VOICE
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

VOLUME 23, ISSUE 6
NOVEMBER/DECEMBER **2016**

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INSIDE

COMMONSENSE

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AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Please visit www.aaem.org for special eligibility criteria)
International Member: $150 (Non-voting status)
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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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AAEM-0916-414

President's Message

The EMR — the Good, the Bad, and the Ugly

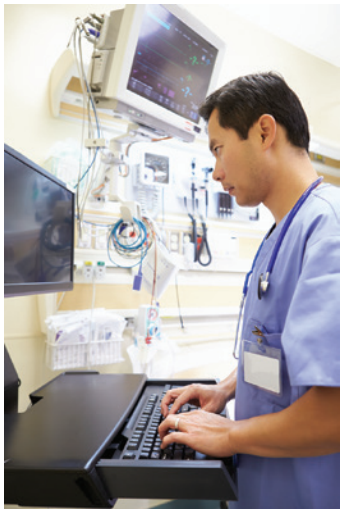
Kevin Rodgers, MD FAAEM
AAEM President

Thanks to the many Indiana University EM Faculty and Alumni who recently participated in a passionate Listserv discussion on the EMR, which provoked this article.

Some days the EMR is your best friend — when it catches an incorrect drug dosage — and some days your worst enemy — can you say "downtime"? As we continue to examine the culprits behind physician burnout, the EMR is high on the list. Many senior physicians I know have retired early based on their experiences with the EMR, and its erosion of their prime motivation for entering medicine in the first place —the patient-doctor relationship. The AAFP President was quoted as saying, "The current system is making me an expensive secretary and data-entry clerk. The burnout comes from the fact that I want to practice medicine, I don't want to treat a computer and interact with an insurance company." A 2013 study from Johns Hopkins showed that interns spent less than ten minutes a day with each hospitalized patient, versus hours in front of a computer screen. Bottom line: our health care system is losing its humanity amid increasingly automated and computer-driven patient interactions (see *The Wall Street Journal*, "Turn Off the Computer and Listen to Your Patient," Caleb Gardner and John Levinson, September 2016).

The fast-paced world of EM unfortunately highlights several of the detrimental effects of the EMR, as it impacts our ability to quickly form an effective interpersonal relationship with our patients. In an attempt to improve efficiency and satisfy the documentation demands of the EMR, many physicians now drag a WOW (workstation-on-wheels) into the patient's room. More than once I have observed an EM resident take an entire history from a patient and never once make eye contact! In a specialty where focused histories and the observation of visual cues impacts our ability to make the correct diagnosis, the EMR and WOW often stand in the way. That said, there are some emergency physicians who are quite skillful at utilizing the WOW in a way that also allows them to make a personal connection with the patient, as well as observe the patient's behavior — not a skill easily or quickly perfected. Composing an EMR on a WOW while simultaneously interviewing the patient is akin to texting and driving, and that's against the law! The power of observation cannot be over-stated. A colleague who uses scribes related a recent incident, in which his direct observation of a very subtle change in the behavior of a five month-old led him to do a lumbar puncture and diagnose bacterial meningitis. How often do the nuances of electronic templates cause us to prematurely anchor on a single diagnosis and exclude the correct diagnosis?

Who knew in 2009, when Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, that keyboarding would become one of the most essential skills required of physicians? Who knew it would spur the dramatic expansion of three industries: the work-station-on-wheels, scribes, and voice recognition software? Who knew how many physician-hours would be spent compiling EMRs and the impact that would have on direct patient interaction? The answer to these dilemmas, as well as the answer to establishing an effective relationship with the patient, is scribes — if you can afford them.



This is not to say we're not our own worst enemies. The size of the data dump that populates the EMR, both generated by the EMR's author and collected from other electronic sources, is truly incredible. The level of detail our type A personalities force us to include … and much of it has zero impact on patient outcome or satisfaction. The ability to write or dictate a succinct, medico-legally sound record that can also be appropriately coded is a lost art, gone with the paper chart. As for wellness, how many extra hours are you spending after work doing charts? Another colleague provided this perspective, "I've never been thanked by a patient for charting more. My family never thanks me for staying late to chart."

So, another multifactorial problem: the EMR and WOWs may be the devil, but physicians are not without blame. This is an issue that threatens both the doctor-patient relationship and the quality of care, and a potential advocacy issue for AAEM. Physicians need to drive the development of future EMR regulations and the implementation of evidence-based best practices. We can sit back and let another billion-dollar enterprise take advantage of us (CMGs were first), or we can work collectively to effect the development of an efficient, effective, and easy-to-use EMR for EM. AAEM is considering launching an EMR Best Practices Sub-Committee that will evaluate and compile best practices for the EMR, as well as engage with CMS, other regulatory agencies, and third party payers in a meaningful discussion that will drive future EMR requirements for emergency physicians. Please let me know what you think, especially if you would like to join: krodgers@aaem.org.

I know many emergency physicians have enjoyed Ed Leap's articles over the years. In celebration of EMRs and for anyone who has or will implement a new EMR system:

Continued on next page

A Go-Live Prayer by Edwin Leap

Reprinted with permission

Lord, maker of electrons and human brains, help us as we use this computer system, which You, Sovereign over the Universe, clearly saw coming and didn't stop.

Thank you that suffering draws us to you.

Thank you for jobs, even on bad days.

Forgive us for the unnecessarily profane things we have said, or will say, about this process.

As we go forward, we implore you: Let our tech support fly to us on wings of eagles and know what to do.

May our passwords and logons be up to date.

Protect us from the dreaded 'Ticket' submitted to help us.

May our data be saved, not lost.

Let the things we order be the things we have.

Shield us from power loss, power surge, virus and idiots tinkering with the system.

Give our patients patience to understand why everything takes three hours longer.

And may our prescriptions actually go to the pharmacy.

Keep us from rage and tirades.

Protect the screens from our angry fists.

May everyone go home no more than two or three hours late.

And keep our patients, and sanity, intact.

Great physician, great programmer, heal our computers.

Amen ■

AAEM Antitrust Compliance Plan:

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

The Moral Arc

Andy Walker, MD FAAEM
Editor, *Common Sense*

We shall overcome because the arc of the moral universe is long, but it bends towards justice.
— Martin Luther King, Jr.

Above are the inspiring words of a brave man, who successfully accomplished his moral crusade even at the cost of his life. But is King's statement true? I fear not. The universe is chaotic, indifferent, and unfeeling. It doesn't have morals. People have morals — well, most people. Unfortunately, people often rationalize the worst kind of behavior to protect their economic self-interests. If the arc of the moral universe is to be bent towards justice, brave and principled people must exert will and effort to do it, and be willing to take chances and make sacrifices to overcome those who put their greed above the just interests of others.

Emergency medicine provides examples of both kinds of people, those trying to bend the arc towards justice and those profiting from injustice. In general, we are a specialty to be proud of. While we sometimes complain about the people who don't need us but crowd our emergency departments, we eagerly and even cheerfully take care of any patient who does need us — the acutely injured and seriously ill — without regard to their ability to pay for our services. And we were doing that as a matter of professional ethics long before EMTALA became law. In my pre-EMTALA experience, it was hospital administrators and on-call physicians, not emergency physicians, who were behind the improper transfer of patients for financial reasons. According to a 2003 report from the Center for Health Policy Research ("The Impact of EMTALA on Physician Practices," by Carol Kane, PhD), in the year 2000 the average emergency physician in the United States donated over $138,000 worth of EMTALA-mandated care — more than ten times the average of all specialties. Sixteen years later, that number is undoubtedly even higher. Emergency medicine has every right to be proud. We uphold the finest traditions of the medical profession, often taking care of patients no one else wants, at times when no one else wants to be there.

Our specialty, however, also has those on the other side. Those who ignore the oath they swore upon entering the medical profession, who prey on and exploit their colleagues for profit. Those who have become wealthy, not from taking good care of difficult patients at inconvenient times, but from picking the pockets of those who are doing that work. If you work for a corporate staffing company — or for some individual contract holders who are just as bad — you are a victim of those on the wrong side of the moral arc. On average, staffing corporations keep over 20% of the professional fees they collect for your services — and that is after they charge you for services actually rendered, such as malpractice insurance and coding & billing. And adding insult to injury, those services are usually provided by a subsidiary of the staffing company that charges you above-market rates. In practical terms, you are working a shift per week entirely for the company. Over the course of a 30-year career, that will cost you two to three million dollars when opportunity costs are included. The emergency physicians who serve in mid-to-upper management positions in such companies should be ashamed, but less ashamed than the emergency physicians who founded, own, or are CEOs in those corporations.

Just as individual emergency physicians have to make a moral decision about what they are willing to do for financial gain, so do the professional societies that represent them. I believe that AAEM is on the right side of the moral arc. That's why I joined in 1993. It is my personal opinion that ACEP is too often on the wrong side. In fact, I believe that ACEP more often represents corporate interests than the interests of individual emergency physicians. That's why I resigned my membership and renounced my status as a Fellow in the mid-1990s, after a decade of membership. I have seen too many good, principled emergency physicians — many who were members of ACEP — come to AAEM for help after first appealing unsuccessfully to ACEP. Some of those were about to have their independent groups wiped out in a corporate take-over. Some, like Dr. Wanda Espinoza Cruz, were apparently fired without peer review or due process for trying to protect their patients (www.tampabay.com/news/health/doctor-says-she-was-fired-for-reporting-low-staffing-at-brandon-regional/2218497).

"Just as individual emergency physicians have to make a moral decision about what they are willing to do for financial gain, so do the professional societies that represent them. I believe that AAEM is on the right side of the moral arc."

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I am not suggesting you should resign from ACEP. Many members of the Academy, including members of its board of directors, are members of the College too. Since it is bigger and richer, there are practical and legitimate arguments for being part of ACEP. So, what do I want?

First, I want you to clearly understand the differences between the Academy and the College, and why it is so important for emergency physicians and our specialty that the Academy continues to grow. AAEM is always on the side of individual emergency physicians and the patients they serve, not corporations. AAEM doesn't accept advertising or sponsorship from staffing corporations that exploit emergency physicians, so it never has a conflict of interest. AAEM doesn't have the founders, principle stockholders, or CEOs and other officers of staffing corporations in leadership positions. If you think that is also true of ACEP, you are wrong.

For the sake of brevity, let's look at just one example: EmCare. Leonard Riggs, once ACEP's president, founded EmCare — now part of Envision Healthcare (www.texacep.org/?page=ppleonardriggs). Dighton Packard, twice president of ACEP's Texas chapter, is chief medical officer for EmCare and Envision (www.emcare.com/about/leadership/dighton-c-packard,-md,-facep). ACEP's current president, Rebecca Parker, is an executive vice-president for EmCare and a senior vice-president for Envision (www.emcare.com/about/leadership/rebecca-parker,-md,-facep).

Just go to EmCare's website (www.emcare.com/about/leadership) and look at how often you see FACEP following the names of its physician-leaders, compared to FAAEM.

> "Destroying independent, democratic emergency physician groups … groups that didn't unfairly exploit their docs, deprive them of peer review and due process, or bind them with post-employment restrictive covenants. I believe that does cross the ethical line, and violates our profession's ethical demand that we treat our colleagues like family."

Second, if you are a member of ACEP, I want you to do whatever you can to make the College better. Yes, even I, a nonmember, want ACEP to be better than it is — an ethically cleaner, less conflicted, more reliable advocate for individual emergency physicians. ACEP is the biggest and wealthiest professional society of emergency physicians in the United States. All of us will be better off with a better ACEP. It will be much easier for AAEM to bend the arc of the moral universe towards justice for emergency physicians if ACEP is helping. That is unlikely to happen if those who lead ACEP are on the wrong side of the arc. ■

Letters to the Editor

Letter in Response to the President's Message "Physician Burnout or Physician Resiliency?" in the July/August 2016 Issue

After reading the article titled "Physician Burnout or Physician Resiliency?" I have come to the conclusion that the issue of physician burnout will not be solved without completely revolutionizing the way our profession views the problem. Most proposals look at the problem of physician burnout as a physician problem. The article adds to this myth by identifying resiliency on the part of a physician as a solution. Such solutions simply continue to enable failure by decision makers in health care by giving them the tools to maintain the status quo and act as if something is being done to address the issue.

The reality of emergency physician burnout is that it is a workplace issue caused by a number of factors: understaffed emergency departments, difficult to use electronic medical records, slow computers and networks, unresponsive consultants, the misapplication of customer service based management philosophies, and malpractice issues. Undoubtedly there are others.

If factory workers suffered from poor morale because of an unsafe work environment, no one would recommend that they be more resilient. OSHA would mandate that the issues be corrected and management would see that it was done. Until we come to see physician burnout as a natural response by highly skilled, motivated, and intelligent individuals to workplace safety issues, nothing will change.

If you are feeling burned out, it's absolutely essential to realize it's not a "you problem." Your hospital is what is falling short. Most emergency physicians lack the ability to make even the smallest of improvements to the environment they work in, so voting with your feet is the absolute best thing you can do to address burnout and secure your future career. When you do, following the three guidelines at the end of the article will help you in your search.

— Milind R. Limaye, DO FAAEM

First, thanks for writing. I love hearing from readers of *Common Sense* and wish more would write. Second, I couldn't agree more with your statement, "If you are feeling burned out, it's absolutely essential to realize it's not a 'you problem'. Your hospital is what is falling short. Most emergency physicians lack the ability to make even the smallest of improvements to the environment they work in..."

As I pointed out in "Responsibility and Authority" in the Jul/Aug 2014 issue of *Common Sense*, because so many emergency physicians have lost control of their departments and lack any authority to change or improve them, but are still held responsible for what happens in them, they work in an environment designed to create what psychologists call "experimental neurosis" and cause burnout. Every case of emergency physician burnout I have seen in my over 30 years of practice was caused, not by some character defect or psychological flaw in the physician, but by a pathologically defective work environment that was created when control of the ED was taken away from the doctors and nurses who care for patients there, and turned over to bureaucrats and administrators. When good doctors are put in an environment where they are prevented from delivering the best possible care as efficiently as possible, they become frustrated and unhappy. When they are held responsible for the flawed department that was forced on them and that they are powerless to change, or harassed over meaningless metrics that distract from actual quality, they burn out. The fundamental truth about burnout is this: burnout is the normal response of a good emergency physician to a malfunctioning ED, when that physician has none of the authority needed to correct the malfunction, but is held responsible for it. If we want to reduce physician burnout, we must restore physicians' professional autonomy.

— Andy Walker, MD FAAEM
Editor, *Common Sense*

For more by Dr. Walker on burnout and its causes, see these issues of *Common Sense* :

Mar/Apr 2013: "A Personal View on Burnout"
Jul/Aug 2014: "Responsibility and Authority"
Mar/Apr 2015: "Moving the Meat: My Recovery from Burnout"
Jul/Aug 2016: "The Medical-Industrial Complex"

Continued on next page

Letter in Response to From the Editor's Desk "Crossing the Line" in the September/October 2016 Issue

Hi Dr. Walker!

I am just a regular old ER doc trying to make a living, and a proud AAEM member who has really enjoyed the editorials regarding CMGs, particularly those regarding EmCare and Rebecca Parker.

I experienced Rebecca Parker and EmCare first hand while staffing Lake Health as a locums during the very time period you have written about. While advocating for myself, my patients, and my reimbursement, I was called names by EmCare directors, and Dr. Parker herself threatened my livelihood if I failed to comply with her edict of signing out and not billing for a minute over the shift unless performing critical care in a single coverage setting.

It's been over 7 years now and I have managed to survive without EmCare, TeamHealth, ApolloMD, or Schumacher. I refuse to staff their contracts. I encourage any doctor I meet on the circuit to avoid them. After many discussions, a few major locums agencies also finally decided to cut ties with these companies, because they grew weary of vendor practices and companies claiming doctors and invoking 5 year non-competes.

I find it distressing that someone wrote about all this in 1998 in the now famous *The Rape of Emergency Medicine*, and yet ER doctors did not heed the warnings. I am only one person, and the effect of my personal black list is not far reaching. What can be done about the harmful effect these companies have on our specialty and patients?

I am willing to serve.
— Name Withheld on Request

Thank you for writing. I regret that we live in a world where you had to ask us not to publish your name, but I understand the reasons for your request. As for your question on what can be done about the corporate staffing companies that prey on emergency physicians, I don't know what else AAEM can possibly do. The Academy does all it can to give emergency physicians the knowledge they need to protect themselves. It takes legal action whenever appropriate, feasible, and cost-effective. Now it has even formed the AAEM Physician Group (AAEM-PG), to support democratic independent groups and found new ones. The only avenue the Academy hasn't yet pursued is forming a union to protect those emergency physicians who are employees — and I'll bet that will happen in the next few years.

As for individual emergency physicians, all they can do is have the moral fiber to refuse management positions in companies that treat their colleagues unfairly. To our specialty's credit, and our profession's, most do. But it takes only a small percentage of emergency physicians willing to violate their professional ethics to keep the contract management industry running.

That brings us to the real question: what more can ACEP do? Those EPs who are members of ACEP should think long and hard about that question, and take it to ACEP leaders like President Rebecca Parker. And they shouldn't accept fears of violating antitrust laws as an excuse to avoid the issue — because that is a lie. If antitrust laws were a legitimate concern in the effort to protect individual emergency physicians from predatory exploitation, the feds would have come after AAEM 20 years ago.

— Andy Walker, MD FAAEM
Editor, *Common Sense*

Strength in Numbers
AAEM 100% ED Groups

AAEM 100% ED Group Membership

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

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

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

For a complete listing of 2016 100% ED Group members, go to **www.aaem.org/membership/aaem-ed-group-membership**.

CMS Announces 2017 Changes for MACRA

Williams & Jensen, PLLC

Center for Medicare and Medicaid Services (CMS) Acting Administrator Andy Slavitt announced in September that providers would have additional options in 2017 to comply with the new payment system under the Medicare Access and CHIP Reauthorization Act (MACRA). While providers cannot receive bonus payments until 2019, the Department of Health and Human Services (HHS) will begin measuring performance through MIPS in 2017.

The decision came after many providers and industry stakeholders expressed significant concerns about the proposed rule released in April. Among the concerns was the ability of providers to meet rigorous new documentation burdens to earn bonus payments under the Merit-Based Incentive Payment System (MIPS), and the need for providers to gain a greater understanding of the requirements to earn bonus payments. Others commented that many providers will not have the option to participate in alternative payment models (APMs), meaning that they can only earn bonus payments through MIPS.

> "AAEM has been among the groups urging HHS to design quality measures that make sense for the varying specialties, a message that has also been embraced by other stakeholders."

AAEM has been among the groups urging HHS to design quality measures that make sense for the varying specialties, a message that has also been embraced by other stakeholders. AAEM also highlighted the importance of providing emergency physicians with robust options to participate in APMs, so that they are not excluded from achieving bonus payments through the use of these models.

A joint letter led by Congressman Pete Sessions (R-TX) cited the proposal's complex reporting requirements for MIPS, and concluded that independent practices would be disadvantaged under the proposal.

While acknowledging that numerous stakeholders had called for a full delay of the new system, CMS' modification would "allow physicians to pick their pace of participation" under the Quality Payment Program in 2017. Providers are given four options that all ensure a physician will not receive a negative payment adjustment — up to 4 percent of Medicare payments — in 2019. Several of the options will also allow providers to qualify for some level of bonus payments in 2019.

The most flexible option allows providers to test the Quality Payment Program by merely submitting any amount of data in 2017. This will enable providers to avoid the negative payment adjustment and give them more time to enable their participation in 2018.

Providers also have the option to participate in the Quality Payment Program for a partial year, and still earn a reduced bonus payment in 2019.

Finally, providers still retain the two original options to participate in the Quality Payment Program for the full calendar year 2017, or to participate in an APM.

To qualify for the five percent bonus under MIPS, a provider must achieve high value care across four performance categories: quality, advancing care information, cost/resource use, and clinical practice improvement activities. Of these four categories, HHS proposed to apply a 50 percent weight in 2017 to the quality category.

At present, this policy is intended to apply only to 2017. The options will be integrated into CMS' final rule, which is expected to be published between October 15 and November 1.

House Panel Advances EMS Legislation

The House Energy and Commerce Committee reported emergency medical services (EMS) related legislation sponsored by Congressman Richard Hudson (R-NC).The "Protecting Patient Access to Emergency Medications Act of 2016 (H.R. 4365) would allow EMTs to administer controlled medication in emergency situations under the supervision of a physician.

The bill was introduced to address concerns that certain life-saving medications that were being transported and administered by EMS personnel could expose emergency responders to enforcement action by the Drug Enforcement Agency (DEA). Narcotics to treat pain and anti-seizure medications were listed as two such examples of controlled substances that could put EMS personnel in jeopardy if they are administered. The bipartisan bill has over 25 percent of the House as cosponsors. Due to broad support, this proposal is among the legislation that could be considered later this year during the Lame Duck session that will be convened after the elections.

An identical bill in the Senate was introduced by Senator Bill Cassidy (R-LA). AAEM has written a letter of support for both bills, urging passage of the legislation. ■

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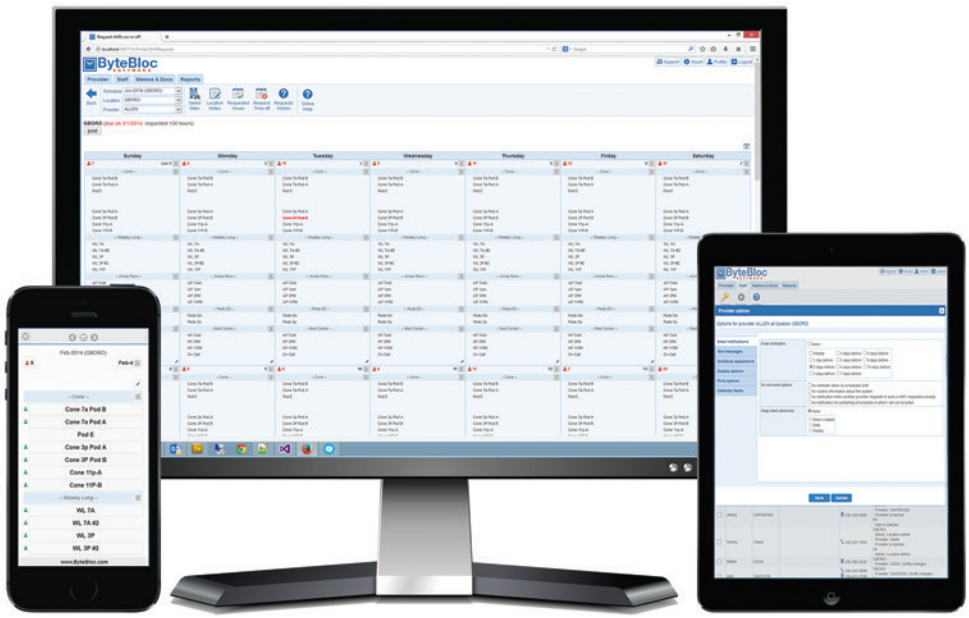

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Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1-1-2016 to 9-15-16.

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

Levels of recognition to those who donate to the AAEM PAC have been established. The information below includes a list of the different levels of contributions. The PAC would like to thank the individuals below who contributed from 1-1-2016 to 9-15-16.

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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.

AAEM CONFERENCES

March 16-20, 2017
- 23rd Annual AAEM Scientific Assembly – AAEM17
  Orlando, FL
  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)

AAEM JOINTLY PROVIDED CONFERENCES

November 14-16, 2016
- The Teaching Course
  New York City
  www.theteachingcourse.com

December 1-3, 2016
- Clinical Updates in Emergency Medicine
  Beirut, Lebanon
  www.avb.edu.lb

September 6-10, 2017
- MEMC-GREAT 2017 Joint Congresses
  Corinthia Hotel Lisbon
  Lisbon, Portugal
  www.emcongress.org

AAEM RECOMMENDED CONFERENCES

November 4-6, 2016
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

December 4-9, 2016
- 37th Annual Current Concepts in Emergency Care
  Maui, HI
  www.emergenciesinmedicine.org

January 12-13, 2017
- 2017 Oncological Emergency Medicine Conference
  Houston, TX
  www.mdanderson.org/education-training/professional-education/cme-conference-management/conferences/oncologic-emergency-medicine-conference.html

April 21-23, 2017
- The Difficult Airway Course: Emergency
  Boston, Massachusetts
  www.theairwaysite.com

May 19-21, 2017
- The Difficult Airway Course: Emergency
  Atlanta, Georgia
  www.theairwaysite.com

September 15-17, 2017
- The Difficult Airway Course: Emergency
  Chicago, Illinois
  www.theairwaysite.com/

October 6-8, 2017
- The Difficult Airway Course: Emergency
  Washington, D.C.
  www.theairwaysite.com

November 17-19, 2017
- The Difficult Airway Course: Emergency
  San Diego, California
  www.theairwaysite.com/

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

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

The Rent vs. Buy Real Estate Decision

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

The classic advice has always been to purchase your home if you can afford it, but in emergency medicine the decision is much more complex. You can't simply compare your rent to a mortgage payment. You have to consider tax breaks, fees associated with purchasing real estate, and how long you expect to stay at your current position. Here's a breakdown as I see it.

Benefits of Home Ownership

- Interest payments and property taxes are deductible.
- When you sell, gains on home value are exempt from federal income tax, up to $250,000 if single and $500,000 if married.
- Making regular mortgage payments forces you to save.
- You can get some significant asset protection, as many states protect home equity from lawsuits.
- As you make mortgage payments and accumulate home equity, it adds diversity to your investment portfolio. Real estate is a great hedge against inflation and correlates only moderately with other investments, like stocks and bonds.
- Mortgage rates are at rock bottom right now, making it easier to purchase a home.

Downsides of Home Ownership

- Most home purchases have a three to five year break-even period, which just happens to coincide with the length of most residencies, making the purchase of a home during residency a toss-up.
- Real estate appreciation barely keeps up with inflation over the long haul. Economist Robert Shiller was awarded the Nobel Prize for proving this.
- Sudden moves or changes in employment can force you to either sell your house or become a landlord. Emergency physicians frequently leave the first position they take after residency.
- The classic teaching is that purchasing a home is a great investment because you don't have to pay rent, but buying a home that is too expensive will harm you financially because of all the associated costs, such as utilities, insurance, maintenance, and the costs of buying and selling. Expect to pay 5% of the value of the house when buying it, 1-2% of the value each year to maintain it, and 10% of the value when selling it.

Benefits of Renting

- You avoid the fees and ongoing expenses associated with buying, maintaining, and selling a home.
- If you decide unexpectedly to change jobs, rental contracts are often annual and are easier and cheaper to terminate than selling a home.
- In high-cost areas like Hawaii, Southern California, and New York City it is often much more affordable to rent than to buy.

Downside of Renting

- You don't get the benefits of home ownership listed above.

Rent vs. Buy Calculators

You don't have to make this decision on your own. Here are two online calculators to help you make your decision:

- Trulia Rent vs. Buy Calculator
- New York Times Rent vs. Buy Calculator

The reality is that this is a very personal choice, and there really isn't a right or wrong answer. What you should do will be based purely on your own values and likely career path. My personal goal is to make sure I have my primary residence paid off and am mortgage-free at retirement.

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

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

Sixth Inter-American Emergency Medicine Congress

Gary Gaddis, MD PhD

The Sixth Inter-American Emergency Medicine Congress (IAEMC), part of an ongoing collaboration between the Sociedad Argentina de Emergencias (SAE) and AAEM, was held June 8-10, 2016, at the Emilio Civit Convention Center in Mendoza, Argentina. The Civit Center is a modern congress hall in the heart of Mendoza, a metropolitan area with a population over a million, served by a large modern airport. Argentina is one of the nations in the hemisphere where emergency medicine is an officially recognized specialty. (The official announcement that emergency medicine would be a recognized specialty in Argentina occurred at the Third Inter-American Emergency Medicine Congress, in 2010.)

Aconcagua Mountain, near Mendoza

Unfortunately, other than invited speakers few AAEM members attended, and a great opportunity was missed. Perhaps people were reluctant to travel to the Southern Hemisphere when it was late fall in that part of the world. Perhaps the destination was too remote for many of us. Travel there does take a full day and a connection through one of the capital cities of South America, but the Mendoza area is a mecca for wine production and outdoor sports and the scenery is beautiful.

The English-language presentations were of high quality, and the venue was spectacular. The American speakers presented coherent, brief, informative reviews of both basic and advanced emergency medicine topics, which were also enjoyed by Spanish-speakers since, as in previous Congresses, simultaneous translation was provided. Thus the Congress continues to be a forum for sharing ideas and concepts across borders and languages.

The Congress also featured a large number of scientific presentations in Spanish. The bilingual speakers invited by AAEM participated in consensus-building sessions in Spanish, the mesas, and the Argentinians valued our participation highly. This was coordinated by Jeff Nielson, and attendee Leo Alonso, MD — who was born in Cuba and lives in Florida — assisted on site.

Among the prominent American speakers was Joe Lex, giving his final medical address, which summarized the development of emergency medicine and what Joe was doing during that development. Dr. Lex was a combat medic in Vietnam when ACEP was founded, and entered nursing school after returning to the States, just as the fight to establish the specialty was occurring. He is part of the first cadre of emergency nurses to achieve CEN status. With the encouragement of a mentor, he entered medical school in San Antonio in the mid-1980s. He graduated from medical school at about the same time the University Association of Emergency Medicine (UAEM) and the Society of Teachers of Emergency Medicine (STEM) merged to form the Society for Academic Emergency Medicine (SAEM), and then started his residency in emergency medicine. His talk was the capstone of a most excellent career in emergency medicine, which included being the first person honored as a Master of the American Academy of Emergency Medicine (MAAEM).

Dr. Lex's talk was compelling, and brought the audience to its feet. He taught everyone much about the origins of our specialty in the English-speaking world, which occurred in the same time frame in the United States, Canada, and Great Britain.

Mendoza, as mentioned above, is the center of Argentina's wine country. The fact that the meeting was held in June, the equivalent of December in the Northern Hemisphere, meant that the vines were void of grapes and most of their leaves. However, many wineries were open and many of those who attended took guided tours, learning about the local cultivation of Malbec grapes, which began in the 1850s. However, the export of fine Malbec wine grew rapidly after Nicolas Catena Zapata began planting Malbec vineyards above 5,000 feet in the 1990s.

The scenery was spectacular! The tallest mountain outside Asia, Aconcagua (22,841 feet), sits above and near Mendoza, and the Andes had a covering of snow that was beautiful from a distance (see photo). Most attendees arrived via Buenos Aires, site of all previous IAEMCs, or Santiago, Chile — though the road through the mountain pass between Mendoza and Santiago was closed by snow during part of the Congress.

The fact that the Congress was moved from Buenos Aires is significant on a number of levels. The Argentinians took a financial risk by agreeing to our suggestion to move the congress out of their capital city. Approximately 40% of the population of Argentina lives within 100km of Buenos Aires, and an even greater portion of Argentina's emergency physicians live in the area. Therefore, in previous Congresses most Argentine attendees could participate without the expense of a long trip and a hotel room.

Those of you aware of Argentina's recent financial challenges can appreciate the risk involved in moving the Congress. The Argentine economy has been in free-fall. The Argentine peso to U.S. dollar exchange rate was about 4:1 during my first visit to Argentina in 2012. By 2014, it was nearly 8:1. In 2016 it was 13:1. That is bad for Argentina, but good for Americans traveling there. We were able to host a faculty dinner for the invited American speakers, their guests, and the leaders of the various

Continued on next page

Latin American emergency medicine societies at a fraction of the cost of that event in the States.

Fortunately the risk taken by the Argentinians was rewarded, as over 800 people registered for the Congress — including doctors, nurses, paramedics, and EMTs — and the Congress broke even, rather than generating the red ink the Argentinians had feared.

The reason AAEM has encouraged the Argentinians to move the Congress from Buenos Aires is to help make the IAEMC the emergency medicine meeting of the Americas. The Argentinians have consistently invited the leadership of other regional emergency medicine societies to participate in the IAEMC. This year, emergency medicine leaders from Brazil, Chile, Uruguay, Peru, Colombia, Costa Rica, Ecuador, Panama, and Mexico participated.

Plans are already underway for the Seventh IAEMC, which will be the first held outside of South America. That Congress will take place in 2017 in San Jose, Costa Rica. We anticipate continuing to have conventional 15-30 minute lectures, as well as the "Pecha Kucha" sessions which have become so popular at AAEM's Scientific Assembly.

Costa Rica is famous for its beauty and eco-tourism, and San Jose is not only familiar to many Americans, it is also much closer to the United States than Argentina. The reason IAEMC has switched from even years to odd is that the next two International Conferences in Emergency Medicine will be in our hemisphere, in Mexico City in 2018 and Buenos Aires 2020. We expect the 2019 IAEMC will also occur somewhere in Central America or northern South America.

In addition to putting on a first-rate Congress with our Costa Rican colleagues, I hope to launch a task force that will help develop tools to provide quality emergency medical care in low-resource environments. Much of South America is very rural. For instance, Argentina has about 41 million inhabitants and extends from the tropics in the north to Cape Horn in the south, where Ushuaia (latitude 54°48' south) is the jumping-off point for cruises to Antarctica. Over 14 million people live in greater Buenos Aires. Other South American nations share this population distribution, with huge cities and vast rural regions. There is great need for improvement in rural emergency care.

I hope many of you will attend the Costa Rican IAEMC in 2017. If you aren't interested in travel to Costa Rica, perhaps you will be interested in the Ninth Mediterranean Emergency Medicine Congress — Tenth GREAT Network Congress (MEMC-GREAT 2017), which will be held September 6-10, 2017 at the Corinthia Hotel in Lisbon, Portugal. We will have further details about MEMC-GREAT 2017 in the next issue of *Common Sense*. ■

Thank You!

We would like to recognize and thank the following ED groups for participating in our 2016 100% and 2/3 Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

AAEM 2016 100% ED Group Membership

- Amarillo Emergency Physicians-TX
- American University of Beirut – Lebanon
- Doctor Urgent Care Clinic – LA
- Campbell County Memorial Hospital – WY
- Cape Emergency Physicians – NJ
- Central Coast Emergency Physicians – CA
- Chesapeake Emergency Physicians – VA
- Crozer-Chester Medical Center – PA
- Drexel University – PA
- ECEP II, PA – NC
- Edward Hospital – LA
- Emergency Physicians at Sumner, PPLC (EPAS) – TN
- Emergency Physicians of Community Hospital Anderson – IN
- Emergency Specialists of Oregon (ESO) – OR
- Florida Hospital – FL
- Fort Atkinson Emergency Physicians (FAEP) – WI
- Fredericksburg Emergency Medical Alliance, Inc.-VA
- Glendale Adventist Emergency Physicians, Inc. – CA
- Greater San Antonio Emergency Physicians – TX
- HealthFront – NM
- Long Beach Emergency Medical Group – CA
- Nebraska Emergency Physicians – NE
- Northeast Emergency Associates – MA
- North ED Physicians – FL
- St. Louis University Hospital – MO
- Salinas Valley Memorial Hospital – CA
- Southern Colorado Emergency Medical Assoc (SCEMA) – CO
- Temple University – PA
- University of Louisville – KY
- University of Mississippi – MS
- West Jefferson Emergency Physician Group – LA

AAEM 2016 ED Group Membership

- BayCare Clinic – WI
- Middle Tennessee Medical Center – TN

National Quality Forum Update

Michael S. Pulia, MD FAAEM
Leslie Zun, MD FAAEM

A few years ago, AAEM joined the National Quality Forum (NQF) in order to provide input during the development and approval of new standards for emergency medicine. The NQF, composed of 430 members and 800 volunteer experts, is the organization that reviews measures prior to adoption by the Centers for Medicare and Medicaid Services (CMS). Ultimately any measures approved by CMS effect the way we practice.

AAEM started the Quality Standards Committee to review and respond to these and other quality related issues. For example, AAEM representatives recently attended the behavioral health measures committee meeting to oppose a proposal on mental health follow up from the ED. Although this measure held insurers responsible for ensuring follow up of mental health patients, there was significant concern that an ED standard might become part of this measure.

The NQF's annual meeting occurred at the end of May and Leslie Zun attended to represent AAEM. The NQF has begun to determine the means to assess quality where it intersects with cost and the Forum now appears to be moving from review of quality measures to applying the value proposition. NQF focused on four action realms: advanced breast care, maternity care, antibiotic stewardship, and patient passport. Some of these, specifically antibiotic stewardship, intersect directly with emergency medicine.

Regarding antibiotic stewardship, CMS proposed all acute care hospitals implement formal programs as a condition of participation. In order to strengthen hospitals existing antibiotic stewardship initiatives or to create new antibiotic stewardship programs, the CDC partnered with NQF and assembled a group of key stakeholder organizations to develop a playbook. To ensure the voice of EM was well represented, AAEM joined the NQF's Antibiotic Stewardship Action Team. In December 2015, Dr. Michael Pulia, Chair AAEM Antimicrobial Stewardship Task Force, represented AAEM during the playbook development meeting at the NQF headquarters. Thanks to Dr. Pulia's contributions, the playbook identifies the ED as a high impact setting for stewardship activities that must be represented in any effort to implement these new programs. The final playbook was released in May of 2016 and can be viewed here:

www.qualityforum.org/Publications/2016/05/Antibiotic_Stewardship_Playbook.aspx

NQF measures and other standards are vetted through the AAEM Quality Standards committee. During the scientific assembly, the committee met with our Washington lobbyist to determine how best to influence standard development as well as to discuss our role in reviewing appropriate measures and how to provide feedback for upcoming measures. The Quality Standards Committee is also documenting the quality standards used by emergency departments throughout the country. In order to accomplish this goal, we are working with the Practice Management Committee to locate and develop these.

Please let us know if you have any questions about what the Quality Standards Committee is doing for the Academy or if you wish to join us by contacting info@aaem.org or joining the committee at www.aaem.org/about-aaem/leadership/committees. ■

Call for 2017 AAEM Board of Directors Election Nominations
Nomination Deadline: December 17, 2016 — 11:59pm CT

AAEM encourages candidates for election to the board of directors who have a previous record of service and commitment to the Academy.

Open Positions for the 2017 Election:
- Five At-Large positions
- YPS director

Nominations

Any Academy member may nominate a full voting or YPS member (for the YPS director position only) for the board. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS director position.

In order to nominate yourself or another full voting member for a board position, please go to www.aaem.org/about-aaem/elections to provide the following information and complete the nomination form and attestation statement.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including Board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities, or any other information detailing why the nominee should be elected to the board. A photo for publication may accompany the statement if the nominee wishes.
6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A current CV for the nominee.
8. AAEM Attestation Statement filled out by the nominee.
9. **Conflict of Interest Form must be completed by the nominee prior to the nomination deadline**.

The information listed above must be submitted to the AAEM office before 11:59pm CT, on December 17, 2016. The nomination form and required information is the same as that for a board position.

The candidate statements from all those running for the board will be available online and also featured in the March/April 2017 issue of *Common Sense*.

Online Voting

New for 2017 voting will occur online only. The online ballots will be available prior to Scientific Assembly and online voting will be available onsite. WiFi will be available in the meeting space and we encourage members to bring a device or computer to cast their ballot.

Elections

Elections for these positions will be held at AAEM's 23rd Annual Scientific Assembly, March 16-20, 2017 in Orlando, FL. Although online balloting arrangements will be made for those unable to attend the Assembly, all members are encouraged to hold their votes until the time of the meeting. Online voting will be available leading up to Scientific Assembly and onsite

The Scientific Assembly will feature a Candidates Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference, and those elected will begin their terms at the conclusion of the Assembly.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us the organization of specialists in emergency medicine. In AAEM, any individual, full voting or YPS member can be nominated and elected to the AAEM board of directors. ■

DEADLINE: December 17, 2016 – 11:59pm CT

CALL FOR AAEM Award Nominations!

DEADLINE:
DECEMBER 17, 2016
11:59pm CT

AAEM is pleased to announce that we are currently accepting nominations for our annual awards. Award presentations will be made to the recipients at the 23rd Annual Scientific Assembly to be held March 16-20, 2017 in Orlando, FL.

Complete nomination criteria and the required online nomination form are found at www.aaem.org/about-aaem/awards. Self-nominations are not accepted. The AAEM Executive Committee will review the nominees and select recipients for all awards.

Individuals can be nominated for the following awards:

Administrator of the Year Award — AAEM encourages members to nominate an administrator deserving special recognition for their dedication to emergency medicine and patient care.

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

Young Educator Award — Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

Resident of the Year Award — Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

James Keaney Award — Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

Robert McNamara Award — Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

Joe Lex Educator of the Year Award — This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who have been out of their residency for more than five years.

Master of the American Academy of Emergency Medicine (MAAEM) — Active members of AAEM may also recommend nominees to the AAEM executive committee for the Master of the American Academy of Emergency Medicine (MAAEM). Full criteria for this designation are available on the AAEM website.

Program Director of the Year Award — This award recognizes an EM program director who has made an outstanding contribution to the field of emergency medicine and AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association (AAEM/RSA).

Nominations will be accepted for all awards until 11:59pm CT, December 17, 2016. All nominations should be submitted in writing and include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

JOIN US IN ORLANDO! A SPECIAL INVITATION FROM THE SCIENTIFIC ASSEMBLY SUBCOMMITTEE

Christopher Doty, MD FAAEM
Evie Marcolini, MD FAAEM
AAEM17 Subcommittee Co-Chairs

WE We are getting geared up for the 2017 Scientific Assembly and we are working to make this the best AAEM conference ever! You might want to register now and put the dates in your calendar for the American Academy of Emergency Medicine's 23rd Annual Scientific Assembly, held in Orlando, from Thursday, March 16th, through Monday, March 20th, 2017. Register now at www.aaem.org/AAEM17.

You can bank on the AAEM Scientific Assembly to provide premier continuing medical education, have your favorite speakers, and be on the cutting edge of medical practice.

We, Dr. Christopher Doty and Dr. Evadne Marcolini, are leading the planning committee again and have hand-picked a stellar group of talented educators to bring you a top-notch conference you have come to expect. We also have managed to keep Dr. Joseph Lex as a senior advisor to the planning subcommittee. Dr. Joelle Borhart is lead on pre-conference courses and Dr. R. Gentry Wilkerson led the Pecha Kucha planning. It is all in place to take the conference to the next level.

Plan to see your favorite plenary sessions and some new cutting edge tracks. Look for:

- Myth-Busting
- When the Shift Hits the Fan
- Financial Wellness for Physicians
- Medicolegal Aspects of Emergency Medicine
- Point-of-Care Ultrasound in Emergency Medicine
- Getting the Right Job
- Operations Boot Camp
- Geriatrics
- EMS

Also, we will continue with our super successful Pecha Kucha sessions for a rapid fire, diverse topic format. These presentations include 20 slides for review of a single topic in just under 7 minutes. These sessions have been tremendously successful for the past several years and are coming to Orlando. In addition, the committee is looking to introduce new sessions including an operations bootcamp, wellness topics, and a procedures session. We are also having small group clinics, experiential learning sessions that you can sign up for in advance.

Specialty sessions were also developed for:

- Women in Emergency Medicine
- International Emergency Medicine
- Legal Contracts in Emergency Medicine
- Diversity in Emergency Medicine
- Resident and Student Association (AAEM/RSA)
- Young Physician Section (YPS)
- 2017 Medical Student Session

Of course, there are also several stellar pre-conference sessions planned for Thursday, March16th and Friday, March 17th which include popular returning favorites as well as new topics to keep our members relevant and informed:

- Ultrasound — Beginner and Advanced with Didactic and Lab Sessions
- Simulation — Pediatric and Obstetric Labs
- So You Think You Can Interpret an EKG?
- 2016 LLSA Review Course
- Resuscitation for Emergency Physicians
- Active Shooter: Are You Ready
- and more!

We are in the final stages of securing a huge keynote speaker for this year, so stay tuned for more information.

Of course, there is no registration fee for AAEM members (with refundable deposit) and there are discounted member rates for pre-conference courses.

We have worked to provide the very best for your education … great speakers and great topics for no charge at a great destination. This Scientific Assembly promises to be a fabulous experience and a premier educational event. Please accept our invitation and come see what we have to offer you. Register now at www.**www.aaem.org/AAEM17**.

Chris
Christopher Doty, MD FAAEM
23rd Annual Scientific Assembly Subcommittee
Co-Chair

Evie
Evadne Marcolini, MD FAAEM
23rd Annual Scientific Assembly Subcommittee
Co-Chair

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The American Academy of Emergency Medicine's 23rd Annual Scientific Assembly (AAEM17) is proudly the premier clinical conference in emergency medicine. Pre-conference activities will take place on Thursday, March 16th and Friday, March 17th. The Scientific Assembly will begin in the afternoon on Friday, March 17th and end on Monday, March 20th, 2017.

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We're focusing on your – the individual emergency physician. We hope AAEM17 will be a rewarding experience where you receive the highest quality education and feel refreshed. Look for wellness themed events througout assembly including the Fun Run and AM Yoga! Learn more www.aaem.org/AAEM17/Wellness

INVITE A FRIEND

If you're a veteran of Scientific Assembly, or if you're planning on attending for the first time in 2017, consider inviting a friend or colleague to join you. Encourage residents and medical students interested in emergency medicine to attend as well. CME will be available; presented by the top clinician educators in emergency medicine.

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Interested in becoming an exhibitor or sponsor of AAEM17? View the exhibitor prospectus and learn more about sponsorship opportunities at www.aaem.org/aaem17/exhibitors.

STAY CONNECTED

For up-to-the-minute information about registration and Scientific Assembly — follow AAEM on social media. Visit AAEM Connect, our interactive dashboard, to view updates from Facebook and Twitter. Look for hashtag #AAEM17.

Six EM Video Channels to Watch

Casey Collier, MD FAAEM
Social Media Committee

No doubt you have noticed that "info-tainment" video content has exploded in the last year on social media sites. Videos published on Facebook have doubled in the last year and are being shared more than ever. This trend can be seen in EM medical content as well.

Emergency medicine content is easily found on video sharing sites across the internet. Many EM educational videos were previously limited to subscription services, hidden behind member paywalls. Now high-quality, entertaining, educational content is freely available at several sites.

Check out these six channels if you need a refresher on a shoulder reduction technique, a summary of a journal article, a lecture from a conference across the globe, and much more.

1. As a visual learner I really appreciate the *NEJM's* Quick Takes: youtube.com/user/NEJMvideo. These are infographic breakdowns of clinical trials akin to Cliff Notes. The gist of the article is conveyed and a discussion often follows in the comments.
2. Procedurettes by Whit Fisher, MD: youtube.com/user/procedurettes. This gives brief, practical, and often humorous tips and tricks for using everyday ED supplies in clever, MacGuyver-esqe medical hacks.
3. A great resource for procedures is Dr. Larry Mellick's Channel: youtube.com/user/lmellick. He is affiliated with the Medical College of Georgia and also posts interesting pathology and physical findings.
4. The Vanderbilt EM Program has a great Vimeo channel: vimeo.com/vanderbiltem. It focuses on bedside ultrasound, and a few "Take 5" videos from Corey Slovis that cover five clinical points in under five minutes.
5. HQMedEd: vimeo.com/hqmeded.
6. SMACC: vimeo.com/smacc. You may know these two names from their conferences or course content – but lectures, ultrasound tips, and short image-focused PK lectures are plenitful on these channels too. Their main pages are also excellent.

You may ask, "Why subscribe to these channels through their video hosting site?" Ease of use, the ability to make playlists, and updates on your homepage with new videos are why I do it. So the next time you fire up your favorite EM podcast, consider searching these channels for similar content in video form.

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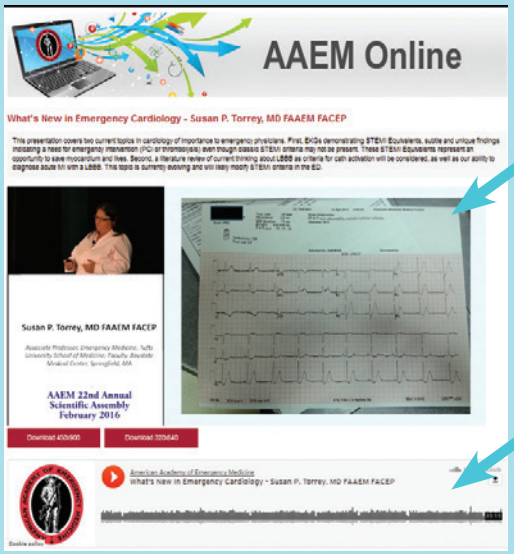

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Women in Emergency Medicine: Developing a Departmental Parental Leave Policy

Robin Naples, MD FAAEM
Associate Program Director, Associate Professor
Lewis Katz School of Medicine, Temple University

I care deeply about women's rights and gender bias in the workplace. Women earn 78 cents on the dollar compared to men. It's even worse if you are a minority woman, ranging from 56-64 cents on the dollar.[1]

Medicine is not immune to gender bias. A British journalist recently published an article bemoaning the "feminization of medicine,"[2] and there was a backlash of comments to an article recently published about the importance of women in EM in April's edition of *ACEP Now*.[3] According to the AAMC, despite nearly equal numbers of women and men matriculating at medical schools for over a decade, women still hold a minority of senior titles and positions (Associate Professor and Full Professor, both tenured and non-tenured; Division Chief; Department Chair; Senior Associate Dean and Vice Dean; and Dean).[4] A more objective study published by *JAMA Internal Medicine* in July 2016 looked specifically at physician salaries for academic appointments, and found discrepancies even when controlling for multiple differences such as volume of patients seen and number of publications.[5]

The argument against women in the workforce often centers around childbearing/rearing and the time away from work that is necessary to birth and care for an infant. The AAMC recently identified women leaving the workforce as an issue, and notes that while new female faculty hires rose in the past several years, so have the proportion of female faculty departures.[4] This leaking pipeline is one factor contributing to the lack of women rising to senior positions in medicine.

While the United States offers many advantages to women, our country's policies fall short of many other developed countries when it comes to working women and "balancing" family responsibilities. This likely contributes to the dropout rate of women in medicine. The U.S. ranked last in a list of 38 countries when it came to legally mandated parental leave (zero weeks paid, 12 weeks protected).[6] There is no federal mandate for parental leave. Individual companies are free to pay their employees for parental leave or not, and in 2012 only 11% of all employees received paid benefits for parental leave.[7] Despite these facts, 40% of all households with children under the age of 18 include mothers who are the breadwinner for the family (37% are married mothers and 63% are single mothers).[8] It is no wonder that American women "choose" to leave the workforce or go part-time. Something has to give and it is usually the woman's career.

How can we effect change?

To address the needs of women in emergency medicine, a working group recently published a best practices guideline.[9] ACEP and SAEM followed suit and came out with a policy statement that can be summarized best in their own words: "The American College of Emergency Physicians/SAEM believes women should not have to choose between their career and their family, and that employers' efforts to recognize and consider all aspects of physicians' lives ultimately furthers a medical career."[9]

> "In an effort to improve the retention of women in our group, as well as create a culture that is accepting of the many facets of our colleagues' lives, our women's group sought to develop a departmental policy addressing issues that affect new mothers and parents."

At my institution, women are fortunate that we have paid medical leave that can be used for maternity leave. Clinical hours during FMLA time are subtracted from one's overall contracted hours, allowing maternity leave to be both protected and paid leave. However, assimilating back into the workforce can be difficult. Add to that the fact that most female faculty returning from maternity leave are junior faculty and haven't developed the political collateral to ask for leniency when they return, and the culture becomes that much more demanding of new mothers returning to work.

In an effort to improve the retention of women in our group, as well as create a culture that is accepting of the many facets of our colleagues' lives, our women's group sought to develop a departmental policy addressing issues that affect new mothers and parents. While certain aspects of the document specifically address issues singular to the postpartum woman, we intentionally used language to allow leniency and flexibility for an adoptive parent or a man who identifies himself as the primary care-giver.

The document was developed within the women's group to address the issues that we had found most challenging in our workplace when returning from maternity leave. It was shared with a cohort of our male colleagues prior to presentation to our Department Chair (Bob McNamara),

Continued on next page

in an attempt to build consensus. I presented the document to Dr. McNamara and our Vice Chair of Operations, after which the language was fine-tuned. The document was then disseminated to the entire faculty and Dr. McNamara fielded comments. Overall, the policy was well received and adopted as departmental policy.

Hopefully this will serve as a catalyst to start conversations within your own group, so that you can find workable solutions to the issues that impact your workforce.

Schedules and Contracted Hours

By allowing a new parent to bank hours ahead of time, the parent can ease back into the work schedule. It takes time to build back the mental and physical stamina that our specialty demands. The ability to meet your obligations to your group but have some breathing room in your schedule on return is a win-win.

Parenting and managing your career is a juggling act. However, when you have to take your infant to the doctor for frequent visits, plan feeding and napping schedules, and find backup child care due to daycare closures or nanny vacation time, the inconsistency of a shift worker's schedule can be the straw that breaks the camel's back. This is why some women EPs choose to be "night owls." It guarantees them a fixed schedule. Our group already has several night-only staff, so even if a new parent wanted this option it wouldn't be available to them. Traditionally, non-night fixed schedules are a privilege reserved for our most senior faculty. Agreeing on a schedule that is both reasonable to the needs of the group and the individual helps lift some of the stress that comes with our shift work, and helps junior faculty parents juggle the demands of career and family. .

We allow the new parent to opt out of night shifts. We felt this disruption of the circadian rhythm could impact the mental and physical health of the faculty member. As stated above, our group has a cache of night-only faculty and a large pool of other faculty members to fill in these open night shifts, and thus it is not onerous to the group.

Lactation Needs

To address the needs of the lactating mother, we felt there were two areas where we could make an impact. Under the Affordable Care Act, federal law requires employers of over 50 people to allow break time for mothers to express breast milk for the first year of the infant's life, as well as a guaranteed lactation room which is not a bathroom.[10] While our hospital has a lactation room, it is located on the eighth floor, which is not very convenient to our ED staff on the ground floor. Therefore, we requested that the space we are currently using be remodeled to allow for internet access and charting, as well as include a refrigerator to store the expressed milk. So the lactating mother can be allowed break time without compromising patient safety, a stipulation was placed in the policy so that a lactating faculty member will not be working shifts in which she is the sole practitioner. Our group staffing patterns allow this.

My concern for women's issues is part of what drove me to work on this policy, but I don't want to paint myself as selfish. I don't have any skin in this game. I have no intention of having more children and utilizing this policy for myself. However, in a sense all of us have skin in this game. It is for our own sanity. If a woman returns to the workplace and finds she can't handle the demands of home and work and pulls out of the workforce, we will be the ones working overtime to cover for the lost manpower. We will be the ones having to spend time interviewing and training new hires. Equally important for the good of emergency medicine, policies like these will keep young female faculty engaged and moving forward with their careers, adding their passion and unique perspective to our specialty.

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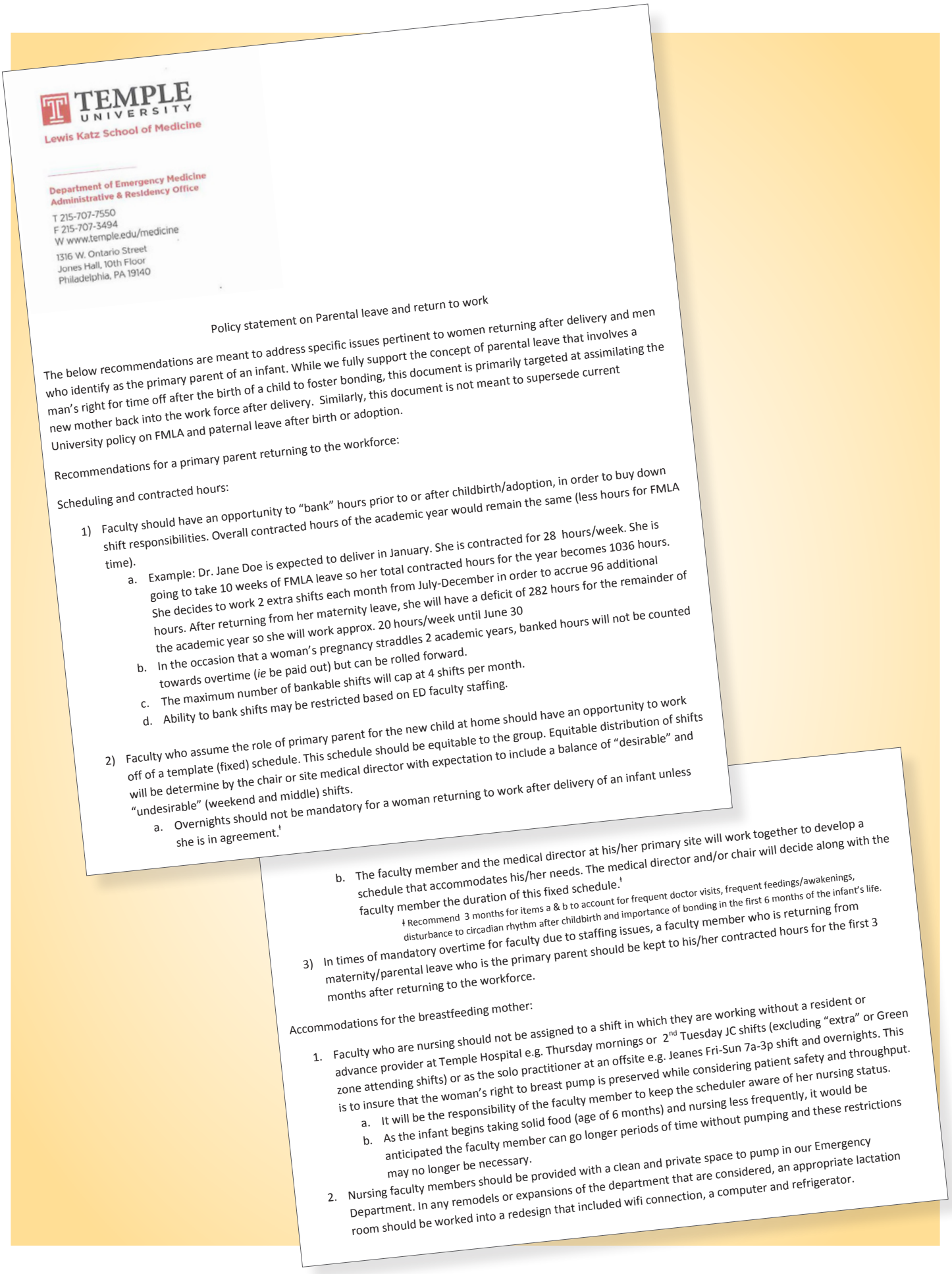

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Policy statement on Parental leave and return to work

The below recommendations are meant to address specific issues pertinent to women returning after delivery and men who identify as the primary parent of an infant. While we fully support the concept of parental leave that involves a man's right for time off after the birth of a child to foster bonding, this document is primarily targeted at assimilating the new mother back into the work force after delivery. Similarly, this document is not meant to supersede current University policy on FMLA and paternal leave after birth or adoption.

Recommendations for a primary parent returning to the workforce:

Scheduling and contracted hours:

1) Faculty should have an opportunity to "bank" hours prior to or after childbirth/adoption, in order to buy down shift responsibilities. Overall contracted hours of the academic year would remain the same (less hours for FMLA time).
   a. Example: Dr. Jane Doe is expected to deliver in January. She is contracted for 28 hours/week. She is going to take 10 weeks of FMLA leave so her total contracted hours for the year becomes 1036 hours. She decides to work 2 extra shifts each month from July-December in order to accrue 96 additional hours. After returning from her maternity leave, she will have a deficit of 282 hours for the remainder of the academic year so she will work approx. 20 hours/week until June 30
   b. In the occasion that a woman's pregnancy straddles 2 academic years, banked hours will not be counted towards overtime (*ie* be paid out) but can be rolled forward.
   c. The maximum number of bankable shifts will cap at 4 shifts per month.
   d. Ability to bank shifts may be restricted based on ED faculty staffing.

2) Faculty who assume the role of primary parent for the new child at home should have an opportunity to work off of a template (fixed) schedule. This schedule should be equitable to the group. Equitable distribution of shifts will be determine by the chair or site medical director with expectation to include a balance of "desirable" and "undesirable" (weekend and middle) shifts.
   a. Overnights should not be mandatory for a woman returning to work after delivery of an infant unless she is in agreement.ǂ
   b. The faculty member and the medical director at his/her primary site will work together to develop a schedule that accommodates his/her needs. The medical director and/or chair will decide along with the faculty member the duration of this fixed schedule.ǂ

ǂ Recommend 3 months for items a & b to account for frequent doctor visits, frequent feedings/awakenings, disturbance to circadian rhythm after childbirth and importance of bonding in the first 6 months of the infant's life.

3) In times of mandatory overtime for faculty due to staffing issues, a faculty member who is returning from maternity/parental leave who is the primary parent should be kept to his/her contracted hours for the first 3 months after returning to the workforce.

Accommodations for the breastfeeding mother:

1. Faculty who are nursing should not be assigned to a shift in which they are working without a resident or advance provider at Temple Hospital e.g. Thursday mornings or 2nd Tuesday JC shifts (excluding "extra" or Green zone attending shifts) or as the solo practitioner at an offsite e.g. Jeanes Fri-Sun 7a-3p shift and overnights. This is to insure that the woman's right to breast pump is preserved while considering patient safety and throughput.
   a. It will be the responsibility of the faculty member to keep the scheduler aware of her nursing status.
   b. As the infant begins taking solid food (age of 6 months) and nursing less frequently, it would be anticipated the faculty member can go longer periods of time without pumping and these restrictions may no longer be necessary.
2. Nursing faculty members should be provided with a clean and private space to pump in our Emergency Department. In any remodels or expansions of the department that are considered, an appropriate lactation room should be worked into a redesign that included wifi connection, a computer and refrigerator.

There's a First for Everything: Surviving and Thriving Through Internship and Pregnancy

Faith Quenzer, DO PGY-1

July was a whirlwind. Fresh out of medical school, I moved to the desert in California to a brand new emergency medicine residency. I was one of five interns and the only female in our inaugural class. Five weeks into the program, I felt strangely tired and nauseated every day. The positive pregnancy test confirmed my suspicion. I knew, without a doubt, that being an emergency physician was exactly what I wanted to do — a stroke in one bed, major trauma in another, appendicitis next to that patient, etc. But now I had the internal turmoil of figuring out how to balance working hard and taking advantage of all the learning opportunities presented to me with proper self-care — which really means baby care. Additionally, the anxiety of having to reveal my pregnancy to my program director, coordinator, fellow residents, and the hospital was a heavy burden. I feared this news might be detrimental to the newly minted EM program and to me as a new physician.

The number of women in the physician workforce has increased substantially over the last couple decades. According to a recent survey by the American Medical Association, approximately 48% of those enrolled in medical school are women. The average age of a graduating medical student is 28.[1-2] For those already in their 30s, the pressure to have children increases as advanced maternal age looms. And complications are a reality for pregnant physicians. According to surveys conducted in surgical specialties, high stress levels and long hours increase the risk of preterm labor, pre-eclampsia, and other obstetrical complications.[3]

"According to a recent survey of female thoracic surgeons, 98% of the women in one program felt that having a child during their training would adversely affect their career. The same seems to hold for other specialties, mostly because many residents don't receive the support they need during pregnancy."

The female physicians I know personally chose to have their children later in residency or after residency. The intern year is critical for building a knowledge base, gaining as much patient interaction as possible, and learning the idiosyncrasies of the hospital. According to a recent survey of female thoracic surgeons, 98% of the women in one program felt that having a child during their training would adversely affect their career. The same seems to hold for other specialties, mostly because many residents don't receive the support they need during pregnancy.[4] Some female residents feel anger or resentment from colleagues because of the extra shifts that have to be covered during their maternity leave. This increases the pressure to take less time off postpartum.[5]

According to surveys in surgical subspecialties, flexibility in resident scheduling helps alleviate the physical and emotional stress of returning to work after pregnancy. Early communication about the pregnancy with program leadership allows for scheduling through less exhausting rotations closer to the due date and helps with maternity leave, especially if the resident has a complication during or shortly after pregnancy. Clear policies and expectations regarding time off help the resident meet board eligibility requirements.[6-8]

With the exception of pediatrics and family medicine, however, well-delineated policies for maternal and paternal leave do not exist. The American Academy of Pediatrics (AAP) has the most comprehensive and straightforward set of recommendations for parental leave during residency.

"[…] All residents including interns receive the benefits consistent with the Family Medical Leave Act (FMLA) and residency programs should guarantee 6 to 8 weeks, at a minimum, of parental leave with pay after the infant's birth or adoption. Additionally, the resident should be allowed to extend the leave time when necessary by using paid vacation time or leave without pay. […] No loss of training of training status if the leave is not more than 3 months."[9]

The American Academy of Family Physicians (AAFP) also has well-delineated expectations regarding time off, call schedules, and co-resident coverage. Both the AAP and AAFP have clear policies that allow parental leave to include both parents as well as adoption.[9-10]

Emergency medicine has the advantage of natural flexibility, with shift scheduling that can allow for parental leave within residency. Time used for maternity leave can often be made up during residency or by extending residency by one to two months. The Policy Statement from the American College of Emergency Physicians (ACEP) upholds overall principles in regards to family leave time, encompassing both residents and attendings. The policy statement also includes using the time to care for sick family members.[11] The American Board of Emergency Medicine (ABEM) requires emergency medicine residents to complete 46 weeks of training per year in both three-year and four-year training programs.

Continued on next page

ABEM states that no more than six weeks total per academic year can be taken off for vacation, sick leave, etc. without extending the residency training.[12] It is unclear whether or not this time is fixed or flexible. Additionally, this family leave time could vary from program to program in its application. If the current policy is fixed, it may not account for postpartum complications or for family bonding time, which may call for more time in the academic year. For example, a resident could save up vacation time and subsequently do a less time-intensive rotation. Allowing flexibility to take off more time in one year due to pregnancy and less time in other years, as long as the average amount of time off for the duration of the program does not exceed six weeks per year, could help accommodate mothers without reducing total training hours.

How did I survive pregnancy during internship? By not going it alone. I gathered as much support and advice as I could, as early in pregnancy as I could. Program leadership knew exactly what was needed and gave me the flexibility I needed to attend to my growing family and to my needs as a resident. My most demanding and difficult rotations, such as trauma surgery and neurosurgery, were scheduled during my second trimester. Attending physicians and nurses in the ICU often warned me of hazardous or infectious exposures. My program coordinator advised me to save the four weeks of allotted vacation time per year. On the advice of many of those I worked with at the hospital, I took an additional four weeks to heal from a difficult delivery. I was unable to walk, stand, or sit without immense pain for six weeks after delivery. Additionally, my husband has a job that requires a two-hour commute one way, but negotiated to work from home two days a week to help with the baby. I arranged for child care from my mother and postpartum doulas, who did some nanny work overnight. They helped with the late night feeding and diaper changing. I had friends from the hospital, old med school classmates, and my church community to help me with meals and laundry.

The bottom line: I got help early and I understood my limitations. I allowed people to help me. It was not easy to admit that I needed the extra time or the extra help. I felt vulnerable and anxious about how the baby and residency would turn out. The support and flexibility demonstrated by my residency program and the hospital were crucial to my success as a resident physician and a new mother. Knowing I had all this support, flexibility, and help allowed me to become confident as both a new mother and as a new emergency medicine resident.

Special thanks to: Dr. Leila Khaezani, Dr. Michelle Mouri, Dr. Joel Stillings, Dr. Randy Culbertson, Dr. Jeff Baker, Dora Miller, and the nurses and my fellow residents at Desert Regional Medical Center.

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The Elusive Resilient Career in Emergency Medicine

Robert Lam, MD FAAEM
Chair, Wellness Committee

Since taking on the role of Physician Wellness and Burnout Committee chair, I have often been asked, "how do I avoid burnout?" As Dr. Rodgers noted in a recent "President's Message," burnout is prevalent in our specialty. I see individuals who are suffering from burnout in my workplace. I imagine you do too. Because this problem is so complex, there is no single answer or solution. From the literature on the subject we know that the drivers of burnout include excessive workload, inefficient systems with huge clerical burdens, non-physician tasks transferred to the physician, problems with work-life integration, malpractice threats, the risk of infectious disease, violence in the workplace, loss of flexibility and control over work, loss of meaning in work, and organizational objectives that conflict with the altruistic objectives of our profession.[1] One important thing to note is that we will not solve this problem with personal resilience strategies alone. Rather, burnout is a complex, multifactorial, system-based problem that requires both individual and organizational, system-based solutions.

What can we as individuals do to promote our own resilience? The first step is to cast away the stigma of burnout. We have been trained to work harder and longer and never admit we need help. The literature clearly shows burnout is a pervasive problem that starts in medical school, continues in training, and follows us throughout our careers. I encourage you to consider using validated self-assessment inventories like the Maslach or Oldenberg Burnout Inventories to confirm your suspicions of burnout. You can find a link to anonymous web-based inventories on AAEM's wellness website: www.aaem.org/about-aaem/leadership/committees/wellness-committee.

Take advantage of resilience and burnout workshops and activities in your area. However, it is important to recognize that the effect of these activities will fatigue with time. A better approach might include prioritizing regular efforts to prevent burnout, the same way you use continuing education to keep up with the latest scientific advances. Promoting your own wellness and resilience regularly is a key to the prevention of burnout.

What key drivers of burnout can you control? Although we always think we should be highly productive and hard-working, is there a sweet spot in the amount of work you take on in regard to longevity? Can you shift your career to include new directions that add interest? Some suggestions include diving more deeply into your subspecialty interest in emergency medicine, such as wilderness medicine, or taking on an educational task.

Would starting something new outside of work relating to your hobbies or interests refresh your mind? Do you need to take a hard look at the organization you work for? Does it give you the appropriate amount of autonomy and flexibility? Does your workplace reflect AAEM's values of fairness, transparency, and due process?

There are disturbing prevalence studies showing that 45% of physicians in all specialties rank high on burnout inventories. The problem cannot lie solely in the individual. We cannot continue to blame the individual or believe this is a problem that only happens to a few outliers. Burnout is a system problem that requires system-based and organizational solutions, in addition to individual efforts. To this end, the goal of the AAEM Wellness and Burnout Committee is to fight burnout with a comprehensive approach. Our vision is to make the Scientific Assembly a motivational retreat, where our members refresh their passion for our specialty with the Assembly's scientific content, social connections, and a new Wellness Track — as well as new rejuvenating practices like Yoga for Early Risers and an informal Fun Run. AAEM is also participating in a multi-organization summit, to tackle this problem from training to retirement by collaborating, pooling resources, and addressing system-based problems. Finally, AAEM continues to fight for your right to professional autonomy and fairness in the workplace.

> "There is hope for a long and resilient career in emergency medicine, but we have our work cut out for us. I would like to invite you to join us on the Wellness and Burnout Committee, as we begin this journey together."

There is hope for a long and resilient career in emergency medicine, but we have our work cut out for us. I would like to invite you to join us on the Wellness and Burnout Committee, as we begin this journey together.

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Just Say Yes – or No – What Is a Young Physician to Do?

Bob Stuntz, MD RDMS FAAEM
Board of Directors, YPS Director

Saying *no* is not my strong suit — just ask my wife. For as long as she has known me, I have been the poster child for what not to do. When asked to do most anything at work, I usually say *yes*. For instance, as chief resident I remember telling my wife how much I disliked quality assurance meetings. Her response: "Knowing you, you'll be chairing the QA committee one day." Sure enough, I have been our QA committee chair since 2013.

Saying *yes* has actually been an important part of my career as a young physician. I have certainly been busy, but saying *yes* and putting in some extra time at work outside the ED has really allowed me to develop my career. Even chairing my group's QA committee has taught me a great deal about running meetings, being an excellent emergency physician, and dealing with medical error. Being willing to say *yes* to opportunity has also allowed me to serve AAEM, which has led to many wonderful experiences. However, as I near the end of being able to label myself a "young physician," I am finally learning to say *no.* Being a residency program director and the father of two young children, and trying to achieve that mythical "work-life balance," has taught me that I simply cannot say *yes* to everything. So as a young physician, when do you say *yes* and when do you say *no*? I believe this will help guide you.

1. **Set your goals, and be open to opportunity.** Possibly the most important part of a successful career is knowing what you want and what your goals are. Use the last six months of residency and your first six months as an attending to try to answer some questions for yourself. How much money do you need to live, and how quickly do you want to pay off your student loans? Where do you want to live, and what kind of practice environment do you want? What do you want in terms of your lifestyle? What do you want to do with your career in EM? While these goals may change over time, setting goals in the short, medium, and long term will help guide your future decisions.
2. **Get board certified, and learn the ropes.** Each year I tell my residency graduates to spend the first six months at their new jobs studying for their Qualifying Exam, and learning to be an attending. Part of this plan includes saying *no* to the many opportunities you will be offered when you start out. Unless you are self-employed, or flying around the country doing locums work like some of my graduates, you will likely be asked to do something non-clinical in your first few months of practice. Whether it's teaching, sitting on a hospital committee, or making the group schedule, new attendings are often asked to help out. If you have found the right practice, they will fully understand that you need some time to focus on achieving board certification and learning to be an attending.
3. **Find mentors and ask their advice.** One of the great benefits of membership in the AAEM YPS is our mentoring program. As a young physician, you should find mentors locally and nationally who are on a career path similar to the one you desire, and ask what they did. Get as much advice as possible. Having good mentors can make a huge difference early in your career.
4. **Start with** yes**, then say** no **more often.** Much like taking a patient history, we want to start broadly and then narrow our focus. Early in your time after residency, say *yes* more often than *no*. Especially in the short term, be willing to try new things, even if they may not seem totally up your alley. You never know when you might find something that sets you off on a new career path. As you grow in EM and in life, your goals and interests may change. As you gain experience and are able to focus your goals, start saying *no* more often. Only say *yes* to those opportunities that will enrich you personally or professionally, and to which you are truly willing to commit. If you said *yes* to something but find it doesn't interest and enrich you, don't be afraid to back off and find someone else for the job.
5. **Be "all in."** Anyone who has run a committee knows the type. Honestly, we have probably all been that type at one time or another — I know I have — the person who is on the committee in name only, who puts it on their CV but doesn't do any work. If you find that you have overstretched your commitments, don't be afraid to trim some of the excess. Focus on those things that enrich you personally or professionally, and remove the things that do not truly peak your interest.
6. **Re-examine and reset.** As you approach the end of your time as a young physician, re-examine your goals and priorities. If your goals and priorities have changed, make sure you realign your commitments. Look for new mentors who have gone where you want to be. And be a mentor to the next generation of young physicians.

"Being a residency program director and the father of two young children, and trying to achieve that mythical "work-life balance," has taught me that I simply cannot say yes to everything."

While patient care and being an emergency physician are our primary responsibilities, the things we do outside the clinical setting can contribute greatly to career satisfaction and longevity. Hopefully, this will help you decide what to do outside the ED. And as we go into the fall, I strongly urge you to say *yes* to getting involved in AAEM — I promise you will be better for it! ■

AAEM/RSA President's Message

From Chaos to Clarity: Leadership in the Resuscitation Bay

Mary Haas, MD

You are managing a busy emergency department, when you hear via the overhead paging system that a new patient has arrived in your resuscitation bay. You scurry from the farthest corner of your department, where you were evaluating a patient with multiple chronic medical problems and multiple complaints. As you book it to the resuscitation bay, you carry the weight of several sick patients you are managing and the knowledge of several on stretchers waiting to be seen, not to mention the full waiting room. You arrive at the resuscitation bay, where a group of people are bustling around as if a storm is about to hit. You see the ambulance pull up to the doorway with lights flashing. In this moment, as leader of the resuscitation, you have the responsibility to transform chaos into clarity.

As I transition into my senior year of residency, this common scenario challenges me to reflect on and improve my leadership and communication skills. What makes a physician a good leader in the resuscitation bay?

Be calm.

Watching the physicians I most respect and admire in the resuscitation bay, I've realized the number one characteristic of an excellent leader is the ability to remain calm. The leader's attitude and demeanor set the tone for the entire room, and a composed demeanor calms the environment and allows the leader to maintain control of the situation. Remaining calm eases the surge of adrenaline that accompanies the management of a crashing patient, allows one to think clearly and see the big picture, and leads to a safer and better resuscitation.

Along these lines, employing "noise discipline" to keep the room quiet will improve the team's overall ability to focus and communicate. A resuscitation often attracts a crowd; as team leader it is important to ensure that only those who are actively participating in the care of the patient and contributing to the work of the team remain present.

Brief the team.

Having a few minutes after the notification of a critically ill patient's impending arrival, to gather the team and get everyone on the same page, is an opportunity to be seized. This precious time can have a hugely positive impact on the flow and success of a resuscitation. Take this time to introduce all members of the team; clearly delineate roles; prepare for procedures by having the necessary equipment handy; and create a shared mental model of the patient's current status, plan, and anticipated disposition. This time also allows the team to ask questions. It is during this time that I reiterate to my team that we will maintain a calm and quiet environment.

Be clear and decisive.

The team leader's role is to step back and monitor the "big picture," to ensure the appropriate order of interventions and their correct completion. To be an effective leader, it is critical that the physician is clear and decisive when communicating orders to the team. This is where closed loop communication comes into play, allowing the sender to know that the request has been heard and the receiver to clarify and confirm. When asking that something be done, make direct eye contact, state the name of the person you talking to, and be as specific as possible. For instance: "Jim, please place a second large-bore IV" is better than "can someone place a second IV?" Also, when requesting that a medication be administered, make sure to clarify the dosage and route. For instance: "Karen, please give 1 gram of calcium chloride via the femoral line?"

Debrief.

After every resuscitation, make an effort to gather your team and debrief. What went well? What could have gone better? This may only take a few minutes of your time, but will bring you closer with your team and improve future resuscitations. It will also help you grow as a leader and show your team that you care about their feedback. Debriefing can also help the group cope with a difficult outcome.

Ultimately, the best way to improve one's leadership skills in the resuscitation bay is to practice, reflect, and seek feedback. Observing my role models run resuscitations has also helped me to identify and mimic behaviors that lead to better team dynamics and better patient care. For many of us, it was the challenge of caring for the critically ill patient that drew us to emergency medicine. Mastering these skills helps us find satisfaction and meaning in our work. ■

"As I transition into my senior year of residency, this common scenario challenges me to reflect on and improve my leadership and communication skills. What makes a physician a good leader in the resuscitation bay?"

AAMC Standardized Video Interview: What We Need to Consider

Aaron C. Tyagi, MD
AAEM/RSA Social Media Committee

Forward: *Please note that after submission of this article, the Standardized Video Interview Project was put on hold this year for further review by the AAMC. However, its implementation remains expected at a later date.*

The Match is a thrilling prospect, equally exciting and daunting, undertaken by thousands of medical students every year. The countless options, calculations, and gut-feelings only add to the intimidating amount of paperwork and documentation to be completed. From Dean's Letters to Letters of Evaluation to transcripts, tremendous effort is exerted by students hoping to secure an interview at a coveted residency program.

Up to that point, applicants are just names and numbers with a photo attached. It is the interview that allows both applicants and programs to take a serious look at each other. However, the interview itself lasts only minutes and the entire site visit — including pre-interview dinner, tours, etc. — may only be a maximum of 20 hours or so. Some students may have the opportunity to rotate at a select number of programs, which offers a more in-depth look for both applicant and program, but this occurs at only a small percentage of programs at which an individual applicant applies. There are also second-look visits, but these are difficult to arrange both financially and logistically.

There is growing concern that the current process doesn't adequately reveal "the intangibles" and paint a complete picture of the applicant. In an effort to offer programs the chance to get a broader and more holistic view of applicants, the AAMC has proposed and designed a tool called the AAMC Standardized Video Interview.

"There is growing concern that the current process doesn't adequately reveal "the intangibles" and paint a complete picture of the applicant. In an effort to offer programs the chance to get a broader and more holistic view of applicants, the AAMC has proposed and designed a tool called the AAMC Standardized Video Interview."

On the surface, the idea seems promising. Currently in the research phase, the tool is not yet available to programs outside the research project, but it is comprised of two stages.

The first stage is recording video interviews of the applicants. From June 27-August 30, applicants participating in the study will be asked a series of six questions. These six questions will stem from two core ACGME competencies: professionalism and communication/interpersonal skills. The applicants then complete a survey regarding their reactions to the interview, and allow the AAMC access to their video scores for collation and analysis with other AAMC databases. The video software is available through HireVue®, which is essentially a digital recruitment tool.

The second stage involves residency programs. The AAMC will collect records from a small subset of residency programs, allowing it to "explore the psychometric properties of the standardized video interview and any possible relationships between AAMC Standardized Video Interview scores, other selection data, and residency performance." In a nutshell, it will take a look at each applicant's data and longitudinal data on a program and its residents, and attempt to make a "best-fit." The AAMC web page goes into more detail regarding how to volunteer, prepare, and participate in the study.

As I said, this seems like a potentially great tool. However, it does come with concerns. For example, if a program director is reviewing 150-200 applicants every cycle, this could potentially add 1,000 additional minutes to the process.

Another area of concern is the fact that this is a "one-take" deal. The AAMC states, "… there are no re-takes. Each applicant is given one opportunity to respond to each question. Once your response is recorded, you will not have the opportunity to re-record it." They attempt to assuage any concerns by allowing applicants to utilize predetermined practice questions available via the HireVue® website. However, this does not take all variables into account. Based on discussions with both residents and medical students, the concern that this is just another "weed-out" tool that benefits programs more than applicants is real.

One might make the argument that the live interview is also a "one-time deal," so why should the video interview be any different? But the obvious flaw in that logic is that during a live interview there are two live individuals in a room, each with the opportunity to evaluate the other. The video interview is completely one-sided, leaving the interviewee vulnerable to the whims of whoever is evaluating the video.

These are just some of the concerns I believe should be considered in regards to this new and potentially beneficial addition to the Match and the interview process. It is great that we are beginning to acknowledge flaws in the current process, and are attempting to correct them. However, we still have a ways to go and must do so carefully and with constant vigilance. ■

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Resident Journal Review

Fever in Returning Traveler

Authors: Megan Donohue, MD MPH; Phil Magidson, MD MPH; Erica Bates, MD; Adeolu Ogunbodede, MD; Mark Sutherland, MD; Akilesh Honasoge, MD
Editors: Michael C. Bond, MD FAAEM and Kelly Maurelus, MD FAAEM

With increasing frequency of international travel, EMPs often find themselves caring for travelers who return ill. According to the International Society of Travel Medicine global surveillance network, fever was the chief complaint in approximately one third of ill travelers. The care of these patients may be challenging given the broad differential diagnosis that must be considered, including many illnesses that are uncommon in the US. This article provides a review of the literature on the epidemiology of febrile illness in the returning traveler and offers an approach to the initial evaluation, management, and diagnosis.

Wilson ME, Weld LH, Boggild A, et al. Fever in Returned Travelers: Results from the GeoSentinel Surveillance Network for the GeoSentinel Surveillance Network. *Clin Infect Dis.* 2007;44:1560-1568.

Wilson et al., utilized a GeoSentinel database to examine the presentation, etiology, and outcome of febrile returned travelers. Data from 31 travel or tropical medicine clinics on six continents was collected from 1997-2006. Of 24,920 patients reviewed, 6,957 presented with fever as the chief complaint. Most travelers with fever presented within 1 month of their return. Fever was more common among those travelers who visited friends, family, or relatives as business and tourism travelers were more likely to have visited a doctor and received prophylactic treatment or vaccines prior to travel.

Travel-related illness may affect many different organ systems and be caused by diverse pathogens. The most common systems affected were: systemic illnesses (35%), diarrheal illnesses (15%), respiratory (14%), genitourinary (4%), dermatologic (4%), and hepatitides (1%) with 22% unspecified. Malaria accounted for the bulk of systemic illness and 21% of all febrile patients. Uncommon illnesses observed included leptospirosis, amebic liver abscess, and viral meningitis.

Hospitalization was required in 26% of the cohort and 12 patients (0.2%) died. The leading causes of death was malaria (n=4). Other causes of note were acute respiratory distress syndrome (n=2), pulmonary embolism (n=1), acute HIV (n=1), angiostrongyliasis (n=1), and Epstein Barr Virus (n=1). The incidence of death attributed to malaria is particularly concerning given some studies show malaria diagnosis is missed on initial presentation 59% of the time.

Geographic variation of disease is noteworthy. For example, malaria is the most common cause of severe febrile illnesses after travel to sub-Saharan Africa while malaria and dengue are equally common causes after travel to Central or South America. The CDC Yellow Book provides a simple set of maps, tables, and graphical summaries of this data. Given this vast array of tropical illnesses and range of severity, an organized approach to evaluation and workup is needed.

Pigott D. Emergency department evaluation of the febrile traveler. *Journal of Infection* 2007; 54, 1-5.

A screening tool for febrile travelers including travel history, exposure history, fever pattern, and physical exam findings may be useful in developing a differential diagnosis and determine appropriate diagnostic testing. Key points of information are: region of travel including layovers, duration of any prophylaxis, contact with bodies of water, exposure to animals or insects, a food diary, and a sexual history. Many emergent disease processes involve the neurologic and dermatologic systems so complete review of systems with emphasis on these areas may help identify the need for hospitalization.

The skin should be thoroughly examined for any rashes, petechiae, or ecchymoses. Mucous membrane bleeding is often indicative of viral hemorrhagic fevers such as Ebola, Marburg, or Lassa, all of which require special precautions.

Schwartz D. Fever in the Returning Traveler, Part Two: A Methodological Approach to Initial Management. *Wilderness and Environmental Medicine* 2003; 14, 120-130.

Schwartz recommends a thorough laboratory evaluation for the febrile traveler including a CBC with differential, Wright stain, thick and thin peripheral blood smears, chemistries, liver function tests, blood culture, urinalysis, and chest radiograph. The presence of gastrointestinal symptoms should prompt testing of stool for ova and parasites, culture, and fecal leukocytes. While these diagnostic tests often do not establish a definitive diagnosis, they may identify patients who require additional testing or hospitalization. Such additional testing may include lumbar puncture, STD testing, or imaging including possible CT or MRI to examine for parasites. Disease-specific serologies are available for some pathogens but the results are often delayed. Treatment should be initiated pending the results if there is a high clinical suspicion.

Kotlyar S, Rice B. Fever in the Returning Traveler. *Emerg Med Clin N Am* 31 (2013) 927-944.

A definitive diagnosis is never made in up to 30% of travelers who return with fever. For those with a definitive cause, the most common are malaria, dengue, typhoid fever, or a rickettsial disease.

Dengue hemorrhagic fever, meningococcemia, and severe rickettsial infection are the most serious disease processes that should be considered in a returning traveler with fever and rash. As these are potentially deadline diseases, patients clinically suspected of having these should be admitted to the hospital on respiratory and droplet isolation. Treatment should be initiated in conjunction with a thorough workup and not delayed until a definitive diagnosis is made.

Malaria commonly presents with cyclical fever which peaks every 3-4 days, chills, rigors, body aches, nausea, gastrointestinal complaints, and

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malaise. Of the four main species of Plasmodium, patients with P. falciparium may present severely ill with fever, DIC, dehydration, and altered mental status due to cerebral edema. Although malaria is classically diagnosed by blood film analysis, EMPs should be aware that rapid antigen testing exists and may be available in many laboratories. Treatment depends on the severity of illness as well as the region of exposure as resistance patterns vary. An important resource is the CDC 24-hour malaria hotline (855-856-4713) with expert consultation available for specific treatment recommendations.

Dengue fever is a common cause of fever worldwide and an increasing cause of fever in returning travelers, especially in those returning from Southeast Asia. Common signs and symptoms are retro-orbital pain, a lateral gaze, myalgias, and arthralgias. This is classically referred to as "break-bone fever." Rash is often, but not always present. Seen mostly in patients with a history or previous dengue infection, dengue hemorrhagic fever is often deadly. Signs and symptoms suggestive of dengue hemorrhagic fever are thrombocytopenia, easy bleeding or bruising, edema, and effusions. Patients should be admitted to an ICU as even with treatment the mortality is nearly 40%. Other viral hemorrhagic fevers, such as Ebola, are treated similarly with intense supportive care and strict isolation.

Yellow fever is another mosquito-borne cause of fever. Symptoms include fatigue, myalgias, vomiting, abdominal pain, and hepatomegaly. LFTs may be markedly elevated. PCR and serologic tests are available for diagnosis and care is supportive.

Typhoid fever is transmitted fecal-orally by Salmonella typhi and should be considered in patients who traveled in regions with low sanitary standards. Although significant variation exists, the average incubation period is three weeks which is often longer than malaria or dengue fever. Symptoms are non-specific and along with fever may include a variety of gastrointestinal complaints including constipation or diarrhea. Two findings that are more suggestive of typhoid fever include "rose spots" which are small pink macules appearing early in the disease process, and the Faget sign or sphygmothermic dissociation which is relative bradycardia during periods of high fever. Typhoid is diagnosed by blood and stool cultures and results are not immediate. Treatment with a quinolone or third generation cephalosporin should be started pending the results if there is a high clinical suspicion.

Rickettsial infection is also a common cause of fever in returning travelers and, among others, includes Rocky Mountain spotted fever, Mediterranean spotted fever, African tick bite fever, typhus, and Q fever. In addition to fever, common signs and symptoms include malaise, myalgias and arthralgias, diarrhea, rash, and lymphadenopathy. The classic triad of rash, lymphadenitis, and inoculation eschar is seen in less than half of all patients. PCR testing is accurate and generally available. While confirmatory tests are pending, treatment with a tetracycline such as doxycycline should be initiated.

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Schwartz D. Fever in the Returning Traveler, Part One: A Methodological Approach to Initial Evaluation. *Wilderness Medicine* 2003; 14, 24-32.

In this article, Schwartz summarizes less common causes of fever in the returning traveler including those caused by bacteria, parasites, and protozoa. Bacterial causes of febrile illness include leptospirosis, bubonic plague, and brucellosis. Parasitic and protozoal causes of febrile illness include African sleeping sickness, schistosomiasis, and leishmaniasis.

Leptospirosis is caused by a spirochete found in the urine and feces of domestic animals and associated contaminated water. An initial flu-like febrile phase occurs 10-21 days after exposure, followed by a second immune-mediated phase which may involve vasculitis, aseptic meningitis, glomerulonephritis, uveitis, and rarely liver failure with DIC. Early treatment with tetracycline during the initial phase prevents later complications.

Bubonic plague is surprisingly still found in the US and abroad. Presentation is characterized by fever, myalgias, and lymphadenopathy which may evolve into an abscess. Treatments include streptomycin or chloramphenicol.

Brucellosis is caused by a gram-negative organism found in unpasteurized dairy and meat. It causes fever, vomiting, diarrhea, lymphadenopathy, and can cause chronic infection if not treated. Trimethoprim/sulfamethoxazole, doxycycline, streptomycin, or rifampin are recommended therapies.

African sleeping sickness is transmitted via the bite of the tsetse fly, and causes fevers, chills, muscle aches, nausea, vomiting, and headache. A well-circumscribed, 2cm-5cm indurated red chancre commonly occurs during the acute illness. Laboratory findings include anemia, leukopenia, thrombocytopenia, and transaminitis. If the parasite burden is high, the diagnosis can be made through stained peripheral smear. If the parasite burden is low, it can be detected by examination of the buffy coat. Over a period of weeks to months, CNS involvement can manifest as personality changes, movement derangements, dementia, coma, and may result in death. Lumbar puncture must be done to evaluate for CNS involvement, and CSF should be examined for the parasite. Pentamadine is the treatment of choice.

Schistosomiasis is caused by a parasite transmitted by freshwater snails in Southeast Asia and Africa. Snails release larvae into water which then breach intact skin leading to infestation. The presentation may vary but typically includes fever, myalgia, headache, and hepatomegaly. Ectopic egg deposition in any organ such as brain, spine, or kidneys leads to a local immune complex-mediated inflammation. CNS sequelae include headache and symptoms of space-occupying lesions, such as visual field deficits, seizure, and incontinence. Focal neurological deficits should be further examined by emergent MRI and appropriate surgical consultation. Diagnosis of schistosomiasis is made by examination of urine and stool for eggs, serology, or western blot. The CDC can aid in providing these testing modalities. Treatment is praziquantel.

Continued on next page

Leishmaniasis is a protozoan infection transmitted via the bite of the sandfly, which is found in the Middle East, Southern Europe, Africa, and South America. Cutaneous manifestations of the infection may take weeks to months to develop and include a non-healing ulcer with heaped-up margins. Visceral Leishmaniasis, which may be fatal, can take months or years to develop and is characterized by fever, poor appetite, and splenomegaly. Diagnosis is confirmed by biopsy, and treatment varies based on disease severity.

Conclusion

A methodological approach to the evaluation of the febrile traveler is key to making the correct diagnosis and providing proper treatment. While a definitive diagnosis is often not made in the ED, we must maintain a high level of suspicion for potential deadly causes of fever and treat them accordingly. EPs should know the identifiable attributes of each disease process and be aware of available resources at the local and federal level including infectious disease colleagues, institutional disaster management protocols, the CDC Yellow Book, and the CDC 24-hour phone line.

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An Interview with Dr. Dan Girzadas, EM Residency Program Director at Advocate Christ Medical Center

Stephanie Cihlar, MS4
AAEM/RSA Medical Student Council President

Interview season is upon us! Fourth-year students are flying around the country and deciding what they want in a residency program. EM residencies vary widely in terms of their length, setting, structure, acuity, and culture. The process of sorting through the characteristics of each program can be daunting, but is critically important to finding the right fit. As I make these tough decisions for myself, I find it helpful to talk to program directors and residents about themselves and their programs. I recently rotated at Advocate Christ Medical Center in Oak Lawn, Illinois, and the program director, Dan Girzadas, MD RDMS FAAEM, graciously agreed to join me for an interview.

SC: Tell me about your current position and what you do.

Dr. Girzadas: I am the EM Residency Program Director at Advocate Christ Medical Center. I am fortunate to lead a team of dedicated faculty members who train outstanding emergency physicians, who can take care of any patient who walks into an emergency department with an injury, illness, pain, or other health or social concern. As program director I also want to make sure our residents feel supported and have the opportunity to reach whatever goal they set for themselves after residency.

SC: Where are you from and where did you get your training?

Dr. Girzadas: I actually was born here at Advocate Christ Medical Center. I worked as an orderly (now called ED tech) here in high school and college and did my EM residency training here.

SC: What about Emergency Medicine attracted you to the specialty?

Dr. Girzadas: I always wanted to be that old-school "country doc" that could take care of any problem a patient presented with.

SC: How long have your been involved in resident education?

Dr. Girzadas: Since 1992.

SC: What is the most rewarding part about being a Program Director?

Dr. Girzadas: Seeing graduates thrive in their fellowships, jobs, and leadership roles after residency.

SC: Are there things that you would change about your job as Program Director?

Dr. Girzadas: No, not really. It's challenging, rewarding, and I think there's no way to take out the tough parts.

SC: What factors should fourth-year medical students be considering when applying and ranking EM residency programs?

Dr. Girzadas: Every program has its strengths and weaknesses. So to me, I think they should ask themselves, which programs get them excited and enthusiastic about being there for three or four years? Are they a good fit with the people and culture at that program. If they have a significant other, will that person also be happy and excited to be there?

Dan Girzadas, MD RDMS FAAEM

SC: What qualities do you look for in an applicant?

Dr. Girzadas: First of all, have they demonstrated that they have the interpersonal skills to get along with others in a stressful environment? If they have that ability and have demonstrated smarts, medical knowledge, and skill, we then know we need to interview them to see if they are a "fit" for our program.

SC: What are common mistakes that applicants make when applying for an EM residency?

Dr. Girzadas: I think students are pretty savvy about applying to programs, so I don't see a lot of mistakes. My only suggestion in general is to bring enthusiasm to every interview. That's the best way to sell yourself.

SC: What does your program offer that is different from other programs?

Dr. Girzadas: We promote the Advocate Christ Medical Center EM residency program as a high-acuity, intense clinical environment where you will work hard but gain a lot of EM experience. We provide opportunities for residents to tailor their experience here to reach any after-residency goals they have set for themselves. We balance all that with supportive residency leadership and a family-type atmosphere among the faculty and residents.

SC: If you could give one piece of advice to interested applicants, what would it be?

Dr. Girzadas: You made a great choice by choosing EM! It is not an easy road but you will be able to make a difference in the world every day. You will work with outstanding, caring people your entire career. You will be rewarded in many ways. Your greatest reward however, will be using your mind and skills to care for others.

SC: I would like to thank Dr. Girzadas for his time and participation in this article. Good luck to the applicants of the class of 2017! ■

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