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COMMONSENSE

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FEBRUARY 17-21, 2016

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Early Registration Deadline: January 25, 2016

COMMONSENSE

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AAEM Mission Statement

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

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

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Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
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AAEM-1115-116

President's Message

Transparency

Mark Reiter, MD MBA FAAEM
AAEM President

Since its inception, AAEM has been medicine's fiercest advocate for workplace fairness and defender of physicians' practice rights. During my term as AAEM president, I've been asked many times what emergency physicians should look for in a practice to minimize their risk of exploitation. I believe the single most important attribute in a fair work environment is *transparency*. Transparency acts as an important check on a group's activities. In a truly transparent environment, financial and governance information will be freely distributed to physicians within the group (in some instances, after a brief probationary period). Sensitive information, especially related to group finances, is automatically provided since many are uncomfortable requesting such information.

I challenge these groups to back up their claims by revealing how many cents of each physician's professional fee dollar goes to clinical physician compensation, as opposed to administrative salaries, administrative expenses, and corporate profit. I challenge these groups to distribute specifics on the total compensation packages of their top executives.

Likewise, many contract management groups own their own coding/billing companies, risk retention groups or malpractice insurers, scribe companies, etc. Their emergency departments then buy the services of these subsidiaries, and the funds to pay for those services are deducted from the hourly compensation of the emergency physicians who work there.

> "Unfortunately, transparency is virtually nonexistent in the majority of emergency medicine jobs. So-called "democratic" groups that do not operate transparently are typically anything but, as they often have something to hide."

Unfortunately, transparency is virtually nonexistent in the majority of emergency medicine jobs. So-called "democratic" groups that do not operate transparently are typically anything but, as they often have something to hide. Likewise, transparency is a foreign concept in most jobs with large contract management groups. Many groups claim that almost all patient care revenue flows back to the emergency physicians who generate that income with their labor, with the corporation barely making ends meet. I find such claims hard to reconcile with multi-million dollar executive salaries, bonuses, and stock options; lavish corporate headquarters; and multi-billion dollar market capitalization for the larger groups.

In some instances, only a few individuals own these subsidiaries and collect windfall profits while claiming they are compensated at the same rate as their colleagues are for clinical work. When these arrangements exist, the specifics should be disclosed to emergency physicians.

If most emergency medicine practice environments offered a fair deal to their emergency physicians, transparency would be the norm. An emergency medicine group stands to benefit from disclosing information to its physicians that shows they are actually being treated fairly. On the other hand, lack of transparency suggests exploitation and unfairness. ■

We're listening, send us your thoughts!

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FORUM

Thursday, February 18, 2016 • 2:00pm-3:30pm

Hear the candidates speak, ask questions, and cast your vote!

Be Careful Who You Work for — AND Where You Spend Your Dues Money

Andy Walker, MD FAAEM
Editor, *Common Sense*

In the November 11, 2015, issue of Emergency Physicians Monthly*, Dr. Greg Henry wrote a column on fraud revolving around the use of PAs and nurse practitioners in emergency departments. Because he omitted a critical and fundamental part of the problem from his analysis, just two days ago I wrote the letter to the editor of* EP Monthly *you see below. Since I have no idea if my letter will be published at all, much less in its entirety, I wanted to make sure you read it by publishing it in* Common Sense.

The PA/NP supervision-fraud issue is just one of the problems that arise when emergency physicians don't own and control their own practices. It's not that emergency physicians who are owner-partners in democratic groups cannot commit fraud, but when they do it is because they have chosen to and the fault is their own — they deserve what they get when they are found out. On the other hand, when EPs work for corporate staffing companies they are routinely kept completely in the dark about coding, billing, and collections; are sometimes told to sign the charts of PAs and NPs whether they provided real-time supervision to those providers or not; and are powerless to change things because they can be fired without cause and without due process — and are often coerced with restrictive covenants as well. Despite all that, those emergency physicians are just as legally liable for the fraud they unknowingly commit as those rare emergency physicians who commit fraud deliberately. So, let's be careful out there.

In his column, "The Truth About APPs," Greg Henry is quite right to say we have a problem with the supervision of nurse practitioners (NPs) and physician assistants (PAs), but things are even worse than he realizes. Dr. Henry identifies only one aspect of the problem when he says, "What we are lacking is a clear vision as to what supervision of non-physician clinicians means." In regard to the supervision of NPs and PAs and the avoidance of fraud, emergency physicians are lacking a great deal more than that.

What many of us lack is any say at all in how NPs and PAs are supervised, much less actual control of that decision. What many of us lack is any knowledge at all of how patients and insurers are billed for our own services, much less the services of NPs and PAs. Only those emergency physicians who own their practices, as part of an equitable and democratic group, get to decide for themselves how the PAs and NPs in their department are supervised (or employed at all) and how their professional services are coded and billed.

The growing number of emergency physicians who work for corporate staffing companies (aka contract management groups or CMGs), like those whose ads fill the last few pages of every issue of *Emergency Physicians Monthly*, have no idea what is billed or collected for their professional services by the CMG. In fact, any attempt to find out usually results in the emergency physician being fired, since CMG employment contracts practically always allow for termination without cause and require emergency physicians to waive any right to due process before termination. If we can't decide for ourselves what proper supervision means, we can't prevent fraud. If we can't see what is billed and collected in our names, we can't recognize fraud after it happens. Yet, as long as our names are on the chart, we are still legally liable for any fraud that occurs.

Thus, when a plaintiff's attorney asks those questions Dr. Henry talks about, the honest answer is "I have no idea how our NPs and PAs are screened and credentialed, because I have no role in that or in their hiring. I have no idea if fraud was committed in my name, because I am not told how my charts are coded and billed, or how much money is actually collected. If I try to find out, I will be fired. I have no choice but to sign the charts as I am told, or I will be fired. I have only two choices: do as I am told and operate in the dark, or work somewhere else — and because of the nationwide dominance of the CMG I work for, 'somewhere else' is a small and ever-shrinking place far away."

How did we wind up in such a situation? First, since CMGs control so much of the emergency medicine job market, many emergency physicians have little choice but to work for one. They have little choice but to sign a contract that allows for termination without cause and without due process, even after a reasonable probationary period. They have little recourse when they are told part of the job is signing the charts of PAs and NPs, even though there isn't enough time during a shift to provide proper supervision. In short, they have little control of their own professional practice — at least the business and financial end of it. Second, in my opinion they have been left largely undefended by our specialty's oldest and largest professional society, ACEP, which seems to me to serve corporate interests over the interests of individual emergency physicians. So, I must disagree with Dr. Henry's statement that "ACEP has no choice but to deal with this issue." Until ACEP pays more than lip service to protecting emergency physicians from predatory employment practices and those who profit from them, it can never deal adequately with this issue. ■

Submit a "Letter to the Editor" at www.aaem.org/publications/common-sense/letters-to-the-editor.

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.

Congress Advances Health Care Bill Offering Potential View into 2017 Reforms; 2016 Agenda Expected to Feature Additional Work on ACA Changes

Williams & Jensen, PLLC

The House and Senate recently passed legislation that would repeal or delay many key components of the Affordable Care Act (ACA). The bill was considered as part of a special procedure known as budget reconciliation, which allowed the legislation to advance with 51 rather than 60 votes in the Senate. The proposal eliminates the ACA's individual mandate to purchase health insurance as well as the mandate on certain employers to provide health insurance to employees. It would phase out the ACA's expansion of the Medicaid program, and defunds or repeals several other sections of the law.

This bill has no chance to become law because it lacks support in Congress to overcome President Obama's veto. However, the legislation, crafted by Republican-led majorities in the House and Senate, offers a potential glimpse into the kind of health care changes that may be enacted in 2017 if a Republican is elected President. The House and Senate leaders maintain that they will attempt to repeal the entire law, but this effort would be challenging as Republicans will almost certainly remain well below a 60 vote supermajority in the Senate following the 2016 elections. One prominent plan, outlined by Senate Republicans, to replace the ACA includes a section on medical liability reform that among other changes would give providers new liability protections under the EMTALA mandate.

The latest Congressional vote caps a mixed year for the health reform law. The U.S. Supreme Court uphold federal subsidies for state exchanges by a vote of six to three, ending what was viewed as one of the most compelling legal challenges to the ACA. In recent months, the most substantive ACA change to date cleared Congress and became law. This law amended the ACA's employer mandate by changing a provision to re-classify businesses that have between 51 to 100 employees as small businesses beginning in 2016.

While additional votes on the ACA are expected in 2016, the potential for significant change is low given that Democrats maintain control of the White House. However, one change that could be considered is the repeal of the ACA's "Cadillac" tax on certain high cost health care plans, a provision that has been criticized by business groups as well as unions. An amendment to repeal this tax was recently approved by a vote of 90 to 10 in the Senate, despite the urging of the Administration to keep the provision intact. The wide bipartisan support for repeal means Congress could seek alternative options for eliminating the tax in the coming months. Another modification that has ongoing bipartisan support is the repeal of the ACA's excise tax on medical devices.

Both of these changes have sufficient support to pass Congress, and possibly even to override a Presidential veto. However, efforts to enact these changes have been slowed by a lack of agreement on how to replace the revenue that would be lost by the repeal of these provisions.

Congress could once again pivot to mental health legislation in the next few weeks and months, as lawmakers see growing support for reforms in the wake of numerous violent acts over the past several years. The health care reconciliation bill would award $500 million in grants to states over two years to address mental health needs and substance abuse. House Speaker Paul Ryan (R-WI) has expressed serious interest in advancing legislation authored by Representative Tim Murphy (R-PA) that comprehensively reforms the U.S. mental health care system. The bill makes several notable changes, including clarifications to HIPAA under certain circumstances to allow physicians to communicate information to caregivers of patients undergoing a mental health crisis, and encourages alternatives to long-term inpatient care for the chronically mentally ill population with the goal of reducing substance abuse and ED visits.

Agencies Finalize Additional ACA Rules; Continue Receiving Input on Doc Fix Replacement

In November, the U.S. Department of Health and Human Services (HHS), Internal Revenue Service (IRS) and the Department of Labor (DOL) issued a joint final rule set to become effective in 2017 that covers a wide variety of regulations under the ACA ("Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act"). This nearly 400 page document includes regulations pertaining to emergency care.

The regulation requires health insurance plans to pay a "reasonable amount" for out-of-network emergency services and continues to permit, under certain circumstances, billing patients for the balance due after insurance reimbursement of emergency services which is often referred to as "balance billing." **However, the regulation states that in the future agencies "will consider ways to prevent providers from billing a participant, beneficiary, or enrollee for emergency services from out-of-network providers at in-network hospitals and facilities." The emergency medicine community is concerned that this Rule and other ongoing efforts will lead to the continued erosion of balance billing and will result in lower emergency department reimbursement rates, causing great stress to the ED safety net and driving quality providers out of emergency care.**

Continued on next page

Meanwhile, the Centers for Medicare and Medicaid Services (CMS) continues to work with physician specialty groups, medical societies, patient advocates, and other stakeholders to develop a system that incentivizes quality, efficient care and rewards good providers with higher payments. Following repeal of the Medicare Sustainable Growth Rate (SGR) in 2015, CMS has received initial input on issues around the development of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Following the period of 0.5 percent Medicare payment increases between now and 2019, physicians will earn bonus payments or incur penalties based on a variety of yet-to-be-determined metrics. Physicians that receive substantial reimbursement through APMs are also eligible for bonus payments. AAEM has provided comments to CMS outlining the emergency medicine perspective on composite score criteria under MIPS and the use of APMs. AAEM will continue to encourage CMS to develop an incentive structure that allows emergency physicians to engage in a patient-centered system that is free from outside influence. AAEM has asked that agencies develop robust options to allow emergency physicians to choose from a range of payment models that will give them an opportunity to earn bonus payments. ■

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

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AAEM CONFERENCES

February 17-21, 2016
- 22nd Annual AAEM Scientific Assembly
  Las Vegas, NV
  www.aaem.org/AAEM16

  Pre-Conference Courses
  February 17, 2016
  Emergency Neurological Life Support — *Jointly Provided by NCS*
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  Challenges in the Management of the Morbidly Obese in the Emergency Department — *Jointly Provided by CAL/AAEM*
  Ultrasound – Beginner
  Simulation – Obstetrics
  So You Think You Can Interpret an EKG?

  February 18, 2016
  Simulation – Pediatrics
  2015 LLSA Review Course
  2016 Medical Student Track
  Operations Management Updates: What You Need to Know in 2016
  Ultrasound – Advanced
  Responding to the Disaster – When Your World Becomes Austere — *Jointly Provided by USAAEM*
  www.aaem.org/AAEM16/preconference

March 12-13, 2016
- Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Orlando
  www.aaem.org/oral-board-review

March 19-20, 2016
- Pearls of Wisdom Oral Board Review Course
  Philadelphia, Los Angeles
  www.aaem.org/oral-board-review

March 23-24, 2016
- Pearls of Wisdom Oral Board Review Course
  Las Vegas
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April 2-3, 2016
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June 8-10, 2016
- Inter-American Emergency Medicine Congress (IAEMC)
  Mendoza, Argentina
  www.aaem.org/education/iaemc

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- International Conference in Emergency Medicine and Public Health (ICEP-Q) 2016
  Doha, Qatar
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March 18-20, 2016
- The Difficult Airway Course: Emergency™
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Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Emily DeVillers to learn more about the AAEM endorsement and approval process: edevillers@aaem.org.

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Looking Ahead: The Basics of Estate Planning

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

Everyone reading this needs to take a few estate planning steps. First, everyone needs a will. Second, everyone needs to make sure your life insurance and retirement accounts have the correct beneficiaries. Third, many should consider working with an estate planning attorney, as I'll explain below.

A properly constructed will ensures that your values and desires are carried out in the event you no longer can communicate them. While you may wish to give your estate to family members, your church, or a charity, without a will, what happens to your assets is dictated by state law.[1] The IRS, a nursing home, your spouse's next spouse, or some other less than desirable entity may wind up with the lion's share of your assets.

Wills

A will designates where you want your assets to go and, if applicable, who will take care of your children. A will usually names the guardian who will take care of your children and the trustee who will manage their assets. These roles can be assigned to the same person, or you can name different people. A will cannot specify when or for what purpose your assets should be given to your beneficiaries, so if you don't have any other documents the assets will be distributed according to your state's law. For example, if you have an estate of $5 million and you die without a will, your children could inherit that money at age 18 or 21, the most common ages of maturity.

If you have a will, upon your death it must pass through probate. Probate is a process that can be tedious, expensive, and lengthy, depending on where you live. During probate, a court validates your will and empowers the executor to use it. Assets like insurance policies and retirement accounts that name a beneficiary do not have to go through probate. Because it is expensive, public, and can be contested, probate is something to avoid if at all possible.

Keep in mind that once you have a will and have named beneficiaries for your life insurance and retirement accounts, you will need to update them if you marry, divorce, have children, your executor dies, one of your beneficiaries dies, you move to a different state, or any other significant life change occurs.

If you want to specify when or for what purpose your assets should be given to your beneficiaries or you want to avoid probate with a trust, this is where an estate attorney enters the picture. A common strategy is to create a trust for the benefit of your children that specifies when they are to receive your assets. For example, my estate plan gives my two children one third of their inheritance at age 20, one third at age 30, and one third at age 40. There are other options, such as granting a trustee the power to release money for certain priorities and creating a more detailed estate plan that communicates your values to your children — such as paying for education or for a down payment on a house even if they haven't yet reached the age at which they'd normally get their inheritance.

Advance Directives

You may also need an attorney to draft advance directives to specify your wishes if a medical emergency should occur. Who will be the decision maker? What are your specific life support decisions should your condition be irreversible? These documents are usually included in a comprehensive estate plan, but what isn't included is the conversation you should have with your family. As emergency physicians we realize these documents are rarely available when decisions must be made, so having a conversation with your family about your wishes may be more important than having the actual documents.

> "A properly constructed will ensures that your values and desires are carried out in the event you no longer can communicate them."

You may also want to grant others the right to make financial decisions in the event of your incapacity by giving them power of attorney. These can be "durable" (used at any time), or specific to certain conditions such as your incapacity.

Estate Tax

The federal estate tax, also known as the death tax, has changed many times since World War I. In 2015 a single person could pass $5.43 million to his or her heirs without any estate tax, and a married couple could pass on $10.86 million. Because most emergency physicians don't have such high net worth, federal estate tax is usually not an issue for us. Individual states, though, may also have estate or inheritance taxes that you need to plan for, because many have much lower limits on what is tax-free. Each state has very different laws, so make sure that any attorney you work with is familiar with the laws of your state.

The estate tax is not relevant if you are passing assets to your spouse. Spouses can pass on unlimited amounts without tax liability. If your spouse is not a U.S. citizen, though, the situation is a lot more complicated.

Continued on next page

If you have an estate worth more than $5.43 million (single) or $10.86 million (married), and you are trying to pass assets to a non-spouse, there are many different and complicated trusts and strategies you can adopt. The bottom line is that you'll need the help of a qualified attorney.

The other option is to give away money as you approach the end of your life, so that your estate is no longer above the limit. Take a look at your finances, get some idea of how much money you are likely to die with, and decide if you should start giving some of it away to charity or family now.

Same-sex couples should consult an attorney, due to the complexities of estate planning in that scenario and the variations from state to state.

Letter of Last Instruction

A final document to consider creating is a letter of last instruction, also known as a "doomsday letter." In today's increasingly electronic world, where financial statements are no longer delivered via U.S. mail, family members may have difficulty locating all the necessary documents in the event of your death. Your letter would help in this case and should include:[2]

1. Funeral instructions.
2. A list of financial assets and liabilities, safe deposit boxes, and any professionals you deal with (financial advisers, attorneys, doctors, etc.).
3. The location of key documents, like birth certificates, titles for cars, wills and trusts, tax returns, and financial statements.
4. User names and passwords for key websites.
5. An inventory of high value household items or possessions, and who you want to receive them (if they are not included in your will).

In summary, just about everyone reading this needs a will and needs to make sure that their life insurance and retirement accounts have the proper beneficiaries listed. In addition, those with more complex or large financial holdings, a desire to shape how and when their assets are bequeathed, a spouse who isn't a U.S. citizen, or a same-sex relationship should consult with an estate planning attorney.

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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. ■

Operational Margin: The Critical Final Pathway in Patient Flow

Joseph Guarisco, MD FAAEM FACEP
Operations Management Committee, Co-Chair

I am one of the early developers and a huge proponent of a patient flow concept known as *split flow*, described in *Common Sense* in the three-part series "Cracking the Code."[1-3] As early as ten years ago, I and others were thinking about this issue. Patient flow pioneers include Mary Ellen Bucco, MBA and Kevin Roche, PhD at Banner Health in Phoenix; Chris DeFlitch, MD at Penn State; Jody Crane, MD MBA in his early days at Mary Washington; and Jeff Finkelstein, MD at Hartford Healthcare in Connecticut. All experts in the field, including me, have been exposed to dozens if not hundreds of emergency departments (EDs) around the country and have participated in the dismantling of poorly performing workflow systems and the installation of what we considered to be our proprietary, best practice workflow scheme. However, I must admit that I have seen less efficient, less cost-effective, and more complex workflows succeed in terms of managing patient throughput. So what gives? Why does one workflow system succeed and another fail? The answer is *operational margin*, which I believe is the critical final pathway in any successful workflow.

What do we know about this topic? There are three noteworthy reviews of the subject. Joe Twanmoh, MD MBA, president of SG2 Consulting in Baltimore, and co-chairman of the AAEM Operations Management Committee, has written and presented extensively on what he calls "Myths in Operations Management," in which he reviews the literature on workflow systems and attempts to draw some conclusions on whether or not there is a breakthrough workflow best practice.[4] There is also the ACEP Task Force on Crowding's "Emergency Department Crowding High-Impact Solutions," commented on by Rick Bukata, MD, in his review article in *Emergency Physician Monthly*, "ED Throughput a Fixable Problem."[5,6] The ACEP task force divided throughput solutions into three categories: high-impact, no impact, and low-impact but expensive. High-impact solutions focus on creating bed capacity in the ED by creating bed capacity in the hospital — moving admitted patients out of the ED faster by discharging inpatients earlier in the day and by load-leveling surgical cases. The entire list is below.

High Impact

- Move admitted patient to hallways upstairs
- Discharge inpatients before noon
- Load level elective admissions and surgical cases

No Impact

- Build a bigger ED
- Discharge units
- Hospitalist co-management
- Ambulance diversion

Lower Impact and Expensive

- Bedside registration
- Fast Tracks
- Observation units
- Physician in triage
- Cancel surgeries
- Scribes
- POCT lab
- Advanced triage
- Adding nurses and support staff

In his commentary on the findings of the ACEP task force, Rick Bukata says "we put a man on the moon; surely we can shorten the wait in the emergency department." In my frequent talks on the concept of throughput, I take a more direct approach by asking, "You're telling me you have a patient waiting, with the provider ten the feet away, and you can't seem to get the two together in a reasonable amount of time. Is that your engineering problem?" Bukata's listing of throughput solutions is below.

- Provider at triage
- Advanced triage protocols
- Pull till full
- APPs
- Scribes
- Fast Tracks
- Super Tracks
- Split flow
- Production incentivized providers
- Point of care testing
- Full capacity protocols

Like Dr. Bukata, I am worried that after 35 years of practice we will end our careers with the issue of capacity management still unsolved. Despite appearing to identify a list of solutions, does the Holy Grail of patient flow still elude us? Eugene Litvak, PhD, CEO of the Institute for Healthcare Optimization in Newton, Massachusetts, has detailed the fatal flaw most managers make in attempting to solve the capacity and supply-demand issues that face emergency departments and entire hospitals. Dr. Litvak says, "As long as patient flow is ignored you cannot solve overcrowding, and as long as you have excessive patient volume and excessive workload you are going nowhere."[7] Ignoring mathematical realty dooms you to failure.

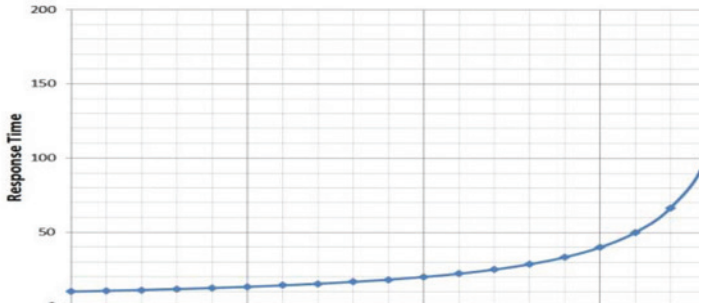
What then is the critical final pathway to efficient patient flow? What is the conceptual approach that manages capacity and delivers consistently smooth patient flow? It is operational margin. A workflow system without operational margin cannot succeed.

To explain, let's look at two distinct environments where the concept of operational margin has been mastered. The first is the fire station. Firefighters are available 24 hours a day — housed in the fire station 99% of the time rather than out fighting fires. The community's goal is to staff that fire station at such low utilization that should a fire develop, there is a 99% probability that those firefighters will be available to fight it. The second is the freestanding emergency department. Freestanding EDs generate patient satisfaction scores over 98%. They utilize providers at a rate of roughly one patient per hour, versus the average ED rate of two patients per hour. Additionally, bed utilization at a freestanding ED averages 700 patients per bed per year, versus an average of 2,000 patients per bed per year in traditional EDs. You can see that freestanding emergency departments operate at much lower resource utilization rates than traditional emergency departments.

Both the fire station and the freestanding ED demonstrate the concept of operational margin. Both create a high probability that the critical resource will be available when needed — a concept that is largely ignored throughout health care, but an industry failure that is now being capitalized on by urgent care clinics and freestanding emergency departments.

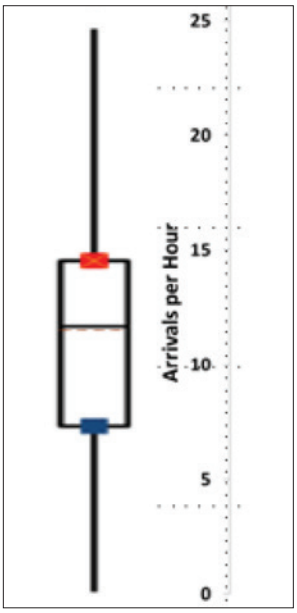
Continued on next page

If you study the classic response time-utilization curve below, you will see that response time as a function of utilization does not degrade in a consistently *linear* way — as utilization approaches 100% it degrades *exponentially*.



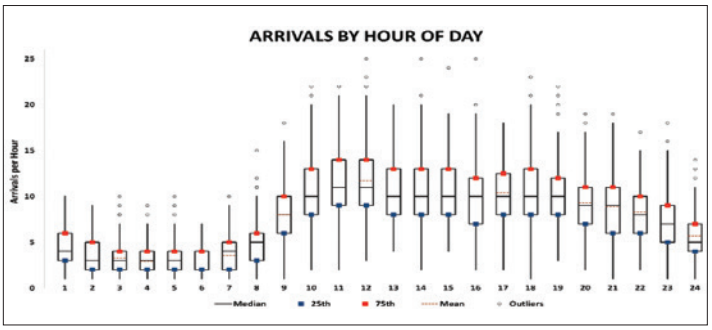
Fire departments and freestanding emergency departments operate on the early, flat part of that curve. Traditional emergency departments — and for that matter, hospitals in general — operate on the steeper part of the utilization curve. This is not a problem if resource demand is flat, consistent over the course of time, and demonstrates very little variance. An example of that might be an outpatient clinic, where demand is filtered (leveled) by the appointment system. This is obviously not the case in the ED, where resource demand (patient flow) is extremely variable. Unless you are content to let performance and service metrics deteriorate, you must keep your ED operating on the lower portion of that curve. That is mathematical reality, and ignoring reality doesn't make it go away. Living on the steep part of the response time-utilization curve means you have zero operational margin, leaving no room for the management of even slight variance. Unfortunately this is standard operating procedure in emergency departments, which are notorious for their lack of surge capacity (long waiting times). Lack of understanding and fear of escalating costs are the most common reasons for hospital administrators' failure to address this problem.

Another way to look at the probability of meeting variable resource demand is to use box plots.



The box plot to the left represents hundreds of thousands of data points and plots a distribution of those points. It shows that the average rate of patient arrivals per hour is 12, there is a 50% probability that between eight and 15 patients will arrive per hour, and a 90% probability that between one and 24 patients will arrive per hour. If you want enough nurses, doctors, and beds to give you a high probability of meeting patient demand most of the time, then you should plan on 15 patients per hour — or even better, 24 — rather than the average of 12. Staffing for the average is equivalent to operating on the steeper part of the utilization curve shown earlier. Any variance in demand towards the upper end of the box will result in an exponential deterioration in response time, with rapidly worsening service performance. In other words, planning and staffing for the 50th percentile of demand rather than the 75th or 90th means you have eliminated any operational margin (surge capacity).

I'll begin to wrap up with the box plot below, which shows 100,000 ED patient arrivals graphed over time of day. Staffing to the average (the horizontal black line in each box), rather than to the 75th (red dot) or 90th percentile (top of the vertical black line), depletes your operational margin and pushes you further (higher) up the slope of the response time-utilization curve shown earlier. That's not good.



A workflow system will succeed only if it creates adequate operational margin. A fast-track, a provider-in-triage, a split flow system, or even a traditional ED that incorporates none of these workflow processes can provide for excellent throughput if it creates enough operational margin. Building a bigger ED and hiring more docs and nurses, though inefficient, can provide great throughput. A provider-in-triage can also provide operational margin if there are enough providers, enough people to draw blood, and enough chairs or recliners for these patients. This was shown in a recent article in *Common Sense*.[8] A split flow system, creating virtual space by minimizing bed use and employing advanced practice clinicians for the low acuity stream, can achieve the same results at much lower cost.[9,10] The critical factor is whether or not these processes are supported and resourced to avoid over-utilization and meet demand most of the time. Operational margin is the key.

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#ilooklikeanEMdoc

Pollianne Ward, MD FAAEM
Women in Emergency Medicine Interest Group

There is a growing movement on social media using the hashtag *#ilooklikeasurgeon.*

Physicians post selfies in scrubs and surgical masks, in operating rooms, in clinics, and in call rooms. All have one thing in common — all are women. This movement came about in response to a similar hashtag, *#ilooklikeanengineer*, spurred by the sexist comments to an ad featuring OneLogin Platform engineer, Isis Wenger. When the ad was released online, there were many accusations that she wasn't "remotely plausible as what a female software engineer looks like." Surgeons experiencing similar sentiments started the new campaign, to highlight the gender disparities that female surgeons face every day. But this is not unique to surgery. Most of my female EM colleagues and I can relate.

As a woman in the emergency department, it is often assumed that I am not a physician. Male (and sometimes a few female) consultants, nurses, paramedics, and patients and their families assume that I am a nurse, X-ray tech, social worker, case manager, lab tech, etc. Rarely is their first thought that I am a physician. Most patient encounters begin with me walking into the room where the patient is talking on a cell phone, and as I stand and wait they say, "I have to go. The nurse is here to talk to me." Patients yell "hey, nurse" to me from their stretchers, even after I spent 15 minutes interviewing and examining them and discussing their plan of care. Patients preferentially speak to the male medical student, addressing him as "doctor," while they ask me to turn the TV up.

The culture that clings to these antiquated stereotypes affects patients' perceptions of the care they receive. The surveys come rolling in, with patients claiming they "never saw a doctor" during their visit. I worry they may lack confidence in my decision-making ability and diagnostic skills, while the male physicians in my group get glowing reviews. In a world where patient satisfaction is increasingly tied to physician pay, this is frustrating and unfair. My male chairman has suggested I wear my white coat during my shifts. That may influence my patients' perception of me as a more confident and trustworthy professional, as many studies have suggested. However, in an age when every lab tech, pharmacist, volunteer, and even housekeeper wears one, the lab coat has lost it's long-standing association with the medical profession. Also, in a recent review of patient preferences for physician attire in the *British Medical Journal Open*, it was found that patients receiving emergency or intensive care have no preference for formal attire and may actually prefer physicians who wear scrubs, regardless of gender.

In addition, I find that patients speak differently to me than to my male colleagues. I am often called "honey," "sweetie," and "baby" — while they are called "sir" and "doctor." Other female physicians are upset by patients consistently addressing them by their first names. I'm told that I'm "too pretty" to be a doctor and met with surprised expressions when I introduce myself as Dr. Ward. This leads me to wonder: what does a doctor look like? Furthermore, what does an emergency physician look like?

While 48% of medical school graduates are female, emergency medicine is still a male-dominated specialty. Only 23.5% of doctors entering emergency medicine residencies in 2010 were female, according to the AAMC report on residencies. This increased only slightly to 37.6% in 2014. This information was surprising to me, as one thing that drew me to EM as a young woman was the more flexible schedule that comes with shift work. It is hard to know how we should begin to address these pervasive stereotypes, but I know the first step is to create greater awareness of the issues women face in medicine and other STEM fields. We should advocate for our female colleagues, not just for equal pay, retention in the medical profession, and access to leadership positions, but for recruitment into specialties such as emergency medicine too. We should question our own biases and call out others when their communication with and about women in medicine and science is not in sync with the reality of the modern world. Maybe the female surgeons are onto something. So let's start our own movement, and hopefully we can change the face of medicine — one selfie at a time.

"As a woman in the emergency department, it is often assumed that I am not a physician."

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"MOCK" Twitter — A Quick Guide for Technophobes

Loice Swisher, MD FAAEM
Social Media Committee

From across the room, I heard, "Hey Loice. I didn't know you were going to be here. What are you doing?"

I glanced up from my phone to see a guy from residency for the first time in more than two decades. I guess he was surprised to see me since I had fallen off the academic map when my preschool daughter was neurologically devastated from a cancerous brain tumor resection. Instead of conferences, abstracts, and committees, my life had been filled with oncology visits, tube feeds, and therapy. Working nightshifts allowed me to take care of her and still have health insurance. I had drifted far from my planned path and I hadn't attended a professional conference in over 15 years.

I replied, "I'm now on the social media committee. I'm tweeting out some pearls from the conference."

I recognized those rolling eyes in front of me and fully anticipated the response, "I don't tweet." I could almost hear him thinking, "Who do you follow? Is it Justin Bieber or the Kardashians? Can anything worthwhile possibly be said in 140 characters? I'm too busy for a time-stealer like that."

Smiling in reply, I answered his thoughts, "I just use Twitter professionally; just for emergency medicine."

There are many out there who mock Twitter; perhaps they don't need it. Maybe Twitter is of no value to them. But for someone like me, who was nearly lost at sea, Twitter was like water for a parched and withering soul.

Anyone who knows me knows that I am a serious technophobe. If I'm to use something that requires being plugged in, then it has to provide me with an undeniable and unequivocal benefit. And it must be easy to use. I'm always shocked when someone asks me for a technology recommendation, as I'm usually the late-adopter. But not so with Twitter. I've decided "MOCK" is the perfect acronym to introduce Twitter to those who might skeptically mock it.

Here is why I'm on Twitter:

M — Motivation:
Tweets have gotten me to click links which I never would have without motivation. Seeing others' threads has renewed my spirit of inquiry. I know that without Twitter I would never have found the online creative magazine, 99u.com, or David Marquet's article "Why Motivating Others Starts with Right Language." What began as a Tweet in my feed, is now my foundation for developing leadership skills in my team.

O — Opportunity:
Having strayed from the academic path for so long, I wondered how I would find connections again. I'm a nocturnist in a community setting. How could I possibly find opportunities? However, with Twitter, opportunities seem to just appear on my screen. And unlocking these opportunities only requires a quick tweeted response. One early response soon led to a book review in Annals.

C — Community:
Working nights can be lonely as there just aren't that many people around. Twitter can help with this as you can build a virtual community to find resources and develop ideas. One of my favorite communities is the Academic Life in Emergency Medicine or ALiEM group and their MEDiC series. Interacting with others, even virtually, has increased my passion for resident education.

K — Knowledge:
And then there are the facts. Much of the initial commentary on any new article or podcast is to be found on Twitter. Twitter is also a place for those who love to challenge dogma. Twitter keeps me up-to-date.

With its short messages covering a multitude of topics and open access, 24/7 format, Twitter seems perfectly designed for the busy EMP. For those looking to re-energize their practice or reignite their passions, Twitter might be for you. It was for me. ■

The Sixth Inter-American Emergency Medicine Congress in Mendoza, Argentina

Gary Gaddis, MD PhD

The Sixth Inter-American Emergency Medicine Congress is rapidly approaching, and I hope you will take advantage of this special opportunity to experience an international emergency medicine congress. The dates are June 8-10, 2016.

The Argentines held prior Inter-American Congresses in Buenos Aires, but for 2016 they have moved the meeting to a new, exciting location — Mendoza, Argentina. Mendoza is at the foot of the Andes Mountains and is at the center of the largest wine-making region in Latin America. Those of you who are oenophiles know that Mendoza is world-renowned for its production of Malbec. Even though the meeting is in June, I have been assured that many wineries will be open for tours. You will also be able to pair your wine with fantastic food. With more than 400 restaurants ranging from five-star palaces to local cafes, Mendoza is a gastronomic delight.

With over 330 days of annual sunshine, picturesque Mendoza is also a center for adventure tourism such as skiing, rafting, and hiking. It is the gateway to Mount Aconcagua, the highest peak outside the Himalayas and a mecca for climbers.

In addition, the Mendoza region was ranked by a 2010 National Geographic survey as one of the top historical destinations in the world.

Mendoza can be reached most easily via connecting flights from Santiago, Chile, or Buenos Aires. Economic forces at play currently make your dollar go farther in Argentina than ever before.

AAEM has contracted with the Sociedad Argentina Emergencias to collaborate in the production of the Inter-American Congress biannually through 2020. This is in keeping with AAEM's commitment to produce one national meeting, the annual Scientific Assembly, and an international congress each year.

The meeting cannot succeed without American attendance and collaboration. You have the chance to attend state of the art lectures in English by distinguished experts, delivering scientific presentations in a location that you will not soon forget. I hope to see you at the 2016 Inter-American Emergency Medicine Congress in Mendoza. ■

New Resource for EPs Treating Suicidal Patients and their Families

The Rocky Mountain Mental Illness Research, Education & Clinical Center (MIRECC) studies suicide, with the goal of reducing suicidal ideation and behaviors in the veteran population. Education is one of MIRECC's three strategic arms, translating research and best practices into resources that support veterans and the families, communities, and providers who care for them.

MIRECC recently released a product entitled "How to Talk to a Child about a Suicide Attempt in Your Family." This product (a combination booklet/video) is designed to provide critical family support immediately following a suicide attempt, with guidance for meeting the needs of three developmental groups: preschool, school-age and teens. As suicidal individuals are often treated and stabilized in an emergency department, this product provides emergency personnel with ready tools to help meet highly specialized patient needs. Each product is available free for virtual download (or hard copy booklet/DVD combination) in either English or Spanish, as well as captioned for the hearing-impaired.

Please visit the "How to Talk to a Child about a Suicide Attempt in Your Family" website (www.mirecc.va.gov/visn19/talk2kids/) to learn more about the project and access the booklet/video online. Print booklets may be ordered free of charge (along with all our other educational resources) through our public order form: www.mirecc.va.gov/visn19/orderform/orderform.asp. ■

Play Smart, Your Brain Matters — New Concussion Resource Available

Funded by the District of Columbia Department of Health, the Children's National Health System, Medstar Sports Medicine, the D.C. Department of Parks and Recreation, the D.C. State Athletic Association, and the Brain Injury Association of D.C. have teamed up to create a toolkit that other states and jurisdictions can use to reduce the long-term health dangers associated with the failure to recognize and treat concussions in young athletes.

The District of Columbia is the first city in the nation to receive funding to explore and enforce the Athletic Concussion Protection Act of 2011 through educational and awareness activities. So far, the public awareness campaign has reached 5,558 students, parents, coaches, and community members in the District of Columbia, and the concussion training program has been completed by over 600 coaches, athletic trainers, and school nurses in the District. Learn more and access the toolkit here: http://childrensnational.org/departments/resources-for-families/dc-concussion-awareness. ■

Scientific Assembly Highlights: Your Guide to AAEM16

"While at the Scientific Assembly, I urge you to come to AAEM's annual business meeting and election forum … you will get to hear from those running for AAEM offices and for the board of directors, ask them questions, and judge their answers. **This is important.**"

—Andy Walker, MD FAAEM
Common Sense, Editor

State of the Academy, Town Hall, & Candidates' Forum and Voting

Thursday, February 18, 2:00-3:30pm

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, Thursday, February 18, 2:00-3:30pm. 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 for 2016 so your vote counts!

Career Connections Fair

Friday, February 19, 6:00pm-8:00pm

Looking for a new employment opportunity? Physicians interested in new opportunities are invited to network with physician recruiters at the London Club, located inside Planet Hollywood on Friday, February 19, 6:00pm-8:00pm. Learn more at www.aaem.org/AAEM16/career-fair.

Career Connections Fair Exhibitors – Visit the AAEM16 website for an updated list!

- CEP America
- Emergency Medicine Associates, P.A., P.C.
- Emergency Service Partners, L.P.
- EMrecruits
- Leading Edge Medical Associates (LEMA)
- LSU Emergency Medicine Health Sciences Center in New Orleans, LA
- Mayo Clinic
- MEP Health
- Weatherby Healthcare
- WPA Emergency Medicine Staffing

See You in Las Vegas!

Women in Emergency Medicine & Diversity Interest Group Networking Event

Details coming soon!

The Women in Emergency Medicine and Diversity Interest Groups warmly invite their members and those interested in joining their groups, to an appetizer reception. This will be a great opportunity for networking and socializing. The reception will immediately follow the Women in Emergency Medicine track at AAEM16. Watch the website for more details! www.aaem.org/AAEM16/socials.

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.

International Reception

Details coming soon

A light reception will immediately follow the International Resident Issues track on Saturday, February 20.

Watch the website for more details.

Pre-Conference Courses

Kick-off AAEM16 by signing up for one of our specialized pre-conference courses. The attention to detail, small course sizes, and specialized instruction is not to be missed. Visit the AAEM16 website for full course descriptions, pricing, and faculty information. www.aaem.org/aaem16/program/preconference-courses

Wednesday, February 17, 2016

Morning Sessions

- 7:30am-12:00pm
  Emergency Neurological Life Support Course (ENLS)
  Jointly provided by the Neurocritical Care Society
- 7:30am-11:30am
  Resuscitation for Emergency Physicians - Part 1
  1.5 day course
- 8:00am-3:45pm
  Challenges in the Management of the Morbidly Obese in the Emergency Department
  Jointly Provided by CAL/AAEM
- 8:00am-3:45pm
  Ultrasound – Beginner

Afternoon Sessions

- 12:30pm-4:45pm
  Simulation – Obstetrics
- 1:00pm-5:00pm
  Resuscitation for Emergency Physicians - Part 2
  1.5 day course
- 1:00pm-5:00pm
  So You Think You Can Interpret an EKG?
  Free for resident members! Registration required.

Thursday, February 18, 2016

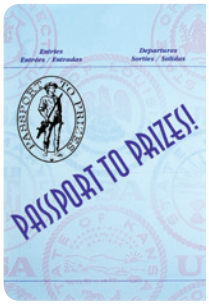
Morning Sessions

- 7:00am-11:45am
  Simulation – Pediatrics
- 7:30am-11:30am
  Resuscitation for Emergency Physicians – Part 3
  1.5 day course
- 8:00am-12:00pm
  2015 LLSA Review Course
  Free for AAEM members! Registration required.
- 8:00am-12:15pm
  2016 Medical Student Track
  Free! Open to medical students only. Registration required.
- 8:00am-12:00pm
  Operations Management Updates: What You Need to Know in 2016
- 8:00am-12:00pm
  AAEM Emergency Physician Assistant Fellowship Challenge Bowl
- 8:00am-12:00pm
  Ultrasound – Advanced
- 8:00am-12:00pm
  Responding to the Disaster – When Your World Becomes Austere
  Jointly Provided by USAAEM

Thank You to Our Exhibitors!

- AHC Media, LLC
- Biodynamic Research Corporation (BRC)
- CEP America
- Chiesi USA, Inc.
- Elsevier, Inc.
- Emergency Medicine Associates, P.A., P.C.
- Emergency Physicians Insurance Exchange RRG
- Emergency Service Partners, L.P.
- EMrecruits
- Emergency Physician Partners
- Enovative Technologies
- EPOWERdoc, Inc.
- EvidenceCare
- Hays Innovations
- Infinite Trading, Inc.
- Intermedix
- Leading Edge Medical Associates (LEMA)
- LocumTenens.com
- LogixHealth
- Mallinckrodt Pharmaceuticals
- Martin Gottlieb & Associates
- Mayo Clinic
- MEDISERV, LTD
- MEP Health
- Mint Physician Staffing
- Mooney & Co, Inc.
- National Medical Professionals
- Neighbors Emergency Center
- NeilMed Pharmaceuticals, Inc.
- Nicka & Associates
- PEPID, LLC
- Practice Velocity
- Rhino Medical Services
- Scribe Solutions, Inc.
- Shift Administrators, LLC
- Staff Care
- Standard Register Healthcare
- TeedCo Healthcare Recruiting
- Texas Association of Freestanding Emergency Centers (TAFEC)
- Texas Tech Health Sciences Center at El Paso
- ThedaCare, Inc.
- TIVA HealthCare, Inc.
- Weatherby Healthcare
- WPA Emergency Medicine Staffing, LLC
- Zerowet, Inc.
- Zotec Partners

View more at www.aaem.org/aaem16/exhibitors-and-sponsors/list.



Passport to Prizes

All conference attendees will receive a passport book in their registration materials onsite. Visit all participating exhibitors in the exhibit hall February 18-20 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/AAEM16/passport.

View the AAEM16 Program

Visit the AAEM website for 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/AAEM16/Program

Connect with AAEM16!

Download our mobile app by scanning the QR code or visiting http://eventmobi.com/aaem16.

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

Follow @AAEMinfo on Twitter and use hashtag #AAEM16 for Scientific Assembly tweets.

Flight information? Dining recommendations?

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

www.aaem.org/AAEM16/travel

Highlights for Residents and Students!

The 22nd 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/AAEM16/residents** **www.aaem.org/AAEM16/students**

Dear AAEM Member,

Enclosed are the candidate statements for the 2016 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 2016 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 February 18, 2016, 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 February 18, 2016 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 February 18, 2016, at 11:59pm CT. Mailed ballots must be received by February 12, 2016.

Balloting Procedure for 2016:

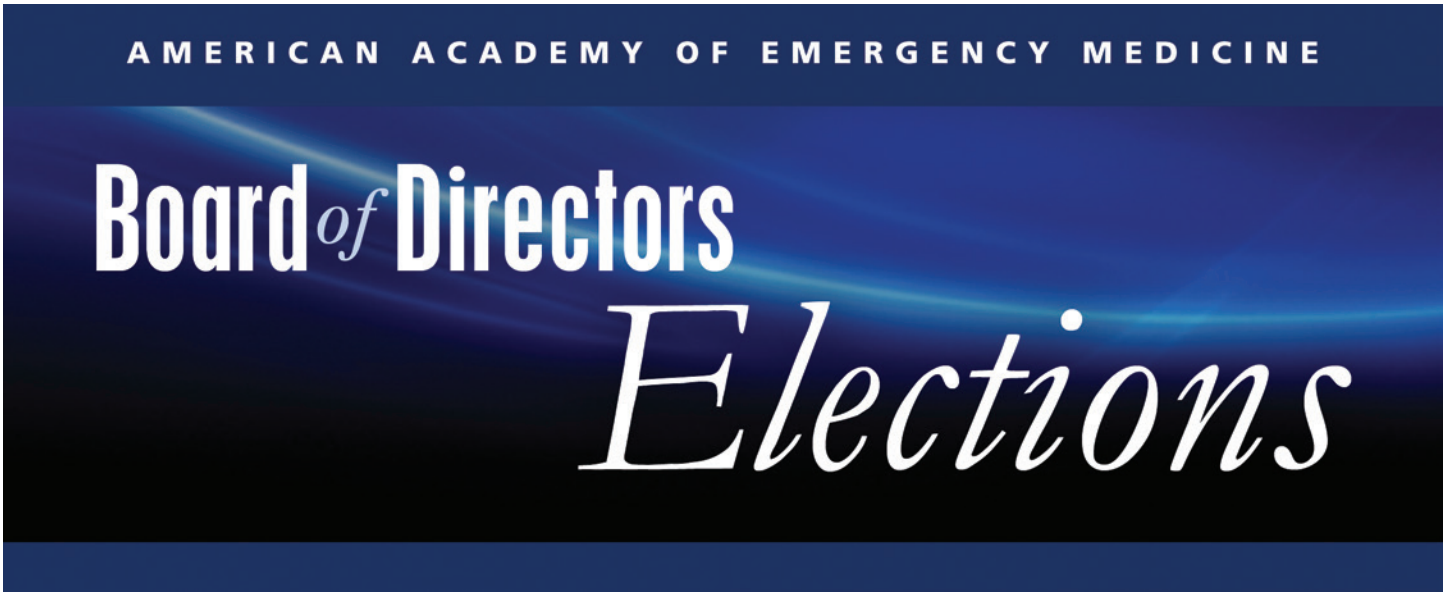
- ***Voting ballots will be available online only prior to Scientific Assembly.***
  Please visit www.aaem.org/elections to cast your vote electronically or download a paper ballot. You may submit ballots by mail to AAEM Elections, 555 E. Wells St., Suite 1100, Milwaukee, WI, 53202. *Please note that 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 February 18, 2016.

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.

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 Las Vegas for the Forum and final elections. ■

President-Elect

To ensure clear planning and leadership succession each term, the AAEM board of directors has introduced a president-election position on the board. This officer will serve a two-year term as president-elect and then transition to a two-year term as president. The 2016 election is unique in that both a president and president-elect will be elected this transition year. In 2018, only a president-elect position will be included on the ballot. ■

Important Dates

- Online voting opens: November 25, 2015
- Mailed paper ballots must be received by: February 12, 2016
- Attend the State of the Academy, Town Hall, & Candidates' Forum: February 18, 2016 from 2:00pm-3:30pm
- Online voting closes: February 18, 2016 at 11:59pm CT ■

Kevin G. Rodgers, MD FAAEM

Candidate for President

Nominated by: Carey D. Chisholm, MD FAAEM; Robert McNamara, MD FAAEM; Mark Reiter, MD MBA FAAEM; and Joel Schofer, MD MBA CPE FAAEM

Membership: 1999-2015
Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2002-2008, 2011-2016
AAEM Foundation Board of Directors 2011-2016
AAEM Vice President 2014-2016
AAEM Secretary-Treasurer 2012-2014
Joe Lex Educator of the Year Award 2009
AAEM Written Board Review Course Top Speaker Award 2012
AAEM Representative ACGME/RRC EM Milestone Working Group 2012-2013
ACCME Subcommittee 2011-2015
ACCME Accreditation Review 2011, 2015
Education Committee Board Liaison 2014-2015
Education Committee 2011-2015
Finance Committee, Chair and Board Liaison 2012-2013
Scientific Assembly Subcommittee Co-Chair 2012-2014
AAEM/RSA's *Emergency Medicine: A Focused Review of the Core Curriculum*, Author
AAEM/RSA Board Liaison 2013-2015
Scientific Assembly, Speaker 2011-2015
AAEM Representative ABEM Board Eligibility Working Group 2015
AAEM/RSA Program Director of the Year Award 2015
Scientific Assembly, Pre-Conference Course Speaker 2010
Scientific Assembly, Photo Competition Judge 2011-2014
Scientific Assembly, Open Mic Judge 2012, 2014
Scientific Assembly, Morbidity & Mortality Judge 2012, 2015
Oral Board Review Course, Examiner 2011
Oral Board Review Course, Director 2011-2014
Written Board Review Course, Speaker 2011, 2013, 2015
Mediterranean Emergency Medicine Congress (MEMC) Executive Committee 2012-2013
Mediterranean Emergency Medicine Congress (MEMC), Speaker 2011, 2013, 2015
Mediterranean Emergency Medicine Congress (MEMC), Abstract Judge 2015
AAEM/RSA Midwest Medical Student Symposium, Speaker 2013-2015
AAEM & AAEM/RSA Residency Visit Speaker 2012-2015
Common Sense Author

"Leadership is the capacity to translate vision into reality."-Warren Bennis

Bob McNamara, Joe Wood, Antoine Kazzi, Tom Scaletta, Larry Weiss, Howard Blumstein, Bill Durkin, Mark Reiter. Big shoes to fill, but I believe that my eleven years on the Board of Directors (including my time as Treasurer and Vice-President) and the opportunity to serve with and learn from this dynamic cadre of AAEM presidents has prepared me for the challenge! I know our organization, I know where we've been, I know where we must go. Today more than ever, AAEM must lead the way as the preeminent EM organization protecting the rights of the individual board-certified EM physician as well as those of our patients. I enthusiastically embrace the opportunity to lead AAEM into the future.

How will we do that?

We must steadfastly uphold our focus on supporting our mission statement. As the influence and control of CMGs continues to grow, we must find new ways to support our members in maintaining and creating fair and equitable practice environments. Insuring that the newly created AAEM Physician Group receives all the necessary resources to successfully grow and sustain democratic EM groups is a major innovative step in the right direction.

We must be diligent in identifying threats to AAEM members such as joint ventures and the elimination of balance billing for out-of-network emergency care. The best counter to these threats is to increase our visibility and influence in Washington with Congress and CMS, thus invoking legislative changes that protect EM physicians across the country.

While we continue to champion the most important AAEM tenant, board-certification in EM, we should challenge and collaboratively work with ABEM on ways to streamline and improve the maintenance of certification process.

We must enhance and expand our educational opportunities for members as well as EM physicians around the world. While maintaining Scientific Assembly as the most renowned and affordable EM educational venue is a given, we should also focus on creating more on-line resources for CME, fostering opportunities for FOAMed, and supporting the development of international EM meetings.

We must increase the productivity of our organization by increasing and utilizing our most important resource, our members. Successful growth of our organization is dependent upon aggressive recruitment and retention of EM residents and medical students through support of the RSA. They are our future! Meanwhile, enhanced productivity is directly tied to utilizing the talents of our members through our committee structure.

My mantra: "There is no greater calling than service to others." When I became involved in AAEM in 1997, I believed it was the best organization in EM through which I could advocate for my patients, colleagues and specialty. Now I want the opportunity to lead those with similar beliefs. As an organization, AAEM is setting the agenda for the future of our specialty and the specialist in Emergency Medicine. I believe I have the foresight, commitment and energy to lead that charge. ■

David A. Farcy, MD FAAEM FCCM

Candidate for President-Elect

Nominated by: Mark Reiter, MD MBA FAAEM; Kevin G. Rodgers, MD FAAEM; and Lisa Moreno-Walton, MD MS MSCR FAAEM

Membership: 2002-2016
Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2015-2017
AAEM Foundation Board of Directors 2015-2017
Florida Chapter Division Board of Directors 2011
Florida Chapter Division President 2011-2014
Florida Chapter Division Immediate Past President 2014-2015
Florida Chapter Division Scientific Assembly Speaker 2011, 2013-2015
AAEM Joe Lex Educator of the Year Award 2015
Oral Board Review Course Examiner 2013, 2015
Scientific Assembly Speaker 2013-2015
Delaware Valley State Chapter Resident's Day Speaker 2013
AAEM & AAEM/RSA Residency Visit Speaker 2015
Mediterranean Emergency Medicine Congress (MEMC), Speaker 2013, 2015
Mediterranean Emergency Medicine Congress (MEMC), Abstract Judge 2013, 2015
State Chapter Committee 2011-2014
AAEM Podcast Contributor 2012-2015

As a member of AAEM since residency, I am honored to be nominated to lead the Academy in the future. I was born and raised in France and moved to the U.S. in 1987. After high school, I joined the U.S. Air Force and served as a medic, which sparked my interest in emergency medicine. As a resident at Maimonides Medical Center, I was enlightened by the lectures given by Dr. McNamara and Dr. Keaney about issues that we would face during our career. AAEM's mission statement strongly resonated with me. AAEM was the only organization truly advocating for its membership. AAEM was committed to core beliefs such as workplace fairness, transparency, and due process. AAEM was the only organization willing to take on well-funded contract management groups, hospital chains, and pharmaceutical companies when their actions could negatively impact emergency physicians and our patients.

As a resident member, I joined AAEM's critical care committee and became the resident representative for that section. My love for critical care led me to complete an emergency medicine critical care fellowship at Baltimore Shock Trauma. More recently, I have created several AAEM podcasts for critical care. Currently, I serve the Chair of the Department of Emergency Medicine at Mount Sinai Hospital in Miami, Florida, a community hospital that also hosts an osteopathic emergency medicine residency. I also serve as their Director of Critical Care.

Since the beginning of my career, I have been dedicated to helping AAEM accomplish its mission and vision. I practice in Florida, which likely has the highest penetration of contract management groups in the country. Workplace fairness is a major issue for emergency physicians in my state. I quickly became active in Florida's AAEM Chapter and was soon elected to the FL-AAEM Board. I served two terms as FL-AAEM President and currently am the Immediate Past President. As FL-AAEM President I developed the FL-AAEM Scientific Assembly, which greatly increased AAEM's exposure to Florida's emergency physicians. In addition, we provided members a free, high-quality meeting for CME, networking, and advocacy; we are currently planning our 5th meeting. When I began my involvement, AAEM had little to no representation in Florida. We rapidly grew our membership and now have a voice and a seat at the table, FL-AAEM has partnered with Florida ACEP on several legislative issues, and a legislative day, and together we have successfully repealed several bills.

I was recently elected to AAEM's Board of Directors. Our current AAEM Board, under Dr. Reiter's leadership, has been exceptional, and we are writing history as we speak. Our specialty is currently under attack, and the Academy is often our only major advocate on important issues that affect all of us. On the AAEM Board, I have been active and vocal, doing my best to represent community and academic emergency physicians, residents, fellows, and students. I am passionate about I will devote my best effort to lead this great organization. ■

Leslie Zun, MD MBA FAAEM

Candidate for President-Elect

Nominated by: William T. Durkin, Jr., MD MBA CPE FAAEM; Robert Suter, DO MHA FAAEM; and Larry Weiss, MD JD MAAEM FAAEM

Membership: 1993-2016

Disclosure: Service to other organizations, President Elect, American Association for Emergency Psychiatry

AAEM Board of Directors 1998-2002, 2011-2016
AAEM Foundation Board of Directors 2011-2016
AAEM/RSA Board Liaison 2012-2013
AAEM David K. Wagner Award 2011
Academic Affairs Committee 2011-2013, 2015
ACCME Subcommittee 2013-2015
Education Committee 2011-2015
Finance Committee 2012-2015
Operations Management Committee 2011-2015
Practice Management Committee 2011-2014
Independent Practice Support Committee 2015
Quality Standards Committee 2014-2015
AAEM Scientific Assembly Speaker 2011-2015
AAEM & AAEM/RSA Residency Visit Speaker 2012-2015
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011, 2013, 2015
Mediterranean Emergency Medicine Congress (MEMC), Abstract Judge 2015
Pan-Pacific Emergency Medicine Congress (PEMC) Speaker 2012
Inter-American Emergency Medicine Congress (IAEMC) Speaker 2014
Common Sense Author 2011, 2014-2015

I am running for President-Elect of the American Academy of Emergency Medicine because I am concerned about the direction emergency medicine is going. Sitting at the table with Jim Keaney, author of *The Rape of Emergency Medicine*, I experienced the humble beginnings of a great organization. The dream was to be the premier emergency medicine organization that represented the little guy, the practicing emergency physician. The goal has always been to secure an equitable and fair practice environment. As the unethical and unequitable practices continue to grow and thrive in this environment, our influence continues to shrink. We need to get back to our roots to protect, educate and promote board certified emergency physicians.

What is needed is to get back to a focus on the working emergency physician? We need to level the playing field for emergency physicians to work in the hospital of their choosing with due process and an equity stake in their practice. We must support AAEM Physician Group Practice, independent democratic groups and expand the benefits for physicians in order to compete with contract management companies. We need to educate students, residents, hospital administrators and other physicians about the detrimental effects of contract management companies. AAEM must be viewed as the "go to" organization both nationally and internationally. No longer can we stand by when other emergency medicine organizations provide their biased positions when queried by governmental and other related organizations. We need to be viewed as the lead organization that always takes the high ground for physicians and patients. And last but most important, we must stop the illegal and unethical collaboration between hospitals and contract management companies to increase their profits by taking physicians fees.

Thank you for your support. I look forward to serving the board certified emergency physician ■

John B. Christensen, MD FAAEM

Candidate for Secretary-Treasurer

Nominated by William T. Durkin, Jr., MD MBA CPE FAAEM; Robert McNamara, MD FAAEM; and Andy Walker, MD FAAEM

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

AAEM James Keaney Leadership Award 2002
AAEM Board of Directors 2012-2016
AAEM Foundation Board of Directors 2012-2016
Finance Committee 2012-2015
State Chapter Committee 2014
Practice Fairness Task Force 2015
Government Affairs Committee, Liaison 2012-2013
Government Affairs Committee 2015
California Chapter Division President 2014-2015
California Chapter Division Vice President 2013-2014
California Chapter Division Board Member 2011-2014
AAEM & AAEM/RSA Residency Visit Speaker 2012
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2015
Mediterranean Emergency Medicine Congress (MEMC), Abstract Judge 2015

I hope to earn your vote as AAEM's next Secretary-Treasurer. As Secretary-Treasurer of AAEM, powered by a passionate, long term commitment to AAEM's founding principles, I will bring over 25 years of extensive experience and innovation in:

- organizational leadership
- managerial (strategic) and financial accounting
- medical practice business valuation
- complex litigation on fair market value of management services in EM
- medicolegal risk management
- medical practice management
- pension fund management
- local, state and national advocacy on complex issues of fairness in emergency medicine work environments

At a time when medical professionalism is under siege by CMGs, I believe broad and deep expertise is needed on the AAEM Executive Committee to best represent the interests of AAEM's members.

AAEM Mission Statement Number 5, the support of fair and equitable practice environments—AAEM's founding principle, has been the heart of my professional life. I've spent major segments of my 40 years in community-based EM struggling to right the wrongs posed by EM contract management groups and large hospital systems. Those struggles began in 1978 with legal action to break a restrictive covenant imposed by one of the original large CMGs in California to allow formation of one of the first democratic independent local EM groups in the state.

From 1997 to 2002, I led the largest legal action in EM's history on the fair market value of EM management services. Victory in that battle prevented the cumulative loss, to date, of over $140 million to working EPs in California and prevented several billion in potential losses to thousands of other hospital based physicians over the intended 30 year duration of the arrangement blocked by the lawsuit. In 2002 I received the James M. Keaney Leadership Award for my role in this incredibly complex legal action.

In February 2012, I was elected to AAEM's Board of Directors on my promise to lead the Academy to become "*an Independent Trustee to promote Fair Market Value transactions in every aspect of the business of EM"* and to create and develop an AAEM "*Practice Fairness Toolkit*" that rigorously delineates what fairness is in the many facets of the practice of EM. On December 5, 2012, I am happy to report that AAEM's Board unanimously approved the establishment of AAEM as *The Trusted Advocate of Fairness in Emergency Medicine*TM and the formation of the *AAEM Practice Fairness Council*.

I would be honored to serve as AAEM's Secretary-Treasurer to repay my debt of gratitude to the Academy through service to its Members.

Education: University of Michigan Medical School (M.D., 1973)
Board Certification: ABEM (1982), ABIM
Selected Professional activities:
California Medical Association (CMA), Delegate
CMA Hospital Based Physician Forum, member
Santa Cruz County Medical Society, Board of Governors
Santa Cruz Emergency Physician Medical Group, Inc., CEO (1992-2011), CFO (1992-2009)SCEP Pension-Profit Sharing Plan Administrator (1992-present)
Med-America Mutual Risk Retention Group (medical liability insurance company), Claims Advisory Council member (2001-2010)
Institute of Management Accountants (IMA), member
National Association of Certified Valuators and Analyst (NACVA), member ■

Lisa Moreno-Walton, MD MS MSCR FAAEM

Candidate for Secretary-Treasurer

Nominated by: Mark Reiter, MD MBA FAAEM; Kevin G. Rodgers, MD FAAEM; David A. Farcy, MD FAAEM FCCM

Membership: 2001-2015
Disclosure: Nothing to disclose at this time.

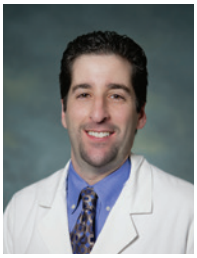
AAEM Board of Directors 2015-2107
AAEM Foundation Board of Directors 2015-2107
ABEM Certification White Paper Task Force 2011
Academic Affairs Committee 2011-2015
Education Committee 2011-2015
Learning Management System Task Force 2014-2015
Scientific Assembly Planning Subcommittee 2014-2015
Women in Emergency Medicine Interest Group 2014-2015
Women in Emergency Medicine Interest Group, Board Liaison 2015
Oral Board Review Course Examiner 2011
Scientific Assembly Speaker 2011, 2012, 2014, 2015
Scientific Assembly Abstract Judge 2012, 2014, 2015
Scientific Assembly Open Mic Judge 2014
Scientific Assembly Diagnostic Case Competition Judge 2014
Mediterranean Emergency Medicine Congress (MEMC) Steering Committee 2015
Mediterranean Emergency Medicine Congress (MEMC) Scientific Committee 2015
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2011, 2013, 2015
Mediterranean Emergency Medicine Congress (MEMC) Abstract Judge 2011, Chair 2015
Mediterranean Emergency Medicine Congress (MEMC) Clinical Case Competition Organizer 2015
Pan-Pacific Emergency Medicine Congress (PEMC) Speaker 2012
AAEM & AAEM/RSA Residency Visit Speaker 2015

When I ran for the Board last year, I shared that when I decided to change specialty from Surgery to Emergency Medicine, I enrolled in EM residency training. I don't believe that it's ethical or responsible to practice EM without appropriate training. I am proud of the body of knowledge and the skill set that define EM as a specialty which cannot be practiced by anyone who has not met the requirements of board certification. I am proud of the Academy's unwavering commitment to the highest standards of practice, graduate medical education, fair and equitable practice environments necessary for delivery of the highest quality patient care, and the establishment of EM internationally as an independent specialty.

Since my election to the Board, I have actively participated in decision making in a timely and thoughtful manner. Last year, I authored a proposal to develop Women in EM Interest Group, and support this IG as Board liaison. This year, I authored a proposal to establish a committee on Diversity and Inclusion, to further broaden the scope of the Academy's membership to better reflect today's diverse EM practice, and to increase our appreciation of diversity and cultural competency, supporting our commitment to every patient's right to the highest level of care. I proposed a scholarship program for international EM residents to attend Scientific Assembly and learn from the Academy- particularly RSA- the true principles on which EM was founded and can thrive. Along with colleagues, I worked with the Polish Society for EM to develop a Young Physician Section, and am working with the Lebanese Society to develop a strong chapter committed to Board certification and residency training. I have engaged the Minister of Health in Cuba in plans for consultation and educational collaboration with the Academy. I have formed an alliance with the National Medical Association and, with Dr. Reiter, am working to establish a joint membership agreement with NMA. At the recent Mediterranean Emergency Medicine Congress, I served on the Scientific Committee and chaired the Abstract Committee, reviewing over 600 abstracts from >60 countries, setting up scientific sessions and engaging representatives from Puerto Rico, Central America and the Middle East to serve as speakers and moderators.

At Louisiana State University-New Orleans, I continue to serve as Professor of Emergency Medicine, Director of Research, Director of Diversity, and Director of HIV and HCV Testing. In addition to the clinical practice of EM, I am a well-funded researcher and an award winning educator.

This year, I again request the honor and privilege of serving you. I am nominated for Secretary-Treasurer by the current president, vice president, and candidate for president elect. As an executive board, we will work collaboratively to accomplish much for the Academy. We are mature enough in our careers to have experience and judgement, yet recent enough residency graduates that our perspective is fresh and current. I promise to work always in support of the Academy's mission and to serve our membership with dedication, passion and pride. ■



Scott Goldstein, DO FAAEM

Candidate for At-Large Director

Nominated by: Self Nomination

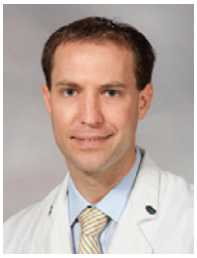
Membership: 2009-2016

Emergency Medical Services (EMS) Committee 2012-2015
Scientific Assembly Speaker 2013

I am Dr. Scott Goldstein, a member of AAEM, an academic and clinically practicing Emergency physician in the Philadelphia area. I have been involved in emergency medicine since 2002. Within these 13 years I have a gained a strong interest in academics, education and pre-hospital medicine.

In my time as an emergency physician I have the honor to be part of many committees locally and nationally, specifically EMS and education, and feel that I would like to expand my involvement to a higher level. This interest is to have a greater impact on the current and future generations of emergency physicians along with our specialty as a whole. AAEM is not just US known, but world renown, for its ability to make change, educate and advance emergency medicine. To be involved with such a prestigious organization on a national level will help me give back to the emergency medicine community in a broader sense.

My local leadership positions as Director of Tactical Medicine and Director of Physician Support Unit along with my involvement with numerous committees within national organizations have prepared me well to take on this next challenge. I would be honored to be your next member at large. ■



Jonathan S. Jones, MD FAAEM

Candidate for At-Large Director

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

Membership: 2009-2015

Disclosure: Service to other organizations, Prior service as President of the Mississippi chapter of ACEP. I now still serve on the MS-ACEP board as Immediate Past President. My term for this position is set to expire in August 2016. The Mississippi state chapter of ACEP is mainly engaged in delivering educational content to EM physicians in Mississippi and is mainly composed of physicians from the University of Mississippi Medical Center (UMMC) which is the only academic center in the state. I was asked to participate in MS-ACEP as I oversee all educational content for the Department of Emergency Medicine at UMMC. I have never held a role in national ACEP. I feel that this service to MS-ACEP is beneficial to EM care in Mississippi and am glad that I participated. I do not feel that this service in any way conflicts with AAEM's mission and feel that it will not impede my dedicated service to the Academy.

AAEM Board of Directors, YPS Director 2015-2016
AAEM Founation Board of Directors 2015-2016
YPS Board of Directors 2013-2014
YPS Vice President 2014-2015
YPS Mentoring Program 2012-2014
Education Committee 2014-2015
Oral Board Review Course Examiner 2011-2015
Common Sense Assistant Editor 2013-2015
Common Sense Author 2012-2015
Scientific Assembly Speaker 2015
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2015
Mediterranean Emergency Medicine Congress (MEMC) Abstract Judge 2015
AAEM & AAEM/RSA Residency Visit Speaker 2015

Over the previous year, I served on the AAEM Board as the YPS director and I now ask for your vote to serve as an at-large director. I would have been content continuing to serve as the YPS director; however, I was recently notified that, as of this year, I am no longer "young" and so have been kicked out of the YPS. So maybe this means that I am now mature and experienced. No, just because I have graduated from the ranks of the young, doesn't mean I automatically get to join the ranks of the experienced. I find myself in that awkward phase that we thought we had all outgrown. I'm now experienced enough to know that the world of EM is not all wonderful, yet I'm naïve enough to keep trying to make it wonderful.

As a residency program director, I have a unique understanding of the challenges faced by new EM physicians today. I see my residents study hard and work hard and get excited about Emergency Medicine. I see them struggle through years of residency so that one day, they can practice good medicine on their own. Unfortunately, I then see some of them graduate into jobs where they cannot practice good medicine.

Over the last several years, I have served the Academy in multiple roles, from YPS Vice-president, to Education Committee member, to Assistant Editor of *Common Sense*, and this past year as YPS Director. To be honest, I have not dedicated my time to the Academy because I inherently love the Academy. No, I have done this because I love Emergency Medicine. Our profession can be the most rewarding and most noble in the world. For some of us it is, but for many it is not. I have served the Academy because it is the only organization which understands the threats to the specialty and which fights for both patients and physicians.

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I am running for an at-large Director position because I want to continue to serve the Academy. I want the Academy to do a better job reaching out to new EM physicians. Too many students, residents, and young physicians still don't understand the importance of due process, restrictive covenants, or other contract issues. Many students and residents, while members of AAEM, do not feel they are valued or encouraged appropriately. Students, residents, and young physicians don't have all the right answers, but they usually have all the right questions. We need to a better job educating and engaging with these groups. These groups often have the energy and ideas to truly affect change. We need to do a better job encouraging this. The first part of this is accessibility. We are colleagues, so please call me (601-421-1033) or email me (jsjones3@umc.edu) any time if you want to chat about Emergency Medicine. ■

Geoffrey D. Lifferth, MD FAAEM

Candidate for At-Large Director

Nominated by: David Lawhorn, MD FAAEM

Membership: 2005-2015
Disclosure: Nothing to disclose at this time.

Tennessee Chapter Division (TNAAEM) Member 2011-2015

I completed my training at the Brigham and Women's/Massachusetts General Hospital Harvard-Affiliated EM residency in 2002, then moved to Tennessee and was a founding partner in a private, democratic, single-hospital group where I eventually rose to become the Business Director. I've served as the Chair of my Hospital's Ethics Committee for the past three years, and will serve as my hospital's Hospital's Chief of Staff starting in January. I am involved in teaching EM residents and medical students when they come to my community hospital near Nashville. I recently became vice-president of the Academy's Tennessee chapter division, TNAAEM.

In my area, many private groups have been displaced by contract management groups over the last three years, which has increased my support for AAEM and its mission and finally pushed me to run for the Academy's Board of Directors. I passionately support the fair and equitable practice of Emergency Medicine, and want to fight for it. I have benefited greatly from AAEM's leadership and support, and I hope to give back by serving on the Board and furthering AAEM's mission. ■

Terrence Mulligan, DO MPH FAAEM FIFEM

Candidate for At-Large Director

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

Membership: 2009-2015
Disclosure: Service to other organizations, Board member, International Federation for Emergency Medicine; Personal interests, international emergency medicine development

Amin Kazzi International Emergency Medicine Leadership Award 2015
International Committee Chair 2015
International Committee Co-Chair 2012-2014
Scientific Assembly International Track Chair 2013, 2014, 2015
Government and National Affairs Committee 2014-2015
Mediterranean Emergency Medicine Congress (MEMC) Speaker 2005, 2007, 2009, 2011, 2013, 2015
Mediterranean Emergency Medicine Congress (MEMC) Executive Committee, 2015
Mediterranean Emergency Medicine Congress (MEMC) Steering Committee 2015
Mediterranean Emergency Medicine Congress (MEMC) Pre-Conference Course Director 2015
Mediterranean Emergency Medicine Congress (MEMC) Scientific Committee 2015
Mediterranean Emergency Medicine Congress (MEMC) Abstract Judge 2015
Inter-American Emergency Medicine Congress (IAEMC) Speaker, Moderator, Pre-Conference Course Director 2008, 2010, 2012, 2014
Pan-Pacific Emergency Medicine Congress (PEMC) Speaker 2014
Oral Board Review Course Examiner 2015
Young Physicians Section (YPS) Mentor 2013-2015

I am pleased and honored to have been nominated for the position of At-Large Board Member of the American Academy of Emergency Medicine. This past year I was the Executive Director of the highly successful 8th MEMC in Rome, and am currently a Board member of the International Federation for Emergency Medicine, representing all North American EM Societies since 2012. I've been an active member of AAEM for many years, and have been very active in AAEM's international programs for more than a decade. In addition, I've also been involved in investigating the formation of a combined Maryland/Washington, D.C. State Chapter of AAEM for the past 12-18 months, which is currently being considered by interested parties.

AAEM represents emergency medicine in its truest expression — with dedication to representing board-certified emergency physicians, ensuring due practice rights, and acting in the best interests of EM and EM specialists. Given my experience in helping build EM and acute care systems in over 35

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countries, I believe that 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 the U.S. and in global emergency medicine development.

I have completed two residencies and board certifications, three Fellowships, and two Masters degrees. I am a Clinical Associate Professor at the University of Maryland School of Medicine, and am Director of our 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 Professor in South Africa, India and China. In addition to working in academic EM, I have also worked extensively over the years in many community ED's, and understand the needs and concerns of the community-based emergency physician.

I am a co-founder and Board member of the African Federation for Emergency Medicine (AFEM), the past Chairman of the ACEP Section for International EM, a past chairman of the ACOEP International EM Committee, 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 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. ■

Joel M. Schofer, MD RDMS CPE FAAEM, Commander, Medical Corps, U.S. Navy

Candidate for At-Large Director

Nominated by: Robert McNamara, MD FAAEM; Mark Reiter, MD MBA FAAEM; and Kevin G. Rodgers, MD FAAEM

Membership: 1999-2016
Disclosure: Nothing to disclose at this time.

AAEM Board Member 2011-2016
AAEM Foundation Board Member 2011-2016
AAEM Young Educator Award 2011
Education Committee 2011-2012
State Chapter Committee 2012
Uniformed Services Chapter Division Secretary-Treasurer 2011-2012
Uniformed Services Chapter Division Scientific Assembly Preconference Planning Committee, Chair 2011-2012
Virginia Chapter Division President 2011-2013
Virginia Chapter Division Past President 2014-2015
AAEM/RSA *Rules of the Road for Medical Students*, Chief Editor
AAEM/RSA *Emergency Medicine: A Focused Review of the Core Curriculum*, 1st & 2nd Ed., Chief Editor
AAEM/RSA *EM Survival Guide*, Co-Editor
AAEM/RSA *Rules of the Road for Medical Students*, 2nd Ed., Author
AAEM/RSA Board Liaison 2010-2012
AAEM/RSA Publications Advisor 2011-2015
AAEM Scientific Assembly, Speaker 2009-2012, 2015
AAEM Scientific Assembly Photo Competition, Judge 2011-2012
AAEM Scientific Assembly AAEM/*JEM* Resident Research Competition, Judge 2011
AAEM & AAEM/RSA Residency Visit Speaker 2014-2015
Mediterranean Emergency Medicine Congress (MEMC), Speaker 2015
Oral Board Review Course Examiner 2014
Western Journal of Emergency Medicine, Clinical Practice Section, Editor 2011-2015
Journal of Emergency Medicine, Peer Reviewer
Common Sense Author 2011-2015

It has been a pleasure serving as AAEM Secretary-Treasurer from 2014-2016. While my military commitments will not allow me to run for the President-Elect position at this time, I would sincerely appreciate the opportunity to continue serving the AAEM membership as an At-Large member of the board of directors. I also appreciate the nomination to do so by Drs. McNamara, Reiter, and Rodgers and thank them for their support.

Our specialty is at a critical juncture in its history where the ever-expanding influence of contract management groups, increased government regulation, and electronic health records collides with physician autonomy and happiness. AAEM needs to continue to serve as a strong voice in the emergency medicine marketplace, advocating for its members as well as the patients they serve. The efforts by the organization, most importantly its efforts to form a physician group to support independent practice and its outreach to policy decision makers, need to continue. In addition, our educational outreach to the future of our specialty, the medical students and residents, should be strengthened to improve the future of our specialty.

My involvement in the board of directors would bring support for all of these critical initiatives and an unparalleled work ethic demonstrated by my extensive involvement in AAEM. I appreciate your consideration and would respectfully ask for your support in the upcoming election. ■

Thomas R. Tobin, MD MBA FAAEM

Candidate for At-Large Director

Nominated by: David Lawhorn, MD FAAEM

Membership: 2002-2015
Disclosure: Nothing to disclose at this time.

Independent Practice Support Committee, Chair 2015

I am honored and excited to be nominated for the AAEM Board of Directors. I would first like to thank Dr. David Lawhorn for the nomination. Given his many accomplishments and years of contribution to AAEM, his confidence in me is appreciated and humbling.

I became a member of AAEM during my first year of residency. Dr. Bob McNamara spoke at my residency in Pittsburgh and I immediately recognized the alignment of AAEM's mission and my own.

During the 11 years of my EM career I have personally experienced many of the great things in our specialty as well as many of the challenges facing Emergency Medicine. I was privileged to start my career with what could be considered the gold standard for Independent Democratic Groups. I had great mentors and teachers within the group and I learned a lot.

Unfortunately that group became one of the causalities of the push by hospitals to forgo community based independent groups and contract with CMG's. That provided the fire for me to become more active in AAEM and promotion of the mission.

Since that time I have continued to work in EM as well as spending more time and effort to help strengthen EM and the mission of AAEM. I obtained my MBA from the University of Tennessee for the sole purpose of strengthening my business knowledge in order better serve EM and the promotion of independent democratic group practices.

I believe I am now at a point where I have the experience and knowledge to serve AAEM and you, the membership, best by being on the board of directors. Thank you in advance for your consideration and support. Please feel free to contact me with any question.

After reading all of the candidate statements; Please take a couple of minutes right now to cast your ballot/vote. Your participation in the election process is critical to AAEM's continued success.

Yours in Service,
Thomas R Tobin, MD MBA FAAEM ■

Robert Stuntz, MD RDMS FAAEM

Candidate for YPS Director

Nominated by: Jonathan S. Jones, MD FAAEM

Membership: 2005-2016
Disclosure: Service to other organizations, I am a member of the social media committee for CORD. I am an Academic Emergency Medicine Social Media Faculty member (SAEM). I am a member of the Annals of Emergency Medicine Social Media Team. I do not chair or lead any of these, and do not feel that my responsibilities with these entities would pose any conflict with my responsibilities to AAEM.

Young Physicians Section (YPS) Secretary-Treasurer 2014-2016
YPS EM Flash Facts Author 2015
Social Media Committee, Chair 2014-2015
Social Media Committee 2012-2013
Young Physicians Section (YPS) Mentor 2015
Oral Board Review Course Examiner 2013

Hello, my name is Bob Stuntz, and I would appreciate your consideration for a position on the AAEM Board of Directors as the YPS director. I am currently the EM Residency Program Director and Vice Chair for Education at WellSpan York Hospital in York, PA.

Since my graduation from residency, AAEM and the YPS have been integral to my professional development. In the first years after graduation, I began pursuing educational interests within AAEM, serving as a Pearls of Wisdom Oral Board Review Course examiner since I was eligible. I also co-authored the introductory chapter to the second edition of the AAEM Focused Review of the Core Curriculum review book, and authored questions for two sections of the AAEM Board Review App, EM Flash Facts. I was fortunate to serve on the AAEM Social Media Committee, and subsequently became Chair. As Chair of the AAEM Social Media Committee, I have been able to lead the development and advancement of an AAEM Educational Twitter account that is staffed by social media committee members. Our goal is to advance AAEM's mission, sharing and advertising the great education we provide. We have also begun a social media column in *Common Sense*, attempting to educate others on the benefits of social media and how to best utilize available resources.

For the last two years, I have had the fortune of serving as the Secretary/Treasurer on the AAEM YPS board of directors. In this role, I have participated in the YPS CV review program and the YPS mentoring program. During my time on the board, I have had the privilege of working with some fantastic people, all of whom are invested in advancing the YPS. Having served on the YPS Board, I would now like to represent the YPS to the AAEM Board.

As I am nearing the end of my seven years of eligibility to be a member of the AAEM YPS, I have experienced firsthand the benefits of membership. AAEM and the YPS have helped me greatly as I have developed in my first years in practice. As a residency program director, I have extensive insight into the issues facing young physicians and residency graduates. As an active member of the YPS board the last two years, I have the insight into the YPS itself, and feel that I can be a strong representative and advocate of the YPS, and young physicians in general, to the AAEM board. It would be an honor to serve as the YPS Director and represent the young physicians within AAEM. Thank you for your consideration. ■

MEMC-GREAT 2015 and Upcoming International Conferences

Gary Gaddis, MD PhD FAAEM

AAEM has a long tradition of presenting important international emergency medicine conferences, and that tradition continued with the Mediterranean Emergency Medicine Congress (MEMC-GREAT 2015) Joint Congress in Rome, September 5-9, 2015. Prior MEMCs were produced and presented jointly with the European Society for Emergency Medicine (EuSEM), beginning with the first MEMC in Stresa, Italy in 2001. After MEMC VII in 2013 in Marseille, France, the leaders of EuSEM informed AAEM that they did not wish to continue to produce the MEMC together. However, AAEM was able to partner with the newly created Mediterranean Academy of Emergency Medicine (MAEM) and the Global Research on Acute Conditions Team (GREAT) to plan and deliver an excellent 2015 MEMC VIII.

As Scientific Co-Chair, I am pleased to report that the Congress was an unqualified success. Between the tracks organized by AAEM, MAEM, and GREAT, more than 150 hours of didactic presentations were available, along with 161 oral research abstracts, and 391 poster abstracts. There were more than 1,000 registrants from 47 different nations. The United States was represented by 135 invited speakers and 116 other registrants. As always, American attendees were able to obtain CME credit for their attendance.

The meeting officially began with an opening session on Sunday, September 6, after various pre-congress workshops held on September 5-6. At the opening session, as has been the custom at prior MEMCs, the top-scored research abstracts were presented and an overall Best Research Abstract Award was given. The winner was Antonia Helbling and her team from the San Antonio Military Medical Center, Fort Sam Houston, Texas, and the Eglin Hospital Department of Emergency Medicine, Eglin Air Force Base, Florida, for "Isopropyl Alcohol Nasal Inhalation Intervention of Nausea in the Emergency Department: A Randomized, Placebo Controlled Human Trial." Dr. Lisa Moreno-Walton, the Research Abstracts Chair, has more details about the abstract presentations in a separate item in this issue of *Common Sense*. In addition to addresses from numerous invited guests, the Minister of Health for Italy attended and made a presentation, in recognition of the growing importance of the specialty of emergency medicine in Italy.

Moving forward, AAEM will continue to produce not only its annual Scientific Assembly, but also international meetings at which AAEM members can obtain CME credit in foreign venues. Our Academy is committed to the delivery of at least one international emergency medicine conference annually, in addition to the annual Scientific Assembly. In 2016 these will include the Sixth Inter-American Emergency Medicine Congress, to be held June 8-10 in Mendoza, Argentina in cooperation with the *Sociedad Argentina de Emergencias*; and the Third Pan-Pacific Emergency Medicine Congress in the fall of 2016, currently still in the early planning stage. These international meetings present AAEM members with a great opportunity to combine international travel to great destinations — for both themselves and their families — with valuable education and CME credit. ■

Publication Clarification

In the November/December 2015 issue of *Common Sense*, we published a list of individuals who had been recognized by ABEM for 30 years of board certification in emergency medicine. We would like to clarify that this list was not intended to represent a cumulative list, rather it detailed the 2015 cohort who had reached their 30-year milestone. Full lists from both 2014 and 2015 are available on the ABEM website at: www.abem.org/public/news-notices-exam-dates-fees/other-news-announcements/abem-30-year-certificates. ■

AAEMLa Resident Conference and Annual Chapter Division Meeting

On October 21, 2015, the Louisiana Chapter Division of AAEM (AAEMLa) held a successful resident conference and annual chapter division meeting at the Louisiana State University Medical School in New Orleans. Presentations included: Ultrasound for Central Lines, Christy Butts, MD FAAEM; Pediatric Emergency Medicine Update, Chris Woodward, DO; The Opiate Epidemic, Maureen McCollough, MD MPH FAAEM; and Domestic Violence in the Emergency Department, Avery Thornhill Callahan, MD.

Physicians in Louisiana are welcome to join AAEMLa. Visit www.aaem.org/membership/chapter-division for more information. First year membership is free. ■

(L-R) Bruce V. Hurley, MD MPH; Avery Thornhill Callahan, MD; and Robert Mercadel, MD

(L-R) Christopher M. Voigt, MD FAAEM and Maureen McCollough, MD MPH FAAEM FACEP

Build Your Niche at AAEM: Palliative Care Interest Group

Palliative care is an opportunity for leadership within emergency medicine. ACEP prioritized Palliative Care in the 2013 Choosing Wisely Campaign.

As our patient population presents increasingly with symptoms of chronic rather than acute disease, palliative care is increasing relevant to emergency medicine. Palliative care is a continuum of care, starting from diagnosis of incurable disease and present until the final stages of hospice and comfort care.

The ED serves as gatekeepers to this continuum. Identifying and getting the right patients plugged in early reaps benefits: reduced ED visits, admissions, and costs, while also increasing quality of life and even survival.

Palliative care is a win-win and it is the right thing to do for our patients.

At Scientific Assembly this year, spend one hour of your time with us and learn more about how palliative care might fit into your practice. We join a broader conversation with our colleagues from ACEP, SAEM, and the American Academy of Hospice and Palliative Medicine.

Our Interest Group panel session will be helpful for those looking to:

- Understand the value of adding palliative care to your emergency medicine practice
- Network and share ideas around research and clinical opportunities in this start-up field
- Explore career opportunities for emergency physicians in palliative care inside and outside of the ED

Keep an eye out in the official program for more details. We are excited to have you join us!

Mari Siegel, MD FAAEM
David Wang, MD

Questions? Contact info@aaem.org. ■

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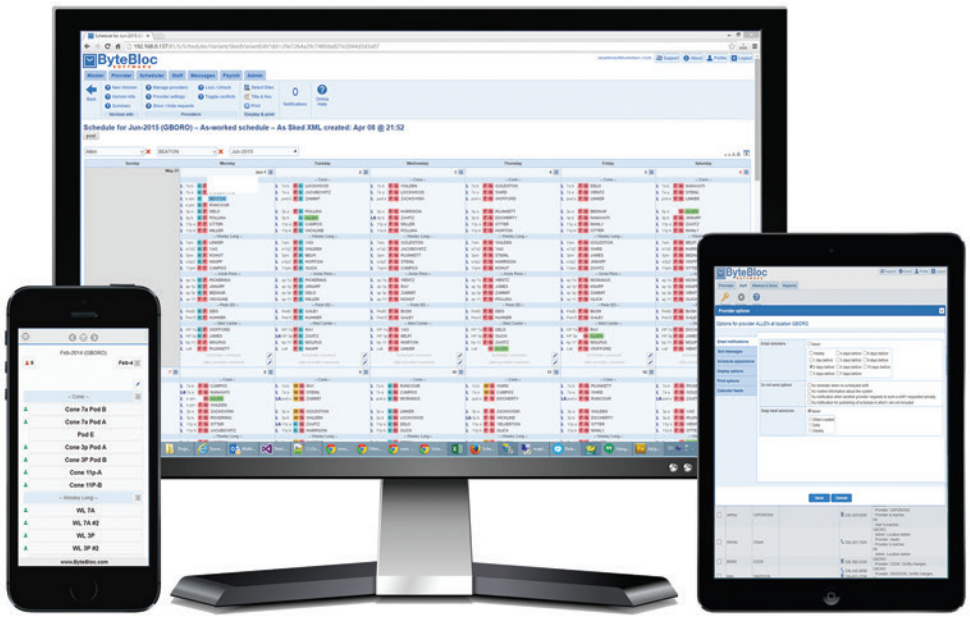

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AAEM/RSA President's Message

Unexpected Patient Demise in the Emergency Department

Victoria Weston, MD
AAEM/RSA President

I could hear the wails of grief coming from our trauma bay. It was the start of my shift, and the prior team had recently terminated an unsuccessful resuscitation. The patient had been chronically ill and had collapsed while checking in at our triage desk. Although the patient had cancer and had been unwell for years, his family was shocked and devastated by their sudden, unexpected loss.

Sometimes you see a patient come through the door and know things aren't going to go well, whether it's the obese tachypnic patient on full face mask gasping for air, the pale patient with an active GI bleed and reeking of melena, or the chest pain patient who is diaphoretic and ill-appearing. Other times, people come in with chronic illness but alert and looking well, only to die suddenly within a few hours of arrival.

There has been ample discussion over the past several years about dealing with unexpected death in the emergency department, and more recently when a photo of a grieving physician went viral earlier this year. We deal with unexpected illness and death on a daily basis — unlike many of our colleagues in other specialties, who practice in more controlled and predictable environments. Telling family members about an unexpected death or critical illness can be more deeply challenging than many of the other things we do.

I recently discussed this with a faculty member affiliated with my institution who has a wonderful bedside manner. She is pragmatic in her practice and honest with patients — when they are critically ill she tells patients they have a high chance of dying that day, and if they need to make any phone calls, now is the time. She is also honest with family members about the expected course. In her experience this has been successful, and although some of her patients have died in the ED, they had the opportunity to say goodbye to their loved ones and their loved ones had the chance to see them one last time and have closure as well.

When initially thinking about this approach, I envisioned myself in the patient's shoes. I wondered how it would feel to face your own mortality, and be told that today would probably be your last day. Then I pictured a patient I saw recently. She was in her fifties, with weeks of worsening abdominal pain. The CT showed a pancreatic mass with widespread metastases. The patient and her daughter were some of the nicest people I'd cared for that day and I dreaded giving them what was, in my mind, a death sentence. As I told the patient and her family, her daughter sobbed but the patient was calm — she already knew.

Addressing code status and goals of care on a busy shift can be a challenge, but perhaps by being forthright about patients' anticipated clinical course, we can help provide closure for patients and their families, allow for proper goodbyes, and set the stage for a more peaceful death. ■

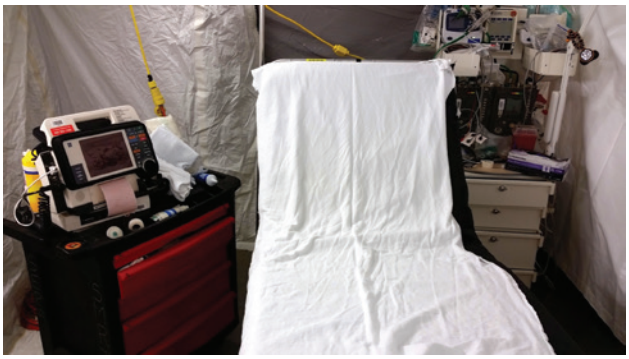
"We deal with unexpected illness and death on a daily basis — unlike many of our colleagues in other specialties, who practice in more controlled and predictable environments."

Disaster Preparedness and the Pope: A Resident's Perspective

Gregory K. Wanner, DO PA-C
AAEM/RSA Publications Committee Chair

Over the course of three days in September the city of Philadelphia went into lock down. The entire downtown area — approximately three square miles — was closed. Much of that area was sealed off with eight-foot tall barriers, guarded by hundreds of armed officers, and only accessible through an airport-style screening process. Our usually walkable city had become a maze of barricades. This was all in preparation for the visit of Pope Francis and up to a million of his admirers.

Philadelphia, a city of 1.5 million people, had reportedly never hosted such a large event spanning several days. Planning began months in advance. With my interest and prior experience in disaster medicine I scheduled an elective during that time, and became involved in some of the hospital planning. I joined a volunteer state medical assistance team and was credentialed to be part of the medical response for this enormous event. The following includes my observations from this unique part of residency, as well as some information for physicians who may be interested in providing care at mass-gatherings or in disaster areas.



"As law enforcement and the city worked out details for security and transportation, hospitals in Philadelphia's downtown area also began planning."

Preparation

As law enforcement and the city worked out details for security and transportation, hospitals in Philadelphia's downtown area also began planning. The possibility of a huge influx of patients and difficulties with supply deliveries led to stocking-up on critical medical supplies for the three-day weekend. Transportation concerns forced hospitals to plan for potential problems in discharging patients and getting staff members to work. To help ensure essential employees were available for their shifts, hospitals set up sleeping quarters and prepared to house employees for several nights. Although security would be tight and attendees probably less rowdy than at many other large events in Philadelphia, the possibility of a surge of patients — whether related to dehydration or a Boston Marathon-like situation — was a consideration during the planning phase.

Hospital Response

During the weekend a huge number of visitors entered the city. Three emergency departments, including two level-one trauma centers, were within a few blocks of the event's security perimeter. Despite the large crowds, including many elderly, the volume at nearby emergency departments was quite low. At Thomas Jefferson University Hospital (one of the trauma centers immediately adjacent to the security perimeter) we prepared for a possible surge of patients with additional staff members, including physicians, available both on-site and off-site via an emergency call list. Fortunately there was no need to bring in extra ED staff and the department remained relatively quiet.

Field Response

While the local emergency departments were seeing fairly low volume, field medical providers were seeing the bulk of patients. Ten medical tents were set-up around the area, a combination of first-aid stations for minor complaints and medical stations for more serious medical issues. I was stationed at the primary medical station located near the main stage, run by the Southeastern Pennsylvania State Medical Assistance Team (SMAT-3). Although I have previously trained and deployed with disaster organizations at the local and federal level, this was my first deployment with the Pennsylvania SMAT. The team's capabilities were truly impressive. Staffed with paramedics, nurses, physicians, NP/PAs, pharmacists, and support staff, the team was well stocked with personnel. Equally impressive was the portable medical facility, with more than twenty treatment areas equipped to handle anything from lacerations to ventilated patients (see photos). During the weekend the SMAT tent treated over 100 patients — most during one afternoon. A majority of the patients, including those with asthma exacerbations and dehydration, were treated and released, while a minority of patients with more serious presentations required transportation to local EDs. Caring for patients at such a large event was an interesting part of residency.

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Interest in Disaster Medicine and Preparedness

There are several ways for interested physicians (both attendings and residents) to become involved in disaster medicine. Hospital disaster preparedness or emergency management committees are a way to get involved in hospital planning. Medical Reserve Corps (www.medicalreservecorps.gov) are local government-affiliated disaster response groups that are present in many communities. On a state level, many states sponsor State Medical Assistance Teams (do a Google search for your state). The federal government, through the National Disaster Medical System (NDMS), sponsors many disaster response groups including Disaster Medical Assistance Teams (DMAT). Additionally, many well-known non-governmental organizations (NGOs) respond to disasters and provide assistance. For additional information consider visiting: www.phe.gov/about/oem/Pages/serve.aspx.

As that September weekend came to a close the crowds returned home, barriers were removed, and Philadelphians got their city back. Hospitals returned to business as usual, with the knowledge and experience gained helping to prepare for the next mass event. ■

Age-Adjusted D-Dimer in the Evaluation of Venous Thromboembolic Disease

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The D-dimer test is an important and widespread tool to assess for venous thromboembolic disease (VTE) in low risk patients. The test has a high sensitivity and negative predictive value; however it is also prone to false positives. Additionally, as D-dimer levels naturally rise with age, the test may lead to more frequent false positives in the elderly than the general population. Recently several investigations examined age related refinements to the interpretation of D-dimer results to rule out VTE. For this month's resident journal review, we review two retrospective studies and one prospective study that evaluate using age-adjusted D-dimer levels to increase its specificity while retaining its sensitivity. Verification of the results of studies could reduce the use of expensive imaging studies, reduce patient exposure to radiation and contrast, and prevent unnecessary hospital admissions and anticoagulation. These issues are particularly pertinent for the elderly population.

Gupta A, Raja A, Ip I, Khorasani R. Assessing the 2 D-dimer age-adjusted strategies to optimize computer tomographic use in ED evaluation of pulmonary embolism. *American Journal of Emergency Medicine*. 2014;(32):1499-1502.

The authors set out to validate a prospective European study by Righini et al., which showed that using higher D-dimer cutoffs for patients older than 50 years were more specific for diagnosis pulmonary embolus (PE) and did not increase the false negative rate.[1] This retrospective study took place from 2011-2013 in a single urban academic ED and used an automated quantitative D-dimer assay with a positive cutoff value of 500ng/mL. The study included 1,055 adult patients with D-dimer levels and computed tomography pulmonary angiograms (CTPAs). Using the traditional cutoff of 500ng/mL, sensitivity of D-dimer for PE was 100% (95% CI, 94.2%-100%) and specificity was 7.4% (95% CI, 5.8%-9.2%).

The authors then adjusted the D-dimer positive cutoff value based on age. Data was analyzed for individual ages (age in years x 10ng/mL) and in decade cohorts (e.g., patients 61-70 years old had a cutoff of 600ng/mL and 71-80 year olds had a cutoff of 700ng/mL). Using these cutoffs, decade-adjusted sensitivity was 98.7% (95% CI 92.1-99.9%) and specificity was 13.5% (95% CI 12.2-16.8%). Yearly-age-adjusted D-dimer had a sensitivity of 97.4% (95% CI 90.2%-99.6%) and a specificity of 16.7% (95% CI 14.4%-19.2%).

The authors concluded that using decade-adjusted cutoffs would have avoided 37 CTPAs (or 19.6% of patients older than 60 with a Wells score ≤4) and using yearly-adjusted cutoffs would have avoided 52 (18%) CTPAs. They note that a 52-year-old and an 87-year-old with a PE would have been missed reducing the decade-adjusted sensitivities to 93.3% and 85.7%, respectively. However, these are not statistically different than the sensitivities calculated for the traditional cutoff.

This study is limited because it is a retrospective review at a single hospital center using a single D-dimer assay which severely limits its generalizability. Also the authors do not comment about the severity of the PEs in the patients who were missed by increasing the D-dimer threshold. Even so this study suggests that for patients with a low Wells score and D-dimer below an age-adjusted cutoff, PE may be safely ruled-out most of the time.

Adams D, Welch J, Kline J. Clinical utility of an age-adjusted D-dimer in the diagnosis of venous thromboembolism. *Annals of Emergency Medicine*. 2014;64(3):232-234.

Adams et al., performed a systematic review and meta-analysis on the use of age-adjusted D-dimer to diagnose VTE. Among the five studies included, there were 13 patient groups. Six of these groups had suspected deep vein thrombosis (DVT) and the other seven groups had suspected PE.

The prevalence of VTE was lowest in patients less than 50 years of age and highest in patients 71-80 years of age. The sensitivity of D-dimer values was similar between ages in the conventional and age-adjusted cutoffs. The specificity of conventional D-dimer testing decreased with age. For example, specificity was 66.8% in patients less than 50 years of age compared to 14.7% in patients older than 80 years of age. The specificity of age-adjusted D-dimer also decreased with increasing age, but to a smaller degree when compared to the traditional cutoff.

This systemic review determined that the use of an age-adjusted D-dimer cutoff in older patients with a non-high clinical probability of VTE improves specificity of the test without compromising sensitivity. In 12 of the 13 groups, the determination of non-high-risk patients was based on clinical decision rules such as the revised Geneva score or Wells score. In the remaining group, it was determined by clinician gestalt (estimated clinical probability of less than 80% for DVT).

There were several limitations to this review. Two different reference tests were used among the studies. In addition, the D-dimer assays were different in each study. Lastly varying D-dimer cutoff values were used in the different studies. Overall this systemic review supported the feasibility of using an age-adjusted D-dimer cutoff to avoid excessive testing for VTE in older patients.

Righini M, et al. Age-adjusted D-dimer cutoff levels to rule out pulmonary embolism; The ADJUST-PE Study. *Journal of American Medical Association*. 2014;311(11):1117-1124.

The ADJUST-PE trial was a multicenter, multinational, prospective study which evaluated if an age-adjusted D-dimer could improve the rate of PE exclusion without increasing false negative results in older patients with suspected PE. The primary outcome was the failure rate of a diagnostic strategy using age-adjusted D-dimer. This was defined as the rate of symptomatic VTE (proximal DVT or PE) during a three-month follow up period in those in whom PE was excluded based on a negative age-adjusted D-dimer and accordingly had anticoagulation withheld. Patients

Continued on next page

were enrolled if they presented to the ED with acute onset chest pain or dyspnea without an obvious explanation for their symptoms.

Patients were placed into groups based on their risk of PE by using either a dichotomized 2-level Wells score (likely versus unlikely) or the simplified, revised Geneva score (high versus non-high). D-dimer levels were measured in the latter groups and interpreted according to an age-adjusted cutoff. In patients <50 years old, the traditional 500mcg/L was used. The study initially risk-stratified 3,324 patients (median age of 63 years old). Of these patients, 2,898 (87.2%) were deemed as non-high risk and therefore underwent D-dimer measurements. 673 (23.2%) of these patients were older than 75. Of the non-high risk group, 817 (28.2%) were below the standard cutoff of 500mcg/L (95% CI, 26.6-29.9%), while 337 patients (11.6%) had a D-dimer above 500mcg/L but below the age-adjusted cutoff (95% CI, 10.5-12.9%). 1,744 (60%) were above the age-adjusted cutoff and went on to undergo diagnostic imaging with CTPA. Using the age-adjusted D-dimer level resulted in 11.6 % more patients being D-dimer negative. Per this pathway, these patients were considered to not have PE.

On three-month follow up of patients with D-dimer levels below 500mcg/mL, the rate of thromboembolism was 0.1% (95% CI, 0.0-0.7%); those with D-dimer levels between 500mcg/mL and the age-adjusted cutoff had a 0.3% rate of thromboembolism (95% CI, 0.1-0.7%). Rate of thromboembolism in those who had positive D-dimer values or who were risk stratified into a high-risk group and who had a negative CTPA was 0.5% (95% CI, 0.2-1.0%).

The authors also looked more specifically at patients above 75 years of age of whom 200 of 673 (29.7%) in total had negative D-dimer levels using the age-adjusted cutoffs (95% CI, 26.4-33.3%). None of these patients had thromboembolic events on three-month follow up. One-hundred fifty seven of the 673 patients older than 75 and in the non-high risk group had a D-dimer level below their age-adjusted cutoff (23.3%) while 43 were below the traditional 500mcg/mL cutoff, thus increasing the rule-out rate in this specific age group from 6.4% (95% CI, 4.8-8.5%) to 29.7% (95% CI, 26.4-33.3%).

This study demonstrates the clinical utility of using an age-adjusted D-dimer cutoff in patients above 50 years of age as compared to a set cutoff of 500mcg/mL. Use of the age-adjusted cutoff increases the proportion of patients that can effectively have PE excluded without significantly increasing false negative rates. This may significantly benefit older patients (>75 years of age) who would fall into a category of nearly five-fold increase in the PE exclusion rate with no significant increase in the false negative rate.

While this study demonstrates how an age-adjusted D-dimer cutoff may result in higher PE exclusion rates in older patient populations, it would be informative to compare an algorithm of this type with one in which a standard pre-selected cutoff (e.g., 500mcg/mL) is used independent of age was used. Failure rates between each arm, as well as important clinical outcomes such as mortality, could be potentially elucidated.

Conclusion

There is a growing body of evidence in the EM literature supporting the use of age-adjusted D-dimer levels to safely exclude VTE in patients at low- or intermediate-risk of VTE in the ED. There are several significant benefits of a higher cutoff value including saving the cost and resources of further imaging as well as protecting the patient from exposure to contrast, radiography, prolonged hospital stay, empiric anticoagulation, and evaluation of inconsequential incidental findings. The studies reviewed here, as well as one recently published in the Annals of Internal Medicine, support the implementation of an age-adjusted D-dimer in EDs.[1]

References:

1. Raja AS, Greenberg JO, Gaseem A, Denberg T, Fitterman N, Schuur, J. Evaluation of Patients With Supected Acute Pulmonary Embolism: Best Practice Advice From the Clinical Guidelines Committee of the American College of Physicians. *Ann Intern Med* 2015 [Epub ahead of print 29 September 2015] doi:10.7326/M14-1772.

NNM: Number Needed to Match

Mike Wilk, MS4
AAEM/RSA Medical Student Council President

For those who like simple answers: senior U.S. medical students who rank at least ten EM programs in the NRMP Match have more than a 95% chance of matching.

In talking to different program directors over the past few months, there is a prevalent belief that EM-bound medical students are over-applying and over-interviewing. Many top applicants are interviewing at nearly 20 programs, even though they will likely match at the top of their list (78% of all U.S. seniors match at one of their top three choices).

Without a doubt, medical students are feeling increased anxiety that EM is more competitive than ever. Though some of this concern is warranted, most of it is imagined. Certainly the number of competitive EM applicants continues to rise, but so have the number and size of programs, thus balancing this increased demand. In reviewing the Match data over the past several years, the competitiveness of the field has not significantly changed. There are a few ways to analyze these data for competitiveness, one of which is the percentage of students matching from U.S. medical schools. Over the past several years about 80% of Matched students come from U.S. schools, while hyper-competitive fields such as ophthalmology or orthopedic surgery typically are over 90%.

Interestingly, many programs banded together this year and agreed to send out interview invitations on the same day (October 16, 2015). This strategy is noteworthy and in theory could change how students select programs at which to interview. However, the majority of programs still sent out invitations before this date, so it had little effect this year.

This behavior of over-interviewing hurts other applicants by taking slots from applicants who are truly interested in particular programs, which then forces programs to over-interview, costing everyone time, money, and effort. On the other hand, everyone seems to have heard the story of that one student who matched at his or her very last choice, or much worse, did not match at all.

Without a doubt, the Match process is an anxiety-provoking and stressful experience for all medical students, considering a computer algorithm decides the future of over 30,000 medical students. Though to be fair, I'm not sure there is a better system. For the vast majority of students, interviewing at and then ranking a maximum of 10 to 15 programs allows them to see a wide variety of programs and, most importantly, results in a nearly guaranteed Match. Anything more is well beyond the number needed to match. ■

"Without a doubt, medical students are feeling increased anxiety that EM is more competitive than ever. Though some of this concern is warranted, most of it is imagined."

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