VOICE
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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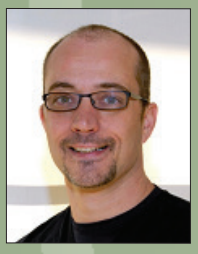

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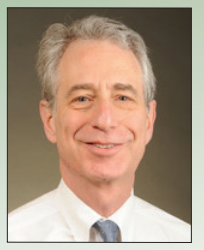

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COMMONSENSE

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AAEM Mission Statement

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

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

Membership Information

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

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

AAEM-0215-051

President's Message

A Dark Day for the Independent Practice of Emergency Medicine

Mark Reiter, MD MBA FAAEM
AAEM President

On January 13th EmCare, the largest staffing corporation in emergency medicine, announced it would be acquiring Emergency Medical Associates (EMA) of Parsippany, NJ and Scottsdale Emergency Associates (SEA) of Phoenix, AZ. EMA has 580 physicians practicing emergency medicine, hospitalist medicine, and urgent care (450 are emergency physicians) at 47 facilities in the Northeast. SEA has 41 emergency physicians serving three hospitals in Arizona. The combined purchase price has been reported to be $380 million. Both groups had a long history as successful independent groups — EMA and SEA formed in 1977 and 1979 respectively. Both groups took pride in operating as democratic partnerships.

I am saddened to see two strong physician-owned and -operated independent groups acquired by a lay corporation with minimal physician ownership or control. I am familiar with many physicians who were partners in EMA or SEA. Both groups had an excellent record of recruiting high-quality physicians. Both groups were entrepreneurial and operationally efficient. As physician-owners with a stake in the success of the practice, EMA and SEA physicians formed close ties to their hospitals and communities. On the other hand, employed physicians working for a distant owner, while providing competent care, may have less motivation to seek excellence in all aspects of emergency department operations.

> "I am saddened to see two strong physician — owned and operated — independent groups acquired by a lay corporation…"

EmCare, as a lay corporation, has a fiduciary duty to its shareholders to maximize profit. At times this may conflict with the best interests of its physicians or the patients they serve. Physician salaries represent EmCare's largest expense. As EMA (in particular) and SEA were large organizations operating with significant economies of scale, it is unlikely that EmCare will realize significant savings through non-clinical cost-cutting. As EmCare seeks to make a profit on its $380 million acquisition, it will likely need to reduce physician salaries, decrease physician coverage, utilize a higher proportion of physician extenders, or recruit physicians willing to work for less. Over time, EmCare needs to earn an extra $612,000 per physician (plus interest) just to cover the cost of the acquisition, and much more than that to earn an appropriate return on investment.

Several EMA and SEA physicians have already contacted AAEM to voice their frustrations and ask for advice. AAEM has been told that EmCare aggressively pushed physicians to sign contracts for much lower salaries, and with other unfavorable terms. AAEM was also told that EmCare is discussing the elimination of a $1.6 million subsidy currently in place at an EMA academic site. Several affected physicians are already interviewing for new jobs.

> "Several EMA and SEA physicians have already contacted AAEM to voice their frustrations and ask for advice"

I can understand why many senior physicians in EMA and SEA are quite pleased with the sale of their groups, since they were nearing the end of their careers and will not be affected much going forward, and they received a sizable financial payout. However, for younger physicians with much of their careers ahead of them, prospects at their current hospitals have dimmed, with potentially both less control and lower compensation. If EmCare is behaving rationally and fulfilling its fiduciary duty to its shareholders, then it expects to earn much more from the labor of these physicians than it spent on acquiring their groups. Physicians who had not yet attained partnership in these groups face a particularly raw deal, as they share in all the downside of the sales without receiving any of the acquisition payout.

January 13th was a dark day for the independent practice of emergency medicine. AAEM is concerned that the future may be bleaker for the 50 facilities involved, the newly EmCare-employed physicians staffing them, and the patients they serve. I was impressed with the successful practices EMA and SEA built, and the solid career prospects they created for their emergency physicians. I am sad to see them end. ■

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.

AAEM Advocacy: Supporting Anti-Restrictive Covenant Legislation in Washington

January 31, 2015

RE: Support of HB 1173

Dear Representative Ricelli,

The purpose of this letter is to convey the strong support of the American Academy of Emergency Medicine (AAEM) for HB 1173 in the Washington State Legislature. AAEM is a national professional society representing over 8,000 specialists in Emergency Medicine. AAEM has longstanding policy opposing the use of restrictive covenants (noncompete agreements that restrict the right of physicians to practice in a geographic area for a period of time after termination of an employment contract). AAEM feels these clauses restrict competition, disrupt the continuity of care, and potentially deprive the public of medical services. Note the American Medical Association's Code of Medical Ethics (Section E-9.02) also considers restrictive covenants to be unethical.

For further information, please see:

AAEM Position Statement on Restrictions on the Right to Practice: http://www.aaem.org/em-resources/position-statements/practice-rights/restrictions

AAEM White Paper on Restrictive Covenants: http://www.aaem.org/em-resources/position-statements/practice-rights/restrictive-covenants

AAEM Mission Statement: http://www.aaem.org/about-aaem/mission-statement

#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.**

Please contact me at mark.reiter@yahoo.com or 919-452-3184 if you have any questions.

Sincerely,

Mark Reiter

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

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Moving the Meat: My Recovery from Burnout

Andy Walker, MD FAAEM
Editor, *Common Sense*

"For the secret of the care of the patient is in caring for the patient."

— Dr. Francis Peabody

In the March/April 2013 issue of *Common Sense*, an article by Dr. Frank Gaudio of AAEM's Operations Management Committee appeared called "Burnout and Productivity." It described the negative effects and practical costs of emergency physician burnout. Reading it before publication prompted me to write of my own experience with burnout, in an editorial called "A Personal View on Burnout." That editorial generated more feedback than anything else I have written for *Common Sense*. In my responses to some of the letters to the editor that followed, I briefly mentioned that I had recovered from burnout and once again looked forward to going to work. I want to more fully describe my recovery and the lessons I learned from the whole experience.

To understand why I suffered burnout to begin with, and went from finding joy in the practice of emergency medicine to dreading going in to work, please read my original editorial (March/April 2013 http://www.aaem.org/publications/common-sense/2013). You will find that essentially two things caused my burnout. First, a complete loss of control over my own work environment — the ED. As any psychologist can tell you, putting someone in a situation over which he has no control but then holding him responsible for the outcome (metrics) is a perfect way to induce experimental neurosis and learned helplessness — and burnout. Second, constant and unrelenting pressure to "move the meat."

Plenty has been written about experimental neurosis, learned helplessness, and the effect on human beings when they are held responsible for results but aren't given the tools or power or authority they need to produce the desired result. In fact, articles on that topic appeared in the July/August 2014 issue of *Common Sense* — "Metric Madness" from an anonymous AAEM member, and my editorial "Responsibility and Authority" (http://www.aaem.org/publications/common-sense/2014). I urge you to reread both articles, and will not discuss that factor any further as a contributor to burnout. Instead, I want to focus on the other promoter of burnout, "moving the meat."

One of the hallmarks of an emergency physician is the ability to act quickly, decisively, and correctly — often in the face of little or no information. While most people in such a situation feel pressured and anxious, emergency physicians feel exhilarated. To us, that isn't pressure at all. It's motivation, not anxiety. That is completely different, however, from the kind of speed called for when someone in the ED says "It's time to move the meat," an expression every emergency physician is familiar with. The first kind of speed — I'll call it "fast action" — is good for the patient, and can be lifesaving. The second kind, moving meat, demeans the patient and turns a human being into a problem, an obstacle to be overcome on the way to getting a new patient into the exam room.

What does moving the meat have to do with my burnout and recovery from it? When a patient has an acute injury or an illness that requires fast action, simply addressing that need and moving on is usually very satisfying for an emergency physician — or at least it is for me. Most of our patients, however, are neither acutely injured nor seriously ill. Most have minor, routine, primary care problems — if they have any acute medical problem at all. Where is the satisfaction for an emergency physician in caring for that kind of patient? It is in seeing him as a human being, a human being who is suffering even if he doesn't have an acute physical illness or injury, and who can benefit from medical care if the physician makes him **feel** better. That is the purpose of our profession, after all — to preserve or restore health when possible, and to **alleviate suffering** always. We are not biologists, technicians, or engineers. We are physicians.

Rendering that kind of patient care, however, and finding satisfaction in doing so, requires enough time to give the patient your undivided, undistracted, unrushed attention. It means making eye contact and listening, rather than staring at a computer or tablet and entering data while you are supposed to be **with** the patient in more ways than just being in the same room. It means focusing on the patient rather than the electronic

> "We are not businessmen selling to customers. We are physicians serving patients."

medical record (EMR). And that is the problem with moving the meat, as opposed to **seeing** the patient. It robs the patient of the feeling of being cared for by the physician, and it robs the physician of the satisfaction of seeing the patient leave feeling better. Everybody loses — except the hospital administrators who care only about metrics, the staffing corporations that care only about maximum coding and patient volume, and the hospital's marketing division that cares only about the average ED waiting time on the billboard beside the nearby highway.

That is what led to my burnout. Not only did my colleagues and I lose control of our own department, laboring under policies and procedures not in the best interests of our patients; we were deprived of the satisfaction of simply making patients feel better, because we had to focus on bad EMR and computerized physician order entry (CPOE) systems rather than human beings, and because the hospital administration's obsession with metrics forced us to move the meat rather than **see** patients.

How did I recover? First, I faced up to the problem. I realized that, even when I was well rested, I dreaded going to work. I also realized the futility of trying to change my hospital or its corporate chain of command and thus restoring my ED to its former excellence. Then, I quit. **If you find**

Continued on next page

yourself in a hole, first quit digging. After six months off, I returned to part-time work in a small, rural ED. Now, not only do I have much better EMR and CPOE software — faster, easier, and safer — because of the lower patient volume I have time to care for patients. Time to talk to them and give them my full attention, without worrying about the particular metric the hospital administrator is obsessed with this quarter. Sure, I would still rather see more patients with acute injuries and serious illnesses, but I feel good about making patients feel better. I once again look forward to going to work. I am happy when I arrive at the ED, and I am almost always still happy when I leave.

> "When you are moving the meat, speed is more important than compassion — or than doing the right thing…"

I am not suggesting that you loaf around at work. I understand the dangers of seeing patients too slowly, leaving them in a waiting room for hours. Neither am I suggesting that you make customer satisfaction a higher priority than your ethical obligation to do the right thing for your patient. We are not businessmen selling to customers. We are physicians serving patients. Enabling an addict's disease by feeding his habit is not what I mean by making the patient feel better. What I mean is telling the addict "I know you are suffering, and I want to help you stop that suffering, but writing you another prescription will prolong your suffering — not stop it." Contrast that with what I used to say to addicts, when my goal was moving meat and getting them out of the ED as fast as possible: "Hi, I'm Dr. Walker. Other than another prescription for Lortab and Xanax, what can I do for you today?" My attitude was, since the drug-abusing patient was going to leave without the desired prescription and unhappy (or mad as hell), why not make that happen as quickly as possible? When you are moving the meat, speed is more important than compassion — or than doing the right thing, which is why you are more likely to give antibiotics for viral infections when you are moving the meat rather than seeing patients.

Of course there will be times when you must pick up the pace, and move the meat for the safety of those still in the waiting room. However, if that is the rule in your ED rather than the exception — especially if you don't have lots of acutely injured or seriously ill patients who truly need a specialist in emergency medicine — you are in danger. You are in danger of losing the satisfaction that ought to come with the practice of medicine, in danger of seeing patients as problems to be solved rather than human beings, and in danger of burning out. While I am proof that an emergency physician can recover from burnout, it is better avoided than treated. Take heed. ■

We're listening, send us your thoughts!

COMMON SENSE
Letters to the Editor

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Voice of the American Academy of Emergency Medicine

Andy Walker, MD FAAEM
Editor, *Common Sense*

VOICE
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

VOLUME 22, ISSUE 2
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Common Sense, like AAEM itself, has prospered and grown tremendously since it first appeared. At first it was published just once a year, and was simple black print on a few white pages. It gradually grew longer and was published more frequently, in three colors. It is now a bimonthly magazine of 40-50 pages, printed on glossy paper in multiple colors. It has clearly outgrown its subtitle of "Newsletter of the American Academy of Emergency Medicine." That is why — in case you didn't notice — on the cover of this issue of *Common Sense* a new subtitle appears: "Voice of the American Academy of Emergency Medicine."

Common Sense is indeed the voice of AAEM. Our Academy's president has a column in each issue, as do the RSA and YPS presidents. Academy committees and task forces also publish news and messages for AAEM members in its pages, and our lobbying firm keeps us posted on legislative and regulatory events in Washington. But *Common Sense* is more than the voice of the Academy — it is a way for members to talk to the Academy, both its leadership and its members at large.

you think AAEM isn't a worthwhile investment of your dues money, write a letter to the editor of *Common Sense*. I guarantee you the Academy is working hard (and largely successfully) to protect you and your patients, but that work isn't always obvious and I welcome the opportunity to explain it and answer questions. Other AAEM members are probably thinking the same thing you are, and would appreciate reading the answer to your question or criticism. If you think reading *Common Sense* is a waste of time, or even if you just don't look forward to reading it, I really want to hear from you. Of course I prefer to be praised for doing a great job — so send those letters in too — but it is far more important for me to hear any criticism or suggestions you have. And controversy makes for entertaining reading, so if you want to speak out on a topic relevant to emergency physicians, please make *Common Sense* your forum with a letter to the editor.

Yes, *Common Sense* is the voice of AAEM — but I want to make it the ears of the Academy too. Please help me by voicing your opinion in its pages. ■

Thank You to Founders Circle Donors!

AAEM believes the future of our specialty and society, are in the hands of our future emergency physicians. As a result, the Founders Circle was developed to encourage sponsorship in emergency medicine residents and residency programs. Founders Circle contributions are earmarked for sponsoring residency program group memberships, thereby introducing those residents to AAEM's mission and core values.

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Health Care Reform Modifications Dominate Agenda in First Months of 2015; Doc Fix Next

Williams & Jensen, PLLC

Proposed Changes to Health Care Reform Law

The U.S. House of Representatives kicked off 2015 by sending several bills targeting portions of the Affordable Care Act (ACA) to the Senate, including legislation that, for purposes of calculating employer requirements, changes the law's definition of full-time work from 30 hours to 40 hours weekly. Another measure sent to the Senate, which is expected to be signed into law, is a bill to exempt employees receiving medical care through the Department of Veterans Affairs (VA) or the Department of Defense (DOD) from counting towards the number of employees in a business for determining the employer mandate under the ACA. Many Congressional Republicans say that both changes will save jobs as both make it easier for small businesses to operate under the ACA. Additionally, the House sent over a separate bill that would fully repeal the ACA; however, this legislation is not expected to pass the Senate nor would it be signed by the President.

More substantive proposed modifications, which may feature prominently on the House and Senate agendas, include repeals of the following portions of the ACA: the 2.3 percent excise tax on medical devices, the mandate that individuals purchase health insurance, and the employer mandate. It is not clear whether there would be enough votes in the Senate to override the President's expected veto to any of these bills, as it would take a minimum of 12 Democrats joining all 55 Republicans to overcome a presidential veto. The vast majority of Congressional Democrats would be expected to oppose these changes. A procedural tool known as budget reconciliation, which will likely be used by Congressional Republicans at some point in 2015, would allow a bill containing various ACA provisions to advance through the Senate and on to the President with just a 51 vote simple majority, rather than the usual 60 vote threshold.

However, the event that could have the most impact on the ACA in 2015 is the Supreme Court decision in King v. Burwell, a case that will decide whether subsidies can be provided in states that do not have state-based exchanges. If the ACA challenge is successful, subsidies to purchase health insurance and the individual mandate to purchase health insurance could be overturned in the 34 states that have a federal exchange. The Supreme Court striking down the subsidies would instantly create uncertainty for the insured population. Centers for Medicare and Medicaid Services (CMS) officials have indicated they do not have a plan in place if this scenario occurs, and it is not clear whether ACA replacement legislation introduced by Congressional Republicans would be received as a starting point for negotiations with Democrats and the Administration. In February, a trio of influential House and Senate Republicans released the "Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act." The CARE act is the Republicans primary plan for replacing the ACA with legislation that provides tax credits for low-income Americans to purchase private health care plans and contains no employer or individual health insurance mandate. The blueprint, which has not yet been released in legislative form, would maintain certain popular provisions that were enacted as part of the ACA, such as the requirement that health plans offer dependent coverage up until age 26, and preventing denial of coverage based on a pre-existing condition.

Trauma and AAEM-endorsed Public Health Bills Advance

In February, the House Energy and Commerce Committee held their first markup of the year, approving several bills including the "Access to Life-Saving Trauma Care for All Americans Act," and the "Trauma Systems and Regionalization of Emergency Care Reauthorization Act." Other bills that have been considered this year at the Subcommittee level included the "Veteran Emergency Medical Technician Support Act," and the "National All Schedules Prescription Electronic Reporting (NASPER) Reauthorization Act."

The trauma bills would reauthorize up to $100 million annually of Trauma Center Care Grants and additional funding for designated trauma centers for the next five years. These two bills have strong bipartisan support in Congress and Members have said that passage would help provide for a robust and functional trauma system in the U.S. and prevent trauma center closures.

In 2014, AAEM endorsed both the Veteran Emergency Medical Technician (EMT) Support Act and the NASPER Reauthorization Act. The EMT legislation would authorize demonstration grants to states to streamline EMT certification and licensure requirements for veterans who have completed military EMT training while serving in the Armed Forces. It essentially makes it easier for these veterans to become licensed EMTs without having to go through duplicative training. The NASPER Reauthorization bill makes improvements to state-based prescription drug monitoring programs (PDMPs), including enhancing physicians' access to real-time patient information.

Doc Fix Deadline and CHIP Reauthorization

The current Medicare Sustainable Growth Rate (SGR, or "doc fix") patch is set to expire at the end of March, resulting in greater than 20% reimbursement cuts for Medicare. Congressional leaders are hoping to build upon their bipartisan work in 2013 and 2014, when bicameral negotiations yielded significant agreement on the payment policies that would replace the SGR. However, in each of those years, policymakers were not able to agree on a means to offset the cost of SGR repeal. Congress is once again in the familiar position of seeking agreement on revenue offsets with just weeks until the expiration of the 17th temporary fix since 2003. In February, the Congressional Budget Office (CBO) estimated that the cost of a permanent SGR fix would be nearly $175 billion, an increase of over $30 billion from the 2014 estimate.

House Ways and Means Committee Chairman Paul Ryan (R-WI) and Senate Finance Committee Chairman Orrin Hatch (R-UT), who both

Continued on next page

assumed their new roles in 2015, have reiterated their support for a permanent fix but acknowledge that there is not yet agreement on how to pay for it. The most likely outcome is another temporary fix in March, possibly in the range of 6 months, setting up more intense revenue discussions that would take place throughout the summer.

SGR legislation has the potential to be a vehicle for other major health care reforms, particularly related to the Medicare system. AAEM has expressed support for a number of policy changes to accompany SGR legislation including: enhanced due process protections for physicians, billing transparency and reform that will allow emergency physicians to see what is billed and collected in exchange for their services, and increased funding for and access to graduate medical education (GME). AAEM has advocated for a physician payment replacement policy that will allow specialty societies and medical boards to provide input in setting quality standards and performance bonuses, rather than a "one size fits all" model that does not account for fundamental differences between specialties. The AAEM Board attended dozens of meetings on Capitol Hill with Members of Congress and staff, specifically focusing on some of these related Medicare policy changes.

Congress and the Administration will also be deciding the future of the Children's Health Insurance Program (CHIP) in the coming months. The program is set to expire at the end of September, but many states have asked Congress to agree on a deal in advance of this deadline in order to provide them with enhanced budget flexibility. The Administration has also called upon Congress to come to bipartisan agreement on CHIP reauthorization. The House and Senate are holding conversations on reauthorization but the timing of legislation is unclear.

Congress and the Administration Continue to Monitor Ebola Threat; Attention Shifts to Vaccines Following Measles Cases

In the final days of 2014, Congress approved $5.5 billion in emergency funding to aid Ebola response efforts, just short of the $6.2 billion requested by President Obama. The bulk of this money was split between the Centers for Disease Control and Prevention (CDC) and the State Department. While there have been no further confirmed cases of Ebola in the United States, Congress continues to monitor the situation in Africa and observe how the funding is being spent. In October, AAEM provided written comments to a Congressional panel seeking input on the Ebola response, highlighting the importance of ensuring that emergency physicians and the critical care community have the resources and access to expert personnel needed to diagnose, treat the sick, and protect caregivers and the public from further harm. Congress also sought AAEM's input on protocols for physicians returning to work after volunteering in Africa.

Congress has initiated a series of hearings in response to increased measles cases. This outbreak has put new focus on the public health debate, and key lawmakers are considering changes to the patchwork of state laws across the country that allow parents to claim a personal belief exemption to avoid vaccinating their children. ■

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

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

AAEM CONFERENCES

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

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

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

August 18-21, 2015
- AAEM Written Board Review Course
  Orlando, FL
  www.aaem.org/written-board-review

AAEM JOINTLY PROVIDED CONFERENCES

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

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

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

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

AAEM-RECOMMENDED CONFERENCES

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

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

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

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

June 10-13, 2015
- High Risk Emergency Medicine – San Francisco
  San Francisco, CA
  www.highriskem.com

June 11-13, 2015
- The Difficult Airway Course: Emergency™
  San Francisco, CA
  www.theairwaysite.com

October 2-4, 2015
- The Difficult Airway Course: Emergency™
  Washington, D.C.
  www.theairwaysite.com

November 20-22, 2015
- The Difficult Airway Course: Emergency™
  San Diego, CA
  www.theairwaysite.com

Dealing with Debt

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

"Annual income, twenty pounds; annual expenditure, nineteen pounds; result, happiness. Annual income, twenty pounds; annual expenditure, twenty-one pounds; result, misery."

— Wilkins Micawber in *David Copperfield*

Debt has a bad reputation. It is prevalent, no one wants it, and everyone who has it wants to get rid of it. Everyone wants to be debt-free.

There is, however, another way to look at debt. Debt is a financial tool to meet your personal and financial goals. For example, according to the Association of American Medical Colleges the median level of medical student debt was $180,000 in 2014. While we'd all agree that this level of debt is high, it has allowed most of us to meet our personal goal of becoming a physician.

> "Don't wait until a crisis hits to get your debt in order."

Dealing with Debt Wisely

Banks and financial institutions see physicians as low-risk and are willing to loan us a lot of money, which can be good or bad. If you are an emergency physician, you can probably get a loan to buy a $100,000 luxury car, and while this might be fun, it is probably not wise. The same thing goes for a jumbo mortgage.

Every time you are considering a loan, you should ask yourself if what you are about to purchase is worth it. Will that fancy car or extra-large house truly bring you happiness? Or does it just bring a ton of overhead, increased expenses, and four extra rooms you'll need to buy furniture for.

As I've discussed in prior columns, the book *The Millionaire Next Door* by Stanley and Danko was a longitudinal study of millionaires. This study showed that most millionaires don't drive expensive cars. In fact, most drive "normal" cars or buy them used. In addition, most don't live in large houses in expensive neighborhoods. Their study showed that physicians are notorious for buying these items to live up to society's expectations. Doctors are supposed to drive luxury cars and live in expensive neighborhoods, right? This is also why they found that physicians under accumulate wealth and have much a lower net worth than their income would predict.

Do yourself a favor and buy a smaller house, drive a less expensive car, and avoid a boat. You don't want to own the boat, you want to be best friends with the owner of the boat. Skip the vacation home. You can probably rent an equivalent home for much less than it would cost to buy it, and in 2013 the Nobel Prize in Economics was given to Robert J. Shiller, who showed that housing prices barely outpace inflation over the long haul, making real estate a less attractive investment.

While the ultimate goal is to get to the point where you can pay cash for cars and other major purchases, you will likely take out loans for some period of time when a major need arises. Here are some financial rules of thumb to keep you from getting in debt beyond what you can handle:

- Monthly debt payments (excluding your mortgage) should be <20% of your monthly income.
- Your housing costs should be <30% of your income.

No matter what debt you accumulate, make sure you always make your payments on time. The #1 factor that goes into calculating your credit score is your ability to make timely payments on your debt, and your credit score will determine the interest rate you are charged on nearly every loan you ever take. One late $50 payment could cost your thousands of dollars on a mortgage, for example.

Credit Cards

"Keeping a balance on your credit card is about the worst financial move you can make."

— Burton G. Malkiel, Chair of Economics, Princeton University
Author of *A Random Walk Down Wall Street*

The quote above says it all. If you are going to use a credit card for the convenience, always pay off the entire balance every month because the interest rates they charge can be very high. If you can't control your credit card debt, cut them up, cancel them, or only have one that you use in special circumstances. If you have to have credit card debt, make sure you ask your credit card company to lower the rate or transfer the debt to a low rate card. Check credit.com, cardtrak.com, or lowcards.com for a list of low rate cards.

Good Debt?

In addition to helping you achieve financial goals that are important to you, debt can be used to limit the amount of your own investments that must be in cash equivalents. Having easy access to credit can provide a nice backstop in case of a sudden need for cash.

If you have equity in your home, a home equity line of credit can serve this purpose. Their interest rates are usually low and the interest is often tax deductible, further lowering the cost of borrowing. Home equity lines of credit (and other lines of credit as well) should be set up in advance, not after you lose your job and are a credit risk. Beware of fees your lender may charge and see if you can find one that will waive them for a slightly higher interest rate. A slightly higher interest rate isn't that big of a deal as you hope to never use this line of credit anyway.

Continued on next page

Student Loans

Many readers will have significant student loans. If you are a resident or fellow, contact your loan servicer to see if you are eligible for deferment of your loans until your salary rises. If you are looking to simplify your loans, investigate student loan consolidation by checking loanconsolidation.ed.gov.

Probably the most important step that residents can take to pay off their student loans is to avoid jumping straight into the "doctor lifestyle" as soon as they graduate residency. If you continue to live like a resident until your student loans are paid off, it shouldn't take more than a few years to get rid of them, after which you can splurge a little and enjoy your income free of student loans. This is easy to type and hard to do, but just a few years of "roughing it" can wipe out your student loans.

Paying Off Debt

When you pay off debt, you are earning an after-tax return equivalent to the interest rate you are being charged. For example, if you pay off credit card debt with an 18% interest rate, this is the equivalent of earning a guaranteed 18% return on your investment tax-free. With the long-term rate of return for the stock market averaging just under 10%, you can see that paying off high-rate debt is often a better move than investing in the stock market. In other words, it makes no sense to pay the minimum on high-interest debt like credit cards while investing in the stock market. Pay off your high interest debt first.

The one exception to this is if you get an employer match on your retirement account contributions. If you get a 50% match, that is an immediate 50% return on your investment, so contribute to your retirement account up to the maximum that your employer matches, then pay off high interest debt.

If you have multiple loans, pay off the one with the highest interest rate first. In addition, see if you can stretch out the payments for your low interest loans over a longer period of time, lowering your monthly payments and freeing up cash to pay off your higher interest debts faster. For example, if you have credit card debt with a 14% interest rate, a car loan with an 8% rate, and a mortgage with a 5% rate, pay off the credit card first, then the car loan, and then the mortgage.

Keep in mind that in general it doesn't make sense to pay off debt when the interest rate is lower than the after-tax rate you could earn on an investment. If you want a number, I would pay off high-interest debt (rates greater than 6-8%) such as credit cards, car loans, and private educational loans. If the rate is less than 6%, as with most mortgages nowadays, it probably makes more sense to invest the money in mutual funds and pay off the debt as slowly as possible.

Another move to consider is to take out a home equity loan to pay off high interest debt. You get a lump sum with a fixed interest rate that is often lower than your current debt and pay it off over 5-15 years. In most cases the interest you pay is tax deductible. Keep in mind that you could lose your house if you default on this type of lean, and beware of any up-front fees that you need to factor into your calculations.

Conclusion

Don't wait until a crisis hits (divorce, job loss, disability, or a lawsuit) to get your debt in order. If you have major problems with debt and need help, seek a fee-only financial planner with experience with high-income individuals who can help you restructure and manage your debt.

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. ■

With A Little Help from Our Friends

Craig Norquist, MD FAAEM

As emergency physicians, all of us have experienced the challenge of having people in the exam room other than the patient ask seemingly endless questions, or the patient who asks you to "explain everything again" to someone on the phone. Often these conversations are appropriate and the questions need to be answered, but you might feel a sense of unease with the extra presence in the room or that someone other than the patient is asking all the questions. After all, your obligation is to the patient, not the entire extended family, and you feel as though you can't spend any more time with all these people and their questions and need to break away.

In the emergency department we routinely break bad news to patients and their family members. In my first article in this "Through the Patient's Eyes" series, I discussed the need to address certain things before dealing with the worst news to be shared, since often the patient will not hear anything else that is said after that. Family and friends who accompany the patient will also be stunned, but they still assume a very important role for the patient at that moment. Information regarding the diagnosis and the next steps to be taken should be relayed to all in the room, and making things clear to the caregivers is as important an ensuring the patient's understanding.

Being diagnosed with cancer myself, and having my wife go through it, means I can speak personally about both sides of this life-altering conversation. Honestly, it is far worse to be the spouse, family member, or friend of someone who receives a bad diagnosis. When my wife and I received our diagnoses (ten years apart), our immediate thoughts ranged from "What does it mean to have cancer?" to "What are the treatment options?" to "How long do I have?" to "Why me?" When it happens to someone you love, your thoughts start with "Why not me instead of them?" and quickly turn to "What do I need to do to help get them through the fight of our lives?" When such news is delivered to you and you are facing your own mortality, at some point you realize it just doesn't matter — as you may be dead and gone soon and how people deal with it is out of your control. Sure, the thought of dying is frightening, but trying to imagine your life without someone you truly love is more frightening than you can imagine — and far worse.

For the physician delivering the news, I can offer some insight that will help you help patients and their loved ones cope a little better. Hopefully you already ask patients if they want other people in the room for serious medical discussions. If not, make it standard practice. It is safe to assume that if others are still in the room when the discussion turns to cancer and chronic illness, then those people are going to be living with the disease along with the patient. Once the bad news is out there, the patient may not hear much that follows, so the others in the room will be absorbing information to relay to the patient over time. They will also be the ones who help organize the innumerable appointments and visits that follow. Furthermore, many caregivers will become the patient's educator, relaying and reinforcing the critical information we provide. Their most important job will be being strong for the patient and offering any encouragement they can. Speaking from firsthand experience as a patient receiving tough news, that feeling of the walls closing in is very real, and at that point someone else will need to step up and carry the ball. Our awareness of this as physicians will help all those affected, not just the patient.

> "Honestly, it is far worse to be the spouse, family member, or friend of someone who receives a bad diagnosis"

We often see family and friends at the worst time possible. These caregivers will need care themselves, in order to persevere in the demanding job at hand. If they are given an idea of what to expect at the beginning, they will be better prepared and may realize they will need help themselves. Their emotional well-being will be tested. Someone they have loved for years may be in the midst of dying, or fighting for life on a ventilator. If no one has had a discussion with the patient on end-of-life care, the loved ones will be making crucial decisions based more on emotion than rational thought or the desires of the patient. Opening these discussions with the patient, family members, and loved ones early can pay dividends as the disease progresses, because everyone is better prepared to make hard decisions when the time comes. We need to be sensitive to all and assume joint decisions will be made. Some patients can face cancer and other chronic diseases by themselves, but most of us are better off with a little help (or a lot) from our friends and family.

The least we can do for those who love our patients is respect their input and questions during visits, and prepare them for what is to come. ■

A Hospitalist's Opinion

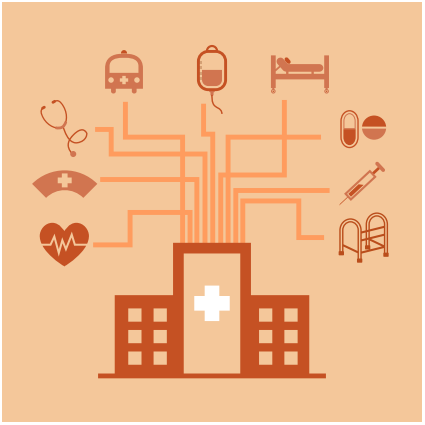
Peter Thompson, MD

Full disclosure: I am an internist and hospitalist. I work with Apogee Physicians, a physician-led and physician-owned group that creates inpatient teams in hospitals around the country. I came to know about your organization, AAEM, through news articles over the summer reporting on Tenet Healthcare's consideration of creating ED-subsidized hospitalist practices in the state of California. I reached out to Dr. Reiter and within minutes he returned my email. A few minutes after that we were talking on the phone about our shared view that the ED-hospitalist model is wrong on many levels. I am thankful for the opportunity to share my views with you now.

The medical marketplace is not always kind or fair. Why is a surgeon paid many more dollars than a hospitalist, who has profound influence over the patient's flow through the hospital? I do not know, and unfortunately it is beyond my control. Rather than utilizing non-hospitalist primary care, however, hospitals have demanded hospitalists — for reasons that include better availability, early commitment to best practices and protocols, and better alignment with the hospital's goals and mission. There is great value in what hospitalists do, whether it is more accurately documenting severity of illness, explaining medical necessity, or participating in hospital process improvement as our patients cross departments and clinical areas while we follow them on their journeys through the hospital. I would like to present what I think are the most important issues brought up by Tenet's proposed business model as it relates to hospitals, EDs, and hospitalist groups.

> "The more we collaborate as professionals with important but different missions, the more we will achieve better results and outcomes…"

From the hospital's perspective, I can see the attractiveness of the cross-subsidy model. It is cheaper, and on the surface implies the automatic coordination of care across hospital departments. But will the model deliver on that implied promise? Hospitals need engaged physician partners and medical leaders, not house staff who are deployed to assume responsibility for patient care that no one else wants to provide. No hospitalist aspires to be a second-class citizen in a model in which he or she is a loss leader or an afterthought. Hospitalists who accept this business model are likely to be those with fewer options, based on either ability or commitment to a particular community. Physicians with more choices will probably decline this "opportunity." There are many other hospitalist positions open that are not in these cross-subsidy, corporate arrangements. In fact, there are several open hospitalist positions for every hospitalist in America. I imagine a similar dynamic is underway for emergency physicians who are being recruited to the combined-specialty, corporate model. Physicians must make a choice, and in this case they have one: go to a practice that will not respect them, or join a practice that is developing medical leaders who strive to sink roots in their communities and contribute to improving their hospitals over the long term. For the hospital, the initial lure of no or low subsidies to its hospitalist practice will fade as the institution fails to meet its goals and achieve its mission. I anticipate a recruiting advantage for EDs and hospitalist groups not participating in the cross-subsidy model.



Financial efficiencies must always be analyzed by the legal and ethical standards that exist in business. In addition, new business constructs will rightly be judged by the results and outcomes they achieve. The ED-hospitalist model will ultimately fail on both levels. While I cannot force state or federal agencies to investigate this model, I do have a great deal of influence over the degree of collaboration between hospitalists and emergency physicians. The more we collaborate as professionals with important but different missions, the more we will achieve better results and outcomes that affect real patients and real hospitals. Competition inspires creativity. The winners should be our patients, our hospitals, and the clinicians who are fairly compensated in an environment where they can do their best work. Over the years, Apogee has developed best practices for working with the ED, in order to achieve the best outcomes for our shared patients. Truly, for our hospitalist practices to succeed, we must successfully collaborate with our emergency medicine colleagues. Not a day goes by that our patients do not benefit from our close communication and shared goal of excellence.

I will focus my time and energy on controlling the things I can control. There is always more we can do to make our patient's journey safer, more consistent, and more efficient. Hospitalists think in terms of systems. Our point of view takes in the entire hospital, from the ED to discharge to the follow-up phone call a few days after discharge. EPs and hospitalists, working together, need to measure outcomes that reflect the continuum from ED to inpatient unit, and work together to improve those outcomes. Sharing metrics is one way to focus our combined attention on processes that matter for patients. I do not need to be paid from your revenue to be fully engaged in improving flow. In fact, it is likely that as an equal in the relationship, with insights and best practices from both the ED and hospitalist worlds, the end result will be better. Outcomes will ultimately determine the winning model. We should be prepared to report our results in collaboration. The opportunity to demonstrate what respected professionals can do together lies before us. Let's get started. ■

Peter Thompson, MD
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Justice Department Recovers Nearly $6 Billion from False Claims Act Cases in Fiscal Year 2014

Below is part of a year-end press release from the Department of Justice, summarizing its recoveries for the federal government in 2014 under the False Claims Act and through whistleblower (qui tam) lawsuits. I deleted the sections not relevant to health care, but if you wish to read the entire press release you will find it here: www.justice.gov/opa/pr/justice-department-recovers-nearly-6-billion-false-claims-act-cases-fiscal-year-2014. *Many emergency physicians are in a position to witness fraud in federal programs, since every ED in the country serves patients in Medicare, Medicaid, or other federal programs. You should read everything below carefully, but here are the* ***most critical*** *facts:*

> Most false claims actions are filed under the act's whistleblower, or qui tam, provisions that allow individuals to file lawsuits alleging false claims on behalf of the government. If the government prevails in the action, the whistleblower, known as a relator, receives up to 30 percent of the recovery.

This means that a whistleblower who is aware of fraud against the federal government files suit against the perpetrator of the fraud, the federal government then takes over as plaintiff in the suit, and if successful shares the damage award with the whistleblower. Usually the suit is sealed (secret) when filed by the relator, and remains sealed until the government decides whether or not to take over as plaintiff. Systemic fraud involving Medicare and Medicaid patients can result in damage payments in the tens or even hundreds of millions of dollars.

> The settlement resolved allegations that Omnicare engaged in a kickback arrangement with skilled nursing facilities to induce the facilities to select Omnicare as their pharmacy provider, in violation of the Anti-Kickback Statute, which prohibits offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid and other federally funded programs.

This means it is illegal for any entity to pay a kickback to another in return for a contract to serve Medicare or Medicaid patients. A hypothetical example in emergency medicine would be a staffing company that pays a hospital in return for the contract to staff the hospital's ED.

If you are aware of fraud against federal programs like Medicare and Medicaid, you should consult an attorney experienced in qui tam suits or call AAEM for help.

— The Editor

Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE
Thursday, November 20, 2014

Justice Department Recovers Nearly $6 Billion from False Claims Act Cases in Fiscal Year 2014

First Annual Recovery to Exceed $5 Billion; Over 700 Whistleblower Lawsuits for Second Consecutive Year

The U.S. Department of Justice obtained a record $5.69 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending September 30, Acting Associate Attorney General Stuart F. Delery and Acting Assistant Attorney General Joyce R. Branda for the Civil Division announced today. This is the first time the department has exceeded $5 billion in cases under the False Claims Act, and brings total recoveries from January 2009 through the end of the fiscal year to $22.75 billion — more than half the recoveries since Congress amended the False Claims Act 28 years ago to strengthen the statute and increase the incentives for whistleblowers to file suit.

"In the past three years, we have achieved the three largest annual recoveries ever recorded under the statute," said Acting Associate Attorney General Delery. "This sustained success demonstrates that these figures result not only from large individual matters, but from a continuous commitment year after year to pursue those who defraud taxpayers and to remain vigilant in identifying those who would unlawfully obtain money from the federal fisc."

The recoveries reflect the administration's priorities to hold the financial industry accountable for its part in the gross misconduct that led to the housing and mortgage crisis, and to continue to root out fraud in the health care industry. In fiscal year 2014, the department recovered an unprecedented $3.1 billion from banks and other financial institutions involved in making false claims for federally insured mortgages and loans. False claims against federal health care programs such as Medicare and Medicaid accounted for another $2.3 billion. These amounts reflect federal losses only. In many of these cases, the department was instrumental in recovering additional billions of dollars for consumers and state treasuries.

"It has been an extraordinary year for civil fraud recoveries, but the true significance is not in breaking records or making history; it is in the billions of dollars restored to the federal treasury," said Acting Assistant Attorney General Branda. "The False Claims Act was enacted both to protect vital taxpayer dollars and deter those who would misuse public funds. The department will continue to enforce the law aggressively to ensure the integrity of government programs designed to keep us safer, healthier and economically more prosperous."

The False Claims Act is the government's primary civil remedy to redress false claims for government funds and property under government contracts, including national security and defense contracts, as well as under government programs as varied as Medicare, veterans' benefits, federally insured loans and mortgages, transportation and research grants, agricultural supports, school lunches and disaster assistance. With more whistleblowers coming forward since the act was strengthened in 1986,

Continued on next page

the government opened more investigations, which led to the surge in recoveries we see today.

Most false claims actions are filed under the act's whistleblower, or *qui tam*, provisions that allow individuals to file lawsuits alleging false claims on behalf of the government. If the government prevails in the action, the whistleblower, known as a relator, receives up to 30 percent of the recovery. The number of *qui tam* suits filed in fiscal year 2014 exceeded 700 for the second year in a row. Recoveries in *qui tam* cases during fiscal year 2014 totaled nearly $3 billion, with whistleblowers receiving $435 million.

Health Care Fraud

The $2.3 billion in health care fraud recoveries in fiscal year 2014 marks five straight years the department has recovered more than $2 billion in cases involving false claims against federal health care programs such as Medicare, Medicaid and TRICARE, the health care program for the military. This steady, significant and continuing success can be attributed to the high priority the Obama Administration has placed on fighting health care fraud. In 2009, Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius announced the creation of an interagency task force, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to increase coordination and optimize criminal and civil enforcement. This coordination has yielded historic results: from January 2009 through the end of the 2014 fiscal year, the department used the False Claims Act to recover $14.5 billion in federal health care dollars. Most of these recoveries relate to fraud against Medicare and Medicaid. Additional information on the government's efforts in this area is available at StopMedicareFraud.gov, a webpage jointly established by the Departments of Justice and Health and Human Services.

The pharmaceutical industry accounted for a substantial part of the $2.3 billion in health care fraud recoveries in fiscal year 2014. Global health care giant Johnson & Johnson and its subsidiaries, Janssen Pharmaceuticals and Scios (J&J), paid $1.1 billion to resolve False Claims Act claims relating to the prescription drugs Risperdal, Invega, and Natrecor. The government alleged that J&J promoted the drugs for uses not approved as safe and effective by the U.S. Food and Drug Administration (FDA). Because J&J marketed the drugs for uses not covered by federal health care programs, the company's promotion of the drugs caused physicians and other health care providers to submit hundreds of millions of dollars in alleged false claims against Medicare, Medicaid, TRICARE and other federal health care programs. The government also alleged that J&J paid kickbacks to physicians and to Omnicare Inc., the nation's largest provider of pharmaceuticals to nursing homes and long-term care facilities. In addition to the federal civil settlement, J&J paid more than $600 million in civil claims for state Medicaid programs and $485 million in criminal fines and forfeitures, making this $2.2 billion global resolution of the government's claims one of the largest health care fraud settlements in U.S. history.

In a separate settlement, the department also recovered $116 million from Omnicare. The settlement resolved allegations that Omnicare engaged in a kickback arrangement with skilled nursing facilities to induce the facilities to select Omnicare as their pharmacy provider, in violation of the Anti-Kickback Statute, which prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally funded programs. The statute is designed to ensure that the decisions of doctors and other professionals in prescribing drugs or recommending providers are driven by the needs of the patient and not the prospect of personal gain. Since claims for services or supplies induced by kickbacks are not eligible for reimbursement under federal health care programs, the government alleged that

Continued on next page

these claims violated the False Claims Act. In addition to recovering $116 million in federal claims, the government recovered $8.2 million that will go to states that jointly funded the Medicaid programs impacted by Omnicare's conduct.

Cases involving hospitals resulted in $333 million in fiscal year 2014 settlements and judgments, with significant recoveries from two hospital chains. Community Health Systems Inc., the nation's largest operator of acute care hospitals, paid $98.15 million to settle allegations that it billed Medicare, Medicaid and TRICARE for inpatient services that should have been provided in a less costly outpatient or observation setting. Halifax Hospital Medical Center and Halifax Staffing Inc., hospital service providers in Florida, paid $85 million to resolve allegations that it violated the Stark Law, which prohibits hospitals from billing Medicare for certain services when referred by physicians who have a financial relationship with the hospital.

The government also had significant recoveries for home health services provided in alleged violation of the False Claims Act. Amedisys Inc., one of the nation's largest providers of home health services, paid $150 million to resolve allegations that it billed Medicare for medically unnecessary services, for services to patients who were not homebound and for violations of the Anti-Kickback Statute. The government alleged that Amedisys management pressured nurses and therapists to provide care based on the financial benefits to Amedisys rather than the needs of patients.

In a trio of cases involving cardiac procedures, the government recovered $85 million based on claims involving potentially life threatening conduct. Boston Scientific Corp., which purchased Guidant LLC and Guidant Sales LLC, and Cardiac Pacemakers Inc. in 2006, paid $30 million to settle claims that Guidant sold defective heart devices to health care facilities that implanted them into Medicare patients. The devices were small defibrillators surgically implanted into patients' chests. When a working device detects an irregular heartbeat, it sends an electrical pulse to shock the heart back to its normal rhythm. The Guidant devices allegedly short circuited, rendering them ineffective. In the other two cases, Kentucky hospitals King's Daughters Medical Center and Saint Joseph Health System Inc. billed Medicare and Medicaid for coronary procedures that the government alleged were unnecessary. King's Daughters paid $39 million in federal claims and $2 million in state Medicaid claims to settle allegations that it billed for medically unnecessary coronary stents and diagnostic catheterizations, and that it had prohibited financial relationships with physicians referring patients to the hospital. St. Joseph's paid $16 million in federal claims and $366,000 in state Medicaid claims to settle allegations that St. Joseph Hospital in London, Kentucky, billed Medicare and Medicaid for numerous invasive cardiac procedures that were performed on patients who did not need them, including procedures involving coronary stents, pacemakers, coronary artery bypass graft surgeries, and diagnostic catheterizations.

Recoveries in Whistleblower Suits

Of the $5.69 billion the government recovered in fiscal year 2014, nearly $3 billion related to lawsuits filed under the *qui tam* provisions of the False Claims Act. During the same period, the government paid out $435 million to the individuals who exposed fraud and false claims by filing a *qui tam* complaint, often at great risk to their careers.

The number of *qui tam* suits rose from 30 in 1987, to 300 and 400 a year from 2000 to 2009, to more than 700 for each of the last two fiscal years. The growing number of *qui tam* lawsuits filed since 2009 has led to increased recoveries, which exceeded $2 billion for the first time in fiscal

Continued on next page

Strength in Numbers

AAEM 100% ED Groups

AAEM 100% ED Group Membership

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

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

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

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

year 2010, and has approached or exceeded $3 billion ever since. As recoveries increased, so have whistleblower awards. From January 2009 to the end of fiscal year 2014, the government paid awards in excess of $2.47 billion.

"We acknowledge the men and women who have come forward to blow the whistle on those who would commit fraud on our government programs," said Acting Assistant Attorney General Branda. "In strengthening and protecting the False Claims Act, Congress has given us the law enforcement tools that are so essential to guarding the treasury and deterring others from exploiting and misusing taxpayer dollars. We are grateful for their continued support."

In 1986, Senator Charles Grassley and Representative Howard Berman led successful efforts in Congress to amend the False Claims Act to, among other things, encourage whistleblowers to come forward with allegations of fraud. In 2009, Senator Patrick J. Leahy, along with Senator Grassley and Representative Berman, championed the Fraud Enforcement and Recovery Act of 2009, which made additional improvements to the False Claims Act and other fraud statutes. And in 2010, the passage of the Affordable Care Act provided additional inducements and protections for whistleblowers and strengthened the provisions of the federal health care Anti-Kickback Statute.

Acting Assistant Attorney General Branda also expressed her deep appreciation for the many dedicated public servants who investigated and pursued these cases — the attorneys, investigators, auditors and other agency personnel throughout the Civil Division and the U.S. Attorneys' Offices, as well as the agency Offices of Inspector General, and the many federal and state agencies that contributed to the department's recoveries this past fiscal year.

"Without the tremendous talent and dedication of the public servants who worked tirelessly to bring these matters to settlement or judgment, the nearly $6 billion in recoveries we announce today would not have been possible," said Branda. "I commend them all for their exceptional efforts." ■

14-1300
Civil Division

AAEM15 Wrap Up: I Get By with a Little Help from My Friends

21ST ANNUAL SCIENTIFIC ASSEMBLY
HILTON AUSTIN ★ AUSTIN, TX

Joseph Lex, MD MAAEM FAAEM
AAEM Board of Directors

The 21st Annual AAEM Scientific Assembly in Austin, Texas: Was it the best yet? Of course! Then again, the 20th was better than the 19th, the 19th was better that the 18th, but you get the idea. And, of course, the 22nd in Las Vegas from February 17-21, 2016, will be better than the 21st.

Am I biased? Again, of course. I headed up the subcommittee that put together the Scientific Assembly this year, a job for which I lobbied. I was lucky and worked with a superior meetings manager, Kathy Uy, who kept us on target. We became friends and eventually we were able to read each other's mind about what needed to be done and in what sequence.

Am I proud of what we accomplished? I am bursting with pride at the efforts put forth by so many people at so many levels — organizers, speakers, and attendees. As far as I can tell, things went without a hitch.

So many people to thank, people whom I am proud to call friends.

> Keep smiling, Keep shining
> Knowing you can always count on me for sure
> That's what friends are for

Work from dozens of people made this meeting a success, but I want to give a special shout-out to five young physicians and friends to whom I entrusted the Pecha Kucha track: Joelle Borhart, MD FAAEM, R. Gentry Wilkerson, MD FAAEM, the husband-wife team of Zachary and Jennifer Repanshek, both MDs and FAAEM, and Siavash Sarlati, MD, who is a resident in training. They essentially organized a conference-within-a-conference and it ran as smoothly as clockwork. I predict all five of these people will be future leaders of our organization. The PK sessions were well-attended and served as a perfect platform to deliver concentrated information in the shortest time possible — 400 seconds and done. As far as I know, we are the only national meeting that serves up two days of bite-sized wisdom in such an appetizing format.

Despite some early acoustic problems, keynote speaker and new friend Simon Carley made us ponder the nature of being an emergency physician, how we think and how we make decisions.

At the daily plenary sessions we got astonishingly good literature updates from some familiar friends: Amal Mattu, MD FAAEM, Corey Slovis, MD FAAEM, and Peter Deblieux, MD FAAEM; and from rising stars Mimi Lu, MD FAAEM (winner of the Young Educator Award), Nilesh Patel, DO FAAEM, and Evadne "Evie" Marcolini, MD FAAEM.

AAEM's SciAss also lit up the Twitterverse during its four-day run, generating more than 6,600 Tweets from 1,190 participants and a total of more than 9,000,000 impressions (as of the time I write this). Kudos especially to electronic friends @ALiEMconf and @mdaware, our top two Tweeters. And did you notice: our Twitter handles (mine is @JoeLex5) were on our name tags this year?

I have now handed over the leadership of this subcommittee to two old and trusted friends, Christopher Doty, MD FAAEM, and Evie Marcolini, MD FAAEM. New leadership brings new ideas, but also welcomes new ideas. I encourage you to send suggestions for topics or tracks, no matter how far-fetched you think they may be, either to me (joelex@aaem.org) or the new co-chairs (info@aaem.org). If you want to present a PK session, let us know. If there's something we are missing, tell us. While compliments are always nice, they don't move things forward. In fact, they tend to breed complacency. Challenge us to make this an even better meeting for you, so that your patients benefit from what you learn.

As your newly elected representative on the board of directors, I made it clear that I was a single-issue candidate: educational advances. I am pleased that the Academy's leadership appointed me to be liaison to the Scientific Assembly Subcommittee, where I can serve as senior adviser, and to the Social Media Committee. I foresee bringing these groups even closer together for the benefit of our members and, of course, our patients.

Did you miss SciAss? Were there sessions that you were itching to attend but couldn't? Don't worry, be happy, for thanks to some long-time friends you can still get the information. Rick Nunez, MD FAAEM, had his EMedHome crew videorecord about 80% of the sessions and they will be in our online learning library (www.aaem.org/education/online-learning-library) at no charge to members by the time you read this. If you want to earn additional *AMA PRA Category 1 Credit*™ you can do so for a small fee. And thanks to Mel Herbert from EM:RAP, audio recordings of all the main track content will be available for download.

Despite bad weather in parts of the nation — I am typing this on a plane circling over O'Hare after being turned back from New York — we had a phenomenal showing. And we could not have done it without a lot of help from my friends.

For good time, for bad time
I'll be on your side forever more
That's what friends are for. ■

AAEM president, Mark Reiter, MD MBA FAAEM, kicked off the 21st Annual Scientific Assembly with his opening remarks.

Simon Carley, MD FRCS(Ed) FCEM, educated and entertained with his keynote address "Evidence, Data, Belief, Denial, and Cognitive Delusion: How Do We Really Practice Emergency Medicine?" Dr. Carley joined us from Manchester, UK.

Larry Weiss, MD JD MAAEM FAAEM, accepts the Master of the American Academy of Emergency Medicine Award from AAEM president, Mark Reiter, MD MBA FAAEM. The MAAEM designation is given to those who demonstrated a long career of extraordinary service to AAEM, leadership, and volunteerism.

21ST ANNUAL SCIENTIFIC ASSEMBLY
HILTON AUSTIN★AUSTIN, TX

AAEM past presidents (L-R) Howard Blumstein, MD FAAEM; Joseph Wood, MD JD MAAEM FAAEM; Larry Weiss, MD JD MAAEM FAAEM; Tom Scaletta, MD MAAEM FAAEM; Robert McNamara, MD FAAEM; William T. Durkin, Jr., MD MBA CPE FAAEM; Amin Antoine Kazzi, MD MAAEM FAAEM. Not pictured: James Keaney, MD MAAEM FAAEM.

2014-2015 AAEM Board of Directors. (Front row, L-R) Robert McNamara, MD FAAEM; Joel Schofer, MD MBA CPE RDMS FAAEM; Mark Reiter, MD MBA FAAEM; Kevin Rodgers, MD FAAEM; William T. Durkin, Jr., MD MBA CPE FAAEM. (Back row, L-R) Andy Walker, MD FAAEM; Kevin Beier, MD FAAEM; Leslie Zun, MD MBA FAAEM; Mark Foppe, DO FAAEM; Andy Mayer, MD FAAEM; David Lawhorn, MD FAAEM; John Christensen, MD FAAEM; Robert Suter, DO MHA FAAEM. Not pictured: Michael Ybarra, MD FAAEM; Stephen Hayden, MD FAAEM; and Meaghan Mercer, DO.

Over 1,700 users logged in to the AAEM15 mobile app for speaker profiles, event schedules, handouts, and more. You can still access the mobile app, available at http://eventmobi.com/AAEM15.

Robert McNamara, MD FAAEM, AAEM past president, fields a question from the crowd during the first AAEM Town Hall Meeting held during the State of the Academy and Candidates Forum.

A record number of attendees joined us in Austin, TX! Attendees enjoyed premier education, engaging networking and social opportunities, and exhibitor interactions.

Amal Mattu, MD FAAEM, speaks at the "Best of the Best in Cardiology"

Evadne Marcolini, MD FAAEM, covers the "Best of the Best in Trauma"

2014 AAEM Written Board Review Course Top Speaker winner, Nilesh Patel, DO FAAEM FACOEP, speaks on the "Best of the Best in Infectious Disease"

AAEM Young Educator Award Winner, Mimi Lu, MD FAAEM, lectures on the "Best of the Best in Pediatrics"

Preconference course attendees engaged with hands-on practice in the Introductory and Advanced Ultrasound courses.

2nd Annual Emergency Medicine Physician Assistant Fellowship Challenge Bowl. Winners from the University of Iowa (center) pictured with PA Challenge Bowl judges (L-R), Gary Gaddis, MD PhD FAAEM; Mimi Lu, MD FAAEM; Kishla Askins, PA-C

Journal of Emergency Medicine Resident and Student Abstract Competition winners (front row L-R) 1st Place: Felix Y. Huang, MD; 2nd Place: Tessa Stamile; 2nd Place: Meghan Swartz, MD. Due to the high quality of the abstracts, the judges awarded two second place winners. Abstract competition judges (back row L-R) Jonathan S. Jones, MD FAAEM; Matthew Graber, MD PhD FAAEM; Gary Gaddis, MD PhD FAAEM; Stephen Hayden, MD FAAEM, Editor, *JEM*

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21st Annual Scientific Assembly Competitions Winners

AAEM/*JEM* Resident & Student Abstract Competition Winners — This competition is designed to recognize outstanding research achievements by residents and students in emergency medicine. Out of a total 55 submissions, eight were selected for oral presentation. Due to the high quality of the abstracts the judges awarded two second place winners. The top oral presentations are as follows:

1st Place: Felix Y. Huang, MD

2nd Place: Tessa Stamile

3rd Place: Meghan Swartz, MD

Photo Competition Winners —
One hundred twenty-five original photographs were presented at the AAEM 21st Annual Scientific Assembly in Austin, TX. Photographs of patients, pathology specimens, gram stains, EKGs, and radiographic studies or other visual data were submitted. The top photos are as follows:

1st Place: Fever and Chest Pain: Not Just Pneumonia, Joseph J. Bove, DO

2nd Place: Not Your Everyday Schizophrenic, Nicholas J. Musisca, MD

2nd Place: A Complicated Case of Shortness of Breath, Allison Zanaboni, MD

Morbidity and Mortality Case Competition —
Graduate physicians presented their best Morbidity and Mortality cases at the 21st Annual AAEM Scientific Assembly. EM residents from an ACGME or AOA accredited emergency medicine training programs presented the case, with faculty presenting a case analysis discussion. Seven cases were submitted and the top four were invited to present at Scientific Assembly. The top four cases are as follows:

Fatal Esophageal Variceal Hemorrhage — Jeffrey D. Chien, MD and Theodore A. Christopher, MD

Undifferentiated Tachycardia in a Frequent Flyer — Sara S. Singhal, MD and Sameer Desai, MD FAAEM

Why did you order that CBC? — Nicholas J. Edwards, MD and Michael E. Takacs, MD MS FAAEM

The Case of the Lost Ovary — Sarah Campeas, MD and Brian W. Walsh, MD MBA FAAEM

Open Mic Winners —
Assembly attendees had an opportunity to present a 25-minute lecture on any topic of their choosing, allowing 16 "new voices" in emergency medicine to be heard and evaluated by education committee members and conference attendees. The top two speakers will be invited to give a formal presentation at the 2016 Scientific Assembly in Las Vegas, NV.

Kevin King, MD FAAEM and Bruce Lo, MD FAAEM

Emergency Medicine PA Fellowship Challenge Bowl Winners —
The 2nd Annual AAEM Emergency Medicine PA Fellowship Challenge Bowl is a friendly competition among Emergency Medicine PA Fellows designed to be entertaining and educational for students, faculty, graduates, and guests.

1st Place: University of Iowa
Nathaniel Shekem, PA-C
Matthew Starks, PA-C ■

2015 AAEM Award Winners

Master of the American Academy of Emergency Medicine (MAAEM) — Larry Weiss, MD JD MAAEM FAAEM
This award recognizes senior AAEM fellows who demonstrated a long career of extraordinary service to AAEM, service as an exemplary clinician and/or teacher of emergency medicine, service to emergency medicine in the area of research and/or published works, service as a leader in the hospital, the community or organized medicine, service in the areas of health policy and advocacy, volunteerism, and other activities or high honors that distinguished the physician as preeminent in the field of emergency medicine.

Peter Rosen Award — Mel E. Herbert, MD FAAEM
This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership. Nominees for this award must have 10 or more years experience in an EM academic leadership position and must be an AAEM member.

James Keaney Leadership Award — Brian R. Potts, MD MBA FAAEM
This award was named after the founder of AAEM and recognizes an individual(s) who has made an outstanding contribution to our organization. The nominees for this award must be AAEM members and have 10 or more years' experience in EM clinical practice.

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

Young Educator Award — Mimi Lu, MD FAAEM
This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. The nominee must be out of residency less than five years and must be an AAEM member.

Joe Lex Educator of the Year Award — David A. Farcy, MD FAAEM FCCM
This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who havebeen out of their residency for more than 5 years. The Educator of the Year Award was renamed the Joe Lex Educator of the Year Award to recognize Dr. Joe Lex for his devotion and commitment to AAEM and its educational programs.

Administrator of the Year Award — Gordon B. Ferguson, FACHE
This award recognizes an administrator deserving special recognition for their dedication to emergency medicine and patient care.

Resident of the Year Award — Andrew W. Phillips, MD
This award recognizes a resident member who is enrolled in an EM residency program, and has made an outstanding contribution to AAEM.

Program Director of the Year — Kevin G. Rodgers, MD FAAEM
This award recognizes an EM program director who has made an outstanding contribution to AAEM. The winner of this award is chosen by the AAEM Resident and Student Association.

International Award — Terrence Mulligan, DO MPH FAAEM FIFEM
This award recognizes a member who has had a meaningful impact on the field of emergency medicine and who has contributed significantly to the promotion of AAEM's goals and objectives.

Departing Board Members — Kevin Beier, MD FAAEM; Mark Foppe, DO FAAEM; Andy Walker, MD FAAEM; Robert McNamara, MD FAAEM; and Michael Ybarra, MD FAAEM

2014 Mitchell Goldman Service Awards —
These awards recognize individuals who made an outstanding contribution by supporting AAEM's educational mission by teaching at oral board review courses. The award was renamed the Mitchell Goldman Service Award to recognize Dr. Goldman for his devotion and commitment to AAEM's Oral Board Review Course and its educational wprograms.

40 sessions: William Gossman, MD FAAEM
25 sessions: Alexandre F. Migala, DO FAAEM
20 sessions: Allen Yee, MD FAAEM; John Kahler, MD FAAEM
15 sessions: Frank L. Christopher, MD FAAEM; Mark W. Donnelly, MD FAAEM
10 sessions: Michael C. Bond, MD FAAEM; Thomas N. Bottoni, MD FAAEM;
Francis X. Chuidian, MD FAAEM; Monica S. Johnson, MD FAAEM;
Michael S. Runyon, MD FAAEM; Andrej Urumov, MD FAAEM;
Robert R. Westermeyer, MD FAAEM;
Kenneth Scott Whitlow, DO FAAEM
5 sessions: Saurin P. Bhatt, MD FAAEM; Tracy Boykin-Wilson, MD MBA MPH FAAEM;
Peter J. Buckley, DO FAAEM; Lara J. DeNonno, MD FAAEM;
Edward Fieg, DO FAAEM; Marilyn Geninatti, MD FACC FAAEM CWS;
Matthew N. Graber, MD PhD FAAEM; Jonathan S. Jones, MD FAAEM;
Daniel E. Lewis, MD FAAEM; Christopher A. Lipinski, MD FAAEM;
Edmundo Mandac, MD FAAEM; Wayne Wolfram, MD FAAEM

Written Board Course Top Speaker Award — Nilesh N. Patel, DO FAAEM
This award recognizes individuals who made an outstanding contribution by supporting AAEM's educational mission by teaching at written board review courses.

Open Mic Competition Awards — H. Andrew Sloas, DO RDMS FAAEM and Siavash Sarlatti, MD
Assembly attendees had an opportunity to present a 25-minute lecture on any topic of their choosing, allowing 16 "new voices" in emergency medicine to be heard and evaluated by education committee members and conference attendees. The top two speakers from 2014 were invited to give presentations at the 2015 Scientific Assembly. ■

Women and the Work of the Academy: A No-Brainer

Megan Healy, MD
Co-Chair, Women in EM Interest Group
YPS Board of Directors

This year's Scientific Assembly showcased several encouraging markers of progress for women within the Academy. Members elected Lisa Moreno-Walton to the Board of Directors and more than 65 members, both women and men, attended the kickoff event for the new Women in EM Interest Group. Additionally, 10 talented women gathered to discuss the issues facing female EPs and plan for the year ahead. All this led me to think about how our challenges as female physicians are tied to the problems of our specialty as a whole. AAEM has been the lone organization to advocate and educate about these threats. Below, I outline three reasons why women should be invested and engaged in the Academy.

1. Contract management groups market themselves to women as a desirable option. As more than 40% of recent EM residency graduates are female, women find themselves recruited more heavily by CMGs, and subsequently offered the less than ideal contracts that come with these positions. With the multiple obligations women often balance in their early career, positions that tout flexible hours and a focus on quality of life may be enticing. One CMG cites "quality of life" as one of three focus areas and advertises flexible work schedules while another's recruitment materials include questions like "Need a location that's a great place to raise a family?" AAEM has provided excellent education on contract issues such as due process and restrictive covenants, and now AAEM has an excellent opportunity and forum in which to specifically address the potentially life changing effects of poor contracts with women who may not be aware of these traps.

2. Women face unique workplace challenges. A Forbes study earlier this year looked at 248 performance reviews of employees from 28 diverse companies. Reviewers included both men and women. While critical feedback was present in 58.9% of the reviews of men, it was present in 87.9% of the reviews of women and reviews of women included higher numbers of personality criticisms. For example, the word "abrasive" was used in 17 women's reviews while it was not used in any reviews of male colleagues. This study hints at some of the unconscious biases harbored by both men *and* women in leadership positions regardless of field. A woman working in an ED run by a CMG, with no due process rights, may vocalize a patient care or safety concern, then find herself subject to these additional biases from the person wearing the suit. AAEM has long stood by physicians who find themselves terminated without cause and unconscious biases only increase potential risk to physicians. Academy membership can help women prepare for and respond to difficult situations, especially as the corporate practice of emergency medicine continues to grow.

3. Women are advocates by nature. Advocacy — for patients and for the integrity of our specialty — is what AAEM is all about. The 2008 Women Matter 2 study from consulting firm McKinsey & Company showed that women in business apply five of nine identified leadership behaviors more frequently than men, specifically: people development, expectation and rewards, role modeling, inspiration, and participative decision making. We can use these skills to develop women leaders and advance the mission of AAEM.

The issues that impact women are the same that threaten all EPs, and our female leaders have valuable skills to bring to the table. This is a win-win for our members and for the Academy. As we continue to increase membership and engagement of a diverse group of physicians, we will harness strengths that benefit us all. Stay tuned for more from the Women in EM interest group. Our current plans include: building online resource networks, identifying barriers to advancement, and providing the focused education and opportunities to help women succeed as we work toward our common goals. Regardless of your gender, if you are interested in contributing to the success of this group and of the Academy, please contact me at: megan.healy@tuhs.temple.edu. ■

Megan Healy, MD
Assistant Professor, Emergency Medicine
Assistant Clinical Director, Episcopal Campus
Temple University School of Medicine

*West*JEM Accepted to the National Library of Medicine MEDLINE Database

Mark Langdorf, MD MHPE FAAEM
Editor-in-Chief, *West*JEM

The *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health* (*West*JEM) is the official journal of the American College of Osteopathic Emergency Physicians, the California Chapter Division of AAEM (CAL/AAEM), and California ACEP, is published by the Department of Emergency Medicine at the University of California, Irvine School of Medicine. It is available online in full text at PubMed Central, *West*JEM.com and *West*JEM.org.

*West*JEM is the only American EM journal that is proudly fully open-access, included in all major medical indices including MEDLINE/Index Medicus, disseminating research and best EM practices to the developed and developing world.

The journal has 48 EM academic department sponsors, six state chapters of AAEM, and four partnerships with national EM societies in Argentina, Chile, Thailand, and Turkey.

The journal has a print circulation of 2,000, electronic distribution of 13,000, and has had more than 3.2 million page hits and downloads of scholarly articles. The journal publishes more than 150 original manuscripts per year in bimonthly issues.

I want to thank all of our supporters, section editors, editorial board, editorial team, and reviewers for their invaluable help in making *West*JEM a first-rate international journal. Special thanks to all at AAEM, Drs. Stephen Hayden, Steven Gabaeff, Mark Foppe, Ms. Kay Whalen and Ms. Janet Wilson for their unwavering support and in-kind assistance. Also my gratitude goes to Drs. Robert Derlet, Robert Rodriguez, Amin Antoine Kazzi, and CAL/AAEM who founded and supported the *California Journal of EM* from 2000 through 2007. ■

AOBEM News & Information

Donald Phillips, DO FACOEP-D FAAEM FACEP
Secretary/Executive Director

Office Move: Effective immediately, all correspondence should be addressed to:

American Osteopathic Board of Emergency Medicine
142 E. Ontario
Chicago, IL 60611
Phone numbers are now:
Phone: (312) 202-8293
Fax: (312) 202-8402

Mail and phones will be forwarded temporarily. Please adjust your address lists.

Oral Examinations: Beginning in 2015, all oral examinations will be administered in Chicago. This decision was made in order to accompany more candidates and diplomats to travel to a more central location in the nation.

The cognitive assessment oral examination (recertification) will be moved to accommodate religious holidays. The exams will now be administered on September 10 and 11, 2015 in Chicago.

CAQs: Effective immediately, all CAQs under AOA authority with the exception of those under Family Medicine jurisdiction are now known as subspecialty certificates. New certificates for current CAQ holders will not be issued until recertification. Diplomates holding these may now refer to themselves as "subspecialty certified in _____"

Hospice and Palliative Medicine: AOBEM has applied to join this conjoint board. We are awaiting BOS approval. When this is complete, requirements will be published.

Critical Care — Surgical: AOBEM diplomates that have completed a surgical critical care fellowship will now be able to sit for this subspecialty examination administered by AOBS.

CME: For the 2013-2015 CME cycle, the caps on the number of specialty CME hours that are allowed from organizations such as state osteopathic associations has been suspended. Diplomates should also be aware that AOBEM still requires 150 hours per cycle. Please refer to http://www.osteopathic.org/inside-aoa/development/continuing-medical-education/Pages/cme-guide.aspx for more information.

Examiners and Item Writers: AOBEM welcomes submissions for qualified diplomates to participate with the board as item writers and oral board examiners. Item writers may be DOs or MDs and must be board certified by AOBEM or ABEM. Item writers are required to complete the online NBOME item writer course and submit the certificate of completion.

Item writers for subspecialty exams are also welcomed. These item writers must hold a subspecialty certificate for which they wish to write items. Currently, we have subspecialty exams in EMS and Toxicology. AOBEM also is a conjoint sponsor for Sports Medicine, Undersea and Hyperbaric Medicine. Our diplomates may also sit for Internal Medicine Critical Care and Surgical Critical Care therefore holders of those certificates may also apply to become item writers and/or subject matter experts. The board anticipates approval to join Hospice and Palliative Medicine soon and holders of these certificates may enlist as item writers as well.

Oral board examiners must be DOs holding current certification by AOBEM or ABEM for at least the previous three years. Oral board examiners are also expected to participate as item writers and Part III (Clinical Examination) examiners. ■

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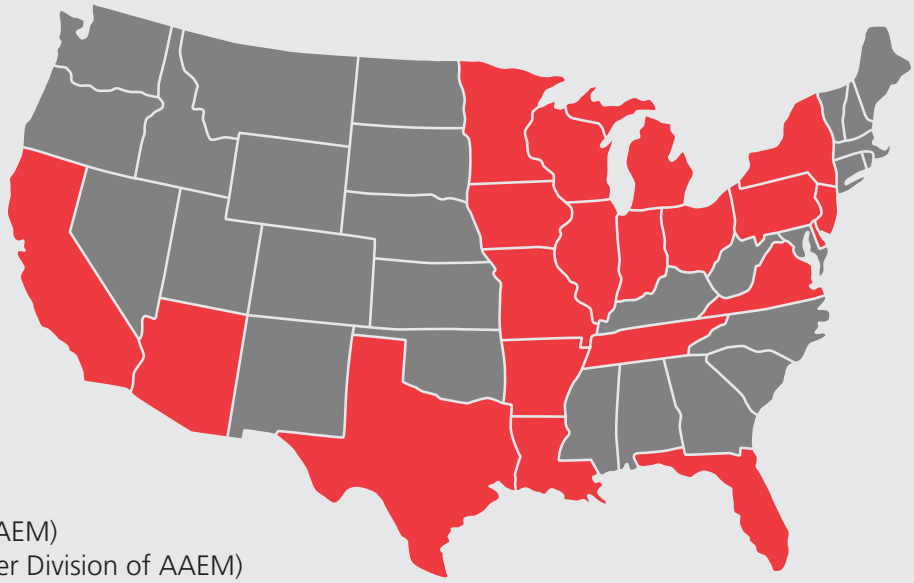

International Chapters

- LAEM (Lebanon Chapter of AAEM)
- MAEM (Mediterranean Chapter Division of AAEM)

*Requires AAEM membership.

The White Coat Investor — Tips for Young Physicians

Jennifer Kanapicki Comer, MD FAAEM
YPS Immediate Past President

"No one teaches you how to think about money in medical school or residency, yet, from the moment you starting practicing, you must think about it."
— Atul Gawande

I was contemplating the subject of my outgoing president's message. I wanted to choose an important topic, one I wish I knew more about as a young physician. Then it came to me: finances. It is often believed that because you're a doctor you are rich, but that isn't the case. First, it costs more to get our job (plagued by student loans with increasing interest rates), the job pays less once you get it (a 2012 paper in *JAMA* showed a decrease in physician earnings of over 28% from 2006-2010), and let's face it — we aren't the best money managers.

So I decided to do something about it. I started reading up on the subject and meeting with a financial adviser. I read financial books targeted to doctors and books on tax strategy. We spend so much of our lives learning to be good doctors. We should also take the time to understand what to do with our hard-earned money. I recently read an amazing book called *The White Coat Investor: A Doctor's Guide to Personal Finance and Investing*, by James M. Dahle, MD. I highly recommend it. Here are some principles I've learned in my quest for financial prowess.

Residents

Learn to save. This is typically the first time in your life you have a regular salary. I remember my intern year, thinking, "Wow, this is the first time I'm earning money rather than paying money in student loans." The typical resident's salary is $45,000-$50,000. This is the same as the median American household income. There is no reason not to be able to live and save on that income. So, learn good saving habits early. Create an emergency fund. This should consist of three to six months of your usual living costs. Invest the money in a safe and easily-accessed way (a savings account or interest-bearing checking account, for example). If eligible, contribute to a Roth IRA. Roth IRAs use after-tax dollars, but this money then grows tax-free and can be withdrawn in retirement tax-free. (A regular IRA uses pre-tax dollars and grows tax-free, but the money is then taxed when withdrawn.)

The golden ticket of residency, and something I wish I knew about earlier, is the Public Service Loan Forgiveness (PSLF) Program. This program allows physicians to have student loans forgiven by working for a public service institution for ten years, **including residency.** Your future job may qualify — I was very surprised to find out mine did! This can save you hundreds of thousands of dollars. Google "Public Service Loan Forgiveness Program" to find out more.

New Attendings

You just graduated from residency and now you're making big bucks. The best piece of advice is to keep living like a resident! Don't grow your spending to match your new income level too quickly. If you live like a resident for a bit longer, the vast majority of your added income can be put toward paying off student loans, saving for the down payment on a home, or saving for retirement. The more slowly you improve your lifestyle, the more wealth you will have later.

Where to Save Now: A Priority list

A question often asked by physicians is "What should I do first?" Here is a "savings hierarchy," a prioritized order of saving that might be optimal for many physicians. Remember: set aside three to six months of living expenses in an emergency fund before you do anything else.

1. **Get the match.** If you have access to a 401(k), 403(b), or 457 plan and your employer offers a matching retirement contribution, take advantage of it. This is free money! And you get the added benefits of tax-deferred growth and compounding returns.
2. Pay down high-interest debt (>9%). If your interest rate is high on credit cards (or car loans, student loans, etc.), use any extra savings to pay down the balance — paying off the debt with the highest interest rate first.
3. **Maximize your tax-deferred retirement plan.** Building tax-deferred savings early makes sense. You may be able to contribute up to $17,500 to your 401(k), 403(b) or other workplace savings account.
4. **Fund an IRA.** As physicians, we often don't qualify for a Roth IRA because of our income level. However, there is no income limit for conversions. That means you can contribute to a traditional IRA with pre-tax dollars and then immediately convert that to a Roth IRA (paying the applicable tax when you do). Remember: Roth IRAs not only grow tax-free, but are tax-free when withdrawn in retirement. Bonus!
5. **Work on key goals.** Are you saving for a down payment on a house? Are you very debt-conscious and feel the need to pay off student debt as soon as possible? Do you want to save for your children's education? (If the latter, consider a 529 college savings plan. It is state-subsidized, with the bonus of tax breaks). Think about what your key goals are and invest your money to focus on them.

This is just the tip of the iceberg. There is so much to learn in the field of personal finance. I suggest you pick up a couple of books and start learning. I am in no way an expert but I continue to learn, because at the end of the day no one cares about my finances as much as I do. ■

2015-2016 Young Physicians Section Elections

President
Sarah Terez Malka, MD

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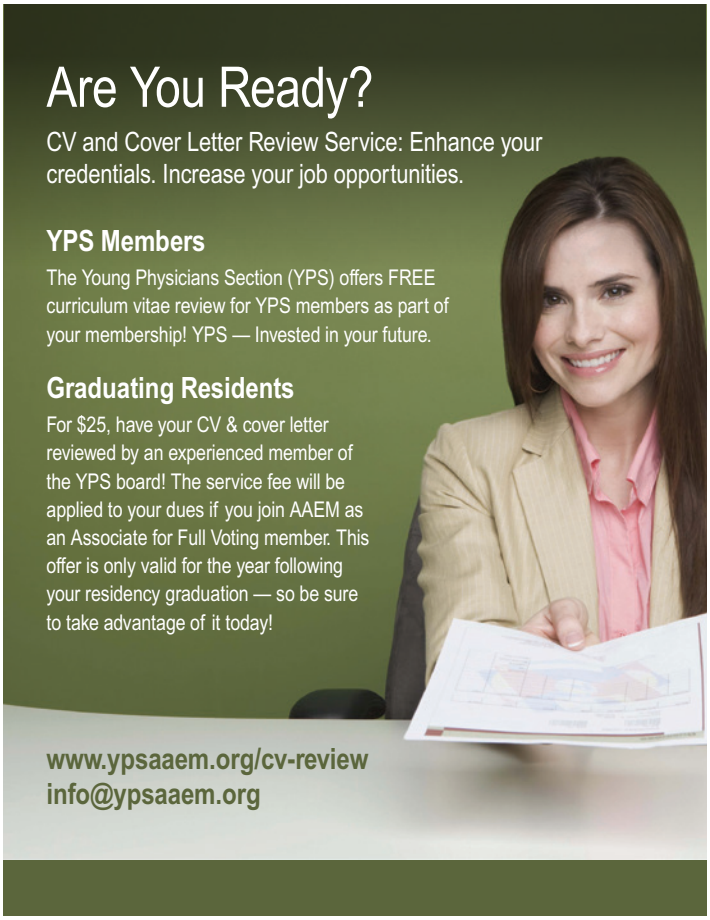

Renewals Begin May 1st!

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AAEM/RSA is with you all the way — renew for the 2015-2016 year for continued academic and career planning benefits, outstanding opportunities for involvement, and premier education.

Are You Moving? Keep in Touch!

If you are a graduating resident or medical student and your email address is changing, we recommend you update your address to one outside of your institution to ensure your benefits will continue without interruption. Log in to your members only account at **aaemrsa.org/myrsa** to list any changes to your name, mailing address, email address or phone number.

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

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AAEM/RSA President's Message

Reflections of a Third-Year Resident

Meaghan Mercer, DO
AAEM/RSA President

Writing this around New Year's Day makes me nostalgic. There is a contagious sense of hope and excitement this time of year. Fourth-year medical students are thrilled that interviews have come to a close, rank lists are in, and Match Day looms around the corner. Interns are feeling comfortable in their shoes, seasoned residents are in the groove, graduating residents are applying for licensure, and nervous excitement accompanies the end of residency. Each New Year's Day I write a letter to myself that includes what I expect from the year and what I hope to achieve. I then seal it, and one year later open it and read it. As I reflect back on the last seven years, I want to leave you my experience and advice.

If you are not stressed, pressured, and stepping outside your comfort zone you are doing something wrong. I have had my fair share of frustrating days, wondering if this training process is healthy. One day when we were rocking and rolling and I was on a mental high over beating my patient per hour numbers, a coding patient was wheeled through the door. As my colleague placed an ultrasound probe on the chest, we realized the patient was coding from cardiac tamponade. As a novice at pericardiocentesis, every ounce of adrenaline I had was released as the needle advanced, hit fluid, and a pulse returned. Such euphoria comes when that hail-Mary procedure actually works! That feeling was quickly punctured by the realization that the department had completely turned over and an attending was dead set on having me run my side of it. As my stress peaked I began to waver, hoping my attending would pick up just one patient, just one, to take the load off my shoulders. He continued to push me and I was angry — I wanted to bask in our success. Looking back on that day I realize all that I have been taught and am capable of doing. I learned more than clinical medicine that day — I was taught how to manage a busy department and how to cope with the highs and lows of a shift — how to be an emergency physician.

Find people who will push you to that breaking point and beyond. In the words of writer Neil Gaiman: *I hope that in this year to come, you make mistakes. Because if you are making mistakes, then you are making new things, trying new things, learning, living, pushing yourself, changing yourself, changing your world. You're doing things you've never done before, and more importantly, you're doing something.*

Find what motivates you. Starting residency, my program director was that person for me, my mentor, and I thrived on positive reinforcement. As residency proceeded, a new program director took over and the spotlight I enjoyed so much was gone. Losing that stimulus turned out to be one of the best things I went through in residency. Initially I knew just how to get a pat on the back, and that is addictive for a student. Once that was gone, I evaluated what actually made me happy instead of setting goals based on someone else. Knowing what you want in your practice and life will lead to a long and happy career.

> "I learned more than clinical medicine that day, I was taught … how to be an emergency physician."

Let go of ego. We have been in school for so long that we are always looking for that "A" grade, the good evaluation, and to be the best. Emergency medicine is a team sport and we are the goalkeepers. Do what is best for the patient and do what is best for you. Put aside your pride and seek out those individuals who will challenge you. Entering the teaching role as a third-year, I appreciate how difficult it is to find a student's weakness and improve it. Thank those educators who give you the feedback you need to improve yourself, even if it stings a little bit.

Overall, be happy! This is a wild ride and some of your best friends will be made in the process. Be good to yourself, your friends, and family. May your coming year be filled with success, growth, and good madness. You will be surprised at all you are capable of. Good luck to you medical students — Match is just around the corner and we can't wait to welcome you to the ranks of emergency physicians. Congratulations to all graduating residents! We hope to see you on the rolls of AAEM's Young Physicians Section. We wish you all the luck and happiness in the world, as this chapter of your life comes to a close and a new one begins. ■

AAEM/RSA Blog: Peer-Reviewed and Educational for All

Andrew W Phillips, MD MEd
AAEM/RSA Publications Committee Chair
AAEM/RSA Blog Editor-in-Chief

The American Academy of Emergency Medicine Resident and Student Association (AAEM/RSA) Blog (http://aaemrsa.blogspot.com) is now a formally peer-reviewed, weekly blog with the explicit aim of grooming residents and students to be strong contributors to the emergency medicine (EM) scientific community.

FOAMed (Free Open Access Medical Education) has exploded, with approximately 140 EM and critical care blogs in 2012 — up from approximately 50 in 2010 — and is generally accepted as a formal medical education tool in its various forms (blogs, Twitter feeds, podcasts, etc.).[1,2-4] The AAEM/RSA blog first posted in 2013, featuring intermittent reprints, opinion pieces, and advice to students and residents.[5] The blog now holds a new and unique niche among the numerous international blogs by focusing on grooming writers, reviewers, and editors in the EM scientific community.

We launched the first installment of weekly articles in Oct 2014, with a new designation for articles that have been peer reviewed. Submissions are reviewed by residents and students using a custom rubric designed by the RSA Publications Committee, based on recommendations by the World Association of Medical Editors.[6,7] A hallmark of the RSA Blog is that it utilizes both the traditional peer review process and a more modern, in-time peer review process in which readers can post comments.[8] New articles are posted every Sunday afternoon.

The blog is run entirely by residents and medical students, from submissions and peer review to publication decisions. Guidance is provided by more senior residents to junior residents and students. Plans for mentorship by attending physicians are underway, and interested attendings from both academic and community settings are strongly encouraged to help us build our program by emailing info@aaemrsa.org. Although student and resident peer review may first appear to be a limitation, it is important to recognize that the blog is not a venue for original research, and residents and students are truly the peers of the RSA. A longer explanation is posted on the blog.[9]

Topics vary according to authors' interests and the time of year, such as holidays and residency interview season. The editorial team was on hand at Scientific Assembly where we presented a poster describing the results of the blog so far and discussed with attendees ways they could become involved. AAEM continues its proud tradition of publication excellence in the AAEM/RSA Blog.

Resources

AAEM/RSA Blog: http://aaemrsa.blogspot.com
Submissions: info@aaemrsa.org

AAEM/RSA Blog 2014-2015 Editorial Team:
Andrew W Phillips, MD MEd, Editor-in-Chief
Gregory K Wanner, DO PA-C, Deputy Editor
Jon Morgan, BS, Copy Editor

The AAEM/RSA blog editorial team extends its gratitude to the RSA members who have written and/or reviewed for the blog and to AAEM for providing the staff resources necessary to route manuscripts and edits in addition to maintaining the blog site on a daily basis. We are especially grateful for the extensive efforts by Ms. Laura Burns and Ms. Madeleine Montony.

Continued on next page

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Literature Update in Pneumonia

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Patients with community-acquired pneumonia (CAP) are frequently seen in the emergency department (ED). According to the National Hospital Ambulatory Medical Care Survey (NHAMCS), pneumonia is the third most common principal ED discharge diagnosis in the United States.[1] In this literature update, we examine: use of point-of-care ultrasound to diagnose pneumonia, obtaining routine blood cultures, risk factors for multi-drug resistant organisms and the efficacy of antibiotic monotherapy versus combination therapy in moderately severe pneumonia.

Prospective evaluation of point of care ultrasonography for the diagnosis of pneumonia in children and young adults. Shah VP, et al. *JAMA Pediatr*. 2013 Feb;167(2):119-25.

Lung ultrasound for the diagnosis of pneumonia in adults: A systematic review and meta-analysis. Chavez MA, et al. *Respir Res*. 2014 Apr 23;15:50.

A prospective observational study by Shah et al., examined the use of ED lung ultrasound (LUS) for the diagnosis of pneumonia in 200 patients. Patient age ranged from birth to 21 years. LUS, performed by ED physicians with various amounts of experience and training, demonstrated an overall sensitivity of 86% and specificity of 89% for diagnosis of pneumonia. Mean time to exam completion was seven minutes. Of the 13 patients with positive LUS and negative chest radiograph (CXR), the majority had lung consolidations less than 1cm in diameter and had a clinical picture consistent with pneumonia. Of the five false negatives (i.e., negative LUS but positive CXR), two were due to operator error and three were true misses (no sign of pneumonia on ultrasound review). There was no statistically significant difference in diagnostic accuracy between physicians who had performed more than 25 scans to those who performed less than 25 scans.

With regards to adult patients, a meta-analysis by Chavez et al., examined the use LUS to diagnose ED, ICU, and floor patients age >18 with pneumonia. Ten articles met the inclusion criteria and were used for analysis. Overall, LUS was 94% sensitive and 96% specific for the diagnosis of pneumonia in adults. When comparing LUS to clinical criteria and chest imaging, either CXR or computed tomography (CT), the pooled sensitivity and specificity were 95% and 94%, respectively. When compared specifically to CT, LUS was 94% sensitive and 99% specific in diagnosing pneumonia.

Point-of-care LUS is a powerful diagnostic tool that complements the history and physical exam. LUS performs well as both a rule-in and rule-out test for pneumonia in the adult and pediatric population, even with less-experienced ultrasound operators. The added benefits of decreased cost, radiation exposure and speed of diagnosis make it an attractive choice for ED patients.

Can we predict which patients with community-acquired pneumonia are likely to have positive blood cultures? Campbell SG, et al. *World J Emerg Med*. 2011;2(4):272-8.

Blood culture use in the emergency department in patients hospitalized for community-acquired pneumonia. Makam AN, et al. *JAMA Intern Med*. 2014 May;174(5):803-6.

A 2011 retrospective chart review by Campbell et al., attempted to identify ED patients with pneumonia who were more likely to have positive blood cultures (BCs). Variables associated with increased likelihood of a positive BC were:

1. Leukopenia (white blood cell < 4.5 x10^9/L), LR=7.75
2. Serum creatinine >1.2 mg/dL, LR=3.15
3. Serum glucose <110 mg/dL, LR=2.46
4. Fever (temperature >38°C), LR=2.25

Patients with all four findings had a LR of 135.53 for a positive BC.

Identifying the causative pathogen in pneumonia is most important in patients who: are elderly, are immunocompromised, have severe disease, or are likely to be infected with atypical or resistant pathogens. As patients with the above findings have a greater incidence of a positive BC, it is reasonable to obtain BCs in this subset of patients with pneumonia.

Additionally, a recent retrospective review by Makam et al., further explored the patterns of obtaining BCs in adult ED patients with CAP. Investigators found that the rate of obtaining BCs for CAP admissions increased from 29.4% (95% CI, 21.9-38.3%) in 2002 to 51.1% (95% CI, 41.8-60.3%) in 2010. This represents a 70% relative increase (p=0.03). For comparison, over the same period, the rate of obtaining BCs for urinary tract infection admissions remained stable (p=.47). Further analysis suggested that collection of BCs was not related to disease severity, as a higher CURB-65 score or intensive care unit (ICU) admission was actually associated with lower odds of obtaining BCs. Of note, BCs were obtained significantly more often in privately-owned hospitals and in cases where antibiotic therapy was initiated in the ED. This final finding suggests that changes in EP practices could significantly decrease unnecessary testing and costs.

A new strategy for healthcare-associated pneumonia: A 2-year prospective multicenter cohort study using risk factors for multidrug-resistant pathogens to select initial empiric therapy. Maruyama T, et al. *Clin Infect Dis*. 2013 Nov;57(10):1373-83.

The 2005 American Thoracic Society/Infectious Diseases Society of America (ATS/IDSA) guidelines state that all patients with healthcare-associated pneumonia (HCAP) be treated empirically with multiple antibiotics directed against multi-drug resistant (MDR) pathogens.[2] Patients considered to have HCAP include those who: reside in a nursing home or other long-term care facility, attend a hemodialysis clinic, or have received IV antibiotics, chemotherapy or wound care within the last 30 days. Some

Continued on next page

argue that not all HCAP patients are at equal risk of acquiring an MDR pathogen; therefore, they may not all require broad-spectrum empiric antibiotics.

This prospective multicenter cohort study utilized a previously-described algorithm to guide therapy for 445 patients with pneumonia requiring admission for either CAP or HCAP.[3] The algorithm stratified HCAP patients as low or high-risk based on the severity of illness and the presence of other risk factors for MDR pathogens, then assigned them to either standard CAP therapy or guideline-recommended hospital-acquired pneumonia (HAP) therapy consisting of two or three antibiotics: an antipseudomonal beta-lactam, a quinolone or aminoglycoside, and optional linezolid or vancomycin.

Among HCAP patients, both the 30-day mortality and presence of MDR pathogens was significantly lower in patients with 0-1 MDR risk factors as compared to those with ≥2 risk factors (mortality: 8.6% vs 18.2%, p=.012, MDR pathogen identified: 2% vs. 27.2%, p<.001). In total, 299 HCAP patients were treated according to the therapy algorithm, with 50.5% receiving CAP therapy. Of these, only 3.2% received inappropriate therapy which interestingly was not independently associated with increased mortality. This study shows that not all HCAP patients require antibiotics for MDR organisms and that some can be treated with typical CAP antibiotics.

β-lactam monotherapy vs β-lactam-macrolide combination treatment in moderately severe community acquired pneumonia: A randomized noninferiority trial. Garin N, et al. *JAMA Intern Med.* 2014 Dec 1;174(12):1894-901.

Optimal antibiotic coverage for CAP covers both *Streptococcus pneumoniae* and atypical pathogens (e.g., Legionella, Mycoplasma, and Chlamydia), usually with the combination of a beta-lactam and a macrolide. Current studies have not provided significant data to show that combination therapy is essential. Furthermore, while macrolides may add anti-inflammatory effects, they can also lead to increased cardiovascular risk as well as antibiotic resistance. Thus, the authors of this study compared the efficacy of standard combination therapy using beta-lactam antibiotics plus a macrolide to that of beta-lactam antibiotics alone.

This multicenter, non-inferiority trial included 580 adult patients with moderately severe CAP. All patients received cefuroxime or amoxicillin/clavulanic acid. Patients randomized to the combination therapy arm also received clarithromycin. The primary outcome was time to clinical stability as defined by vital signs at day seven and secondary outcomes included 30 and 90-day mortality.

For the primary outcome, 41.2% of monotherapy patients and 33.6% of combination therapy patients were not clinically stable at day seven (p=0.07), which did not fall within the predefined CI boundary to demonstrate non-inferiority. There was also no overall difference in survival or time to clinical stability, but there was a trend towards better outcomes in the combination therapy arm for patients with higher Pneumonia Severity Index (PSI) or CURB65 scores.[4,5] There was a statistically significant increase in readmissions and a trend towards more severe events in the monotherapy arm. Ultimately, these findings support the current practice of combination therapy.

Conclusions

For patients presenting to the ED with suspicion of pneumonia, consider use of point of care ultrasound. Consider the necessity of blood cultures for CAP and the requirement for MDR organism coverage. Finally for patients with CAP admitted to the hospital, combination therapy may be the most appropriate antibiotic option to ensure rapid improvement and a good outcome.

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Medical Student Council President's Message

Marathon Medicine: Interview with George Chiampas, DO

Mike Wilk, MS3

Battling through a crowd of runners moving in the opposite direction, I ran as fast as I could from the medical tent to a young man sweating profusely, who had fallen down in the street. "Hey, are you OK? Why don't you come sit in our tent for a minute?" I asked him. "Just help me up, I'm almost to the finish line," he yelled as I gave him a hand up. At mile 23 of the Chicago Marathon, this type of interaction with runners seemingly repeated itself over and over again as nearly 45,000 runners stayed fiercely determined to finish at any cost. For a few unlucky runners, that cost was a trip to the hospital.

As one of over 2,000 medical volunteers at the 2014 Bank of America Chicago Marathon, we provided care for problems as minor as muscle cramps and as serious as severe dehydration, hypoglycemia, hyperthermia, and cardiac arrest. The medical teams consisted of doctors, nurses, physical therapists, occupational therapists, massage therapists, EMTs, medical students, and other health care volunteers. This year 21 medical teams were distributed throughout the course, in addition to the main medical tent with more advanced equipment near the finish line. It was truly astonishing to see the coordination and work required to successfully manage the medical side of a mass event such as the Chicago Marathon.

I had the opportunity to speak with the medical director of the 2014 Bank of America Chicago Marathon, Dr. George Chiampas. After completing his emergency medicine residency Dr. Chiampas took a distinctive path within the field, going on to complete a sports medicine fellowship in 2006. With his fellowship training, and extensive experience working with sports teams such as the U.S. soccer team and at various endurance events, he took over as medical director of the Chicago Marathon in 2007. He is Assistant Professor of Emergency Medicine and Sports Medicine at Northwestern Memorial Hospital in Chicago, IL.

Mike: How did you get interested in specializing in both emergency medicine (EM) and sports medicine?

Dr. Chiampas: During my years as an intern and resident at Cook County (1999-2003), I kind of always had an interest in sports medicine, but at that time it was not a very common path to do both together. I started volunteering as a team physician for my high school, Loyola Academy in Wilmette, IL, so on my free time I would come up and cover the football games and really enjoyed that aspect of it. Then, I started volunteering with the Chicago Marathon throughout my residency.

After I was an EM attending physician for two years, I had an opportunity for a sports medicine fellowship in Chicago and I was actually the first ER fellow in the program there. After I finished that fellowship, the person who was the medical director for the Bank of America Chicago Marathon was ready to step down and given my background, he felt I had the best experience for the job and that's how it came about in 2007.

Mike: What are you responsible for as medical director of the Chicago Marathon?

Dr. Chiampas: I'm responsible for recruiting and providing education to all the medical volunteers in regards to endurance events issues. I ensure there are enough supplies and other resources distributed throughout the course. Other components involved in the event include overseeing and coordinating private ambulances, bike teams, foot teams, golf cart teams, liaisons, the incident commander for the event, Chicago Fire Department, Chicago Police Department, public health officials, and many other agencies. The Bank of America Chicago Marathon has probably become operationally one of the leaders in the world in regards to emergency management and public safety with some of the protocols we put in place.

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Medical volunteers in the main medical tent before the race.

Medical student volunteers at the Bank of America Chicago Marathon. From left to right: Molly Kalmoe, MS3, Sarah Carlson, MS3, and Mike Wilk, MS3.

Mike: What advancements have you developed or utilized as the medical director?

Dr. Chiampas: We were the first marathon that introduced hands-only CPR and AED education through online videos across all the runners and volunteers, for almost five years now. This education is important since the number one factor with sudden cardiac arrest is response time. We implemented it in Chicago and it has since become best practice in marathon medicine.

Another aspect that we implemented was the event alert system, which is a flag classification that allows us to communicate with runners before and during the race. Any sort of incident, such as a fire in the city, can be relayed to the runners. Additionally, we utilized a unified command system that was developed after the 9/11 attacks. Its use in a marathon was first established in Chicago in 2008.

Mike: How has technology played a role in managing the race?

Dr. Chiampas: One was utilizing data visualization, which allows us to identify key components of the event and communicate that within the command system. We've devised our own patient tracking system, which allows us to know if a runner has been checked into a medical tent on the course. In real time, we know where runners are being cared for and what kind of patients we are seeing. On a cold day, if we see the majority of injuries in this area, then if the next year we have the same temperatures then we can put our resources and manpower in those areas.

Also, we need to prevent a surge of patients in hospitals since even on a good day we will see 2-3% of runners needing medical care. If any medical system across the world had to manage two hundred 911 calls in a few hours it would overload their system. Thus, one of our goals is to minimally impact the hospital system and make sure participants as well are safe.

Having a communication system, unified command, and mass event and patient tracking system all have become standard protocols for the marathon.

Mike: What are the most important aspects in regards to disaster preparedness?

Dr. Chiampas: We have preplanned shelters around the city that have been identified. We plan for the worst and hope for the best. Weather is often a major factor as lightening or high wind can change conditions quickly. Being able to divert runners on the course and have supplies if those situations were to occur are some of the processes we work on all year long for marathon day. Having a system that can adjust to any of these incidents and allows you to communicate to runners and provide shelter and safety is the key.

Mike: Are there any major memorable events over the years that have really stuck with you or changed the way you provide medical care?

Dr. Chiampas: 2007 was the year that we had the heat and humidity, which forced us to stop the race 2.5-3 hours into the marathon. It was something that was difficult at the time and we received a lot of criticism for it, but the industry and public now understand it was the right decision. Public safety and the safety of the runners is number one, and we've been able to look at that day and move forward and build off of that.

Mike: Were any changes made after the 2013 Boston Marathon Bombing?

Dr. Chiampas: The federal government became more engaged, but they recognized the structure in place in Chicago before the Boston Marathon bombing and it was a matter of looping the federal agents and their support into the structure in place. We didn't need to reinvent the wheel. Obviously, you have to look at your event after any marathon, not just Boston, as any event is always different. We are constantly striving to find ways to improve the marathon.

Mike: Do you work with any other marathons?

Dr. Chiampas: We collaborate with all the world marathon major events — Tokyo, Boston, London, Berlin, Chicago, and New York City — to provide the best practices during these endurance events. I would like to make people aware of the International Institute for Race Medicine (IIRM), which allows the marathon medical directors around to world to set best practices with regards to endurance events.

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

Dr. Chiampas: The Bank of America Chicago Marathon really is a venue that brings in the best talent across the city. It is one of the best things the city does and I'm grateful to be a part of it. ■

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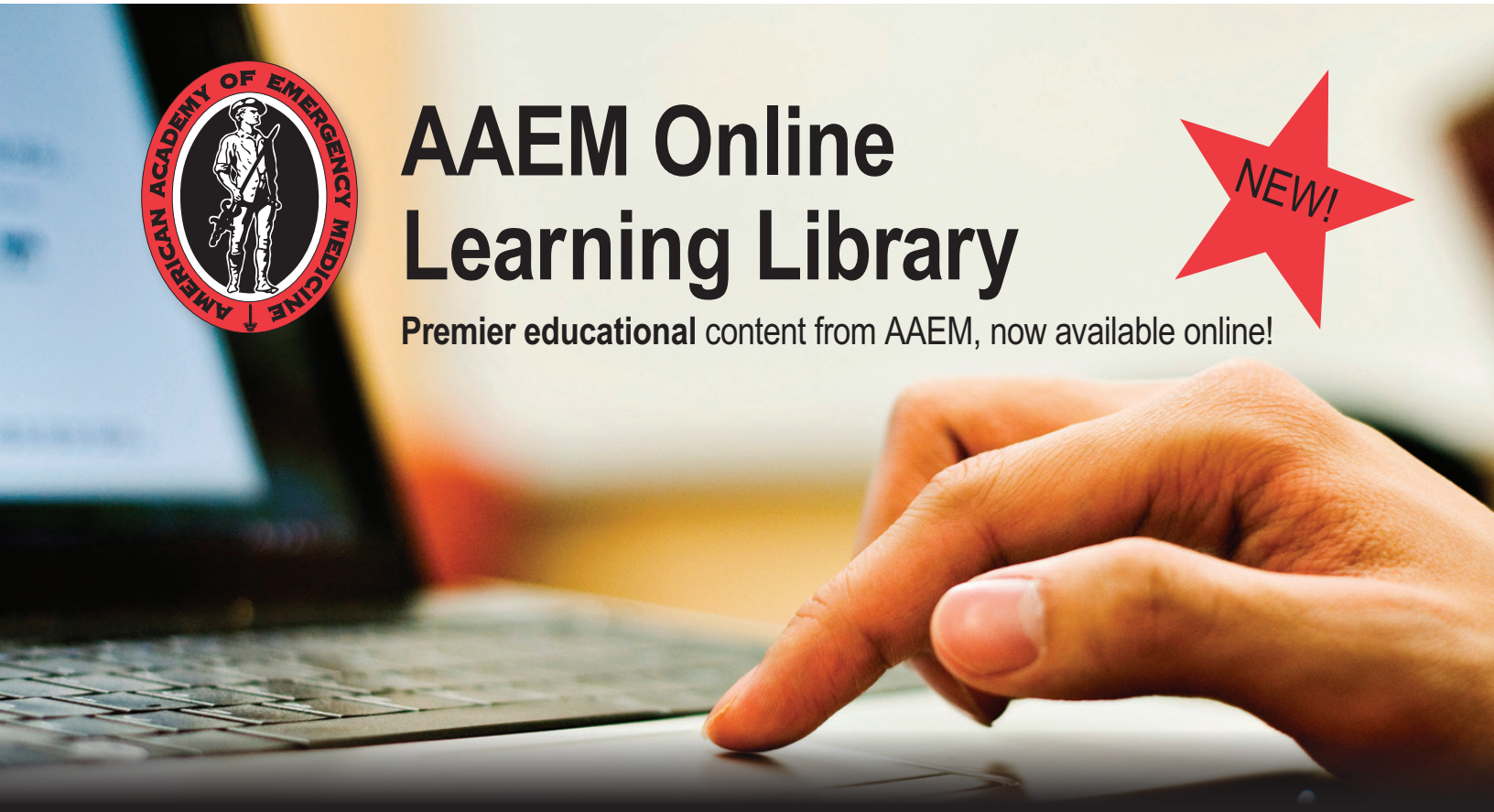

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