a total of $341,000,000 in revenue from 259 government contracts since the year 2000. CMG1 had a total of 81 contracts totaling $33,000,000 in revenue over its entire history of government contracting. Small and disadvantaged? Maybe at one time, but

> "This success story is just one example of how Academy leaders go beyond their job description to help members..."

the government's rules allowed CMG2 to carry that designation for nine years after it was assigned, giving CMG2 preference points in contract negotiations. It was still legally defined as a "small, disadvantaged" company. And there was no requirement for prior ED staffing experience! The company's prior experience was in providing PAs and nurse anesthetists to various facilities. The only physician the company had ever contracted with was a psychiatrist who resided in same area as CMG2's owner.

One of my colleagues wrote a variety of letters to the command structure, both within the hospital and at the regional level. His letters were ultimately answered with, "Thank you for your interest and service, but we must remind you that your letters could be interpreted as interfering with contract negotiations between the government and a supplier." As a subcontractor he was considered an "interested party." There was no frank statement that he was risking his job or legal action, but he was uninvited to offer any additional opinions.

I decided to write my Senators and Representatives, and a few other folks in Congress too: Senator Claire McCaskill, Chair of the Government Oversight Committee for Contracts; Senator Carl Levin, then Chair of the Armed Services Committee; and Representative Beto O'Rourke, the newly elected congressman from the district where my ED was located. I never heard from Levin at all. In response to a letter of inquiry from my Senator, John Cornyn, the Army's Regional Command stated that the CMG had been properly vetted and that all legal channels were followed. The Command stated there was no basis for concern and it hoped the physician(s) would understand its recommendation to proceed with the contract was to protect the best interests of the Army and serve the government of the United States of America.

I contacted Bill Durkin, then president of the American Academy of Emergency Medicine. Dr. Durkin listened to my story and then calmly replied that he was familiar with CMG2. He understood contract issues. He understood that military contracts were mixed with a political agenda. He also understood our concerns about the competence of CMG2. He saw the irrationality of replacing one CMG with another, while at the same time inviting every emergency physician to stay on the job. What then was the point of changing CMGs? Dr. Durkin set up a meeting with Rep. Beto O'Rourke. The specifics of the meeting were never divulged to me. Nevertheless, things changed after that meeting. The government was clearly on notice that one of the most influential emergency medical societies in the country felt this was important.

The government then kept CMG1 on the job for two more terms, hoping CMG2 could find emergency physicians to take over our jobs. CMG2 was never able to attract a single physician under its contract terms. Only two physicians from our group even talked with CMG2. In the end, CMG2 withdrew from its award and the contract went back up for bids. We were unable to retain CMG1, but the new CMG kept all of us and even gave us a raise.

So what are the lessons to be learned from this experience?

- Emergency physicians must consider whether the ideal practice is best achieved through a CMG or the establishment of an independent, democratic group. This case again demonstrates that the focus of a CMG is on its bottom line, not your personal welfare or the quality of your practice. It also demonstrates that a "no experience required" policy emboldens those who are willing to take on the business aspects of ED management and form a CMG at your expense. I recommend you put in the sweat equity to develop your own group, so you can remain in your community and not be forced into an itinerant lifestyle.
- If you decide you to fight a CMG takeover or form your own group, realize that not everyone in your group will help you. Those close to retirement may not want to make waves; some may have other sources of income to fall back on; some won't care about being in control of their practice and won't share your goal of avoiding a corporate takeover, because they don't mind working for the benefit of shareholders. Some will even be afraid of being black-balled by the CMG, worried that they will be unable to find a job in the future. Finally, some will be afraid they'll have to do the schedule or be intimidated by other aspects of running an emergency medicine group. Remember that AAEM has published a number of articles on how to form and maintain your own group, usually offers a Business of Emergency Medicine course immediately before the annual Scientific Assembly, has a business/management track at the Scientific Assembly, and now even offers a textbook that walks you through the process of establishing your own group — authored by board member Dr. David Lawhorn. AAEM is always there to listen, advise, and help.
- Invest in yourself, stay in AAEM, and bring in new members! My thanks to Bill Durkin and the American Academy of Emergency Medicine. ■

PeerCharts™ online

The Ultimate EMR Plugin

Mirror your practice, improve document quality, and most importantly, deliver your message.

The PeerCharts Online™ Platform Delivers:

- Concierge Customer Care
- Personalized Content to Mirror Your Practice
- Simple and Convenient EMR/EDIS Interoperability
- Flexible Click, Talk, Type™ Input
- Single-Click Clinical History
- Maximum Efficiency at Minimum Cost
- SaaS Platform Simplicity (no installation; low initial cost; secure anywhere access)

Emergency Medicine Documentation
Integrated Dictation
Bedside Paper Templates

EvolveMed

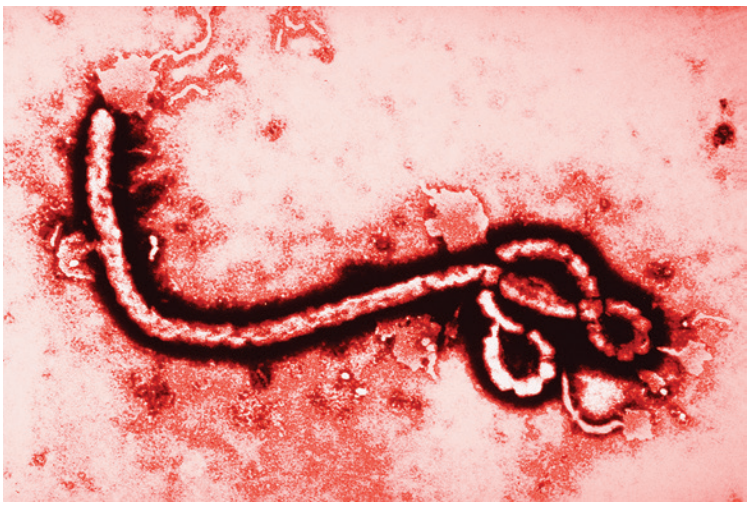
175 West 200 South #4004, Salt Lake City, UT 84101 • 800.301.4901

www.peercharts.com

Ebola: Be Concerned but Don't Panic

Gary Gaddis, MD PhD FAAEM

The recovery of Dr. Craig Spencer, who contracted Ebola while working in Guinea and was hospitalized in New York on October 23, 2014, represents an opportunity to highlight some of the good news about Ebola infections.



Americans understandably fear Ebola, an unfamiliar risk. The case fatality rate in Africa exceeds 50%. Thomas Eric Duncan, who had recently arrived from Liberia, died of Ebola at Dallas Presbyterian Hospital on October 8, 2014, after being admitted on his **second** visit to that hospital's emergency department (ED). The nurse who cared for Duncan on his **first** ED visit entered his history of recent travel from Liberia into the electronic health record (EHR) during that visit, but more on that later.

The first piece of good news is that the six Americans treated for Ebola in the United States since August — physicians Kent Brantley, Rick Sacra, and Craig Spencer, nurses Amber Vinson and Nina Pham, and missionary Nancy Writebol — have all survived. Second, none of the American household or casual contacts of these Ebola patients — Mr. Duncan's contacts, the two planeloads of passengers who traveled with Ms. Vinson, and the numerous casual contacts of Dr. Spencer — have contracted Ebola.

Third, everything went right in the events leading up to Dr. Spencer's hospitalization:

- Spencer responsibly monitored his symptoms and temperature twice daily after he returned, symptom-free, from Guinea. Ebola is not contagious until symptoms such as diarrhea, vomiting, or fever appear.
- Spencer called 911 the day he developed a slight fever, and told dispatchers he might have Ebola but was not critically ill and could wait for appropriate transport. Emergency medical services (EMS) personnel with the necessary training and personal protective equipment (PPE) were then dispatched to take him to Bellevue Hospital, the New York hospital best prepared for Ebola patients. A select subset of New York EMS first-responders and Bellevue personnel had drilled for at least two months prior, in order to respond properly to the threat of Ebola while protected by PPE.
- Dr. Spencer knew that a typical, immediate EMS response was **not** necessary. A moderate delay to allow PPE-protected medics to respond was preferable to an immediate response by a crew without PPE and special training.
- Days, not minutes or hours, elapse between initial symptoms and the risk of death from Ebola infection. Unlike strokes, heart attacks, or major trauma, when minutes and seconds truly do matter, **early symptoms of Ebola infection do not constitute a time-critical emergency**. Patients with fever who suspect Ebola should do what Dr. Spencer did when he became febrile.

Emergency department procedures and the EHR at Dallas Presbyterian both failed Mr. Duncan. A nurse recorded Duncan's travel into the EHR on his first ED visit, but did not verbally alert Duncan's emergency physician to that travel. The emergency physician apparently failed to ask about travel on his own. Also, the EHR apparently did not enable the nurse to dispatch an electronic alarm to the doctor. Critical data obtained by the nurse's careful history remained buried under all the other trivial EHR verbiage.

The primary lesson to be learned from Duncan's case is that an EHR full of data does not guarantee that the information will be put to good use. No emergency physician has the time to read every entry in an EHR, which is repeatedly revised during a patient's stay in the ED.

A root-cause analysis of Duncan's tragic death should blame **both** the design and function of the EHR **and** sub-optimal verbal communication in the Dallas Presbyterian ED. I hope EHR designers learn something from this failure and engineer solutions to the low signal-to-noise ratio problem exemplified by the EHR. The bottom line: there is no connection between the amount of data collected and recorded and how usefully it is delivered to those who need it. In fact, when it comes to the EHR, there might be an inverse relationship between the amount of data recorded and the odds that critical data will be properly used. ■

More Evidence for the Superiority of Board-Certified Emergency Physicians

A study published in the October issue of *Academic Emergency Medicine* has added to the scientific literature supporting the superiority of board-certified emergency physicians: http://onlinelibrary.wiley.com/enhanced/doi/10.1111/acem.12486/. For a review of the older literature on this topic, see the paper available on the Academy's website here: www.aaem.org/em-resources/position-statements/board-certification.

Don't let anyone get away with telling you — or your hospital administrator — that the value of board certification in emergency medicine is unproven, or that certification by the Board of Certification in Emergency Medicine (BCEM) is equivalent to certification by ABEM or AOBEM. The history of BCEM and its parent organization, the American Board of Physician Specialties (ABPS), is explained in the article "Legitimate" in the Jan/Feb 2014 issue of *Common Sense* (p.13), available here: www.aaem.org/publications/common-sense/2014.

Tune in to learn more.

For more information on how AAEM works to protect board certification — listen to episode 17 of the *Emergency Physicians Advocates: Legal & Policy Issues in EM* podcast titled: "Academic Advocacy." In this episode, Larry Weiss, MD JD FAAEM, Professor of Emergency Medicine at the University of Maryland School of Medicine and past-president of AAEM, discusses AAEM's history of advocacy for academic emergency physicians. Discussion points include, the formation of the EM specialty and how AAEM works to protect board certification. ■

2014 Pan-Pacific Emergency Medicine Conference

William T. Durkin, Jr., MD MBA CPE FAAEM

The second PEMC was held in Daejeon, South Korea on October 13-15. There were over 1,200 attendees, including moderate representation from America. William Durkin, MD MBA CPE FAAEM, immediate past president, represented the Academy and gave the Opening Remarks as well as a keynote session. Dr. Kang Hyun Lee, President of the Korean Society of Emergency Medicine (KSEM), and his board were perfect hosts. The English track was very well received. As can be seen from the accompanying pictures, all had a good time!

Dr. Durkin and Terrence Mulligan, DO MPH FAAEM FIFEM, met with the KSEM delegation and it was agreed that the 3rd PEMC would be held in a venue outside Korea. It is hoped that a final decision is made prior to the upcoming AAEM Scientific Assembly in March. ■

Terrence Mulligan, DO MPH FAAEM FIFEM, speaking at PEMC

William T. Durkin, Jr., MD MBA CPE FAAEM, takes the stage for opening remarks at PEMC

Join a State Chapter

AAEM STATE CHAPTERS

AAEM members can make an impact on the local level by forming a state chapter of AAEM.

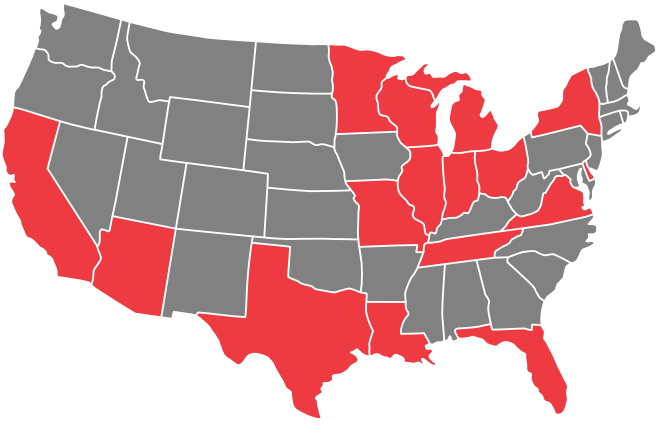
Although emergency physicians are certainly encouraged to join both their state chapter and national AAEM, this is not a requirement in most chapters. Those physicians who wish to belong solely to an AAEM state chapter are free to do so.

Please visit the state chapters page of our website at www.aaem.org/membership/state-chapters to find out more.

Available AAEM State Chapters

- Arizona
- California
- Delaware Valley
- Florida
- Great Lakes
- Louisiana
- Missouri*
- New York
- Texas
- Uniformed Services
- Tennessee
- Virginia

*Requires AAEM membership.



CALL FOR MEMBERS:

JOIN THE FREESTANDING EMERGENCY CENTER INTEREST GROUP

We would like to create an AAEM Freestanding Emergency Center Interest Group that would benefit from the collective wisdom and experience of interested emergency physicians nationwide. Since the publication of AAEM's Freestanding Emergency Department Position Statement in 2009 (www.aaem.org/em-resources/position-statements/2009) there has been a proliferation of freestanding emergency centers (FECs).

FECs face a variety of unique clinical, operational, and legal/regulatory issues. If you would like to be a part of this interest group, please contact Joe Ybarra, MD (rjybarra5@gmail.com) or Setul Patel, MD MBA FAAEM (spatel@nec24.com). **We would like to hold an initial meeting at the AAEM Scientific Assembly in Austin, TX, in February/March 2015.** Watch the AAEM website for additional updates.

Point of Care Ultrasound: Have We Gone Too Far?

Bob Stuntz, MD RDMS FAAEM
YPS Secretary-Treasurer

Full disclosure: I absolutely love and believe in point of care ultrasound (POCUS). I spent an extra year in fellowship to enhance my knowledge and skills. I was the director of our residents' ultrasound (US) rotation and continue to be active in our residency US education program. We have fantastic US faculty who provide excellent education to our residents, covering a broad range of basic and advanced topics over three years. Recently, one of my residents who was nearing graduation asked me a simple question that really got me thinking: "When I go out into community practice, what US skills do I need to know that are really going to make a difference?" The more I thought about it, the more I began to wonder, have we taken POCUS a little too far?

POCUS is, at its core, physician recognition that certain diagnoses can be made at the bedside with US, saving time, money, and radiation. Ultimately, POCUS should enable high quality and timely patient care. For instance, we can diagnose a AAA or identify free fluid in a hypotensive trauma patient with hemoperitoneum. Research has shown time after time that emergency physicians (EPs) are facile with US, enabling faster dispositions. Better patient care arose from the integration of focused clinical questions and bedside imaging to make the right diagnosis.

When I entered fellowship, I wanted to get more advanced and push the limits of what US can do at the bedside. I found an ever-increasing list of new US applications to learn and perfect. As time goes on, however, I find myself most often using the basics in the clinical setting. The question arises, can you do too much US? While difficult, I think the answer is *yes*.

A study was recently published in *The Lancet Respiratory Medicine* looking at POCUS in undifferentiated dyspnea.[1] Patients presenting to the emergency department with dyspnea of unknown origin were randomized to either standard workup as determined by the provider, or POCUS performed by a single experienced operator. The study found that while the correct initial diagnosis was made more often in the US group, there was no difference in patient-oriented outcomes. Patients had no change in hospital length of stay between the US and control groups, and those in the US group got more thoracic CT scans, more echocardiograms, and more thoracentesis. Rory Spiegel (@EMnerd_) and others have written some great reviews regarding this study,[2,3,4] and they are certainly worth reading for more details. While the study itself is not perfect, it does raise important questions. As POCUS experts have become more advanced, the mantra seems to be that more is better. Yet, if patient-oriented outcomes are not improved, are our investigations really finding things that benefit the patient, or are we just contributing to over-testing and over-diagnosis?

Continued on next page

New Voices in EM, Sign Up for an Open Mic Session!

Speak at the 21st Annual Scientific Assembly, on Monday, March 2 from 8am-6pm

ww.aaem.org/AAEM15/open-mic

The floor is yours — the Open Mic Session is your unique chance to speak at a national meeting on the topic of your choice. Ten of the slots will be filled in advance — six will be filled onsite, on a "first-come, first-served" basis.

The top two speakers will be invited to give a formal presentation at the 2016 Annual Scientific Assembly in Las Vegas, NV. To sign up, contact Kathy Uy at kuy@aaem.org or call 800-884-2236

AAEM Young Physicians Section
Invested in your future.

Sponsored by the Young Physicians Section

From an educational standpoint, let us consider residents who may not have great enthusiasm for US, or our more experienced colleagues who are being told they need to learn to use it after years of practicing without it. Our residents' milestones include transcranial doppler as an advanced modality, a test I have yet to utilize in the emergency department. I keep thinking back to what my resident asked — what do EPs really need to know to have the greatest impact on patient care and patient-oriented outcomes? Will such advanced topics entice the skeptics to learn US, or drive them away?

If we, as proponents of POCUS, truly believe EPs should be using this technology universally, we need to focus on how to create as many believers as possible. The 2008 ACEP Emergency Ultrasound Guidelines say, "Typically, emergency ultrasound is a goal-directed focused ultrasound examination that answers brief and important clinical questions in an organ system or for a clinical symptom or sign involving multiple organ systems."[5] Our basic skills — AAA, basic echocardiography, FAST, biliary, intrauterine pregnancy evaluation, basic renal ultrasound, and procedural guidance — are what truly change management and affect our patients the most. Demonstrating the impact these skills have when added to excellent clinical care will attract those skeptical EPs to learn US and incorporate it into their clinical practice.

We must continue pushing the envelope with US research and clinical practice. Experts will continue to be the leaders in emergency ultrasound, and the continued movement of the frontier in this area is crucial. However, if we are to convert nonbelievers then POCUS enthusiasts must aim to raise the bar on basic skills. While striving to advance our specialty, we should emphasize that you don't have to master advanced US applications to deliver great clinical benefits. Perhaps most importantly, we must continue to do studies and ask ourselves hard questions. Ultimately, we first got interested in POCUS because of the positive impact it had on patient care. That should continue to be our goal, and we need to make sure our scans are accomplishing what we think they are.

References

1. Laursen et al. Point-of-care ultrasonography in patients admitted with respiratory symptoms: a single-blind, randomized controlled trial. *The Lancet Respiratory Medicine*.2014 Aug 2(8):638-646.
2. http://emnerd.com/case-shadows/
3. http://www.emlitofnote.com/2014/07/ed-hocus-pocus-or-just-hoax.html
4. http://stemlynsblog.org/jc-pocus-breathless-patient-game-changer/
5. ACEP Emergency Ultrasound Guidelines. 2008. http://www.acep.org/content.aspx?id=32878

Bob Stuntz, MD RDMS FAAEM, is the Assistant Program Director at the Wellspan York Hospital Emergency Medicine Residency, and secretary-treasurer of the AAEM Young Physicians Section. His main interests are point of care ultrasound, social media, and the integration of social media in medical education. You can find him on Twitter @BobStuntz, or email any questions or comments to bobstuntzmd@gmail.com. ■

AAEM/RSA President's Message

Residents & Students: See You in Austin!

Meaghan Mercer, DO
AAEM/RSA President

The Scientific Assembly (SA) is just around the corner, and we cannot wait to see you in Austin, February 28-March 4. As I look back, I realize this will be the sixth SA I have attended. I remember my first, as Dr. Mattu took the stage and the energy of the room made me realize how remarkable our specialty is. I have seen people lining the walls, willing to stand for an hour to hear the greats speak and new presenters rise and deliver pearl-packed, animated talks that make me want to be part of this world. No matter where you are in your training there is never a sense of hierarchy, and the connections you make are life-long. One of my attendings and I were chatting recently and he said something that really struck me. Emergency medicine is better than any fraternity or sorority you could join. The friends you make in residency and in this specialty are for life, and each year we get to have a reunion to celebrate.

This year we have a great lineup of speakers and events, including the medical student track and RSA/YPS track. Each is designed to address a unique aspect of our training and how to excel in it. I want to say thank you to all the medical students who volunteered for our medical student ambassador program. Your help is greatly appreciated. For all our attendees, please keep your eye out for them and help them with our survey feedback. We also welcome everyone to join us at our second annual Career Connections Fair! We are trying something new this year and combining our social with the chance to meet potential employers. Learn about what democratic group means, what to look for in a contract, make some connections, and land your dream job.

I also encourage you to become an active participant. Even if you can't make it to Austin you still can be a dynamic voice. Join in the social media presence and hop on Twitter #AAEM15. By joining the global community you can engage in education, sharing and vetting ideas in real time. I've been amazed at how one pearl sparks a conversation that educates thousands. Well-known FOAMedites Anand Swaminathan (@EMswami,) Michelle Lin (@M_Lin,) Salim Rezaie (@srrezaie,) and numerous residency programs were part of the dialogue last year, and we cannot wait to see what this year will bring. To sweeten the fun of learning we will be tweeting out the location of hidden prizes throughout the conference.

Not only can you get involved during the conference, you can get involved in leadership too. Being part of RSA for the last six years, I have had the privilege of guiding this organization and it has given me more than I ever expected. Gaining valuable leadership skills, seeing what goes on at the political level, business and contract pearls, and numerous friends — all the work has been worth it. All of us are aware of burn out, but find your passion and see the impact you can make. Consider running for the Medical Student Council (MSC), Resident & Student Association (RSA), or Young Physician Section (YPS) board. Invest your passion, knowledge, time — and you will get a ten-fold return on your investment. ■

Standardized Sign-Outs in the ED: An Opportunity to Improve Patient Safety

Peter Malamet, OMS-IV, Philadelphia College of Osteopathic Medicine
Andrew W. Phillips, MD MEd, Stanford/Kaiser Emergency Medicine Residency Program
Sarah Williams, MD, Stanford University, Division of Emergency Medicine

The Importance of Sign-outs

Emergency physicians routinely perform sign-outs, both at shift change and during consultations and admissions. Sign-out, also known as a hand-off or turnover, is a time to summarize information about current patients and transition their care from one provider to the next. This sign-out can be between emergency physicians (EPs) or between EPs and other health care providers. However, despite being so common in everyday practice, sign-outs continue to be cited as a large source of medical error in the emergency department (ED).[1] It is critical for patient safety that this process is optimized.

The ideal sign-out happens in a quiet area with no distractions, with sufficient time to discuss pertinent aspects of patient care.[2] This may be possible on a medicine floor, although even here there are challenges. However, this is particularly difficult to achieve in the ED.[3,4] Nonetheless, recent research shows that a standardized sign-out process can reduce medical errors.[3]

Standardized Sign-Outs

Multiple studies support the use of a standardized sign-out process.[1,5,6] However, in practice this has been challenging to implement. Kessler et al., reported that only 10.9% of emergency medicine (EM) residents reported that they received hand-off education.[3] In addition, 93.9% of EM program directors stated that assessments of hand-off proficiency were not conducted in their program.[3] This is a troubling statistic in light of multiple studies showing that poor transfer of care practices can lead to significant patient morbidity.[7] Horwitz and colleagues showed that 29% of house staff had a patient who experienced an adverse event after ED to inpatient transfer.[7] Many contributing factors, such as communication failures and inaccurate or incomplete information and orders, have the potential to be corrected with a better sign-out process.[7]

One form of standardization that has been studied across other specialties is using acronyms or other mnemonics during sign-out. Connor and colleagues found success using an "IMOUTA" acronym with otolaryngology residents.[8] This stands for identifying data (I), medical course (M), outcomes possible tonight (OU), responsibilities to do tonight (T), and opportunity to ask questions or give feedback (A). In this study, residents who used the acronym felt much better prepared for on-call duties.[8] A component of this acronym that deserves to be highlighted is the opportunity to ask questions. Multiple articles have discussed the need for active listening.[1,8] The physician who is receiving the sign-out needs to be encouraged to ask questions and clarify information.

Another form of standardization can be a template that practitioners carry with them. Bavare and colleagues used a pocket card template in the pediatric intensive care unit.[10] The front of the card contained: situation and background, patient identification, primary diagnosis, problems, condition, disposition, code status and lines. The back of the card contained the assessment and goals. In their study, according to a pre- and post-survey comparison, there was perceived improvement with sign-out completeness and comprehensibility.[10]

Dubosh et al., recently found success using a sign-out checklist with residents in the ED. The components of their checklist included: HPI, ED course, pending studies, likely disposition, possible issues and algorithms for disposition.[11] In this study, trained research assistants monitored the sign-outs before and after implementation of the checklist.[11] There were statistically significant improvements in the areas of HPI, ED course, possible diagnosis and team awareness of the plan.[11] In addition, there was no difference in the amount of time the sign-out took (1.39 vs 1.42 minutes).[11]

Physicians can also find blank templates online. Organizations such as Safer Sign-out provide templates and offer training and other tools that can help standardize sign-outs, as do I-PASS (www.ipasshandoffstudy.com/publications) and TeamSTEPPS (www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html).[12]

Electronic standardized sign-outs deserve special mention as well. Some EDs use full electronic medical records (EMR), while others utilize a hybrid system of paper charting and EMR. There are currently electronic record programs that can assist with sign-out. Van Eaton and colleagues used the University of Washington Computerized Rounding and Sign-out System (UWCores), a web-based system, for sign-out.[13] Physicians can organize their patient lists and add patient data, labs, etc. With this system, 69.6% of residents reported better sign-out quality and 66.1% agreed there was a better continuation of care.[13] A related study using UWCores showed fewer skipped patients during rounds and less time spent pre-rounding.[14] It may be possible to implement and customize this type of EMR system for ED use. Physicians can track their patients on the computer throughout the shift, then have a uniform template with all the pertinent information available at the end of the shift. The training required for a new EMR functionality may be initially resource intensive. However, as it is adopted into the work-flow this could be a very convenient tool.

Practical Challenges

Aside from the lack of standardization, there are numerous other factors that can lead to a poor sign-out experience. These include a loud and disruptive background, uncertainty about which physician is in charge post sign-out when both are still physically present, lack of "red flags" that help identify dangerous hand-offs, the desire to be concise, and the economic build of the physician group.[1] These system issues each need to be addressed. However, a standardized hand-off algorithm can decrease the probability of error and makes such issues easier to address. This is the

Continued on next page

goal of a standardized sign-out. Even when there is a full department with numerous distractions, a safe and effective sign-out can be accomplished in a reasonable time frame.

Conclusions

The importance of improved hand-offs is supported by multiple leading health organizations. The American College of Emergency Physicians recommends the use of hand-off training and assessment and support tools to enhance the transition of care process.[16] Additionally, for the Next Accreditation System, the ACGME established the Clinical Learning Environment Review (CLER).[16] This focuses on the quality and safety of the patient care environment.[16] A main component emphasizes formal education and enhanced processes for the transition of patient care.[16]

Several sign-out tools are already available, as discussed above. Which tool is chosen will depend on several departmental considerations and further studies are indicated to determine the optimum design for ED use. However, it is already clear that utilizing a standardized sign-out in the ED has the potential to drastically improve patient safety and should be considered an important part of departmental policy.

The views expressed in this article are those of the author and do not represent the official position of the U.S. Air Force, Department of Defense, or U.S. Government.

References

1. D. Cheung D, Kelly J, White M, et al. Improving Handoffs in the Emergency Department. *Annals Of Emergency Medicine* [serial online]. February 1, 2010;55(2):171-180. Available from: Scopus®, Ipswich, MA. Accessed July 16, 2014.
2. Cohen M, Hilligoss P. The published literature on handoffs in hospitals: Deficiencies identified in an extensive review. *Quality And Safety In Health Care* [serial online]. December 1, 2010;19(6):493-497. Available from: Scopus®, Ipswich, MA.
3. Kessler C, Shakeel F, Velez L, et al. An algorithm for transition of care in the emergency department. *Academic Emergency Medicine: Official Journal Of The Society For Academic Emergency Medicine* [serial online]. June 2013;20(6):605-610. Available from: MEDLINE, Ipswich, MA. Accessed July 18, 2014.
4. Kessler C, Shakeel F, Velez L, et al. A survey of handoff practices in emergency medicine. *American Journal Of Medical Quality* [serial online]. September 2014;29(5):408-414. Available from: CINAHL Plus, Ipswich, MA.
5. Starmer A, Sectish T, Landrigan C, et al. Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle. *JAMA: The Journal Of The American Medical Association* [serial online]. December 4, 2013;310(21):2262-2270. Available from: MEDLINE, Ipswich, MA. Accessed July 27, 2014.
6. Dhingra K, Elms A, Hobgood C. Reducing error in the emergency department: A call for standardization of the sign-out process. *Annals Of Emergency Medicine* [serial online]. December 1, 2010;56(6):637-642. Available from: Scopus®, Ipswich, MA. Accessed July 27, 2014.
7. E. Horwitz L, Shah N, Meredith T, Kulkarni R, Jenq G, Schuur J. Dropping the Baton: A Qualitative Analysis of Failures During the Transition From Emergency Department to Inpatient Care. *Annals Of Emergency Medicine* [serial online]. June 1, 2009;53(6):701-710.e4. Available from: Scopus®, Ipswich, MA. Accessed July 16, 2014.
8. Connor M, Bush A, Brennan J. IMOUTA: A proposal for patient care handoffs. *Laryngoscope* [serial online]. November 2013;123(11):2649-2653. Available from: CINAHL Plus, Ipswich, MA. Accessed July 18, 2014.
9. F. Foster S, Manser T. Receiving care providers' role during patient handover. *Trends In Anaesthesia And Critical Care* [serial online]. August 1, 2012;2(4):156-160. Available from: Scopus®, Ipswich, MA. Accessed July 16, 2014
10. Bavare A, Shah P, Roy K, Williams E, Lloyd L, McPherson M. Implementation of a Standard Verbal Sign-Out Template Improves Sign-Out Process in a Pediatric Intensive Care Unit. *Journal For Healthcare Quality: Official Publication Of The National Association For Healthcare Quality* [serial online]. November 1, 2013;Available from: MEDLINE, Ipswich, MA. Accessed July 16, 2014.
11. Dubosh N, Fisher J, Tibbles C, Carney D. Implementation of an Emergency Department Sign-Out Checklist Improves Transfer of Information at Shift Change. *Journal Of Emergency Medicine* [serial online]. January 1, 2014;Available from: Scopus®, Ipswich, MA. Accessed August 24, 2014.
12. Emergency Medicine Patient Safety Foundation. (2014). *Safer sign out.* Retrieved July 27, 2014, from http://safersignout.com/
13. Van Eaton E, Horvath K, Pellegrini C, Lober W, Rossini A. A randomized, controlled trial evaluating the impact of a computerized rounding and sign-out system on continuity of care and resident work hours. *Journal Of The American College Of Surgeons* [serial online]. April 1, 2005;200(4):538-545. Available from: Scopus®, Ipswich, MA. Accessed July 18, 2014.
14. Wohlauer M, Rove K, Pell J, et al. The computerized rounding report: Implementation of a model system to support transitions of care. *Journal Of Surgical Research* [serial online]. January 1, 2012;172(1):11-17. Available from: Scopus®, Ipswich, MA. Accessed July 20, 2014.
15. Jaquis WP, Kaplan JA, Carpenter C, et al. (2012). *Transitions of Care Task Force Report.* American College of Emergency Physicians.
16. ACGME. *Clinical Learning Environment Review (CLER) Program*. Available from: http://www.acgme-nas.org/cler.html.

Anaphylaxis in a Nutshell

Authors: Eli Brown, MD; Kaycie Corburn, MD; Jacqueline Shibata, MD; Lee Grodin, MD
Edited by: Jay Khadpe, MD FAAEM; Michael Bond, MD FAAEM

The emergency department (ED) is the most common place for treatment of anaphylaxis. While epinephrine is clearly indicated, the *Emergency Medicine Practice Update Guidelines of 2011* state, "Despite a unified consensus around epinephrine as first-line treatment, patients are more likely to receive corticosteroids and antihistamines." Prospective randomized controlled trials comparing medications for the treatment of anaphylaxis in humans are lacking, thus guidelines are based primarily on theory and anecdotal evidence. This summary examines various therapies and evaluates recommended ED observation times and dispositions.

Simons F, Gu X, Simons K. Epinephrine absorption in adults: Intramuscular versus subcutaneous injection. *Journal of Allergy and Clinical Immunology*. 2001;108:871-3.

Due to its β1-adrenergic effects such as vasoconstriction, increased peripheral vascular resistance, and decreased mucosal edema, epinephrine is the mainstay of anaphylaxis treatment. Epinephrine's β2-adrenergic effects include bronchodilation and decreased release of histamine as well as other inflammatory mediators. The authors note that low plasma levels of epinephrine are associated with enhanced release of inflammatory mediators, vasodilation, and hypotension.

This prospective, randomized, blinded, placebo-controlled, six-way crossover study investigated the plasma concentration of epinephrine in healthy volunteers 180 minutes after injection of 0.3mg either subcutaneously (SC) in the deltoid region or intramuscularly (IM) in the vastus medialis or deltoid. This small study (13 males enrolled) showed that plasma concentrations of epinephrine were significantly higher ($p<0.01$) with IM administration in the thigh compared to SC administration in the arm. Surprisingly, neither SC nor IM injections into the arm resulted in significantly higher plasma levels than endogenous levels triggered by placebo (normal saline) injections.

The authors suggest that the high blood flow in the vastus medialis and the localized vasoconstriction associated with subcutaneous injections may account for this difference. While it is not known whether these results can be extrapolated to patients having anaphylaxis reactions, this data is consistent with other published pediatric data. The authors recommend IM injection in the thigh as the preferred route of epinephrine administration for the treatment of anaphylaxis.

Brown S, Blackman KE, Stenlake V, Heddle RJ. Insect sting anaphylaxis: Prospective evaluation of treatment with intravenous adrenaline and volume resuscitation. *Emergency Medicine*. 2004;21:149-154.

Brown and colleagues published the first-ever prospective evaluation of the treatment of anaphylaxis with IV epinephrine and volume resuscitation. This Australian study initially investigated the efficacy of venom immunotherapy in 68 patients with known hypersensitivity to *Myrmecia pilosula* (Jack Jumper Ant).

The placebo group did not undergo immunotherapy and thus offered a rare insight into anaphylactic reactions in a monitored setting with a chronological record of allergen-exposure, onset of signs and symptoms, and initiation and response to therapy. All 21 placebo patients had systemic reactions to the ant sting. The time from envenomation to symptom onset was two to 27 minutes. The most common initial symptoms were generalized itching and perioral sensations; 21 (100%) experienced generalized erythema; 19 (90%) developed anaphylaxis and required epinephrine; five (24%) required fluid resuscitation; and nine (43%) required continued epinephrine infusion due to recurrence of the reaction after the initial epinephrine treatment. Symptoms resolved upon reinstitution of epinephrine for all nine of these patients. Hypotensive patients required significantly longer and higher total doses of epinephrine, $p=0.02$.

All cases of hypotension were associated with relative bradycardia. Two patients required atropine, which appeared to prevent them from impending cardiac arrest. All but two of the patients in this study recovered within four hours suggesting epinephrine infusion and volume resuscitation are an effective treatment for anaphylaxis. Atropine may also be an important adjunct for patients with hypotension and bradycardia.

Schummer C, Wirsing M, Schummer W. The pivotal role of vasopressin in refractory anaphylactic shock. *Anesth Anal*. 2008;107:620-664.

Cardiovascular collapse from severe anaphylaxis can be difficult to manage and does not always respond to epinephrine. Such cases are referred to as refractory anaphylactic shock. This article describes six case reports in which vasopressin was used to restore hemodynamic function.

Vasopressin restores vascular tone by a number of mechanisms including the activation of Vq receptors that mediate vasoconstriction, the closing of ATP-sensitive K+ channels, the modulation of nitric oxide, and the enhancement of adrenergic and other vasoconstrictor drugs. It is also hypothesized that vasopressin acts as an anti-inflammatory agent during anaphylactic shock by antagonizing the effects of nitric oxide.

The estimated incidence of anaphylaxis during anesthesia is 5-10 per 100,000 cases, and when it occurs is lethal 3%-10% of the time. While epinephrine and fluid resuscitation are the mainstays of treatment, further treatment options are less well described. Anecdotal evidence supports using a potent vasoconstrictor such as norepinephrine or vasopressin. The case reports in this article describe an immediate positive effect of vasopressin in restoring intraoperative hemodynamic stability in the setting of general anesthesia.

All six incidents occurred during general anesthesia for major surgery. The trigger substances identified in these cases were aprotinin, metamizol, and gelatin (substances known for their anaphylactic potential). All patients received epinephrine (cumulative dose range: 1mg-3mg), methylprednisolone (1000mg), crystalloid infusion (range: 1000mL-2000mL), and norepinephrine infusions (range: 0.4 mcg/kg/min to 1.2 mcg/kg/min). In addition, three cases received 6% hydroxylethylstarch (range: 250mL-1000mL); one case received dimitenden (8mg), ranitidine

Continued on next page

(50mg) and lidocaine (100mg); and one case received an unreported dose of H1 and H2 blockers. All six cases received vasopressin (range: 2-5 units). Hemodynamic stabilization was achieved in all cases; however, the exact timeline of events was not included in the case series.

While largely anecdotal, these cases demonstrate that vasopressin may help if circulatory function deteriorates quickly despite adequate standard treatment. The American Heart Association has conceded that their treatment guidelines for anaphylaxis are based more on consensus than evidence. These authors advocate that vasopressin administration be included in the guidelines for management of anaphylactic shock.

Yin R, et al. Improved outcomes in patients with acute allergic syndromes who are treated with combined H1 and H2 antagonists. *Annals of Emergency Medicine*. 2000;36(5):462-468.

Antihistamines, H1-blockers, are a standard component of the treatment of patients with allergic symptoms. There is little data on how the addition of an H2 blocker affects patients with on-going allergic syndromes. In this study, the authors hypothesized that the addition of an H2 blocker would improve outcomes for patients presenting with acute allergic syndromes.

Subjects were eligible to participate in the study if they had acute urticaria, acute angioedema, acute unexplained stridor, or acute pruritic rash after exposure to food, medication, or latex. Pregnant patients and patients who had symptoms for more than 12 hours were excluded. The subjects were randomized into two groups. All subjects received diphenhydramine 50mg IV. In addition, one group received ranitidine 50mg IV while the other group received an equal volume of normal saline IV. Supplemental medications such as epinephrine, corticosteroids, bronchodilators, intravenous fluids, oxygen, and additional antihistamine doses were given at the clinician's discretion. Data including heart rate, blood pressure, physical findings, side effects, and symptoms were collected at baseline, one hour, and two hours after treatment. The primary outcome was resolution of urticaria or angioedema at two hours post-treatment.

One hundred patients were recruited for the study over 12 months between May 1998 and April 1999. There were no significant baseline differences between the two groups. Resolution of urticaria was greater in the ranitidine group both at one hour and at two hours (93.7% vs. 73.8%, p=.02). Additionally, the number of areas of urticaria was significantly less in the ranitidine group. Overall, significantly more patients in the placebo group received additional H1 antihistamines.

Of the patients with urticaria, 30 also had angioedema. Nineteen patients had angioedema without urticaria. Resolution of angioedema and urticaria at two hours was significantly greater in the ranitidine group (70.5% vs. 46.5%, p=.02). Heart rate decreased in both groups with a slightly greater decrease in the ranitidine group at one hour. Subjective symptom scores were not different between the two groups.

This study showed the advantages of adding H2 blockers to the standard H1 blocker treatment for ongoing allergic syndromes. This study was not sufficiently powered to analyze the benefits of H2 blockers on anaphylaxis as only two patients in the study had hypotension and only 12 patients had wheezing without a history of asthma. While the addition of H2 blockers to the treatment regimen for allergy syndromes appears to improve cutaneous manifestations, the benefit on hypotension and bronchospasm is unknown. Additional studies are needed to explore these patient populations.

Mehr S, et al. Clinical predictors for biphasic reactions in children presenting with anaphylaxis. *Clinical & Experim. Allergy*. 2009;39:1390-1396.

How long should a patient be observed after being treated for anaphylaxis? The reason for observation is the dreaded biphasic reaction, which in this study was defined as a second phase reaction (not caused by antigen re-exposure) occurring after a one-hour symptom-free period following the initial anaphylactic reaction. This study aimed to identify risk factors associated with patients who experienced biphasic reactions.

This was a retrospective record review case study of children in one tertiary pediatric ED in Melbourne, Australia from 1998-2003. Anaphylaxis was defined as an episode involving the respiratory or cardiovascular system associated with one or more features involving the skin or GI tract. Only admitted patients were included. Exclusion criteria were patients taking beta-blockers, immunosuppressants, antihistamines, or corticosteroids.

The study included 104 patients with 95 having uniphasic reactions, 12 with biphasic reactions, and two with protracted reactions. There were no significant differences between uniphasic and biphasic patients in regard to demographics, atopic history, anaphylactic trigger, or clinical features. Biphasic reactors were significantly more likely to have received >1 dose of epinephrine during the initial episode of anaphylaxis (58% vs. 22%,

Continued on next page

p=0.02), although route or time to epinephrine did not differ. Biphasic reactors were also more likely to receive IV fluid boluses (42% vs. 8%, p=0.01) although interestingly, the total amount of fluid received and the rate of hypotension did not differ between the groups. The need for >1 dose of epinephrine or a fluid bolus during the initial reaction was a sensitive predictor, 92% (95% CI 62-100%) of a biphasic reaction with a negative predictive value (NPV) of 99%. Specificity was 76% with a positive predictive value (PPV) of 32%. Of note, there was no difference in use of steroids or antihistamines between uniphasic and biphasic reactors. The median time from onset of initial anaphylactic reaction to onset of biphasic reaction was 8.8 hours (1.3-20.5 hours). Of the 12 biphasic reactors, one was more severe, four were similarly severe, and seven were milder than the initial reaction.

This study is limited by its retrospective design, inability to measure biphasic reactions in non-admitted individuals, single center study at a dedicated pediatric facility, small numbers, and inadequate documentation. Also, reactors who only had skin or GI symptoms, which are now included in the definition of anaphylaxis, were excluded, leaving unanswered the question of whether a lack of cardiovascular symptoms or respiratory symptoms puts a patient at lower risk for biphasic reactions.

Biphasic reactions were seen in 11% of patients in this study. They were very unlikely in patients who only received one dose of epinephrine or no fluid bolus. If a pediatric patient requires multiple doses of epinephrine, the authors suggest a longer period of observation may be necessary as these patients may be at higher risk for biphasic reactions, although prospective studies are needed to confirm this conclusion.

Grunau B, et al. The incidence of clinically important biphasic reactions in emergency department patients with allergic reactions or anaphylaxis. *Annals of Emergency Medicine.* 2014;63(6):736-744.e2.

The goal of this study was to find the incidence of clinically important biphasic anaphylactic reactions. Included were 2,819 ED visits with an allergic (2,323) or anaphylactic reaction (496). Anaphylaxis was defined as having three organ systems involved or allergen exposure with two systems affected or systolic blood pressure (SBP) <90mmHg. A biphasic reaction was defined as an anaphylactic reaction occurring after complete resolution of the original reaction without antigen re-exposure.

This retrospective cohort study took place in two urban academic hospitals in Vancouver, Canada from 2007-2012. Exclusion criteria were: age <17, asthma as a primary diagnoses, or known to have non-allergic angioedema. The authors used a seven-day follow-up period and a regional ED database to identify return visits throughout the province.

185 patients had subsequent ED visits, with five (0.18%) meeting criteria for a clinically significant biphasic reaction. Two of these occurred while the patient was still in the ED and three occurred post-discharge. There were no fatalities. Twenty patients (0.70%) were lost to follow-up.

Limitations of the study include its retrospective design, subjective definition of allergic reaction, inclusion of only two hospitals (urban Canadian), and documentation dependence (i.e. may have missed diagnoses of "rash" that returned to have anaphylaxis which actually may have been a biphasic reaction). Authors note 147 patients self-administered epinephrine and it is unclear if they met definitions for anaphylaxis before being evaluated by providers.

In this study, biphasic reactions were rare (<0.18%) and occurred anywhere from minutes to days after the initial episode which makes determining an appropriate observation period challenging. The incidence of biphasic reactions in this study is quite different than the incidence in the preceding study of a pediatric population. The authors emphasize the importance of clear discharge instructions and prescription of epinephrine auto-injectors.

Clark S, et al. Multicenter study of emergency department visits for insect sting allergies. *J. of Allergy and Clinical Immunology*. 2005;116(3):643-649.

Guidelines for anaphylaxis recommend use of epinephrine, teaching of proper techniques for self-administration of epinephrine, and referral to an allergist. This study found that compliance with these guidelines is very low. This was a multi-center retrospective cohort study looking at 11 academic EDs in the US and Canada from 1999 to 2001.

The authors identified 617 patients with allergic reactions (58% local allergic, 11% generalized allergic, and 31% anaphylaxis). 13% of patients received epinephrine while in the ED (16% received epinephrine before arrival). 97% of patients were discharged home, but only 15% received discharge instructions to avoid an offending agent. 27% received a prescription for self-injectable epinephrine and 20% had a documented referral to an allergist. Only six of 259 (2.3%) patients received all three recommended interventions.

Study limitations are mainly related to its retrospective design and documentation issues. Despite these limitations, there is likely room for improvement in compliance with the guidelines. The authors conclude that there is an "untapped opportunity" for ED staff to prevent potentially life-threatening allergic reactions.

Conclusions

Despite a lack of high quality studies on the subject, several useful clinical pearls can be garnered from the literature on allergic reactions on anaphylaxis. Patients with anaphylaxis generally do well when treated with intramuscular epinephrine given in the lateral thigh. In refractory cases, atropine and vasopressin may be helpful. Anti-histamines and corticosteroids need to be studied more, but H2-blockers are likely helpful for cutaneous allergic reactions. Most patients with anaphylaxis can be safely discharged home after a short observation period with a prescription for epinephrine and clear discharge instructions to watch for biphasic reactions. Additionally, these discharge instructions should include education on trigger avoidance, indications to return to the ED, and how to use an epinephrine auto-injector. Close follow up with an allergist should be arranged. ■

Medical Student Council President's Message

Tuscany Emergency Medicine Initiative: An Interview with Kevin Ban, MD

Mike Wilk, MS3

International endeavors within the field of emergency medicine (EM) continue to expand and grow. Many EM programs now allow residents to do rotations abroad and a few even offer international EM fellowships. Today, we will focus on a particular international EM project in Italy, the Tuscany Emergency Medicine Initiative (TEMI), which has trained over 900 Italian physicians in EM at the Universities of Florence, Pisa and Siena. A collaborative effort of the Tuscany Ministry of Health and Harvard Medical Faculty Physicians, this project serves as a successful model for others interested in starting their own projects. When the TEMI project began in 2003, EM was not recognized as a specialty and no residency or other EM training programs existed in Italy.

TEMI was created as three projects: 1) a train-the-trainers course to provide qualified physician-instructors to teach EM; 2) a train the current practitioners project for all the regional physicians already working in emergency departments; and 3) a masters program that would serve as a bridge to establishing the first Italian residency program in emergency medicine.

I spoke with the director of TEMI, Dr. Kevin Ban, a former Harvard Faculty member who currently serves as chief medical officer at Dovetail Health.

Mike Wilk: Where did the idea for TEMI come from?

Dr. Ban: Our department cosponsored an emergency medicine and disaster management conference in September 2002 with the University of Florence to commemorate 9/11, which caught the interest of the dean of the medical school. We started talking about the problems in training EM physicians because there was no formalized training. They had people from over 20 different specialties including OB/GYN, ophthalmology, pediatrics, general surgery, and internal medicine working in 42 emergency departments without formalized training and they were having a lot of bad outcomes. They wanted to standardize care through an education program and all these conversations came out while we were doing the conference.

Mike Wilk: So how did you start the program and what were the different components of it?

Dr. Ban: We started with a train-the-trainers group consisting of 24 physicians at the University of Florence and developed a working curriculum. Then, we expanded the program to Pisa and Sienna and had about 90 EM trainers after two years. Once we had the physician educators, we started doing a regional certification program for all the physicians working in the 42 regional emergency department, which was an abbreviated course, but still fairly comprehensive.

At the same time, we developed a masters program and made it similar to a three-year residency program (Italian residency is five years). Many parts of that curriculum were later adopted nationally when Italy decided to make it a specialty around 2007. The regional certification and masters programs happened in parallel.

Mike Wilk: What were some of the greatest challenges you saw with the program?

Dr. Ban: Convincing people this would be a serious and meaningful program was initially a real challenge. After the second year, the people began to understand that it was a serious course and wanted to be involved in it. But the first year was a challenge. It was fundamental to have the political support of the regional administration and decision-makers, but even more important was ensuring that people at the point of care embraced the program. The majority of them did and started to see the value in what we were doing. We were also very careful to incorporate their ideas into the training curriculum, which became an iterative process seeking to improve.

Mike Wilk: Did TEMI play any role in the eventual creation of the Italian EM specialty?

Dr. Ban: When we started thinking about this program and what it would look like, we hoped the EM residency would ultimately come together. I don't think any one event led to the birth of the EM residency in Italy, instead it was a number of factors that lead to the creation of the EM specialty and the timing of the TEMI project happened to be right. We helped them build the educational infrastructure and they did the rest.

Mike Wilk: What advice would you have for others interested in developing an international training program?

Dr. Ban: Ideally, political support should span the entire continuum starting with the people providing care who will benefit from the program all the way through to the administrative decision makers. I think if you have one without the other, it will be a struggle to be successful.

Mike Wilk: Thank you for speaking with me today.

Dr. Ban was involved in writing a paper highlighting the keys to successfully creating an international EM project, which were termed the Eight Cs: collaboration, context, culture, credibility, consulting, consistency, critique, and conclusion. For those considering creating or joining an international EM project, it is a fantastic resource to review.

In 2009, 26 Italian EM residency programs were approved. They began training in 2010 and will graduate in 2015. For the first time, Italy will have its own residency-trained emergency medicine physicians. ■

With AAEM You Have:

Lowest annual dues of all emergency medicine organizations. Dedicated Support. Unparalleled Value.

Benefits at Your Fingertips

AAEM members receive discounted access to:

- EMedHome
- Peer Charts
- PEPID
- EMresource.org *
- Canopy Medical Translator App * — FREE
- ShiftGen *
- *Journal of Emergency Medicine* — FREE Online/Paper Subscription

*New Benefits!

A Steadfast Advocate

We advocate for you, the individual emergency physician. Your professional and personal welfare are our primary concern.

- Advocacy through professional Washington lobbyists
- The AAEM PAC — dedicated to protecting the future of EM
- Support & legal assistance provided to members whose rights are threatened
- Joint Ventures — Several large hospital networks and CMGs have recently formed joint ventures whereby the two entities control the physicians' practice and split profits from the physicians' professional fees. AAEM is actively opposing these arrangements through a variety of regulatory and legal avenues.
- Tenet Health — Tenet has proposed to terminate the emergency medicine contracts at 11 of its California EDs so it can offer these profits to a large CMG in return for taking over all of its money-losing hospitalist and anesthesiology contracts. AAEM and CAL/AAEM have been aggressively advocating for the affected physicians and have been educating Tenet and the public on how this plan may negatively affect quality of care.
- Due Process — AAEM has been meeting with CMS and members of Congress regarding expanding due process protections for emergency physicians.

The AAEM Network

The Academy is over 8,000 strong and growing. We offer multiple ways for you to plug into the organization and interact with your fellow members.

- **Listen in** to our podcasts — over 10,000 downloads *
- **Read up** on insights & opinions in *Common Sense*, our member magazine — inspire discussions with your colleagues, write us a Letter to the Editor
- **Engage on** what's important to you via AAEM Connect, a centralized dashboard of social media & interactive elements www.aaem.org/connect

*New Benefits!

AAEM Connect

Professional Toolkit

Benefits and support provided for managing or starting democratic groups.

- Leadership training resources from the American Association for Physician Leadership
- The exclusive AAEM Job Bank — browse open positions that are consistent with the mission and values of AAEM
- Comprehensive insurance program from Hays Affinity including: malpractice, health, disability, life, umbrella, auto/home, dental & vision, and long-term care *

NEW!

Hays
All. Together. Certain.

Premier Educational Opportunities

We provide affordable, high-quality continuing medical education in emergency medicine in person and online.

AUSTIN TEXAS

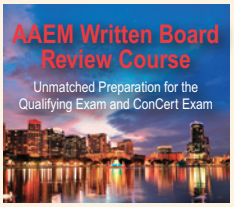
FEBRUARY 28 – MARCH 4, 2015
HILTON AUSTIN★AUSTIN, TX

Registration Now Open!
www.aaem.org/AAEM15

- Foremost clinical conference in EM: the AAEM Annual Scientific Assembly. Registration is FREE for members with a refundable deposit.

MEMC MEDITERRANEAN EMERGENCY MEDICINE CONGRESS
September 2015 ROME, ITALY
www.aaem.org/education/memc

- VIII[th] Mediterranean Emergency Medicine Congress



www.aaem.org/written-board-review

AAEM PEARLS of WISDOM
ORAL BOARD REVIEW COURSE

www.aaem.org/oral-board-review

- Highly recommended Oral Board and Written Board Review Courses

www.aaem.org/education/online-learning-library

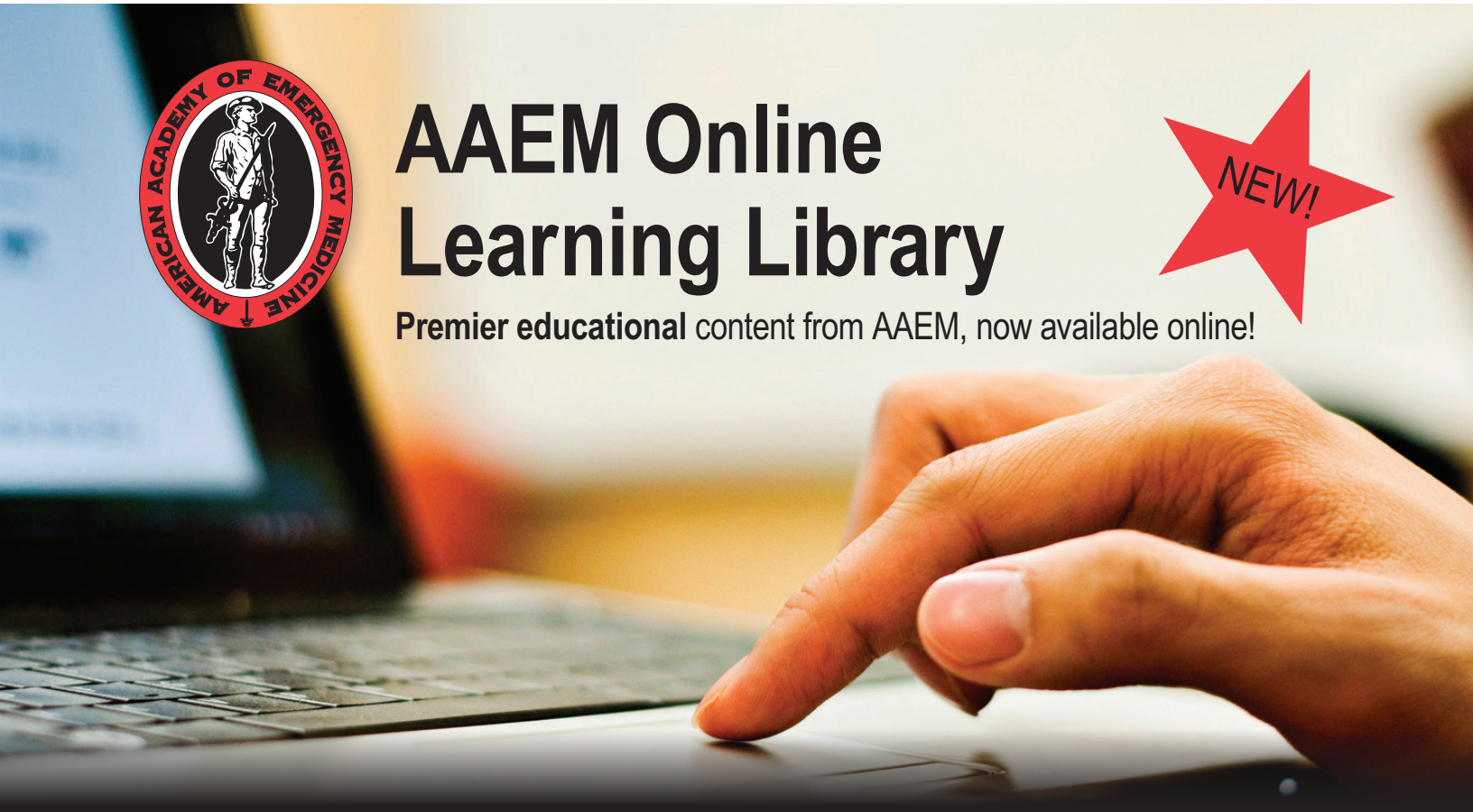
- NEW: Online Learning Library – AAEM's exceptional educational content is now available online with CME options.

Renew Today for 2015!

www.aaem.org/renew

COMMONSENSE
555 East Wells Street / Suite 1100
Milwaukee, WI 53202-3823

Pre-Sorted
Standard Mail
US Postage
PAID
Milwaukee, WI
Permit No. 1310



AAEM Online Learning Library

NEW!

Premier educational content from AAEM, now available online!

- Exclusive rates for AAEM Members and more content on the way!
- Superb, AAEM-quality educational content with *AMA PRA Category 1 Credits*™ available.
- Now Available
  - 2014 AAEM Scientific Assembly — FREE access for members!
  - 2014 Written Board Review course — Exclusive rates for members!
    - Up to 40 hours of intense EM board review
    - Taught by experienced faculty
    - Comprehensive review — easy online access!

Log In Today!

www.aaem.org/education/online-learning-library

American Academy of Emergency Medicine