THE NEWSLETTER
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

VOLUME 21, ISSUE 4
JULY/AUGUST **2014**

WWW.AAEM.ORG

INSIDE

President's Message
From the Editor's Desk
Washington Watch
Foundation Donations
AAEM News
Upcoming Conferences
YPS News
AAEM/RSA News
Job Bank

Register Now!

July 15, 2014
Washington, D.C.

www.aaem.org/advocacy-day

AAEM & AAEM/RSA Advocacy Day

– Learn advocacy skills & be a voice for EM!
– Join with your fellow members to make an impact.

CELEBRATING 20 YEARS of EDUCATION 1994-2014

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

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

COMMONSENSE

Table of Contents

President's Message....3
From the Editor's Desk....4
Letters to the Editor....6
Washington Watch....8
Upcoming Conferences: AAEM Sponsored and Recommended....11
Foundation Donations....12
PAC Donations....13
View from the Podium....14
AAEM News
- New AAEM Position Statements and Clinical Practice Statement....17
- Dollars & Sense....19
- Metric Madness....22
- Issues Commonly Faced by Emergency Physicians....24
- Pain Medicine Certification Approved for Emergency Physicians....27
- Attention AOBEM Candidates Applying to Take Part I in March 2015....28
- Report Injuries & Deaths Related to Consumer Products to the CPSC....28

Young Physicians Section News
- Infant and Toddlers in the ER: Beyond Popsicles and Stickers....30

AEM/RSA News
- AAEM/RSA President's Message....33
- AAEM/RSA Editor's Letter....34
- Resident Journal Review: What is the Evidence for Therapeutic Hypothermia?....37
- Medical Student Council President's Message....41
- Job Bank....42

AAEM Mission Statement

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

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

Membership Information

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

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

President's Message

Recent Advocacy Efforts and Strategic Plan

Mark Reiter, MD MBA FAAEM

Wait-Time Guarantees

In recent years, many hospitals have begun guaranteeing that their emergency department patients will be seen by a physician within a specified interval, such as 15 or 30 minutes. Often, these guarantees are advertised heavily, creating lofty expectations for patients. In some hospitals, significant pressure is put on the emergency physicians to ensure patients are seen within the guaranteed interval. Every emergency physician I know does their best to evaluate new patients as fast and as safely feasible. Forcing emergency physicians to reduce their attention on truly emergent patients to ensure that less emergent patients are seen within the wait-time guarantee just doesn't make sense, and can potentially compromise patient care. Wait-time guarantees do not take into account patient acuity or surges in patient volume, and as a result they may put the most critical patients in the emergency department at risk. AAEM recently published a position statement opposing emergency department wait time guarantees, and contributed to a feature story on the topic for *Emergency Medicine News*. If your emergency department offers wait time guarantees, you might consider sharing both with your hospital leadership.

Prescription Drug Monitoring Programs

In many states, utilizing a prescription drug monitoring programs (PDMP) has become an effective tool for physicians to help control prescription drug abuse. However, several states are considering legislation to require emergency physicians to access the PDMP prior to writing any narcotic prescription. AAEM opposes this requirement, which may create unnecessary delays in care. It doesn't make sense to require the emergency physician to take several minutes out of a busy shift to check the database on a patient with a new ankle fracture who requires a narcotic prescription. AAEM recently passed a new position statement on PDMPs and contributed to media interviews on this topic too. AAEM also calls for data sharing between state PDMPs and the eventual creation of a federal PDMP. In addition, AAEM supports prescription data being available in the PDMP in real-time and being integrated into electronic medical records, to minimize the burden of accessing this information. PDMPs can be a very useful tool for the emergency physician, but these programs should be optimized to be as useful and convenient as possible.

Joint-Ventures

In last issue's "President's Message," I discussed a new "joint venture" arrangement where hospitals and contract management groups jointly own the emergency physician group, and split the profits resulting from emergency physicians' professional fees. Since then, several hospital networks and contract management groups have either started new joint ventures or expanded existing joint ventures. AAEM is concerned with this trend, which we feel is bad for emergency physicians and bad for our patients, and may be in violation of corporate practice of medicine laws, fee-splitting laws, and anti-kickback laws. AAEM is the only professional organization that is fighting for its members on this issue. AAEM has brought its concerns to a variety of federal and state agencies, many of which have voiced significant concerns with the legality of these arrangements and are investigating. AAEM has also passed a position statement noting its opposition to these joint ventures and has discussed the issue with the media.

Advocacy Day

On July 15th, AAEM and AAEM/RSA will be holding a member Advocacy Day in Washington, D.C. AAEM and AAEM/RSA members are invited to join AAEM leaders and our lobbying firm, Williams & Jensen, as we discuss a variety of advocacy issues with our nation's leaders. We will break into small groups to discuss issues with members of Congress. If you are interested in attending, please contact the AAEM office for more information. If you've never participated in something like this before, I encourage you to give it a try. www.aaem.org/advocacy/aaem-advocacy-day.

As I write this, I have just returned from the AAEM Board's Strategic Planning retreat. The board took a comprehensive look at our Academy, with a focus on how we can best advocate for our mission and provide maximum value to our members. AAEM's board of directors outlined a variety of top advocacy priorities and will be developing a variety of new benefits for our members and their groups. More information will be coming soon. As always, if you have any ideas for how the Academy can better serve you, please let us know.

Take care,

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

AAEM Antitrust Compliance Plan:

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

Responsibility and Authority

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

Later in this issue of *Common Sense* you will find "Metric Madness." It was written by a member of our Academy who asked me to publish it anonymously, because "I need to keep my job for now." As you can see, I agreed. It tells a story that is sad for several reasons, and addresses issues that are critical for our specialty, the quality of patient care in our EDs, and for the medical profession in general. I urge you to read it carefully and make it known to your colleagues who aren't members of AAEM.

I am a simple guy, and as my IQ drops with age, my thinking gets even more simple. In reading "Metric Madness" I was thus struck by two simple, fundamental ideas. The first is duty. Whether it was the Hippocratic Oath, the Oath of Maimonides, the World Medical Association's Declaration of Geneva, or some other oath or declaration — all of us have pledged upon our honor to do the best thing for our patients, putting their health above our own interests. Among other things, this imparts on us a duty to advise patients honestly on what is best for them, even if they don't want to hear that — and even if it hurts our patient satisfaction scores (a good example of a bad idea).

In the modern world of emergency medicine, however, our duty to act in our patients' best interest means much more. It means when someone — whether out of greed, stupidity, or ignorance — wants to change how we practice medicine in a way that hurts patients, we must resist. We must object. We must fight back. That is why our colleague wrote "Metric Madness." That is why I am an active member of AAEM and its Tennessee chapter (TNAAEM). That is why I agreed to be the editor of *Common Sense*. These are my ways of fighting back against all the forces that interfere with my ability to exercise my professional judgment in the best interest of my patients.

For most of my career I never wanted to do anything but take care of acutely injured and seriously ill patients in the emergency department. And truly, that's still all I want to do. I don't want to do clinical research. I don't want to be an administrator. I don't really even want to be involved in organized medicine. I feel compelled by **duty** to be active in AAEM and organized medicine. Most of all by a duty to my patients, but also by a duty to those emergency physicians who came before me and established our specialty, and to those who will follow me.

When a hospital administrator comes up with a bad idea that will lower the quality of care in your ED, you and your colleagues have a duty to try and stop him — not by directly opposing him, but by figuring out what he really wants to accomplish and coming up with a more realistic and constructive way to get there — a way free of all the disastrous unintended consequences that administrators seem to generate. When our malfunctioning legal system pushes you to put patients through unnecessary testing and treatment for your own protection, resist by seeking tort reforms that will reduce or eliminate defensive medicine and its horrible waste of resources. When government bureaucrats or insurers want you to do things that are dangerous or wasteful, object loudly and publicly. Write your local newspapers and elected officials. **Maybe even write for *Common Sense***. But whatever you do, when someone wants to interfere with your ability to do what you think is best for your patients, do **something**!

The other fundamental idea that struck me in reading "Metric Madness" is how the link between authority and responsibility has been severed in medicine. All specialties suffer from this phenomenon, but it seems most severe in emergency medicine. As usual, we are the canaries in the coal mine.

Up until as recently as the beginning of my own career, physicians were in charge of medical care. Quite fairly, we were also held responsible for the quality of that care. Both the feds and commercial insurers paid claims based on whether or not the test or treatment was ordered by a licensed physician. Except for an occasional plaintiff's lawyer and jury, nobody but other physicians second-guessed a physician's judgment. Hospitals were run, and sometimes even owned, by physicians. Many older physicians became hospital CEOs when they retired from clinical practice. The vast majority of physicians owned their practices and answered only to patients and to other physicians — their peers. We really were the captains of the ship. We had **both** responsibility **and** authority. Sadly, this is no longer the case. We still have all the responsibility when something goes wrong or someone is unhappy, but in many EDs we have none of the authority we need to prevent those things. Many emergency physicians are nearly powerless to influence how their ED is run, yet they are blamed when it runs badly.

"Metric Madness" describes what happened when one group of emergency physicians lost control of their ED. What the author of "Metric Madness" suffered reminds me of what I endured at the HCA hospital where I worked for many years, before similar events late in my tenure there led to my burnout and early retirement in 2012.[1]

For most of those years I had one of the two best emergency medicine jobs in Tennessee. But then HCA forced an electronic medical record (EMR) on us that tremendously slowed patient flow. Then came computerized physician order entry (CPOE) software that was slow, inflexible, difficult to use, and dangerously error-prone.[2] Combined, these systems forced us to spend **far** more time with computers than with patients. Then came a reorganization of the ED into "pods." Instead of one large ED with roughly thirty beds and several emergency physicians working side by side, each emergency physician was assigned 8-11 beds. Instead of next seeing the patient who was sickest or had been waiting the longest, each emergency physician saw only the patients put in his or her individual pod. This reduced our flexibility and surge capacity, since one time-consuming patient (a complex wound repair or other long procedure, procedural sedation, a critically ill or unstable patient, etc.) brought

Continued on next page

patient-flow through that pod to a halt. It was like working in a ten-bed, single-coverage ED in which all ten beds were always full. Those of you who have worked in a single-coverage ED should stop and ponder that for a moment...

Then came the final blow that made this bad-enough situation unbearable: metrics. At the same time we were saddled with bad EMR and CPOE systems and our ED was reorganized into pods, HCA began to put tremendous emphasis on metrics — especially the door-to-doctor (DTD) time. More complete measures of physician productivity, such as patient/hour or RVU/hour, didn't seem to matter at all to our corporate administrators. It was all about door-to-doctor time, and one time-consuming patient in your pod would ruin your DTD metric for the day. A few would ruin your metric for the entire month, and that brought unpleasant attention from the hospital administrator. That kind of pressure takes all the joy out of work. Alcoholics, drug addicts, psychotic patients, critically ill patients — that's not pressure. An administrator breathing down your neck about something you can't control, because he has taken from you all decision-making authority for your own ED — that's pressure!

In fact, that goes beyond just destroying morale. That is a perfect set-up for inducing an experimental neurosis, and might explain some of the learned helplessness that now seems to afflict so many physicians, including emergency physicians. As defined by Psychology Wiki:

Experimental neurosis is produced in the laboratory by putting subjects in a situation where they are required to make discriminations or produce problem solving responses that are beyond their capacity to produce. This is a learned helplessness paradigm when aversive stimulation consistently follows their inevitable failures.[3]

There are all kinds of "aversive stimuli" short of losing a job, but being fired for not meeting a metric certainly qualifies as aversive. The author of "Metric Madness" tells of a physician who lost his job because of bad length-of-stay (LOS) metrics. That metric didn't seem to matter to my corporate administrators — all they cared about was the DTD time — but I am not surprised their emphasis has shifted. Many of the administrators and managers I have known over the years seemed to have the attention span of a gerbil on crack. One thing is critically important during one quarter, just to be cast aside the next quarter when something else becomes the Holy Grail of management.

I happen to know the emergency physician who lost his job to metric madness. He is clinically excellent, ethical, and compassionate. I would happily have him as my own or my wife's emergency physician, and I would hire him if I were an ED director. Like all of us, he is a unique combination of personal and professional strengths and weaknesses. He has bad LOS metrics but goes years between patient complaints, because he spends lots of time with patients and they love him for it. On the other hand, I have great LOS metrics but bad DTD times, because emptying ED beds and making dispositions — whether through discharges or admissions — is my first priority. The point is, once metric madness infects an ED any of us can be fired anytime, depending on which metric is in fashion at the moment.

All of us will face this kind of senseless and intolerable situation if we don't find a way to regain control of our EDs and our practices — restoring the link between responsibility and authority so that physicians decide what ought to be measured and how, and what ought to be done with the data. If we cannot take back control of our departments from non-physician administrators and bureaucrats, then we should find a way to shift onto them the responsibility we currently bear for ED performance. **Responsibility should follow authority**.

References

1. Walker A: A personal view on burnout. *Common Sense – the newsletter of the Academy of Emergency Medicine* 2013; 20(2):36-37.
2. Walker A: EHRs: boon or bane? *Tennessee Medicine – journal of the Tennessee Medical Association* 2013; 106(10):25-26.
3. http://psychology.wikia.com/wiki/Experimental_neurosis ■

Letters to the Editor

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

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

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

— The Editor

Letter in response to the March/April "From the Editor's Desk" article titled "Malpractice":

I am writing in response to Dr. Andy Walker's excellent piece titled "Malpractice" in the March/April issue of *Common Sense*. Although I never was a fan of Shakespeare, the quote from Julius Caesar at the start of his editorial is right on the money (pun intended — see below). Dr. Phil has always been more on my level than Shakespeare. Dr. Phil frequently deals with two people in terrible conflict with each other. One of his common tactics is to challenge each of them to stop pointing the finger at the other one and to stop spending all of their energy taking the other person's inventory. He then challenges each of them to examine what part of the conflict they themselves own and what they can each do from their own side to help the situation. If we look for things that we can do in a positive or constructive way to help the lawsuit problem that we have, this Dr. Phil strategy relates to one of the important points in Dr. Walker's editorial: the only thing you can control is your own behavior.

Along those lines, I wanted to share with your readers and my fellow AAEM members something that we did a few years ago in our Rhode Island ACEP Chapter. (I have been a proud AAEM member for many years, but there is no Rhode Island AAEM chapter). We adopted a non-binding and voluntary resolution in our chapter that tried to take a positive step against the problem of the big-money, hired-gun expert witnesses that so willingly slurp from the trough of the malpractice litigation system. As everyone knows, expert witnesses on both sides in malpractice actions frequently demand an hourly rate of compensation significantly higher than the hourly rate that they receive for practicing medicine (assuming that they do actually practice medicine). The Rhode Island ACEP Resolution is as follows:

"The Rhode Island Chapter of the American College of Emergency Physicians recommends that its members consider accepting compensation for medical expert legal work equal to the approximate hourly compensation rate that they earn working as practicing emergency medicine physicians. Medical expert legal work includes all medical expert case review and testimony."

We felt that, as emergency physicians, our greatest value to society comes from the expert care that we give our patients and from our research, teaching, and administrative activities that advance the specialty (and thereby advance patient care). We recognized that one thing that physicians have direct control over is their own medical expert compensation rate. First, we hoped that if physicians voluntarily limited medical expert fees, it might contribute positively, even if only in a small way, to controlling our rising malpractice insurance rates. Second, and more importantly, we hoped that a move from within the medical community to control costs to the system by reducing medical expert fees would demonstrate to the public and to the legislature that we were willing to take the first step toward reform ourselves. Rhode Island ACEP recommended that its members should take the lead in this area to do the right thing from an ethical, an economic, and a political perspective.

Our resolution could certainly be criticized because it is a voluntary resolution and has no actual teeth for enforcement. The lawyers told us that it had to be that way and that we could not make specific recommendations about compensation rates. Although it is mostly a symbolic move, if the practice of accepting a compensation rate for medical expert work similar to what you receive for actually being a practicing physician caught on across the country and in other specialties, we might actually see some positive change, even if it is in just a small way.

Glenn Hebel, MD FAAEM FACEP

Thank you for writing. Your feedback makes *Common Sense* a better newsletter. Your expert witness reform proposal is interesting, and if it could be enforced would certainly get rid of those unethical experts who are in it purely for profit and will say anything for money. From what I have seen, that would mean a lot fewer plaintiff's experts. Unfortunately it would take the passage of new laws to institute your idea, and since your reform idea would hurt plaintiffs far more than defendants, that ain't gonna happen.

There is another way to accomplish your goal of taking most of money out of being an expert witness, however. Although this too would require new laws, tort lawyers might be more likely to go along with it because it involves equal risk for both the plaintiff and defendant.

Instead of each side retaining its own experts — and paying them — the court would appoint a panel of three board-certified physicians in the same specialty as the defendant to agree on one expert opinion. They

Continued on next page

would be drawn from a pool of volunteers in each state and either serve for free or be paid by the court rather than one side or the other. Imagine the impact on the jury when the judge informs them that a panel of experts who aren't being paid by either side has determined that there was or was not malpractice. Of course far fewer cases would go to trial under this system, because a defendant would be much more likely to negotiate a settlement once he heard the court-appointed expert panel had decided against him. And a plaintiff would be more likely to give up and drop the suit once he learned that the only expert opinion the jury would hear was going to favor the defendant. In fact, either side that chooses to proceed to trial despite an adverse opinion from the expert panel and then loses should be forced to pay all expenses for the winner.

This knife cuts both ways — with equal risk for both the plaintiff and defendant — and would reduce the cost of the whole malpractice litigation system, with lower expert witness costs and fewer trials. It is fairer to plaintiffs because the legal system would consume less of the damage award, and it is fairer to emergency physicians because only board-certified specialists in emergency medicine (ABEM or AOBEM) could serve as experts. Currently I see far too many cases in which physicians from other specialties testify against emergency physicians, because they are too ignorant of our specialty to realize how ignorant they are.

Thanks again for writing — now go start a state chapter of AAEM in Rhode Island!

— The Editor

Letter in response to the May/June 2014 "In the Pit" article titled "Scribes: How Did We Ever Live Without Them?":

When road-blocks are placed in our paths, most of us are good at finding work arounds. Physicians are being forced to pay for the privilege of beta-testing software for the profits of second tier companies that have ingratiated themselves with the federal government. Thus, I would not describe being forced to pay for a scribe to make the use of a poorly designed product as a win-win situation. Charting is the responsibility of the physician. That record is the only real link you have to prior patient encounters. You may choose to use a scribe or a dictation service, but in the end you must proof-read and correct every piece of information placed in the chart under your name. We cannot simply delegate that responsibility and assume that it is carried out properly.

I tried using a scribe. I measured, with a stopwatch, the time charting versus a chart done by a scribe. I found that I spent longer proof-reading and correcting the note than if I had done it right the first time myself. I have trouble getting third year residents to document properly, let alone someone with no medical training. If you use a scribe, you generally need to see an extra three to four patients a shift to make a scribe pay for themselves. If you are relatively slow using an EMR, then this may make since. However, if I am already seeing three to four patients an hour, there is not a lot of room left to safely increase productivity. When I compare the time I am able to spend at the bedside against my colleagues using scribes, there is no difference. To boot, CPOE takes longer than charting and scribes cannot enter orders.

What we need is a less cumbersome way to chart. Charts now do not reflect our care of patients. Just try reading a chart from an EMR; it is easier to read *JAMA*. Everything is centered around billing and CMS metrics. Had this been left to market forces, we might have something better than Pong. However, the federal government is adept at taking technology and making it dysfunctional. So, I know how we survived before scribes ... we had a better charting system. Paper ... How sad is that?

Dave Bryant, DO FAAEM

I appreciate your letter, and I agree with you. No EMR I have seen — especially the one without voice recognition that HCA forced on me and my colleagues — is as fast, flexible, accurate, legally protective, and descriptive as dictation. An ED chart should be as unique as the patient encounter that generated it, and a point-and-click EMR can't get anywhere close. You are right about the reason for this mistake: the technology and the market for it were not allowed to evolve naturally — the federal government, with the HITECH Act, forced EMRs on us before they were ready.

As you point out, good technology doesn't require the creation of a whole new class of workers (scribes) to accomplish something that was already getting done. On the contrary, that is a sign of bad technology — very, very bad. In this case, so bad it would disappear if the doctors and nurses who are forced to use it had any choice in the matter.

There is one other thing that bothers me about scribes, and I pointed this out to my colleagues soon after we realized just how bad our EMR was. When a hospital takes dictation away from its emergency physicians and substitutes an EMR so bad that scribes are necessary, it shifts the cost of generating medical records from itself to its emergency physicians — and those records are the property of the hospital and are used by the hospital for billing, just as much as by emergency physicians. That is wrong.

— The Editor ■

Burwell Confirmed as HHS Chief; Administration Emphasizes Positive ACA Developments

Williams & Jensen, PLLC

In June, the Senate voted overwhelmingly to confirm Sylvia Mathews Burwell as Secretary of the Department of Health and Human Services (HHS). Although the Affordable Care Act (ACA) remains controversial, Burwell faced minimal opposition during the confirmation process, with bipartisan members of the two Senate committees of jurisdiction generally offering support for the nominee's qualifications for the job. Burwell does not have previous experience in the health care sector, and most recently served as Director of the Office of Management and Budget (OMB). At OMB, she played a key role during the partial government shutdown that occurred in the fall of 2013. Several prominent Senate Republicans who voted in favor of Burwell were satisfied by her commitment to provide quick responses to Congressional inquiries and member letters. Burwell also pledged transparency in HHS' operations and to hold an open dialogue on the agency's prioritis.

Burwell stressed that her time at OMB prepared her to make difficult choices regarding the cost of health care and emphasized the need for better research and delivery of treatment. In response to questions about the Medicare Sustainable Growth Rate (SGR) formula, Burwell said she was committed to repealing and replacing the SGR by the end of the year. Burwell said that there is bipartisan support for changes and expressed her desire for a permanent solution that will lead to more predictable physician payments.

Burwell reported that the Congressional Budget Office's estimates for federal spending on health care have decreased significantly and extended the solvency of the Medicare Trust Fund. Burwell expressed support for prevention initiatives, stating that these efforts are critical to improving the overall health of the country and that HHS should build upon the private sector's efforts to promote wellness.

Democratic committee members focused on positive enrollment data including the Administration's estimate that over 8 million individuals have now obtained health insurance under the ACA. (Although, how many of these people were previously uninsured is unclear). The percentage of enrollees between the ages of 18-34 has increased, although concerns remain that the number of young, healthy enrollees are too low to prevent future premium increases.

Senate Republicans utilized Burwell's confirmation hearings to outline their own proposals to reform the health care system, which includes allowing small businesses to combine their purchasing power to offer employees lower cost health plans; giving employers more freedom to reward employees for leading healthier lifestyles; giving governors more flexibility to spend Medicaid dollars in ways that deliver better health care at lower costs; and helping states stop the proliferation of bad lawsuits. It is uncertain whether House Republicans will hold a vote on an alternative to the ACA, but the GOP continues to cite concerns about increasing premiums, canceled health plans, and "selective exemptions" for certain individuals and entities under the law.

Burwell's predecessor, Kathleen Sebelius, had occupied the post since the beginning of President Obama's Administration. Burwell's confirmation comes at a critical juncture for implementation efforts of the ACA, as the Federal exchange hub HealthCare.gov is taking on a more prominent role as many states have declined or failed to set up their own exchanges. Premium information for 2015 has also started to become available, with some states projecting double digit percentage increases in monthly payments. However, premium changes are expected to vary widely so a fuller picture is expected to develop over the next several months.

AAEM to Hold Advocacy Day in July; Congress' Health Care Agenda Takes Shape for Remainder of 2014

On July 15, AAEM and AAEM/RSA members will descend on Capitol Hill to meet with Members of Congress, health care policy staff, and committee staff to highlight issues important to the membership. As a follow-up to three successful Advocacy Days in 2013, participants will continue to highlight the importance of due process rights for emergency physicians. Previous Advocacy Days have raised the profile of due process for emergency physicians on Capitol Hill and among regulators, and facilitated a dialogue between the Hill and key executive branch policymakers. Participants will also engage with their Members of Congress on the enforcement of the laws relating to anti-kickback, fee-splitting, and corporate practice of medicine laws that are being violated by joint ventures between hospitals and contract management groups (CMGs). Advocacy Day also includes a Hill visit instructional session and FAQs in the morning, and features remarks by a lunch speaker. Additional information on the upcoming Advocacy Day is available on AAEM's website: www.aaem.org/advocacy/aaem-advocacy-day.

After finalizing a deal earlier this year to patch the SGR through next Spring, Congress is not expected to send any major health care-related bills to the President in the remaining months before the mid-term elections in November. However, discussions at the Committee level will continue on identifying revenue provisions that can be utilized to pay for an expensive permanent SGR fix in early 2015.

Two more narrow initiatives with implications for emergency medicine have emerged in recent months: legislation to promote mental health care and efforts to treat and reduce the prescription drug and heroin abuse epidemic that is on the rise across the country. Congressman Tim Murphy (R-PA), a clinical psychologist, has introduced legislation entitled "The Helping Families in Mental Crisis Act." The bill is one of several legislative efforts that has garnered additional attention following the May shooting in Isla Vista, California. Provisions of the legislation include: (1) clarifying HIPAA under certain circumstances to allow physicians to communicate important information to parents and caregivers of patients undergoing a mental health crisis; (2) providing for increased access to care for the most critically ill patients at psychiatric facilities; (3) encouraging alternatives to long-term inpatient care for the chronically mentally ill

Continued on next page

population such as the "Assisted Outpatient Treatment" program which has demonstrated promise in reducing substance abuse and ED visits; and (4) providing relief from federal tort claims for physicians serving in a voluntary capacity at community mental health clinics and federally-qualified health centers.

The House and Senate have also turned their attention to an increase in prescription drug abuse and heroin use. At recent Congressional hearings convened to examine this issue, witnesses and Members of Congress discussed prevention and treatment efforts. There was agreement that efforts should be focused on prevention, the proper treatment of addicts, and strategies to reduce the number of overdoses. One such strategy that was discussed was the utilization of state-based prescription drug monitoring programs (PDMPs) to help physicians and pharmacists track addicts. AAEM encourages prescriber and pharmacist access to PDMPs but opposes mandatory accessing of PDMP profiles, which may create unnecessary delays in care.

Stakeholders also encouraged steps to allow naloxone to be more widely available, including some level of immunity for those administering the drug. Naloxone was described as an effective emergency opioid overdose reversal medication, and its ability to save lives was touted by many expert witnesses and lawmakers.

Meanwhile, Congress continues to examine efforts by HHS and the Centers for Medicare and Medicaid Services (CMS) to implement provisions included in recent legislation. Following the Congressionally mandated delay in compliance with the International Classification of Diseases (ICD)-10 included in the most recent SGR fix legislation, CMS has announced the expected release of an interim final rule "in the near future" that will require the use of ICD-10 beginning on October 1, 2015.

In May, CMS and the Office of the National Coordinator for Health Information Technology (ONC) issued a joint proposed rule designed to provide temporary relief to providers and hospitals unable to meet the definition of "meaningful use" of electronic health records (EHRs) under the 2014 edition of certified EHR technology (CEHRT). According to ONC officials, the purpose of the proposed rule is to be responsive to stakeholder feedback and to address the concerns of "smaller providers and rural hospitals" that have not been able to attain the 2014 CEHRT technology. Specifically, CMS and ONC propose to allow certain providers and hospitals that qualified for meaningful use EHR technology to qualify for incentive payments in 2014 using either the 2011 certification or a combination of the 2011 and 2014 certifications. For 2015, eligible providers and hospitals must use technology certified under the 2014 CEHRT). ■

Upcoming Conferences: AAEM Directly & Jointly Provided and Recommended

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

AAEM CONFERENCES

August 19-22, 2014
- AAEM Written Board Review Course
  Orlando, FL
  www.aaem.org/written-board-review

August 27-28, 2014
- AAEM Oral Board Review Course
  Las Vegas, NV
  www.aaem.org/oral-board-review

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

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

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

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

JOINTLY PROVIDED

July 25-27, 2014
- 2nd International Trauma, Emergency & Critical Care Conference
  Bayahibe, Dominican Republic
  www.itecc2014.com/

AAEM-RECOMMENDED CONFERENCES

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

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

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

November 14-16, 2014
- The Difficult Airway Course: Emergency™
  San Diego, CA
  www.theairwaysite.com

Tweet with Us

Follow @AAEMinfo for up-to-the-minute updates!

LinkedIn twitter

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1/1/14-5/21/14.

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

Donor

Mark Reiter, MD MBA FAAEM

Contributor

Juan F. Acosta, DO MS FAAEM
Leonardo L. Alonso, DO FAAEM
Terence J. Alost, MD MBA FAAEM
Aaron D. Andersen, MD FAAEM
Jonathan D. Apfelbaum, MD FAAEM
Carmelito Arkangel, Jr., MD FAAEM
Aditya Arora, MD FAAEM
Eric Y. Baden, MD FAAEM
Garo Balkian, MD FAAEM
Robert Bassett, DO FAAEM
Philip Beattie, MD FAAEM
Brett Bechtel, MD FAAEM
Dale S. Birenbaum, MD FAAEM
Joshua P. Bobko, MD FAAEM
Michael A. Bohrn, MD FAAEM
Mark Avery Boney, MD FAAEM
Eric W. Brader, MD FAAEM
Greg Bredemeier, MD FAAEM
J. Allen Britvan, MD FAAEM
Heather C. Bruner, MD FAAEM
Michael R. Burton, MD FAAEM
Thomas J. Calvert, MD FAAEM
John W. Cartier, MD FAAEM
Anthony Catapano, DO
Frank L. Christopher, MD FAAEM
Garrett Clanton, II, MD FAAEM
Robert Lee Clodfelter, Jr., MD FAAEM
Steven K. Costalas, DO FAAEM
Peter B. Cridge, MD FAAEM
Ramon L. Cruz Rivera, MD FAAEM
Eric S. Csortan, MD FAAEM
Stanley Czarnecki, MD FAAEM
Robert J. Darzynkiewicz, MD FAAEM
Jerry E. Davis, MD FAAEM
Francis X. Del Vecchio, MD FAAEM
Manuel J. Delarosa, MD FAAEM
Scot M. DePue, MD FAAEM
Robert L. Dickson, MD FAAEM
Steven E. Diebold, MD FAAEM
John J. Dillon, MD
John Timothy DiPasquale, MD FAAEM
Walter D. Dixon, MD FAAEM
Aaron D. Dora-Laskey, MD FAAEM
Louis J. Durkin, MD FAAEM
David A. Dwyer, MD FAAEM
Elizabeth A. Fair, MD FAAEM
Michael J. Falk, MD FAAP FRCP FAAEM
Jacob R. Fenster
Deborah M. Fernon, DO FAAEM
Clifford J. Fields, DO FAAEM
Patrick M. Flaherty, DO FAAEM
Mark A. Foppe, DO FAAEM
Robert A. Frolichstein, MD FAAEM
Paul W. Gabriel, MD FAAEM
Kathryn Getzewich, MD FAAEM
Bassam Gholam, MD FAAEM FACEP
Steven R. Ginder, MD FAAEM
Samuel H. Glassner, MD FAAEM
Robert C. Greaves, MD FAAEM
Kevin Griffith, MD JD FAAEM
Robert E. Gruner, MD FAAEM
William B. Halacoglu, DO FAAEM
Dennis P. Hanlon, MD FAAEM
John C. Haughey, MB BCH BAO FAAEM
Victor S. Ho, MD FAAEM
John Hopkins, DO FAAEM
David R. Hoyer, Jr., MD FAAEM
Felix Y. Huang, MD
Irving P. Huber, MD FAAEM
Elizabeth J. Hull, MD FAAEM
Timothy J. Huschke, DO FAAEM
Tapio O. Innamaa, MD
Carroll Don Johnson, MD FAAEM
P. Scott Johnston, MD FAAEM
Shammi R. Kataria, MD FAAEM
Bilal A. Kattan, MD
Brian M. Kelley, DO FAAEM
John H. Kelsey, MD FAAEM
Christopher L. Klingenberg, MD FAAEM
Deborah Korik, MD FAAEM
Ron Koury, DO FAAEM
Chris Kramer, DO FAAEM
Keith J. Kuhfahl, DO FAAEM
Erik Kulstad, MD FAAEM
Chaiya Laoteppitaks, MD FAAEM
David W. Lawhorn, MD FAAEM
Liza Lê, MD FAAEM
Jonathan D. Lee
Richard Lee, MD FAAEM
Stephen J. Leitner, MD FAAEM
Donald J. Linder, DO FAAEM
David Liss, MD
John W. Love, MD FAAEM
Eric Lubliner, MD FAAEM
Michael Lucca, MD FAAEM
Christopher K. Marcuzzo, MD FAAEM
Scott P. Marquis, MD FAAEM
David Mason, MD FAAEM
John R. Matjucha, MD FAAEM
Erica S. McKernan, MD FAAEM
Valerie G. McLaughlin, MD FAAEM
David E. Meacher, MD FAAEM
Chris A. Meeker, MD FAAEM
Lisa D. Mills, MD FAAEM
Claud E. Morgan, MD FAAEM
Elizabeth A. Moy, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Nicholas J. Musisca, MD
Melissa Natale, MD FAAEM
Michelle S. Nathan, MD FAAEM
Craig Norquist, MD FAAEM
Paul D. O'Brien, MD FAAEM
Isaac A. Odudu, MD
Robert Verne Oliver, MD FAAEM
Alonso J. Osorio-Giraldo, MD FAAEM
John C. Owens, MD FAAEM
Vanessa C. Peluso, MD FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Catherine V. Perry, MD FAAEM
Frank S. Pettyjohn, MD FAAEM
Patricia Phan, MD FAAEM
Donald G. Phillips, DO FAAEM
Andrew T. Pickens, IV, MD JD MBA FAAEM
Matthew W. Porter, MD FAAEM
Robert H. Potts, Jr., MD FAAEM
Michael S. Pulia, MD FAAEM
Yadira Ramos-Arias, MD FAAEM
Kevin C. Reed, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Phillip L. Rice, Jr., MD FAAEM
Howard M. Rigg, III, MD FAAEM
Ralph J. Riviello, MD FAAEM
Francisco Rodriguez, MD
Steven B. Rosenbaum, MD FAAEM
Eric M. Rudnick, MD FAAEM
Roque Ruggero, MD FAAEM
Stewart Sanford, MD FAAEM
Marc Santambrosio, DO FAAEM
Charles A. Schmier, MD FAAEM
David T. Schwartz, MD FAAEM
H. Edward Seibert, MD FAAEM
Eric M. Sergienko, MD FAAEM
Sachin J. Shah, MD FAAEM
William M. Shapiro, MD FAAEM
Laura Shih, DO FAAEM
Richard D. Shih, MD FAAEM
Jonathan F. Shultz, MD FAAEM
Michael E. Silverman, MD FAAEM FACP
Larry L. Simpson, MD FAAEM
Katarzyna B. Sims, MD
Michael Slater, MD FAAEM
Henry E. Smoak, III, MD FAAEM
Marc D. Squillante, DO FAAEM
Michael G. St. Marie, MD FAAEM
Christopher H. Stahmer, MD
Robert E. Stambaugh, MD FAAEM
Keith D. Stamler, MD FAAEM
David R. Steinbruner, MD FAAEM
Gregory J. Sviland, MD FAAEM
Jalil A. Thurber, MD FAAEM
Charles W. Todd, MD FAAEM
Jorge Danl Trujillo, MD FAAEM
Christopher P. Visser, MD FAAEM
Roland S. Waguespack, III, MD FAAEM
Benjamin Walrath, MD FAAEM
Jonathan Wassermann, MD FAAEM
Scott G. Weiner, MD MPH FAAEM
Gregory A. West, MD FAAEM
Christopher R. Westfall, DO FAAEM
Kay Whalen, MBA CAE
William David Wilcox, Sr., MD FAAEM
Joanne Williams, MD FAAEM
Janet Wilson, CAE
Emily Wolff, MD FAAEM
Samuel Woo, MD FAAEM
Patrick G. Woods, MD FAAEM
George Robert Woodward, DO FAAEM
Marc B. Ydenberg, MD FAAEM
Anita M. Ziemak, MD FAAEM

Recognition Given to PAC Donors

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

Levels of recognition to those who donate to the AAEM PAC have been established. The information below includes a list of the different levels of contributions. The PAC would like to thank the individuals below who contributed from 1/1/14-5/21/14.

Congressional

Michael R. Burton, MD FAAEM

Member

Bobby Abrams, MD FAAEM
Leonardo L. Alonso, DO FAAEM
Aaron D. Andersen, MD FAAEM
Justin P. Anderson, MD FAAEM
Carmelito Arkangel, Jr., MD FAAEM
W. Lynn Augenstein, MD FAAEM
Eric Y. Baden, MD FAAEM
Garo Balkian, MD FAAEM
Mike Barker, MD FAAEM
Robert Bassett, DO FAAEM
Paul S. Batmanis, MD FAAEM
Andrew H. Bauer, MD FAAEM
Philip Beattie, MD FAAEM
Donald R. Bennett, MD FAAEM
Joshua P. Bobko, MD FAAEM
Mark Avery Boney, MD FAAEM
Eric W. Brader, MD FAAEM
Greg Bredemeier, MD FAAEM
J. Allen Britvan, MD FAAEM
Charles B. Cairns, MD FAAEM
Anthony J. Callisto, MD FAAEM
Derek M. Carlson, DO FAAEM
John W. Cartier, MD FAAEM
Anthony Catapano, DO
Jacob Chachkes, MD FAAEM
Garrett Clanton, II, MD FAAEM
Robert Lee Clodfelter, Jr., MD FAAEM
Ramon L. Cruz Rivera, MD FAAEM
Eric S. Csortan, MD FAAEM
Brian J. Cutcliffe, MD FAAEM
Stanley Czarnecki, MD FAAEM
Christopher Xavier Daly, MD FAAEM
Robert J. Darzynkiewicz, MD FAAEM
Jerry E. Davis, MD FAAEM
Francis X. Del Vecchio, MD FAAEM
Scot M. DePue, MD FAAEM
Pierre G. Detiege, MD FAAEM
Robert L. Dickson, MD FAAEM
Steven E. Diebold, MD FAAEM
John J. Dillon, MD
Elizabeth A. Fair, MD FAAEM
David A. Farcy, MD FAAEM FCCM
James E. Ferguson, MD FAAEM
Clifford J. Fields, DO FAAEM
Mark A. Foppe, DO FAAEM
Ryan P. Frank, DO FAAEM
William T. Freeman, MD FAAEM
Robert J. French, DO FAAEM
Robert A. Frolichstein, MD FAAEM
Paul W. Gabriel, MD FAAEM
Leigh S. Galatzan, MD FAAEM
Steven H. Gartzman, MD FAAEM
Stuart M. Gaynes, MD FAAEM
Robert Bruce Genzel, MD FAAEM
Kathryn Getzewich, MD FAAEM
Bassam Gholam, MD FAAEM FACEP
Daniel V. Girzadas, Jr., MD RDMS FAAEM
Brad S. Goldman, MD FAAEM
Hermann Gonzalez, DO FAAEM
Robert C. Greaves, MD FAAEM
Jay A. Greenstein, MD FAAEM
Thomas W. Hale, MD FAAEM
Jack L. Harari, MD JD FAAEM
John C. Haughey, MB BCH BAO FAAEM
Jerris R. Hedges, MD FAAEM
Melanie S. Heniff, MD FAAEM FAAP
Victor S. Ho, MD FAAEM
Scott D. Hodge, MD FAAEM
Mark P. Hoornstra, MD FAAEM
John Hopkins, DO FAAEM
David R. Hoyer, Jr., MD FAAEM
Felix Y. Huang, MD
Irving P. Huber, MD FAAEM
Leland J. Irwin, MD FAAEM
Howard E. Jarvis, III, MD FAAEM
P. Scott Johnston, MD FAAEM
Shammi R. Kataria, MD FAAEM
Bilal A. Kattan, MD
Kathleen P. Kelly, MD FAAEM
David W. Kelton, MD FAAEM
Adam Edwin Kennah, MD FAAEM
Lenard M. Kerr, DO FAAEM
Christopher L. Klingenberg, MD FAAEM
Robert D. Knight, MD FAAEM
Kevin P. Kooiker, MD FAAEM
Kenneth H. Koster, MD FAAEM
Frederick Kotalik, MD FAAEM
Erik Kulstad, MD FAAEM
Stephen Lamsens, MD FAAEM
Chaiya Laoteppitaks, MD FAAEM
David W. Lawhorn, MD FAAEM
Robert E. Leyrer, MD FAAEM
Gregory J. Lopez, MD FACEP FAAEM
John W. Love, MD FAAEM
Le Lu, MD FAAEM
Maja L. Lundborg-Gray, MD FAAEM
Richard G. Lyons, MD FAAEM
Christopher K. Marcuzzo, MD FAAEM
Scott P. Marquis, MD FAAEM
David Mason, MD FAAEM
Emily Jeanne Massey, MD FAAEM
John R. Matjucha, MD FAAEM
Dan M. Mayer, MD FAAEM
Nimish Mehta, MD FAAEM
Benson G. Messer, MD FAAEM
Keith Messner, MD FAAEM
Jeffrey Alan Moore, MD FAAEM
Elizabeth A. Moy, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Melissa Natale, MD FAAEM
Karl A. Nibbelink, MD FAAEM
Michael O'Brien-McGinty, MD FAAEM
Isaac A. Odudu, MD
Robert Verne Oliver, MD FAAEM
Alonso J. Osorio-Giraldo, MD FAAEM
Ramon J. Pabalan, MD FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Catherine V. Perry, MD FAAEM
Paul M. Petty, MD FAAEM
Patricia Phan, MD FAAEM
Rian John Pillitteri, MD FAAEM
Jeffery M. Pinnow, MD FAAEM
Robert H. Potts, Jr., MD FAAEM
Michael S. Pulia, MD FAAEM
Vitaut N. Ragula, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Matthew P. Rhames, MD FAAEM
Phillip L. Rice, Jr., MD FAAEM
Melanie Richman, MD FAAEM
Howard M. Rigg, III, MD FAAEM
Walesia L. Robinson, MD FAAEM
Edgardo M. Rodriguez, MD FAAEM
Francisco Rodriguez, MD
Steven B. Rosenbaum, MD FAAEM
Eric M. Rudnick, MD FAAEM
Roque Ruggero, MD FAAEM
Stewart Sanford, MD FAAEM
Lawrence R. Schiff, MD FAAEM
Charles A. Schmier, MD FAAEM
Michael C. Schmitt, MD FAAEM
Dirk C. Schrader, MD FAAEM
H. Edward Seibert, MD FAAEM
Eric M. Sergienko, MD FAAEM
Sachin J. Shah, MD FAAEM
William M. Shapiro, MD FAAEM
Brendan P. Sheridan, MD FAAEM
Chester D. Shermer, MD FAAEM
Jonathan F. Shultz, MD FAAEM
Michael E. Silverman, MD FAAEM FACP
Katarzyna B. Sims, MD
Michael Slater, MD FAAEM
Robert D. Slay, MD FAAEM
Evans S. Smith, MD FAAEM
Wade Smith, DO FAAEM
Henry E. Smoak, III, MD FAAEM
Donald L. Snyder, MD FAAEM
Stefan O. Spann, MD FAAEM
Christopher H. Stahmer, MD
Keith D. Stamler, MD FAAEM
David R. Steinbruner, MD FAAEM
Joel B. Stern, MD FAAEM
Robert E. Suter, DO MHA FAAEM
Gregory J. Sviland, MD FAAEM
William E. Swigart, MD FAAEM
Mark D. Thompson, MD FAAEM
Jalil A. Thurber, MD FAAEM
Charles W. Todd, MD FAAEM
David Touchstone, MD FAAEM
Evan B. Tow, DO FAAEM
Owen T. Traynor, MD FAAEM
Patricia L. VanDevander, MD MBA FAAEM
Robert Wells Vizzard, MD FAAEM
Roland S. Waguespack, III, MD FAAEM
Steven M. Walkotte, MD FAAEM
Wm. Bruce Watson, MD FAAEM
H. Michael Webb, MD FAAEM
James Allen Webley, MD FAAEM
Scott G. Weiner, MD MPH FAAEM
Gregory A. West, MD FAAEM
Ellen J. Westdorp, MD FAAEM
Christopher R. Westfall, DO FAAEM
Joanne Williams, MD FAAEM
Emily Wolff, MD FAAEM
George Robert Woodward, DO FAAEM
Anita M. Ziemak, MD FAAEM

www.aaem.org/publications

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

21st Annual Scientific Assembly

Joseph Lex, Jr., MD FAAEM MAAEM

It's time to think about the next Scientific Assembly — scheduled for Austin, Texas, from February 28 through March 4, 2015. The success of the 20th gathering in New York back in February will be tough to surpass. That's why I need your help.

It is my great honor to once again be in charge of putting together the AAEM Scientific Assembly. I did it for five years from 2001 to 2006, before handing the reins over to Kevin Rodgers. But I lobbied for the job one more time, and I need to show that the trust put in me by Education Committee Chair Mike Epter and President Mark Reiter is warranted.

Where We Have Been

Our innovations over the last few years have been huge. Point-counterpoint arguments remain very popular. The literature review sessions are always welcome. The shorter sessions with built-in breaks between speakers have allowed attendees more freedom in choosing what to attend and are well received.

AAEM has always been ahead of the curve on educational innovations. We had our first workshop on simulations in Orlando more than 10 years ago — and it was a failure. We had only about six people show up, as the whole concept of learning through simulation was still quite new. Now, of course, it is part of what we do every year.

Three years ago we tried "flipping the classroom" — I recorded my talk and made it available for people to preview by download or streaming two months before the Scientific Assembly. People would listen in advance, then come and ask questions about what they had heard. Again, we were ahead of the curve. People showed up expecting to hear a lecture in standard fashion, as virtually no one had listened in advance. But now that adult-learning concepts are more readily accepted and people have become more comfortable with online learning, it's time to try it again.

Our "Open Mic" session continues to help us find the future voices of EM education. It is now copied by other organizations, but they require that people submit their topics and CVs in advance. Only AAEM takes the chance of allowing someone to sign up on the day of the session, to give an unvetted talk on the topic of their choice. More than 100 people have "auditioned" for AAEM since we started this innovative session, and this privilege has been abused only a small number of times.

Our big innovation for 2014 was the Pecha Kucha (Japanese for "chit chat," also called PK) sessions — 20 slides at 20 seconds each — a total of 6 minutes 40 seconds to cover a topic or get an idea across. We were apparently right on target with this, as every chair was occupied and people lined the walls of the room, with more outside in the hall trying to hear what was going on.

Continued on next page

Where We Are Now

For many years, I think it was safe to say that AAEM Scientific Assembly was the premier educational event in emergency medicine. This may no longer be true. It's not that AAEM has slipped — not by a long shot. We continue to give our members the best forward-looking information on all aspects of clinical emergency medicine. But in the last few years, I have attended meetings in Ireland (ICEM2012) and Australia (SMACC and smaccGOLD – that's Social Media And Critical Care) that had some of the best teaching — and teachers — I have ever heard. I have also heard many of these people speak at AAEM Scientific Assemblies — Haney Mallemat, Scott Weingart, Rich Levitan, etc.

Where Do We Go From Here?

I need your help to keep us at the forefront of EM education. I need you to tell us the best teachers you have heard in the last few years, with an emphasis on the "third generation" teachers — people who may only be a few years out of training but who have already demonstrated outstanding teaching skills.

With the explosion of FOAMed (Free Open Access Medical Education) resources — blogs, podcasts, commentaries — we will continue to guide you into the best ways for keeping current on a daily basis, even if you feel you're "not of the Twitter generation." From my personal perspective, I've been getting Social Security checks for several months now and consider Twitter to be my primary source of new information in EM. I was recently forced into getting an iPhone after resisting for many years, but somehow I had accumulated more than 3,000 followers on Twitter before this happened. In other words, if I can do it, you can do it.

I also want your involvement in a new way. As you know, AAEM does not charge its members to attend Scientific Assembly; it's part of your member benefits and we intend to keep it that way. This means that people who speak at Scientific Assembly do so only for transportation and hotel reimbursement — they do not get a speaker's stipend. And that tells you AAEM's reputation is such that people will gladly speak at our meetings without expecting anything more than their expenses being paid.

Obviously we want to expand the Pecha Kucha session, our most successful innovation in 2014. We will do at least one full day of PKs in Austin. We will determine the time allotted for this session by the number of people who want to speak. Rather than assign topics, I want you to submit your idea for a PK that you want to give. A subcommittee will consider all the submissions and determine which topics and speakers to choose. Remember the rules: 20 slides, 20 seconds each, a total 6 minutes 40 seconds, and then off. If chosen, you will present for the love of teaching. If chosen, you will have to submit the usual information about Conflicts of Interest for CME purposes. You will have to write two or three questions for CME purposes. You will not be compensated for transportation or lodging **unless** you are invited to give another talk.

I have other ideas too: a half-day track on the philosophy of being a physician, and perhaps a session on how medicine's history should help form its future. We'll even leave an hour or two for last-minute developments that occur after the final program is published, months before the conference.

Or you can email me ideas directly at JoeLex@AAEM.org. You can also Tweet me @JoeLex5 or message me directly at 215-495-2588. I will take any and all ideas into consideration, as long as the anticipated results are 1) improved patient care and outcomes or 2) improved well-being for the practicing emergency physician. ■

New AAEM Position Statements

The following position statements have been approved by the AAEM board of directors. All AAEM position statements can be accessed online at www.aaem.org/em-resources/position-statements.

Emergency Department Wait Time Guarantees

The American Academy of Emergency Medicine (AAEM) opposes emergency department wait time guarantees. Wait time guarantees potentially compromise patient care by forcing emergency physicians to reduce their attention on truly emergent patients to ensure that less-emergent patients are seen within the wait time guarantee interval. As wait-time guarantees do not take into account patient acuity or surges in patient volume, they may put the most critical patients in the emergency department at risk. Although EDs strive to increase efficiency to minimize patient delays, wait time guarantees should be discouraged.

Prescription Drug Monitoring Programs

AAEM encourages prescriber and pharmacist access to prescription drug monitoring programs (PDMPs), which can be a useful tool to identify possible prescription drug abuse. AAEM supports the interstate data sharing between state PDMPs and calls for standardization between states and the eventual creation of a federal PDMP. PDMPs should report prescriptions in real-time and be integrated into electronic medical records. AAEM opposes mandatory access of PDMP profiles for emergency physicians, which may create unnecessary delays in care. ■

New AAEM Clinical Practice Statement: Ultrasound Should be Integrated into Undergraduate Medical Education Curriculum

Chair: Steven Rosenbaum, MD FAAEM
Authors: Lisa D Mills, MD FAAEM; Zachary Soucy, DO FAAEM
Reviewers: Ashley Bean, MD FAAEM; Jack Perkins, MD FAAEM

Reviewed and approved by the AAEM board of directors (5/30/2014).

Policy Statement:

It is the position of the American Academy of Emergency Medicine that ultrasound should be integrated into the core curriculum of undergraduate medical education.

Background:

Medical diagnostic ultrasound has been used by various specialties since the 1950s. Contemporary point of care ultrasound (POCUS) was first researched and utilized by emergency physicians in the mid 1980s. Emergency physicians have formally defined and pioneered POCUS over the past two decades. Research in a broad array of applications indicate improved patient care via procedural safety and success,[11,13,17] improved diagnostic accuracy,[20,21,22] decreased procedural pain,8 decrease time to critical interventions,[11, 22] and decreased time to discharge.3

The practice of POCUS continues to grow. In the most recent decade there is an expanding role for POCUS across many specialties in medicine. As hospital wide ultrasound application has increased many healthcare institutions struggle to meet the growing educational needs of faculty and residents to obtain standardize ultrasound training. In addition, multiple specialties have POCUS fellowships and specialized POCUS training during other fellowships.

Continued on next page

Leaders in the field of US technology in medical education have implemented longitudinal ultrasound training programs into the core medical school curriculum. Early research demonstrates that the technology is viewed by students as enjoyable[4,6,10,16,23] and useful in various specialties.[1,6,16] Furthermore studies demonstrate better student understanding of complex core anatomic and physiologic concept[s6,19,23] and improved physical exam skills[7,9,12,14,15] with the incorporation so US into the curriculum. Practical application of POCUS also provides early clinical correlates, thus further engaging the students.[4,10]

Given the broad and diverse use of US in contemporary medical practice, multiple medical societies have supported the incorporation of US into the core medical school curriculum. The American Institute for Ultrasound in Medicine (AIUM), a multidisciplinary society, has advocated for the integration of US training into core medical school curricula. In 2013, at the 2nd World Congress on US in Medical Education, over 85 medical schools convened to discuss US in medical education.

Incorporation of US into the core medical school curriculum enhances learning of core concepts, improves understanding of the physical exam, engages students in active learning, and is viewed as useful and enjoyable by students. Early integration of US in medical training incorporates a key, broadly used, and growing medical technology thus better preparing current students for practice they will encounter as the next generation physician.

References and Literature Grading

1. Afonso N, Amponsah D, Yang J, Mendez J, Bridge P, Hays G, Baliga S, Crist K, Brennan S, Jackson M, Dulchavsky S. Adding new tools to the black bag — introduction of ultrasound into the physical diagnosis course. *J Gen Intern Med.* 2010 Nov;25(11):1248-52. Grade E, Adequate
2. Berrington de Gonzales A, Mahesh M, Kim K, Bhargavan M, Lewis R, Mettler F, et al. Projected cancers risks from computed Tomographic scans performed in the United States in 2007. *Arch Intern Med.* 2009;169(22):2071-77. Grade B, Good.
3. Blaivas M, Harwood RA, Lambert MJ. Decreasing length of stay with emergency ultrasound examination of the gallbladder. *Acad Emerg Med.* 1999;6:1020-3. Grade C, Good.
4. Brunner M, Moeslinger T, Spieckermann P. Echocardiography for teaching cardiac physiology in practical student courses. *Am J Physio.* 1995;268.6 Pt 3 (1995): S2. Grade F, Poor
5. Brenner DJ, Hall EJ. Computed tomography — An increasing source of radiation exposure. *New Eng J Med*. 2007;357:2277-84.
6. Brown B, Adhikari S, Marx J, Lander L, Todd GL. Introduction of ultrasound into gross anatomy curriculum: Perceptions of medical students. *J Emerg Med.* 2012 Dec;43(6):1098-1102. Grade E, Adequate
7. Butter J, Grant TH, Egan M, Kaye M, Wayne DB, Carrión-Carire V, McGaghie WC. Does ultrasound training boost Year 1 medical student competence and confidence when learning abdominal examination? *Med Educ.* 2007 Sep;41(9):843-8. Grade E, adequate.
8. Constantino TG, Parikh AK, Satz WA, Fojtik JP. Ultrasonography-guided peripheral intravenous access versus traditional approach in patients with difficult access. *Ann Emerg Med.* 2005;46:456-461. Grade B, good.
9. Decara JM, Kirkpatrick JN, Spencer KT, Ward RP, Kasza K, Furlong K, Lang RM. Use of hand-carried ultrasound devices to augment the accuracy of medical student bedside cardiac diagnoses. *J Am Soc Echocardiogr.* 2005 Mar;18(3):257-63. Grade E, adequate.
10. Hoppmann RA, Rao VV, Poston MB, Howe DB, Hunt PS, Fowler SD, Paulman LE, Wells JR, Richeson NA, Catalana PV, Thomas LK, Britt Wilson L, Cook T, Riffle S, Neuffer FH, McCallum JB, Keisler BD, Brown RS, Gregg AR, Sims KM, Powell CK, Garber MD, et al. An integrated ultrasound curriculum (iUSC) for medical students: 4-year experience. *Crit Ultrasound J.* 2011 Apr;3(1):1-12. Epub 2011 Feb. Grade E, adequate.
11. Keyes LE, Frazee BW, Snoey ER, et al. Ultrasound guided brachial and basilica vein cannulation in emergency department patients with difficult intravenous access. *Ann Emerg Med.* 1999;34:711-714. Grade E, adequate.
12. Kobal, SL., et al. Comparison of effectiveness of hand-carried ultrasound to bedside cardiovascular physical examination. *Amer J Cardiol.* 2005;96(7):1002-6. Grade E, adequate
13. Miller AH, Roth BA, Mills TJ, et al. Ultrasound guidance versus the landmark technique for the placement of central venous catheters in the emergency department. *Acad Emerg Med.* 2002;9:800-805. Grade B, Good
14. Mouratev G, Howe D, Hoppmann R, Poston MB, Reid R, Varnadoe J, Smith S, McCallum, B, Rao V, DeMarco P. Teaching medical students ultrasound to measure liver size: comparison with experienced clinicians using physical examination alone. *Teach Learn Med*. 2013 Jan;25(1):84-8. Grade C, adequate
15. Panoulas VF, Daigeler AL, Malaweera AS, Lota AS, Baskaran D, Rahman S, Nihoyannopoulos P. Pocket-size hand-held cardiac ultrasound as an adjunct to clinical examination in the hands of medical students and junior doctors. E*ur Heart J Cardiovasc Imaging.* 2013 Apr;14(4):323-330. Grade D, adequate
16. Rao S, van Holsbeeck L, Musial JL, Parker A, Bouffard JA, Bridge P, Jackson M, Dulchavsky SA. A pilot study of comprehensive ultrasound education at the Wayne State University School of Medicine: A pioneer year review. *J Ultrasound Med.* 2008 May;27(5):745-9. Grade E, adequate
17. Rothschild JM. Ultrasound guidance of central vein catheterization: Making health care safer: A critical analysis of patient safety practices [Agency for Healthcare Research and Quality Web site]. Publication No. 01-E058. Available at: http://www.ahrq.gov/clinic/ ptsafety. Accessed December 14, 2013. Grade E, good
18. *Syperda, VA., et al. Ultrasonography in preclinical education: a pilot study. J Am Osteopath Assoc.* 2008;108(10)601-5. Grade D, adequate
19. Swamy M and Searle RF. Anatomy teaching with portable ultrasound to medical students. *BMC Med Educ.* 2012;2:99. Grade D, adequate
20. Squire BT, Fox JC, Anderson C. ABSCESS: Applied bedside sonography for convenient evaluation of superficial soft tissue infections. *Acad Emerg Med.* 2005;12:601-606. Grade C, good
21. Tayal VS, Hasan N, Norton HJ, et al. The effect of soft-tissue ultrasound on the management of cellulitis in the emergency department. *Acad Emerg Med.* 2006;13:384-388. Grade C, good
22. Tayal V, Graf C, Gibbs M. Prospective study of accuracy and outcome of emergency ultrasound for abdominal aortic aneurysm over two years. *Acad Emerg Med.* 2003;10:867-71. Grade C, good
23. Tshibwabwa ET, Groves HM. Integration of ultrasound in the education programme in anatomy. *Medical Education.* 2005;39:1148.doi: 10.1111/j.1365-2929.2005.02288.x Grade E, adequate
24. Wittich CM, Montgomery SC, Neben MA, Palmer BA, Callahan MJ, Seward JB, Pawlina W, Bruce CJ. Teaching cardiovascular anatomy to medical students by using a handheld ultrasound device. *JAMA.* 2002 Sep;288(9):1062-3. Grade D, good ■

Dollars & Sense

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

Dr. Schofer offers some excellent advice below, and his ongoing series on basic personal finance for emergency physicians is shaping up to be one of the best things Common Sense *has published under my editorship. I hope all our residents and new attendings read it carefully.*

Although I have done more things right than wrong, I have made a few painful financial mistakes in my 55 years. One of the two worst mistakes I made was buying "variable universal" life insurance rather than term insurance — one of the topics Dr. Schofer mentions below. The other was trading in an overseas wine futures market. That ended badly...

There is one other thing I feel compelled to mention. While most families ought to have three to six months of income saved for emergencies, as Dr. Schofer says, I believe emergency physicians should have six to 12 months of income saved in a fairly liquid, easily accessible form. Every single emergency physician is virtually guaranteed to lose at least one job unexpectedly, and most of us will lose more than one. Be prepared.

— The Editor

There are a number of steps a physician should take to establish a sound financial plan. Older or more established physicians have likely taken many if not all of these steps, but those who are younger or just starting their career may find that a number of these basic steps remain on their to-do list. The steps to build your financial foundation are listed below in order, from those you should do first to those you should do last, although your personal situation may vary. These topics will all be discussed in detail in future columns.

1. Make Sure You Are Adequately Insured

In general, there are two types of insurance. There is insurance you don't have enough of, and insurance you have too much of. Rarely do you have the right amount of coverage, unless you annually review your insurance needs.

Usually you will need and want include malpractice, health, auto, renters or homeowners, umbrella liability, and disability insurance. Insurance you may or may not need, depending on whether you have others who depend on your income, includes term life insurance. Insurance you probably don't need includes any form of permanent or "cash value" life insurance.

2. Build an Emergency Cushion

Most financial experts recommend that you have three to six months of living expenses stashed away for emergencies. Potential emergencies will vary based on your situation, but some common concerns include lawsuits or legal expenses, unexpected car or house trouble, family emergencies, or medical bills. The best place to have this emergency money is in a bank savings account or money market fund. A money market fund is almost as safe as a bank account, but historically has offered a higher rate of return. The reason it is "almost" as safe as a bank account is that a money market fund is not FDIC (Federal Deposit Insurance Corporation) insured, while bank accounts are.

3. Be Smart About Your Debt

You should pay off your high interest debt before you begin investing. The reason is that paying off high interest debt, like your credit card balance, is the equivalent of earning that interest rate as an investment return. In other words, if you are being charged 15% interest on your credit card, paying it off is the equivalent of earning 15% on that money — which is a pretty nice return! In general, you should pay off any debt before you start investing if the interest rate you're being charged is more than the after tax rate you could receive on an investment. This number will vary based on your investments, but if you're looking for a number, you should probably pay off any debt with an interest rate of 8% or greater, and consider it if the rate is 6-7%.

Finally, Burton G. Malkiel, Chair of Economics at Princeton University and the author of the best-selling book *A Random Walk Down Wall Street* says, "Keeping a balance on your credit card is about the worst financial move you can make." I have to agree. If you carry a credit card balance, you need to pay that balance off and keep it off with a disciplined budget.

4. Invest MAXIMALLY in Tax-Favored Retirement Plans

Certain savings vehicles offer tax advantages to encourage saving for retirement. These plans most commonly include 401(k), 403(b), and Individual Retirement Accounts or IRAs, such as a Roth IRA. The tax benefits of these plans offer massive benefits over time, which allows your investment to grow larger. For example, if you make a $4,000 contribution to a taxable investment account each year for 45 years, you'll end up with approximately $600,000 — assuming an 8% annual return on your investment. If you make this same investment in a tax-deferred plan that yields the same 8%, you'll have approximately $1.7 million. Which would you rather have?

5. Invest in Stock and Bond Mutual Funds

Investing in stock and bond mutual funds (not individual stocks and bonds) is the simple way to both diversify your investments and get higher returns than more conservative investments such as bank accounts, money market funds, or certificates of deposit (CDs). In addition, it is the only way you can invest and stay ahead of inflation. If you put your money in a savings account that earns 2% but inflation is 3.5% that year, you just lost 1.5% of your purchasing power. With the historical inflation rate averaging 3%, you can't even keep up with inflation and break even without taking some risk and earning a return of at least 3%.

Investing in stock and bond funds is not for the weak of heart, as you can lose money in the short term. But over the long term, taking on higher risk leads to higher return. Only you know how much risk you are willing to take, but you should take as much as you can while still sleeping at night. I don't remember which investment book I read this in, but if you invested

Continued on next page

$1 in the following investments in the year 1800, this is how much money you would have had in 2005:

- Gold — $27
- Treasury Bills (low risk government bonds) — $4,828
- Corporate bonds (moderate risk) — $17,843
- Stocks (the highest risk investment on this list) — $11,000,000

I ask again, which would you rather have? Increased return means increased risk.

6. Consider Buying Instead of Renting

This decision is more complicated than simply comparing your monthly rent versus the amount of a mortgage payment. Things you will have to consider include tax breaks, fees associated with buying a home or condominium, how long you think you will you live there, and other factors. In general, the benefits of home ownership include the fact that mortgage interest is tax deductible and significant gains on home value are tax exempt when you sell. In addition, home ownership forces you to save by making mortgage payments and building equity in your home. In most situations, you should own a home if you can possibly afford it. Owners get rich, renters do not.

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. ■

ARE YOU SICK OF MAKING BIG FINANCIAL AND INVESTING MISTAKES?

FREE REPORT REVEALS:

"7 BIG Money Mistakes Doctors Make and How To Fix Them So You Can Stop Making Work Mandatory and Start Making Work Optional!"

****** DOWNLOAD NOW AT ******

WWW.PHYSICIANWEALTHSOLUTIONS.COM

Let's Talk Reality. You and I both know the brutal truth of practicing medicine:You've lost your autonomy and have control over almost nothing

You're fed up because you may be...➡ Having high stress ➡ Burned out ➡ Making big mistakes with your finances and investments ➡ Getting bad advice from your current financial advisor ➡ Tired of working because you have to not because you want to

I KNOW YOU WANT TO MAKE WORK OPTIONAL

Whipping your finances and investments into shape and fixing your biggest mistakes is the key!

In my report you will learn: ★ 7 financial mistakes that could cost you more than your annual income ★ A secret your financial advisor might not be telling you ★ One of the big killers of investment returns ... AND MORE!

Why Should You Believe Me? I'm Setu Mazumdar, MD, CFP®, and I'm an emergency medicine physician just like you, but I retired from practicing medicine before age 40! I made a ton of financial mistakes, and I'm downright angry that doctors get poor advice from many financial advisors. Now as "The Financial Planner For Doctors" I help physicians like you get your finances and investments in order.

Setu Mazumdar, MD, CFP®
President, Financial Planner, and Emergency Medicine Physician

PHYSICIAN WEALTH SOLUTIONS
The Doctor's Prescription For Making Work Optional

GET FREE REPORT AT WWW.PHYSICIANWEALTHSOLUTIONS.COM

Metric Madness

Name Withheld Per Request

Some years ago, a friend of mine who is a family counselor told me, "You have high expectations in an unrealistic environment." She meant working in an emergency department. She meant being a physician. I have heard this several times over the years from people in other industries.

Most emergency physicians treat their patients like family. We would want our spouse, sibling, child, or parent to be treated exceptionally well in the emergency department. This aspiration leads us to have high expectations of ourselves and to strive for excellence.

The emergency department **is** an unrealistic environment. It may seem normal to us, but what we do is crazy compared to other jobs and to other settings in the medical world. We do not work in an office or operating room, which is typically elective, linear, and for the most part controlled. Our environment forces us to be multitasking efficiency experts, faced with numerous variables out of our control, overwhelming information flow, interruptions and personal interactions — all at once! And the pressure keeps building: CMS, the Joint Commission, ABEM, state and hospital requirements, etc.

One for-profit hospital chain has now placed even more demands on its physicians and nurses: metrics (beyond those now required by the federal government). A "metric" is a time-based measurement related to the documentation of an activity by a clinician. A metric is either within arbitrarily set limits or outside those limits, and if outside the limits is printed in red on the report sent to the hospital administrator each month. Many of the metrics used by this hospital chain conflict with each other, making it impossible to meet all of them simultaneously and adding to the unrealistic demands placed on the emergency department. Hospital administrators may use the failure to meet metric standards as a reason to discipline or fire emergency physicians.

Here are some examples of those metrics. I now have to see patients in ten minutes or less from the time of their arrival in the ED — not from the time they arrive in an exam room, but from the time they walk up to reception. And even if more than one patient arrives at the same time, I am not allowed to sign up for more than one at a time on the EMR (electronic medical record). There must be at least two minutes between sign-ups. Try complying with those conditions in a 40,000 patient/year department!

Next is the "push to fill" rule. I am responsible for eight rooms, and if three of the rooms empty and fill again, I remain responsible for the ten minute metric on those patients and subject to the two minute lockout. If I am in a room working on a septic patient and cannot leave when those three rooms fill, that's just too bad for me and my statistics.

But that is just the beginning. There is also a thirty minute metric, measured from the time of patient arrival to the ordering of laboratory and radiology tests. There is a thirty minute metric from patient arrival to the administration of pain medicine for a suspected long bone fracture — not the **ordering** of pain meds, but the **reception** of those meds by the patient. Distal fibula fractures that look like a sprained ankle and buckle fractures in a child's forearm are included in this metric. If the nurse cannot give pain medicine or draw blood within the thirty minute window, at the end of the month that metric is highlighted in red under my name.

Last is the length of stay (LOS) metric, set at three hours. It does not matter why the patient is still in the department after three hours. Whether it is related to my management or circumstances beyond my control, I am responsible for the LOS.

In 2012, a boarded emergency physician in my hospital system was asked to resign from a very high acuity, high volume emergency department because of bad LOS metrics. There was no discussion with the hospital CEO about delays in getting patients to the floor. It was the physician's fault entirely. The CEO took no responsibility for the functioning of his inpatient units.

Since violating LOS has become a firing offense, other metrics are undoubtedly fair game too. I am an independent contractor and have no recourse, since I am sure the corporate contract management group (CMG) I work for isn't watching my back. Since the hospital chain and the CMG have monopolies in the region, I may well have to move if I am fired. Or maybe I'll become a travel doctor — Texas is sounding pretty good right now.

The use of metrics is not inherently unreasonable. It is one way to establish parameters for tracking the passage of time in relation to volume and acuity. Metrics give us a quantitative way to think about our efficiency and

Continued on next page

performance. However, in this system the metrics actually conflict with each other, making them impossible to achieve. They do, however, satisfy the data-dependent manager who mistakenly equates good patient care with an isolated number. Not surprisingly, as far as I know, no practicing emergency physicians or nurses — the true efficiency experts in the ED — were consulted on choosing or implementing ED metrics.

What **would** be useful is a daily database of information to review and evaluate. Data related to surges, staffing at the time of surges, timing of ancillary services ordered and completed, the acuity level associated with the number of patients per hour, LOS, and other multivariable data points. These data could be evaluated and used to develop a "trigger" system that responds to the needs of the ED, as well as the needs of a variety of other departments.

A simple example: if five admitted patients remain in the ED for more than four hours, then the house supervisor activates hallway beds on inpatient units. Although establishing such a policy does not require researching a database, imagine how such information would help justify that kind of rule and assist in ED management. With this approach, and with emergency physicians' involvement, a more relevant and productive system of triggers and metrics could be designed — and used for management improvement rather than as a threat. This type of database is possible: I have seen one in action.

One additional note on this situation: the CMG I work for is now sharing its profits from my hard work with the hospital chain through a joint venture — a win-win for them, and another blow to morale for me. The current situation is extremely discouraging. Many of my colleagues feel the same way. We are watching our industry consolidate into regional monopolies, with decisions that have huge impacts on clinical quality made by nonphysicians who are clueless as to what constitutes good patient care, while emergency physicians become economic pawns with less and less power — even in their own departments. ■

Issues Commonly Faced by Emergency Physicians

The Academy receives so many calls for help from emergency physicians that Dr. Joel Schofer has written the notes of advice below. These will be posted on the Academy's website and are intended to help you and your group avoid some issues before they become problems, begin to deal with problems on your own before AAEM gets involved, and brief you on how the Academy can help once it is involved. Many of these calls come from emergency physicians who aren't AAEM members — at least not until their own specialty society rejects their pleas for help because it doesn't involve itself in "private business matters." So, if you know of colleagues who are not yet Academy members, urge them to join AAEM ***now*** *— before they have to turn to the Academy as their last remaining hope.*

— The Editor

American Academy of Emergency Medicine

ISSUES COMMONLY FACED BY EMERGENCY PHYSICIANS

The American Academy of Emergency Medicine (AAEM) is *the* specialty society of emergency medicine and is proud to help and support its members and our specialty. There are several issues emergency physicians most commonly contact AAEM about, including the following:

1. Threats to the employment of individual emergency physicians or emergency medical groups, such as the issuance of requests for proposals (RFPs) for an existing emergency professional services contract or the attempted hostile takeover of an existing contract by a contract management group.
2. Contractual termination without due process or peer review.
3. Assistance with a malpractice suit.
4. Post-contractual employment restrictions (restrictive covenants or non-compete clauses).

AAEM ASSISTANCE

AAEM has seasoned emergency physicians within its leadership, who collectively have many years of experience troubleshooting and resolving the problems that many emergency physicians experience. AAEM believes it is essential to stand behind emergency physicians and its principles, and offers its assistance with professional challenges. *AAEM cannot provide legal advice or make referrals to a specific attorney.*

Assistance offered in the past includes:

1. Education and advice on these issues. Position statements and articles on the AAEM website may serve as valuable resources.
2. Phone calls, letters of support, or site visits on behalf of a physician or group.
3. Support of legal actions, usually based on laws prohibiting the corporate practice of medicine or fee-splitting. The AAEM Foundation has provided financial assistance in such matters.
4. Referral to experienced emergency medicine expert witnesses.
5. Evaluation of potentially remarkable testimony by the AAEM Legal Committee, once the case is closed. If deemed remarkable, the expert's testimony is published on the Academy's website for all members to see.
6. AAEM liability insurance from Hays Affinity.

In specific situations, AAEM commonly recommends that emergency physicians consider some of the actions below, in addition to calling the Academy for help.

CORPORATE PRACTICE OF MEDICINE

It is best to avoid contract instability by being proactive long before a physician group faces a threat. Once a threat is present, the group often faces an uphill battle.

1. Be acutely aware that your contract is under continuous external threat. Corporate groups inundate hospital administrators with direct solicitations, advertisements in their literature, and booths at their meetings.
2. Review your hospital contract with an attorney. Try to get contract language that requires notice if your performance is falling below expectations or if another bid for the contract is being formally considered. If another group threatens your hospital contract, ask your attorney to determine whether the competing group operates in compliance with state corporate practice of medicine laws.
3. Make sure your group is performing as well as possible and providing high quality patient care. If your group is well run, a competitor will not be able to improve your emergency department. That is, however, not what they will tell the hospital administration. They will claim that they can and will improve the ED. You need to refute that argument with solid performance data.
4. If you have a hospital subsidy, the corporate groups will say they can cover the ED without one or for less. You need to develop a written analysis of why you have a subsidy and how it contributes to the quality of care by allowing appropriate staffing of the ED. This should be periodically reviewed with the CEO.

Continued on next page

CORPORATE PRACTICE OF MEDICINE (continued)

5. Establish personal and professional relationships with members of the medical staff, hospital administration, and local community. Build alliances, particularly with other hospital based departments. Try to get a position on the hospital board of directors or get to know those who sit on it.
6. Meet with the CEO on a regular basis. Garner support from influential members of the medical staff, administration, and community. Have them advocate on the group's behalf with the hospital CEO and administration.
7. Publicize the good work your group is doing in the hospital and community.
8. Make sure your group has a significant presence in the hospital medical staff leadership and committees.
9. Inspire your group to be a cohesive unit. Seek agreement from all members that they will leave if a competitor takes over, and publicize this unified stance. Set up a meeting with hospital administration that everyone will attend.
10. Check with friendly secretarial staff to see what information you can gather.

CONTRACTUAL TERMINATION WITHOUT DUE PROCESS OR PEER REVIEW

1. Review your contract with an attorney immediately, as you may have a very limited time to request or demand a fair hearing. Your attorney may recommend that you demand a hearing regardless of any waivers you agreed to in your contract.
2. If possible, do not sign away your right to due process. Review the AAEM white paper on due process when negotiating a contract.
3. Hold on to all communications related to your job performance, both positive and negative. Keep a personal record of your successes and patient compliments. Review any complaints and take them seriously, writing and filing a response as necessary.
4. Publicize the issue in the AAEM newsletter, *Common Sense*.
5. The AAEM Foundation may consider extraordinary cases for funding.
6. Contact AAEM for advice if confronted with what you believe is an unjust termination.

MALPRACTICE ASSISTANCE

1. Call your malpractice insurance company to be assigned an attorney, who will guide you through the process and be your advocate. *AAEM cannot provide legal advice or referral to a specific attorney.*
2. Do not talk to anyone else - including family, friends, or colleagues - about the case without the permission of your attorney. You can speak to your spouse, as that is legally protected.
3. Contact AAEM if you feel you have been victimized by unfair or inaccurate expert testimony.
4. AAEM may provide an amicus brief in extraordinary cases involving issues of general importance to our members.
5. Do not underestimate the emotional impact of being sued; you should consider taking advantage of local or state medical society resources for litigation stress.

POST-CONTRACTUAL RESTRICTIONS (RESTRICTIVE COVENANTS)

1. Review your contract with an attorney. If possible, do not sign a non-compete clause. If you must sign one, try to restrict the scope.
2. Review the AAEM white paper on restrictive covenants when negotiating a contract.

American Academy of Emergency Medicine

555 E. Wells St., Suite 1100, Milwaukee, WI 53202-3823
phone: 1-800-884-AAEM • fax: 414-276-3349 • e-mail: info@aaem.org • website: www.aaem.org

This information is also available online at www.aaem.org/em-resources/issues-commonly-faced-by-eps.

PeerCharts™ online

The Ultimate EMR Plugin

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

The PeerCharts Online™ Platform Delivers:

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

Emergency Medicine Documentation
Integrated Dictation
Bedside Paper Templates

EvolveMed

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

www.peercharts.com

Pain Medicine Certification Approved for Emergency Physicians

On April 24, 2014, the Board of Directors of the American Board of Medical Specialties (ABMS) approved the American Board of Emergency Medicine (ABEM) joining the American Board of Anesthesiology (ABA), the American Board of Physical Medicine and Rehabilitation (ABPMR), and the American Board of Psychiatry and Neurology (ABPN), in offering certification in pain medicine. This co-sponsorship arrangement provides an opportunity for emergency medicine residency graduates to pursue fellowship training in pain medicine, and upon successful completion of that training, seek subspecialty certification in pain medicine through ABEM.

More than 70% of patients who come to the emergency department have a chief compliant of some type of pain, and at least 40% have an underlying pain condition.[1] The presence of subspecialty experts in emergency medicine will help to promulgate the science and practice of pain medicine throughout the specialty of emergency medicine.

ABEM President, James H. Jones, MD, stated that, "Pain Medicine is a rapidly expanding area of interest, practice, and research within Emergency Medicine, and is a natural extension of our specialty. Our patients will directly benefit as this subspecialty grows and matures. This adds to the opportunities available for subspecialty certification provided by ABEM."

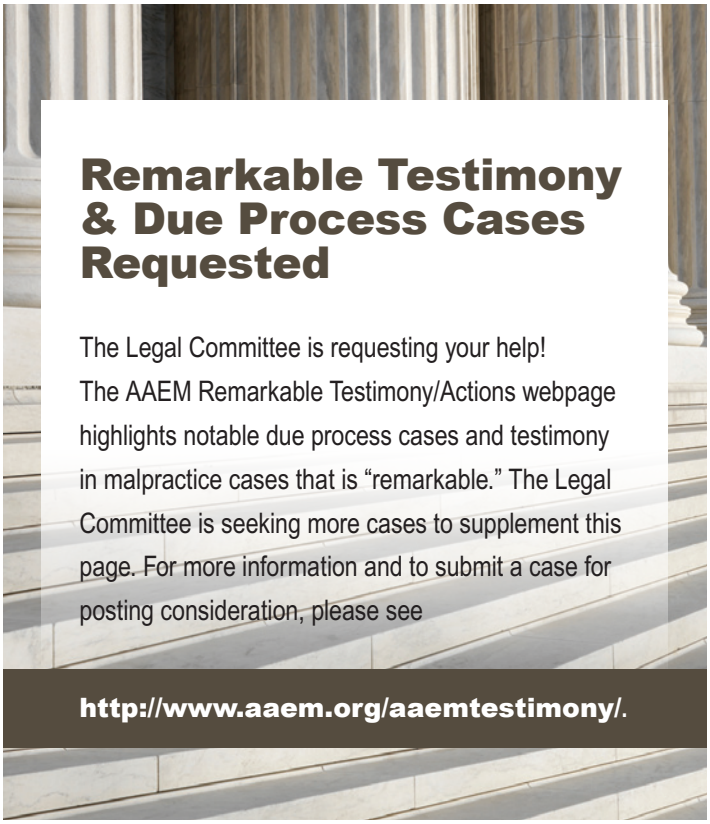
To be able to take the subspecialty certification examination, ABEM diplomates must have successfully completed a one-year, ACGME-accredited pain medicine fellowship program. They also must adhere to the ABEM Policy on Medical Licensure, hold a valid ABEM certificate, and be participating in the ABEM MOC program. Those who fulfill all requirements may apply to ABEM to take the examination. The eligibility criteria and application are available on the ABEM website (www.abem.org).

Pain medicine becomes the ninth subspecialty available to ABEM-certified physicians along with anesthesiology critical care medicine, emergency medical services, hospice and palliative medicine, internal medicine–critical care medicine, medical toxicology, pediatric emergency medicine, sports medicine, and undersea and hyperbaric medicine. ABEM diplomates also have pathways to subspecialty certification in clinical informatics (through the American Board of Preventive Medicine), and surgical critical care (through the American Board of Surgery).

1. Todd KH. Pain and prescription monitoring programs in the emergency department. *Ann Emerg Med.* 2010;56:24-6.

About ABEM

Founded in 1976, the American Board of Emergency Medicine (ABEM) develops and administers the emergency medicine certification examination for physicians who have met the ABEM credentialing requirements. ABEM has over 31,000 emergency physicians currently certified. ABEM is not a membership organization, b ut a non-profit, independent evaluation organization. ABEM is one of 24 Member Boards of the American Board of Medical Specialties. ■



Remarkable Testimony & Due Process Cases Requested

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

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

JOIN A Committee!

The ACCME Subcommittee, a branch of the Education Committee that maintains AAEM's CME Program, is actively recruiting members.

Subcommittee activities include:

- Ensuring that each educational activity meets the criteria set forth by the Accreditation Council for Continuing Medical Education (ACCME)
- Reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly sponsored activities to ensure all ACCME guidelines are met and the appropriate number of CME credits are determined

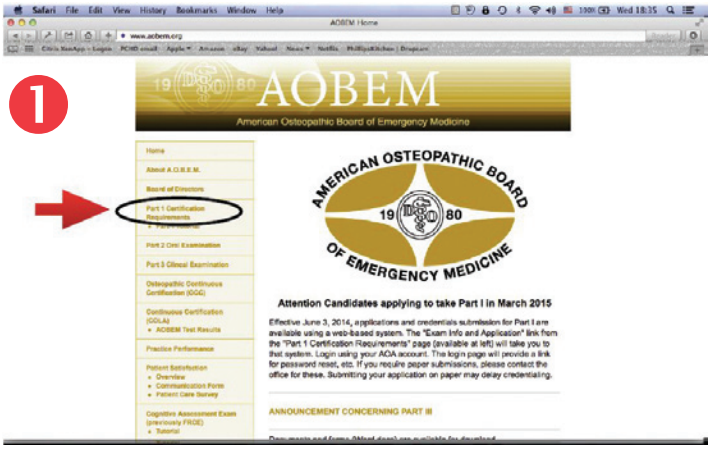
To learn more about the responsibilities of all of our committees and to complete an application, visit: www.aaem.org/about-aaem/leadership/committees

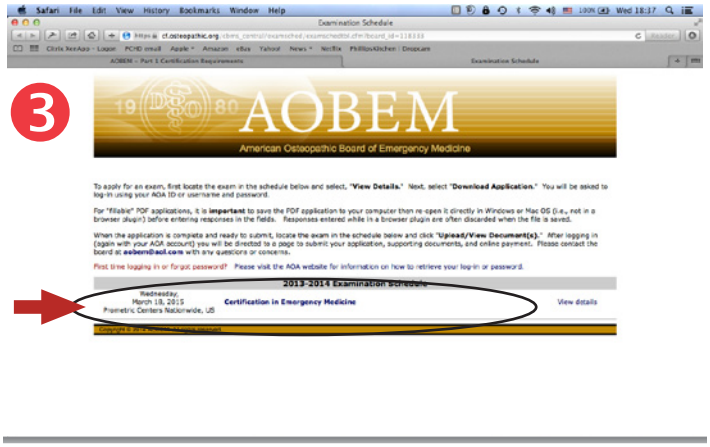
Attention AOBEM Candidates Applying to Take Part I in March 2015

Effective June 3, 2014, applications and credentials submission for Part I are available using a web-based system. From www.AOBEM.org go to the "Exam Info and Application" link from the "Part 1 Certification Requirements" page (available in the left hand navigation column), this will take you to that system. Login using your AOA account. The login page will provide a link for password reset, etc.

Handwritten paper applications will be accepted, but are discouraged. If you require paper submissions, please contact the office for these. Submitting your application on paper may delay credentiaw

The deadline for completing your application is September 1, 2014. ■





Report Injuries & Deaths Related to Consumer Products to the CPSC

UNITED STATES CONSUMER PRODUCT SAFETY COMMISSION

The U.S. Consumer Product Safety Commission (CPSC) strongly encourages medical professionals, especially emergency department physicians and nurses, to report all injuries and deaths related to consumer products to www.SaferProducts.gov. It is the publicly available consumer product safety information database website of the CPSC. For more information about the CPSC, please visit www.CPSC.gov and for additional information about reporting to www.SaferProducts.gov, please read CPSC's Commissioner Robinson's Statement titled, "It's All About the Data!" ■

Infant and Toddlers in the ER: Beyond Popsicles and Stickers

Terez Malka, MD
YPS Board Member

As a combined emergency medicine/pediatrics resident, I've spent the past five years immersed in the world of snot, poo, and tears that is pediatric emergency medicine and have also followed children across the realm of their care from the inpatient setting to my outpatient clinic. Below are some key lessons I've learned over the course of my training, in addition to knowing that popsicles cure, well, almost everything.

Plate the Pee

With the eradication of many previous big players in serious bacterial infection, the full septic workup is a rapidly disappearing phenomenon in the majority of febrile children. So what do you do with the febrile infant with vague viral symptoms or no obvious source of infection?

I would argue that your first-line test in a febrile infant or toddler should be a urine culture. UTI continues to affect about 10-16% of febrile neonates under eight weeks old and 2%-5% of all febrile children under two, including those with other potential fever sources such as otitis media or upper respiratory infection symptoms.[1,2] Unfortunately, a urinalysis or urine dip is not sufficient and has a markedly poor sensitivity (about 82%) in infants and young toddlers.[4] This is likely because they don't keep urine in their bladder long enough to allow the accumulation of a detectable amount WBC esterase or nitrites.

What does this mean for practice? Keep in mind that the presence of an otitis media or URI symptoms in a febrile child are not sufficient to rule out UTI and that urinalysis alone is not an adequate screening test. Strongly consider UTI in all febrile children under two, especially in young infants, females, uncircumcised males, and those who have had fever for >72 hours. Most importantly, if you're going to send a urinalysis, send a culture too.

Use the Parent

Good luck localizing a source of discomfort in a writhing, fussy nine-month-old. It can be tempting to just X-ray the entire child based on their wrenching screams as you lightly brush past any part of their body. In the truly fussy, stranger-averse, or scared young child, a large portion of the physical exam can be completed by the parent. A parent or loved one can place the stethoscope over the heart and lung fields for you, can palpate the quadrants of the abdomen, and can demonstrate range of motion of extremities (pat-a-cake and leg bicycles work well). You can also palpate the abdomen by placing your hand over the parent's or over the patient's own hand in older kids (a great solution for ticklish adults too)!

In any child, offer parents the option of holding the patient in his or her lap throughout the exam and save the invasive exam elements such as looking in the ears and throat for last. Also keep a light close by — if the child does happen to scream or cry during another part of the exam, sneak a quick look into their throat while their mouth is already open.

Parents are Your Patient Too

How many times have you walked in the room and had the parent tell you "she's had a really high fever" and been "lethargic" all day. Oh, and "she's vomited everything she's tried to eat for four days" and "she's not eating at all." Meanwhile, the child is jumping on the bed, eating a bag of Cheetos, and shouting the lyrics to her favorite Taylor Swift song.

Can you trust mom's assessment? When it comes to the fever, probably. A 1996 study in *Annals of Emergency Medicine* suggests that mom's (or dad's) hands are relatively accurate. Parental fever detection sensitivity was 81.8% and specificity 76.5% when compared with a rectal mercury thermometer. Specificity was over 96% when compared with tympanic thermometry.[5]

As for the other symptoms? As a general rule, parents know their children better than anyone else and the majority don't bring their child into the ED for every febrile illness, ache, or pain. When parents' level of concern or reported history just doesn't match the exam, it's time to get curious. Questions like: "Have they ever had these types of symptoms before? What happened? What treatment usually works when they have symptoms like this?" — and most importantly, "What are you most concerned about today?" will help elicit the parent's agenda and true underlying concern. Once you have that key piece of information, you can reassure them or direct your treatment to address their fear.

Continued on next page

Gaining parental buy-in and trust is critical to ensuring compliance with your plan. The good news is that most parents will make the right choices for their kids when armed with the right information. A 2007 randomized controlled trial of children who received "wait and see antibiotics" for acute otitis media found that 62% of parents did not ultimately fill their prescription compared with 13% in the standard prescription group.[6] When we arm parents with good information and address their underlying concerns, we can work together to help their kids feel better.

References

1. Bonadio et al. Urinary tract infection in outpatient febrile infants younger than 30 days of age: A 10 year evaluation. *Pediatr Infect Dis J.* 2014 Apr; 33(4):342-4.
2. Lin et al. Urinary tract infection in febrile infants younger than eight weeks of age. *Pediatrics.* 2000 Feb; 105(2):E20.
3. Hoberman et al. Urinary tract infections in young febrile children. *Pediatr Infect Dis J.* 1997 Jan; 16(1):11-7.
4. Bachur et al. Reliability of the urinalysis for predicting urinary tract infections in young febrile children. *Arch Pediatr Adolesc Med.* 2001 Jan; 155(1):60-5.
5. Hooker et al. Subjective assessment of fever by parents: comparison with measurement by noncontact tympanic thermometer and calibrated rectal glass mercury thermometer. *Ann Emerg Med.* 1996 Sep;28(3):313-7.
6. Spiro et al. Wait-and-see prescription for the treatment of acute otitis media: A randomized controlled trial. *JAMA.* 2006 Sep 13; 296(10):1235-41. ■

NY AAEM

New York Chapter of the American Academy of Emergency Medicine

JOIN THE REORGANIZED

New York Chapter of AAEM (NYAAEM)

FREE membership for 2014 — become a member today!

Ideas on how to kick-start the chapter?
Questions on how to get involved?

Email info@nyaaem.org or call 800-884-2236.
www.nyaaem.org

AAEM
Young Physicians Section

Invested in your future.

Interested in shaping the future of emergency medicine?

Become a mentor!

YPS is looking for established AAEM members to serve as volunteers for our virtual mentoring program. YPS membership not required to volunteer.

Visit www.ypsaaem.org/mentors or contact info@ypsaaem.org

Find us on Facebook

Start Here.

Residency Graduates: Invest in Your Future

AAEM/RSA was with you all the way — now as your journey through residency concludes — continue on your path with AAEM. Join today as an associate member.

Invest in your future and join the Young Physicians Section (YPS) and access specially designed resources for your first seven years following residency.

As your journey through residency concludes — continue on your path with AAEM.

www.aaem.org/join

Special Offer

Get 18 months of AAEM and YPS membership for the price of 12 months. Act today and become part of the AAEM family.

AAEM
Young Physicians Section

Invested in your future.

AAEM/RSA President's Message

Who We Are

Meaghan Mercer, DO
AAEM/RSA President

Although our specialty is relatively young, the concept of emergency medicine has been fundamental throughout time. Physicians have always been expected to be available at all hours of the day, ready to intervene. In the early 1900s specialization began to occur. As we have evolved we have been stereotyped as many things, including cowboys and jacks-of-all-trades, but masters of none. I disagree; we do more than dabble in all specialties. We are masters of a craft that encompasses many categories, but specifically we are experts in resuscitation, the emergent airway, toxicology, and coordination of care.

We are masters of resuscitation. It's what sets us apart from our colleagues in other specialties. Resuscitation is a fast paced, top-down approach to medicine. While other specialties gather data, analyze the information, and then formulate a plan — we have to take a crashing, undifferentiated patient and intervene with little to no information. Resuscitation requires rapid synthesis of information and relying on your training. In his book, *Thinking Fast and Slow*, Daniel Kahneman states, "Intelligence is not only the ability to reason; it is also the ability to find relevant material in memory and to deploy attention when needed." Our unique training allows us to use our cognitive and subconscious brain in rapid ways, to both recognize patterns and intervene while analyzing our actions and thinking outside the box. We also recognize that decision-making is imperfect. We use methods to allow for cognitive unloading. Preplanning — knowing what to do in the worst-case scenario at all times — checklists and simulation are all tactics that allow us to counteract our cognitive biases to create the best patient outcomes.

BVM, blade, boogie, glidescope, cric kit — we are experts in emergent airway. It is always argued that RSI, intubation, and airway management should be undertaken by the person most experienced with the technique, and that is the EP. We are often called for the rescue airway throughout the whole hospital. We train in all techniques and continue to research, perfect, and practice emergent airway management. The emergency department does not have a checklist of last meals, cardiac status, or a quiet operating room setting; we provide airways when they are needed most.

Acute poisonings, recognition of overdose, chemical exposures, and preparing for biological or radiological attacks — we are specialists in acute toxicological management. As one of three sponsoring boards (ABEM, the American Board of Pediatrics, and the American Board of Preventive Medicine) the American Board of Emergency Medicine recognized the importance of sub-specialization in medical toxicology. Even without fellowship training, we recognize and intervene early in a wide variety of toxin and toxicant exposures, positively affecting the clinical course of our patients. We are trained to recognize unintentional and intentional overdoses of prescription and nonprescription medications, drugs of abuse, chemical exposures, environmental hazards, envenomations, and other toxins.

Often overlooked and undervalued is our expertise at coordination of care. This takes training and talent in diplomacy, an intricate understanding of each work environment in the hospital, effective utilization of resources, and information transmission. We are taught the art of consultation and know that there are two reasons to call a consultant: to ask a question or to get something done. We connect admitting physicians with consultants, we set the stage for the patient's hospital course, and we are expected to remember the intricate details of the patient encounter and relay those in a concise, fluid manner. With 70% of hospital sentinel events coming from communication errors, we are the first line in prevention.

It is more than the adrenaline, chaos, fast pace, euphoria, drug seekers, and late nights; it is perfection. Research, challenging dogma, pioneering free open-access medical education — we are more than just cowboys. We are masters of the field and are passionate about who we are. We are emergency physicians. ■

RSA Editor's Letter

The Adult Learner: Has Medicine Missed the Mark?

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

On a recent whim I searched Google for "emergency medicine education fellowship" and "learning theory." During this entirely non-rigorous search I found that most of the first forty hits were programs specifically mentioning their emphasis on teaching Adult Learning Theory. In fact, even most non-educators reading this have probably heard of ALT. I would wager, however, that you have not heard of Situated Cognition, Cognitive Apprenticeship, Social Learning Theory, or Sociocultural Theory.

Who cares? Why does this matter to the everyday practitioner? Why does this matter to emergency medicine (EM)? The answer lies in the often gross misinterpretation of Adult Learning Theory and the strong case that it does not qualify as legitimate theory, thus leaving learners and teachers selling each other short of the most effective education. Additionally, the medical education community is beginning to move away from emphasizing Adult Learning Theory, and it is important that EM practices education with the most accurate information possible.

This is a two-part series that will first explore the criticisms of ALT, and later offer a breadth of alternatives that together inform us well about how we (adults and children) learn.

Androgogy and Adult Learning Theory

Andragogy has multiple definitions that depend on decade and geographic location,[1] but is essentially the study of adult learning. While the concept of andragogy began with Plato, the term was coined in 1833 by Alexander Kapp and later refined by Malcolm Knowles in 1970.[2] Although andragogy and ALT are often used synonymously, ALT as presented by Knowles and other education and psychology researchers is really one of many theoretical attempts to explain learning by adults.[1]

ALT begins with the concept that children and adults fundamentally learn differently. The premise is that adults and children have existential differences and therefore learn differently, which spawned a heated debate in the 1980s about whether any subgroup (race, sex, etc.) with existential differences deserves its own learning theory.[3] Note that there are social differences between different groups with different existential ideas as well; this is important for later theories.

If we assume that andragogy exists because there is a life-outlook difference between children and adults, we must accept that learning theories such as gynagogy, infantagogy, adolescagogy, and geragogy are also possibilities.[2] Simply reading the list of a few examples out loud can make one question the existence of so many different theoretical differences between groups of learners.

In the setting of great criticism from cognitive psychologists, educational psychologists, and even his mentor, Dr. Knowles de-emphasized the difference between andragogy and pedagogy. Prior to the 1970's, pedagogy was largely interpreted as education of any human, not just children.[3]

Despite naming his initial publication "The Modern Practice of Adult Education: Andragogy Versus Pedagogy," Knowles later wrote:

So I am not saying that pedagogy is for children and andragogy is for adults, since some pedagogical assumptions are realistic for adults in some situations and some andragogical assumptions are realistic for children in some situations. And I am certainly not saying that pedagogy is bad and andragogy is good; each is appropriate given the relevant assumptions (Knowles, 1979, p. 52).[4]

Adult Learning Theory Tenets

Regardless of the debate around andragogy's existence, and by extension an entire theory that could explain it, let us examine the assumptions that ALT posits. According to Knowles, an adult learner:

- has an independent self-concept which allows for self-directed learning
- has a rich repository of life experience by which s/he learns
- has learning needs related to changing social roles
- is problem-centered and interested in immediate application
- is internally motivated to learn.

Continued on next page

No research to date has shown that these assumptions do not apply to children.[2] An excellent critique by a nurse educator breaks down each of Knowles' tenets with evidence as early as 1993, and this is repeated in medical education literature in 1999 and 2006.[2,5,6] As a simple thought experiment, if you have ever bemoaned a mandatory meeting that you knew in your heart of hearts was good for you, we can immediately scratch assumptions 1 and 5.

Why does the medical community care so much for ALT, and in an evidence-based practice jump feet first into it? Probably because it makes us feel special as adults — better than children.[2] It is also easier to understand and remember: Adult Learning Theory — learning for adults.

The grosser sin is the misinterpretation of ALT, because that impacts our learning in a palpable way. How many times have you heard an educator say, "You're an adult learner; do your reading," or "You're an adult learner; figure it out." Self-directed learning is merely a component of ALT, and has moved into its own area of research since the ALT fallout of the 1980s, with it's own Annual International Symposium on Self-Directed Learning. A review in 2000, however, already noted steady decline in publications in this area of research,suggesting again that the tenets of ALT may not provide a solid theoretical foundation for learning. [7]

This is not to say that the tenets of Adult Learning Theory have no value — perhaps as prescriptive teaching methods (self-directed learning), techniques, or a general utility in mindset. However, we risk ignoring much of what the education community knows when we accept ALT as a completely valid theory and build curricula exclusively around it.

The other learning theories presently being explored by cognitive psychologists, learning scientists, and educational psychologists have much more to offer: social components, building cues, etc. We will examine the strengths and weaknesses of those theories in the next issue.

References

1. Merriam SB. Andragogy and Self-Directed Learning: Pillars of Adult Learning Theory. *New Directions For Adult & Continuing Education*. 2002 Jan 1;2001(89):3-14.
2. Milligan F. In defence of andragogy. *Nurse Educ Today*. 1995 Feb 1;15(1):22-7.
3. Davenport J, Davenport JA. A chronology and analysis of the andragogy debate. *Adult Education Quarterly.* Sage Publications; 1985;35(3):152-9.
4. Knowles MS. Andragogy revisited part II. *Adult Education.* 30(1):52-3.
5. Norman GR. The adult learner: a mythical species. *Acad Med.* 1999 Aug;74(8):886-9.
6. Bleakley A. Broadening conceptions of learning in medical education: the message from teamworking. *Med Educ.* 2006 Feb;40(2):150-7.
7. RB B, Editor. *Two decades of literature on SDL: A content analysis.* 14 Ed. Boynton Beach, FL, USA.

Thank You! AAEM/RSA 2013-2014 100% Residency Programs

The following residency programs registered
all of their residents as AAEM/RSA members for the 2013-2014 year.
We sincerely appreciate the enthusiastic support of these physicians and their programs.

AAEM RSA
With you all the way.

- Advocate Christ Medical Center
- American University of Beirut
- Baylor College of Medicine
- Baystate Medical Center
- Beaumont Health System
- Beth Israel Deaconess
- Boston Medical Center
- Brigham & Women's Hospital
- Conemaugh Valley Memorial Hospital
- Emory University School of Medicine
- Florida Hospital
- Georgetown/Washington Hospital Center
- Hennepin County Medical Center
- Henry Ford Health System
- Indiana University
- Johns Hopkins University
- Kern Medical Center
- Louisiana State University – New Orleans
- Marietta Memorial Hospital
- Medical College of Wisconsin
- Medical University South Carolina
- MetroHealth
- Metropolitan Hospital Center
- Morristown Memorial Hospital
- Northwestern University Feinberg
- Ohio State University
- Penn State - Hershey Medical Center
- Regions Hospital
- Resurrection Medical Center
- Stanford University Medical Center
- St. Luke's University Health Network
- St. Joseph's Medical Center
- Temple University Hospital
- Texas Tech University
- Thomas Jefferson
- UNECOM - Kent Hospital
- University Hospitals, Case Medical Center
- University of Arizona
- University of Arkansas
- University of California - Irvine
- University of California-San Diego
- University of California- San Francisco
- University of Chicago
- University of Iowa
- University of Louisville
- University of Maryland
- University of Michigan
- University of Mississippi
- University of Nevada-Las Vegas
- University of Oklahoma
- University of Wisconsin Hospital
- Vanderbilt University
- Wake Forest University Baptist Medical Center
- York Hospital

AAEM/RSA 100% Residency Program Membership

100% membership saves you time and money! By signing up 100% of your residents with AAEM/RSA, you save 10% on all memberships, as well as complete the process with one easy payment. Each resident in your program will enjoy all the benefits of resident membership, plus you will be given an additional discount on the new AAEM/RSA Written Board Review book: *Emergency Medicine: A Focused Review of the Core Curriculum*.

To view all benefits available to residents visit: www.aaemrsa.org/benefits/aaemrsa-resident-benefits.

To learn more about 100% membership visit:
www.aaemrsa.org/membership/residency-programs.

Resident Journal Review

What is the Evidence for Therapeutic Hypothermia?

Authors: Carina Sorenson, MD; David Bostick, MD MPH; Daniel Boutsikaris, MD; Neil Christopher, MD; Kami Hu, MD; Phil Magidson, MD MPH; Adeolu Ogunbodede, MD; Nick Santavicca, MD; Michael Scott, MD; David Wacker, MD PhD
Editors: Michael C. Bond, MD and Jay Khadpe, MD

What is the Evidence for Therapeutic Hypothermia?

Nearly 360,000 out-of-hospital and 209,000 in-hospital cardiac arrests occurred within the United States in 2013. It is well known that systematic post-arrest care improves overall mortality following return of spontaneous circulation (ROSC). Over the last decade, therapeutic hypothermia has become a vital part of post-arrest care due to its ability to improve the likelihood of meaningful neurologic recovery. In light of recent literature challenging the previously recommended hypothermic target temperature of 33°C, this "Resident Journal Review" will assess the initial evidence behind therapeutic hypothermia, the evidence allowing for its application to ever broader clinical scenarios, and the newest data pointing towards non-inferiority of higher target temperatures. We will attempt to reconcile the seemingly conflicting evidence provided by the newest studies of therapeutic hypothermia with our current standard practice, thereby providing recommendations of how therapeutic hypothermia should be implemented in 2014.

The Origins of Therapeutic Hypothermia

Severe neurological impairment occurs following cardiac arrest due to prolonged global cerebral ischemia. Prior to 2002, only animal models of therapeutic hypothermia had been used to demonstrate its usefulness in reducing these neurologic sequelae. In February 2002, two randomized controlled trials showing the utility of post-arrest therapeutic hypothermia in humans were published. These studies both showed substantial increases in the percentage of patients with meaningful neurological recovery who were treated with therapeutic hypothermia. This was a groundbreaking advance as no other intervention to date had been shown to improve neurological outcomes in post-arrest patients.

Bernard SA, et al. Treatment of comatose survivors of out-of-hospital cardiac arrest with induced hypothermia. *NEJM* 2002; 346, 557-63.

The primary outcome of this study was sufficiently good neurological function to warrant discharge to home or a rehabilitation center, rather than discharge to a long-term nursing facility or death. Disposition was determined by a rehabilitation specialist, who was blinded to the treatment received. There was a statistically significant tendency toward discharge to home or rehabilitation in the therapeutic hypothermia group (49% vs. 26%, p=0.046 for 95% CI). Secondary outcomes included differences in hemodynamic, biochemical and hematologic parameters. While there were some transient statistically significant differences in pulse, mean arterial pressure, systemic vascular resistance, cardiac index, serum potassium, serum glucose, and arterial pH between the groups, the clinical significance of these is uncertain.

The relatively small sample size (77 subjects) allowed for statistically significant differences in baseline characteristics between the study groups despite randomization (more bystander-performed CPR and male sex in the normothermia group). Nonetheless, as one of the pioneer randomized trials on therapeutic hypothermia, this study remains a landmark in the field of post-arrest care.

The Hypothermia after Cardiac Arrest Study Group. Mild therapeutic hypothermia to improve the neurologic outcome after cardiac arrest. *NEJM* 2002; 346, 549-555.

This study was a randomized controlled clinical trial taking place in nine European centers from 1996-2000, comparing mild hypothermia (HT) with standard normothermia (NT) following cardiac arrest.

A total of 137 and 138 patients were enrolled into the HT and NT groups, respectively. Hypothermia had to be discontinued in 14 patients. One patient in each group was lost to follow up. Overall, the two groups had generally similar baseline characteristics. Fifty-five percent of the HT group had favorable neurologic outcomes at six months, as compared to 39% in the NT group (risk ratio, 1.40; 95% CI, 1.08-1.81). This generated a number needed to treat (NNT) of six (95% CI, 4-25). Six-month mortality was 14 percentage points lower in the HT group (risk ratio, 0.74; 95% CI, 0.58-0.95), yielding a NNT of 7 (95% CI, 4-33). Complication rates (70% in HT vs. 73% in NT) were similar, but did show a trend toward higher rates of infectious problems in HT group (37% vs. 29% for pneumonia; 13% vs. 7% for sepsis).

Continued on next page

As with the Bernard study, a limitation of this study was that personnel immediately involved in the initial 48 hours of patient care could not be blinded to treatment assignments. Despite this limitation, the evidence put forth by this study and the Bernard study provided the evidence that eventually led to the routine use of hypothermia in post-arrest care.

Current American Heart Association Guidelines

Therapeutic hypothermia was incorporated into the American Heart Association (AHA) guidelines in 2005. The remaining studies that will be reviewed in this RJR were published after the most recent AHA Guidelines from 2010. A review of those guidelines follows.

Peberdy MA, Calloway CW, et al. 2010 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care science. Part 9: Post–cardiac arrest care. *Circulation.* 2010;122:S768-86.

These guidelines recommend that all comatose adult patients with ROSC after out-of-hospital VF cardiac arrest should be cooled to 32°C to 34°C (Class I, LOE B). The data for this recommendation comes from the two studies reviewed above as well as additional studies with historical control groups showing improved neurological outcomes after therapeutic hypothermia for comatose survivors of VF cardiac arrest.

The Use of Therapeutic Hypothermia for Non-Shockable Rhythms

Given that in the 2010 AHA guidelines there were no randomized controlled trials supporting the use of TH for patients presenting with non-shockable rhythms, an area of interest has been the use of hypothermia for these patients. Below we discuss a 2012 meta-analysis of all the studies addressing this issue to date, and then look in detail at one study comparing neurological outcomes in patients with non-shockable versus shockable rhythms treated with TH.

Kim YM, Yim HW, Jeong SH, Klem ML, Callaway CW. Does therapeutic hypothermia benefit adult cardiac arrest patients presenting with non-shockable initial rhythms? A systematic review and meta-analysis of randomized and non-randomized studies. *Resuscitation.* 2012;83:188-196.

This systematic review and meta-analysis examines two randomized and 12 non-randomized studies of adult cardiac arrest survivors who initially presented with non-shockable rhythms. It pools the data from these studies to compare survival and neurological outcomes in TH versus standard of care or normothermia.

Looking at the two randomized trials, the pooled relative risk (RR) for six-month mortality was 0.85 for patients in the hypothermia group compared to the standard care group. However, this was not a statistically significant difference (95% CI 0.65-1.11). For the non-randomized studies, the hypothermia group did have a statistically significant reduction of in-hospital mortality, with a pooled RR of 0.84 (95% CI 0.78-0.92). The pooled RR for poor neurological outcomes on discharge was not significant (0.96 [95% CI 0.90-1.01]).

This study was limited in terms of the breadth and quality of evidence available for review. However, it did conclude that use of TH following non-shockable cardiac arrests is associated with reduced in-hospital mortality.

Soga T, et al. Neurological benefit of therapeutic hypothermia following ROSC for out of hospital non-shockable cardiac arrest. *Circ J.* 2012; 76:2579-2585.

This study examined the efficacy of post-ROSC cooling in adult patients with witnessed out-of-hospital non-shockable cardiac arrest using data from the J-PULSE-Hypo registry.

The primary endpoint of the study was favorable neurological outcome at 30 days. The authors found significant differences between the non-shockable group (NSG) and shockable group (SG) in 30-day favorable neurological outcomes (32% NSG and 66% SG; odds ratio 0.25; CI 0.14-0.42). The NSG also had a significantly decreased survival (59% NSG vs. 85% SG; odds ratio 0.25; CI 0.15-0.44). There were no significant differences between the two groups in regards to occurrence of complications during the first seven days after cardiac arrest. With regards to the subgroup analysis, both groups had equally favorable neurological outcomes in the first quartile (90% NSG vs. 92% SG, OR 0.80; CI 0.09-7.24). However, with a longer time to ROSC, patients in the NSG had less favorable neurological outcomes than those in the SG.

This study showed that when time to ROSC is short, patients treated with hypothermia have favorable neurological outcomes regardless of their initial rhythm.

Early Initiation of Therapeutic Hypothermia

Optimal time to cooling has been an area of active research, and both animal and human studies have shown early cooling to be ideal. The

Continued on next page

Helpful Documents to Navigate Your Career!

AAEM/RSA has organized some free resources that will help you as you go forward with you career in emergency medicine.

Helpful Documents for Students

- How to Ace Your Emergency Medicine Residency Interview
- Online Emergency Medicine Resources for Medical Students and Residents

Helpful Documents for Residents

- The "Perfect" Job: What to Look For — And Watch Out For — In a Future Employer
- Types of Practice Opportunities in Emergency Medicine
- Senior Timeline
- Sample Interview Questions
- The Business of Emergency Medicine - Part 1: From Care to Compensation
- Key Contract Issues for Emergency Physicians

Visit www.aaemrsa.org/resources, to access these helpful documents and much more!

next two articles discuss two topics particularly relevant to emergency medicine providers, namely prehospital and intra-arrest initiation of hypothermia.

Kim F, Nichol G, Maynard C, et al. Effect of prehospital induction of mild hypothermia on survival and neurological status among adults with cardiac arrest. A randomized clinical trial. *JAMA*. 2014;311:45-52.

In this randomized controlled trial, Kim et al., studied the effect of prehospital institution of TH on survival in unconscious patients with out of hospital cardiac arrest who had return of circulation.

The intervention group was treated with up to two liters of normal saline cooled to 4°C, while the control group received standard pre-hospital care. Both groups received standard BLS and ACLS-based interventions. Patients were enrolled in the trial regardless of the rhythm [i.e., VF ("shockable") vs. non-VF ("non-shockable")]. The primary outcome data was stratified by initial rhythm.

Among the two cooling strategies, there was no difference in survival to hospital discharge (62.7% of intervention group vs. 64.3% of control group, p=0.69 for VF patients, and 19.2% of the intervention group and 16.3% of the control group in non-VF). There was also no difference in percentage of patients with favorable neurologic outcome at discharge between the intervention and control groups with either initial rhythm.

Overall, given a lack of expected benefit and an increase in some adverse effects, this study does not support the institution of TH using cold intravenous fluids in the prehospital setting.

Scolletta S, Taccone FS, Nordberg P, et al. Intra-arrest hypothermia during cardiac arrest: A systematic review. *Crit Care*. 2012; 16:R41.

The authors of this review conclude that intra-arrest therapeutic hypothermia (IATH) improves survival and neurologic outcome when compared to post-arrest therapeutic hypothermia or normothermia. However, this is mostly based on experimental improvements in cardiac or neurologic function. The human data on IATH is very limited, and survival benefit has also been difficult to show. To date, human data have not shown a statistically significant benefit in survival, apart from subgroup analysis for patients with short CPR time. While IATH seems promising in experimental models, further human studies are needed to prove any clinical usefulness.

Optimal Target Temperature in Hypothermia

The temperature used for TH traditionally has been 32-34°C, as this was the temperature used in the original 2002 studies. This target

Continued on next page

temperature was extrapolated from prior work done in animal studies. Here we will discuss a study that attempts to identify the exact optimal target temperature within this range, and finish with the new landmark study published in the *New England Journal of Medicine* that compares a target temperature of 33°C to 36°C.

Kim J, Yang H, Lim Y, et al. Effectiveness of each target body temperature during therapeutic hypothermia after cardiac arrest. *The American Journal of Emergency Medicine.* 2011;29:148-154.

The authors of this paper set out to assess outcomes as well as early and late complications associated with each target temperature within the range set forth by the AHA guidelines: 32°C, 33°C, and 34°C .

Overall, there were 62 patients enrolled. Thirteen patients were selected for a target temperature of 32°C, 21 patients for 33°C, and 28 patients for 34°C. There was no difference in neurologic outcome or mortality between the target temperatures. Complications were assessed, and there was a higher incidence of hypotension during the maintenance phase in the group achieving a target temperature of 32°C (OR=6.8, p=0.023).

This paper suggested that the lower targets of the recommended therapeutic range (32-34°C) are associated with an increased number of complications without added neurologic benefit.

Nielsen N, Wetterslev J, Cronberg T, et al. Targeted temperature management at 33°C versus 36°C after cardiac arrest. *N Engl J Med.* 2013; 369(23):2197-206.

The TTM Trial was an international, multicenter, randomized, controlled trial of 939 comatose adult patients between 2009 and 2012 with out-of-hospital cardiac arrest (OHCA) secondary to presumed cardiac cause, with sustained (>20 minutes) ROSC.

Investigators found no mortality benefit to cooling to a goal of 33°C versus 36°C (50% v. 48% mortality, p=0.51) and no difference between groups in the composite outcome of death or poor neurologic function (either by Cerebral Performance Category (CPC) or Rankin scale) at 180 days (RR 1.02, 95% CI 0.88-1.16, p=0.78). When using the best/lowest documented CPC, there was still no benefit in the 33°C group (RR 1.04, 95% CI 0.89-1.17). There was a trend towards a 3% higher risk of serious adverse events (pneumonia, catheter-site bleeding, etc.) in the 33°C group (p=0.09), with a 6% higher rate of hyperkalemia reaching significance (p=0.02). An exception was for intracranial bleeding, for which there was a trend towards increased risk in the 36°C group (1.1%, p=0.09).

While the TTM trial is the best-powered study so far, it did not have the sample size to detect a less than 20% relative risk reduction in mortality, meaning there may be a smaller but still clinically important benefit to lower temperatures that the study was unable to detect (to be fair, lower mortality reductions would require thousands of patients).

While not without its limitations, this study is the best-designed investigation into TH yet, with higher numbers, inclusion of patients with non-shockable rhythms and OHCA, and a pre-specified protocol for withdrawal of life-sustaining measures with intention-to-treat analysis and relatively distant follow-up. Instead of comparing TH to no temperature control at all, the TTM trial looks at a comparison of different actively-maintained temperatures. The lack of difference between the two groups perhaps indicates that it is not the temperature per se, but the amount of effort invested in patient care and monitoring or the active prevention of fever in both study arms that provides the benefits to survival and improved neurologic functioning post-cardiac arrest.

Conclusion

We look forward to seeing how the recent literature is incorporated into the 2015 AHA Cardiopulmonary Resuscitation Guidelines. In the meantime, based on the literature reviewed above we continue to recommend that therapeutic hypothermia be initiated in the ED as soon after ROSC as possible. Both a 33°C and 36°C temperature goal are reasonable, and goal temperature should be chosen according to your individual patient and your hospital's protocol. Therapeutic hypothermia should be practiced with attention to providing optimal overall post-arrest care. ■

Medical Student Council President's Message

Start the New Academic Year Right with AAEM/RSA

Mike Wilk, MS3

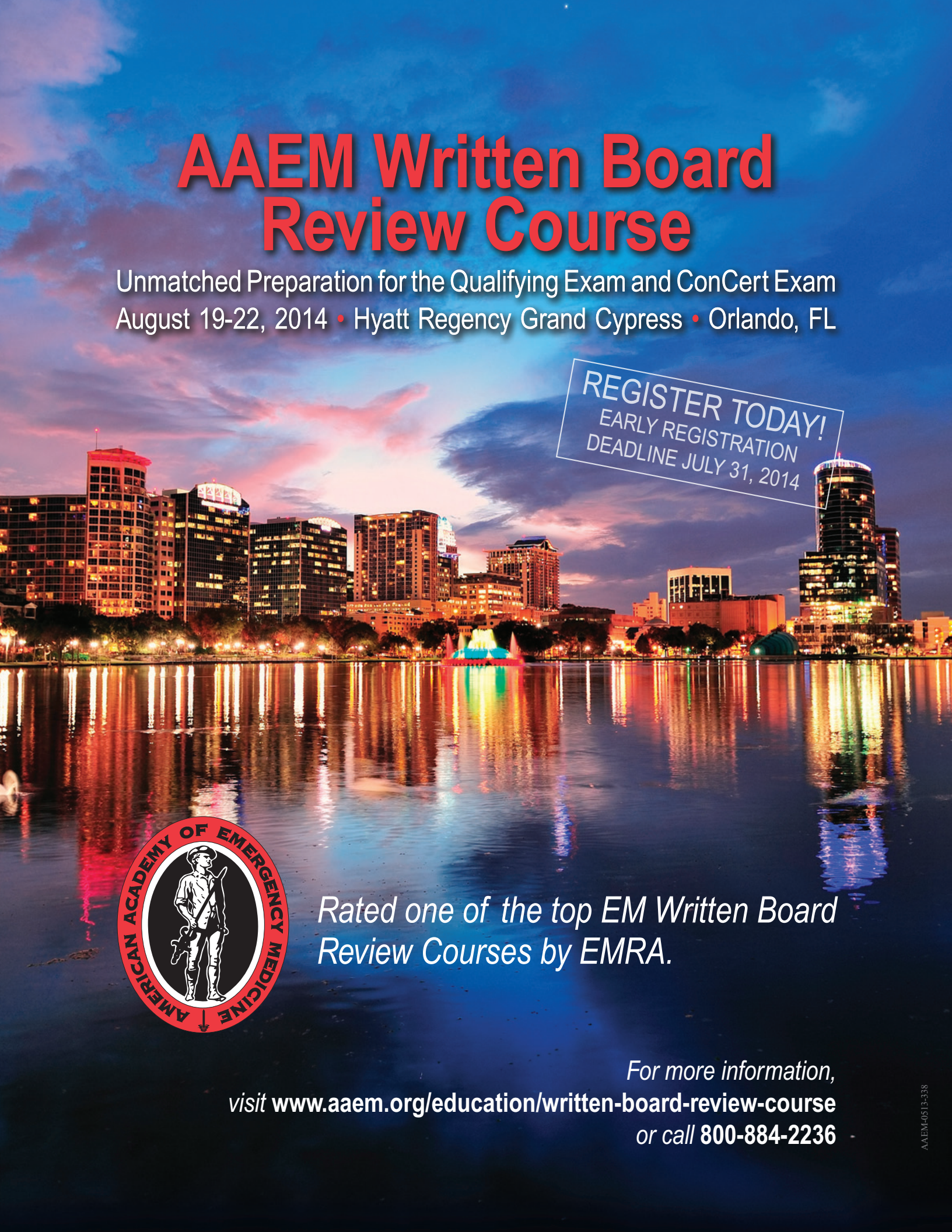
As newly minted physicians begin their residencies this July, a new academic year is already upon us! MS1s will soon be figuring out how to pass anatomy. MS2s will be scrambling to find the best way to defeat the USMLE Step 1 Exam®. MS3s will be learning to adapt to their rapidly changing clerkships and MS4s will shortly be putting together their residency applications.

For those students considering or already committed to the field of emergency medicine, AAEM/RSA has the resources you need no matter where you are on the path to residency. We offer discounts on many EM books and a free membership to EM:RAP (Emergency Medicine: Reviews and Perspectives), a popular monthly podcast. All paid AAEM/RSA members receive a copy of the book, *Rules of the Road for Medical Students*, providing invaluable information covering virtually all EM topics from the first year of medical school to fellowships. Utilize *EM Select* while applying for residency, an interactive residency database tool that helps organize the application process. Additionally, you can attend one of our regional medical student symposiums to hear from experts in the field and network with other students, residents, and program directors.

Did you just decide on the EM specialty or simply have yet to demonstrate your commitment to this career? AAEM/RSA has numerous opportunities for you to get involved. Become a site coordinator for your school or join one of the many committees (Advocacy, Communications, Education, International, Membership, or Publications). Are you knowledgeable about a particular topic or did you see an interesting case while in the emergency department? Consider writing an article and publishing it in our e-newsletter, *Modern Resident*. Apply to be a medical student ambassador and volunteer at the Annual Scientific Assembly next year in Austin, Texas (February 28-March 4, 2015). For residents interested in public policy, consider the new congressional fellowship on policy and advocacy, a one-month opportunity to work with Congressman Raul Ruiz, MD, on Capitol Hill. All of this and much more can be found on the AAEM/RSA website.

It is my pleasure to introduce the other members of the Medical Student Council: Vice President, Faith Quenzer (Western University of Health Sciences); Northeast Representative, Joshua Horton (New York University School of Medicine); West Representative, Melanie Pollack (Western University of Health Sciences); Midwest Representative, Jennifer Stancati (Loyola University Stritch School of Medicine); South Representative, Jaimie Huntly (Medical College of Georgia); and International Ex Officio Member, Mark Tschirhart (St. George University School of Medicine).

I encourage you to take advantage of the many resources and opportunities AAEM/RSA has to offer as you enter the next stage of your medical education. On behalf of the Medical Student Council, I look forward to serving you over the next year. ■


AAEM Written Board Review Course
Unmatched Preparation for the Qualifying Exam and ConCert Exam
August 19-22, 2014 • Hyatt Regency Grand Cypress • Orlando, FL
REGISTER TODAY!
EARLY REGISTRATION DEADLINE JULY 31, 2014
AMERICAN ACADEMY OF EMERGENCY MEDICINE
Rated one of the top EM Written Board Review Courses by EMRA.
For more information,
visit www.aaem.org/education/written-board-review-course
or call 800-884-2236
AAEM-0513-338