

# COMMON SENSE

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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 quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

### Membership Information

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

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 (Please visit [www.aaem.org](http://www.aaem.org) for special eligibility criteria)

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.

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## President's Message

# AAEM's Prime Focus: Due Process and Your Rights

Kevin Rodgers, MD FAEM  
AAEM President

Since its inception, AAEM has championed the rights of the individual board-certified/eligible emergency physician. AAEM has steadfastly carried that torch and shaped the national agenda that has defined and enforced those rights. It is what AAEM is known for, it is what separates AAEM from SAEM, CORD, and ACEP. Due process, the first and foremost of those rights, has been and continues to be AAEM's prime focus as we fight for the inclusion of unwaivable due process rights for physicians in Medicare's Conditions of Participation.

Unfortunately, due process rights are not yet guaranteed. Hence we have the recent Summa Health catastrophe, with the summary termination of over 60 emergency physicians (Summa Emergency Associates-SEA) which clearly violates physician practice rights as delineated in the AAEM, AMA, and ACEP policies on due process. Of course the impact is even more far reaching than that, with long term implications that define a true catastrophe. There were no winners here, except maybe the eventual contract holder. The community, patients, medical staff, EMS, residents, the residency program, medical academia, the institution, and the specialty of emergency medicine — everyone lost a little something: integrity, respect, professionalism.

We should all be saddened by what occurred. Almost overnight the Summa Emergency Medicine residents lost their beloved program leadership. Shar Jwayyed, the now-former program director, was just named a winner of the 2017 ACGME Parker Palmer Courage to Teach Award. Gone is Summa's seasoned and vetted core academic faculty, and their established mentoring and teaching relationships have been completely disrupted. The timing was also excellent — right in the midst of resident recruitment season. It has been reported that residents even received threatening emails concerning their return to work. I doubt the ACGME would have approved having residents work in an environment devoid of program leadership and vetted core faculty. Common sense says you cannot recruit a quality program director or core faculty in five days, but there was no plan to allow for a smooth transition of the residency.

Since this take-over seemed like a fait accompli, USACS had the ethical and professional duty to work out a plan with SEA for transitioning the residency smoothly — either that or refuse to take the contract. Apparently though, when there's money to be made residents just become collateral damage. It is clear that every EM organization supports a change that will protect residents/residencies and their faculty from similar occurrences in the future. I doubt the ACGME/RRC can do anything to rectify the Summa situation, but moving forward they must

craft requirements that guarantee due process and protect residents, residencies, and faculty from such a sudden and unplanned transition. Apparently the outcry from every EM organization did have some affect, since the CEO of Summa Health recently submitted his resignation. Too little, too late.

**“Medicine is threatened with becoming just another business rather than a profession, with doctors as run-of-the-mill employees, widgets that can be easily interchanged and just as easily fired. This is where the corporatization of EM is taking us — unless we stop it.”**

Unfortunately the Summa residents were not the only group affected. As AAEM works to preserve transparent, equitable, physician-owned practices in EM, the termination of SEA — which provided Summa Health with top notch EM care for over 40 years — is quite distressing. The new group, USACS, touts physician ownership but also has a major private equity partner that creates lay influence over its operations, something AAEM opposes. Although the state of Ohio recently nullified its prohibitions on the corporate practice of medicine, AAEM remains concerned when lay corporations

have an ownership stake in an EM practice. While we could also get into the ethical aspects of this contract negotiation — that is a slippery slope of “he said-she said” and not for outsiders to debate without all the facts, which may never be known.

I also would venture to say that many academic physicians, typically employed by medical schools or their faculty practice plans, never thought that the “business” of emergency medicine would ever impact them. Many never joined AAEM because they felt that concerns such as due process, restrictive covenants, joint ventures, and fee-splitting would never really affect them. Unfortunately, the Summa situation has given us a very disturbing glimpse of the potential negative impact that the business of EM can have on a community, a residency, and an academic institution. And get ready for more, because as previous CORD President Eric Katz pointed out, “Dollars speak louder than passion.”

Medicine is threatened with becoming just another business rather than a profession, with doctors as run-of-the-mill employees, widgets that can be easily interchanged and just as easily fired. This is where the corporatization of EM is taking us — unless we stop it. For all emergency physicians, the Summa situation is a wake-up call to take a more active interest in how emergency physicians are treated. AAEM has championed that concern since 1993. ■

### AAEM Antitrust Compliance Plan:

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

# The Academy and the College

Andy Walker, MD FAAEM  
Editor, *Common Sense*



*Dr. Steven Kailes' letter to the editor is so well done and on such an important topic, I decided to dedicate my regular column to responding to it. If you haven't read it, please go to the 'Letters to the Editor' section and read it now.*

Thank you for writing. I am grateful that you read *Common Sense* and appreciate the time and effort you took to write. I welcome criticism

as much as praise, especially when it is as thoughtful and articulate as yours. Besides, I have been hoping for a few angry letters to the editor since I took over *Common Sense* five years ago. Until your letter, I was preparing to go from provocative to incendiary — so I thank you and AAEM's lawyer thanks you!

As for the substance of your letter, first I want to assure you that the Academy (AAEM) and the College (ACEP) do agree on many issues and cooperate on many initiatives. Just a few recent examples of this include joint efforts to persuade Congress to pass a bill allowing paramedics with standing orders to give controlled substances and carry those drugs on their rigs; an appeal to the Centers for Medicare/Medicaid Services (CMS) to enforce existing rules and make sure emergency physicians are paid for real-time EKG interpretations; and an attempt to get the Veterans Administration to drop its unnecessary and offensive policy of requiring board-certified emergency physicians to pass a test on procedural sedation and rapid sequence intubation each year, and even go to the OR and prove to an anesthesiologist they can intubate competently. The Academy and the College also agree on fundamental issues like tort reform and the insurance industry's attempt to cap out-of-network fees and restrict or ban balance billing. And at least recently, it seems both organizations have the same regard for board-certification (ABEM or AOBEM) in emergency medicine.

However, I hope my criticism of the College is just as thoughtful and articulate as your criticism of me — and not just "ACEP bashing" — and I think that criticism is both well-deserved and important. First, it is important for emergency physicians to understand the differences between the Academy and the College, because some battles that are important to our specialty would be lost — or more likely, never even fought — if emergency physicians had to depend on the College. The defense of board certification, which most of us take for granted, is one example. While the College now seems to be fully on board in regard to legitimate board certification in emergency medicine, this wasn't always the case. If you don't know that history, you should read my article "Legitimate" in the summer 2010 issue of *Common Sense*, available at AAEM's website (<http://www.aaem.org/UserFiles/file/commonsense0510.pdf>).



**"Perhaps the most currently glaring difference between the Academy and the College is AAEM's lonely crusade to protect emergency physicians from unfair treatment in the workplace, both from predatory financial practices and assaults on their professional autonomy."**

In that article I quote the newsletter of ACEP's Section on Certification and EM Workforce, which credits the College with obtaining recognition from the state of Florida for an alternative board, the Board of Certification in Emergency Medicine (BCEM). (Even now, BCEM will grant board certification in emergency medicine to physicians who have never completed a residency in emergency medicine.):

*2000 — ACEP Board approves "Recognition of Certifying Bodies in Emergency Medicine" policy, which includes the asterisk statement: "ACEP acknowledges that there exists a non-ABMS and non- AOA certifying body, the Board of Certification in Emergency Medicine (BCEM), that may allow emergency physicians who do not meet existing training standards of ABEM or AOBEM to present themselves for evaluation and testing in the clinical content of emergency medicine and achieve certification based on specified criteria. This ACEP policy is not intended to pass judgment on the work of BCEM."*

*2001 — ACEP representative quietly presents ACEP's official "Recognition of Certifying Bodies" policy to the Florida Board of Medicine; the Florida BOM subsequently votes to officially recognize the BCEM.*

I also describe the hearing at which the Florida Board of Medicine voted to recognize BCEM and its parent, the American Association of Physician Specialists:

*ACEP's Florida chapter did have a representative at the meeting, and when asked for his opinion on the AAPS and BCEM, Dr. Michael Lusko simply reiterated the ACEP policy quoted in the time line above. This neutral-sounding policy has been described by Dr. Timothy Geno, ACEP member and BCEM diplomate, as "...benign neglect, not supporting BCEM, but not condemning them either."<sup>5</sup> Furthermore, two members of the Florida Board of Medicine were members of AAPS. One, Dr. Peter Lamelas, was a diplomate of BCEM as well as a member of ACEP.*

Continued on next page



If a member of AAEM had done such things, he or she would be subject to ethics charges and censure, possibly including expulsion from the Academy. Yet, as far as I know, none of the ACEP/FCEP members involved in getting state recognition for BCEM were ever disciplined in any way by the College or its Florida chapter. And, as late as 2009, the College allowed members who were not certified by either ABEM or AOBEM to apply for fellowship. That is why, when you see "FACEP" following an emergency physician's printed name, **you cannot assume he or she has ever been board certified** — at least not by ABEM or AOBEM. I know that ACEP and FCEP have evolved since that embarrassing BCEM incident, and I'm glad to hear that your experience in FCEP has been positive. However, all emergency physicians should recognize that the Academy's presence has pressured the College to move in the right direction. At the very least, ACEP's evolution would have been much slower if the Academy weren't there, criticizing ACEP when it failed our specialty.

Perhaps the most currently glaring difference between the Academy and the College is AAEM's lonely crusade to protect emergency physicians from unfair treatment in the workplace, both from predatory financial practices and assaults on their professional autonomy. As the well-publicized case of Dr. Wanda Espinoza Cruz in your own state shows (<http://www.tampabay.com/news/health/doctor-says-she-was-fired-for-reporting-low-staffing-at-brandon-regional/2218497>), this is about protecting patients as much as emergency physicians. Like dozens and dozens of ACEP members before her, Dr. Cruz went to the College for help, and like those other members of ACEP she found she had to turn to the Academy. (For other examples of how the Academy has come to the rescue of emergency physicians, see page 16 of the Jan/Feb 2014 issue of *Common Sense*: [www.aaem.org/publications/common-sense/2014](http://www.aaem.org/publications/common-sense/2014)).

In addition to securing the same due process and peer review for emergency physicians that is guaranteed to other specialists on the medical staff, and thus allowing us to practice good medicine and protect our extremely vulnerable patient population, fair treatment in the workplace includes a financial element. Staffing corporations like EmCare, TeamHealth, and many others — also known as contract management groups (CMGs) — derive their profit from the professional fees of emergency physicians. First, they charge their emergency physicians for services actually rendered, such as coding & billing services and malpractice insurance — both often bought from a subsidiary of the CMG. Then, they take (on average) **another 20-25%** of their emergency physicians' collected professional fees. In contrast, a locally owned, democratic EM group typically pays no more than 10% of its expended compensation for administration. Including opportunity costs, this difference can add up to two or three million dollars over a 30-year career. To add insult to injury, some hospital chains and CMGs — like HCA and EmCare — have now formed joint ventures in which the CMG kicks back

some of the emergency physicians' collected professional fees to the hospital in return for the contract to staff its ED. Now, not only does the CMG have its hand in our pockets, so does the hospital!

And all this is done behind a veil of secrecy. While federal regulations say physicians have to be told how much money is billed and collected for their services by a third party, try asking your CMG's local medical director to show you the books. You'll probably find yourself fired "without cause." And what if you bring up a quality issue, complain about dangerous under-staffing, or resist orders to do unnecessary tests or admit patients who don't need to be in the hospital? Well, ask Dr. Cruz how that turns out or watch the *60 Minutes* story called "The Cost of Admission" (<http://www.aaem.org/calendar/current-news/the-cost-of-admission---60-minutes-segment-available-online>).

Because their profits go to enrich shareholders and company management, CMGs add a layer of cost to an already expensive health care system — without delivering anything to doctors or patients valuable enough to offset or justify that cost. They generally strip emergency physicians of 1) the ability to control their own departments and make decisions that affect patient safety, such as staffing levels; 2) the ability to see what is billed and collected in their names, and thus of the ability to prevent or detect billing fraud; and 3) due process and peer review, allowing them to be fired and stripped of their staff privileges — not for practicing bad medicine, but for practicing good medicine and defending their patients. So yes, I do believe that the interests of CMGs — and their profit margins — directly conflict with the interests of practicing emergency physicians, and that **anyone in a management position in both a CMG and an emergency medicine professional society must betray one or the other.**

That is why I was shocked and disappointed when ACEP again elected someone from CMG upper management to its presidency. I know that has been a common occurrence in ACEP's history, but I thought the College had moved beyond that. And although I am no longer a member of the College — having resigned when I became convinced ACEP had sold out our specialty and become a front for corporate interests — since ACEP is larger than AAEM and has a much bigger budget, **all** emergency physicians are better off when the College does the right thing.

So thanks again for writing, and rest assured that the Academy and the College do work together whenever possible and will continue to do so. Realize too that competition from AAEM, and sometimes criticism, makes ACEP a better organization. And finally, with regret, I must also assure you that I believe CMGs are predators and emergency physicians their prey (or perhaps more accurately, parasites and hosts), and that no one can honestly and consistently lead both a CMG and a professional society for emergency physicians — so I will continue to point out and criticize such conflicts of interest in the time I have left as Editor. ■

# Letters to the Editor



## Letter in response to the “From the Editor’s Desk” column “The Moral Arc” in the November/December 2016 issue

Dr. Andy Walker, Editor of *Common Sense*

I just read your message in the recent issue of *Common Sense*. I have to say I have grown tired of the ACEP-bashing abundantly reproduced from AAEM’s leadership over the years. You stated, “I want you to clearly understand the differences between the Academy and the College.” Then, your examples imply ACEP must be on the side of corporations. Further, leadership of or even employment by staffing corporations, by default, means ACEP and its

leaders must not be looking out for the individual physician. Not a “fair and balanced” description and one that does much to perpetuate the divide between the Academy and the College.

Interestingly, as I read through the rest of the magazine issue, it is apparent ACEP and AAEM share most of the same issues, direction, and priorities. In fact, I have noticed these similarities over many years.

I truly appreciate AAEM’s desire to preserve the ideal work environment for the individual emergency physician. Indeed, that is why I have maintained my AAEM membership for over a decade. I have only ever worked for independent groups, aside from my time on active duty service with the US Navy. I would prefer to keep it that way.

With that being said, ACEP-bashing always points to some past or current leaders within ACEP who have been leaders or employed within large contract management groups. However, this “guilt by association” assumes some sinister plot to take advantage of individual physicians. I have not witnessed that to be true. Through the Florida chapter of ACEP, I had worked for years alongside a physician from another part of the state before it ever became known to me that he is a senior vice president with EmCare. Whenever he spoke, he always spoke with the individual physician’s best interests in mind. I never heard him speak on behalf of EmCare or corporate medicine, for that matter.

In fact, most of the people I know today who work for CMG’s, as well as many of the partners I have worked with in independent groups, want nothing to do with the business of emergency medicine. They want to clock in and clock out, get paid and leave the rest to someone else. Surely you know this type, also. However, no group would survive if it did not tend to the business of emergency medicine. The business of EM has costs and even a small group will find it needs to allocate some “administrative time” for their leaders in order to manage this business. I have not found a group where these leaders are willing to do so for free, on their own time, and only be compensated for the clinical work they do.

Yes, I don’t want to be taken advantage of by any group skimming off the top of my hard-earned revenue just to line their pockets. Yes, I also recognize I will be required to contribute to the costs of billing, liability insurance, and “management” of my group.

I am happy to see AAEM maintain its principles of looking out for the “little guy.” ACEP is hard at work for emergency physicians but does not become involved with contracts between a physician and their employer or group.

Yet, continually detracting from ACEP as an organization, and ACEP’s leadership simply because of who they work for rather than what they say and do, has grown tiresome and seems out of touch with the ACEP I know well. The two organizations could do so much more if they worked together on common issues currently being tackled independently.

I implore you and AAEM’s other leaders to simply agree to disagree with ACEP on some issues and to work together on others. No family exists without some differences of opinions on how things should be done. But, in the end, we are all the same family and can succeed together if we will work together.

Respectfully,

— Steven B. Kailes, MD MPH FAAEM FACEP

Thank you for writing. Your criticism is rational and articulate, and I appreciate the time and thought that went into your letter. In fact, your letter is so well done and on such an important topic that I have decided to devote my “From the Editor’s Desk” column in the Mar/Apr issue of *Common Sense* to replying to it and explaining my position.

— The Editor

Continued on next page

Dear Dr Walker:

I have been an emergency physician for 20+ years and have worked under a number of models with various groups. I must take exception to the oft-stated position among AAEM leaders that CMGs are somehow more vile than privately run contracts. I offer my personal experiences, admittedly unscientific with an N of 1, but very real. I will not name specific physicians, groups or cities, but they know who they are.

One private group recruited me after they had already been given notice of termination and had me scheduled the very last week they had the contract to staff the ED and never said a single word to me.

Another group strung me along on a 'partnership' track but the founder maintained a 51% controlling interest and overrode the group's recommendation to let me join, without a reason. I quickly realized he intended to retire and did not want to split the profit. As I suspected, he retired and left the group with no succession plan and they were forced to become hospital employees at 35% lower pay. Fortunately, I saw the writing on the wall and had already left.

Yet another group had a fee-for-service model where a flat rate was paid until collections caught up. After a few months, the 'open books' were not reflecting my productivity accurately and I was told there wasn't anything more to be paid. The rest of the group received the largest bonuses ever. Obviously, they were skimming my productivity. I resigned, giving my 90 days notice and even still covering a holiday before leaving. 3 months later, I received a \$13,000 bill for tail coverage. If I had simply walked away and quit, they would have had to pay. But because I was honorable, it wasn't covered.

Also, another independent contractor group suddenly decided we needed to be 'on-call' several days per year because other physicians were calling off on weekends and holidays and it was difficult to get coverage. Of course, no incentive was offered to pick up those shifts and there was no compensation for the time we were expected to be available for a last-second call-in. My time away from work is just as valuable as time at work.

Clearly, private groups are often just as unscrupulous as any national CMG. Many of these same small groups sell out their practices to CMGs and pocket handsome profits by a tiny part of the groups' management and leave the rest to fend for themselves. AAEM should fight for fairness for all emergency physicians in all practice settings rather than paint CMGs as EM's bogeyman.

Sincerely,

— Robert J. Benkendorf, MD MMM FACEP FAAEM

I agree completely. Like you, I have seen more than one independent, "democratic" group that was anything but democratic and equitable. Many individual contract holders are as bad or worse than corporate staffing companies. Rest assured that AAEM fights for fair and equitable treatment in the workplace for all emergency physicians — whether they are hospital employees, part of an independent local group, or working for a huge staffing corporation. The basic principles of fairness are the same in each situation.

There is, however, one important difference between an independent physician-owned group and a staffing corporation (contract management group or CMG), and it is fundamental to the business model of each. A purely physician-owned group may be fair and democratic — meaning it is owned equitably by its physician members, with each having an equal share of ownership and control, each having full knowledge of the group's revenue and expenses, each having the protection of peer review and due process within the group, and each being free of post-employment restrictive covenants. A CMG not only usually does not provide these things, it cannot provide all these things because it derives its profit - and riches for its principle shareholders and upper management — by taking money away from emergency physicians far in excess of any value it returns to those physicians or their patients. Thus, while it is true that being entirely physician-owned is no guarantee of democracy and fair treatment in an emergency medicine group, it is also true that a CMG that exists to enrich its management and lay shareholders cannot be democratic or treat its emergency physicians fairly.

— The Editor



## Response to an Article? Write to Us!

We encourage all readers of *Common Sense* to respond to articles you find interesting, entertaining, educational, or provocative. Help us stimulate a conversation among AAEM members.

[www.aaem.org/publications/common-sense](http://www.aaem.org/publications/common-sense)



# Price Confirmed as HHS Secretary

Williams & Jensen, PLLC



Congressman Tom Price (R-GA) has recently received Senate confirmation as Secretary of the Department of Health and Human Services (HHS). The confirmation vote occurred strictly along party lines with all Republicans voting to confirm and all Democrats and Independents voting against or abstaining. Dr. Price will be the first physician to lead HHS in over 20 years. He is an orthopedic surgeon and has worked in private practice and as Medical Director of the Orthopedic Clinic at Atlanta's Grady Memorial Hospital.

Republicans cite Dr. Price's private and public sector experience when referring to his expertise on health care issues. They express confidence that he is the leader the Agency needs as the Administration and Congress begin the complicated task of unwinding and then replacing the Affordable Care Act (ACA). During the confirmation process, he has faced pointed questions from some Democrats about conflicts of interest, citing his ownership of certain stocks in the biomedical industry.

Like President Trump and many Republicans in Congress, Dr. Price has discussed the importance of keeping several elements of the ACA such as the ability to stay on a parent's health insurance policy until the age of 26 and allowing those with pre-existing conditions to purchase affordable plans.

There are over 1,300 statements within the ACA indicating that the HHS Secretary "may or shall" do certain things. These statements refer to a variety of topics including employer and individual plans, the rules around health care exchanges, coverage requirements, and many other important features. Congressional Republicans have expressed confidence in Dr. Price's ability, upon confirmation, to immediately consider actions that can be taken at HHS to make changes and reforms to the current system, even before Congress begins to replace certain elements of the law.

Congress is poised to advance a full repeal of the ACA in the coming weeks, although plans of a replacement law remain unsettled. Republican leaders have admitted that significant challenges exist in passing a comprehensive replacement measure, so some are now advocating for a step by step approach to passing reforms over the next year. Central to this policy debate is the desire to make the health care system more efficient, including the need to reduce unnecessary visits

to emergency departments. Many Members on both sides of the debate concede that increased access to health insurance has led to more use of available services including EDs.

Meanwhile, the Trump Administration has already taken several executive actions to dismantle the law, such as issuing an order that would stop enforcement of the penalty for those that do not comply with the ACA's individual mandate to purchase health insurance. In interviews, Trump has stated his desire to provide health insurance coverage for more Americans, perhaps even all Americans. Some Congressional Republicans have taken a different approach to in order to gain support for reform, saying their solutions will provide more people access and choice within the health care system, give states additional flexibility in spending federal health care dollars, and give consumers more options by expanding health savings accounts (HSAs).

Republican's desire to find alternative reforms that can pass Congress and be signed into law will dominate the agenda for the first part of 2017, with other legislative priorities such as individual and corporate tax reform taking a backseat.

## The Future of MACRA

During the confirmation process, Dr. Price and Seema Verma, President Trump's nominee to lead the Centers for Medicare and Medicaid Services (CMS), have also faced questions about the future of the new physician payment system being implemented under the Medicare Access and CHIP Reauthorization Act (MACRA).

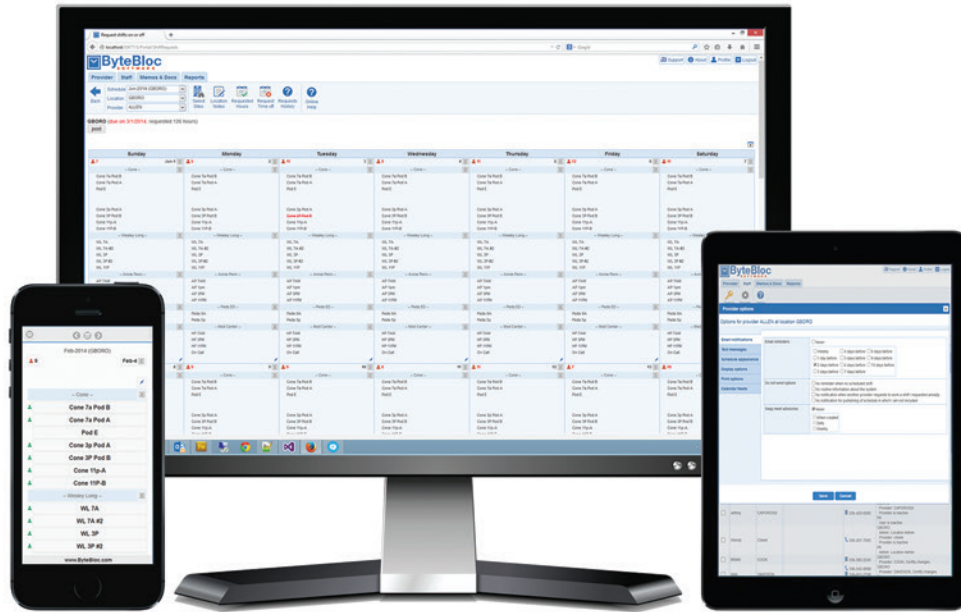
As a Member of Congress, Price was critical of MACRA, citing the additional burden the law will place on physicians. At a minimum, it is expected that MACRA will undergo further proposed changes designed to make it easier for physicians to meet requirements.

Former HHS officials that worked on finalizing the rule under President Obama say that the agency has already modified the physician payment system in response to criticism from providers. They note that recent changes allow doctors to do very little in 2017 to avoid future negative payment adjustments scheduled to take effect in 2019.

In addition to reducing the law's burden on small and mid-size practices, providers have also sought the ability to provide more input on quality standards as well as more eligibility options for MACRA bonus payments. The Academy has provided detailed input to CMS, and has also encouraged policymakers to consider additional changes to enhance quality of care, such as enforcing due process rights for physicians. ■

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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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Delaware Valley Chapter Division (DVAAEM)

## Residents' Day and Meeting

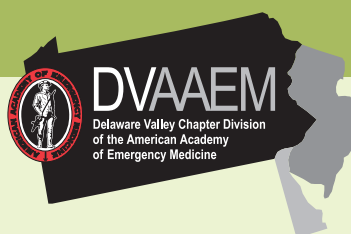
**Wednesday,  
April 19, 2017**

7:30am-4:00pm

4th Floor Auditorium, Student & Faculty Center  
Temple University, Philadelphia

**Free registration for DVAAEM members**

[www.aaem.org/membership/chapter-divisions/dv-residents-day](http://www.aaem.org/membership/chapter-divisions/dv-residents-day)



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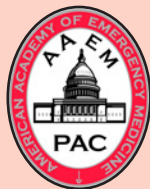
Registration opens January 2017

Poster submission opens February 6, 2017

Poster deadline March 13, 2017



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AAEM PAC is the political action committee of the American Academy of Emergency Medicine. Through AAEM PAC, the Academy is able to support legislation and effect change on behalf of its members and with consideration to their unique concerns. Our dedicated efforts will help to improve the overall quality of health care in our country and to improve the lot of all emergency physicians.

All contributions are voluntary and the suggested amount of contribution is only a suggestion. The amount given by the contributor, or the refusal to give, will not benefit or disadvantage the person being solicited.

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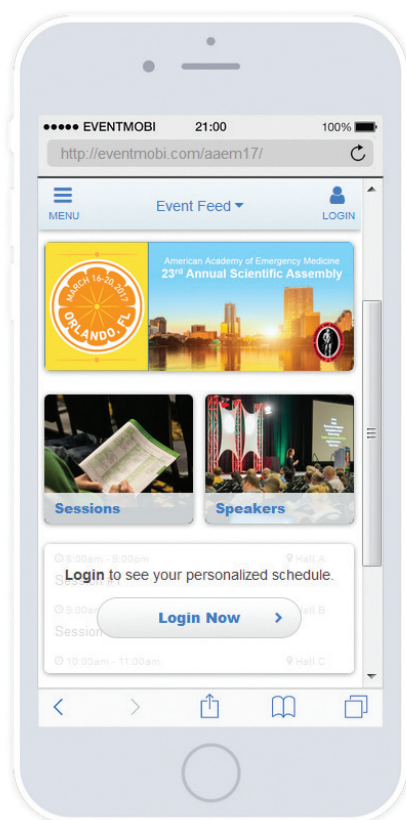
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## Upcoming Conferences: AAEM Directly & Jointly Provided and Recommended

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

### AAEM CONFERENCES

#### March 16-20, 2017

- 23rd Annual AAEM Scientific Assembly – AAEM17  
Orlando, FL

[www.aaem.org/AAEM17](http://www.aaem.org/AAEM17)

#### Pre-Conference Courses

##### Thursday, March 16, 2017

- Resuscitation for Emergency Physicians — 1.5 day course
- Ultrasound: Beginner
- EM Talk: Communicating Serious News (Organized by the AAEM Palliative Care Interest Group)
- Simulation — Obstetrics & Pediatrics
- So You Think You Can Interpret an EKG? (FREE for AAEM/RSA Resident Members!)

##### Friday, March 17, 2017

- 2016 LLSA Review Course (FREE for AAEM Members and AAEM/RSA Resident Members!)
- Advanced Ultrasound
- Active Shooter: Are You Ready? (Jointly Provided with USAAEM)

#### April 1-2, 2017

- Spring Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Orlando

[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

#### April 8-9, 2017

- Spring Pearls of Wisdom Oral Board Review Course  
Las Vegas

[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

#### April 5-6, 2017

- Spring Pearls of Wisdom Oral Board Review Course  
Philadelphia, Los Angeles

[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

#### August 14-18, 2017

- Written Board Review Course  
Orlando, FL

[www.aaem.org/written-board-review](http://www.aaem.org/written-board-review)

#### September 16-17, 2017

- Fall Pearls of Wisdom Oral Board Review Course  
Philadelphia, Los Angeles

[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

Registration Opens Early May 2017

#### September 23-24, 2017

- Fall Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Orlando

[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

Registration Opens Early May 2017

#### September 27-28, 2017

- Fall Pearls of Wisdom Oral Board Review Course  
Las Vegas

[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

Registration Opens Early May 2017

### AAEM JOINTLY PROVIDED CONFERENCES

#### April 19, 2017

- DVAAEM's Residents' Day and Annual Meeting  
Philadelphia, PA

[www.aaem.org/membership/chapter-divisions/dv-residents-day](http://www.aaem.org/membership/chapter-divisions/dv-residents-day)

#### April 21-22, 2017

- FLAAEM's 6th Annual Scientific Assembly  
Miami, FL

[www.flaaem.org/events/scientific-assembly](http://www.flaaem.org/events/scientific-assembly)

#### September 6-10, 2017

- MEMC-GREAT 2017 Joint Congresses  
Corinthia Hotel Lisbon  
Lisbon, Portugal

[www.emcongress.org](http://www.emcongress.org)

### AAEM RECOMMENDED CONFERENCES

#### March 30, 2017

- Zika Overview: A 360 Degree Look at the Epidemic at ACMT 2017  
Annual Scientific Assembly  
San Juan, Puerto Rico

[www.acmt.net/2017\\_Zika\\_Satellite.html](http://www.acmt.net/2017_Zika_Satellite.html)

#### April 21-23, 2017

- The Difficult Airway Course: Emergency  
Boston, Massachusetts

[http://www.theairwaysite.com/pages/page\\_content/Airway\\_Emergency\\_More.aspx](http://www.theairwaysite.com/pages/page_content/Airway_Emergency_More.aspx)

#### April 29-30, 2017

- Myanmar Emergency Medicine Updates Symposium  
Yangon, Myanmar

#### May 11-14, 2017

- 48th Annual Middle East Medical Assembly  
Beirut, Lebanon

<http://cme.aub.edu.lb>

#### May 19-21, 2017

- The Difficult Airway Course: Emergency  
Atlanta, Georgia

[http://www.theairwaysite.com/pages/page\\_content/Airway\\_Emergency\\_More.aspx](http://www.theairwaysite.com/pages/page_content/Airway_Emergency_More.aspx)

#### May 30-June 2, 2017

- High Risk Emergency Medicine San Francisco 2017  
San Francisco, California

#### September 15-17, 2017

- The Difficult Airway Course: Emergency  
Chicago, Illinois

[http://www.theairwaysite.com/pages/page\\_content/Airway\\_Emergency\\_More.aspx](http://www.theairwaysite.com/pages/page_content/Airway_Emergency_More.aspx)

#### October 6-8, 2017

- The Difficult Airway Course: Emergency  
Washington, D.C.

[http://www.theairwaysite.com/pages/page\\_content/Airway\\_Emergency\\_More.aspx](http://www.theairwaysite.com/pages/page_content/Airway_Emergency_More.aspx)

#### November 17-19, 2017

- The Difficult Airway Course: Emergency  
San Diego, California

[http://www.theairwaysite.com/pages/page\\_content/Airway\\_Emergency\\_More.aspx](http://www.theairwaysite.com/pages/page_content/Airway_Emergency_More.aspx)

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: [edeillers@aaem.org](mailto:edeillers@aaem.org).

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



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Applicants must have graduated from an accredited Emergency Medicine Residency Program and be board eligible or board certified by ABEM or AOBEM. We seek candidates with strong interpersonal skills and the ability to work collaboratively within diverse academic and clinical environments. Observation experience is a plus.

For additional information, please contact:

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## Dollars &amp; Sense

## Should You Invest in Real Estate?

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



Just about everyone who invests does so in major asset classes including stocks, bonds, and cash equivalents. When it comes to real estate, though, you'll find widely divergent opinions about its importance in an investment portfolio. There are some well-respected people and institutions who say that real estate investing is unnecessary, and there are others who will tell you it should

be your primary asset class. I've recently debated whether I should start investing more heavily in real estate, so I wanted to lay out the basic arguments for and against real estate investing.

### What is Real Estate?

The answer to this question is not simple because real estate investing comes in many forms. There are relatively passive ways of investing in real estate, such as Real Estate Investment Trusts (REITs). According to Investopedia, a REIT is "a type of security that invests in real estate through property or mortgages and often trades on major exchanges like a stock." In other words, you can simply invest in a REIT like you do any other stock, mutual fund, or exchange-traded fund (ETF).

Just send your money to your investment company, and you own a little slice of passive real estate.

There are more active methods of investing in real estate, such as fixing and flipping. You purchase a property, you make improvements to it, and then you sell it to someone, hopefully for a profit. As you can imagine, this would take quite a bit more work than investing in a REIT.

There are probably over 100 other ways you can invest in real estate. This abbreviated link (<https://goo.gl/A6Gaiv>) will take you to an article on Bigger Pockets, one of the largest websites about real estate investing, entitled "The Top 100 Ways to Make Money in Real Estate." Check that out if you are interested.

### Arguments Against Investing in Real Estate

Regular readers know that Vanguard is my go-to source for both advice and my own investments. Vanguard considers real estate an alternative

investment, and according to them "alternatives usually come with more risks and higher costs." They believe that a diversified portfolio of stocks and bonds provides enough diversification and that alternative investments are unnecessary. Only "sophisticated investors" should consider alternatives, and they see direct real estate investment as "expensive and time-consuming." Most people have exposure to real estate in the equity in their house and diversified stock/bond funds than often include REITs, real estate companies, and mortgage-backed securities. For these reasons, Vanguard doesn't think additional investment in real estate is necessary.



"When compared to stocks or bonds, which have a global, efficient market, real estate often has a local, inefficient market. This means that if you are willing to look, you can probably find some bargains out there much more easily than you can find a bargain stock."

Another argument against real estate investing is that it can quickly become a second job. While you can hire property managers, they are probably not going to provide the level of service most Type A, detail-oriented physicians desire. Most of us are already fully employed and don't need a second job. If we did, we could very easily get paid \$200/hour or more to do one. This opportunity cost is difficult for real estate to compete with. In addition, owning investment properties can create additional legal risk.

When you purchase an individual property, it is like buying a single stock. You are taking what is called

an uncompensated risk. Larry Swedroe defines an uncompensated risk as, "Risk — that is, the risk of owning single stock or sector of the market — that can be diversified away. Since the risk can be diversified away, investors are not rewarded with a risk premium (higher expected return) for accepting this type of risk." Essentially, you are putting all your eggs in one basket that is not diversified by location or property type. Investing in real estate via a REIT can avoid this problem because REITs invest in properties that are diversified (Swedroe, 2008).

Real estate is an illiquid asset class with high transaction fees. While I can sell my stock or bond mutual funds or ETFs in seconds online and pay extremely low expenses to do so, it will take me weeks or months to buy or sell a property. In addition, I'll likely pay 5-10 percent of the price in transaction costs.

Continued on next page

## Arguments for Real Estate Investing

Real estate is easily acquired, most often by purchasing your own single family house or condominium. You have to live somewhere, and there are several tax advantages to owning where you live. Interest payments on your mortgage and property taxes are tax deductible. If you sell your property, capital gains of up to \$250,000 if you're single or \$500,000 for couples are tax-free. In addition, paying a mortgage forces you to save by making regular payments, some of which pay off the principle balance of your loan. That is money you'll get back when you sell.

When compared to stocks or bonds, which have a global, efficient market, real estate often has a local, inefficient market. This means that if you are willing to look, you can probably find some bargains out there much more easily than you can find a bargain stock.

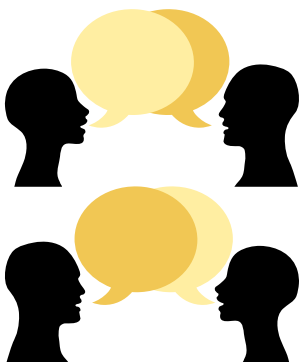
One of the goals of diversification is to have investments that are not correlated with each other. In other words, when investment A drops in price you have investment B that does not. When compared to stocks and bonds, real estate is not perfectly correlated with other investments and therefore provides diversification.

You can use leverage or "other people's money" to increase investment returns. Instead of buying a property for \$120,000, you could buy three \$160,000 properties with a \$40,000 down payment on each. This can increase your returns, but in a down market it can also dramatically increase your losses. As many found out during the housing market crash, leverage is a double-edged sword.

Real estate is an inflation hedge. Burton Malkiel says, "A good house on good land keeps its value no matter what happens to money" (Malkiel, 2015). Rents and property values tend to rise as prices rise, preserving your purchasing power. Since your mortgage payment doesn't change with inflation, while rents are going up your mortgage payment remains the same. Stocks do hedge inflation somewhat, but the companies they represent and the stocks themselves tend to get hurt as the prices of raw materials rise.

## The Bottom Line

There are a lot of different ways to invest in real estate, passively investing in REITs, fixing and flipping, owning rental properties, and all sorts of other investment opportunities. Like Vanguard, I don't think it is necessary to invest in real estate, but it is something to consider if you think you will either enjoy it or believe the value it adds to your investment portfolio is worth the effort.



## Participate in Research at AAEM17 — Bacterial Infections in the ED

As part of an ongoing research study we will be conducting in-depth interviews with emergency physicians regarding how you manage bacterial infections in the emergency department. Interviews will last approximately 1 hour and you will be compensated \$100 for your time. Thank you for considering. If you are potentially interested in participating or would like more information about this study, please contact the principle investigator, Michael Pulia, MD FAAEM, at [mspulia@medicine.wisc.edu](mailto:mspulia@medicine.wisc.edu)

## Bibliography

- Malkiel, B. G. (2015). *A Random Walk Down Wall Street*. New York: W. W. Norton & Company.
- Swedroe, L. E. (2008). *The Only Guide to Alternative Investments You'll Ever Need*. New York: Bloomberg Press.

If you have ideas for future columns or have other resources you'd like to share, email me at [jschofer@gmail.com](mailto: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.* ■



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# Updates from the American Board of Emergency Medicine

## EMS Application Period Open

Diplomates can now submit applications for the September 25, 2017, administration of the EMS Certification Examination. Upon receiving a completed application form, ABEM will review your credentials and independently verify that you have met the eligibility criteria.

The EMS Eligibility Criteria and the application form are available on the ABEM website. Additional information about the application period for this and other ABEM subspecialty examinations is available in the accompanying table.

## Practice Pathway Closures

The practice pathway for Anesthesiology Critical Care Medicine (ACCM) will close in 2018 on the final date of the 2018 ACCM application cycle.

The practice pathway for Emergency Medical Services (EMS) will close July 1, 2019, the final date of the 2019 EMS application cycle.

If you have any questions about subspecialty certification, please contact ABEM at [subspecialties@abem.org](mailto:subspecialties@abem.org), or 517-332-4800, ext. 387. ■

## 2017 Subspecialty Examinations with Cycles

Examination Type	Examination Date(s)	Application Dates	Registration Dates	Scheduling Dates
Anesthesiology Critical Care Medicine	October 14, 2017	February 6 – August 28, 2017	February 22 – September 13, 2017	March 6, 2017 – September 14, 2017
Emergency Medical Services	September 25, 2017	January 3 – June 30, 2017	March 1 – September 24, 2017	March 1, 2017 – September 24, 2017 (scheduling allowed up to one day prior to the exam date)
Internal Medicine – Critical Care Medicine	October 18, 2017	February 20 – May 25, 2017	May 1 – June 30, 2017	March 1 – October 15, 2017 (deadline for cancellation two days prior to the exam date)
Pain Medicine – Certification	September 9, 2017	February 6 – July 24, 2017	February 22 – August 8, 2017	March 6, 2017 – August 9, 2017
Pediatric Emergency Medicine – Certification	April 3, 2017	Closed	September 1, 2016 – January 16, 2017	September 1, 2016 – January 19, 2017
Pediatric Emergency Medicine – Recertification, Spring	March 1 – 31, 2017	January 3 – March 10, 2017	January 3 – March 13, 2017	January 3 – March 30, 2017
Pediatric Emergency Medicine – Recertification, Fall	August 15 – September 30, 2017	January 3 – September 8, 2017	April 1 – September 15, 2017	April 2 – September 29, 2017
Sports Medicine – Certification & Recertification, Summer	July 11 – 15, 2017	January 9 – June 16, 2017	February 17 – June 23, 2017	February 17 – June 30, 2017
Sports Medicine – Certification & Recertification, Fall	November 6 – 11, 2017	January 9 – September 18, 2015	July 21 – September 25, 2017	July 21 – October 2, 2017
Undersea and Hyperbaric Medicine – Certification				TBD
Undersea and Hyperbaric Medicine – Recertification	April 23, 2017 Denver, CO April 30, 2017 Denver, CO May 23, 2017 Portland, OR June 28, 2017 Naples, FL August 24, 2017 Baltimore, MD October 15, 2017 Linthicum Heights, MD	January 5, 2017 – 1 day pre-exam	At least 14 days pre-exam	NA





# COUNTDOWN TO AAEM17 – SEE YOU IN ORLANDO!

Evie Marcolini, MD FAAEM and Christopher Doty, MD FAAEM  
Co-Chairs, Scientific Assembly Planning Committee



The 2017 Scientific Assembly is just a few weeks away. Please join us in Orlando from Thursday, March 16-Monday, March 20.

We are thrilled to announce our keynote speaker will be Dr. Ronny Lynn Jackson, Physician

to the President! You will not want to miss his fascinating lecture, "The White House: When Emergency Medicine Meets Executive Medicine."

This year the Scientific Assembly will feature a new learning format: Small Group Clinics. Breaking the traditional lecture mold, Small Group Clinics will allow a limited number of participants to learn procedures such as joint aspiration, transvenous pacing, and dental blocks in a small group setting. There will also be small group discussions of bedside teaching pearls, vertigo maneuvers, and resuscitation tips. Take advantage of this unique opportunity to learn from the experts in an intimate, small group setting!

The high-yield plenary sessions are back and feature your favorite speakers. Start off each day learning "What's New In..."

- Infectious Disease
- Resuscitation
- Critical Care
- Neurology
- Pediatrics
- Trauma

While busy learning the most up-to-date information on the best care for your patients, don't forget yourself! Too often physicians put themselves last. The 2017 Scientific Assembly will provide multiple opportunities to attend to your own wellness, including mental and physical group exercise sessions as well as a dedicated Wellness Track:

- Saturday, March 18<sup>th</sup>
  - 6:30am Early Risers Yoga Session
  - 8:00pm AIRWAY @ AAEM Storytelling Session
- Sunday, March 19<sup>th</sup>
  - 6:30am 5K Fun Run or Walk
  - 1:30pm Wellness Track

Building on the success of last year's inaugural Women in EM Track and panel discussion, we have again dedicated time to addressing the specific challenges female physicians face as leaders in the emergency department. Join us for:

- Navigating the Nurse Relationship
- Women and Unconscious Bias
- Lead the Way: Pearls from Women Leaders

No one can forget that Orlando was the site of the deadliest mass murder by a single shooter in United States history. The Scientific Assembly will feature a special session on Monday, March 20 on the emergency response to the tragedy, "#OrlandoUnited: Coordinating the Medical Response to the Pulse Nightclub Shooting." You will not want to miss this powerful presentation.

The Scientific Assembly continues to be the premier educational event in emergency medicine — and it is still free to AAEM members! We hope you will join us in Orlando for five days of education, networking, socializing, and fun. ■

## 2017 State of the Academy and Candidates' Forum

**Friday, March 17,  
2:00pm-3:30pm**



You're invited to AAEM's annual business meeting and election forum. You'll hear directly from the AAEM president about the successes of the past year and the direction the Academy is headed.

You'll also hear from those nominated for the board of directors and be able to ask them questions before casting your vote in the election.

**Be involved, be informed, join us!**

American Academy of Emergency Medicine  
**23<sup>RD</sup> ANNUAL SCIENTIFIC ASSEMBLY**

Hyatt Regency Orlando

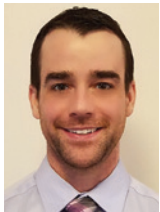


To vote online and learn more visit: [www.aaem.org/elections](http://www.aaem.org/elections)



## SESSIONS FROM THE OPERATIONS MANAGEMENT COMMITTEE

Jason Hine, MD  
Operations Management Committee



It is time to start getting excited about Orlando in March, and not just because of the 65 degree average temperature. The educational content coming from the Operations Management Committee alone will be worth the trip. In fact, I assure you that you'll prefer the air conditioned lecture hall, brimming with informative nuggets and enlightening pearls, to the hot Orlando sidewalks. To assist attendees in find-

ing material that peaks their interest, our content is divided into three tracks. Here is part of what's in store for you at the 2017 AAEM Scientific Assembly:

### Administration Session

This session starts with an important question: "Do You Have the Right Intake System?" As your patients' first point of contact with the emergency department, this is (sadly) an often overlooked facet of ED patient flow. Joseph Twanmoh, MD MBA FAAEM, the Operations Management Committee chair, walks you through the important aspects of finding and implementing the best intake system for your ED.

A topic which all physicians should care about follows, "How to Decrease Your 30-Day Readmissions." No one enjoys walking into a shift and hearing, "Remember that patient from last week? He's back." Additionally, high 30-day readmission rates can be incredibly taxing to the department's bottom line. Learn how to improve your numbers and make your CEO happy with this great talk by Gary Gaddis, MD PhD FAAEM.

The session closes with a look into the future. The way CMS pays for health care is changing. Lemeneh Tefera, MD, bring us up to speed with "Coming Down the Pike: What is MACRA and What is in the Future at CMS?"

### Getting the Right Job

We all want to be happy in our jobs. We all want a good schedule, to have satisfying professional interactions, and be well compensated. Unfortunately, fulfilling these desires is far from guaranteed. Learn how to land the right job and assure yourself a satisfying career with this session.

Robert McNamara, MD MAAEM FAAEM, leads this session with "The AAEM Physician Group: Lessons Learned and What to Pay Attention To." Dr. McNamara will review vulnerabilities and potential areas of improvement for physician-owned groups, and present valuable insights on this often controversial topic.

Larry Weiss, MD JD MAAEM FAAEM, follows with a talk nearly all physicians should attend, "Contract Evaluation — Tips to Use in Your Next Job Search." Signing a contract is an intimidating process. You know the basics of contract assessments and the red flags to look for, but sifting through that pile of paperwork can be overwhelming. What is hiding in there? What are you missing? Help keep that fine print from coming back to bite you with this informative talk.

Finally, what if there are parts of your contract you don't like? Or perhaps more likely, what if your contract has remained stagnant for years and needs some updates? In this session, learn the important principles and keys to success in negotiating with "Negotiating Skills — Can We Use Principles?" This talk led by Eric Isaacs, MD FAAEM, is guaranteed to help you in your next negotiation.

### Operations Boot Camp

In this session we delve into the core competencies of ED operations. After all, it is primarily through mastery of these fundamentals that we gain success and make progress for our department. Through these talks you will take a fresh look at some old classics such as staffing, operational margins, and dealing with CMS.

Jody Crane, MD MBA FAAEM, leads off with "Staffing Your ED — How to Win the Nursing Argument." As we all know, this pivotal topic is difficult to master. Dr. Crane gives you a leg up on this challenging issue.

Dr. Crane is followed by Joseph Guarisco, MD FAAEM, who discusses a key concept to improving throughput: operational margin. In his talk "Creating Operational Margin: The Critical Final Pathway to all Throughput Solutions," Dr. Guarisco highlights the fine points of utilization and response times, focusing on the give and take between the two.

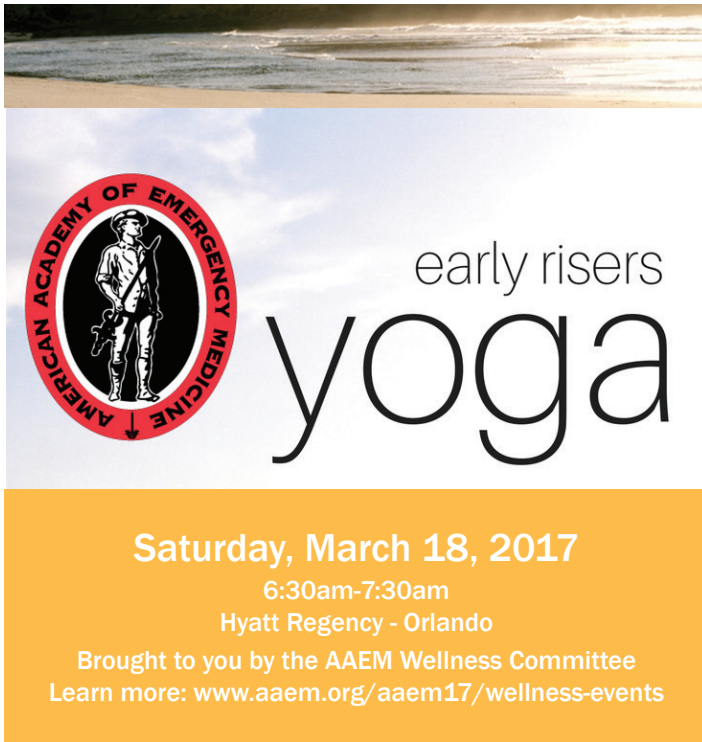
For the final talk in this session, Dr. Crane returns to discuss the ever-present CMS. In his segment "Pressure From Above — CMS Demands and Pitfalls," Dr. Crane addresses the constant pressure CMS puts on ED operations, outlines some means of dealing with this stress, and highlights common pitfalls in doing so.

### Summary

We are incredibly proud of the educational content in these sessions. With the breadth of topics covered and an array of nationally recognized and talented speakers, the Operations Management sessions will truly have something for everyone. We look forward to seeing you in Orlando. ■



# WELLNESS AT AAEM17



**early risers  
yoga**

**Saturday, March 18, 2017**  
6:30am-7:30am  
Hyatt Regency - Orlando

Brought to you by the AAEM Wellness Committee  
Learn more: [www.aaem.org/aaem17/wellness-events](http://www.aaem.org/aaem17/wellness-events)



**FREE**  
for AAEM members  
attending AAEM17.  
Preregistration  
required.

**AAEM17  
5K FUN RUN**

Join the AAEM Wellness Committee in  
promoting EM physician resiliency by  
participating in the first AAEM17

## 5K Fun Run/Walk!

**Sunday, March 19, 2017**

6:30am-7:30am

Hyatt Regency-Orlando

## REGISTER NOW!

<http://www.aaem.org/aaem17/attendees/funrun>







## AAEM17 EXHIBITORS

Be sure to stop by the exhibit hall at AAEM17 and see what these groups have to offer!

AcelRx Pharmaceuticals, Inc.  
Alliance for Physician Certification & Advancement (APCA)  
American Osteopathic Board of Emergency Medicine (AOBEM)  
Arbor Pharmaceuticals, LLC  
CEP America  
CIPROMS Medical Billing  
ConsenioHealth, LLC  
Ellis Medicine  
Emergency Excellence  
Emergency Groups' Office  
Emergency Medicine Associates, P.A., P.C.  
Emergency Medicine of Indiana  
Emergency Physicians Insurance Exchange RRG  
Emergency Service Partners, L.P  
EMrecruits  
Feel Good, Inc.  
Fisher & Paykel Healthcare, Inc.  
Gulfcoast Ultrasound Institute

Infinity Healthcare  
Insurance Data Services, Inc.  
Intermedix  
Kaiser Permanente - Washington Permanente Medical Group  
Leading Edge Medical Associates (LEMA)  
LocumTenens.com  
Locum Leaders  
LogixHealth  
Martin Gottlieb & Associates  
Mayo Clinic  
Medicus Healthcare Solutions  
Mint Physician Staffing  
Newsura Insurance Services  
Nick & Associates, Inc.  
Nova Innovations  
Ochsner Health System  
PATHFAST  
Penn State Health Milton S. Hershey Medical Center  
PEPID, LLC

PhysAssist Scribe, Inc.  
Praxair Healthcare Services  
Precision Medical Devices, LLC  
Reading Health System  
Relias Learning  
Rhino Medical Services  
Rochester Regional Health  
ScribeAmerica  
Scrivas  
Shift Administrators, LLC  
Smith & Nephew  
SonoSim, Inc.  
Staff Care, Inc.  
Sycamore Physician Contracting  
Texas Tech University Health Sciences Center El Paso  
TIVA Healthcare, Inc.  
Urgent Care Consultants  
Weatherby Healthcare  
Zerowet, Inc.  
Zotec Partners

Learn more about Passport to Prizes [www.aaem.org/aaem17/passport](http://www.aaem.org/aaem17/passport).



The AAEM and RSA Wellness Committees proudly presents: Airway @AAEM

## Airway: True Stories from the Emergency Room

**Saturday, March 18th, 2017**  
7:30pm-9:30pm  
Hyatt Regency - Orchid Room  
Orlando, FL  
Cash Bar Available

### We all have stories to tell.

They are sometimes funny or inappropriate or heartbreaking. Others affirm our decision to become doctors in the first place.

This night promises to showcase the great range of human experience — to enlighten minds, expose vulnerabilities, and quietly suggest ways to overcome the challenges we all face each day.

**We are actively RECRUITING STORYTELLERS for the event.** All types of stories about ANY TOPIC related to your experience as an emergency physician are welcome.

If you have a great tale to tell, please email us an audio recording of your complete story to [airway.contact@gmail.com](mailto:airway.contact@gmail.com).



Find out more about Airway @AAEM at: [www.aaem.org/aaem17/wellness-events](http://www.aaem.org/aaem17/wellness-events)



Dear AAEM Member,

Enclosed are the candidate statements for the 2017 AAEM board of directors election.

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



Statements from each of the candidates full listing of previous board service and awards, and AAEM activities dating back five years are on the following pages. Please review the enclosed information, then exercise your democratic right to vote for the representatives you would like to see serve as AAEM's leaders. Remember, we have a one member, one vote system, so your voice counts. Please follow these instructions for casting your ballot in the 2017 election.

### **If You Will Attend the Scientific Assembly:**

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- ***We recommend that you do not complete your official ballot at this time.*** There will be a Candidates' Forum held during the Scientific Assembly on March 17, 2017, 2:00-3:30pm where you can hear the candidates respond to direct questions from the voting membership. You will be asked to submit your ballot online at the conclusion of that Forum.
- ***If certain of your choices or unsure if you will attend the Forum,*** you may vote online at [www.aaem.org/elections](http://www.aaem.org/elections). Voting will remain open until March 17, 2017 at 11:59pm ET.

### **If You Are Unable to Attend the Scientific Assembly:**

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- You may complete your official ballot online at [www.aaem.org/elections](http://www.aaem.org/elections). Online voting will remain open until March 17, 2017, at 11:59pm ET.

### **Balloting Procedure for 2017:**

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- ***Voting ballots will only be available online.***  
Please visit [www.aaem.org/elections](http://www.aaem.org/elections) to cast your vote electronically.

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

Sincerely,

Kay Whalen  
Executive Director



## Robert A. Frolichstein, MD FAAEM

### Candidate for At-Large Director

Nominated by: Robert McNamara, MD MAAEM FAAEM; Sumeru Mehta, MD FAAEM; Mark Reiter, MD MBA FAAEM

Membership: 1998-2017

Disclosure: Nothing to disclose at this time.

Independent Practice Support Committee 2016-2017

Palliative Care Interest Group 2016-2017

"The doctor, to the extent he is a doctor, considers only the good of the patient in what he prescribes, and his own not at all"--Plato

As President of Greater San Antonio Emergency Physicians (GSEP), the first group to join the American Academy of Emergency Medicine Physician Group (AAEM-PG), I believe I can bring material experience and capability to the AAEM Board that will assist the Academy in it's efforts to advance and protect the independent practice of emergency medicine.

We are held to a lofty standard as physicians. Our profession, and the resulting social contract, demands that we consider the patient's well-being above anything else. This is becoming increasingly difficult in today's practice of medicine as we are continually pressured by entities under control and management of non-physicians that may, or may not, have the best interest of the patient in mind. As a leader in an independent democratic group that has survived and thrived through tumultuous hospital mergers, gaining, then losing, then regaining hospital contracts, buy-out offers, and workforce shortages, I am immensely proud of our recent decision join the AAEM-PG. This decision reflects our confidence that remaining independent of the potential to be influenced by non-physician owners always creates the best environment for doing what is best for our patients.

After graduating from the University of Missouri-Columbia School of Medicine, I served ten years in the United States Army receiving my EM residency training in San Antonio, Texas at Brooke Army Medical Center and Wilford Hall Medical Center. During this residency, I first became aware of the values of AAEM during a residency visit by Dr. Robert McNamara. The discussion that day, perhaps harmonizing with values I already possessed, shaped the values I carried into the future. Throughout the years, it has become evident that my values coincide with the AAEM Vision Statement "A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference."

I have been a leader in GSEP for twelve of my fifteen years with the group, serving on the GSEP Board of Directors, as ED Medical Director, as member and chair of numerous hospital committees, and as GSEP President for the last six years. Given the opportunity, I will use my experience, my commitment to a belief that remaining an independent democratic group is important to help prevent further erosion of our autonomy, and my passion for preserving the sacred physician-patient relationship to serve the Academy and each of it's members to the best of my ability. ■



## Megan Healy, MD FAAEM

### Candidate for At-Large Director

Nominated by: Kevin Rodgers, MD FAAEM

Membership: 2010-2017

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2016-2017

Young Physicians Section Board of Directors 2014-2016

Resident and Student Association Board of Directors  
2012-2013

Marketing Task Force 2016

Women in Emergency Medicine Committee, Co-Chair 2015

Women in Emergency Medicine Committee, Board Liaison 2016

Scientific Assembly Speaker 2015, 2016

Common Sense Author 2015, 2016

I have been an active member of AAEM/RSA and AAEM since beginning residency training at Temple University Hospital in 2010. As RSA Advocacy chair, I organized the first RSA Capitol Hill Day in 2012 and have continued to participate in our lobbying visits every year since that time. I am well versed in the threats to our specialty and enjoy engaging with our members of Congress on vital issues, such as due process for physicians. In 2015-2016, my primary focus as founder and co-chair of the new Women in Emergency Medicine (WiEM) committee was to recruit, retain and champion female emergency physicians in our organization. I led the planning of the first WiEM social in 2015, women's track at SA in 2016, and collaborated with the Diversity and Inclusion Task force to host a larger social event that welcomed members of both groups in 2016. I was honored to serve the past year on the Board as an appointed At-Large member. In this role, I championed a proposal for a Lactation Room at SA 2017 for our members who are mothers to nurse/pump, and brought to the board a plan for a new Ultrasound Section, led by experts from my home institution. I also chaired the new Marketing Task Force to take a fresh look at AAEM's logo and slogan as we plan ahead for the continued success of the Academy in 2017 and beyond.

Continued on next page



The future of AAEM lies in reaching young physicians to educate them on our core values and to engage and retain our very active and talented resident and student members. The focus of our efforts should be in two areas: education and advocacy. The first step is by continuing to provide the highest quality educational offerings at Scientific Assembly and through our Board preparation courses by using innovative learning formats. The second step is to reach our members, especially young physicians and those in training, and our representatives in Congress about the principles of fair practice environments so that we can shape the future of our specialty for the better. I believe my recent efforts demonstrate my desire to push our organization forward and grow the benefits we provide to our members, while staying true to the central mission on which we were founded. Education and advocacy - for the emergency physician and ultimately for our patients - are the lifeblood of the Academy and I hope to continue to lead on the Board of Directors with these central themes as my guide. ■



## **Bobby Kapur, MD MPH FAAEM**

### **Candidate for At-Large Director**

Nominated by: David A. Farcy, MD FAAEM FCCM

Membership: 2012-2017

Disclosure: Nothing to disclose at this time.

Academic Affairs Committee 2013-2017

Inter-American Emergency Medicine Congress Speaker 2012, 2014, 2016

AAEM has been and continues to be the pivotal organization advocating for both emergency physicians' and patients' rights in our nation's Emergency Departments. In addition, AAEM's members have inspired medical students, guided residents in training, and collaborated with physicians in other countries. I have had the privilege as a member of AAEM to serve in these various roles. I completed residency in Emergency Medicine from Yale New Haven Hospital and fellowship in International Medicine from Brigham & Women's Hospital. Then I was the International Emergency Medicine Fellowship Director at George Washington University from 2004-2009 where I started 4 Emergency Medicine residency programs in India, helped launch an Emergency Medicine residency in Beijing, and led a 3-year project in Turkey to provide training courses for more than 2,000 physicians working in Emergency Departments in government hospitals. I worked with the AAEM International Committee as faculty for both the Mediterranean Emergency Medicine Congress and the Inter-American Emergency Medicine Conference. For these achievements, I was awarded the "Fellow of the International Federation of Emergency Medicine." In 2009, I was recruited to Baylor College of Medicine (BCM) to develop and start the new Emergency Medicine residency program, and within 10 months, we received full initial accreditation for the residency program with 14 residents each year. During this time, I served on the AAEM Academic Affairs Committee, and as Program Director, I ensured we had 100% resident membership in AAEM. In 2014, I led a 6-person team from BCM to provide Ebola preparedness & response training in Nigeria at the height of the epidemic in the country. In 2015, I was recruited as Chief of Emergency Medicine at Jackson Memorial Hospital (JMH) in Miami, and the Jackson Memorial Hospital/ University of Miami Emergency Medicine residency program received initial full accreditation and was started in June 2016. The JMH/UM residency program is also 100% AAEM resident membership. In addition, I am the senior editor for the first book in the field of Emergency Public Health titled Emergency Public Health: Preparedness and Response.

It is an honor to be nominated for an At-Large Position on the AAEM Board of Directors, and if elected, I will continue to work with my AAEM colleagues and use my experiences to support AAEM's mission to provide each person with access to high-quality emergency care provided by emergency medicine specialists. I will work with AAEM's national, state and local leadership to support emergency physicians in their professional endeavors and provide resources for their personal wellbeing, and I will encourage the voice and efforts of our Resident and Student Association as they train to be the future of our specialty. ■



## Robert P. Lam, MD FAAEM

### Candidate for At-Large Director

Nominated by: Jonathan S. Jones, MD FAAEM

Membership: 2002-2017

Disclosure: Nothing to disclose at this time.

Oral Board Review Course Examiner 2012-2016

Wellness Committee, Chair 2016-2017

Wilderness Medicine Committee 2015-2016

Social Media Committee 2012-2016

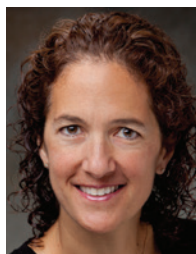
Diagnostic Case Competition Award 2016

*Common Sense* Author 2016

Dear Colleagues:

Most importantly, I am a practicing emergency physician in an independent democratic group staffing a busy university affiliated community hospital. I am also a teacher who believes in medicine as a profession. I feel honored to be entrusted to make a difference every day serving on the front lines of medicine and I am committed to sharing this honor and responsibility with students. One of the greatest challenges we, as emergency physicians, currently face is burnout. Unfortunately, burnout has already impacted many of us with a reported 65% of emergency physicians having lost the joy of practicing this great profession through disengagement and physical exhaustion. The syndrome of burnout is part of my own story as well as the source of my passion to fight against it. I am proud to serve AAEM and my colleagues as Chair of the Wellness and Burnout Committee as we journey together to find evidence based solutions to this complex problem.

In these challenging times, we must receive support from the institutions that advocate for the practicing emergency physician and no institution is better situated to champion wellness and fight burnout than AAEM. The Academy was founded on this advocacy and continues to fight for our right to practice in fair and equitable work environments. There is no greater example of this advocacy then when AAEM come to the aid of our democratic group when we lost our contract to a contract management group. Over the years AAEM has given me education, professional relationships, advocacy, and service opportunities. I believe that it is time for me to give back to my colleagues and this organization that I believe in. It would be my honor to serve my fellow colleagues on the AAEM board of directors. I hope you will support me in this endeavor. ■



## Evadne G. Marcolini, MD FAAEM FACEP

### Candidate for At-Large Director

Nominated by: David A. Farcy, MD FAAEM FCCM

Membership: 2005-2017

Disclosure: Nothing to disclose at this time.

ACCME Sub-Committee 2013-2016

Education Committee 2013-2016

Mentorship Sub-Committee 2016

Scientific Assembly Speaker 2013-2016

Scientific Assembly Planning Committee Co-Chair 2015-2016

Scientific Assembly Abstract Competition Reviewer 2015

Mediterranean Emergency Medicine Congress Speaker 2015

Inter-American Emergency Medicine Congress Speaker 2012, 2014

It is a great honor to be nominated to the Board of Directors of AAEM. I have been a member of AAEM since 2005, back when I was a resident, trying to figure out the landscape of emergency medicine, and what different organizations mean to the practicing emergency physician. As I discovered, AAEM does the best job of representing the individual emergency physician and focuses on how to do the right thing for those who are giving excellent patient care to all patients, irrespective of cultural or socioeconomic backgrounds. The world of medicine, including emergency medicine is changing. It is no longer as simple as doing the best job we can in taking care of patients; we must understand and attend to the details of financial, legal and management practices in order to accomplish the best care for our patients. This is more complicated than what we learned in medical school, and takes a team of dedicated experts to interpret, communicate and implement changes in our practice structure. My role has been in education and integrating AAEM membership into an active role in the Academy.

In all of my activities with AAEM, I have appreciated the spirit of the individuals who organize and participate in the Academy and its activities. We are a diverse group of professionals dedicated to excellence in taking care of patients as well as taking care of each other. We volunteer our time to make AAEM and emergency medicine the best that it can be. Part of this mission includes communicating our values to the next generation, and getting them involved. This has been a core element of my work on the Education committee, and the Scientific Assembly. My goal is to continue representing the best that we stand for, and to educate, inspire and recruit younger professionals to become involved. It has been exciting to see new educators and speakers step up to the plate in our education activities, as well as to mentor them in involvement in their growth as educators. I look forward to contributing my talents to the Board, and to earning your vote! ■



## Brian R. Potts, MD MBA FAAEM

### Candidate for At-Large Director

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

Membership: 2002-2017

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2016-2017

Young Physicians Section Board of Directors 2008-2009

Young Physicians Section Board of Directors, Vice President  
2009-2010

Young Physicians Section Board of Directors, President  
2010-2011

Young Physicians Section Mentor 2012-2015

Resident and Student Association, Student Representative  
2002-2004

Resident and Student Association, Secretary-Treasurer  
2004-2005

Resident and Student Association, Vice President 2005-2006

Resident and Student Association, President 2006-2007

Resident and Student Association, Immediate Past President  
2007-2008

California Chapter Division Board of Directors, Resident  
Representative 2005-2008

California Chapter Division Board of Directors, Secretary  
2008-2010

California Chapter Division Board of Directors, President  
2010-2011

California Chapter Division Board of Directors, Immediate Past  
President 2011-2012

California Chapter Division San Francisco Speaker Series,  
Co-Chair 2012-2015

AAEM Residency Visit Speaker 2016-2017

Chapter Division Committee 2012-2016

Government Affairs Committee 2012

Membership Committee 2016

Resident of the Year Award 2005

James Keaney Award 2015

I would like to ask for your vote for At-Large Director to represent you on the AAEM Board. As a current At-Large Director, I have enjoyed my role as the board liaison for the Membership and State Chapter Division committees as well as my direct involvement with two board task forces. If elected, I would continue as a voice for AAEM's community emergency physicians. Our Board should reflect a diverse group of both academic and community emergency physicians to best represent our organization's membership. I believe strongly in AAEM's mission and vital efforts to improve the practice environment for all emergency physicians, defend the value of board-certification, and provide excellent educational activities. AAEM's hard work to promote fairness in the workplace (control over professional fees, equitable ownership, due process, open books) can directly impact the job environment for emergency physicians in a positive way.

Through medical school, residency, and now while in community practice, I have held numerous national and state leadership roles within AAEM and previously served on the AAEM Board as a past YPS Director (2011) and past AAEM/RSA President (2007). Additional key positions where I contributed to AAEM include YPS President and Medical Student Section President. For five years, I served on the RSA Board of Directors in various positions and was involved in RSA's early development, and RSA's continued growth and success have been exciting to watch over the years. Closer to home, I have been actively involved with the California chapter (CAL/AAEM) as a member of the chapter's Board of Directors since 2006 and served as President in 2010.

After finishing my emergency medicine residency at UC-Irvine in 2007, I went to work in for a small private democratic group in the San Francisco Bay Area (Berkeley Emergency Medical Group). I am currently the medical director and chair of emergency medicine for our Berkeley campus. As the group's CFO, I'm also actively involved in managing our group's operations, so I understand the complexities of running a group practice and the challenges we face within the health care system. I feel fortunate to be a partner in a group which embodies the cores values of AAEM. My work with AAEM has always been to help support the growth of the democratic group model, so more emergency physicians can have the opportunity to work in an environment and for a group like mine.

In closing, I joined AAEM as a medical student and have been actively involved in AAEM leadership ever since. In 2015, I was the recipient of the James Keaney Award. I've been fortunate to work with many amazing past AAEM leaders, current AAEM leaders, and AAEM staff over the years and in many ways consider AAEM to be part of my extended family. I would be honored, if elected, to continue supporting the mission and values of AAEM and serving as a champion for AAEM's members. ■





## Thomas R. Tobin, MD MBA FAAEM

### Candidate for At-Large Director

Nominated by: William Durkin, MD MBA CPE FAAEM; David A. Farcy, MD FAAEM FCCM

Membership: 2002-2017

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2016-2017

Independent Practice Support Committee, Chair 2015-2017

Chapter Division Committee 2016-2017

AAEM Residency Visit Speaker 2012-2017

I was fortunate enough to have been part of the Board of Directors for the past year. I was appointed to fill a one year vacancy left from last year's election. I continued to chair the Independent Practice Support Committee during the past year.

During the past year, I contributed to several projects. These included advocating and fighting for EM Physician rights in billing and employment. Supporting and successfully pushing back against insurance companies continued efforts to not fairly pay EM physicians for patient care.

It has been my pleasure to serve every EM Physician in my roles as part of AAEM. I have spent my whole career supporting, advocating and fighting for EM Physicians and the independent practice of medicine. Ultimately benefiting the patients for which we care every day.

I ask that you allow me to continue to serve you at AAEM as a member of the board of directors. Thank you for considering me and voting for me. ■



## Jennifer Kanapicki Comer, MD FAAEM

### Candidate for YPS Director

Nominated by: Self Nomination

Membership: 2007-2017

Disclosure: Nothing to disclose at this time.

Young Educator of the Year Award 2016

Resident and Student Association Board of Directors  
2008-2010

Young Physicians Section Board of Directors 2010-2011

Young Physicians Section Board of Directors, Secretary-  
Treasurer 2011-2012

Young Physicians Section Board of Directors, Vice President  
2012-2013

Young Physicians Section Board of Directors, President 2013-  
2014, 2016-2017

Young Physicians Section Board of Directors, Immediate Past  
President 2015-2016

Young Physicians Section Mentor 2012, 2014-2015

California Chapter Division Board of Directors 2011-2013

California Chapter Division Board of Directors, Secretary  
2013-2014

California Chapter Division Board of Directors, Vice President  
2014-2016

California Chapter Division San Francisco Speaker Series, Co-  
Chair 2012-2015

Women in Emergency Medicine Committee 2015-2017

Education Committee 2016

Chapter Division Committee 2016

Scientific Assembly Speaker 2015-2016

Scientific Assembly Open Mic Judge 2015-2016

For the past year it has been my pleasure serving on the AAEM/YPS Board of Directors as President. I, with the support of AAEM/YPS, have accomplished a lot in the past few years. Our ALiEM-AAEM Social Media and Digital Scholarship produced the very popular multimedia product, AAEM/YPS Rules of the Road. This is an important tool that we provide to our members to help make the transition into their post-residency life as smooth as possible. Under my presidency we also launched "AAEM/YPS EM Flash Facts," an application used to help our members prepare for the EM boards, help educators teach EM topics to students, and assist learners in reviewing important EM topics portably. This was a huge accomplishment that was no easy feat, but a rewarding endeavor in order to provide our members this amazing benefit. On a local level, I am serving as the Cal/AAEM Vice-President. This role allows me the opportunity to be the Co-Director of the San Francisco Speaker Series, a great way for Northern California physicians to network and learn from amazing local speakers.

Also under our YPS belt this year is a very successful Scientific Assembly. We have been working on improving mentor/mentee relationships and are planning on continuing the very successful annual "Mentor/mentee Lunch" at Scientific Assembly in 2017. We are also working to bring back the YPS/RSA Social and will be continuing to host Open Mic. We are always working on new initiatives to provide opportunities to young physicians.

As for my background outside of AAEM, I have completed two fellowships and serve as an Assistant Professor at Stanford. My first fellowship was in International EM, and the second in Academics. I am very honored to have the title of Assistant Residency Director for the Stanford/Kaiser Residency Program. I am also the course director of a Stanford Undergraduate course entitled Introduction to Emergency Medicine. Given my passion for teaching and residents, I look forward to continuing to promote resident education and help shape new EM physicians.

I ask that I be elected as YPS Director, in order to continue utilizing AAEM to advance emergency medicine, provide new resources to its members and support to its youngest physicians. I have served many roles on both RSA and YPS and now look forward to working more closely with the AAEM board. ■



AMERICAN ACADEMY OF EMERGENCY MEDICINE

# Board *of* Directors *Elections*

## Candidate Platform Statements

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

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

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

## Online Voting

New in 2017 ballots will only be available online. We encourage all members to attend the State of the Academy, Town Hall, and Candidates' Forum and all eligible members to cast their vote online. ■

## Important Dates

- Online voting opens: January 23, 2017
- Attend the State of the Academy, Town Hall, & Candidates' Forum: March 17, 2017 from 2:00pm-3:30pm
- Online voting closes: March 17, 2017 at 11:59pm CT ■

# Welcome to MEMC-GREAT 2017!

Lisa Moreno-Walton, MD MS MSCR FAAEM  
Secretary-Treasurer, AAEM  
Executive Chair, MEMC-GREAT 2017



On behalf of the Executive and Scientific Committees, it is my pleasure to welcome you to the 9th Mediterranean Emergency Medicine Congress (MEMC), jointly organized by the American Academy of Emergency Medicine (AAEM), the Global Research on Acute Conditions Team (GREAT), and the Mediterranean Academy of Emergency Medicine (MAEM), to be held in Lisbon, Portugal on September 6-10, 2017.

MEMC-GREAT 2017 is an opportunity to share the very best practices from high-resource countries with mature EM specialties, countries where EM has only recently achieved specialty status, and low-resource countries where dedicated professionals have found ways to deliver the best possible care in austere environments. The Congress is a multinational collaboration of teaching and learning, based on the belief that every country's emergency physicians have knowledge and experience that will benefit all of us. We have so much to learn from each other, and MEMC offers us the opportunity to understand the benefits of a variety of approaches to the practice, teaching, and learning of EM!

The MEMC-GREAT 2017 plenary and concurrent sessions will cover important aspects of emergency medicine — including acute heart conditions, critical care, basic and advanced ultrasound, immigrant and refugee health, tactical and military medicine, current trends in trauma resuscitation, updates in toxicology, the development of prehospital care systems, and so much more. We welcome back some of the most outstanding speakers from past MEMC's, and we will introduce to an international audience some of the best speakers from AAEM Scientific Assemblies. MEMC is honored that Professor Lee Wallis, President of the International Federation of Emergency Medicine (IFEM), has accepted our invitation to give the keynote address. Prof. Wallis is a strong proponent of inclusion in emergency care, and has pioneered the development of EM in Africa. Plenary session speakers include Drs. Amal Mattu, Jim Ducharme, Antoine Kazzi, Peter DeBlieux, Eveline Hitti, and W. Frank Peacock.

But our Congress will not be complete without **you**! We still need speakers for our many and varied tracks, and we have opportunities for less experienced speakers at the Pecha Kucha sessions. As always, we encourage you to submit research abstracts for consideration as oral and poster presentations, using the submission link on our website. *The Journal of Emergency Medicine (JEM)* is sponsoring a poster and oral abstract competition, and the 25 best abstracts (determined by the Abstract Review Committee) will be published in *JEM*. The remaining 25 will be published in the *Western Journal of Emergency Medicine*. The primary authors of the top three abstracts will be invited to deliver a ten-minute oral presentation during the Opening Ceremony. **We need AAEM members to join our GREAT and MAEM colleagues as abstract reviewers, and as moderators for both the didactic tracks and the oral abstract tracks.**

We invite you to explore all that Lisbon and its surrounding area has to offer. Lisbon is renowned for its celebration of history and culture. World-class beaches offer swimming, surfing some of the best waves in the Atlantic, or simply relaxing and catching some sun. Taxis are cheap and buses and trains are just a couple of blocks from the hotel, and can quickly take you to a UNESCO World Heritage medieval village, as well as castles, fortresses, churches and religious sites, an oceanarium, or an amusement park. Modern parks and jogging paths and a zoo are within walking distance of our hotel, and the magnificent bodegas where delicious ports and other wines are produced are only a few hours away. Indeed, Portugal has been voted the best emerging wine region in the world! News about organized bus excursions will soon be available.

So come join us for a unique, cutting-edge, truly diverse educational experience in one of the most enchanting and affordable cities in Europe. Bring your family, and enjoy the best mix of professional and family activities. Our Congress will not be the same without you, so please meet us in Lisbon and allow us the pleasure of welcoming you personally to what we believe will be the best international conference of the year!

To volunteer as a track, PK speaker, abstract reviewer or abstract moderator please contact [info@emcongress.org](mailto:info@emcongress.org). To submit an abstract for presentation at the Congress, please go to our website:

[www.emcongress.org](http://www.emcongress.org). ■

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The IX<sup>th</sup> MEMC is jointly organized by the American Academy of Emergency Medicine (AAEM), the Global Research on Acute Conditions Team (GREAT), and the Mediterranean Academy of Emergency Medicine (MAEM).

**Me  
Mc** MEDITERRANEAN  
EMERGENCY MEDICINE CONGRESS

**GREAT NETWORK CONGRESS**  
FOCUS ON INNOVATIONS AND TRANSLATIONAL  
RESEARCH IN EMERGENCY MEDICINE



# Update from the Lebanese and Mediterranean Academies of Emergency Medicine

Lisa Moreno-Walton, MD MS MSCR FAAEM  
AAEM Board of Directors



The Department of Emergency Medicine at the American University of Beirut (AUB) and the Lebanese Academy of Emergency Medicine (LAEM) held the Second Annual Clinical Updates in Emergency Medicine (EM) Conference in Beirut, Lebanon from Nov 30-Dec 2, 2016. The Conference was supported by the Mediterranean Academy of Emergency Medicine (MAEM) — AAEM's first regional

international Chapter — as well as the Middle East/North Africa Clinical Toxicology Association (MENATOX), the American College of Medical Toxicology (ACMT), and the Emirate Society of Emergency Medicine (ESEM).

The scientific program was organized by Eveline Hitti, MD FAAEM, Chair of the Department of EM at AUB; Gilbert Abou Dagher, MD FAAEM, EM Residency Director at AUB; Ziad Kazzi, MD FAAEM, EM Faculty and Toxicologist at Emory University, with an adjunct faculty appointment at AUB; and Alex Vu, MD, Global Emergency Medicine faculty at Johns Hopkins University. The goals of the conference were to bring clinical updates and current practice guidelines to community emergency physicians in Lebanon and the Middle East, and to integrate emergency nursing into all levels of emergency care.

The conference was attended by 188 community and academic physicians, students, and nurses from Lebanon, the Middle East, and the rest of the world. Drs. Hitti, Kazzi, and Abu-Dagher secured an impressive line-up of some of the top speakers in emergency medicine, such as Professor Judith Tintinalli and an AAEM leadership delegation that included Kevin Rodgers, AAEM President; Lisa Moreno-Walton, AAEM Secretary-Treasurer; and AAEM board members Bob Suter and Terrance Mulligan. Top speakers from our own EM faculty community included Drs. Gilbert Abou-Dagher (EM Residency Director, AUB), Mazen el-Sayed (Medical Director), Jose Lopez (Chair, Cleveland Clinic Abu-Dhabi), Jacques Kobersy (Cleveland Clinic, Abu Dhabi), Brent Morgan (Grady Health Systems/Emory University), Mohamad Moussa (University of Toledo), and Afif Mufarrij (Head of Department of the AUB-Affiliate ED). The AUB Vice-President /Dean was represented by Associate Dean for Education, Professor Kamal Badr.

His Excellency the Lebanese Minister of Health was represented by AAEM's own former President, Professor Amin Antoine Kazzi, founding chair of the AUB Department of Emergency Medicine and the founder and Acting President of the Mediterranean Academy of Emergency Medicine.



Mediterranean Academy  
of Emergency Medicine  
- MAEM -



Lebanese Academy of Emergency Medicine  
LAEM

While most AAEM members know MAEM as a co-organizer of the bi-annual Mediterranean Emergency Medicine Congress (MEMC), few are aware of the critical role that MAEM has played in the development of emergency medicine in the Middle East. In fact, MAEM's work at the American University of Beirut represents the single largest and most successful effort in global emergency medicine development that AAEM has ever seen. **Every single resident and full-time faculty member is a member of AAEM or the AAEM/RSA.**

Through the work of Drs. Kazzi, Hitti, and other dedicated colleagues, a full academic Department of Emergency Medicine has been established at AUB, providing state-of-the-art emergency care and education at standards expected in the US. Led by faculty certified by the American Board of Emergency Medicine, the department developed a four-year residency program that will graduate its second class in June. This residency, under the direction of Gilbert Abu Dagher, MD FAAEM, is one of only three emergency medicine programs outside the United States that is certified by the Accreditation Council for Graduate Medical Education. Many AUB EM residents are already going on to do fellowships in the United States. The Mediterranean and Lebanese Chapters are already having a major impact across the Middle East and around the Mediterranean Sea, and we expect more remarkable accomplishments in years to come. Save time on your calendar for the next AUB-LAEM Conference, in November 2017. ■



(L-R) Drs. Brent Morgan, Lisa Moreno, and Ziad Kazzi (left to right) enjoy a faculty break and celebrate the Christmas season at the Mir Amin Palace.

## AAEM/RSA President's Message

## Lessons from My First Lobbying Experience

Mary Haas, MD  
AAEM/RSA President



In December I traveled to D.C. with the AAEM Board of Directors, for my first Advocacy Day. I admit I did not know what to expect, and although I looked forward to actively advocating for our specialty, the idea of lobbying intimidated me. Would I know how to “speak the language?” How would I make Congressional staffers understand the importance of our cause, let alone care about it? I was both excited

and nervous for this new and very important experience.

It was eye-opening and incredibly educational. On the morning of our visit to Capitol Hill we reviewed our big issue, due process, one of critical importance for emergency physicians. “Due process” refers to a fair hearing in front of peers on the hospital medical staff, prior to the termination of a physician's privilege to practice there.

Although due process is important for many reasons, the most important is that it allows us to do the right thing for our patients without the fear of being unfairly terminated. With the increasing corporatization of medicine and expansion of CMGs (contract management groups, such as EmCare and many others), there is increasing pressure on emergency physicians to practice in a way that puts profit first. As providers to the most vulnerable patients and the safety net for the most under-served, emergency physicians must be able to practice in a way that puts patients first — as physicians have sworn to do for millennia. We must fight to protect our professional ethics.

As we lobbied for due process, I walked away with a few key points about successful lobbying on the Hill that I will take with me to future Advocacy Days.

### Make it personal.

At the beginning of each meeting, we provided the staffer with our cards so that they had our names and contact information. We opened each meeting by introducing ourselves and identifying our home states. We asked each staffer about themselves and their background. One was in the process of applying to medical school. Identifying such common ground allowed us to more effectively engage him in the conversation. As emergency physicians, connecting with others quickly is our strong suit, and we can use this to our advantage when advocating for important issues.

### Provide anecdotes.

Another important strategy is to provide specific stories that illustrate the problem and its solution. When discussing due process we shared

examples of emergency physicians who have been unfairly terminated for trying to take good care of patients, such as Dr. Wanda Cruz, an emergency physician who was fired from her job in Florida for answering her hospital CEO's questions about dangerous conditions in the ED. She was fired the next day, after the hospital CEO called the CMG to discuss recent cutbacks in coverage. Telling a story makes the issue real, and helps non-physicians understand its importance.

### Don't just talk, have a conversation.

When lobbying, it is easy to talk at someone for 30 minutes, but much less effective than having a conversation. The advice I received was to talk for a few minutes, ask a question to engage the person we were speaking with, and then provide additional thoughts and details.

### Do your homework and know the issue.

While providing specific anecdotes is necessary and powerful for making a point, numbers and statistics also have their place. The more you have researched your issue and know about the topic, the less intimidating it is to speak about it and the easier it is to speak with passion and conviction. I spent time prior to our lobbying sessions reading about due process, and that gave me a much greater appreciation for the topic and a deeper understanding of it.

To a seasoned lobbyist my learning points may seem obvious. Lobbying is rarely discussed in

residency, however, and advocacy is not a major focus of the curriculum. Many residents will never acquire the skills to be an advocate, unless they take it upon themselves to seek knowledge about the issues facing our field and the means by which to make change happen. This is critically important, however, as we are the future of our field. We have a duty to ourselves, our colleagues, and most importantly our patients to have a voice and use it effectively. One of the most important benefits of RSA is its ability to fill this gap in residency education by providing advocacy resources and opportunities. We are working on expanding Advocacy Day this year, to include a day of didactics to facilitate and maximize the lobbying experience. RSA also continues to offer the Congressional Elective in D.C. ([www.aaemrsa.org/leadership/opportunities-for-involvement/congressional-elective](http://www.aaemrsa.org/leadership/opportunities-for-involvement/congressional-elective)).

As for due process, AAEM will continue to work with both Congress and CMS to make it an undeniable right under Medicare's Conditions of Participation, so that emergency physicians cannot be forced to waive due process and peer review in employment contracts. If you would like to learn more about due process, listen to Larry Weiss's excellent podcast on the website under the publications/podcasts tab. ([www.aaem.org/publications/podcasts/emergency-physician-advocates](http://www.aaem.org/publications/podcasts/emergency-physician-advocates)). ■



L-R: Matt Hoekstra, Williams & Jensen; Mary Haas, MD; Brian Potts, MD MBA FAAEM; Kevin Rodgers, MD FAAEM

## AAEM/RSA Editor's Message

## Point-of-Care Ultrasound

Aaron C. Tyagi, MD

Vice-Chair, Social Media Committee



It is the start of your shift. You are just starting to get settled in after taking sign-out, when one of the nurses comes over and says he needs a physician in room 22 immediately!

You enter the room to find a patient in obvious distress, diaphoretic, tachypnic, sitting straight up in the bed. You immediately assess his ABCs. He exhibits

severe dyspnea but his airway is intact. He has a generous amount of soft-tissue for a neck, so it is difficult to assess his trachea. You move on to his breath sounds. They are somewhat decreased on the right compared to the left, but there are some audible breath sounds on the right — though they may be transmitted sounds. No adventitious sounds. Peripheral pulses are palpable and fast. Vital signs show a heart rate of 112, a respiratory rate of 29, blood pressure in the 140s/90s, and a SpO<sub>2</sub> of 94% on room air.

What do you do now? Wait for a “STAT” chest X-ray? Place a chest tube on the side with decreased sounds and ask questions later? Or do you grab your bedside ultrasound and perform a quick, focused assessment of vital structures? Currently in a case like this, many may elect to go for a handy ultrasound, as the use of point-of-care ultrasound (PoCUS) is

**“The ACGME recently added “emergency department bedside ultrasound” to the list of required procedures an emergency medicine resident must have documented in order to graduate.”**

now firmly established as a diagnostic adjunct in the typical emergency physician's toolbox.

Commonly utilized in blunt trauma assessment (FAST and eFAST), PoCUS has evolved to aid in the diagnosis of a wide range of pathology. Just type “pocus” into ClinicalKey or another search-engine, and numerous articles describing the use of PoCUS for ocular pathology (retinal detachment), orthopedic injuries (shoulder dislocations), and procedures (nerve blocks, central venous catheters) will pop up. Many studies detail how PoCUS improves our time-sensitive diagnostic ability and reduces the risk of complications during common procedures, such as central venous catheterization.<sup>1,2</sup>

This has gone hand-in-hand with increasing degrees of training in PoCUS. Fellowships and other certifications in ultrasound exist for those who wish to pursue them. That, coupled with the explosion of Free Open-Access Meducation (FOAMed), has produced great articles and resources such as 5MinSono, where Drs. Jacob Avila and Ben Smith demonstrate the many exams that can be completed at the bedside in short video tutorials.

Another great off-shoot of PoCUS is the development of protocols for the detection and identification of pathology. Examples of such protocols are BLUE/FALLS, RUSH, and eFAST. These are evidence-based aides that increase our diagnostic capability and decrease radiation exposure for our patients.<sup>3</sup>

As I go through residency training, I have noticed that some programs have dedicated ultrasound blocks, others offer ultrasound electives, and still others have no dedicated ultrasound curriculum but build that training into regular ED time. The minimum number of studies is 150. This can be found at the ACGME website, under Portals and FAQs for EM. Additionally, medical schools such as UC-Irvine are proposing four-year ultrasound curricula for their medical students.<sup>4</sup> Beginning with an interest group and then a rotation for fourth-year medical students, this gained so much popularity at UC-Irvine that faculty and administrators noticed and formulated a dedicated longitudinal curriculum for those interested.



Developments like these are encouraging and exciting for an emergency medicine trainee like me to see, as a hopeful future leader in our field and in medical education. While having minimum requirements and dedicated rotations is a good start, using ultrasound and PoCUS on a daily basis is where true proficiency comes from. I envision of a future in which all emergency physicians are experts in PoCUS, and interpreting ultrasounds is as routine for us as reading an EKG.

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## Resident Journal Review

# Updates in Pharmacology: Interactions and Adverse Effects of Psychiatric Medications

Authors: Erica Bates, MD; Philip Magidson, MD MPH; Robert Brown, MD; Megan Donohue, MD; Akilesh Honosage, MD

Editors: Michael C Bond, MD FAAEM; Kelly Maurelus, MD FAAEM

## Introduction

Over the past decade, the number of psychiatric medications dispensed has increased dramatically and now annually numbers in the tens of millions. As emergency physicians now frequently encounter patients on psychiatric medications, understanding potential complications and potentially life threatening reactions is necessary. This journal review covers common potential side effects, adverse reactions, and drug-drug interactions of various psychiatric medications commonly found in the ED.

**Gill SS, et al. Syncope and its consequences in patients with dementia receiving cholinesterase inhibitors: a population-based cohort study. *Arch Intern Med.* 2009 May 11;169(9): 867-73.**

Worldwide, over 24 million patients have dementia and many are prescribed cholinesterase inhibitors. While the true efficacy of these medications is still being determined, the side effect profiles are well known and frequently not discussed. Syncope is a one common side effect resulting in increased morbidity and health care utilization. The authors of this study sought to identify the relationship between the use of cholinesterase inhibitors and syncope-related outcomes.

This large, population-based cohort study was conducted in Canada. The investigators used a health care database system to identify 19,803 community dwelling adults over the age of 65 with a diagnosis of dementia who had been prescribed a cholinesterase inhibitor. Specifically, these medications were donepezil, galantamine, and rivastigmine. The same database was also used to establish a control group of 61,499 patients with dementia and similar demographics who had not taken the aforementioned medications within the year preceding study enrollment. These two groups were then analyzed for four main outcomes: hospital visits for syncope, hospital visits for bradycardia or complex atrioventricular block, premature pacemaker insertion, and hip fracture.

The results showed that patients receiving cholinesterase inhibitors were more likely than controls to experience each complication, specifically, for a hospital visit for syncope (31.5 vs 18.6 events per 1,000 person years; adjusted hazard ratio, 1.76; 95% CI, 1.57-1.98); for a hospital visit for bradycardia (6.9 vs 4.4 events per 1,000 person-years; hazard ratio 1.69; 95% CI 1.32-2.15); for permanent pacemaker insertion (4.7 vs 3.3 events per 1,000 person-years; hazard ratio 1.49; 95% CI 1.12-2.00), and for hip fracture (22.4 vs 19.8 events per 1,000 person-years; hazard ratio 1.18; 95% CI 1.04-1.34).

Cholinesterase inhibitors increase vagal tone, which can lead to syncope. Although the study findings are observational, they are consistent with the pharmacologic mechanism and resulting physiologic response one could expect in patients taking these medications. While EPs typically do not prescribe these medications, we should be aware of their side effect profile. As many dementia patients are poor historians, the EP may

have to perform a record review or contact family in order to determine the patient's medication list. Identifying a potential cause for syncope or bradycardia in the ED may allow patients to forego potentially invasive procedures, such as pacemaker insertion, when something as simple as a medication reconciliation might accomplish a similar goal.

**Dols A, et al. The prevalence and management of side effects of lithium and anticonvulsants as mood stabilizers in bipolar disorder from a clinical perspective: a review. *Int Clin Psychopharmacol.* 2013 Nov;28(6): 287-96.**

Medication side effects are distressing to patients and are often a cause of poor compliance. This is particularly true of mood stabilizing agents, including lithium, valproate, lamotrigine, and carbamazepine. This paper reviewed side effects of these medications, all commonly used for the treatment of acute mania or bipolar depression. The authors reviewed all PubMed publications that reported data on side effects in patients with bipolar disorder through December 2012. Side effects were reviewed systematically including neurologic, gastrointestinal, metabolic, endocrinologic, nephrogenic, dermatologic, cognitive, sexual, hepatologic, hematologic, and teratogenic. Of note, this study did not review efficacy of medications on treatment of the underlying mood disorder.

Tremor is the most common neurologic side effect and is present in up to 65% of patients using lithium and 1-6% of those on valproate. Prevalence is decreased by avoidance of caffeine, nicotine, and SSRIs or with the concomitant use of propranolol or vitamin B<sub>6</sub>.

Gastrointestinal side effects including nausea, vomiting, and diarrhea occur in up to 50% of patients taking lithium or valproate.

Hypothyroidism is the most common endocrine side effect and occurs in 5% of patients taking lithium, which inhibits thyroid hormone secretion by several mechanisms. This usually develops within the first few years of treatment, and up to 2% of lithium-treated patients require treatment with levothyroxine. Additional risk factors for the development of hypothyroidism include iodine deficiency, cigarette smoking, and the presence of autoantibodies. Valproate and carbamazepine may less commonly result in hypothyroidism.

By inhibiting ADH, lithium may cause nephrogenic diabetes resulting in polyuria, dehydration, thirst, and polydipsia. Use of lithium for ten or more years is also associated developing chronic renal failure. Therefore, monitoring of renal function and lithium levels is imperative.

Cognitive side effects including loss of memory and motor speed have been most studied with lithium. The previously discussed side effect of hypothyroidism may also result in cognitive decline. After excluding other potential causes of cognitive decline, therapeutic strategies such as

Continued on next page



focusing attention, rehearsing information, use of mnemonics, and use of visual concepts may help patients manage cognitive side effect.

Sexual side effects, primarily decreased sexual desire, have been reported in up to 14% of patients taking lithium. Carbamazepine may have this effect by increasing sex hormone-binding globulin, which can diminish the activity of sex hormones. Few options exist to counteract this side effect, but alternative medications for bipolar such as oxcarbazepine or lamotrigine have not been associated with changes in hormone levels.

Hepatologic side effects usually manifest as asymptomatic transaminitis or hyperammonemia and are both dose related. These occur in up to 40% of patients taking valproate, though severe hepatotoxicity is very rare. Valproate induced hepatic encephalopathy marked by tremor, ataxia, drowsiness and disorientation is also rare and carnitine is being explored as a treatment.

Transient leucopenia is most notable hematologic effect of mood stabilizers, occurring in approximately 10% of patients taking carbamazepine. White blood cell counts may decline by 25% but usually return to baseline without discontinuation of therapy. Carbamazepine should only be discontinued if the WBC falls below 3,000, neutrophils fall below 1,000, or infection is present.

Many mood-stabilizing agents are teratogenic, particularly during the first trimester. Lithium increases the risk of cardiac abnormalities, such as Ebstein's anomaly, 10-20 fold. Valproate use during the first trimester is associated with a 5-9% risk of neural tube defects, as well as atrial septal

defects, cleft palate, hypospadias, polydactyly, and craniosynostosis. Carbamazepine is associated with a 1% risk of spina bifida, total anomalous pulmonary venous return, cleft lip, diaphragmatic hernia, and hypospadias. Lamotrigine use is the only mood stabilizer reviewed here that did not increase risk of major birth defects. Patients taking mood stabilizers who are found to be pregnant may require medication adjustment or substitution. However, medications should not be stopped abruptly; rather the patient should be strongly encouraged to discuss their medications and pregnancy with their psychiatrist.

Fortunately, most side effects of mood stabilizers are temporary and diminish over time. Prevalence is decreased by use of extended release formulations, temporary dose reduction, and slow titration. Risk of side effects increase with patient age and medication dose. Therefore, it is worth remembering that when used in combination valproate can increase lamotrigine levels and carbamazepine can lower lamotrigine levels. This review serves as a reminder that mood stabilizers may be the cause of various symptoms which patients seek ED evaluation. Awareness of the side effect profile of these medications can help EPs formulate a more complete differential diagnose and treatment plan for these patients.

**Warnock JK, Morris DW. Adverse cutaneous reactions to mood stabilizers. *Am J Clin Dermatol*. 2003 Jan 4(1): 21-30.**

Mood stabilizing medications, such as carbamazepine, valproate, topiramate, gabapentin, and oxcarbazepine, are associated with a higher

Continued on next page

**DON'T MISS**  
the YPS and RSA  
Session  
at AAEM17

**Sunday, March 19, 2017**  
10:15am-3:20pm

Be sure to attend the joint AAEM/RSA (Resident & Student Association) and YPS (Young Physician Sections) session for specialized talks on:

10:15am-11:25am	Specialties Fellowship Panel
11:35am-12:05pm	Social Media: Taming the Beast
1:30pm-2:00pm	Three Financial Tips That EVERY Young Doctor Needs to Know
2:10pm-2:40pm	Financial Expert Panel
2:50pm-3:20pm	Three Bedside Teaching Pearls to Bring to Your Next Shift



risk of severe cutaneous reactions than many other psychotropic medications. This article reviewed dermatologic complications of mood stabilizers, which can range from benign skin eruptions to life-threatening reactions.

Exanthematous rash, an erythemic maculopapular eruption often resembling measles, is a relatively common (>1%) side effect of mood stabilizers. This rash may spread across the entire body, including the mucosa, palms, and soles. Carbamazepine, valproate, topiramate, and gabapentin are also associated with photosensitivity reactions in sun-exposed areas, typically occurring within several days of starting the medication. The phototoxic form causes erythema, edema, hyperpigmentation, and possible desquamation in exposed areas. Photoallergic reactions occur one to two weeks after medication initiation and produce an immunologically mediated response which can include papular, vesicular, eczematous, lichenoid, bullous, or urticaria lesions. Carbamazepine, lithium, valproate, gabapentin, and oxcarbazepine are associated with drug induced alopecia and psoriatic eruptions. Drug discontinuation generally improves both conditions, although patients with more extensive or severe symptoms may need additional treatment by a dermatologist.

Carbamazepine, lamotrigine, oxcarbazepine, and valproate are associated with systemic hypersensitivity reactions. These events generally occur within two months of starting the medication and are characterized by fever, rash, and organ dysfunction, such as hepatitis or renal impairment. Patients may initially present with fever, malaise, and pharyngitis before onset of the rash, making the diagnosis more challenging. Treatment includes discontinuing the trigger medication, systemic steroids, and antihistamines.

Erythema multiforme is a cutaneous condition characterized by red macules, papules, vesicles, and most classically by target lesions, which can be distributed symmetrically over the body. It generally occurs within days of medication use and is associated with carbamazepine, valproate, lamotrigine, gabapentin, and oxcarbazepine. The lesions may progress to mucosal involvement and subepidermal separation of up to 10% of body surface area (BSA). If suspected, the medication in question must be immediately discontinued. Dermatology should be consulted and the patient should be monitored closely for progression.

Steven Johnson Syndrome (SJS) and Toxic Epidermal Necrolysis (TEN) are life-threatening conditions marked by subepidermal desquamation of the skin and mucosal surfaces. Skin loss involving 10-30% BSA is considered SJS, and >30% BSA sloughing is classified as TEN. These patients face similar risks as severe burn patients such as fluid loss, electrolyte disturbance, and severe infection. SJS carries a 10% mortality rate, which increases to 45% with TEN. Care includes immediately stopping the responsible medication, pain control, fluid and electrolyte replacement, infection management, and typically transfer to a burn center. Of note, concomitant use of lamotrigine and valproate or carbamazepine increases the risk of SJS and TEN.

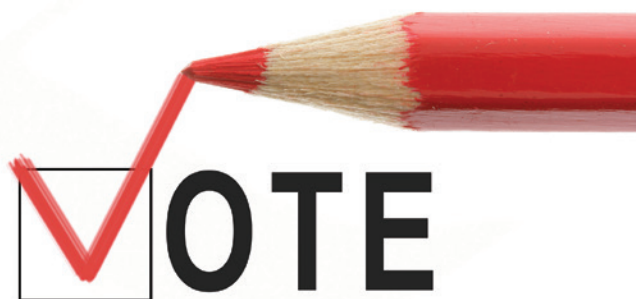
As mood stabilizing drugs are associated with multiple cutaneous disorders, some deadly, a high index of suspicion and thorough medication history is necessary for all patients who potentially takes these medications.

**Rasimas JJ, Liebelt EL. Adverse effects and toxicity of the atypical antipsychotics: what is important for the pediatric emergency medicine practitioner. *Clin Pediatr Emerg Med* 2012 Dec 1; 13(4): 300-310.**

Continued on next page

## AAEM/RSA 2017-2018 Board of Director and Medical Student Council Elections

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Use of Atypical antipsychotic (AAP) medications, such as risperidone, aripiprazole, and olanzapine, in children of all ages has significantly increased over the past two decades. In 1996, 6.8% of all antipsychotics prescribed in children were AAPs while in 2001 95.9% are AAPs. This increase in prescriptions can be explained by the growing list of conditions that show benefit with atypical antipsychotics, including acute agitation, psychosis, bipolar disorder, ADHD, oppositional defiant disorder, conduct disorder, and autism. However, with this large increase in use comes a significant increase in ED visits for side effects and overdoses.

First generation, or typical, antipsychotics are classified as either high or low potency based on their affinity for the Dopamine 2 (D2) receptor. Higher potency D2 receptor antagonism, as seen with haloperidol, results in a higher rate and severity of extra pyramidal symptoms (EPS). Lower potency antipsychotics, such as chlorpromazine, have a larger anticholinergic effect and thus are able to counteract the risk of EPS, but have a resultant increase in antimuscarinic effects. AAPs have even lower potency for the D2 receptor, and add 5-hydroxytryptamine (5-HT) receptor antagonism. This lowers the incidence of EPS but increased the overall number of potential side effects.

Acute dystonic reactions such as oculogyric crisis, torticollis, or laryngeal dystonia can develop within hours to weeks of initiating or changing dosages and can often be mistaken for a seizure. Neuroleptic malignant syndrome (NMS) can occur with all antipsychotics. NMS often presents within two to four weeks of beginning treatment or changing dosage, but can also occur with dehydration or febrile illness. Other side effects such as akathisia, Parkinsonism, and tardive dyskinesia can often be mistaken for other psychiatric or neurological disorders.

Most AAPs are associated with significant weight gain, insulin resistance, and dyslipidemia. These effects are most common with clozapine, olanzapine, risperidone, quetiapine, and aripiprazole. These effects can be socially debilitating, especially for children.

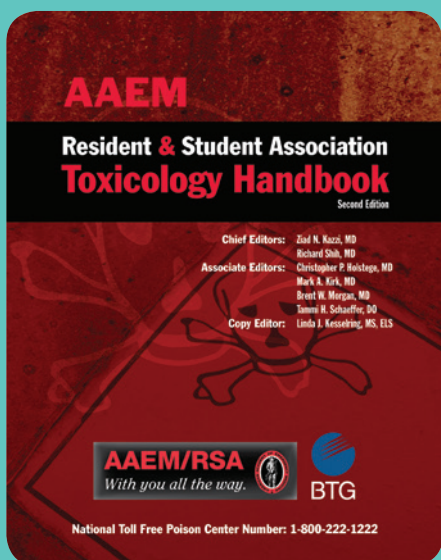
AAPs are also associated with QT prolongation and complications from this such as torsades de pointes. Without an underlying genetic QT prolongation, the changes caused by AAPs are often not lethal; however, they may be in patients with underlying cardiac disease. Screening electrocardiograms are controversial, especially in children without underlying cardiac disease, but a thorough family history of sudden death or prolonged QT should be taken before starting any patient on antipsychotics.

AAPs have a higher incidence of anticholinergic and antimuscarinic symptoms. Such as dry mouth, urinary retention, orthostatic hypotension, and dizziness. All antipsychotics, including AAPs, may also lower the seizure threshold.

ly in recent years. Although respiratory depression is uncommon, central nervous system (CNS) symptoms may include drowsiness, somnolence, or coma. The anticholinergic side effects can manifest as agitation, delirium, or hallucinations. Cardiovascular symptoms may include tachycardia, hypotension, and QT prolongation. However, there have been no known cases of torsades in children due to acute overdose. Management is largely supportive, but activated charcoal can be used if ingested within one to two hours. Whole bowel irrigation may be useful in ingestions of sustained release formulations. In rare circumstances, lipid emulsion may even be considered. Treatment should be based on cardiopulmonary monitoring and correction of electrolyte abnormalities.

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**Ramsey TD, Lau TT, Ensom MH. Serotonergic and adrenergic drug interactions associated with linezolid: a critical review and practical management approach. *Ann Pharmacother.* 2013 Apr; 47(4): 543-60.**

This literature review was drawn from English language articles in PubMed, MEDLINE, EMBASE, and International Pharmaceutical Abstracts to describe human studies of serotonergic and adrenergic drug interactions with linezolid. The authors analyzed three prospective, randomized controlled trials, six retrospective studies, and 31 case reports for signs of serotonin toxicity as defined by the Hunter Serotonin Toxicity Criteria or Sternbach's Criteria. They used the Horn Drug Interaction Probability Scale to assess the probability of drug interactions in case reports. The number of healthy volunteers in the three prospective studies was small (14 each for interactions of linezolid with dextromethorphan, propanolamine, and pseudoephedrine). There were 32 cases identified from the retrospective studies and case reports, the former pooled from phase 3 and 4 randomized controlled trials and chart reviews with more than 5,000 patients.

The authors conclude there are no clinically relevant interactions between linezolid and dextromethorphan, phenylpropanolamine, or pseudoephedrine, though the latter two do raise average blood pressure 14 and 32 mmHg respectively. The incidence of serotonin syndrome in the largest retrospective analysis was 0.24% and not significantly different from a comparator control. The incidence from chart reviews calculated from much smaller populations of from 24-72 patients showed incidence rates as high as 4% for medications such as sertraline, venlafaxine, mirtazapine, and buspirone. Case reports existed for interactions with bupropion, diphenhydramine, and hydroxyzine resulting in severe hypertension and

delirium. Among all cases studied, there were two deaths but the cause of death was not clearly linked to the drug interaction and in all other cases symptoms resolved within 10 days. Case reports described a washout period to avoid drug interactions and found persistent risk as distant as 18 days after withholding fluoxetine. A dose-response increased risk was not observed.

Conclusions from this paper are that the incidence of serotonin syndrome may be much lower than the previously estimated level of 25%. Linezolid associated serotonin syndrome appeared to have a low mortality but propensity and severity of the condition appeared multi-factorial and in some ways patient-specific, leading the authors to suggest clinicians should be familiar with signs of serotonin syndrome and educate their patients to report these early. Typical treatment for serotonin syndrome includes cyproheptadine or benzodiazepines. It is also noteworthy that phenytoin is not first line therapy for seizures in serotonin syndrome and propranolol is discouraged for treating hypertension as it may provoke shock from autonomic dysregulation.

### Conclusions

Psychiatric medication use is common in the U.S. population, and EPs should be aware of potential side effects of these drugs in both adults and children. Although EPs are unlikely to prescribe many of these medications directly, patients may present first to the ED with complications. A careful medication history and mindfulness of potential interactions with other drug classes, such as antibiotics, are important for patient safety and can minimize morbidity and mortality. ■



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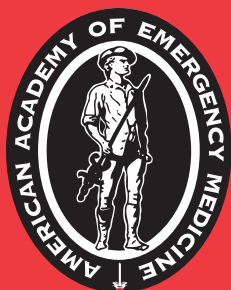
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